

Marburg: the next big headline out of Africa

While Avian flu has been getting the full attention from all health organisations and wide coverage in the media, in its present state, the general public is safe unless they indulge in drinking raw ducks blood and other similar delicacies. The reported death toll in Viet Nam is around 50 and it is now recognised that many others have contracted avian flu and survived without serious illness.

Our attention is rightly on avian flu in case it mutates and there is a species jump with person to person infection. Until that happens we are in a watch and wait phase.

As yet, the media have given little attention to the Marburg virus outbreak in West Africa. As of 9 April, 214 cases of Marburg haemorrhagic fever have been reported in Angola in an outbreak that began in late 2004. Of these, 194 have died. The previous record was 123 deaths during a 1998-2000 epidemic in the Democratic Republic of Congo.

Angola's Uige Province, with a population of some 500,000, remains the epicentre of the outbreak, accounting for almost 90% of the cases and deaths. Fear and ignorance are fuelling the outbreak as locals are too suspicious of medics in "astronaut" suits to let them take away infected loved ones. Terrified residents stoned World Health Organisation (WHO) workers' vehicles late last week, putting a brief halt to their operations to contain the disease. People are hiding their patients at home because they're scared. That means the virus keeps on spreading in the community. Mobile surveillance teams resumed operations on April 9th following intensive campaigns to improve public understanding of the disease.

Campaigns have benefited from support by the provincial governor and officials from the health department, who have made personal visits to affected communities. Religious leaders are also helping to sensitize the public.

Some improvements are already apparent. More alerts to suspected cases and deaths are being reported directly by residents. Some 360 contacts are being followed up by the teams in Uige, but more improvements are needed to detect cases earlier, ensure their isolation and supportive care, and find and manage contacts.

WHO is concerned that deaths are continuing to occur within the community, as care of patients by family members without adequate protective equipment greatly increases the risk of further transmission. Staff at Uige's large provincial hospital also need training and equipment to reduce the risk that routine surgical and laboratory procedures might endanger staff and other patients.

Known as one of the most virulent diseases affecting mankind, Marburg, which is related to Ebola, has a fearsome reputation and is known to bring an exceptionally gruesome death. Marburg virus disease presents as an acute febrile illness and can progress within 6--8 days to severe hemorrhagic manifestations. After an incubation period of 5--10 days, onset of the disease is sudden and is marked by fever, chills, headache, and myalgia. Approximately the fifth day after onset of symptoms, a maculopapular rash might occur, after which nausea, vomiting, chest pain, sore throat, abdominal pain, and diarrhoea might appear. Signs and symptoms become increasingly severe and can include jaundice, inflammation of the pancreas, severe weight loss, delirium, shock, liver failure, massive haemorrhaging, and multi-organ dysfunction. The disease often presents as flu in the early stage, leading to the spread of the virus among family and health care workers.

Fatality rates for outbreaks of Marburg VHF have ranged from approximately 25% to 80%; mortality has been higher in outbreaks in which effective case management was lacking. No vaccine or curative treatment is available, and supportive treatment should be used. The

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Would you be scared if these health workers knocked on your door?

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virus can be spread to humans through direct contact with body fluids (e.g., blood, saliva, and urine) of an infected person or animal. Thus, the best protection for persons in or travelling to the outbreak area is to avoid direct contact with body fluids from potentially infected persons. Virus transmission also might be possible through contact with objects (e.g., medical equipment) that have been contaminated with infectious material. The virus has been reported to survive for as long as several days on contaminated surfaces. Hospital infection-control practices for infected patients should include contact and droplet precautions, in addition to wearing eye protection or a face shield

An isolation ward, dedicated to the care of Marburg haemorrhagic fever patients, has been established at this hospital by Médecins sans Frontières. Concern arises from the risk that persons infected with the virus might be admitted for another suspected illness and undergo testing or treatment procedures without adequate precautions.

Doctors and nurses treating Marburg patients can offer little beyond treatment to ease the pain -- and even that is limited by the fact that to avoid accidental infection of health staff, patients are rarely given injections. Faced with this enemy, medical staff working at the specially-set up isolation unit at Uige's provincial hospital are taking no chances and are using "full bio-protection suits" that take half an hour to put on and a gruelling 45 minutes to take off, a procedure that presents the most risk of contamination.

"These are difficult working conditions, especially with the heat," Monica Castellarnau, Medecins Sans Frontieres (MSF) emergency coordinator for the outbreak, said by telephone from Uige, a city of about 500,000. "They must have short shifts, usually every three hours they have a break," she said. "The hardest thing for the medical people is their feeling of helplessness. They know there is no cure for the disease."



Healthcare workers attending to a 24yr old woman

Castellarnau said while many people in the city had no choice but to go on with their daily lives, it was clear the population was traumatised. "They're very scared. Now we have a big problem in town because people don't want to touch dead bodies," she said. "We mustn't underestimate the trauma this has created among the population. People are scared to the point that even a dead husband or father is someone to stay away from, People are scared to go to hospital because that's where it all started," she added.

Castellarnau said it would take more resources and commitment to stamp out an epidemic she said was "far from being contained". "It's like a big puzzle where all the pieces need to be in place if we don't want all the efforts to go to waste. We don't know if we're at the peak of the epidemic or if it's still going up. But it's not going down," she said.

Well Marburg is a long way away so we in Oceania are safe aren't we? Well yes we seem to be, but this is not just an

Equatorial Africa problem. The name Marburg is a clue. The virus was identified in Marburg, Germany after locals were infected by imported monkeys. Note also that NGO staff sent to Angola have contracted Marburg and died. The Marburg incubation time in the present outbreak ranges from 3 – 10 days - ample time for an aid worker to travel home. Last week, an Italian paediatrician died of haemorrhagic fever in Angola, according to Medici con Africa, the relief organisation for which she worked. Nine people who were in contact with the paediatrician have been isolated in an Italian hospital. The risk of cross country infection was demonstrated when a child with links to Angola presented at the Morningside Clinic in Johannesburg showing symptoms of the infection. Solly Mabothe, spokesperson for South Africa's health department, said isolation wards had been prepared in hospitals in all nine provinces and health practitioners had been thoroughly briefed on the symptoms of haemorrhagic fever. He said, however, that a thorough investigation had indicated that the child did not show symptoms of the untreatable haemorrhagic fever, which is caused by the Marburg virus. There is no laboratory in South Africa that can perform tests for the Marburg virus, so samples were sent to the CDC for testing. If testing shows the child is positive there will be contact tracing issues with passengers on the plane if the child recently arrived from Angola. If the child was infected in South Africa, then there would be contact issue with whoever recently arrived from Angola. As the numbers increase in Angola, especially in Luanda, it will become increasingly difficult to avoid exporting the virus via passengers leaving Luanda. WHO experience with outbreaks of viral haemorrhagic fevers, including the closely related Ebola, underscores the importance of rapidly sealing off opportunities for the amplification of transmission within health care settings. ●

Marburg Morphology

Virions have a complex construction and consist of an envelope, a nucleocapsid, a polymerase complex, and a matrix protein. Virions are enveloped. Virions are filamentous, or pleomorphic; with extensive branching, or U-shaped, 6-shaped, or circular forms occur (particularly after purification); flexible and about 80 nm in diameter; 790 nm long (after purification).

The surface projections are distinctive ; knob-shaped peplomers. The surface projections are composed of one type of protein. The surface projections are evenly covering the surface. They are spaced widely apart; the surface projections are embedded in a lipid bilayer. The surface projections comprise surface glycoproteins (GP). Surface projections are 10 nm long; spaced 10 nm apart. Capsid/nucleocapsid is elongated and exhibits helical symmetry. The nucleocapsid is helical; is cross-striated; 50 nm in diameter.

Axial canal is distinct; 20 nm in diameter; basic helix is obvious; pitch of helix is 5 nm.

Morphologically aberrant forms are observed (after centrifugation).



Resilient Bangladesh: Can we help?

Robert Patton

An old woman squatted in front of me, her tear-filled eyes focused on me, hoping for an answer. I was at a loss for words. Other people looked at me hopefully. What can I say? This wasn't the first time that I had dumbly sat there and had no answers. And yet there was the expectation I would provide answers.



Late October 2004 I attended an emergency management strategic planning workshop in Costa Rica, organised by ADRA (Adventist Development and Relief Agency) as part of their international network development programme. At the workshop I gave a presentation to a representative group from ADRA's global network in which I enthusiastically shared the direction I believe ADRA should be forging - an emphasis on disaster mitigation, rather than disaster response. Afterwards, the ADRA Country Director for Sweden approached me, agreed with what I had presented and asked me to turn my words into action in Bangladesh.

As far as I was concerned, I had no option. March 2005 saw me in Manikganj District, about 90 kilometres southwest of Dhaka city, Bangladesh, conducting a flood mitigation assessment as a forerunner to writing a proposal to secure funding for a pilot flood mitigation project. A colleague and friend, Ben Thomas from Willis Risk Consulting, worked with me on the assessment, providing valuable input, including the photos accompanying this article.

Manikganj District has a predominantly rural population with an average population density of about 900 people per square kilometre. Compare this to New Zealand's 14 people per square kilometre. Like the rest of Bangladesh, the district is a flood plain, dissected by the Padma and Jamuna rivers which converge on the boundary of the district to form the largest river in Bangladesh. Despite being 150 kilometres inland, the district is only eight metres above sea level so drainage after heavy monsoon rains is slow. Every year 90 percent of the land area in this district is covered in water. In a good year the floodwaters may subside after one month, in a bad year 100 percent of the district is covered in water and it will be there for three months.

As I sat listening to villagers' stories of what happens each year, I was amazed at the resilience of these people. Every year their lives are a continual floodwater cycle. In July they move their household to the nearest road that is above "high water level" and camp there for up to three months until the monsoon floods subside. Then they go back to their house to spend the next three months rebuilding their home and gardens and trying to make enough money to survive in the next six months - then the cycle starts again. Compounding this is a spiral of debt, where the interest being charged can be up to 120% per annum!

I not only listened to the impact that flooding has each year on these people, I also sought their ideas on how things could be changed for the better; what might they already be doing to improve things. Over the period of a few days, as I moved from village to village, ideas emerged on what could be done to make a difference in the lives of these people. These were their ideas - things they were already trying and were working. All they needed was a little help. The despair and hopelessness that I had felt initially was being replaced with a glimmer of hope.

The key to improving the lives of these people was to work towards keeping them in their homes and villages during the monsoon. Already there has been some success where some homes had been raised on mounds of mud, above the anticipated flood levels. What prevented others from doing this was time; every minute of every day was spent in earning enough to eat, they had no time to carry mud to raise their house site. But just raising houses is not enough to keep the social and economic fabric of their society functioning. Market places have to be operating, there needs to be communication paths between homes and markets and schools need to stay open.



A householder points to the usual flood level on his house

Ironically, but commonly world wide, during flooding there is little or no access to a safe water supply. In Bangladesh the tube wells are under water. There are very few latrines

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so the practice of open defaecation means the flood waters are heavily contaminated.

What can be done? If markets and schools are raised above flood level, then tube wells can be placed there for public access during times of flood. Latrines can be constructed on raised house sites, using a design common in Bangladesh whereby a pit is dug and lined with concrete rings. As long as the pit is deeper than the raised area, they will improve sanitation immensely.



A raised house

Making these changes will not only improve the health status of people, but the cost associated with the annual relocation, loss of employment and rebuilding houses will be removed and hopefully break the spiral into debt.

This all sounds great, but how will it translate into reality? Is it really implementable and will it actually make a difference?

I believe it can work. I have documented an achievable plan, submitted it for funding and all being well, the project will commence later this year for a two-year pilot programme in two villages with a total population of about 7,000 people.

Something has to be tried. I think of the elderly woman, who with tears in her eyes, shared that she is not able to productively help her family any more. She lives with her son, his wife and their three children and there is not enough food to go around.



Tears ran down her cheek as she said that she eats food that her grandchildren should have, that they need so they can go to school and learn while she eats and does nothing, depriving her family of the food they need. What can she do? The answer to her question has come not from me, but the community that she lives in. ●



“Norm” no more

Since she returned from Britain, Ministry of Civil Defence Advisor Sarah Norman, with her background as an NHS Emergency Manager, has been a great advocate for and supporter of emergency management in New Zealand healthcare settings.

Sarah has been known to one and all by her self conferred soubriquet of Norm. But no more. In February Sarah married Jim Stuart-Black, National Manager Special Operations, New Zealand Fire Service.

For one who had worked through the Manawatu floods last February and understood fully the capricious nature of our weather gods, picking February for a wedding was a brave choice. Perhaps Sarah had in mind the somewhat flawed adage that ‘lightning does not strike twice in the same place.’

It seems the weather gods got the same “do not disturb” instruction Sarah issued to all her colleagues. The weather remained fine and as the photos show, the happy couple really enjoyed themselves.

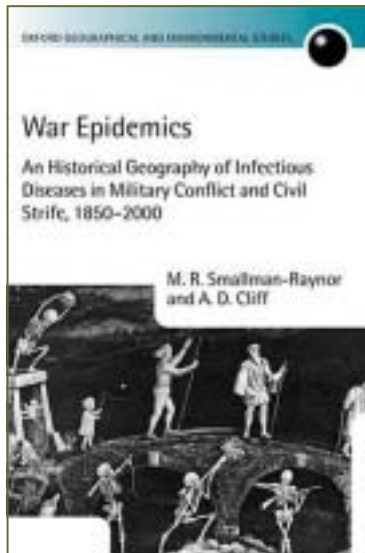
We wish Sarah and Jim a long and happy life together. May they not talk shop 24 hours a day. ●

Book Review

War Epidemics: An Historical Geography of Infectious Diseases in Military Conflict and Civil Strife, 1850-2000

By Matthew R. Smallman-Raynor; Andrew D. Cliff, Oxford University Press

War and pestilence, two of the apocalyptic horsemen, are likely to scare off most casual readers. Couple this with a weighty 839 pages and a US\$200 price tag means this book is destined for specialist library bookshelves. That is a pity because, despite those handicaps, Matthew Smallman-Raynor and Andrew Cliff have been successful in drawing together the synergies between war and pestilence in what they describe as "historical geography."



They define historical geography as an interdisciplinary effort to assess wartime disease impacts that are based on reliable, analyzable, archival, war materials. They chose to examine "modern wars and lesser, allied conflicts" because reliable information became available largely after 1850. These data allow them to create elaborate modelling that may best explain disease spread (for example, the diffusion of HIV/AIDS in Africa). They are selective in their analyses, and this may limit interest in those who desire a complete one-stop shop for a definitive book on wartime-associated epidemics.

The authors discuss why civilian and displaced populations must also be considered in these analyses. Using epidemiologic organizational methods and sophisticated bio-statistical modelling, they describe and analyze in meticulous detail hundreds of major conflicts and their attendant sequels. The authors do not claim to comprehensively cover all war epidemics, although they may have nearly done so. They make comparisons between historical morbidity and mortality trends in peace time vs war then follow with discussions of massive civilian dislocations.

The major thrust of the book is time-space analyses of major post-1850 conflicts. The authors' rationale for civilian peacetime-wartime statistical comparisons appears logical, allowing a case-control comparison of disease rates and the discussion of a "third" population affected by war (in situ civilians, refugees, displaced persons, concentration camps, prisoners of war, etc). The authors posit "a basic epidemiological principle": "the geographical *dispersal* of highly concentrated (urban) populations -- like the geographical *concentration* of widely dispersed (rural) populations -- serves as an efficient mechanism for the historical propagation of war epidemics in civil populations." In other words, an army

conscripted from urban dwellers who are then marched into new territories will spread disease. At the same time, immunologically naive rural populations, when forced behind besieged walls, fall victim to and spread common communicable diseases

This work provides countless new facts and observations, and a wide array of tables, figures, and commentaries. For example, the authors offer a fresh look at the dispersion of the 1918 influenza pandemic and a discussion of mitigating results from a massive maritime quarantine imposed by Australia on its returning troop ships

Part III, the largest portion of the book, is devoted to an in-depth discussion of major conflicts selected from a 5 x 5 matrix of world regions and disease themes. Thus, Pan America, Europe, Asia/Far East, Africa, and Oceania are cross-tabulated against military mobilization, military camps, emerging and re-emerging diseases, sexually transmitted diseases (STDs), and island epidemics. Five chapters are devoted to a discussion of each of these themes; a sixth chapter deals with 4 other unique themes seen in 5 other wars. A final, brief Part IV ends the book with discussions of the first Gulf War, Bosnia-Herzegovina, Afghanistan, and the Sudan as well as a brief summary of biowarfare and bioterrorism activities and the future war-associated morbidity and mortality projections. Surprisingly, there is no mention of disease in World War II German concentration camps (of which the data are presumably available), although analyses of the diaspora of postwar refugees and other more recently displaced populations are quite detailed.

War Epidemics explains exactly how war rapidly produces ecologic change, population displacement, and environmental disruption, fostering new, unnatural niches for rapid diffusion of these diseases. For example, Chapter 9 dealing with more recent events (World War II, Korea, and Vietnam), offers fascinating historical detail on the emergence of scrub typhus, Korean hemorrhagic fever (KHF), and pneumonic plague, respectively.

A series of maps and graphs of KHF cases in 1952-1953, with an attendant discussion, focuses on how the displacement of organized farming near the battlefield fostered the emergence of hantaviral disease from burgeoning mouse populations in the central plains of Korea. A series of graphs, maps, and histograms documenting the incidence of plague in Vietnam from 1906 and its spread in the years 1951-1970. The authors discuss the reversal of rice delivery from rural areas to cities during the Vietnam War that caused infected rodents to "follow the rice" into the interior. It is clear by many internal references that the authors envision this book as a work in progress. Yet, *War Epidemics* is already a seminal work on war and infectious diseases and an essential reference for anyone seeking a deeper understanding of this topic. ●



Case Study: The Value of Convergence

Following the terrorist events of 2001, Duke Energy, a Fortune 500 multi-national company based in Charlotte, North Carolina, recognized that as an owner/operator of critical infrastructure assets in gas pipelines and electricity generation sectors, they needed to validate their own capabilities. This initiative, written up by Tom Bowman and Michael Mobley as a case study in the [April edition of CPM](#) offers insights that can be modified and adopted by healthcare organizations.

Duke Energy quickly established an internal team, called the Enterprise Safety and Security Network (ESSN), to evaluate existing emergency/crisis related processes and make appropriate recommendations. This cross-functional team sponsored and endorsed by senior company management, included representatives from both operating business units as well as corporate support functions such as security, human resources, public affairs, information technology and safety / health. Following a six-month review, the ESSN team provided 42 broad-based improvement recommendations. A key message was to focus on what needed to be done, not how to do it.

Launched in October 2001, the ESSN team delivered its recommendations in March 2002. Some key recommendations included:

- Establishing an integrated crisis management structure to support event escalation between the unit, site and corporate levels
- Developing a crisis management focus (to supplement strong existing emergency response capabilities in the operating business units)
- Bringing corporate security, business continuity and crisis management functions into one organization to enhance synergies by the creation of a corporate crisis management programme office to provide overall accountability and direction.

Duke Energy launched its Business Continuity and Crisis Management Program Office in June 2002. The Program Office focused extensively on the integration of emergency response activities up the management chain, as well as across the company's many business units. It was essential to address needs identified within individual business units, as well as across the enterprise. Standardized alert levels, response thresholds and notification criteria were established. Duke Energy adopted the federal Department of Homeland Security's five-level alert model and established a common language for crisis response.

The corporate policy regarding crisis management and business continuity was updated to expand the scope of business continuity and to incorporate crisis management as a corporate accountability. The Program Office became responsible for establishing guidelines and program criteria; business units were accountable for implementing processes in accordance with these elements. Once again, the focus was on the "what" rather than the "how" to allow business units to implement elements applicable and appropriate for the nature of their operations.

Among the challenges for the Program Office was establish-

ing procedural commonality across the enterprise. This challenge was addressed by establishing an integrated crisis management structure to support event escalation between the site, business unit and corporate levels. Emergency response efforts are handled at the lowest organizational level possible. Escalation of response actions is dependent upon the severity of the event and its impact on the company's operational capabilities, financial health or reputation. A three-tiered approach is used to address incidents and crises:

Site Emergency Response Teams – First-response focused, dealing with operational emergency responses at specific sites, with 10% of their efforts involving response planning. Teams are comprised of site supervision and local resources.

Business Unit Crisis Management Teams – Manages the business unit's response actions and business continuity issues; facilitate oversight of operational responses and integration with corporate crisis management activities. Teams are led by senior business unit leaders and representatives from key functional support organizations (public affairs, human resources, environment / safety / health, etc.)

Enterprise Crisis Operations Centre (ECOC) Team – Provides overall coordination, strategic planning and mitigation recommendations, not operational oversight. A senior executive leads this team, which includes representatives from key corporate support organizations (public affairs, human resources, environment / safety / health, security, finance, legal, purchasing, and facilities). The Program Office develops and executes processes supporting the ECOC team.

This tiered structure works well, because it involves input and support from all levels of operations and helps ensure aligned objectives.

Integrating the Disciplines

One of the most significant initial activities was the integration of separate functions into a more tightly structured organization. Specifically, the business continuity, crisis management and corporate security (e.g., physical security, background screening) functions were placed into a new organization called Continuity, Insurance and Security Services (CISS). Information security remained within the IT department. Additionally, the following initiatives were put into place:

- The CISS organization is aligned with the company's risk management department and reports to the Chief Risk Officer.
- Lessons learned from exercises and post-incident reviews are shared among crisis management teams.
- The Program Office held a summit conference in 2004 for business unit crisis management leaders to discuss crisis management topics.
- Numerous intelligence sources are regularly monitored for pre-indications of possible activity that could impact the company.

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- The company identified key operating assets and processes within business units and across the enterprise that are either critical (absolutely necessary) or essential (very important); they are reviewed for business continuity and crisis management plans as well as for security and insurance purposes.
- Training, especially in crisis management leadership skills, is an important initiative during 2005.
- The company uses the Incident Command System (ICS) as one of our crisis management models.
- Efforts are underway to use an Internet-based virtual emergency operations center application as part of the crisis response process.
- Business units are exploring new automated emergency notification systems.
- Crisis management processes are validated through exercises ranging from tabletop scenario discussions to full-scale activations involving multiple organizational levels.

Summary

As Duke Energy's Crisis Management Program Office approaches its third year, significant progress has been made, including:

- A dedicated resource that focuses solely on crisis management planning, mitigation, strategy and best practices;
- A vastly improved notification response and integra-

tion process;

- An improved understanding of accountabilities and relationships relative to crisis management planning and response;
- A methodology to address monitoring of "creeping crisis" elements;
- Integration of strategy and mitigation planning into response efforts; and
- Broad-based consistency in crisis management planning and response.

The convergence of business unit and corporate crisis management processes has evolved over the last three years. Initial issues of business unit autonomy, organizational "silo" mentality and integration of roles have been ironed out through valuable validation exercises. The focus remains on the "what", not the "how", of future needs and this strategy continues to be successful. Crisis management and business continuity are becoming more firmly embedded in the company's culture.

Emergency notification and response processes have improved to the point where crisis management teams convene within 20 minutes of most incidents. Team members throughout the company have developed a strong understanding of their roles and responsibilities. The value of the company's integrated crisis management structure has been tested and proved through activation during several real events. As a result, synergies and consistency in approach have strengthened the corporation's emergency and crisis response capabilities. ●

Tornados, Curiosity and Residential Care

Graeme McColl



At 1pm on Thursday March 10th, a tornado swept through part of the business and residential area of Greymouth on the West Coast. Buildings and vehicles were badly damaged, power supplies cut and for a time confusion reigned.

Luckily, neither the ambulance service nor Grey Base Hospital suffered damage, and the emergency services responded quickly to assess the situation and end the confusion. There were only three casualties from the event and one medical admission.

From a health perspective, regional coordination was activated. Contact was maintained with the incident controller, Ebel Kremer, at Grey Hospital and the Christchurch Hospital duty manager and the Ministry of Health were alerted.

Grey Hospital did not need to fully activate their emergency plan due to the few casualties and the fact that for a rare occasion they had specialist staff available if required. The emergency generators also worked as required.

However, curiosity kicked in and although the duty manager at Christchurch Hospital briefed their emergency management team, others outside this group decided they needed to know more.

So it came to pass that in the middle of what could have

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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

Up coming Conferences

12 - 13 May 2005

Planning for an Earthquake Crisis

Gracefield, Lower Hutt

Cost \$600 + GST

More information from

www.naturalhazards.net.nz/courses

16 - 20 May 2005

14th World Congress on Disaster and Emergency Medicine

Edinburgh, Scotland

Cost £620 before 4 May

More information from www.wcdem2005.org

4 - 5 July 2005 Auckland

7 - 8 July 2005 Wellington

Evolved Methodologies in Business Continuity Planning

Cost \$1695 +GST

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11—15 July 2005

7th ITACCS International Chief Emergency Physician Training Course on Mass Casualty Incidents

Dunedin

Cost \$1200 +GST

More information from

<http://itaccs.healthotago.co.nz/itaccs7.htm>

Editor's soapbox



Reading Robert Patton's story on the incredibly resilient villagers in Bangladesh I mused on how in our technologically advanced healthcare organisations, our capacity to adapt to adverse events is limited by that same technology and associated support service. My musing has four strands.

My first strand of thought was a discussion I had been having with an eminent disaster medicine specialist on the differences between disaster medicine and emergency management. Years ago, in simpler times, there would not have been a difference.

My second strand of thought was from a presentation by Dr Charmaine Tate, a New Zealand Army doctor deployed to Banda Aceh. The doctors and nurses in the Anzac field hospital were significantly outnumbered by necessary support staff. The ability of the field hospital to provide advanced health care was restricted by the limited availability of allied services such as radiology and laboratory.

My third strand of thought is the current Marburg virus outbreak in Angola. Dedicated aid agency personnel have to use advanced Personal Protection Equipment while trying to control the outbreak. This equipment, which increases their resilience, has built a barrier between them and the afflicted population they seek to serve.

The fourth and final strand is an observation on the industrial action currently bedevilling some DHBs. Non striking staff have accepted the reduction of services and have mucked in to continue to provide the best care they can under the circumstances.

In Banda Aceh, Angola and New Zealand, the key to adaptive capacity has been the ability and willingness of people to adjust and get on with the job the best they can. The key ingredient in all this is Attitude. Emergency Plans and back up equipment are important for mounting the best response when an event overwhelms our minimisation measures. But without a "can do attitude" our resilience (or adaptive capacity) to the adverse event may not cut the mustard.

Bruce Parkes

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been a major incident, Grey Hospital had to divert resources to handle telephone calls from Health Professionals who should have been aware of the regional coordination plan and **thought** about the situation Grey Hospital was likely to be facing at that time and not bothered them.

The situation also highlighted the need for planners to engage in urgent consultation with residential care providers about their emergency plans. As has happened in other areas, many of those in residential care think all they have to do in an emergency is to send their residents to the local hospital. Rest Homes are businesses and must meet their responsibilities to clients. The local video store, which also evacuated, didn't send their clients to the hospital just because they had to evacuate their business premises.

Finally, the weather on the coast was not suitable for helicopter/light aircraft flights, road was the only way in and out.●