fers are being transported in these inadequate units. In rural areas, small community hospitals often are located several hours by road from specialized hospitals. The development of multidisciplinary transport teams trained and equipped to perform this task is feasible for most rural hospitals. These teams could be assembled from existing hospital staff. We have developed a working model that sets priorities according to our needs and limitations. We also consider that it could be used by other hospitals with characteristics similar to ours.

I.7
Mobile Field Hospital

Dr. med. Reinhold Schultze
Siegen, Germany

This poster presented a proposal for a mobile field hospital on a container basis. Two operation theaters—one combined X-ray and laboratory unit, one unit for post-operative care, one unit for intensive care, and one unit for preoperative measures—are enclosed in a hermetic system to keep out dust and gases.

Outside of this nucleus, one needs further containerized elements for electric power, water refining, laundry and sterilization, and a satcom station for running the hospital. One also must consider a kitchen with cleaning automatons, showers, and chemical toilets to maintain the hygiene of the personnel engaged in the mission. These can be placed separately.

All other elements of a field hospital, such as admission with decontamination, triage and waiting zones for patients already treated, and patient wards, can be set up in existing buildings or tents.

The presentation also will show the difficulties of enlarging the working area by telescopic wall elements within a shelter, the problems of transportation, and the composition of these elements to a hermetic compound to allow operations under sterile conditions. Hygiene better than that necessary for deshocking, maintenance of vital functions, or stabilization of fractures, is essential.

I.8
Computer Program to Calculate Different Trauma Scores and to Record the Data of the Patients

Wim (M.A.A.) Van der Heyden, Surgeon
Chief Medical Adviser of the Netherlands Red Cross
Traumatologic Department Surgeon, Dijkzigt Hospital
Rotterdam, Netherlands

This program works on personal computers with a version of MS-DOS. The program consists of the following aspects:

A. Extend components (input the data of a patients in the data base); B. Read components on the screen; C. Record alterations (change data of a existing patient); D. Calculation of trauma scores.

Sort the data for:

E. Names; F. Ages; G. Hospital numbers; H. Trauma mechanism (penetrating or blunt); I. Trauma scores; J. Specific injuries.

The input consists of 26 items:

1) Name; 2) First name; 3) Birth date; 4) Location (emergency department or others); 5) Hospital number; 6) Date of accident; 7) Blunt/penetrating injury; 8) Respiratory rate; 9) Systolic blood pressure; 10) Glasgow Coma Scale (GCS) eye score; 11) GCS motor score; and 12) GCS verbal score.

When it is necessary to make a choice, a help screen shows the possibilities:

13–26) The classification of the anatomical injury score (AIS)-scores by the different body regions. Some help screens bring the user to the exact injury by walking through a decision tree.

After finishing input item entry, there are three screens:

The first displays all the data for this patient and there is a possibility, if necessary, to change one or more of the items. The second screen displays the AIS-codes, and the third displays the calculated trauma scores: GCS score; Triage RTS; RTS; ISS; TRISS; and ASCOT.

There will be a demonstration of this program for interested colleagues.

I.9
Interactive Learning in Triage Tactics

A.K. Mattila Matti, MD, PhD
Kuopio, Finland

The survival of severely injured patients in major accidents and disasters is greatly dependent on correct tactics, including decisions of priority order in transportation and care. There is an imperative demand to effective tactical training in triage principles at the scene, but there are few real possibilities to acquire experience. Computer-aided training opens new dimensions for interactive repetition of triage responsibilities. TRIAGE software is aimed to simulate an accident scene, in which you are prompted to make decisions on task priorities to save causalities. TRIAGE software is written for IBM-compatible PCs including a mouse, hard disk, and color monitor. This method means nearly unlimited technical possibilities of training.

The principal goal is to keep all simulated causalities alive using the actual emergency-care resources in suitable priority order. The trainee must make quick and intelligent decisions and use available resources appropriately. An automatic recording of decisions provides an important evaluation reply. Each TRIAGE package includes nine accidents with a progressively increasing number of victims. Simultaneously, resources remain unaltered. Consequently, there are increasing needs for proper tactics and priority decisions. All the logical features of interactive learning are included in this simulation package with the goal to improve tactical preparedness for true accidents.