

In conclusion, the physical setting in which mass casualty events occur dramatically affects the pattern of injury in resulting casualties, their outcomes, and the associated impact on health services. Therefore, this information ought to be integrated with mass casualty triage guidelines.

Oleg Zaslavsky, RN, MHA  
Doctoral student, University of Washington

DOI: 10.1097/DMP.0b013e31819b0df2

## REFERENCES

1. Lerner EB, Schwartz RB, Coule PL. Mass casualty triage: an evaluation of the data and development of a proposed national guideline. *Disaster Med Public Health Preparedness*. 2008;2(Suppl 1):S8–S10.
2. Arnold JL, Halpern P, Tsai MC, et al. Mass casualty terrorist bombings: a comparison of outcomes by bombing type. *Ann Emerg Med*. 2004;43:263–273.
3. Zaslavsky O. Medical management of mass casualties of suicide bombing: lessons learned from the Israeli experience over the last few years. Paper presented at the annual conference of the Israeli Emergency Nursing Association, Tel Aviv, Israel, March 23, 2003.

### Lerner et al reply:

Thank you for allowing us this opportunity to respond to the thoughtful comments submitted by Mr Zaslavsky regarding our recent article in *Disaster Medicine and Public Health Preparedness*. Although we agree that the data from Israel are compelling in demonstrating that event circumstances are a factor in predicting injury, our goal was to address the initial sorting of patients by first responders. We believe that we all can agree that the initial responders to a large-scale event will find a scene that is chaotic, and that their first priority will be to bring some type of order to the chaos. The triage process needs to be extremely simple, easy to remember, and rapid; it would not be possible in most circumstances to access a protocol book and determine the best triage process for the circumstances. Furthermore, we designed the SALT triage guideline to be consistent with the move toward an all-hazards approach, and thus the guideline should be applicable for any scenario with multiple patients.

The actual cause of the event may not be clear upon dispatch or even upon arrival of the responders, thereby making it difficult for first responders to use a triage methodology that is alterable based upon etiology. Furthermore, given anecdotal reports of providers responding to mass casualty incidents and not using any consistent triage method, we are concerned that a system that is too complicated will not be used at all.

We would like to be clear that we feel that triage is a dynamic process that typically begins with limited information, resources, and providers. At these initial stages, we believe it would likely be difficult to use a complicated multipossibility triage scheme. As the process unfolds and more information, resources, and providers become available, however, it may be possible for the process to evolve and become more sophisticated, in part by incorporating critical information about the nature of the incident. This may even take the shape of a tool that could be created for hospital personnel to use as casualties arrive. We strongly feel that we need to change the mindset that the initial response to different types of disasters requires a different initial triage approach. The reality is that initially the simplest approach is probably the most likely to be used and therefore to be most effective.

As we state in our article, our goal is to have the SALT triage guideline grow and evolve as the science of triage develops. This guideline should not be viewed as the final product but the beginning of a process that will be driven by science and improved over time. We hope that this is just the beginning of our national dialog on triage, and that we can come to consensus and move forward with a national guideline.

E. Brooke Lerner, PhD, Richard B. Schwartz, MD,  
Philip L. Coule, MD, Eric S. Weinstein, MD,  
David C. Cone, MD, Richard C. Hunt, MD,  
Scott M. Sasser, MD, J. Marc Liu, MD,  
Nikiah G. Nudell, NREMT-P, Ian S. Wedmore, MD,  
Jeffrey Hammond, MD, Eileen M. Bulger, MD,  
Jeffrey P. Salomone, MD, Teri L. Sanddal, BS, NREMT-P,  
Graydon C. Lord, MS(c), NREMT-P,  
David Markenson, MD, and Robert E. O'Connor, MD

DOI: 10.1097/DMP.0b013e3181a4cb70