for problem-focused and 9.5/16 (95% CI = 9–10) for emotion-focused coping strategies, significantly higher (p <0.001) than for less-useful coping which scored 7.5/16 (95% CI = 7.2–7.9). Behavioral disengagement, and denial were used rarely, and alcohol/drugs were almost never used, with scores of 6.3/16 (95% CI = 5.9–6.7), 5.3/16 (95% CI = 5.0–5.7) and 4.5/16 (95% CI = 4.2–4.9), respectively. Doctors chose humor as a coping response significantly more often (p <0.001) than did nurses, scoring 9.6/16 (95% CI = 8.5–10.7) compared to 7.1/16 (95% CI = 6.3–7.8) for nurses. Filipino healthcare workers turned to religion as a coping response significantly more (p <0.001) than non-Filipinos, scoring 14.4/16 (95% CI = 13.3–15.4) compared to 9.9/16 (95% CI = 9.0–10.9) for non-Filipinos.

Conclusion: With a supportive hospital environment, ED healthcare workers chose adaptive strategies to cope with the SARS outbreak. Humor was strongly preferred by doctors, while Filipino healthcare workers turned to religion as their preferred coping response. In planning psychosocial interventions and mental health services, management should be aware of these preferences.

Keywords: coping; disaster; doctors; humor; nurses; psychological; religion; SARS

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Coping with Terrorism: Denial Versus Grief

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A terrorist attack is a national disaster unlike any other natural or man-made catastrophe. Its aim is to cause pain, destruction, and disruption of life in order to achieve political gain. When such an attack occurs, the global reaction is one of shock. This reaction becomes differential very quickly. Whereas the national reaction wanes rapidly as life gets back to normal, the reaction of the involved individuals becomes endless. On the national level, there is a massive response of denial, which is encouraged by the authorities that try to eliminate signs of the attack as soon as possible. This denial reaction is necessary in order to maintain life. The responses of the involved individuals are of loss and grief. National and Individual reactions are in conflict. The denial aggravates the mourning. Feelings of anger, disappointment, lack of understanding, and resentment usually characterize those in mourning. However, the denial response is natural and represents a wish for self-defense that does not mean lack of caring. Therapists should be aware of the appropriateness of the denial and be able to cope with such denial while working with the victims.

Keywords: denial; grief; response; terrorism

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Theme 2: Civil-Military Collaboration

Chairs: Edita Stok; Tim Hodgetts

Theme 3: Education for Disaster Medicine

Chairs: Geert Seynaeve; Judith Fisher

Overview of Actions Taken by Hellenic National Centre for Emergency Care Responding to the 07 September 1999 Earthquake in Athens

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The Hellenic National Centre for Emergency Care is an emergency medical system in Greece that provides prehospital emergency medical care. It has a Special Unit for Disaster Medicine (ETIK) responsible for planning, responding, training, and exercising for disasters. This presentation describes the 1999 earthquake in Athens, pointing out the actions that must be improved and what must be done in this direction, using the Conceptual Framework model for "Disaster Medicine" as developed by the World Association for Disaster and Emergency Medicine (WADEM) and the Task Force for Quality Control of Disaster Medicine.

Athens, the capital of Greece, has a population of 4 million, and has a dense concentration of buildings. On 07 September 1999 at 14:56 hours, an earthquake (magnitude of 5.9 on the Richter scale) struck Athens. A total of 100 buildings collapsed (both residential and industrial), 5,000 buildings were damaged (among them two hospitals), 85 persons were trapped alive, 143 people were found dead, 750 people were wounded, and 80,000 people were left homeless.

The emergency medical services (EMS) response was organized promptly, but problems were identified. Problems in planning and management included: (1) there was not an adequate plan; (2) only radio communication was available; (3) difficulties in resupplying and in finding specific supplies; (4) little awareness of potential hazards, such as the chemicals from collapsed industrial buildings; (5) difficulty in data collection and on-site documentation; (6) no cooperation and coordination between emergency medical services and other on-site forces (especially at the command level); (7) difficulties coordinating with hospitals; (8) insufficient forensic facilities; (9) diversity of international assistance provided was difficult to coordinate; (10) psychological support was not centrally organized and was not coordinated; and (11) inaccurate media coverage of the event.

From the medical aspect, we did not encounter many difficulties due to experiences obtained from everyday work and previous earthquakes. Prehospital triage and treatment were provided, and 85 people were rescued—most of them within the first 12 hours, and two persons were rescued in the next 24–48 hours. Unfortunately, many victims died in the hospitals due to their injuries.

There were 8,782 tents established in >11 camps. Medical assistance for the people that lived in the tent camps was delivered by EKAB, in coordination with other teams such as the Red Cross, hospital medical teams, army hospital medical teams, and the medical teams provided by non-governmental organizations.

Conclusion: The lessons learned included the need to improve planning. EMS must be educated better in risk assessment, preparedness, and planning for major incidents.

Keywords: Athens; buildings; conceptual framework; coordination; earthquake; emergency medical services; medical care; mortality; planning; preparedness; rescue; Task Force for Quality Control of Disaster Medicine; tents; World Association for Disaster and Emergency Medicine

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Disaster Health Education and Training: A Pilot Questionnaire to Understand Current Activities

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Introduction: Following a World Association for Disaster and Emergency Medicine (WADEM) Seminar to progress Disaster Education and Training held by the Education Committee in Brussels in October, 2004, it was apparent that there was no single tool available to assess knowledge, skills, and resources within this field.[1,2] It was decided to pilot such a tool using the fifty delegates present to assess whether it would facilitate information sharing and curriculum development in disaster health education.

Methods: The WADEM Education committee had devised a reference scheme based on seven educational levels,[1] within a framework based on the Bradt model.[3] A questionnaire was developed, based on this scheme, to answer the following questions:

1. Was training delivered using seminars, lectures, papers or books?
2. Was it delivered face-to-face or by distance learning?
3. Was it occasional or routine?
4. Was it delivered as part of initial training or as continuing education?
5. To whom is it given and by whom?
6. What competencies are taught?
7. Is there a charge?
8. Is it accredited, either internally or externally?
9. In what language is it delivered?

The pilot was sent out to all delegates and the responses were analyzed.

Conclusions: The pilot proved to be a useful tool to share knowledge within the WADEM. It could be repeated and updated regularly (possibly annually). Wider use is recommended to evaluate current educational resources, not only in disaster medicine, but also in the wider educational field. It will facilitate the development and audit of accredited courses.[4,5]

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Keywords: assessment; disaster; education; health; training; World Association for Disaster and Emergency Medicine (WADEM)

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National Strategy of Training Disaster Medicine Service Experts in Russia

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Introduction: Technogenic accidents and disasters have increased over the last three years in Russia. In this context, a greater importance is given to problems of terrorism, thus necessitating training disaster medicine service experts to reduce health after-effects of emergencies.

The top institution for training of disaster medicine experts is the Institute for Disaster Medicine Problems, located at the All-Russian Centre for Disaster Medicine "Zaschita" (ARCDM "Zaschita"), and in other regions in Russia – regional institutes for advanced medical training constitute a part of disaster medicine sub-faculties.

A primary goal of the national strategy of education involves the training of highly qualified, disaster medicine experts for minimizing emergency after-effects and the realization of the strategy of medical care delivery at prehospital and hospital stages, preparedness of medical institutions for mass admission of the injured and patients, and timely medical care delivery.

Methods: Within the framework of the Institute for Disaster Medicine Problems, the following tasks are being solved: (1) organization and implementation of occupational training and certification of disaster medicine experts in the sphere of management, treatment and prophylaxis; (2) implementation and coordination of scientific research, relating to topical disaster medicine problems; (3) implementation of regional and inter-regional drills on basic disaster medicine problems (radiation and chemical accidents, terrorist attacks, etc.); (4) training scientific and teaching personnel for disaster medicine; and (5) development and introduction of new forms of training (modular training, telemedicine conferences, etc.).

More than 6,000 students underwent training in 20 cycles of disaster medicine professional skills during 2000–2003. Being the Euroasian training center, ARCDM "Zaschita" conducts out-training cycles in NIS-republics.

Discussion: The new standardized curricula were highly praised by the Ministry of Health in Russia and recommended for higher institutions for training disaster medicine experts. The basis of the curricula is formed of modern scientific and practical developments in disaster medicine and provide new teaching aids (information and telemedi-