fessionals and increasing the early retirement of experienced staff. It is time to begin the awareness campaign to both prepare new graduates and recognize it in senior staff. How much is enough for our nurses and doctors to give of themselves and their own lives in caring for others in emergency and traumatic life events?

Keywords: compassion fatigue; coping silent witnesses; vicarious traumatization
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Database as an Evidence Base—Lessons Learned from Terrorism-Related Injuries among Israeli Civilians

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Introduction: Terrorist attacks have become a worldwide threat. Many theories and papers have been published as principles for mass-casualty incident (MCI) management. This presentation will analyze these principles to determine if they are evidence based.
Methods: Data on terrorist-related MCIs in Israel registered by the Israel National Trauma Registry between October 2000 and December 2005 were analyzed.
Results: Between October 2000 and 30 June 2003, 1,661 patients were hospitalized and recorded in the Israeli National Trauma Registry due to terrorist-related injuries, and 55,033 were hospitalized due to other trauma. Among terrorist victims, 55% were between the ages of 15 and 29 years, compared to 22% in this age group for non-terrorist-related trauma patients. The results examined the following questions: (1) Arrival and hospitalization patterns: Do severe injuries arrive first?; (2) Triage: Has triage changed due to new mechanisms of penetrating injuries, such as shrapnel, nails, and bolts included in explosives?; and (3) Differences in resource consumption by casualties due to terrorist attacks.
Conclusions: While theories and papers have been published as principles for MCI management, they do not always match the evidence-based data.

Keywords: evidence base; injuries; Israel; research; terrorism
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Comparison of Disaster Response Approaches in Canada and the United States: Ontario's EMAT vs. Florida 1 DMAT

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Introduction: Approaches in disaster response differ between the US and Canada. Since the late 1980s, the US has developed and maintained the National Disaster Medical System that has responded to numerous disasters within the United States. Since the terrorist attacks in New York on 11 September, Canada has taken an interest in disaster response. The province of Ontario has developed a deployable Emergency Medical Assistance Team (EMAT), modeled in large part on the Disaster Medical Assistance Teams (DMATs) in the US. The author is both the Chief Medical Officer of Florida One DMAT in Fort Walton Beach, Florida and an Incident Commander of the Ontario EMAT, giving him a unique perspective on the similarities and differences in disaster response and preparedness between the US and Canada.
Methods: The paper will be a qualitative comparison of the Ontario EMAT and Florida One DMAT based upon the author's work with the two teams.
Results: Florida One DMAT is an experienced, full DMAT in existence since the late 1980s and based upon three deployable teams of 35 persons each (total 105), whereas the Ontario EMAT normally deploys as a single team of >100 personnel. The DMAT is self-sustaining for a minimum of 72 hours in austere conditions, while the Ontario EMAT depends on existing infrastructure to support its operations (living quarters, food, and water must be available at the deployment site). The DMAT is deployable "anytime, anywhere", while the EMAT is primarily intended for surge capacity to assist overwhelmed existing health facilities. There are other notable differences that will be discussed along with a number of similarities.
Conclusions: The US and Canada have chosen different styles for their disaster response teams. Both models have their advantages and disadvantages but seem to work for the needs of their respective countries.

Keywords: Canada; comparison; disaster medical assistance teams; emergency medical assistance teams; response; United States
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Hospital Emergency Department Referral Patterns in a Disaster

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Introduction: During the past 30 years, the emergency medical services (EMS) system has developed into an effective means of delivering prehospital medical care and transporting ill or injured victims to definitive medical care. A main presumption in most hospital disaster planning is that patient arrival will be through a directed EMS response and distributive transport system allowing for the orderly triage of arrivals and the control of numbers arriving at each hospital serving disaster victims. In spite of these systematic strengths, case reports in the literature and major incident after-action reports have shown that most patients who present at a healthcare facility following a disaster or other major emergency do not necessarily arrive via ambulance.
Purpose: If these reports of arrival of patients outside of an organized transport system are accurate, hospitals and EMS systems should be planning differently for a mass convergence of patients on the healthcare system. Hospitals may need to consider alternative patterns of patient referral including self-referral when performing major incident planning and methods to divert non-critical patients to alternate locations.
Methods: A 25-year retrospective review of published data was conducted to identify reports of patient care during disasters or major emergencies that included the categorization of the patient's method of arrival. Data were aggregated and analyzed using a structured mechanism.