

DISASTER AND MASS CASUALTY MANAGEMENT: A COMMENT ON THE ACS POSITION STATEMENT

by Eric R. Frykberg, MD, FACS, Jacksonville, FL

On September 11, 2001, the U.S. was dealt a body blow from which we are still recovering. Beyond the ruthlessness and evil of the attacks on the World Trade Center and the Pentagon, and the tragic loss of innocent lives, was our realization of how naïve and unprepared we were for the consequences of terrorism that much of the rest of the world experiences regularly. We had developed a complacency as to our invulnerability to such attacks, feeling that terrorist activity only affects others in faraway places. We felt no motivation to plan for such attacks or their prevention, as much of the rest of the world does with greater effectiveness.

In fact, America has been feeling the bite of terrorist murders of our citizens for at least two decades, including, among many incidents, the bombing of the U.S. Marine barracks in Beirut in 1983, the TWA hijacking in Beirut in 1985, the bombing of Pan Am Flight 103 over Lockerbie, Scotland, in 1988, the World Trade Center bombing in 1993, the Oklahoma City bombing in 1995, the Khobar Towers bombing in Saudi Arabia in 1996, the Centennial Olympics bombing in Atlanta in 1996, the two U.S. Embassy bombings in Africa in 1998, and the bombing of the USS *Cole* in Yemen in 2000. In 1990 alone there were over 1,500 isolated instances of terrorist bombings within our own country with

more than 220 casualties and 27 deaths. On sober reflection about our sudden awakening to the need for preparedness after 9/11, it could be asked, “What took us so long?”

Certainly the American medical community recognized its disturbing lack of preparedness and experience in caring for the victims of mass casualty disasters after 9/11, as it did also following the Oklahoma City bombing six years before and the World Trade Center bombing eight years before. It is clear that managing large numbers of acutely injured victims who present all at once involves principles quite different from our everyday management of injured patients. These principles must be learned as a

new and distinct skill set through an intense educational effort if we are to reach the proper levels of medical preparedness for terrorist events.


This education is especially true for the community of surgeons represented by the American College of Surgeons. Surgeons should be the obvious leaders of disaster planning and management efforts at the local, regional, and national level, as triage and rapid decision making for large numbers of patients are an integral part of what we normally do every day. In particular, trauma centers and systems represent an infrastructure for disaster management and a national disaster system that is already in place, as they already include and have the essential liaisons with the prehospital services, government bodies, law enforcement, search and rescue, health care resources, and public health agencies that are essential to comprehensive disaster management.

Clearly, history tells us that the most common and most likely problems that can be predicted to result from terrorist events, by far, involve severe bodily injury (that is, shootings, fires, bombings, building collapse), which falls entirely within the sphere of what surgeons do and what trauma centers are designed to handle. Even in the quite unlikely, but nonetheless possible, scenario of disasters that do not specifically involve surgical problems (for example, floods, hurricanes, earthquakes, and biologic, chemical, or nuclear events), surgeons and trauma centers will provide a valuable resource of personnel and equipment geared to the handling of mass casualties.

It is important that the apathy of past years, which led to surgeons and surgical organizations taking a backseat in the field of disaster preparedness, be replaced by vigorous efforts to energize, educate, and mobilize surgeons to actively participate in this field that should long ago have become an intrinsic part of surgical training and practice.

The American College of Surgeons has adopted the accompanying position statement (see p. 14), as drafted by the Committee on Trauma, to emphasize and justify the importance of surgical involvement in all disaster efforts and to assert its commitment to achieving

this goal. The statement also makes the point that surgeons must work as part of a large multidisciplinary team if we are to succeed in disaster management. The College, through the Ad Hoc Committee on Disaster and Mass Casualty Management of the Committee on Trauma, has already made great headway in developing liaisons with a number of important organizations involved in disaster planning and management, including the National Disaster Medical System, the Centers for Disease Control and Prevention, the Oklahoma State Injury Prevention Office, the American Public Health Association, the American College of Emergency Physicians, the National Association of EMS Physicians, the U.S. military, and the Department of Homeland Security. Several educational products and programs arising from these relationships have already been developed or are in development and are being made available through the ACS Web site.

We in the surgical community have a lot of catching up to do, but progress is being made. All surgeons are encouraged to become active in their own community disaster planning programs, and we invite all interested surgeons to participate in the College's activities to foster widespread understanding of disaster management. 

Dr. Frykberg is professor of surgery, University of Florida College of Medicine, Jacksonville. He is also Chair of the ACS Ad Hoc Committee on Disaster and Mass Casualty Management of the Committee on Trauma.

