

between survivors and non-survivors (3.20 ± 1.34 and 6.57 ± 4.40 respectively, $p < 0.001$).

Conclusion: In our study, APACHE III score and ED lengths of stay were higher versus other studies in Iran and other countries; which show more critical patients presenting to our hospital and limited ICU beds versus patients. This study results nevertheless there was significant difference between predicted and observed mortality rates, the APACHE III scoring system is applicable to evaluating care, treatment and prognosis of ED patients, as is used in ICU.

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(P2-26) EMS-Assessed Mass Casualty Incident: A Pilot Surveillance

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Background Recently the number of disaster and mass casualty incident (MCI) is increasing in Korea, but there have been few administrative reports or technical reports for disaster and MCI. An ad hoc basis data collection method is usually incomplete and outdated. This study was conducted to investigate the new surveillance system composed of EMS based real time survey and medical records based in-depth survey.

Methods: A retrospective review was conducted of the 119 fire department call center database and ambulance running sheets in one metropolitan city. The data on all transported patients with non-medical reasons (fire, rescue and others) between May 2006 and December 2008 was reviewed. We selected all data from the accidents which had more than 2 casualties to exam the feasibility and conducted in-depth surveillance based on medical records.

Results: The total number of accidents was 2,027 with 2,625 patients. The number of accidents which had more than 2 patients was 307 (total 898 patients) and more than 6 patients was 19 (total 176 patients). Among the “MCI” events, 15 cases were traffic accidents (125 patients, 71.0%), 4 cases were fire (51 patients, 29%). Total 142 medical records (80.7%) were reviewed. Admission rate was 32.4% (46 patients) and overall mortality was 3.5% (5 patients).

Conclusion: This nationwide public EMS system could contribute to the establishment of the systematic disaster database.

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(P2-27) Simulation of Transport During a Major Incident

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Transportation capacities belong to the key factors of the response to a major incident. Available resources, both in terms of personnel and equipment, must be transported, usually by ambulances, to the incident location. In the other direction, casualties must be transported to hospitals and other health care facilities for further treatment. For this reason, the efficiency of the response is greatly determined by ambulance travel times and the ability of health

care facilities to absorb large numbers of patients. We propose methods to compute the travel times to and from the incident location based on a classified road network. The methods take into account different attributes that depend on ambulance type and capacity, road quality, time of day, weather or actual traffic density. Correctly computed travel times are crucial not only for optimal deployment of all resources within the analyzed region, but also for the evaluation of the readiness of the emergency health care system for a major incident. We have included the methods in an agent-based simulation of transport during the response. From the simulation outputs and with the help of geographical information systems and information visualization methods we have synthesized maps that represent the capability of a region to absorb a major incident defined by a scenario. When combined with risk maps and maps of population density the synthesized maps allow emergency management authorities to find critical points and gaps in the emergency health care service.

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(P2-28) Collaboration Between Nurses and Physicians in the Emergency Department: An Indonesian Study

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Background: Positive collaboration between nurses and physicians is essential in all areas of care especially in emergency practice. This is because it has a significant relationship with the quality, safety, accountability, and responsibility of care. Three areas are positively related to collaborative interaction between nurses and physicians: provider outcomes, patient outcomes, and organizational outcomes.

Aim: To examine nurses' and physicians' attitudes towards nurse-physician collaboration in the Emergency Department of Dr Saiful Anwar General Hospital, Malang, Indonesia.

Methods: The study was a comparative descriptive quantitative study using a modified Jefferson Scale of Attitude towards Physician-Nurse Collaboration. Data were collected from 47 nurses and 24 physicians who participated in the study. Descriptive statistics, parametric and non-parametric inferential statistics were used to determine group scores and to examine differences between groups, as well as to determine the relationship between demographic characteristics and participants attitudes.

Results: Emergency nurses had significantly more positive attitudes toward collaboration than emergency physicians ($p < 0.001$). Emergency nurses had significantly higher scores in three of four underlying factors of the instrument: “physician dominance”, “nurse autonomy”, and “caring as opposed to curing”. The effects of gender, age, education, and experience in other hospitals on nurses' and physicians' attitude towards collaboration were not statistically significant. However, experience in the Emergency Department of Dr Saiful Anwar General Hospital was significantly related to participants' attitudes towards collaboration ($p = 0.023$).

Conclusions: The findings of this study indicate that both organizational and individual strategies should be developed to enhance the nurse-physician collaborative relationship. Inter-professional education may enhance health care professionals'

attitudes towards collaboration. A larger and more representative sample is needed for future research, especially examining relationships such as between collaboration of these health professionals and patient outcomes and work place satisfaction.

Keywords: nurses; physicians; collaboration; emergency; Indonesia

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(P2-29) Educational Model for Pre-Hospital Disaster Management in Haiti and Beyond

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Introduction: There has been increased international awareness and a need to provide accessible and essential emergency preparedness training in developing countries that has resulted in the recognition of new teaching needs and number of new initiatives to meet these needs.

Methods: These teaching methods have been applied in Haiti before and after the 2010 earthquake. They include: - Established a “Train the trainer” model - Established civilian first responder training - Basic Life Support (BLS) and First Aid - Implemented medical training using the Meti Simulator models - Conducted post-training Disaster drill - Conduction of post training assessment - Succession model of training.

Results: A total of 54 people completed a BLS course and 67 completed a First Aid course. 12 participants completed the First Aid and BLS Instructors course. 95 program participants completed an end of course survey. 41 participants had no prior BLS/First Aid training or exposure. The course participants included 2 physicians, 22 students, 8 nursing students, 7 nurses, 20 teachers, 12 health workers, 5 drivers, and 14 laborers. 92 of those surveyed stated they would recommend this course to a friend. 88 participants stated that hands on learning helped them better learn the course material.

Conclusion: This training model has been well received in rural Haiti and can be applied in other developing countries. We would like to standardize training protocols that will serve as a foundation for self-sustaining higher-level emergency, pre-hospital, disaster training and management. This will improve the general quality of health care delivery. Our next pilot of this program will be in other parts of Haiti and in Khartoum, Sudan.

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(P2-30) Development of Disaster and Emergency Medicine in Nepal

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Nepal, a landlocked country between China and India, is developing disaster and emergency medicine. In 2007, the Nepal Disaster and Emergency Medicine (NADEM) Center was formed with the aim of developing this specialty in Nepal. The

first hospital was built in July 1889. It wasn't until 1988 that a Disaster Response Team was organized following a stampede incident in the national stadium in Kathmandu. The country often experiences disaster and emergency situations due to geographic and natural hazards and political tensions.

In 1984, the Institute of Medicine, Tribhuvan University Teaching Hospital created emergency services with general practitioners (GPs) directing and providing services. Since then, almost all emergency services of different hospitals are run by GPs with house officers, nurses, and paramedics. There still is a lack of training and proper management, and limited equipment and infrastructure to provide needed disaster and emergency services to the people. The NADEM Center is developing coordination objectives between different emergency service providers to organize ways of service providing. This will be done through NADEM's continuing medical education and publication of *Journal of Nepal Disaster and Emergency Medicine (J-NADEM)* and NewsHealth; coordination among emergency medical services (prehospital), in-hospital services, and disaster and critical care medicine; and planning and implementation of different research, training, workshops, seminars, and conferences in disaster and emergency medicine with cooperation from the world. The NADEM Center will develop International Institute of Disaster and Emergency Medicine.

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(P2-31) The Situation of the Development of Disaster Medical Assistant Team in Japan

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Background: After the Great Hanshin-Awaji Earthquake, the disaster countermeasures concerning medical care in Japan changed drastically. In 2005, the Japanese government began to develop a domestic, rapid, medical response system called Disaster Medical Assistance Team (DMAT) for the purpose of rapid medical correspondence in the acute phase. As of 12 July 2010, 393 institutions and 734 teams (3,700 persons) were trained. A DMAT is important not only to the response to large disasters such as earthquakes, but also the response to local disasters. It is important to establish the DMAT system of each prefecture and district.

Methods: The DMAT system at the local level was described at the 15th World Congress on Disaster and Emergency Medicine. During the present Congress, the development and activities of the DMAT system over the past three years will be reported.

Results and Conclusion: Eight local districts in the DMAT system have been developed, and progress has been made in the fields of policy, operative plans, and agreement among each province. The system of inter-prefecture mutual aid must be built upon in the near future.

Keywords: acute phase; Disaster Medical Assistance Team; Japan; preparedness; response

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