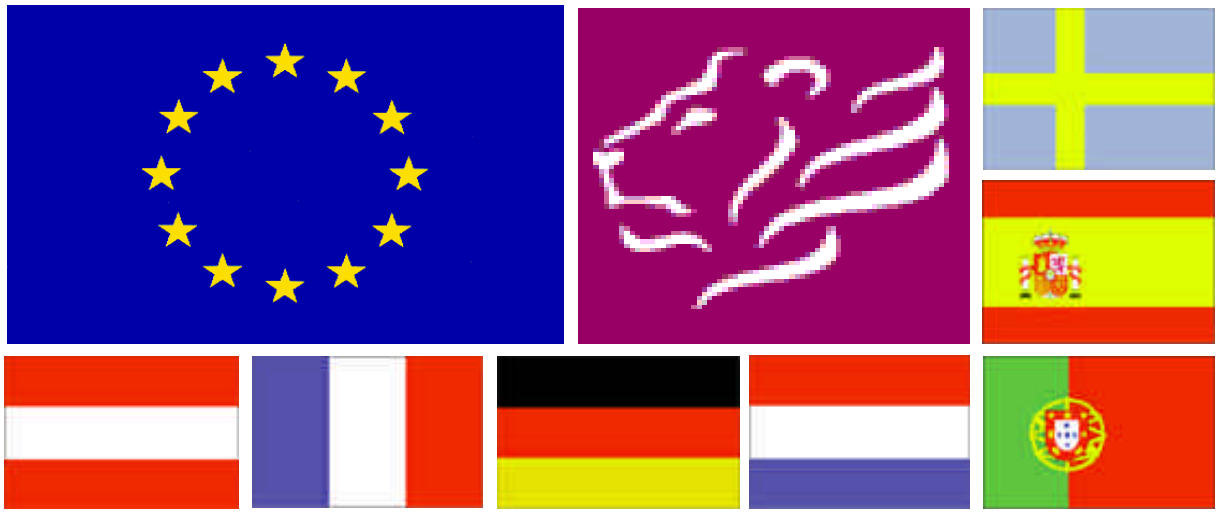
Major Project on Disaster Medicine

Final Report and Action Plan



Struck by a large-scale accident or disaster, people living or travelling in the European Union Member States should receive the same high quality medical care

The Hague, February 2000

Major Project on Disaster Medicine

Final Report and Action Plan

February 2000

Contents

Major Project on Disaster Medicine
in the context of the Community Action Programme
in the field of Civil Protection

Final Report and Action Plan

February 2000

Introduction

The major project on Disaster Medicine was launched in the context of the Community Action Programme in the field of Civil Protection (1998-1999). The project is co-ordinated by the Netherlands Ministry of the Interior and Kingdom Relations and a core group comprising Austria, France, Germany, Portugal, Spain and Sweden. This report reviews the project for the period 1998-1999 and contains the proposed Action Plan for the period 2000-2002.

Review of the Pilot Project

Initial Objectives of the Disaster Medicine Project

The objectives of the Disaster Medicine Project were determined as follows:

- the networking of specialists and structures of the Union in the field of Disaster Medicine (via an internet site) in order to stimulate and support co-operation in case of major accidents (points of contact, inventory of bilateral and trans-border agreements, definitions of methods used to evaluate performance and quality, etc.);
- definition of a common training programme for trainers in the field of Disaster Medicine to be proposed at European level;
- the establishment of guidelines for the practical implementation of psychosocial support actions for rescue workers and victims as well as for families and other non-victims present in an accident;
- the establishment of an action plan for future actions in this field.

Activities

In order to reach the objectives, several activities have been organised in the context of the major project by member states. Representatives of all member states were invited to attend all these activities. In parallel the Core Group held 5 meetings and discussed several aspects and problems linked with the development of a European dimension in the field of Disaster Medicine.

Completed activities:

- "Workshop on Disaster Relief Medicine". A ***survey*** followed by a ***workshop*** to identify Disaster Medicine structures, definitions and sociological, psychological, legal and

financial aspects of Disaster Medicine (10-12 February 1999, Nainville les Roches, France, at the Institut National d'Etudes de la Sécurité Civile).

- "Preparatory meeting for the pilot course for teachers and instructors in Disaster Medicine". A ***workshop*** on the analysis of training needs in the field of Disaster Medicine (6-9 April 1999, Linköping, Sweden, at the University of Linköping).
- "Preparing emergency executives and professionals to handle the psychosocial dimension of disaster". A ***workshop*** on preparing rescue-workers of civil protection on facing the psycho-social dimension of disasters (20-21 May 1999, Arras and Lille, France at the Service Departmental d'Incendie).
- Four ***workshops*** in the context of the "International Conference on Disaster Management and Medical Relief". A ***conference*** on the organisation of public health response systems in emergency situations, operational chances and restraints in Disaster Medicine, and managing the psycho-social aftermath of collective emergency situations (14-16 June 1999, Amsterdam, the Netherlands, organised by the Ministry of the Interior and Kingdom Relations).
- "Catastrophe medicine course international module". A ***workshop*** on medico-sanitary aspects of disasters (21-25 June 1999, Madrid, Spain, at the Escuela Nacional de la Proteccion Civil).
- "National Training Programme of Medical Assistance and Disaster Management". A large scale ***exercise*** with three scenarios in which the medical chain was practised (3-5 September 1999, Chalon sur Saône , France, organised by the Institut National d'Etudes de la Sécurité Civile and the Fire Brigade of Saône et Loire, France).
- "Pilot EU-course in Disaster Medicine" A pilot course for trainers in Disaster Medicine (18-22 October 1999, Linköping, Sweden at the University of Linköping).

Planned activities:

- "Workshop on Psycho-social acute care in the event of a crisis (e.g. an extraordinary incident, accident or disaster)". A workshop on the participation of voluntary teams to ensure the psychological assistance for victims' family members in an accident area. (22-24 May 2000, Vienna, Austria, organised by the Unit for Civil Protection, Crisis Management and Security of the City of Vienna)

Brief structured reports of all the completed activities are annexed.

Conclusions

Please note that this chapter is drawn from the Core Group meetings and the conclusions of the workshops conducted so far.

Objective I: The networking of specialists and structures of the Union in the field of Disaster Medicine (via an internet site) in order to stimulate and support co-operation in case of major accidents (points of contact, inventory of bilateral and trans-border agreements, definitions of methods used to evaluate performance and quality, etc.)

This objective has been partially achieved through the organisation of the above mentioned activities. Participants in the workshops were identified per member state and this was the first step towards the establishment of the network. A pilot internet site based on the CIRCA generic tool has been established including all the workshop participants with an e-mail address. The opening and full exploitation of the site is foreseen in the context of the next phase of the Major Project. In fact working with national and international counterparts, it appeared very quickly that firm networks of high-level experts focusing on medical, organisational and psycho-social aspects of Disaster Medicine are scarce or not at hand. Thus a strong network in Europe will provide a solid base for effective cooperation, and facilitate the development of new programmes in the future.

<u>However the following Challenges were identified in the context of the major project</u>:

<u>Cooperation</u>
Emergency medical care is to be seen as a public task. Actual practice has shown that emergency situations are much better handled and managed when a multi-disciplinary approach is chosen. To improve and optimise emergency care and disaster relief, a broad based consensus for all services and actors involved is needed. The national organisations for medical aid determine the shape and function of large scale medical aid organisations. Interdisciplinary cooperation is not a second nature of relief organisations, nevertheless lessons learned show the beneficial effects. Compatibility and operability of medical care and its organisational aspects, have not created a European supported strategy on this issue.

The major concern in the organisation of disaster medicine is to improve the quality of the care given to the victims.

- Ample medical presence is available at all the levels of disaster management (even if this availability is not considered equally according to the different countries)
- The medical influence has obliged to evolve the practice on all the levels of the organisation of the rescue.
- This influence depends at the same time on the progress accomplished by medical science in the field of resuscitation and feedback.
- The “fatality” concept is strongly fought about in the European Union countries. But it creates problems of an ethic nature and of adapting of behaviour when these countries have to interfere in missions outside the European Union.
- The representations (of a psycho-social kind) of catastrophes or disasters or calamities differ in the various countries. The same words do not cover the same concepts.
- The criteria to define these notions differ in the various countries:
  - the size of the catastrophe
  - the number of casualties
  - the disproportion between lack of means and importance of needs
  - the consideration of a real psycho-social trauma

The INESC study showed variations in the systems of command. The relations between the operational and decision making hierarchy are not situated at the same level. The location of the medical hierarchy varies per country, whether the criterion is the organisation (locally, regionally, nationally), or it has to do with the location of the doctors, specialised in disaster medicine or not, in the chain of care.

Terminology

Lack of uniformity in terminology is an obstacle for international communication, cooperation, consensus and therefore progress in the field of disaster medicine. The number of terms that are used within and between countries is utterly confusing. Cross border assistance between member states is hindered by this terminology gap, other problems occur in the field of communication and education. A substantial first step has been achieved in the context of the French workshop and exercise and a first version of a multilingual dictionnary has been compiled with the association of the term to the description of the different phases of the Chain of Emergency Relief.

Quality of Disaster Medicine

There is no global system available to collect data for auditing the quality of medical care in large scale emergency situations. Assessing trauma severity and analysing trauma related data is a good way of measuring the quality and effectiveness of behaviour, performance, care and assistance. Statistics will play an increasingly important role in auditing performances, therefore auditing standards should be set up and data should be collected, registered, processed and evaluated. The results can be used, subsequently, as a basis for the development of refined national policies, legislation, professional standards, medical protocols etc.

- Medical statistics will, therefore, increasingly, play a more important role in auditing the performance of medical care in emergency situations
- It is apparent that quality of treatment and speed of treatment are preconditions for optimising the “golden hour”-concept; time is of course a critical factor in patient survival and recovery
- The chain management offers perspectives and solutions for the scarcity of medical care, intrinsic time-related problems in medical care and interdisciplinary cooperation to enlarge the effect of medical care. But, every chain has a weaker part: until now it seems to be found within (parts of) the medical organisations itself.
- The society demands the same high quality of medical care irrespective of who is the care provider, civilian or military. This means that the same standards should apply in both systems.

Organisation and processes

The role of Disaster Medicine professionals has historically developed in different directions in various countries, which has lead to the realisation of various Disaster Medicine Systems. Organisational structures differ largely and are very difficult to compare. By focusing on the underlying processes in Disaster Medicine, a clear analysis of functions can be made, strongly contributing to cooperation at all levels of Disaster Medicine.
Determining the role of specialised doctors, with a post-academic diploma in Disaster Medicine, is not a common policy in all member states. Certain major life saving actions are practised by different actors due to legal and educational restrictions. Main conclusion is that most of the actors mentioned cannot be superposed from one country to another. The quality of service and mutual recognition of qualifications may play an important role in this area.

The need for a “systematic” analysis of catastrophes with the use of the notions of “processes” and “critical thresholds” is not felt the same way by all. According to some countries, the reaction to a major violation of public order demands only reinforcement of the already existing means. For other countries, the rupture in normal behaviour provoked by a major

violation of public safety demands a fast change in the way of thinking about the event and the composition of responses.

It is possible to determine three major categories of organisations:
- the organisation of the rescue is predominant and the management of care is centred in hospitals. This evokes the problem of the rapidity of the interventions and the organisation of the evacuation, especially for the victims most in need of assistance.
- the organisation focused on a permanent evaluation of needs, both on the care as well as the rescue without central steering. This evokes the problem of real co-ordination.
- the organisation is centred on the management of care, which evokes the problem of precise medical triage based on available hospitals and medicalised transports.

Cross-border assistance

Cross-border assistance in large scale situations should be requested and provided in complete "medical chains" in order to avoid problems with command, control and communications (use of radio frequencies, legal limitations, chain of command, restricted responsibilities, language and terminology related difficulties). Output performance indicators per chain will optimise planning in these circumstances. These indicators are not yet available.

- The number of categories of actors varies with the countries (due to the size, the education and training system, evaluation and feedback.)
- The actors cannot be superposed from one country to another
- Certain life saving gestures (such as handling an IV) could be practised by different actors, according to their country. It would be difficult to determine them on the site, in case of a border crossing major accident.

Objective II: Definition of common training programme for trainers in the field of disaster medicine to be proposed at European level.

This objective has been achieved through the organisation of the two workshops in Linköping, Sweden. The main conclusion of this activity has been that the proposed Swedish methodology should be expanded and adapted to different risks and environments.

In this context it was also established that different educational systems are used to achieve a certain quality-level for Disaster Medicine specialists. There is a definite need for training and education in Disaster Medicine, however, those programmes for education and training existing today are insufficiently available in many places. Centres with, as part of their curricula, a particular focus on Disaster Medicine should exist in all European countries. The concept for training-of-trainers as developed by the Swedish authorities, which is based on simulation exercises, is already widely supported, and could serve as a model for Disaster Medicine Training in Europe. By using common training systems for professionals with similar tasks in Disaster Situations, cross-border assistance is strongly facilitated.
These various ways of compiling the means of disaster management generate different styles of education and training, from specialised education and training of doctors that are specialists already, charged with forming their "own" rescue teams, up to "crash courses" for all kinds of actors who deal with taking care of the victims of a catastrophe. Several countries of the European Union find themselves between these two extremes.

A model for education and training in disaster medicine was presented at the Linköping course, based on previous experiences from and development of national and international courses, including the WHO diploma course in disaster medicine. All delegates had the opportunity to actively participate in the model.

- Single parts of the model (for example the part dealing with hazardous material) should be modified towards more problem-based interactivity in accordance with the rest of the course
- The simulation exercises where considered very valuable and recommended as the proper tool for effective promotion of knowledge and accurate training. Of special value was considered the simplicity and realism of the model (realistic times, realistic resources, and effects of different decisions clearly illustrated).
- The delegates considered the model possible to apply in all member states represented in the pilot course and easily adjustable to any organisation. The French delegates anticipated some partly political problems in introduction of an educational model from another country, but still considered the model suitable after adjustment to the local organisations.
- There is a need for training and education in disaster medicine, and those today existing programmes for education and training in many places are insufficient.
- Specialised centres for disaster medicine should be established in all European countries
- Centralised training of teachers and instructors should be started as soon as possible.

The recommendation from the participating delegates was that the model used during the pilot course, with some modifications and with adjustment to the local organisations, would be very suitable as a training model. Teachers and instructors could be trained in centralised training centres in the different countries.

To build up such an organisation, it is suggested, that 3-4 more courses should be run as soon as possible, using the existing facilities, so that a staff of trained instructors should be available in the different countries to be able to start the programmes described above.

The curriculum defining the minimum level for theoretical knowledge and practical skill, produced by the International Society of Disaster Medicine, should be revised and adapted to the European countries, which could be done by a working group from the European countries appointed by the core-group.

Objective III: The establishment of guidelines for the practical implementation of psychosocial support actions for rescue workers and victims as well as for families and other non-victims present in an accident.

This objective has been partially achieved. Activities in the field of psycho-social care indicated the necessity to create basic guidelines for the European Community. The discipline of psycho-social care is a professional field which is recognised as indissoluble connected to Disaster Management and as such should be incorporated in all plans and activities related to disasters. The “Statements of Amsterdam” show great involvement of specialists in psycho-social care to create a European forum in the context of official Disaster Management structures where specialists can meet, provide training and methodological guidance on the use of models for psycho-social disaster management.

- Limiting the field strictly to disaster situations make no sense at all where preparing the professionals is concerned. One cannot expect to provide efficient and durable preparation for professionals to handle highly unusual and diversified events (disasters) without preparing them to cope efficiently with daily situations - in an emergency, procedures carried out on a daily basis will be followed successfully.
- It is important to remember that the main goal of crisis management, in particular where the psychosocial dimension is concerned, is the return to "normal" for the persons affected.
- The importance of the implicaton of executives is underlined as a key dimension for the implementation and perpetuation of training programs geared at developing efficient psychosocial support for victims and professionals alike.
- The awareness of rescuers (theory, group workshops, ..) in the manifestations and mechanisms of stress, the behaviour and reactions of the victims (which can include professionals), available victim support facilities, attitudes to be avoided with victims must be improved.
- Rescue personnel need more practical training (simulations, event analysis).
- Specialised professionals must improv their awareness of stress of victims and professionals involved, the consequences of Post Traumatic Stress Disorder (PTSD), and means to prevent it.
- Training in communication, listening, helping, defusing, debriefing, managing stress.
- Psycho-social needs in major accidents and disasters should be recognised and psycho-social support be provided as a right for all those who may be affected (from direct victims to rescue workers, etc.) in all phases of disasters and in the longer term aftermath of disasters.
- Psycho-social multilevel programs using educational systems should be promoted as a proactive component of effective disaster management.
- There is a basic need to develop practical tools - qualitative and quantitative indicators - for monitoring and evaluating psycho-social interventions and their process in psycho-social disaster management should be created.
- A European forum where specialists in psycho-social work in disasters can meet and provide training and methodological guidance on the use of adequate models for psycho-social disaster management.

The second part concerning the victims, members of their family and other non-victims present in an accident is expected to be completed in the Vienna workshop in May 2000.

Objective IV: The establishment of an action plan for future actions in this field.

The following section contains a policy view on the action programme for the next two and a half years (2000-2002) to be implemented in the context of the new Community Action Programme in the field of Civil Protection (2000-2004).

Major Project on Disaster Medicine 2000-2002

Mission Statement

European society expands apace in all its facets. Industrial and urban complexes are burgeoning in all member states. In turn this generates specific requirements in terms of production and logistics in industry, and for the every-day transportation needs of the people of the EU. Taken as a whole, this spells higher risks, including the chance of being involved in a major accident or disaster.
This upward risk factor will impinge on economic growth and could well increase the number of victims with severe injuries – physical, psychological or both – with the likelihood of permanent disability, plus secondary victims, including families. This will entail a high overall cost for EU-economies, its people and its overall social environment.

Self-evidently, Civil Protection has a role in ensuring safety for the people of Europe. And, alongside fire fighting, rescue, emergency alarms, marine pollution measures etc, disaster medicine is a key component here.
While all EU citizens (are entitled to) expect quality of protection and care, there are significant differences in risks, geographic and demographic factors between member states. Fortunately, there are also substantial commonalities.

The member states have made great efforts to establish an acceptable level of preparation to counteract major accidents and disasters. Hence, there are ample opportunities for mutual sharing and learning and for the evolution of common, accepted practices.

Indicators, like the EU barometer confirm that free movement of persons within the Union will raise safety expectations by business or leisure travellers. On a Union-wide level the Disaster Medicine programme can help reduce national differences in the organisation, quality and availability of help. The EU "112 programme" is a good example of how national differences can be bridged. The Disaster Medicine programme cannot and will not generate immediately visible results for the general public. Instead, it will focus on relevant policy makers and experts, while seeking to influence the longer-term quality of Disaster Medicine. As a European initiative it will bridge the gap between national interests.

Complexity of Disaster Medicine, plus the diversity of the national policies rule out short-termism in solutions. Notwithstanding, we see clear potential for boosting mutual knowledge exchanges and networking. (It is imperative that the networks also include the various national authorities, umbrella organisations and policy makers in the Union.)
Together, the contacts and the sharing will yield concrete measures for practical application at the regional and national levels, while levering convergence in practices and methods.

Long term goal of the Disaster Medicine project:

"Struck by a large-scale accident or disaster, people living or travelling in European Union Member States should receive the same high quality medical care"

Aims of the Major Project on Disaster Medicine 2000-2002

Disaster Medicine is a broad field of interests. Hence, we propose that the Programme 2000-2002 will focus on these three key items:

- cross-border mutual assistance between member states
- psycho-social care
- preparation for major accidents and disasters

In practice, policy papers and guidelines for publication and information dissemination will be developed around these core items.
The topics to be clarified in cross-border assistance will include common nomenclature, legal restrictions on personnel and equipment, communications, training needs, common badging of emergency personnel, and expectations on the quality of the assistance. Practical exercises will help analyse the problems of cross-border actions.
Subjects treated around preparations for major accidents and disasters will include development of performance indicators, quality of care, management of the medical chain and the development of scenarios.
Meanwhile, efforts focused on psychosocial care must help generate a professional network of experts - and a European guideline covering the organisation of this area.

With an eye to workable, pragmatic outcomes, the Major Project on Disaster Medicine will establish a small, centralised working party; this will be tasked with producing policy papers, policy reports and proposals for further activities. The working party will make maximum use of expertise in the Core Group and among the available groups of experts. For considerations of efficiency there will be fewer workshops and exchanges than under the previous action plan. At the same time, the use of expertise of member states will be maximised. In dissemination of information the working parties will use advanced techniques like the Disaster Medicine domain on the EU/Circa system. The Netherlands has offered to organise a working party and to co-ordinate the work of the Disaster Medicine project.

It is our considered opinion that by focusing on the three items above, the project will both promote national policies in Disaster Medicine, and enhance community policy for a safer Europe.

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In the first Core Group meeting a working plan for the planning period 2000-2002 will be developed on the basis of the mission statement. Prority will be given to the three key items:

- cross-border mutual assistance between member states
- psycho-social care
- preparation for major accidents and disasters

This working plan, together with proposals for further activities from the member states, will be submitted for the June meeting of the MCCP.

General Conclusions and Recommendations

In 1999 and in the context of the major project, much progress has been made in key areas of Disaster Medicine. The workshops have contributed to a deepened insight in the problems encountered during Disaster Medicine operations, have opened discussions focused on the use of many different Disaster Medicine systems, and have lead to international attention given to difficulties confronted with in triage procedures, bottlenecks and opportunities in training and exercise, psycho-social care and many other subjects.

The Core Group succeeded in reaching its primary goal to identify the main areas of development in the field of Disaster Medicine. The large high-level response of all member states and the vitality of the discussions indicate that Disaster Medicine is an essential field and a lot more work must be done in the near future. The network of high-level experts is eager to continue their work that will lead to concrete solutions of severe problems that may cost lives of European citizens.

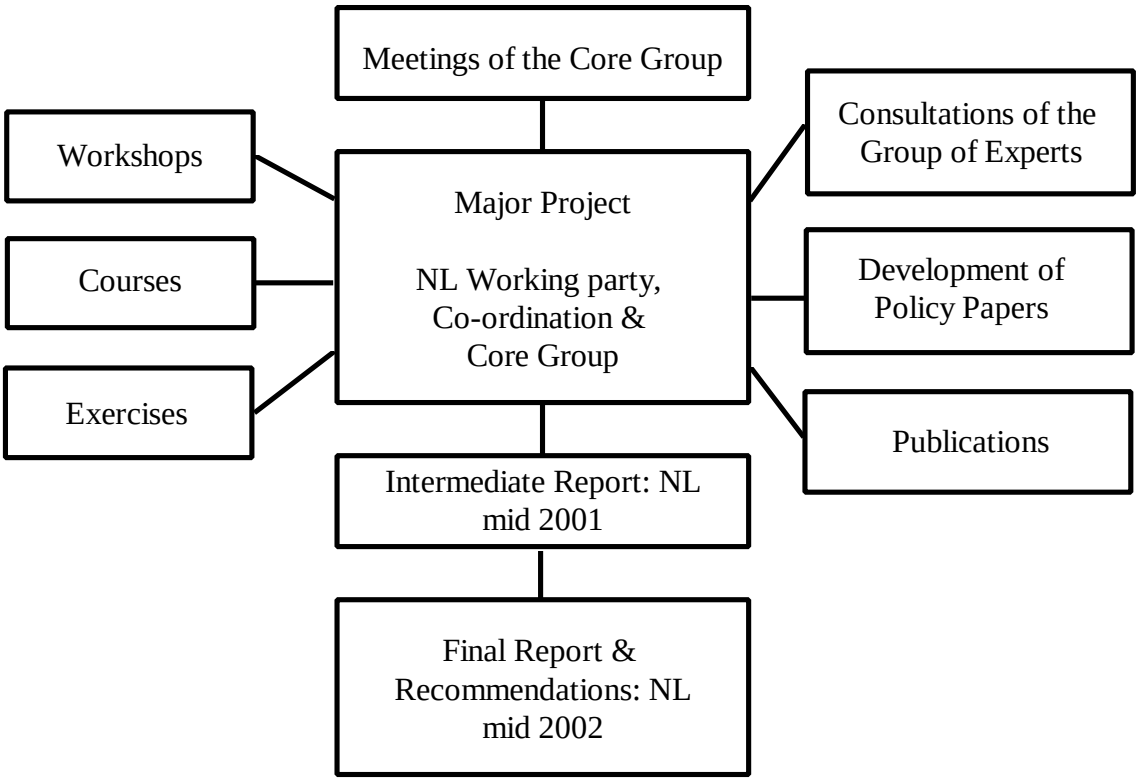
The outcome of the workshops confirmed the Core Group's opinion that Disaster Medicine plays a meaningful role as one of the key entities of civil protection. Based on the basic principles of regular health care and in most cases using existing means and infrastructure, Disaster Medicine plays a vital role in saving lives in case of a major accident or disaster.

Considering Disaster Medicine being based on regular health care, the topics in the Intermediate Report and Action Programme are merely focused on the organisational aspects of Disaster Medicine. Issues related to the medical treatment of victims are covered by Health Programmes and thus neither is nor will be an item of the Disaster Medicine Action Plan.

Disaster Medicine systems demand a multi-disciplinary approach, and therefore need national coordination and communication involving all organisations. The key for success in the working area of the Disaster Medicine project is to stimulate this process. Significant questions aimed at the multi-disciplinary approach, the principle of chain management, quality management, information exchange and a continuous cycle of lessons learned are ahead of us.

To complete the activities in the field of Disaster Medicine new proposals are developed by the member states on the basis of experiences gained in the first phase of the project. By its contents and its process the Disaster Medicine project contributes to the formation of national policies, keeping in mind that the development of a policy in Disaster Medicine is seen as a responsibility of national authorities.

Disaster Medicine Project Architecture 2000-2002



Annex A

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of the Core Group on Disaster Medicine

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Annex B

Country Reports

Austria
France
The Netherlands
Sweden

Country Report Austria

Report of the Austrian pilot – project on "Disaster-Medicine"
Part I

Workshop on "Psycho-social Acute Care in the Event of a Crisis (e.g. an extraordinary incident, accident or disaster)"

❖ Product Evaluation

➢ Outline of the activity

- In recent years, more attention has been accorded to the psycho-social care of emergency service workers – briefing and debriefing – as well as to the psycho-social acute care of victims of accidents and disasters, and the appropriate interfaces for debriefing measures.

  In July 1999, the City of Vienna concluded a project on "Psycho-Social Acute Care in the Event of a Crisis " and made response teams available for such incidents. In this context, EU-wide co-operation is clearly to be aspired. The workshop to be held in Vienna from 22-24 May 2000 represents a first step in this direction.

➢ General and operational aims

- General aim is the development and the presentation of the "Vienna Manifesto on Psycho-Social Acute Care in the Event of a Crisis", which constitutes the most important output of the intended workshop. The Manifesto will include a plan for the design and institutionalisation of a network of experts as one of the operational aims.

- A questionnaire relating to the theme will be sent out in advance of the workshop. The responses will be evaluated and summarised and will constitute further input for the "Vienna Manifesto".

- Another outcome of the workshop will be a more detailed outline of further steps to be taken within the project.

➢ Target groups

- Institutions/Organisations/NGO's concerned with psycho-social acute care on a national and on an international level

- **Main outcomes**

  - The "Vienna Manifesto" including guidelines for training, preparation and organisation as well as a description of the scientific background
  - A concrete plan for a network of experts exchanging information, news and developments and the first step to set up this network
  - Further steps of the project

- **Proposition for further activities**

  - The proposed project for a task group "Psycho-social care" under the umbrella of the Core-Group "Disaster-Medicine" seems to be a very acceptable way to get an overview about the whole subject. By the Austrian project some guidelines for the issue "acute care" can be developed which are to be discussed. The organisers of this project are looking forward to participating in this task-group and to bring in their results.

Report of the Austrian pilot – project on "Disaster-Medicine"
Part II

Workshop on "Psycho-social Acute Care in the Event of a Crisis (e.g. an extraordinary incident, accident or disaster)"

❖ Process evaluation

- **Full description of the activity**
  - See enclosure
- **Number of participants; participating countries**
  - Approximately 75 participants coming from all EU-member states
- **Organisations involved (on national level)**
  - Chief Executive Office for Rapid Relief and Aid Programmes of the City of Vienna – Unit for Civil Protection, Crisis Management and Security
  - An informal committee for preparation and organisation of the project as well as for scientific researches
  - Federal Ministry of the Interior
  - A national task group "Psycho-social care" chaired by the Viennese Unit for Civil Protection, Crisis Management and Security; participants are representatives of all Austrian governmental and voluntary organisations dealing with problems of psycho-social care
  - (Federal Ministry of Health)
- **Working methods**
  - A moderator will lead through the entire workshop. He/she will be responsible for the smooth running of the programme, the co-ordination of the content and a summary of the results. A concrete, official summary of results will be presented at the end of the workshop.
  - A questionnaire relating to the theme will be sent out in advance of the workshop. The responses will be evaluated and summarised and will constitute further input for the "Vienna Manifesto".

- **Point of contact**

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- **Evaluation of the working process**

  - By the informal committee for preparation and organisation of the project as well as for scientific researches

- **Embedding of the activity in national activities and organisations**

  - By the national task group ”Psycho-social care” chaired by the Viennese Unit for Civil Protection, Crisis Management and Security; participants are representatives of all Austrian governmental and voluntary organisations dealing with problems of psycho-social care

- **Feedback to national policy**

  - Hopefully by the outcomes of the ”Vienna Manifesto”

- **Recommendations for further activities**

  - The proposed project for a task group ”Psycho-social care” under the umbrella of the Core-Group ”Disaster-Medicine” seems to be a very acceptable way to get an overview about the whole subject.
  - The ”Vienna Manifesto” as an input on an European level to be developed by the participating countries
  - Organisation of a permanent network of experts with one country (organisation/person) as the focus and the ”motor” of the activity
  - An international congress organised as a meeting of experts exchanging information and presenting new developments – could be one result of the work of the task group ”Psycho-social care”

Enclosure

Workshop on "Psycho-social Acute Care in the Event of a Crisis (e.g. an extraordinary incident, accident or disaster)"

In recent years, more attention has been accorded to the psycho-social care of emergency service workers – briefing and debriefing – as well as to the psycho-social acute care of victims of accidents and disasters, and the appropriate interfaces for debriefing measures.

In July 1999, the City of Vienna concluded a project on "Psycho-Social Acute Care in the Event of a Crisis " and made response teams available for such incidents. In this context, EU-wide co-operation is clearly to be aspired. The workshop to be held in Vienna from 22-24 May 2000 represents a first step in this direction.

In order to obtain the results specified under "general objectives" and "expected results", the organisers suggest the following structure:

Day one of the workshop will start, after the official welcome, with an introductory paper on the topic of "Major incidents and their dramatic consequences from the perspective of a journalist". Subsequently, an internationally recognised expert in psycho-traumatology will present the keynote address relating to the theme of the workshop. The organisers have asked Professor Rolf J. Kleber (University of Tilburg, Netherlands) to act as speaker.

On the first afternoon, participants will report on pertinent existing structures and experiences.

Day two will be devoted to the preparation of the "Vienna Manifesto" in four parallel task groups (TGs):

TG 1:	Intervention and response structures (intra- and inter-institutional management)
TG 2:	Psycho-social acute care (tasks, limits, possibilities, resources)
TG 3:	Initial and further training of psycho-social acute-care workers (didactics, quality assurance)
TG 4:	"Promotion" – Furthering co-operation at the national and international levels

The work of each task group will be guided by a moderator, a scientific consultant and a rapporteur.

Day three will open with two input papers on topics relating to the theme of the workshop:

- Aspects of psycho-social briefing and debriefing of emergency workers - didactics and training.
- Connections between psycho-social acute care and long-term follow up care.

These two papers are to be presented by two people from the participating countries with pertinent experiences in emergency service work.

The second part of the morning will be devoted to the presentation of the results of the TGs: reports by the rapporteurs and discussion in the plenary.

The workshop will be concluded by the presentation of the "Vienna Manifesto on Psycho-Social Acute Care in the Event of a Crisis", which constitutes the most important output of the intended workshop. The Manifesto will include a plan for the design and institutionalisation of a network of experts.

A further outcome of the workshop will be a more detailed outline of further steps to be taken within the project.

A moderator will lead through the entire workshop. He/she will be responsible for the smooth running of the programme, the co-ordination of the content and a summary of the results. A concrete, official summary of results will be presented at the end of the workshop.

A questionnaire relating to the theme will be sent out in advance of the workshop. The responses will be evaluated and summarised and will constitute further input for the "Vienna Manifesto".

In the opinion of the organisers and scientists involved in the project, this workshop can only represent a first step within a more comprehensive master project.

Country Report France

REPORT PILOT PROJECT "DISASTER MEDICINE"
The participation of INESC

A/ EVALUATION OF THE PRODUCT

1. The activity in general

The French participation, realised by INESC, the National Institute for Civil Protection Studies, was twofold:
- organising a self tuition workshop at Nainville-les-Roches from 9 to 12 February 1999,
- participating at an operational exercise at Chalon-sur-Saône on 3 and 4 September 1999.

2. Description of the general and operational goals of the activity

2.1 The self tuition workshop of February was supposed to set off and hold a debate in order to make an inventory of the various methods and practices in the field of disaster medicine used by the rescue services in the countries which are member of the European Union, aiming at harmonising the existing training in Europe.

2.2 The exercise which was organised at Chalon on September 4 was intended to make visible, in full size:
- the performance of the medical rescue chain in France, in the case of a catastrophe,
- the organisation of medical training, in France, in the field of disaster medicine.

3. The target groups

3.1 Self tuition workshop of February
- doctors specialised in emergency care
- national and locals authorities in charge of disaster management
- fire service officers
- responsibles of associations or professions that are implied in rescue operations in case of a catastrophe.

Police responsibles are considered member of the target group as well, but no country considered it necessary to send representatives.

3.2 Exercise of September 4
The observers of the exercise were of the same kind as those of February. It should be noted however, that the representatives of the medical corps and the health services outnumbered the other operationally responsible persons (such as fire service officers).

4. Main results in relation to the general and operational objectives

4.1 Self tuition workshop of February
- Compilation of a base glossary, common for all fifteen countries and regrouping the concepts attached to the structure of the safety chain and to the competence of the intervening actors.

- Realisation of a study based on the compared organisation of the safety chain, seen from differents angles, organisationally, medically, socially and psychologically, juridically and financially, educationally.

4.2 Exercise of 4 September

The presentation, in the field, of the French safety chain in case of a catastrophe, was deployed to face three major accidents, a rescuing in case of a traffic accident, extrication and chemical risk, with 120 victims in total, made it possible to open a comparative debate on the existing structures in the different representative countries.

5. Considerations

From the self tuition workshop and the responses to a complementary questionnaire the following information can already be drawn:

5.1 For all the countries

The major concern in the organisation of disaster medicine is to improve the quality of the care given to the victims.

a) Ample medical presence is available at all the levels of disaster management (even if this availability is not considered equally according to the different countries)
b) The medical influence has obliged to evolve the practice on all the levels of the organisation of the rescue.
c) This influence depends at the same time on the progress accomplished by medical science in the field of resuscitation and feedback. This is illustrated by the representation of four catastrophes: Furiani (France), Bradford (Great Britain), Zeebrugge (Belgium) and N'Sam (Cameroon). In each case, the medical actors have been obliged to modify their common and/or planned behaviour.
d) The "fatality" concept is strongly fought about in the European Union countries. But it creates problems of an ethic nature and of adapting of behaviour when these countries have to interfere in missions outside the European Union.

5.2 Points of discussion between the European union countries.

a) The representations (of a psycho-social kind) of catastrophes or disasters or calamities differ in the various countries. The same words do not cover the same concepts.
b) The criteria to define these notions differ in the various countries:

- the size of the catastrophe
- the number of casualties
- the disproportion between lack of means and importance of needs
- the consideration of a real psycho-social trauma

c) The need for a "systematic" analysis of catastrophes with the use of the notions of "processes" and "critical thresholds" is not felt the same way by all. According to some countries, the reaction to a major violation of public order demands only reinforcement of the already existing means.

For other countries, the rupture in normal behaviour provoked by a major violation of public order demands a fast change in the way of thinking about the event and the composition of responses.

d) These various ways of compiling the means of disaster management generate different styles of education and training, from specialised education and training of doctors that

are specialists already, charged with forming their "own" rescue teams, up to "crash courses" for all kinds of actors who deal with taking care of the victims of a catastrophe. Several countries of the European Union find themselves between these two extremes.

5.3 Presentation of the second questionnaire

At the request of the participants in the self tuition workshop of February, a second questionnaire was sent (with a 100% response). The originality of this questionnaire consists of several points, which makes is necessary to elaborate on with regard to the possible continuation of this labour at a European level.

a) The questionnaire consists of three parts:

- a glossary
- a determination of the competencies of the actors involved in taking medical care of victims
- a representation, in the form of a framework, of the organisation of the rescue chains and the on-site care during a specific railway accident.

The way in which the questions were posed made it possible for both theorists as well as practitioners, and people both in the administrative as well as the clinical field, to respond by giving their opinions.

b) The glossary, reversed compared to a normal glossary, did not propose words, but the concepts, in order to have every country fill in their terms.
The glossary showed variations of concepts, for old words (catastrophe) as well as new words (triage). For example, the terms care and triage need to be specified since they do not seem to cover the same categorisations of victims nor the methods to treat them.

The glossary showed variations in the systems of command. The relations between the operational and decision making hierarchy are not situated at the same level. The location of the medical hierarchy varies per country, whether the criterion is the organisation (locally, regionally, nationally), or it has to do with the location of the doctors, specialised in disaster medicine or not, in the chain of care.

c) The competencies of the actors.
- the number of categories of actors varies with the countries (due to the size, the education and training system, evaluation and feedback..?),
- The actors cannot be superposed from one country to another,
- Certain life saving gestures (such as handling an IV) could be practised by different actors, according to their country. It would be difficult to determine them on the site, in case of a border crossing catastrophe.

The above obviously poses the question of the place, the number and the education and training of these actors and the criteria of their determination in the organisation of disaster medicine.

d) The organisational frameworks.

It was possible to determine three major categories:

- the organisation of the rescue is predominant and the management of care is centred in hospitals. This evokes the problem of the rapidity of the interventions and the organisation of the evacuation, especially for the victims most in need of assistance.
- the organisation focused on a permanent evaluation of needs, both on the care as well as the rescue without central steering. This evokes the problem of real co-ordination.
- the organisation is centred on the management of care, which evokes the problem of precise medical triage based on available hospitals and medicalised transports.

5.4 Conclusion

a) The work that has been done makes it possible to target the points on which the various countries might wish to develop their mutual comprehension:

* about the concepts:

- triage, the borders, modalities
- the medicalisation in the field, the actors, the structures
- the chain of command, the actors, the responsibilities
- taking care psychosocially of the people implied, the length, the actors, the modalities

* about the competencies of the actors

Certain gestures are “hinges” between rescue and care (handling an IV, psychological support to victims and people implied…)

In order to achieve comprehension between countries, it might be preferable to determine the actors by their competencies and not their professions.

* about the organisational frameworks

- the three main groups of frameworks need verification,
- “objective” criteria to construct these groups do not exist at this moment,
- the variations are due to phenomena of hyperspecialisation, the state of regulations, and to cultural problems which could not be specified.

b) The work that has been done should be continued by new methods.

These simple questionnaires at the workshop have permitted to specify the fields of research, but more specified working methods are necessary to assist in the mutual knowledge of the functioning in the various countries. In particular, the common construction of analysing and observation tools with the use of modern information and communication techniques should be privileged.

c) Because there is still a number of questions without an answer

- What are the criteria to objectify that decide that this or that event is a disaster?
- Could these criteria be the object of a classification acceptable for all the countries of the European Union?
- Are the objectives of general disaster management and those of disaster medicine identical in each country?
- Is it nowadays still a question of mobilising behaviour and specific strategies?
- Are behaviour and strategies susceptible to future evolution in the various countries?

d) The field of disaster medicine is a coupling item at a European level.

- disaster medicine is a hinge between emergency medicine, war medicine and humanitarian medicine,
- it evokes ethical problems (confrontation of cultures and religions with regard to dying and surviving)
- these problems should have concrete and immediate solutions in order to not aggravate the vulnerabilities of our societies,
- these solutions depend on the progression of medical science and concrete organisational problems,
- these solutions should be researched and found, whatever the existing system is in the various countries of the European Union.

6. Propositions for future activities

The programme, engaged under the moral authority of the Netherlands, has developed itself according to propositions from different countries, with regard to their competencies and their particular knowledge. This competence and knowledge has in the past been somewhat overvalued, at the expense of the coherence of the common programme which has given the impression, at first, to be a compilation of activities without real coherence or threads between them.

Looking back, one could think that the programme running in the year 1999 should be the joint reflection of all the countries participating in the project, in such a way that it enables them to come to a conclusion which is open, but certainly common as well. From this fact, it could be conceived that the activities should be determined in such a way that the conclusions of one activity serve as a starting point for the reflection of the following activity. In this way, a better coherence of the system can be guaranteed.

B/ EVALUATION OF THE PROCESS

1. Description of the activity

The self tuition workshop, organised by the National Institute for Civil Protection Studies, from 9 to 12 February 1999, was integrated in the European disaster medicine programme, piloted by the Netherlands.

The workshop was destined to was supposed to set off and hold a debate which made it possible to make an inventory of the different methods and practices used by the rescue services of the member states of the European Union in the field of disaster medicine and was composed of a presentation and an analysis of these methods used in the different European countries. The workshop was completed with a practical presentation in the form of a large scale exercise to illustrate the French framework.
The workshop took place from Wednesday 10 to Friday 12 February 1999. The exercise that completed the workshop, took place on 3 and 4 September 1999.

In order to properly organise the debate during the workshop, the responses to a questionnaire sent to the future participants where returned to the organisers, to determine beforehand the axes of reflection and the composition of the workgroups. The compilation of the responses was realised before the workshop and presented at the beginning of the meeting.

This first stage was followed by working in subgroups where doctors specialised in emergency care and other operational parties worked together. This made it possible to analyse the various methods used in each country in the subgroup and with regard to the various criteria which had been concluded from the results of the questionnaire: operational, medical, psycho-social, juridical and financial aspects.

A first restitution was aimed at determining the similarities between methods and classify them with the help of categories. At the end of this, working in subgroups again to find the common points in each category.

Five statements by experts made it possible to sustain the reflection of the participants on concrete catastrophes. Each national representation also informed the other participants about some particular aspects of emergency and catastrophe medicine in their own country.

The conclusion of this first meeting brought a new research with regard to a glossary of essential terms. A new questionnaire associated to this glossary was addressed to the 15 member countries in order to determine the operational structures of each country, as well as the competencies of the medical actors. This was made the object of a synthesis.

The example of the French rescue chain was presented in full size, as part of an operational exercise, which emphasised the way of the evaluation of the education and training of doctors specialised in emergency care in France.

2. The participants

During the two activities (self tuition workshop and exercise) the fifteen countries of the European Union were represented.

During the self tuition workshop, this European audience was composed of some sixty persons, of which forty three were non-French and a strong representation of the medical corps or health services (32 doctors specialised in emergency and catastrophe medicine, doctors of which 14 were French)

42 observers, of which 38 were non-French, participated in the exercise of September. Apart from some exceptions, this group was the same as the group of February.

3. Organisations implied

The National Institute for Civil Protection Studies was the principal organiser of the two activities.

The Academic Delegation for Continuous Education (DAFCO) of the university of Rouen was involved as a subcontractor, for the animation of the activities, the technical elaboration of the questionnaire and the compilation of the responses.

The Departmental Direction for Fire and Rescue Service of Saone-et-Loire was also involved as a subcontractor, for the operational realisation of the exercise.

Finally, the National Institute for Civil Protection Studies has lead these two activities in close collaboration with the Defence and Civil Protection Direction and the medical faculty of Nancy.

4. Evaluation of the working methods

The working methods that have been used are mentioned in the paragraph mentioned below.

- The use of the questionnaire made it possible to start the reflection of the self tuition workshop thanks to the constant conclusions coming forwards from the compilation of the responses. The debate brought forward the need to enlarge it with the two other coupling items of the operational structures and the competence of the health actors. In any case, the preceding questionnaire must have a privileged position, because it enables to engage the discussion in an early state and contributes to determining the similarities that allows the composition of well balanced working groups.
- The limited effective strength made it possible to work in subgroups, particularly favourable to the analysis of the criteria determined by the responses of the questionnaire and the development of the reflection in stages.
- Resorting to experts contributed to reconnecting the reflection with the reality of the facts.
- The choice of the exercise, even though it presents just a very limited framework because the conditions of the work (place, time and the choice of actors, etc.) contributed to draw a practical image of a structure "thrown" in the field to answer to a catastrophe and makes it possible to establish comparisons among the observers.

5. Contacts

No comments.

6. Articles, essays and other sources of information used.

Nil.

7. Evaluation of the working procedure.

- The two activities lead by the National Institute for Civil Protection Studies assisted by a national workgroup composed of five doctors from the fire service and the SAMU (medicalised emergency ambulance service), an operational one and a psychological one.
- A constant link was kept with the European pilot group of which the animation work had been received very well.

8. Integration of activities in the organisations and national activities.

These two activities did not create a stir nationally.
Nevertheless, the participation of the disaster medicine exercise should be noted, realised at the zonal echelon (several departments) under the authority of a departmental body.

9. Consequences for the national politics.

No comment

10. Recommendations for future activities.

See chapter 6 ‘Propositions for future activities’ under ‘A/ evaluation of the product’.

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workshop européen
Prise en charge de la dimension psycho-sociale des catastrophes

WORKSHOP HELD IN ARRAS AND LILLE (FRANCE) ON MAY 20th AND 21st 1999:

PREPARING EMERGENCY EXECUTIVES AND PROFESSIONALS TO HANDLE THE PSYCHOSOCIAL DIMENSION OF DISASTERS

A SUMMARY

The exchanges that took place in plenary sessions between experts brought together within this workshop brought to light considerable differences in the approaches and levels of experience in the various European countries. Ideas converged, however, where assessing the needs of victims and the necessity of preparing all those involved in handling the psychosocial side of emergency care were concerned.

Four specialised workshops were held :

- PREPARING DECISION-MAKERS AND EXECUTIVES TO HANDLE THE PSYCHOSOCIAL SIDE OF A CRISIS
- PREPARING EMERGENCY PROFESSIONALS TO MANAGE THEIR OWN STRESS (IN RELATION WITH LEVELS OF PERFORMANCE)
- PREPARING EMERGENCY PROFESSIONALS TO PROVIDE A SUITABLE RELATIONAL APPROACH TO DISASTER VICTIMS
- PREPARING SPECIALISED EMERGENCY PROFESSIONALS TO PROVIDE PSYCHOSOCIAL SUPPORT (DEFUSING, DEBRIEFING,…)

Workshop organisé par les SDIS du Nord et du Pas-de-Calais
Avec le soutien de la CEE – Direction Générale XI
Direction scientifique: EPISTEME

These workshops mainly dealt with the following areas :

1. Reaching a common definition for the problem considered
2. Assessing which targets are concerned by the measures to be taken and determining the goals for each target
3. Developing recommendations for implementing solutions to improve awareness and provide training to the various professionals involved.

The outcome was then presented in plenary session.

For convenience sake we will designate "victims" all the persons affected physically or mentally by a critical situation.

1. Reaching a common definition for the problem considered :

Two main points emerged from this work:

⇨ **Limiting the field strictly to disaster situations make no sense at all where preparing the professionals is concerned.** One cannot expect to provide efficient and durable preparation for professionals to handle highly unusual and diversified events (disasters) without preparing them to cope efficiently with daily situations - in an emergency only procedures carried out on a daily basis will be followed successfully.
All participants, however, indicated the lack of a psychological dimension in the daily practice of emergency care professionals.
It appeared clearly to everyone that working on disaster situations provides a unique opportunity for reconsidering day-to-day support but also that improving daily management remains a necessary stage to improve the management of disaster situations.

⇨ **It is important to remember that the main goal of crisis management, in particular where the psychosocial dimension is concerned, is the return to "normal" for the persons affected.**

Within the current trends of research, there is a risk of over-developing psychosocial support measures which would actually be adding problems for victims (too much medical care, too much assistance,…).

2. Assessing targets / Determining goals for each target

The overall goal is to develop measures to benefit either directly or indirectly both the professionals in emergency care and the victims.
A consensus had to be reached first concerning the needs of :

- The victims
- The executives and professionals as far as their response capacity to the needs of the victims (civilian populations or colleagues) is concerned
- The executives and professionals as potential victims of the disasters with which they are dealing

During workshops and plenary sessions, all those dealing with emergency situations were divided into five target categories depending on the specificity of their work and their subsequent training needs :

[1] **Decision-makers**
[2] **Executives**
[3] **Rescuers**
[4] **Specialised professionals**
[5] **Experts**

*Table A **"targets and goals"** provides a definition of the various categories of emergency professionals and presents the goals for the measures to be implemented which were listed during workshops and plenary sessions.*

3. Recommendations for actions to be carried out in terms of improvement of awareness and training of the various professionals involved

Where preparing the executives and rescuers [2,3] is concerned, it is to be noted that most countries in Europe have already considered if not experimented solutions, ranging from basic awareness training to the implementation of more sophisticated programs including simulations enabling participants to project themselves into various situations thus enabling them to get a feeling of what victims are confronted with. In the light of the exchanges that took place within the workshop, it would seem that most of the contents and tools necessary for preparing rescue professionals [2,3] are fairly well identified, but that the actual implementing of training programs is often hindered by the lack of precise knowledge of the needs of each target category and by a lack of awareness on the part of decision-makers [1] of their importance (which means insufficient funds are allocated to information and training).

Participants from countries where training programs for specialised emergency care professionals [4,5] in the field of psychosocial support have already begun, pointed out the importance of keeping the knowledge fresh and insisted particularly on the necessity of regular supervision by an acknowledged expert in the field.

Even if we all admit that the problematical of the preventive and curative management of the psychosocial dimension of the disasters is not really determined and that researches still remain necessary, the goal of the discussions carried on within the different groups was to emphasize the different experiences already implemented or attempted in the various European countries in order to benefit from the experience gained through them.

*Table B **"Recommendations"** shows all the suggestions and recommendations produced in the workshops and plenary sessions*

Table A : TARGETS and GOALS

MAIN TARGETS of the programs to be developed		**NEEDS / MAIN GOALS of the programs to be developed**
MANAGERS 2 levels stood out:	➔ **"Decision-makers"** [1] **: Mainly local government and civil servants representing the State who are in charge of managing the crisis.** Few countries have understood the necessity of preparing decision-makers or even the media.	Improving decision-makers' awareness and knowledge of : ⇨ the psychosocial side of disasters ⇨ the impact of their own stress on their capacity to deal with information and make the best decisions.
	➔ **"Executives"** [2] **:** Officers & non-commissioned officers from fire departments, the police or the armed forces ; head physicians, persons in charge of voluntary organisations…	Developing executives' awareness of: ⇨ the psychosocial dimension of emergency care ⇨ the impact of their own stress on their capacity to manage their teams ⇨ the needs of these teams.
EMERGENCY PROFESSIONALS 3 levels stood out:	➔ **"Rescuers"** [3]**, i.e. those who by profession can or will be in the front line, in direct contact with the victims** : rescuing, treating, transporting, protecting or controlling them… (these include firemen, doctors, nurses, ambulance men, policemen, soldiers, …).	⇨ Avoiding damaging behaviour towards victims (in particular too much care) ⇨ Avoiding, in the same time, too great an identification with the victims.
	➔ **"Specialised professionals"** [4] **in the field of psychosocial support** : these can be rescue or care professionals, or simply voluntary persons, inasmuch as they qualify for the work, have undergone specific training and are supervised by experts.	⇨ Providing them with the necessary knowledge, know-how and know-how-to-be to provide victims with adequate support ⇨ Avoiding, in the same time, too great an identification with the victims
	➔ **"Experts"** [5] **:** psychologists, psychiatrists and sociologists also requiring specific training. Defining this training will mean much more research which is the only way to get a precise understanding of what is involved.	⇨ Counselling decision-makers on the psychosocial aspect of a crisis ⇨ Preparing and supervising the specialised professionals ⇨ Long-term support (psychotherapy)

Table B : RECOMMENDATIONS

Decision-makers [1]	*The specialists agreed that decision-makers are unprepared for crisis management and recommended a two-level approach :* ⇨ Improving awareness (experience feed-back, films, conferences,…) of: - the psychosocial dimension of disasters (difficulties and needs of the populations and professionals involved) - the importance of defining the modalities of the best possible co-ordination between the various public services and with private associations (such as The Red Cross) - the psychological aspect of information management, decision making and of the stress factor of the decision-makers themselves. ⇨ Practical training regarding optimal information management ; crisis management and communication (real-life simulations) *Such preparation programs will imperatively need adjusting to the kind of decision-maker involved and will have to take into account the small amount of time these persons can devote to their training.*
Executives [2]	*Participants underlined the importance of the implication of executives as a key dimension for the implementation and perpetuation of training programs geared at developing efficient psychosocial support for victims and professionals alike.* ⇨ Training in the psychological dimension and technique for crisis management.
Rescuers [3]	⇨ Improving awareness (theory, group workshops,…) of : - the manifestations and mechanics of stress - the behaviour and reactions of the victims (which can include professionals) - available victim support facilities - attitudes to be avoided with victims. ⇨ More practical training (simulations, event analysis,…) : - Basic training in the relational approach of victims - Stress management - Problem-solving.
Specialised professionals [4]	⇨ Improving awareness of the stress of the victims and professionals involved, of PTSD, of means of prevention. ⇨ Training in communicating, listening, helping, defusing, debriefing, managing stress.
Experts [5]	The workshop on experts considered premature any recommendation for training. This meeting of experts was the first to take place on this theme in Europe, it mainly enabled us to identify the necessity to continue and develop the research in the field of prevention, support and care for psychological trauma victims. It also reinforced the idea of the importance of breaking the isolation of experts by developing and maintaining permanent contact (research projects, development of a web site with an interactive forum,…).

Country Report The Netherlands

Report of the European Union Pilot Project on Disaster Medicine

The Netherlands

Part I - Organisation of Public Health Response Systems in Emergency Situations

A. Format product evaluation

1. Outline of the activity

Workshops focused on the "Organisation of Public Health Response Systems in Emergency Situations" as part of the International Conference on Disaster Management and Medical Relief (DMMR), Amsterdam, the Netherlands, 14-16 June 1999.

2. Description of the general and operational aims of the activity

Medical and organisational professionals in Disaster Medicine were invited to discuss long-term objectives around cost-effective organisation of Disaster Medicine. Participants had the opportunity to discuss organisational, process-oriented topics, and to participate in Table-Top presentations.

Topics covered:

- Organising medical care effectively in large scale emergency situations
- Auditing performance of medical care in large scale emergency situations
- Flexibility of Disaster Medicine systems
- Training health care workers in Disaster Medicine
- Table-top presentations: three disaster scenarios for Hamburg (Germany), Marseilles (France), San Francisco (USA) and Rotterdam (the Netherlands).

3. Target groups

The workshops focused on the "Operational Chances and Restraints in Disaster Medicine" were designed for:

- local, regional and national authorities;
- policy makers in Disaster Management and Medical Relief;
- operational managers;
- health care managers;
- medical and paramedical relief staff;
- scientists;
- publicists;
- other professionals engaged in Disaster Management and Medical Relief.

4. Main outcome connected to the general and operational aims

- Preparedness, training, coordination and communications are the key elements for effective disaster medicine operations;
- A disaster is not over when the last victim has been hospitalised; governments must prepare themselves for the long-term consequences;
- The Conference stressed the importance of the involvement of the public.

5. Conclusions and recommendations

Organising medical care effectively in large scale emergency situations

- It is clear that, in several European countries (Sweden, United Kingdom and the Netherlands were compared), disaster relief, crisis-management, contingency planning and emergency medical care are public tasks;
- Actual practice has shown that emergency situations are much better handled and managed when a multi-disciplinary approach has been chosen;
- To improve and optimise emergency care and disaster relief a broad based consensus, for all services and actors involved, is needed;
- The national organisations for medical aid determine the shape and function of large scale medical aid organisations;
- Interdisciplinary cooperation is not a second nature of relief-organisations although many disasters showed the beneficial effects. Standardisation of medical care and its organisational aspects, although well understood by the professionals, have not created an international supported strategy on this issue;
- The solution for scarcity, lack of real experience and the possibility to train new methods and tactics, from lessons learned elsewhere, could be found in an international medical relief organisation, comparable with military peace-keeping organisations. High mobility, state of the art equipment, well trained, interdisciplinary work experience are some of the qualities of such an organisation.

Auditing performance of medical care in large scale emergency situations

- Assessing trauma severity and analysing trauma-related data is a good way of measuring the quality and effectiveness of medical behaviour, performance, care and assistance;
- Medical statistics will, therefore, increasingly, play a more important role in auditing the performance of medical care in emergency situations;
- In medical auditing, standards should be set up, data collected, registered, processed and evaluated. The outcome are necessary for an accurate quality assessment. The results can be used, subsequently, as a basis for the development of new policies, legislation, professional standards, protocols, handbooks, trauma-scores, evaluation reports and norms for handling time;
- During the discussions, it became clear that emergency medical care is an insufficient basis for disaster medical care. This means that new solutions should be developed for tackling the emerging problems;

- It is apparent that quality of treatment and speed of treatment are preconditions for optimising the “golden hour”-concept; time is of course a critical factor in patient survival and recovery;
- The new concept of chain management is seen as an effective way to improve the functioning of the emergency medical care system and to upscale to the level of disaster medical care. The ultimate objective of chain management is to create a synergy between the existing interests and subcultures of the different emergency services. Eventually a common vision and approach should origin;
- The chain management offers perspectives and solutions for the scarcity of medical care, intrinsic time-related problems in medical care and interdisciplinary cooperation to enlarge the effect of medical care. But, every chain has a weaker part: until now it seems to be found within (parts of) the medical organisations itself.

Flexibility of Disaster Medicine systems
- Keep Disaster Medicine plans and systems as simple as possible;
- In preparing for disasters, scores and indices are useful tools to determine the minimum capacity;
- A Disaster Medicine systems should dare to use unusual resources like first responders and first-aiders;
- At the international level, there is a need for the use of common terminology.

Training health care workers in Disaster Medicine
- Training is an absolute ‘must’ in all disciplines in Disaster Medicine;
- Training needs to be frequent and interactive;
- Simulation training is an excellent tool for teaching skills.

Table-top presentations: three disaster scenarios for Hamburg (Germany), Marseilles (France), San Francisco (USA) and Rotterdam (the Netherlands).
- Lack of uniformity in terminology is an obstacle for international communication, co-operation, consensus and therefore progress. The number of terms that are used within and between countries is utterly confusing. The development of a cross reference tool for terms and terminology would be a good idea. Terminology should include training issues as well as cover system access for dispatch centres ("112" in Europe).
- It is not clear what is meant with a dispatch centre or a communication centre. For future reference and development, a dispatch centre should be referred to as a communication centre.
- What is, if any, the legal basis to define required response intervals per service (police, fire service, ambulance), per country. This is an item with plenty of confusion but clearly one that dictates both (public) expectancies and performance standards.
- The concept and philosophy behind the up-scaling of services, which particularly Rotterdam favours, should be explored further. There is a school of thought that believes that disaster medicine has nothing to do with the routine emergency services. And then there are those who believe that you can take your routine emergency services and upscale it all the way through a multiple casualty incident to a fully fledged disaster response. I am pleased to report that there was a unanimous decision which confirmed the necessity for an up-scaling mechanism rather than a separate disaster versus routine emergency medical systems.

- Should there be a legal basis for disaster plans and the responsibilities described therein. This was also confirmed and fully endorsed by the workshop.
- Then an interesting question which we did not resolve: who is legal responsible when something goes wrong?
- The next point deals with triage. Triage is practised by all but the approaches are different. It varies from spontaneous triage: those who can move will move away and those who stay behind are therefore in need for medical attention, through a more mathematical or scientific approach to triage.
- The workshop revealed that the distribution of patients away from the scene to hospitals remains an issue of fuzzy logic.
- Overall cost and reimbursement of the disaster/emergency services provided are issues that are not very clear in any of the cities.
- We move to Outcome. The question should not be "are we good?" or "are we bad?", but the better question to raise in our opinion is “how good is good enough?”: answering that question forces you to quantify.
- Another point dealing with outcome is that, despite public expectations to the contrary, disasters never have a "good" outcome. The outcome is always bad, one can only make it "less bad". This issue affects public, professional, and political expectation.
- The final point dealt with is "aftercare", which will be dealt with by Prof. Quintijn in more detail. Suffice to say that each of the participants in the workshop has a system of aftercare in place, assigns a high priority to it, but many different methods of debriefing are used.

6. Propositions for further activities

Embedding of conclusions and recommendations in European Union Disaster Medicine Project.

B. Format process evaluation

1. Full description of the activity

The core of the Conference took place on Monday 14 and Tuesday 15 June 1999. Both days included plenary sessions during which leading national and international authorities shared their specific experiences from their political and administrative perspectives.

The Conference comprised four half-day sessions, each with up to seven parallel workshop topics in-and-around Disaster Management and Medical Relief. Debate featured prominently between national, regional and local authorities, policy-makers, health care managers, medical and paramedical relief staff, scientists, publicists, et cetera, to encourage discussion, promote the exchange of fresh ideas and to rigorously assess current efforts. This provided both traditional and innovative opportunities for participation.

Several field trips on Wednesday 16 June 1999 gave participants a first hand-view of scenarios and contingency planning for Disaster Management and Medical Relief in the Netherlands.

2. Number of participants; mention the participating countries

Average of 60 participants per workshop; most European Union countries represented, 40 countries represented world-wide.

3. Organisations involved (Disaster Medicine-related only)

Workshop 'Organising medical care effectively in large scale emergency situations'

- United Kingdom, Wiltshire Ambulance Services, NHS Trust
- Sweden, Stockholm, Emergency and Disaster Planning, National Board of Health and Welfare
- The Netherlands, Public Health Service Amsterdam
- The Netherlands, Lelystad, Public Health Service Flevoland
- The Netherlands, The Hague, PGHOR, Crisis Management and Fire Services Department, Netherlands Ministry of the Interior and Kingdom Relations
- The Netherlands, the Hague, Department of Somatic and Curative Care, Ministry of Health, Welfare and Sports

Auditing performance of medical care in large scale emergency situations

- United Kingdom, Manchester, Hope Hospital
- The Netherlands, Amsterdam, Public Health Service Amsterdam
- The Netherlands, Amsterdam, Department of Surgery/Trauma Surgery, University Hospital Vrije Universiteit
- The Netherlands, The Hague, Alons and Partners Consultancy BV
- The Netherlands, Utrecht, Dutch Institute for Health Care Improvement
- The Netherlands, The Hague, Office of the Army Surgeon-General

Flexibility of Disaster Medicine systems

- Israel, Home front Command, Israel Defence Forces (IDF)
- Sweden, Linköping, Department of Surgery, University Hospital
- The Netherlands, Utrecht, The State Inspectorate of Health Care
- The Netherlands, The Hague, Department of Crisis Management and Fire Services, Ministry of the Interior and Kingdom Relations

Training health care workers in Disaster Medicine

- Sweden, Linköping, Department of Surgery, University Hospital
- USA, Denver Colorado, Department of Emergency Medicine, Denver Health Medical Centre
- The Netherlands, Rotterdam, Dijkzigt University Hospital
- The Netherlands, Maastricht, Department of Surgery, University Hospital
- The Netherlands, Apeldoorn, Bureau Medical Service Section G4, Headquarter 1 Division "Zeven December"
- The Netherlands , Hilversum, Medical Training Centre of the Netherlands, Armed Forces (OCMGD)

Table-top presentations: three disaster scenarios for Hamburg (Germany), Marseilles (France), San Francisco (USA) and Rotterdam (the Netherlands).

- USA, San Francisco, Emergency Medical Services Agency
- France, Marseille, Fire Brigade (BMPM)
- Germany, Hamburg, Fire Brigade
- The Netherlands, Rotterdam, Public Health Service

4. Working methods (evaluation of)

2 Hour lecture workshops during which a minimum of 25 minutes was reserved for open discussion. Speakers generally had approximately 15-20 minutes for their presentation, participants were able to interact with speakers during and directly after each presentation. Basic philosophy was that discussions were to be focused on policy and process rather than casuistry. The lengthy time for the presentations and discussion offered the opportunity for in-depth conversations, which was well appreciated by all participants.

Also, ample time in the programme was devoted to comparison of disaster medicine systems. Using Table-Top presentation of three disaster scenarios, from small to major scale, speakers from San Francisco, Hamburg, Marseilles and Rotterdam shared their organisational and general approaches, plus the underlying medical and organisational philosophy. Delegates were able to participate 'hands-on' while each city presented one scenario per workshop. The fourth workshop was devoted to follow-up discussion and conclusions.

5. Points of contact

- Director General for Civil Protection (DG11), European Union, Brussels, Belgium
- Disaster Medicine Project Office, Crisis Management and Fire Services Department, Ministry of the Interior and Kingdom Relations, The Hague, The Netherlands
- Inspectorate of Health Care, Ministry of Health, Welfare and Sports, The Hague, the Netherlands
- Military Medical Service Agency, Netherlands Ministry of Defence, The Hague, the Netherlands

6. Papers, essays and other sources of information used for the activity

Please refer to the DMMR Internet site at http://dmmr.minbzk.nl.

7. Evaluation of the working process

In order to get a feel for the precise relevant subject matters for the workshops, individual discussions were held with national and international renowned experts in Disaster Medicine. Basic philosophy was that discussions were to be focused on policy and process rather than casuistry. Based on their views, a tentative programme was put together and further developed by specialised working groups consisting of experts from different disciplines in Disaster Medicine, all with their individual network and expertise.

During the initial discussions with national and international counterparts, it appeared that networks were not at hand. New contacts were to be found and made which took much time and effort, especially considering the large variety in methods and responsibilities in Disaster Medicine systems all over the globe. It follows as a matter of course that a strong network in Europe will provide a solid base for effective cooperation, and facilitate the development of new programmes in the future.

8. Embedding of the activity in national activities and organisations

The Disaster Medicine subjects covered during the DMMR-Conference meshed closely with the 'Dutch Project on Medical Assistance for Accidents and Disasters (PGHOR)'. The conference provided an international platform for the PGHOR project to verify the effectiveness and efficiency of the newly developed system for medical care in large scale emergency situations.

Secondly, some of the core-subjects were focused on civil-military cooperation in disaster medicine, and therefore brought together actors from both fields for information exchange and discussion. Contacts have been established and further plans are being developed.

9. Feedback to national policy

Through the above-mentioned PGHOR-project, a continuous discussion took place between the main actors in Disaster Medicine and the conference-organisers, thus using these canals for feedback both ways.

10. Recommendations for further activities (process orientated)

- The need for a solid and strong network in Disaster Medicine and the necessity to allocate time and money to this purpose;
- To continue the discussion on civil-military cooperation (CIMIC);
- To avoid repetition of research and other activities in Europe, but rather to work with existing structures and information;
- To focus on the taxonomy and process of Disaster Medicine.

Report of the European Union Pilot Project on Disaster Medicine

The Netherlands

Part II - Operational Chances and Restraints in Disaster Medicine

A. Format product evaluation

1. Outline of the activity

8 Workshops on "Operational Chances and Restraints in Disaster Medicine" as part of the International Conference on Disaster Management and Medical Relief (DMMR), Amsterdam, the Netherlands, 14-16 June 1999.

2. Description of the general and operational aims of the activity

This was a forum for civil and military medical professionals to exchange ideas on the latest developments in Disaster Medicine.

Topics covered:

- Functioning of pre- and post hospital systems
- Professional positioning in differing Disaster Medicine systems
- Compatibility of military and civil medical care
- The role of specialised trauma care centres
- Medical response to nuclear, bacteriological or chemical exposure
- Vulnerability of hospitals
- Ethics and triage
- Technological developments in Disaster Medicine

3. Target groups

The workshops focused on the "Organisation of Public Health Response Systems in Emergency Situations" were designed for:

- local, regional and national authorities;
- policy makers in Disaster Management and Medical Relief;
- operational managers;
- health care managers;
- medical and paramedical relief staff;
- scientists;
- publicists;
- other professionals engaged in Disaster Medicine.

4. Main outcome connected to the general and operational aims

- Preparedness, training, coordination and communications are the key organisational elements for effective disaster medicine operations;
- A disaster is not over when the last victim has been hospitalised; governments must prepare themselves for the long-term consequences;
- The Conference stressed the importance of the involvement of the public.

5. Conclusions and recommendations

Functioning of pre- and post hospital systems

- It is necessary that doctors are deeply involved in the management of disasters, and are trained in Emergency Medicine, decision making and, through exercise, how to work with other emergency services;
- Discussion:
  - should emergency medicine be viewed as an independent discipline in disaster management;
  - who is the right man or woman as the leader of the medical relief organisation in disaster situations

Professional positioning in differing Disaster Medicine systems

- The role of the Disaster medicine professionals has historically developed in different directions in various countries. This has lead to the realisation of laymen, nurse and doctor directed Disaster Medical Systems in both civilian and military situations;
- Although there is a general opinion that special trained doctors are preferable, it is still at discussion who is the right man or woman as the leader of the medical relief organisation in disaster situations;
- Stated is that Disaster Medicine should be Global Medicine. This can be achieved by standardisation in education of Disaster Medicine. Also standardisation of registration is very important for feedback in training;
- Much improvement in the quality can be made by co-operation in education and team-training between defence and civil organisation.

The role of specialised trauma care centres

- Specialised Trauma Care Centres should not attract all those casualties which have a natural tendency to come to that centre. It is, therefore, very important that the other hospitals in the surroundings, the smaller hospitals, the teaching hospitals, the non-university hospitals, have their own role in disaster management;
- It is of utmost importance, even inevitable, that medical doctors are deeply involved in the management of disasters;
- Discussion point: should emergency medicine be viewed as an independent discipline in disaster management.

Vulnerability of hospitals

- Hospitals can suffer from an internal disaster as well as an external disaster; both should be prevented.
- Prevented at all costs should be that an external disaster also becomes an internal disaster, causing the injured community to be without any medical resources.
- Prevention can be found in early warning systems, the location, structure and infrastructure of the hospital, placing particular focus on the water supply, the (often ignored) sewage system and the communication means.
- Especially the role and commitment of personnel is important during disasters. In disaster situations medical personnel must work long and also unscheduled hours while in the same time many will suffer from the effects of the disaster at home.
- Hospitals should have regular and realistic drills in disaster situations.
- The lessons learned by the Dutch Hospital Millennium should carried into the next millennium. A similar and prolonged structure of cooperation should be continued after the millennium.

Ethics and triage

- Triage is a dynamic process, a continuing process and a progressive process. Therefore triage in disaster situations is not identical to triage in daily Emergency Medical Systems;
- There is a need for clear definitions of triage;
- Triage has two aspects: a technical aspect (the right person has to receive the most appropriate therapy) and an ethical aspect (the common human rights and medical-ethical codes should be respected);
- To enhance the capabilities of triage, triage procedures need to be standardised;
- To facilitate ethical aspects an international declaration of human rights during triage should be established;
- Education and training in triage is needed;
- Training in ethics does not exist. Ethics lie in the heart of every person and consists of moral values that we all share. As such mutual respect between all persons and parties involved in disaster medicine is in essence the good basis for triage.

Technological developments in Disaster Medicine

- Technological developments in disaster medicine mainly concentrate on improving communication between the field and command and control centres;
- The information management system is vital for good decision making;
- There are also developments in the improvement of the quality of personnel. Computerised training and education facilities for triage is one of the latest examples. Other developments like Virtual Reality and simulator- technology contribute to better training facilities.

Compatibility of military and civil medical care

- With the termination of the cold war, military doctrines have been adapted to the changing political environment and have been increasingly involved in the management of emergencies and major disasters;
- Within the resources of most nations, military forces display unique technological and logistical capabilities;

- Integration and co-operation between the military and civilian medical sectors is fruitful;
- The society demands the same high quality of medical care irrespective of who is the care provider, civilian or military. This means that the same standards should apply in both systems;
- Society demands a high efficacy of the available medical and other resources in case of a disaster, mass casualty or armed conflict. This means that co-operation and ability to co-operate in terms of management must be planned and trained before the incident occurs;
- Maximum coordination between military and civil health care is achieved by having specialist medical care for military personnel carried out by civilian carers.

Medical response to nuclear, bacteriological or chemical exposure

- Deliberate or accidental exposure of groups of people to nuclear, biological or chemical agents creates special problems because the threat is invisible;
- Care workers may be just as much in danger as the potential casualties - and this in turn hampers practical implementation, logistics and motivation;
- Self-evidently, medical systems must be able to respond meaningfully to this type of emergency.

6. Propositions for further activities

Embedding of conclusions and recommendations in national activities and European Union Pilot Project on Disaster Medicine.

B. Format Process evaluation

1. Full description of the activity

The core of the Conference took place on Monday 14 and Tuesday 15 June 1999. Both days included plenary sessions during which leading national and international authorities shared their specific experiences from their political and administrative perspectives.

The Conference comprised four half-day sessions, each with up to seven parallel workshop topics in-and-around Disaster Management and Medical Relief. Debate featured prominently between national, regional and local authorities, policy-makers, health care managers, medical and paramedical relief staff, scientists, publicists, et cetera, to encourage discussion, promote the exchange of fresh ideas and to rigorously assess current efforts. This provided both traditional and innovative opportunities for participation.

Several field trips on Wednesday 16 June 1999 gave participants a first hand-view of scenarios and contingency planning for Disaster Management and Medical Relief in the Netherlands.

2. Number of participants; mention the participating countries

Average of 60 participants per workshop; most European Union countries represented, 40 countries represented world-wide.

3. Organisations involved (DM-related only)

Functioning of pre- and post hospital systems

- Belgium, Antwerp, Stuivenberg Hospital, Department Intensive Care and Center for Hyperbaric Medicine
- Belgium, Brugge, Departement of Emergency Medicine, Sint Jan Academic Hospital
- USA, Denver Colorado, Health Medical Centre, Department of Emergency Medicine
- The Netherlands, OLVG Hospital, Amsterdam
- The Netherlands, Oude Meer, Mobile Hospital Systems, Fokker Aerospace

Professional positioning in differing Disaster Medicine systems

- Belgium, Leuven, University of Leuven
- Germany, Berlin, Department of Surgery (Traumasurgery), German Red Cross Westend Hospital
- The Netherlands, Groningen, Academic Hospital
- The Netherlands, Arnhem, Netherlands Association for Emergency Nursing
- The Netherlands, The Hague, Joint Medical Policy Staff, Ministry of Defence

Compatibility of military and civil medical care

- Israel, Home Front Command (HFC), Israel Defence Forces (IDF)
- Sweden, Hammaroe, Swedish Armed Forces Medical Training Centre
- USA, Hawaii, Tripler Army Medical Centre, Centre of Excellence in Disaster Management and Humanitarian Assistance
- The Netherlands, Utrecht, Academic Hospital Utrecht, Department of Intensive Care and Clinical Toxicology
- The Netherlands, Valkenburg, Royal Netherlands Naval Air Station
- The Netherlands, The Hague, Ministry of Defence, Military Medical Service Agency

The role of specialised trauma care centres

- Germany, Berlin, German Disaster Medicine Society
- Germany, Berlin, Red Cross Westend Hospital, Department of Surgery (Traumasurgery)
- United Kingdom, Manchester, University and Hope Hospital
- The Netherlands, Amsterdam, OLVG Hospital
- The Netherlands, Rotterdam, Dijkzicht University Hospital

Medical response to nuclear, bacteriological or chemical exposure

- United Kingdom, Cardiff, University of Wales, WHO Collaborating Centre for Chemical Accidents
- USA, Atlanta, Centres for Disease Control and Prevention, National Centre for Infectious Diseases
- The Netherlands, Rotterdam, Erasmus University, Department of Virology
- The Netherlands, Utrecht, Academic Hospital, Department of Intensive Care and Clinical Toxicology

Vulnerability of hospitals

- Canada, Montreal, Department of Public Health
- Poland, Wroclaw, Wroclaw University of Medicine
- USA, Worcester, University of Massachusetts, Emergency Medicine Department
- The Netherlands, Breukelen, Hospital Millennium Platform

Ethics and triage

- Belgium, Leuven, University of Leuven, Disaster Medicine
- France Lyon, Mobile Intensive Care Unit (SAMU '96)
- Germany, Tübingen, Eberhard Karls University, Department of Surgery
- USA, Hawaii, Tripler Army Medical Centre, Centre of Excellence in Disaster Management and Humanitarian Assistance

Technological developments in Disaster Medicine

- Italy, Rome, Department of Civil Protection, Office of Diplomatic Affairs
- Sweden, Stockholm, National Board of Health and Welfare

- The Netherlands, Soesterberg, Netherlands Organisation for Applied Scientific Research (TNO), Human Factors Research Institute
- The Netherlands, Cuijk, Maassen Consulting B.V.
- The Netherlands, Groningen, Academic Hospital Groningen
- The Netherlands, Hilversum, Royal Netherlands Army, Medical Training Centre of the Netherlands Armed Forces (OCMGD)

4. Working methods (evaluation of)

2 Hour lecture workshops during which a minimum of 25 minutes was reserved for open discussion. Speakers generally had approximately 15-20 minutes for their presentation, participants were able to interact with speakers during and directly after each presentation. Basic philosophy was that discussions were to be focused on policy and process rather than casuistry. The lengthy time for the presentations and discussion offered the opportunity for in-depth conversations, which was highly appreciated by all participants.

5. Points of contact

- Director General for Civil Protection (DG11), European Union, Brussels, Belgium
- Disaster Medicine Project Office, Crisis Management and Fire Services Department, Ministry of the Interior and Kingdom Relations, The Hague, The Netherlands
- Inspectorate of Health Care, Ministry of Health, Welfare and Sports, The Hague, the Netherlands
- Military Medical Service Agency, Netherlands Ministry of Defence, The Hague, the Netherlands

6. Papers, essays and other sources of information used for the activity

Please refer to the DMMR Internet site at http://dmmr.minbzk.nl.

7. Evaluation of the working process

In order to get a feel for the precise relevant subject matters for the workshops, individual discussions were held with national and international renowned experts in Disaster Medicine. Basic philosophy was that discussions were to be focused on policy and process rather than casuistry. Based on their views, a tentative programme was put together and further developed by specialised working groups consisting of experts from different disciplines in Disaster Medicine, all with their individual network and expertise.

During the initial discussions with national and international counterparts, it appeared that networks were not at hand. New contacts were to be found and made which took much time and effort, especially considering the large variety in methods and responsibilities in Disaster Medicine systems all over the globe. It follows as a matter of course that a strong

network in Europe will provide a solid base for effective cooperation, and facilitate the development of new programmes in the future.

8. Embedding of the activity in national activities and organisations

The Disaster Medicine subjects covered during the DMMR-Conference meshed closely with the 'Dutch Project on Medical Assistance for Accidents and Disasters (PGHOR)'. The conference provided an international platform for the PGHOR project to verify the effectiveness and efficiency of the newly developed system for medical care in large scale emergency situations.

Secondly, some of the core-subjects were focused on civil-military cooperation in disaster medicine, and therefore brought together actors from both fields for information exchange and discussion. Contacts have been established and further plans are being developed.

9. Feedback to national policy

Through the above-mentioned PGHOR-project, a continuous discussion took place between the main actors in Disaster Medicine and the conference-organisers, thus using these canals for feedback both ways.

10. Recommendations for further activities (process orientated)

- The need for a solid and strong network in Disaster Medicine and the necessity to allocate time and money to this purpose;
- To continue the discussion on civil-military cooperation (CIMIC);
- To avoid repetition of research and other activities in Europe, but rather to work with existing structures and information;
- To strictly focus on taxonomy and process of Disaster Medicine.

Report of the European Union Pilot Project on Disaster Medicine

The Netherlands

Part III - Managing the psycho-social aftermath of collective emergency situations

A. Format product evaluation

1. Outline of the activity

Four half-day sessions devoted to control and management of the psycho-social impact of collective emergency situations ('Managing the psycho-social aftermath of collective emergency situations') as part of the International Conference on Disaster Management and Medical Relief (DMMR), Amsterdam, the Netherlands, 14-16 June 1999.

2. Description of the general and operational aims of the activity

During the four half-day sessions the different aspects of psycho-social management of disaster victims were subject of discussion and analysis.

The goal of this international working group was the formulation of some statements and propositions concerning this recently developed discipline. The working group believes their contribution can serve as a basic frame guideline for the whole European Community for further development of a scientifically sound, coherent and dynamic structure for the psycho-social care of disaster victims.

3. Target groups

The sessions focusing on psycho-social care were designed for:
- (psychological) health care managers;
- medical and paramedical relief staff;
- psycho-social crisis counsellors;
- scientists;
- publicists;
- other professionals engaged in psycho-social care.

4. Main outcome connected to the general and operational aims

The discipline of psycho-social care is a professional field which is recognised as indissoluble connected to Disaster Management and as such should be incorporated in all plans and activities related to disasters affecting people.

5. Conclusions and recommendations

- By definition models for psycho-social disaster management have to be used as dynamic instruments and not as static patterns where victims have to fit in;
- Where the basic philosophy of approach in the matter of psycho-social care is one of prevention, the curative aspect should not be neglected in the whole care process;
- Proposed pragmatic psycho-social disaster management models are not always suited for application in different types of disaster, nor in different types of cultures and communities (All cultures have their own mechanisms to cope, our task is to not to replace them by some others but to make them more effective);
- All psycho-social management programmes reveal the high importance of the information-management problem, the question can be asked whether it wouldn't be necessary for the information-management to develop structural co-ordination platforms between the actors responsible for the psycho-social care and the authorities, responsible for the whole disaster management.

6. Propositions for further activities

Statements of Amsterdam* :

- That psycho-social needs in disaster be recognised and that psycho-social support be provided as of right for all those who may be affected (from direct victims to rescue workers, etc.) in all phases of disaster and in the longer term aftermath of disaster;
- Psycho-social multilevel programs using educational systems should be promoted as a proactive component of effective disaster management;
- The need to develop practical tools - qualitative and quantitative indicators - for monitoring and evaluating psycho-social interventions and their process in psycho-social disaster management
- To create a European forum where specialists in psycho-social work in disaster can meet and provide training and methodological guidance on the use of adequate models for psycho-social disaster management.

The working group leaves the initiative for further development and implementation of their thoughts to the responsible policy-makers of the European Community (Directorate General XI).

Note: Draft Project Document is currently being written and will be available shortly.

B. Format Process evaluation

1. Full description of the activity

The core of the Conference took place on Monday 14 and Tuesday 15 June 1999. Both days included plenary sessions during which leading national and international authorities shared their specific experiences from their political and administrative perspectives.

The Conference comprised four half-day sessions, each with up to seven parallel workshop topics in-and-around Disaster Management and Medical Relief. Debate featured prominently between national, regional and local authorities, policy-makers, health care managers, medical and paramedical relief staff, scientists, publicists, et cetera, to encourage discussion, promote the exchange of fresh ideas and to rigorously assess current efforts. This provided both traditional and innovative opportunities for participation.

Several field trips on Wednesday 16 June 1999 gave participants a first hand-view of scenarios and contingency planning for Disaster Management and Medical Relief in the Netherlands.

2. Number of participants; mention the participating countries

Appr. 25; Speakers from Austria, Belarussia, Belgium, Italy, Switzerland (IFRC and WHO), Ukraine, United Kingdom

3. Organisations involved (DM-related only)

- Austrian Office of Civil Defence, Disaster Relief and Security, Vienna, Austria
- Centre for Crisis and Clinical Psychology, Crim, Ukraine
- Centre for Crisis Psychology, Queen Astrid Military Hospital, Brussels, Belgium
- Centre for Crisis Psychology, Sheffield, United Kingdom
- Centre for Mental Health, Perrugio, Italy
- Centre for Victims of Trauma and Catastrophe (EOS), Pavia, Italy
- Crisis Management and Fire Services Department, Ministry of the Interior and Kingdom Relations, The Hague, The Netherlands
- IFRC Chernobyl Project, Minsk, Belarussia
- IFRC Psychological Support Programme, Geneva, Switzerland
- Red Cross Flanders Social Intervention Service, Brussels, Belgium
- WHO Department of Mental Health, Geneva, Switzerland

4. Working methods (evaluation of)

Presentations of 9 speakers and open discussion during three sessions, fourth session discussion and conclusion. Reasonably small group of selected experts allowed for open and direct discussion. Much time was needed for introduction and presentations, due to which shortage of time for actual discussion occurred.

The conclusions drawn from the two-day discussion provide an excellent base for the new programme for psycho-social care within the framework of Disaster Medicine.

5. Points of contact

- Director General for Civil Protection (DG11), European Union, Brussels, Belgium
- Centre for Crisis Psychology, Queen Astrid Military Hospital, Brussels, Belgium
- Disaster Medicine Project Office, Crisis Management and Fire Services Department, Ministry of the Interior and Kingdom Relations, The Hague, The Netherlands
- Inspectorate of Health Care, Ministry of Health, Welfare and Sports, The Hague, the Netherlands
- Military Medical Service Agency, Service Commodore (RNN), Netherlands Ministry of Defence, The Hague, the Netherlands

6. Papers, essays and other sources of information used for the activity

Please refer to the DMMR Internet site at http://dmmr.minbzk.nl.

7. Evaluation of the working process

In order to get a feel for the precise relevant subject matters for the workshops, individual discussions were held with national and international renowned experts in psycho-social care (WHO, IFRC, Brussels Queen Astrid Military Hospital, Utrecht University Hospital). Basic philosophy was that discussions were to be focused on policy and process rather than casuistry and treatment methods. Based on their views, a tentative programme was put together and further developed by a specialised working group at the Queen Astrid Military Hospital in Brussels, Belgium.

8. Embedding of the activity in national activities and organisations

The Disaster Medicine subjects covered during the DMMR-Conference meshed closely with the 'Dutch Project on Medical Assistance for Accidents and Disasters (PGHOR)'. The conference provided an international platform for the PGHOR project to verify the effectiveness and efficiency of the newly developed systems for medical (psycho-social) care in large scale emergency situations.

Further, the Dutch National Association of Municipal Public Health Services (LVGGD) has recently finalised a handbook for the development of an 'Action-plan for psycho-social care in emergency situations'. The LVGGD will be requested to participate in future activities.

9. Feedback to national policy

Given the recent focus in the Netherlands on the psycho-social consequences of the Bijlmer plane crash of 1992, as well as the Kossovo crisis and the earthquake in Turkey, it is obvious that psycho-social care is taking in a more prominent role in the field of Disaster Medicine. By informing national organisations like the LVGGD and the PGHOR project of the activities undertaken by the European Union Pilot Project on Disaster Medicine, national follow-up will be initiated.

10. Recommendations for further activities (process orientated)

To thoroughly asses current efforts and to follow-up on the conclusions, recommendations and statements through the European Union Disaster Medicine Project.

Country Report Sweden

Report from preparatory meeting for the pilot course for teachers and instructors in disaster medicine
Linköping (Sweden) April 06 – 09, 1999

On request, the report from this meeting is hereby given according to the guidelines received from the Netherlands September 1999.

Format product evaluation

1 Outline of the activity

This workshop was organised in order to discuss and prepare the first pilot course in Linköping in October 1999.

2 Aims of the activity

The aims of the work shop were:

- Follow up of the discussions of the first work shop in Nainville-les-Roches, France.
- Planning of the first pilot course for teachers and instructors in disaster medicine in Linköping October 18-22, 1999.

3 Target groups

Delegates from participating countries selected by the different governments or responsible governmental institutions.

4 Main outcomes

As a result from the workshop, a preliminary programme for the pilot course was settled (and enclosed) and presented at the Congress in Disaster Medicine in Amsterdam, June 1999.

5 Conclusions and recommendations

See under point 4.

6 Propositions for further activities

To run the course October 18 – 22 according to the suggested programme.

Format process evaluation

1 Full description of the activity

The programme for the workshop is enclosed.

2 Number of participants; mention the participating countries

List of participants is enclosed.

3 Organisations involved

The Swedish governmental Board of Health and Welfare, The Linköping University and The Centre for Teaching and Research in Disaster Medicine, Linköping, Sweden.

4 Working methods

The workshop was informal with requested time devoted for discussions with participation of all delegates. For further details, see enclosed programme.

5 Points of contact

Potential speakers for the pilot course were discussed and contacted

6 Papers, essays and other sources of information used for the activity

International guidelines for teaching and training in disaster medicine (ISDM).
ISDM handbook in disaster medicine (manuscript).
Models and facilities for simulation exercises were presented.

7 Evaluation of the working process

The informal way of running this work shop was evaluated as successful. Agreement was reached on each point of the programme without controversies.

8 Embedding of the activity in national activities and organisations

This cannot be done until after the pilot course.

9 Feedback to national policy

This cannot be done until after the pilot course.

10 Recommendations for further activities (process orientated).

The pilot course should result in a course manual and proposal for future courses for teachers in disaster medicine within the European Community.

Report from the EU-pilot course for teachers and instructors in disaster medicine Linköping (Sweden) October 17-22, 1999

The report from this course is on request given according to the guidelines received from the core-group through Mr. Dick Fundter, the Netherlands.

I Format product evaluation

1. Outline of the activity

One-week pilot course for teachers and instructors in disaster medicine. Programme enclosed.

2. Aims of the activity

The aims of this pilot course were:

- To present for teachers and instructors from the member states a model for education and training in disaster medicine
- To let the delegates be exposed to and actively participate in this training model
- To discuss and evaluate the suitability of this model for use in the different European countries, the need of adjustment and the possibility to apply it in the different organisations.
- To discuss, based on the experiences from the pilot course, how to continue the work to improve education and training in disaster medicine in Europe.

3. Target groups

Teachers, instructors, leaders and administrators of courses in disaster medicine in the member states. The participants were selected by the member states (maximum two from each country). List of participants enclosed.

4. Main outcomes

a) A model for education and training in disaster medicine was presented, based on previous experiences from and development of national and international courses, including the WHO diploma course in disaster medicine. All delegates had the opportunity to actively participate in the model.

b) The experiences were carefully evaluated by one hour evaluation in the end of each day plus a separate evaluation in the end of the course.

c) The results of this evaluation were:
   - Single parts of the model (for example the part dealing with hazardous material) should be modified towards more problem-based interactivity in accordance with the rest of the course
   - The simulation exercises where considered very valuable and recommended as the proper tool for effective promotion of knowledge and accurate training. Of special value was considered the simplicity and realism of the model (realistic times, realistic resources, and effects of different decisions clearly illustrated).
   - The delegates considered the model possible to apply in all member states represented in the pilot course and easily adjustable to any organisation. The French delegates anticipated some partly political problems in introduction of an educational model from another country, but still considered the model suitable after adjustment to the local organisations.

5. Conclusions and recommendations

It was concluded and agreed upon by all participants that:

a) There is a need for training and education in disaster medicine, and those today existing programmes for education and training in many places are insufficient.
b) Specialised centres for disaster medicine should be established in all European countries
c) Centralised training of teachers and instructors should be started as soon as possible.

6. Propositions for further activities

The recommendation from the participating delegates was that the model used during the pilot course, with some modifications and with adjustment to the local organisations, would be very suitable as a training model. Teachers and instructors could be trained in centralised training centres in the different countries.

To build up such an organisation, it is suggested, that 3-4 more courses should be run as soon as possible, using the existing facilities, so that a staff of trained instructors should be available in the different countries to be able to start the programmes described above.

The curriculum defining the minimum level for theoretical knowledge and practical skill, produced by the International Society of Disaster Medicine, should be revised and adapted to the European countries, which could be done by a working group from the European countries appointed by the core-group.

II Format process evaluation

1. Full description of the activity

See enclosed programme.

2. Number of participants and participating countries

See enclosed list of participants.

3. Organisations involved

The Swedish National Board of Health and Welfare, the Linköping University and the Centre for Teaching and Research in Disaster Medicine, Linköping, Sweden.

4. Working methods

The methodology was designed according to the above described "aims of the activity" (see I:2). For further details, see enclosed programme.

5. Points of contact

Participation of the EU core-group during the evaluation of the course.

6. Papers, essays and other sources of information used for the activity.

International guide-lines for teaching and training in disaster medicine (ISDM). Copies of slides from all the lectures and also video-tapes from the exercises distributed to all participants.

7. Evaluation of the working process

See above under I:4-6.

8. Embedding of the activity in national activities and organisations

See under I:4.

9. Recommendations from further activities

See under I:5.

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