Position Paper:

Priorities in Medical Responses to Disasters

World Association for Disaster and Emergency Medicine

The following document was drafted by a Task Force of the World Association for Emergency and Disaster Medicine (WAEDM) and was adopted by the General Assembly of the 6th World Congress on Emergency and Disaster Medicine in Hong Kong on 15 September 1989.

Position

Emergency and disaster medical care should hold a priority position in every nation's health care plan. As such, the World Congress endorsed the *Call to Action* put forth by the International Conference on Emergency Health Care Development on 18 August 1989 in Washington, D.C.*

It is the responsibility of emergency health care providers at all levels (physicians, nurses, ambulancemen, paramedics, administrators, and policy-making officials) to establish a disaster response system within and as a part of a community's total emergency response plan. This plan must be based on existing, documented research and firsthand experience, and should integrate the following principles:

1. As the preliminary act in developing a coordinated medical response to a disaster, the community as a whole must be well-prepared. Hence, all members of the community available must be trained in the essentials of Life Supporting First Aid (LSFA) including simple rescue techniques. This training must be re-inforced periodically through the media and other mechanisms.

2. Existing, local medical and paramedical personnel must be identified and trained in the basics of field medical care so that emergency health care providers will be available immediately from within the disaster zone.

3. Fire, police, and other prehospital professionals should be trained in basic rescue and engineering extrication techniques.

4. A system for emergency transportation for victims, responders, and essential equipment and supplies should be established and staffed by personnel trained in Life Supporting prehospital medical techniques.

5. Ongoing evaluations of local and regional disaster risks coupled with structural hazard assessments should be conducted in order to better forecast the types and scopes likely to be encountered for a given area. An essential component of this program is the support and coordination of the active development of research models which integrate types of natural and man-made disasters, injury patterns, and health care resources which will be needed to care for victims.

6. Staging areas within a zone in which there exists a potential for a disaster to which victims, and preappointed, trained local medical, paramedical, law enforcement, and emergency transport personnel automatically will converge, must be preidentified by local, health care providers. Such areas need not be contiguous with each other but must be well-

Task Force

Steven J. Rottman, MD, Task Secretary General, WAEDM, UCLA Center for Prehospital Care, Los Angeles, California, USA
Jakov Adler, MD, Director of Disaster Services, Jerusalem, Israel
S. William A. Gunn, MD, Hon. Treasurer, WAEDM, European Centre for Disaster Medicine, Geneva, Switzerland
Andrei Kisselev, MD, Director of Field Operations, League of Red Cross and Red Crescent Societies, Geneva, Switzerland
Jurg Koller, MD, Swiss Disaster Unit, Bern, Switzerland
Susan McHenry, MD, National Association of State EMS Directors, Richmond, Virginia, USA
Eric Noji, MD, The Johns Hopkins University, Baltimore, Maryland, USA
Ernesto Pretto, MD, Resuscitation Research Center, Pittsburgh, Pennsylvania, USA
Remi Russbach, MD, Chief Medical Officer, International Committee of the Red Cross, Geneva, Switzerland
Robert R. Simon, MD, Director, International Medical Corps, Los Angeles, California, USA
Yasuhiro Yamamoto, MD, Japan Medical Team for Disaster Relief, Tokyo, Japan

known by those likely to be involved. Such staging areas will be made known to all, including the lay public, through public educational campaigns. In the event of a disaster resulting in mass casualties, each of these areas will be staffed by the assigned personnel predesignated above, provided with adequate communications equipment and operators, and supplied with those basic survival and medical materials necessary for the provision of urgent care during the immediate post-disaster period.

7. Adequate communication capabilities are an essential element of any disaster preparedness program. These must include multiple links to the staging areas from regional command centers so that such centers may be kept apprised of the health care needs of the affected area(s). Regional aid responses must be facilitated and coordinated by such centers and they must remain informed of the needs of the area and of all of the resources which may be brought to bear to assist in the operations.

8. A disaster preparedness plan should be established, exercised, and re-evaluated on a regular basis at the regional, state, and provincial levels.

9. National health policy should include a coordinated, interdisciplinary approach to mass casualty disaster preparedness and management including defined roles and participation of both the military and volunteer aid agencies.

10. An inventory should be established for cataloging and updating the many voluntary aid and mobile disaster units available world-wide. This inventory should be made available to national and international health planners so that each may be appropriately assessed and included as part of each nation's disaster plan.

11. International relief agencies, national disaster response teams, and international health organizations should work cooperatively to improve the availability, capability, and effectiveness of international disaster efforts. Such programs should be based on the past-performance of these responders as well as the specific needs of the disaster-affected area. A single coordinating agency should be responsible for the deployment of all such assistance.

These principles are put forth by the World Association for Emergency and Disaster Medicine in concert with the beginning of the 1990s, the United Nations' International Decade for Natural Disaster Reduction. The WAEDM offers the willingness of its participants to assist in the further development of the positions stated above.

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* Reprinted from *Prehospital and Disaster Medicine* 1989; 4:197–198. International Conference on Emergency Health Care Development, Hyatt-Regency Hotel, Crystal City at National Airport, Washington DC Metropolitan Area, 15-18 August 1989.

Delegates from 78 countries who are involved with improving their local or national emergency services convened in the United States Capital for this four day conference. The conference consisted of a series of discussions and workshops in which case studies, experiences, and lessons learned were shared. Lastly, an *ad hoc* panel set forth global goals and solutions for the next decade in a CALL TO ACTION for WORLDWIDE EMERGENCY HEALTH CARE DEVELOPMENT IN THE 1990s.

The delegates to the International Conference on Emergency Health Care Development, out of concern for the increasing worldwide human and economic loss due to trauma and other medical emergencies, have reached the following understandings:

1. Emergency health care (EHC) consists of the timely provision of those preventive and curative interventions which can relieve pain or prevent disability and death;

2. Emergency health care involves the management of injury (Codes E800-E900 of the International Classification of Diseases), acute medical illness, and emotional illness;

3. Emergency health care is a basic need in all countries;

4. Injuries are responsible for increasing morbidity and mortality in countries of all levels of economic development, and frequently have a much more severe effect on children and the working age population. Many injuries are preventable through health promotion and simple modifications in the home, school, and work environments;

5. Recent advances in health care organization and medical technology have made it possible to decrease significantly, the adverse effects of health emergencies;

6. When an injury or sudden illness occurs, the first response usually is provided by family members or bystanders. Community education can improve this response;

7. The majority of medical and traumatic illnesses typically present to the primary care system; and

8. When disasters occur, the first medical response is provided by local providers of routine emergency health care.

Based on these observations, we call for the following actions:

1. All authorities concerned with health at national, regional, and local levels should recognize Emergency Health Care as an integral part of the primary health care system, and should ensure that their primary health care systems are capable of responding to

emergencies;

2. Health authorities should make optimal use of local personnel and the community at large by employing improved management techniques and training;

3. Health authorities should integrate into existing and future public educational activities curricula on injury prevention and responses to emergencies and disasters;

4. The health care community should make its contribution to the International Decade for Natural Disaster Reduction by:

a) strengthening local capabilities for responding to multiple casualty incidents using local personnel;

b) ensuring that national committees for the decade are fully aware of the potential of EHC services in effectively reducing the impact of disasters; and

c) adopting prevention and preparedness measures likely to reduce the number of casualties in a disaster;

5. World health authorities should collaborate in their efforts to bring to the attention of policy makers, the public health consequences of health emergencies, and the need to improve local, urgent health response capabilities;

6. International health agencies and development organizations should collaborate in funding and assisting Emergency Health Care Development as a primary health care infrastructure improvement program; and

7. National and international disaster preparedness offices and agencies should work carefully with local emergency health care directors to coordinate plans for response to potential large scale events.

This resolution was developed by an Ad-Hoc Committee of the Conference. It was discussed, amended, and approved by the full Conference on 18 August 1989.

The major sponsors of the conference included the: U.S. Public Health Service-Health Resources and Services Administration; U.S. Department of Transportation-National Highway Traffic Administration; World Health Organization; and Pan American Health Organization. Collaborating organizations included the: United Nations Children's Fund; United Nations Disaster Relief Office; U.S. AID, Office of Foreign Assistance; and Partners of the Americas.