

27 Disaster Medical Planning

EXPERIENCE, THEORY AND PRACTICE

Grahame Ambrose

The principles of disaster medical planning in New South Wales are outlined in the Health Functional Area Supporting Plan to the State Disaster Plan (DISPLAN), which was prepared by the State Emergency Management Committee in compliance with the State Emergency Management Act, 1989. That Act provides the authority for the overall management of emergencies endangering the safety or health of persons in the State that require a 'significant and coordinated response'. Each State or Territory has such Acts and Plans.

DEFINITION OF DISASTER

A medical disaster is an incident involving multiple casualties, which is beyond the capacity of available resources to manage. Other health-related disasters may not involve multiple casualties, but have the potential to do so; for example, public health disasters. It should be noted that in a medical context, the more commonly used terminology 'emergency' has a different meaning from that used in DISPLAN. For this reason, the word 'disaster' continues to be used, to avoid confusion when other agencies use the word 'emergency'.

AIM IN DISASTER MEDICAL PLANNING

The aim of the Health Services Disaster Plan is to ensure the coordination of all health services—medical (including hospital and ambulance), public health and mental health services—for response to, and recovery from, an emergency (disaster) occurring anywhere within New South Wales, as required under the provisions of DISPLAN.

PRINCIPLES OF DISASTER MEDICAL MANAGEMENT

The aim of providing medical and health services in the event of a disaster is to provide the greatest good for the greatest number of people. This may involve a reversal of normal procedures and priorities. Assessment, and mobilisation of resources may precede the treatment of individual casualties.

Planning for disasters is based on the four-phase concept of prevention, preparedness, response and recovery.

Prevention

Mitigation against the effects of disasters may involve a range of medical and preventive health strategies, including immunisation against communicable diseases, sanitation measures, personal hygiene, hazardous waste disposal, vermin and vector control, immigration and customs controls, education and public warning notices.

Preparedness

The resources (personnel and material) which may be needed are rapidly mobilised and deployed. Medical resources are mostly involved in the preparation and response to disasters. The 'all hazards' approach is adopted as the basic concept in providing for response to and recovery from disasters. This framework provides the organisational structure for flexibility in adapting to the needs of each particular hazard.

- The Health Functional Area Supporting Plan provides for the following:
- Control, command and coordination of medical resources.
 - Appropriate prehospital medical and health management for casualties.
 - Transport of casualties to appropriate facilities for definitive care.
 - Public health management of disaster situations.
 - Counselling services for disaster victims.
 - Continuing medical and health services during the recovery phase.
 - Provision for disabled persons in the community.

Response

This refers to the actions taken immediately after, and during the occurrence of, hazard impact to minimise the effects of the incident. It is during this phase that medical resources will be most active, and when the control, command and coordination of all resources will be assumed according to the provisions of the Act, and the Plans supporting it.

The principle of achieving the greatest good for the greatest number of casualties is effected by the process of triage, which is the sorting, prioritisation and distribution of casualties according to their need for resuscitation, transport and definitive care. Triage is a continuing process, beginning at the site of the incident and continuing in hospitals. It matches needs to available resources, to achieve the best outcome for the greatest number.

Assessment and triage will precede individual management of casualties, which may be a reversal of conventional medical procedures. Medical treatment in the field may be required if overwhelming numbers of casualties prevent early transport to hospitals for definitive care, or if prolonged delays in achieving transport necessitate out-of-hospital medical management.

Triage and treatment of minor casualties in the field may obviate the need for transport of all casualties to hospital, although this must be done with caution, having in mind the risks of missed injuries because of inadequate facilities on site.

Transport of casualties is under the direction of the Ambulance Commander, who coordinates the movement of all casualties by whatever means. This is done in consultation with the Medical Commander to ensure that the right casualties are delivered to the right place, at the right time, by the right means.

Distribution should be planned to prevent single institutions being overwhelmed while others are underutilised.

Normal casualty transport systems are used wherever possible, and must be coordinated by the Ambulance Service, which will also be responsible for