

3. Cranmer H: Humanitarian Studies Initiative for residents: An innovative program for doctors in training. (USA).
4. Punt C: Primary trauma care: Training hospital staff in trauma management. (Netherlands).

#### *Education and Training II: Competencies 2*

5. Caldicott GE: Bombs, blasts, and bullets (B3)—Using knowledge to arm the innocent. (Australia).
6. Ardalan A: Just-in-time (JIT) lectures: An efficient approach for increasing disaster risk awareness. (Iran).
7. Furberg RD: Analysis of interdisciplinary simulation-based triage training for disaster preparedness and response. (USA).
8. van der Eng DM: Measuring competencies as indicators for trauma. (Netherlands).
9. Paturas J: Training in disaster management: Enhancing post-graduate clinical preparedness through a novel curriculum. (USA).

#### *Education IV Standards in Emergency and Disaster Medicine*

1. Seynaeve G: Conceptual framework for education and training in disaster health. Conclusions of the work of WADEM's Education Committee. (Belgium)
2. Archer F: Design and evaluation of an education program for health professionals on the core components of emergency preparedness and disaster health at the graduate level at one Australian university. (Australia)
3. Reilly MJR: Designing Sustainable hospital preparedness training: A three-phased approach. (USA)
4. Haraguchi Y: Importance of disaster medicine and the significance of the Compendium. (Japan)
5. Theunissen NCM: Preparing physicians for military expeditions by using adventure based learning. (Netherlands)
6. Spencer C: Cultural diversity: A challenge for emergency health. (Australia).

#### *Education and Training VI: Credentialing*

1. Seynaeve G: The changing scope of disaster health. (Belgium).
2. Rimple DR: Creating a medical student elective in disaster medicine. (USA).
3. Eryilmaz, M: 2006 Kocatepe inferences on triage and trauma suggested by Ankara triage and trauma working group. (Turkey).

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## **Care of the Dead**

*Chair: Claude de Ville de Goyet*

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The session on care of the dead has attracted a lively audience with high expectations. Those expectations were met by the two speakers. One presentation by Professor Maat related in-depth and technical details of the experience of identifying dead bodies in the aftermath of the tsunami in Thailand while the second one by Malchielse focused on the role of the forensic nurse in a hospital.

Professor Maat's presentation described the application of techniques and skills used by Interpol for the identification of thousands of bodies in Thailand. The presence of approximately 50% foreign tourists among the missing contributed to a surge of expert teams assisting the Thailand authorities. Strict guidelines set up by the Thailand Police in charge of the identification required the compliance with several criteria of identification: clothing and personal effects (most of them ripped off by the waves), matching fingerprints when available, and DNA tests. Procedures adopted to collect this evidence in a legally indisputable manner, were illustrated. The main conclusions were first, that DNA forensic collection in decaying bodies is a complex matter requiring extreme precautions and surgical skills to avoid potential DNA contamination

of the samples. Similarly, fingerprinting of cadavers demanded unexpected skills. At the policy level, the commitment and leadership of the Thailand Government ensured that all foreign teams adopted similar techniques and contributed reliably to the central database.

The presentation on forensic nurses shed considerable light on a little known nursing specialty. The role of the forensic nurse is far from limited to the handling of dead bodies. In some countries, it is becoming an essential protector of the legal rights of the patients who are victims of violence, rape or abuses. Collecting and preserving legal evidence is essential from the very first contact with the victim in health services.

Both presentations stressed the importance of proper handling of victims (seeking care or dead) from a psychosocial perspective. One cannot overstate the mental health implications for relatives grieving for their missing ones or the victims from violence demanding justice.

Perhaps, what was not covered during the animated discussions with the experts is most revealing of the progress made in the care of dead bodies. Not a single speaker raised the issue of dead bodies being a major public health risk. It appears that the support of WADEM to the promotion of WHO/PAHO guidelines on the management of dead bodies is ultimately meeting success.

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## **Quality Indicators for Prehospital and Disaster Medicine**

*Chairs: David Bradt; Joost Bierens*

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The main questions sought to be answered in this session were: (1) How does one measure whether or not quality work has been done?; (2) What is an indicator?; (3) With what machine do we measure indicators?; and (4) How much information do you need to come to a decision? The participants offered their own perspectives in response to these questions.

In response to the question of, "what is an indicator?" Rüter answered that the aim of an indicator is to improve command and control during a disaster or an emergency. Bierens responded by asking about the level of ambition associated with such an aim. Next, Rüter described how the indication process works. He stated that experts have modeled what happened during an emergency and have indicated guidelines for the goals of interventions. He added that it has been a quantitative research project. Lastly, he stated that when the indicators are not met, there is "room for improvement".

Hoogervorst offered his perspective on indicators—indicators contain the critical limits of characteristics of the trauma chain. Because not all factors can be controlled the limits do not always have to be achieved but, for example, in only 80% of cases. In this study, there are time, competence, result, and chain indicators. The indicators were established through a Delphi procedure in which 140 persons have participated.