company Euro-Flite Ltd. Air Ambulance developed a medical evacuation program for patients coming from Russia to Finland or to another western country. Annually EMA/Euro-Flite arranges some 70 air-ambulance flights from Russia and other previous Soviet states.

The patients are escorted mainly to hospitals in Helsinki, but also to other locations in Austria, Belgium, Germany, and Great Britain, where high quality medical care is available. For patients in need of urgent treatment, it is mandatory to provide the care in the closest possible hospital, which meets the highest standards of western medical care. Depending on each case, EMA recommends and arranges a receiving facility. When the patients are sufficiently stable, they can be escorted further to their respective home countries like the USA or Canada.

Many of the escorted patients have been evacuated from remote, oil drilling sites in Western Siberia, where living conditions are very rough and health-care facilities are insufficient. These patients have suffered from both medical conditions such as heart and lung problems or traumatic injuries. Due to the lack of available local health care on the hardship drilling sites, preparedness for both emergency treatment as well as an efficient evacuation program is needed.

The EMA has at least one medical team on stand-by for emergency medical evacuations 24 hours a day. If required, the Euro-Flite dedicated air-ambulance aircraft can depart within as little as two hours from the go-ahead. The medical team and equipment are tailored to meet the special requirements of each case. Thanks to the vast flying experience into Russia, medevacs, even from distant areas in Siberia, are possible without delay.

Keywords: air ambulance; air-medical; evacuation; expatriates; Finland; medical care; responses; Russia; trauma

G-55
Historical Review of Aeromedical Evacuation of Emergency Patients in Japan

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Wounded patients should be evacuated in a short time following their injury in order to save their lives. Evacuation and transport of wounded patients have been performed in Europe, especially by French Army since 1920, not so long after the first flight of an airplane by Wright Brothers at Kityhark, United States of America in 1903.

Dr. Terasu, who studied war medicine in France, gained experience about a aeromedical system for the evacuation and transportation of wounded soldiers by a specially designed airplane by French Army. After he came back from France, Dr. Terasu sent to the headquarters of Empirical Army, a report about the usefulness of aeromedical evacuation using such a specially designed airplane. In 1925, the Air Division of the Headquarters of Empirical Army ordered to Dr. Terasu to design a hospital airplane.

The first hospital airplane was delivered in 1925. In 1932, these airplanes were sent to Manchuria on the occurrence of the Manchurian Incidents. From 1932 to 1934, hospital airplanes evacuated 1,512 soldiers and saved their lives. A total of 33 hospital airplanes were built by 1940. But unfortunately, those airplanes have not been constructed since that time, since the Empirical Army had other priorities for aircraft construction.

There have been no more hospital airplanes built in Japan until now. Compared with other forms of patient transportation, airplanes can transport patients long distances and in a short time. Therefore, they will be very useful during a disaster or catastrophe.

We should prepare aeromedical systems for transportation of the patients by airplane for disasters in Japan.

Keywords: Airmedical transport; hospital aircraft; transportation; trauma

Panel Discussion (3)
Disaster and Mental Health in Asian Countries
Tuesday, 11 May, 10:30-12:30
Chair: Reiko Homma True, Naotaka Shinfuku

PN3-1
Disaster Mental Health in Asian Countries — Towards Culture-Friendly Care

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The author worked as Regional Adviser in Mental Health for the Office of the Western Pacific of the World Health Organization for 13 years from 1981 to 1994. During his assignment in Manila of the Philippines, he collaborated with Philippino mental health specialists to promote psychological care for the victims of a series of natural disasters (such as the earthquake in Baguio, the eruption of Mt. Pinatubo, etc.) Also, he outlined the plan to provide mental health care for the population of disaster-torn (mostly man-made disaster) Cambodia.

These experiences have raised his awareness on the importance of psychological care for the victims of disasters. Soon after his return to Kobe, Japan, he experienced the Great Hanshin-Awaji Earthquake on 17 January 1995. Since his office is situated at the center of the Earthquake, he became a victim and at the same time, an observer of physical and psychological problems among the victims. He received and coordinated programs for many specialists from foreign countries (mostly from USA and Europe) to provide psychological care to the victims. However, he found specialists care services less useful in Kobe. Psychological support from volunteers and nearby housewives based on their common sense, has been much more useful to lessen the grief of the victims.

Many victims still are suffering from a variety of psychological and physical problems even four years after the Great Hanshin-Awaji Earthquake. However, the

rate of PTSD is reportedly rare comparing those in Europe and in USA.

Are there any differences of psychological problems among disaster victims in Kobe or in Asia compared to those among the victims in other cultures? Also, is there any difference and culture-specific way in Asia to provide psychological care to the victims?

The author would like to make a summary review of disasters in the Western Pacific Region, and would like to comment on the need to promote a culture-friendly care system in Asia.

Keywords: disasters; earthquake; Great Hanshin-Awaji Earthquake; mental health; problems, psychological; workers, mental health; volunteers

PN3-2
Cultural Diversity in Mental Health Disaster Assistance in the United States: Consideration of Services to Asian-Americans

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Over the past several decades, we have witnessed significant development in mental health disaster assistance activities and the publication of exhaustive on the subject in the United States. However, little information is available about how to address the culturally diverse groups among the affected population, despite the presence of many ethnically and culturally diverse groups. This presentation will focus on the disaster assistance lessons learned in reaching out to Asian-American communities in California.

In working with disaster victims in the USA, we emphasize the need to set aside the traditional psychotherapeutic approaches, to be prepared to offer practical help, to do outreach, and to design flexible interventions appropriate for different phases of disaster. With Asian-Americans, we need to be even more flexible, much less formal about psychotherapeutic interventions, and to avoid the stigma of psychiatric labeling. It is because many Asian cultures traditionally have stigmatized mental illness, which often will result in ostracism for all members of the family. For this reason, very few will consider approaching mental-health professionals unless the level of disturbance becomes severe and dangerous.

An effective approach, we have learned, is to capitalize the Asian-American's receptivity toward education, and to organize an aggressive prevention, education campaign about the impact of disasters on mental health. Through the use of community forums, television, newspapers, and radio programs, we try to increase the community's awareness about the normal nature of the traumatic stress reactions and the benefit for early interventions.

Another approach is to recognize the tendency for Asians to express psychological stresses through psychosomatic complaints, and to work closely with or through primary care physicians, who provide care for a large number of these patients When using psychotropic medications, we try to take into consideration what is known about drug metabolism and drug action for Asians, e.g., effective dosage for tricyclic antidepressants or benzodiazepines tend to be less for Asians than is needed for Caucasians.

Keywords: awareness; culture; diversity; education; media; mental health; reactions; recognition; stigma; stress; treatment

PN3-3
Mental Health in Disaster: The Philippine Experience

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Disasters are adverse life experiences that cause human casualties, damage to property, and severe economic losses. Disasters disrupt the physical, psychosocial, spiritual and ecological aspects of an individual and a society. Thus, they are referred to as a catastrophic event that impacts on the human community.

The Philippines have been ravaged by many disasters, especially during the past decade. The more devastating among these are: the earthquake of 1990, the volcanic eruption of Mt. Pinatubo in 1991 and its subsequent lahar flows through 1996, the flash flood in Ormoc City and other towns, the sinking of passenger ships, the Ozone Disco fire, the Pagoda River tragedy, the explosion of Flight 387, etc.

The occurrence of disasters has been more frequent in developing countries like the Philippines. This results in greater numbers of victims who already are socially disadvantaged with poor health, and other poor socio-economic conditions. The reactions to such an event may be immediate (arising immediately upon the impact of the event) or shortly afterwards. While recovery may be expected for most following the impact of the disaster, delayed psychosocial and even psychiatric symptoms of the post-traumatic stress disorder or depression may be manifested within a few years after the event. The extent of these psychological problems, identified through the use of the Self-Reporting Questionnaire, that was found among victims of the Mt. Pinatubo disaster was 92% one month after the eruption, and 76% nine months later. The prevalence of psychiatric syndromes, using the 40-item, Present State Examination administered 2–3 years after the disaster among the victims of the Mt. Pinatubo lahar and floods, was 31% for anxiety and 31% for depression. A similar frequency of symptoms also was identified among survivors of the earthquake.

Psychosocial interventions for disaster victims were undertaken since the earthquake. of 1990. The methods involved the group process called Psychosocial Processing (PSP) and Critical Incident Stress Debriefing (CISD). These were undertaken with disaster victims of the Mt Pinatubo disaster and other disasters that have occurred in the Philippines. Psychosocial interventions also involved training other health professionals, social workers, psy-