

mileage to the out-of-hospital setting relative to the hospital was not taken into account because the impact of this difference was assumed to be negligible. Subsequent to the study period, the regional coroner's office emphasized the need for emergency physicians to complete the death certificate and to call the coroner's office only when the death met certain criteria. Presumably, this would reduce the cost of the coroner's investigation for each in-hospital ED pronouncement. However, requests for additional responsibility and more paperwork must be weighed against competing service and academic demands, and the routine practice of calling the coroner has not significantly changed.

Dr. Gall identifies an important factor that may limit the generalizability of our results to other regions as alluded to in the limitation section of the manuscript. We thank the Editor for the opportunity to respond and to Dr. Gall for his cogent comments and his interest in this subject.

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**Pine Lake Tornado:
the rural response**

To the editor:

We read with interest the Pine Lake Disaster article by Sookram and colleagues¹ in the January issue of *CJEM*. Having been involved in the disaster response we feel it important to comment. Certainly, learning from such disasters will improve preparedness for

future events, but accurate information about the response and the experiences of those directly involved are essential. Having read the article, we are not sure that this occurred.

The article discusses the value of physicians at the scene and indicates, correctly, that there was a STARS flight physician on site. In our opinion he should be praised for his actions in managing and triaging patients for transfer. The article also states that, within 2 hours, Edmonton emergency physicians were on site, but this observation diverges from our own experience.

In the aftermath of the tornado, Guardian Ambulance, the primary EMS responders to the event, rapidly contacted Innisfail Hospital (which normally covers the Pine Lake area), and requested a physician presence. In response, we left for the scene approximately an hour after the tornado touched down. After arriving, the only physicians we encountered were the STARS physician and one other physician, who arrived later in the evening. Despite being part of the tornado response, neither of us have been approached for any comment on the events of the day. The question is, if input from physicians and support staff both at the scene and at smaller regional hospitals was not solicited, can meaningful conclusions be drawn from limited reports of what occurred?

On a personal note, and reflecting our desire for accurate reporting of the event, we are concerned that the *CJEM* article focuses on the response of and the care provided by secondary and tertiary hospitals. Whilst most of the severely injured patients were correctly sent to centres with the facilities to cope with them, a large number were sent to Innisfail and other primary care hospitals. The lack of acknowledgement of the role played by these other hospitals and care providers is a cause of upset to many of the people involved.

Given that many disasters occur in areas remote from large urban hospitals, it seems that the rural and primary care disaster response should surely be of interest, yet it seems our contributions are not considered to the same degree as those of the larger centres. We do not want to belittle the efforts of anyone involved, and it was heartening to see how so many people came together to deal with the tornado, but we do have concerns about the way the disaster response was portrayed, and we would be interested in the authors' response to these concerns.

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Reference

1. Sookram S, Borkent H, Powell G, Hogarth WD, Shepherd L. Tornado at Pine Lake, Alberta — July 14, 2000. Assessment of the emergency medicine response to a disaster. *CJEM* 2001;3(1):34-7.

[One of the authors responds:]

Thank you for reading and responding to our article. It was an unfortunate oversight that we did not solicit your input since, clearly, your perspective would have been valuable. As you suggest, Guardian Ambulance and the other early responders did a wonderful job establishing a triage station and recruiting help from the later-responding services. Health centres, rural hospitals and caregivers from Olds, Innisfail, Stettler, Three Hills, Lacombe and other small communities performed well during the night and made invaluable contributions to the disaster response.

An earlier draft of the article contained a more extensive discussion of the role of smaller communities. Unfortunately, for reasons of space, and perhaps because of our own more urban

perspective, we narrowed the focus of the article and perhaps failed to give credit where credit was due. This was not an intentional slight, and an apology is warranted.

With respect to the physician response, I compiled first-hand accounts from the STARS physician and 3 other physicians who flew to the disaster site with me on the night in question. Additional information was compiled during debriefings in Red Deer over the following weeks, and much of the information was subsequently confirmed and published by Hogarth and Neil.¹ It is not surprising our paths did not cross, since I worked most of that evening at the Red Deer airport treatment unit, receiving badly injured patients from the

scene, from Red Deer Hospital and from primary care centres like yours. So, just as you were unaware of the contributions of the Edmonton physicians, I was unaware of yours. Had I known of your direct participation, I would have invited you to contribute your perspective to the article. I thank you for bringing it to my attention.

Your experience and perspective, described in the letter above, adds an important dimension to the picture. It might be appropriate to publish this experience or consider presenting it at an appropriate venue.

Of interest, there will be a Disaster Medicine stream at the CAEP 2002 meetings in Hamilton, Ont., next spring that you might be interested in con-

tributing to. Further information on the Disaster Medicine track is available from Dr. Garnet Cummings at the Royal Alexandra Hospital in Edmonton (gcummings@ualberta.ca).

Once again, thank you for your insight, and I apologize for not providing an adequate discussion of the primary care facility's important role in disaster response.

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Reference

1. Hogarth WD, Neil GF. Tornado at Pine Lake, Alberta — July 14, 2000. Anatomy of a disaster: one hospital's experience and recommendations. *CJEM* 2001;3(1):38-40.

CAEP 2001 Research Grants Applications

Hoffman-La Roche Limited (HLR) has agreed, once again, to provide a \$25 000 unrestricted grant to support the CAEP Research Grants Competition. HLR's generous support allows CAEP to offer several research grants this year, and Canadian emergency medicine (EM) researchers are eligible to apply for individual grants of up to \$5000.

The goal of the CAEP Research Grants Competition is to promote and support Canadian EM research. Consideration will be given to applications from all centres, irrespective of affiliation (e.g., community physicians, non-university centres and rural physicians are encouraged to apply); however, only applications from CAEP members will be reviewed. Resident, fellow and student projects must be supervised by a CAEP member who is ultimately responsible for the completion of the project and is listed as the principal or co-investigator. Experienced researchers who graduated from their residency or research training programs more than 5 years ago are not eligible for this competition. A working group of the CAEP Research Committee will review grant proposals and allocate funds on the basis of methodological quality, originality and generalizability in the Canadian EM setting.

Process

Proposals for research projects must be delivered to the CAEP office no later than 5:00 p.m. (EST) on **September 3rd, 2001**. Fax and email versions of proposals will **not** be accepted. The grants will be reviewed, and all applicants will be notified of the funding decisions by October 1, 2001.

Proposals must be no more than five (5) pages of single-spaced text (excluding references and appendices). Size 12 font and unadjusted margins are mandatory. The proposal should be formatted under the following headings: Structured Research

Abstract (limit: 1 page), Introduction/Rationale/Research Question/Methods (limit: 3 pages), Timing/Future Plans (1 page), and References (limit: 20 references). The research data collection tool and abbreviated curriculum vitae (<3 pages) of the principal investigator must be appended. Proposals that fail to comply with these rules will be returned to the author(s) and will not be reviewed.

Applications will be considered from all areas of interest to emergency medicine. Proposals may involve practice audits, feasibility studies, meta-analyses or small clinical projects.

Budget

Maximum grant funding is \$5000 per grant. Grants in excess of \$5000 will **not** be considered, unless proof of alternative and secured funding is provided. A single page outlining the use of the grant resources is mandatory as an appendix to all grant applications. No funding will be provided for presentations at meetings, conference travel or major equipment purchases (e.g., computers). Funding unclaimed within 12 months of the deadline will be reallocated.

Expectations

Successful applicants must provide a final report on the research project and they will be encouraged to present their completed projects at the CAEP Annual Scientific Meeting.

For further information, please contact the CAEP Head Office.

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