



Living in the 'New Normal': Is Surge Capacity a Myth or a Reality?

Bruce Parkes

Neil Simon, writing in the Contingency Planning September issue, postulates that today we live in what might be called the "New Normal". The unpredictability of a crisis creates great concern and increases already high levels of stress and strain. No one knows what will happen, or when. Reality is the recognition of our inability to "control" things we once thought were in our control. Due to these significant changes in human existence we need to explore two key questions: Why do we do what we do? Is it appropriate for today's times?

Years of training and life experiences have reinforced our response to emergencies. This automatic navigating system allows us to successfully react to situations most of the time. However, assumptions of the past have changed, and we need to examine our own fundamental assumptions and adjust our response mechanisms. Without this analysis, we are at risk and we create risks for others.

Today's receivers of emergency services have a different set of expectations as compared to the simpler times of the past. First, they expect a high level of expertise in managing a crisis. Second, they are less forgiving of emergency services when their needs can not be immediately met. The media has further reinforced this perception.

Today's environment requires us to reassess our thought processes and actions. We need to evaluate our training and "emergency" response paradigms by looking at our fundamental assumptions. The assumptions we grew up with no longer apply so we need to build trust with employees and colleagues and integrate today's collaborative approach with traditional command and control metrics. We must climb the ladder of inference with open eyes when living in the new normal.

So let's look at the assumption that we have an ability to create significant surge capacity. We have coasted through this winter with the lowest incidence of influenza for the past few years. While overall numbers are still down, spring has brought with it a patient influx that has brought major city hospitals to a standstill. "Hospitals Flooded" shouted the headlines. The New Zealand Herald published a snapshot of North Shore Hospital on August 25. They reported there were:

- ✘ 42 patients for 25 acute beds
- ✘ All corridor spaces filled
- ✘ 14 patients awaiting ward beds
- ✘ Surgery was on hold as flu takes over

On September 1, North Shore's emergency care centre experienced its busiest ever 24-hour period, seeing 195 patients. Like many other hospitals caught in this "flu wave" it has not got any better. Overall, average daily presentations are 20% higher than average. All wards have 5 + patients over their contracted bed numbers e.g.

41 patients in a 35 bed ward and ECC has an average of 90 patients at any one time (in a 61 bed unit). ECC staff are working under relentless pressure, described by one experienced clinician as "trench warfare conditions".

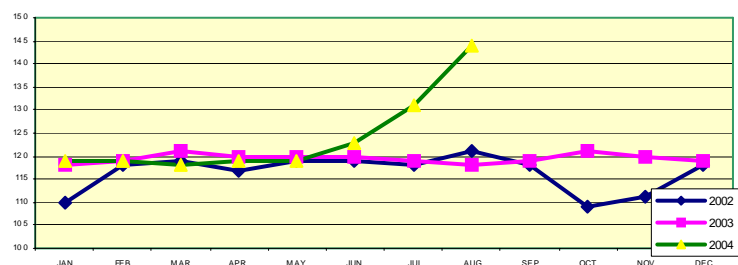
North Shore looked at activating its Major Incident Plan and found it had gone way past the workload the plan envisaged. North Shore has worked hard and well beyond the call

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North Shore Hospital ECC All Visits 2002 - 2004



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of duty to cope, as have other hospitals around the country. In August, Waikato Hospital's emergency department clocked up its busiest month on record, seeing 4500 patients. The previous highest month was 4400 in June 2003.

In all hospitals besieged staff working in overloaded conditions are somehow managing to complete their professional tasks by stint of immense effort and goodwill. Much maligned "anonymous management" are pitching in to help. Not just when they can, in some hospitals they are even being rostered for duty in Emergency Care.

Are we really being stretched? A comparison with the load experienced by Canberra Hospital during the January 2003 bush fires is illuminating (no pun intended). As reported in the Medical Journal of Australia (MJA) vol 181,1 pp 40-42, Canberra Hospital is a modern 483 bed tertiary hospital whose Emergency Department treats 52,000 adult and paediatric patients annually.

"On the 18th of January 2003, at the height of the emergency, there were 252 presentations to the hospital ED, almost 7 standard deviations above the daily mean of 137 for the period 1998-2002. However the number of admissions (52) was less than 3 standard deviations above the mean for the period (34). To our knowledge, this is the highest number of patient presentations from a single event treated in one ED since Cyclone Tracey devastated Darwin in 1974. It represents one of the largest responses to a disaster ever by a single Australian hospital, although injuries were less severe overall than in many other disasters."

The Canberra ED presentations dropped to circa of 130 - 150 within a day— unlike an influenza wave that rolls inexorably on and on. The MJA article offers as a disaster definition, "an event that overwhelms available resources". On both numbers and definition criteria, influenza waves regularly push us into a "disaster situation".

Hospitals commonly adopt a strategy of appealing for people with minor ailments to go to a GP rather than a hospital emergency department. We do not have precise data on GP workload, although the NZ Herald reported that in South Auckland, the estimated flu rate was 228 cases per 100,000 patient population. That is, at the best, an 0.2% infection rate and on anecdotal evidence significantly under reported.

Influenza surveillance data, which shows trends rather than absolutes and tries to pick up the large unnumbered underbelly of those with the flu who do not consult their GP, is the normal proxy.

Based on the surveillance data for the first week of September Tairāwhiti has an epidemic with 833 cases per 100,000 patient population. Yet Gisborne Hospital is not under the extreme pressure faced by its big city counterparts. Tairāwhiti certainly is not awash with primary health providers, so is the answer highly skewed data or different community behaviour for seeking health care?

While our hospitals are struggling with the effect of a rela-



Auckland City Hospital ED in a rare quiet moment

tively low population infection rate, pandemic modelling, based on a 35% infection rate, currently being undertaken for the Ministry of Health suggests that our hospitals will have sufficient surge capacity to cope with a pandemic wave. In large part this surge capacity will be created by diverting patients to the primary sector. Yet the same model clearly shows that the primary sector will be overwhelmed. The unspoken but clear assumption is that people will not get

the care they might have expected and will have to look after themselves. Yet we have not started to condition and educate our populations for this role. Perhaps Tairāwhiti, with its rural pioneering culture has had the answer all along.

None of this is new or remarkable. Technically sophisticated health care is a limited resource. No matter how hard we try some people are going to miss out. Just as any military commander does, we have to be clear about the level of missed care (casualty level) that we (and they) are prepared to accept.

Our communities are not stupid and with any thought will realise that access to care will be limited in a "disaster". However, as there has been no consultation and debate we do not know the level of risk our communities are prepared to accept. Throwing money at the problem is not a solution. In an environment of continual overdrafts in health care funding, any additional funding will quickly be lost in the system.

In the United States, the Agency for Healthcare Research and Quality has released a tool to help State and local officials quickly locate alternate health care sites if hospitals are overwhelmed by patients due to a bioterrorism attack or other public health emergency. The alternate care site selection tool is included in a new report entitled, *Rocky Mountain Regional Care Model for Bioterrorist Events*.

In the event of a bioterrorist event or other public health emergency where hospitals may be overwhelmed by a sudden influx of patients; the alternate care site selection tool is designed to allow regional planners to locate and rank potential alternative sites—stadiums, schools, recreation centres, motels, and other venues—based on whether they have adequate ventilation, plumbing, food supply and kitchen facilities, and other factors.

It seems finding a facility and even beds might not be too hard. Finding sufficient (or any) medical and nursing staff seems to be a far harder proposition.

As our National Provincial Rugby Championship currently so patently demonstrates, working as a team we will be able to achieve far more than relying on a few 'stars' to carry the load. Some DHBs are working well with their non DHB providers, others are not. Without full co-operation across the sector, creating surge capacity is nothing more than a planning dream.

Meanwhile, hospitals are still seeking a cure for the perennial problem of waiting. 🎵

A Disaster Waiting to Happen

While discussing our current influenza wave a colleague commented, "we wouldn't know whether this is just a sudden rush or the start of a pandemic". It took a while to recognise the evidence of the 2001 anthrax distribution in the United States.

The Natural Hazard Observer, published by the University of Colorado in Boulder has been running a series on "Disasters Waiting to Happen". We publish the scenario featured in their May 2004 edition. As you read it you may be comforted by thinking Pasadena is a long way away and "it couldn't happen to us". But what gives you confidence that we would do better? Resisting the temptation to change the location and organisation to reflect a New Zealand setting, we leave it to you to customise it to your city as you contemplate your ability to cope.

Plague on Pasadena



Yersinia pestis, the bacteria that causes plague, is endemic in California. However, cases of the respiratory form of the disease, pneumonic plague, are highly unusual. Pneumonic plague is likely to be disseminated in an aerosol form and arise from a bioterrorist event. Plague is highly communicable and can be fatal if not treated within 24 hours. The respiratory form of the disease is characterised by high fever, chills, headache, malaise and a productive cough. Effective disease control requires isolation of infected individuals until they have been on antibiotics for three days. Most hospital laboratories are able to culture and identify *Y. pestis* within 48 hours, although faster methods do exist. Prophylaxis is recommended for all persons exposed to the aerosol and for close contacts of confirmed cases.

It has now been four days since the first cases of plague were reported to the Pasadena Public Health Department. Based on epidemiological evidence, the Federal Bureau of Investigations (FBI) suspects that the release of the aerosolised plague occurred at the Pacific Movie Theatres in Pasadena. They have classified the event as a terrorist act. The results of their ongoing investigation have not yet been shared with the people of Pasadena and surrounding areas, but they are keeping the public informed of their activities. The following is a review of what has happened so far.

The First Cases

Early Monday morning, Amber, a 14 year old volley ball star at Pasadena High School walked into the emergency room at Huntington Memorial Hospital complaining of a

high fever, headache and a watery productive cough. While in the waiting room, Amber started to have difficulty breathing and became cyanotic. She was then taken immediately for examination. A chest x-ray suggested pneumonia and Amber was admitted to hospital but not placed in isolation. She was started on antibiotics while doctors waited for the results from blood and sputum cultures.

In the middle of the afternoon two patients walked into the emergency room at Kaiser Hospital in Pasadena and another two walked into St Luke Hospital in Pasadena. All four shared similar flu like symptoms, including shortness of breath and what appeared to be pneumonia. One of the patients at Kaiser died and his body was transported to the Los Angeles County Coroner's Office.

Later that day another patient arrived at Huntington Memorial Hospital with flu like symptoms and a bloody productive cough. By the time he presented a staff shift change had occurred and the emergency room doctors and nurses knew nothing about Amber's case. Since the cases were being cared for by different doctors and at different facilities, it was virtually impossible to recognise that these cases were part of an impending epidemic.

Signs of an Epidemic

Around 1:30 a.m. on Tuesday, Pasadena Emergency Medical Services began receiving calls from people in severe respiratory distress. From 1:30 to 4:00 a.m., EMS transported a total of 17 people to Pasadena hospitals. Ten were taken to Huntington Memorial, five to St Luke, and two to Kaiser. Both Huntington Memorial and St Luke closed their emergency rooms to EMS transports, but that did not stop people from walking in. By 4:00 a.m., both hospitals had received 15 walk ins each. All the patients had flu like symptoms.

At 4:30 in the morning an emergency room physician from Huntington Memorial called the Pasadena Health Department's after hours reporting line but was unable to leave a message. He asked his staff to find another number but they could not find one. The doctor decided to call the Pasadena Police Department for assistance. A confused police operator transferred the call to the Public Works Department. Frustrated, the doctor called back and spoke to the supervisor who said the police would locate and alert the health officer.

The Health Department Responds

By 8:30 a.m. on Tuesday, Pasadena Public Health were mobilising. A surveillance advisory was issued asking area physicians to be on the look out for pneumonia like illnesses and to report them to the Department of Public Health by phone or fax immediately. An epidemiology investigation team was sent to interview the cases at Huntington Memorial. Unfortunately, due to the number of cases, they quickly discovered they did not have enough staff to conduct individual investigations. Instead the DPH began collecting samples for analysis at the Los Angeles County Public Health Lab. Additional cases were flooding area hospitals and all area intensive care units were filled

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beyond capacity, rapidly overwhelming both the hospital system and the health department. The health officer called the Los Angeles County Department of Health Services, Centres for Disease Control (CDC) and the California Department of Health Services for support.

By Tuesday evening the Los Angeles County Public Health Laboratory Director confirmed *Y pestis* as the causative agent in the Huntington Memorial cases. Pneumonic plague had hit Pasadena. The FBI was notified by both the Pasadena and Los Angeles County health officials and the California Department of Health Services issued state wide advisories. The FBI, Department of Homeland Security and other national enforcement agencies quickly took over the search for those responsible.

The Pasadena Public Information Officer issued a general press release noting that plague had been released in Pasadena. The release immediately went to all the papers and was broadcast on the radio. The officer explained that the pneumonic form was highly contagious and described the symptoms to the public. She also outlined plans for mass distribution of antibiotics to exposed persons and defined exposure parameters. The City of Pasadena set up a toll free hot line for people to call for information, and a second number for psychological counselling. Many people decided that it was no longer safe to live in Pasadena and tried to leave the city causing massive congestion on freeways 110, 134 and 210. The city's emergency management team was activated and opened an Emergency Operations Centre to respond to these and other issues.

On Wednesday morning support staff from the CDC arrived in Pasadena. Los Angeles County Department of Health officials were busy conducting investigations into plague cases within its jurisdiction. The CDC began the process of shipping antibiotics from the Strategic National Stockpile to Los Angeles.

Despite warnings against using the 111 system for questions and concerns, the system for Pasadena became overwhelmed. The Los Angeles County Coroner reported that his facility was completely overwhelmed by the 101 fatalities. The California Health Alert Network (CAHAN) reported that cases of the plague were appearing in San Diego, Orange and San Bernardino Counties.

Meanwhile, Pasadena health officials were establishing prophylaxis distribution centres at the Rose Bowl and Pasadena City College, and finalising the method of distribution. They decided to use EMS to distribute the antibiotics. When the public discovered that the prophylaxis centres had been established, they flocked to them demanding



Chest Radiograph of Patient With Primary Pneumonic Plague
Radiograph shows extensive lobar consolidation in left lower and left middle lung fields.

medication. Pasadena Police had problems controlling the massive crowds and put out a call for mutual aid. Primary care physicians reported to the health department that many patients were demanding antibiotics while others wanted Xanax or Valium. By this time, area hospitals were running low on supplies and staff were becoming concerned about their personal safety.

End is in Sight

By Thursday evening, federal authorities and the Pasadena Public Health Department estimated that 6,297 people had passed through the Pacific Theatres during the release of *pestis*. The agencies are working to identify and evaluate those people and those who came into contact with them. It is predicted that isolation strategies, along with the distribution of the prophylaxis antibiotics from the National Strategic Stockpile will quell the epidemic, although there may still be spasmodic cases occurring for several weeks.

For the future

A citywide review of the public health response to the event is scheduled for next month. All local response agencies who were involved, along with federal agency representatives, staff from local and state media outlets, hospitals, city government, private voluntary organisations and others will participate in a debriefing session to identify the successes and challenges of the response. Particular emphasis will be placed on intra-agency communication and information sharing, risk communication, and the distribution of medicine and medical supplies. Prior to the city wide review, hospitals, organisations and agencies will conduct individual in house examinations of their response roles. National attention is focussed on this event due to its multi-jurisdictional nature and the fact that it was an intentional act. 🎵

The scenario was written by Kimberley Shoaf and Joshua Alexander of Community Health Sciences at the University of California at the Los Angeles School of Public Health, Centre for Public Health and Disasters in Los Angeles, California. www.cphd.ucla.edu/

Project Bio-Shield Becomes Law in USA

On July 21, the president signed Project Bio-Shield (Public Law 108-276) into law, enabling the purchase and provision of tools to improve medical countermeasures to protect Americans in the event of a chemical, biological, radiological, or nuclear attack. The goals of the project, which is being overseen by the secretaries of health and human services and homeland security and involving other federal agencies as appropriate, are to develop and make available effective drugs and vaccines.

Specifically, Project Bio-Shield will expedite research and development on medical countermeasures conducted by the National Institutes of Health, give the Food and Drug Administration the ability to make promising treatments quickly available in emergency situations, and ensure that resources are available to pay for "next-generation" medical countermeasures. The complete text of Project Bio-Shield is available in any federal repository library and on the Library of Congress Web site at <http://thomas.loc.gov/> 🎵

Bio-defence: If Risk Communication is the Answer, What is the Question?

"How will the public react to a biological attack?" is a fundamental question underpinning U.S. policy and practice pertaining to terrorism preparedness and response. In recent years, widely divergent approaches to the issue of mass response to bioterrorism have emerged. When catastrophic terrorism was a serious but postulated danger, officials often considered public reactions to a biological event as part of the crisis to be contained (e.g., the "worried well" would pour into hospitals, hindering health care workers' ability to treat real victims). The complex realities of September 11, 2001, and the anthrax letter attacks that same year, however, have helped refine the understanding of the public not simply as a problem to be managed, but as a constituency to be served-anxious people in need of good information about the danger and what to do about it.

This essay advances a third approach, encouraging authorities to place the challenge of public communication within a broader understanding of the governance dilemmas that bioterrorism poses for the U.S.

From Crowd Management to Credible Communication

The attitudes of decision makers and responders toward the public in the context of bioterrorism have shifted from an emphasis on containing disorder to communicating information. In past hypothetical scenarios, members of the public usually surfaced as mass casualties or hysteria-driven mobs that self-evacuate affected areas or resort to violence to gain access to scarce, potentially life-saving antibiotics and vaccines. Prior to 2001, official response systems were often built around the notion of the public as a problem to be managed during a crisis. This bias, which remains to a certain extent today, precludes consideration of and planning for ways to solicit the cooperation of affected populations.

Communication failures during the serial tragedies of 2001 spurred recognition of the essential role of public outreach in managing the effects of a bio-attack. Following the anthrax crisis, federal health authorities identified risk communication and health information dissemination as one of seven priority areas required to upgrade the ability of state and local health departments to respond to bioterrorism. Critical reflection on responses to the 2001 terrorist attacks prompted the release of many helpful analyses and guidebooks for officials regarding successful communication with the media and the larger public. Today, practitioner and policy-maker interest in public communication remains high.

This invited comment from Monica Schoch-Spana, of the Centre for Bio-security, University of Pittsburgh Medical Centre, was first published in the *Natural Hazards Observer* September 2004 edition.

Communication as the Means to an End, Not an End in Itself

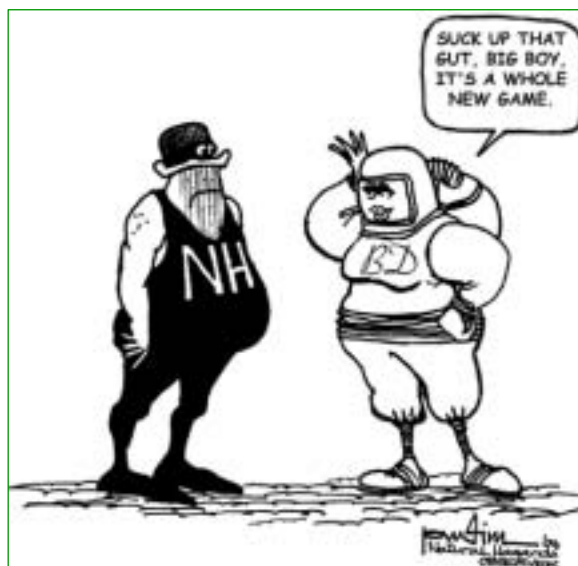
As 2001 demonstrated, open and informative relationships among citizens, government, and public health and safety authorities are fundamental to the nation's ability to cope with unconventional terrorism. U.S. leaders and responders should be lauded for embracing effective crisis and risk communication as remedies for a potentially anxious, sceptical, or resistant public. However, authorities should be careful not to approach improved communication as a "quick fix" for the more complex underlying tensions that can precede or emerge during bio-attacks or other health crises.

Public communication and risk communication have become code words with which to skirt the multifaceted realities associated with community response to terrorism, bioterrorism in particular. When authorities say they want better communication with the public, what they tend to mean is they want public buy-in, compliance, and understanding-possibly even absolution-when tough choices arise (e.g., how to distribute scarce resources in an emergency). When the public calls for better communication from officials, they are asking for inclusion, consideration, and mutual respect as peer decision makers; expert guidance on which they can act; and proof that their needs have been considered. As the U.S. gravitates toward communication as a key to improved bioterrorism readiness, we need to reflect more thoughtfully on what exactly we want that communication to accomplish.

Leadership, Public Engagement, and Governance Dilemmas

The aim of a bio-attack is to create suffering and disruption by introducing an epidemic of infectious disease. Whether natural or deliberate, such an outbreak poses unique dilemmas. Leaders must tend to immediate life-and-death matters, such as caring for the sick; ward off socially corrosive effects, like ostracism of the afflicted; and curtail negative economic effects. Conflicts of interest, priority, and purpose can emerge in pursuit of these goals. The Centre for Bio-security of the University of Pittsburgh Medical Centre convened the Working

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Group on "Governance Dilemmas" in Bioterrorism Response to develop a set of analytic templates for decision makers faced with these difficult situations.

Goals of Bioterrorism Response

A larger focus on strategic goals helps stave off the temptation to focus on managerial and scientific aspects of response while neglecting civic, social, ethical, and economic dimensions.

- Limit death and suffering through preventive, curative, and supportive care; tend to the vulnerability of children, the elderly, and the physically compromised.
- Use the least restrictive interventions to defend civil liberties while containing infectious agents that cause communicable disease.
- Preserve the economic stability of victims as well as hard-hit industries, cities, and neighbourhoods.
- Discourage scapegoating, hate crimes, and the stigmatization of people or places as contaminated or unhealthy.
- Bolster the ability of individuals and communities to rebound from unpredictable and traumatic events; provide mental health support to those who need it.

Novel Dangers Posed by Bio-attacks

The premeditated use of bio-weapons magnifies the already unfamiliar dangers posed by large disease outbreaks. Epidemics are complicated events due to their biology, but also because they provoke fear, contradictory impulses, and competing social aims.

- An epidemic's outcomes—suffering, death, lost livelihood, and commerce—are troubling. Leaders and the public may deny that a problem exists, or intervene too quickly without regard to the effects of their actions
- People need to make sense of random and terrifying events, but epidemics elude quick and easy explanation. The nature of a disease, a population's vitality, and the responsiveness of health institutions affect how an epidemic will unfold.
- A mysterious disease can prompt an individual to isolate oneself and blame others for the tragedy or, in contrast, to care for victims while disregarding one's own safety.

Recurrent Governance Dilemmas during Epidemics

Once acknowledged, an epidemic exerts immense political and social pressure for decisive, visible action—especially when due to a bio-attack. Apparent and sometimes genuine conflicts among strategic goals can arise, such as balancing disease control imperatives with those of civil liberty, economic stability, and stigma prevention.

The ability to stop disease that spreads person-to-person and uphold individual freedoms rests largely on leaders taking proactive measures.

- Make bioterrorism response plans public before a crisis occurs; a well-informed population is more likely to cooperate with advice for reducing the spread of disease.
- Sketch out the big picture; make it clear that personal actions can affect the safety of others (e.g., remind people that staying home from work or school when ill protects others from getting sick).
- Use disease controls that respect ideals of autonomy, self-determination, and equality.
- Provide goods and services that help people comply with health orders (e.g., set up vaccination clinics in locations accessible to people without cars).
- Restrict civil liberties, if necessary, only in a transparent and equitable way.

Social Trust and Coping with Crisis

Breaches of social trust are likely during a bio-attack. Social and economic fault lines as well as preconceived notions about the government, the public, and the media can alienate leaders and the public from one another.

Officials' ability to earn the public's confidence regarding the allocation of scarce resources may hinge on the following steps:

- Account for income disparities in response plans; anticipate the need for free or low-cost prevention and treatment;
- Make planning transparent so that the public sees that access to lifesaving resources is based on medical need and not on wealth or favoured status;
- Be open about eligibility criteria for goods and services, especially when tough choices arise unexpectedly; and
- Show thorough preparations to protect vulnerable populations, thus bolstering everyone's sense of security. 🎵

The collective purpose of the analytic templates highlighted above is to refine leadership skills. The goal is to create realistic expectations on the part of leaders about the societal challenges posed by large disease outbreaks so they are better prepared to protect and actively support cooperation and trust between a community and its leaders.

Increasing emphasis upon enhanced public communication is a positive development - that must be supplemented with robust discussion among leaders, and between leaders and the public, as to what constitutes an optimal response.

Malaysian bird flu jumps quarantine zone and other alarums

Newer events have taken over the headlines but Avian flu is still bubbling away. This week ProMed reports that Malaysia has detected 3 new outbreaks of bird flu in its north-eastern state of Kelantan. The discovery of the disease outside a 10 kilometre quarantine area set up for an earlier outbreak is a worrying new development for veterinary department officials, who had given assurances that the outbreak was contained within the zone.

"Authorities will cull birds in the infected area immediately," said Hawari Hussein, director-general of the veterinary department. Hawari said the disease was also detected in 2 villages within the quarantine zone around the settlement where the deadly H5N1 bird flu virus, responsible for 28 human deaths in Asia so far in 2004, was 1st discovered in August.

Hawari said authorities were carrying out house-to-house surveillance and conducting tests to find out whether the virus had spread to other areas. A 26-year-old man and an 8-year-old girl from one of the villages were admitted to hospital for observation after developing coughs and flu-like symptoms, said the director of the Health Ministry's Disease Control Division, Ramlee Rahmat. "They have a history of contact with the dying chickens," he said.

Officials say the disease was first brought into Malaysia by fighting cocks that had been exposed to the virus in Thailand and claimed that the new outbreaks were caused by the continued smuggling of chicken meat. [This statement is in need of substantiation as it is generally agreed that chicken meat is less likely to play a role in the dissemination of the virus among avians than are live animals.]

Malaysia is seeking an urgent meeting with Thai authorities to discuss measures to combat the spread of the virus.

Thailand has been criticised by the World Health Organisation (WHO) for not doing enough to monitor birds capable of carrying the deadly avian flu virus following the kingdom's 9th human death last week. The WHO fears that the H5N1 virus could mutate into a highly contagious form that triggers a global human flu pandemic.

Mystery bird deaths are also causing concern in the Balkans where thousands of birds were found dead in Greek nature preserve

Thousands of migratory birds in the Greek nature reserve

of Lake Koronia have died in recent months in what birds specialists are calling "an ecological catastrophe."

Hundreds of dead gulls, tern and ducks -- at least 15 species in all -- were discovered just in the last few days, the sources said last week. Autopsies and tests of water samples from the lake are underway, but experts do not yet know what is responsible for the sudden wave of avian fatalities, described by Xenofon Kappas, spokesman of the Greek ornithological society, as "a major ecological catastrophe."



The Greek news agency ANA put the Lake Koronia avian death toll at 3000, but experts said that more than 10 000 dead birds have been found on the lake in recent months. The birds are presumably migrating from Northern Europe with no logical connection with the Asian outbreaks. However, it is worth noting that aquatic birds are the common carriers and spreaders of avian viruses.

The Mayor of Salonika, 520 kilometres north of Athens, adopted "emergency measures" to deal with the crisis, reported ANA, and water samples have been sent to Salonika University for testing. Fishing has also been banned, though no dead fish have been found.

Lake Koronia is one of 27 parks in Greece that are part of Natura 2000, a European Union-sponsored network of bird sanctuaries and threatened habitats. The Lake is also one of 10 Greek ecological sites protected by the Ramsar treaty, an international convention on wetland ecosystems adopted in 1971.

A 90-year-old man said to his doctor, "I've never felt better. I have an 18-year-old bride who is pregnant with my child. What do you think about that?"

The doctor considered his question for a minute and then said, "I have an elderly friend who is a hunter and never misses a season. One day when he was going out in a bit of a hurry, he accidentally picked up his umbrella instead of his gun. When he got to the Creek, he saw a beaver sitting beside the stream. He raised his umbrella and went, 'bang, bang' and the beaver fell dead. What do you think of that?" The 90-year-old said, "I'd say somebody else shot that beaver."

The doctor replied, "My point exactly."

Editor's soapbox



The HEMNZ Bulletin is published monthly by the Risk Management Unit of St John Northern Region for all those interested in emergency management in health care settings

Articles and comment on emergency management issues are welcomed

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Check out our Web site at
www.hemnz.org.nz

A colleague with a long career in a range of emergency services has recently moved into a role with a health service provider organisation. Our current winter flu rush has exposed him to a realisation that, more than other emergency services, health services are on a "war footing"; and we have many competent managers and clinicians leading the struggle to provide quality safe care to the never ending numbers in need.

Regularly we find our normal workload takes us way over the numbers we have set down for activating our Major Incident Plans. With the changed nature of healthcare delivery those kept in hospitals are sicker than ever before. Creating surge capacity is not reserved for 'disasters' it is a regular daily occurrence. Hospitals cope through staff working smarter and harder. The good news from this is that we have regular experience and live training in coping with excessive patient workloads. The bad news is that our staff are getting worn down through not getting sufficient stand down time after their "tours of duty".

With hospitals swamped by everyday demand for service, where are the sick and injured from an extraordinary event to go? Wherever it is, what are we, as emergency planners, doing to make sure they will get adequate care when they get there and there will be adequate support for those providing that care?

Bruce Parkes

Up coming Events

29 September -1 October 2004

New Zealand Institute of Health Management Conference: Showcasing New Zealand—innovation from isolation

Rotorua Conference Centre

More information from www.nzihm.org.nz

1 October 2004

Health Recovery Workshop

Waikato Hospital, Hamilton

Cost \$30 + GST

More information from robertpatton@xtra.co.nz

10 – 15 October 2004

RedR Essentials of Humanitarian Practice EHPO4

Motu Moana Scout Camp, Green Bay, Auckland

Cost \$700 incl GST

This induction course for disaster relief and humanitarian aid workers is based on similar residential 5-day courses held by RedR in Australia and UK. And is a prerequisite for acceptance for disaster relief work with UNHCR and other Aid Organisations.

Topics introduced by the Course include relief situations, International Humanitarian Law, team management, Standards, gender and cultural issues, role of UNHCR, personal health and safety, security and dealing with the media.

More information from www.redrnz.org.nz

14—15 October 2004

The Natural Hazards Centre Course Programme 2004

Planning for a Volcano Crisis, at Wairakei More information from www.naturalhazards.net.nz

18 – 19 October 2004

New Zealand Private Hospital Association Conference

Westpac Trust Stadium, Wellington

Cost \$800 incl GST

More information from www.nzpha.org.nz

4 – 6 November 2004

New Zealand Risk Management Society Conference

Te Papa, Wellington

More information from www.risksociety.org.nz

17 - 18 November 2004

North Island CDEM Conference

Sky City Conference Centre, Auckland

Cost: \$440 + GST

More information from www.aucklandcity.govt.nz/council/documents/defence/conference.asp

9 - 10 December 2004

Improving Safety and Security in the Health Workforce

Carlton Crest Hotel, Auckland

More information from www.archi.net.au