THE SECOND INDIA DISASTER MANAGEMENT CONGRESS
4-6 NOVEMBER 2009
THEMATIC CLUSTER - I: EMERGENCY HEALTH MANAGEMENT
SESSION-2: Mass- Casualty Management
Concept Note

A. Introduction

Disasters which are small in shapes and sizes impact a small number of people and put intense demands on the health system for a short period, while other mega disasters may involve a large number of casualties but reach a plateau only after a latent period, placing heavy continuing demands on the health system. For some natural disasters like cyclones, floods and volcanoes-hospitals are likely to receive advance warning and be able to activate their disaster plan before the event. For other natural disasters, such as earthquakes and landslides, and many man-made disasters such as chemical plant explosions, industrial accidents, building collapses and acts of terrorism do not provide advance warning. Because of the heavy demand placed on their services at the time of a disaster, hospitals need to be prepared to handle such an unusual workload with and without prior warning. This necessitates a well documented and tested disaster management plan (DMP) to be in place in every hospital.

Hospitals are essential life line service providers. And emergency response and mass casualty management is a distinctive stage of disaster management activities at the hospitals. Quick response is one of the key objectives and a significant yardstick of success of effective mass casualty management during pre and hospital phase of disaster management. This requires special attention due to the vital functions hospitals and emergency responders perform. Planning for quick and effective mass casualty management is aimed to include core dimensions such as field and hospital triage, triage principles and methods, pre-hospital emergency care, emergency room management, hospital mass casualty plan, dealing with special mass casualty issues, Basic Life Support, psychological triage.

The hospital preparedness for disasters is a dynamic process and plays crucial role in easy mobilization of the staff, bed, equipments and supplies in a safe environment during any mass casualty or mass gathering incidents. These occasions could happen due to terrorism, bomb blast, festival gathering, natural disasters such as earthquakes, major

vehicular accidents, communal riots, etc. Therefore, strengthening the capacity of casualty medical officers, hospital managers and surgeons on basics of mass casualty management is essential for any hospital's better disaster preparedness and effective response to the patients to avoid the situation of a secondary disaster.

While responding to a mass casualty event, the goal of the health and medical response is to save as many lives as possible. Rather than doing everything possible to save every life, it will be necessary to allocate limited resources in a modified manner to save as many lives as possible.

B. Context

Disasters and other emergencies create unique ethical challenges of resource allocation, triage, incapacity, privacy, expenditure, human resource planning and so on. The cardinal virtues of effective teamwork in emergency and disaster medicine can help meet these multifaceted and unpredictable challenges long before they arise in clinical practice. In disaster situations, time exigencies do not allow for protracted moral reflection and ethical deliberation; thus preventive measures and policies that amplify virtue and ensure ethical practice are warranted. For example, disaster preparedness drills and related exercises most include opportunities for character and team building as well as ensure optimal distribution of scarce medical resources. Fostering virtue proactively may be thought of as a kind of moral vaccination against the ethical pitfalls inherent in emergency medical service provision. Seven virtues that express the qualities, dispositions, and uniqueness of the ideal emergency health-care team member are offered: prudence, non-judgment, self-effacement, compassion, trustworthiness, resilience and communication. Truly realized, these virtues can transform emergency and disaster workers from a state of mere competence to a state of sheer excellence. Prior to 1950 in the West and in many developing countries today, the responsibility for health care was and is largely assumed by the family. As the delivery of health care has become increasingly institutionalized and complex, the various health professions that emerged, including emergency medicine, began to recognize their interdependence. As specialization increased, and the variety of roles and professions in health care grew, the need for the coordination of health care became evident. A team of health professionals has come to replace the family while providing a useful mechanism for delivery of

quality care. To instill the institutionalized and best coordinated MCM, the National Disaster Management Authority has recently issued comprehensive guidelines for Medical Preparedness and Mass Casualty Management following natural or manmade disasters. Training and capacity building of doctors and para-medical staff is an important component of the national guidelines towards this goal.

C. **Objectives** – the broad objectives of the session would be to:

- Discuss the various dimensions of MCM during disasters and MCI
- Share the experiences of practitioners from hospitals and filed.
- Discuss the issues pertaining to research & development, and capacity building in MCM
- Discuss good practices of MCM prevail in India

D. **Sub Themes** – The broad areas that would be dealt during the deliberations are:

i. Recent trends in evidence based research in MCM practices
ii. Innovativeness in service provision models: Govt vs. private hospital practices
iii. Model Hospital Disaster Management Plan and Standard Triage protocol
iv. Emerging issues

E. **Expected Outcome**

While the session is expected to bring together bounds of knowledge and practices in the sub theme areas from various scholars, researchers and practitioners across the country, one of the key expected outcomes would be to put these collated deliberations in a formal manner through a printed and updated compilation of the papers presented.

F. **Session Plan** – the tentative broad session plan would be as follows:

Date: 5th Nov 2009, Duration: 14:00-17:00, 3 hours/180 minutes, Hall No-6, Second Floor, Vigyan Bhawan

Chair- Dr. M C Mishra, Chief, JPN Apex Trauma Centre, AIIMS, Co-Chair – to be decided, Rapporteur – to be decided

Session plan

Sub Themes-4	Duration:35minutes each
Inauguration-closing, & Discussion	Duration: 40 minutes
Total papers- 10-12	Duration of presentation- 12 minutes