

The paper details trends in gang violence and victimization, considering them in terms of accepted chronological phases of disaster. Drawing from the experience of other forms of conflict disaster, future research needs are defined, asserting that gang victimology and epidemiology are unexplored areas within community health and disaster studies which deserve the attention of the emergency and disaster medical community.

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Terrorism: The Belfast Experience

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In civilian practice, most gunshot wounds are due to low-velocity weapons, whereas high-velocity weapons are commonly used in military warfare. As a result of civil disturbances in Northern Ireland, injuries due to both low- and high-velocity arms frequently have been encountered as well as those caused by bomb explosions. Injuries due to bomb blasts predominantly affected the peripheries, head, and neck suggesting that clothing had a protective effect.

Terrorist activities caused more than 20,000 civilian injuries and more than 10,000 injuries to security forces during a 24-year period. The peak incidence of injuries and highest mortality was in 1972.

All hospitals, which may be called upon to deal with a major disaster, should have a well-developed disaster plan which can be put into action rapidly and efficiently. A mechanism for triage of the injured into categories by a senior doctor in the accident and emergency department is of valid importance. Prompt resuscitation and urgent treatment of the critically ill is mandatory. Multiple injuries to the head, chest, abdomen, and limbs often require the expertise of different specialists working together and coordinating their activities.

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The Bologna Terror Bomb Disaster

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During the last 20 years, terrorist activities of different kinds have become increasingly common as expressions of extreme political groups. The mass injury effect of bomb attacks presents medical care organizations with special problems. Not only do a large number of severely injured patients quickly need to be provided with adequate care, but many of the patients also often exhibit a complicated and special pattern of injuries.

In August 1980, a terrorist bomb attack was made on the central railway station of Bologna, Italy. Altogether, 291 persons were injured, 73 of whom died at the scene. An analysis of the nature of the injuries and the mechanism by which they occurred showed that three types of bomb injuries could be distinguished: primary blast injuries (pulmonary injuries and flash-burns), and secondary and tertiary injuries (concussion, lacerations, and fractures), the latter two types from flying debris set in motion by the blast wave or propulsion of the body.

Many of the patients with primary blast injuries of the chest initially were in relatively good condition, but developed progressive respiratory changes within 24 hours. In some of these victims, blast injury of the chest was combined with perforation of a tympanic membrane. Several persons sustained burns, mostly extensive but superficial and located on unprotected parts of the body. Stones flying through the air caused severe injuries and most of the deaths were due to crush injuries when the station building collapsed. More predominant than the primary blast effects were the secondary effects.

Because the secondary and tertiary effects of a bomb explosion often lead to multiple injuries, these patients require considerable therapeutic and medical care resources. By an evaluation of the degree of severity of the injuries with use of the Anatomic Injury Score and Injury Severity Scoring systems, the injurious effects of different types of disasters can be estimated and the findings can serve as basis for future planning of disaster preparedness.

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The Medical Response to the Conflict in Yugoslavia

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The tragic events in Bosnia are a disaster that keeps unfolding without, as yet, any obvious foreseeable endpoint. The delivery of medical care in a war situation by civilians in a disaster that has no defined limit poses problems for health agencies.

The experiences of delivering medical-aid in these circumstances will be described.

The special role of assessment of health needs will be emphasized with reference to missions in Croatia, Bosnia, Serbia, Montenegro, and Macedonia.

The relationship of the medical response in these circumstances as opposed to a disaster with fixed endpoint will be explored. Particular attention will be paid to the relationship between local medical practitioners and the outside aid agencies.