Medical Response Protocols For International Events In Canada

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International Conventions and Agreements on Diplomatic Relations for Internationally Protected Persons (IPPs) stipulate that the host country must provide emergency health care to visiting dignitaries. In Canada, Health Canada assumes the responsibility for medical contingency plans for major international events (e.g., G7, APEC, Francophone Summit, Summit of the Americas)

Health services provided to IPPs include conventional, non-mass casualty, health care intended to protect the IPPs from further illness or injuries, and conventional mass casualty health care that relates to terrorist situations, multi-car motorcade accidents, or chemical, biological attacks.

In planning such services, Health Canada's organisational challenges include training medical personnel and emergency responders, acquisition of special equipment and pharmaceuticals, crisis communication, inter-agency cooperation, and limited access for medical personnel in areas of increased security. Over the years, the scope of our medical plans has increased because of the need to protect not only visiting IPPs, but also emergency responders, medical staff, and security personnel.

Joint planning of emergency care with the political scenarios and coordination with other multi-disciplinary key groups such as security, fire, ambulance, and health care remains a challenging process.

Keywords: Health Canada; health services; internationally protected persons; mass casualties; planning; protection; protocols; training

Medical Staff Response to the Introduction of Peer-Supported Critical Incident Stress Management (CISM): A Study of Attitudes at a Tertiary Hospital

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Background: Debate continues over the positive and negative effects of critical incident stress management (CISM) and debriefing. In March 1997, St.Vincent's Hospital Melbourne (an inner city tertiary level teaching hospital) trained a team of 44 staff volunteers from nursing, medical, orderly, clerical, pathology, security, kitchen, and managerial staff in the use of CISM techniques. The training involved a 3-day, full-time course on the "Mitchell Method" of voluntary, peer-supported, non-intrusive, non-operational, early intervention.

Aims: To identify medical attitudes to CISM following its introduction at a tertiary medical centre.

Methods: A questionnaire was sent to medical staff employed at the hospital to assess their attitude towards CISM 18 months after its introduction. Replies were anonymous.

Results: Replies were received from 155 of 378 medical practitioners (41.0%). Response rates varied from 54.3% for 1st year interns, to 39.6% for senior staff. Perceived problems and advantages of CISM varied with the level of medical experience. 87% of all respondents supported the presence of a CISM Team at the hospital, but there was wide variation as to which format of CISM best suited medical staff.

Conclusion: The long-term benefits of CISM remain controversial. However, there is evidence that voluntary, non-intrusive, peer-supported CISM team intervention by trained staff, can aid subjective wellness in the short-term. The structure of the CISM for medical staff may need to vary with each incident.

Keywords: attitudes; crisis intervention; disasters; hospitals; peers; post-traumatic stress disorder (PTSD); stress disorders; stress management

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