

## EXECUTIVE SUMMARY

Our American Medical Association (AMA), through its Center for Disaster Preparedness and Emergency Response, will work collaboratively with the Federation and others to develop and disseminate a comprehensive disaster management education and training program for physicians and other health professionals. The National Disaster Life Support (NDLS) program will enable physicians, medical students, other health professionals, and other first responders to acquire a fundamental understanding and working knowledge of their effective contributions to disaster management at the clinical and public health response levels and become knowledgeable of their integrated professional roles and responsibilities inherent in a community, state, or regional response. This will be accomplished through three stand-alone courses that can be incorporated into various training curricula. The courses, Basic Disaster Life Support (BDLS), Advanced Disaster Life Support (ADLS), and Core Disaster Life Support (CDLS), are targeted to physicians, nurses, pharmacists, dentists, and public health and allied health professionals, as well as public safety and emergency medical services workers. Upon successful completion of the ADLS and BDLS classes, participants receive “certificates of training” and course completion cards, and are eligible for continuing medical education credit.

The overarching purpose of the NDLS program is to provide the basic knowledge and skills set that all health and safety workers need to competently respond to an intended or naturally occurring public health emergency. Such training will help create and sustain a seamless and integrated disaster life support system at the national, state, and community levels. The NDLS courses provide the working knowledge and skills to enable emergency responders to:

- Recognize the potential for a mass casualty incident and identify quickly when a dangerous incident has occurred;
- Rapidly alert the public health and emergency response systems;
- Participate in a multidisciplinary, coordinated response;
- Cope with the unusual search, rescue, triage, and treatment challenges that occur in disaster situations;
- Protect themselves and others from harm;
- Recognize their roles and limitations in disaster response efforts;
- Communicate confidently with the public and the media about the response plans and capabilities; and
- Seek additional information and resources.

Through the NDLS program, our AMA can be recognized as an important national resource for enhancing disaster preparedness and response capabilities of both civilian and military providers. By institutionalizing training throughout the health system, our AMA can better ensure that readiness remains high even during periods of seeming safety and stability. Building a well-trained and well-prepared health workforce through an all-hazards approach provides the dual benefit of bolstering medical and public health systems to respond to terrorism and other public health emergencies, which will truly strengthen the public health infrastructure.

REPORT OF THE COUNCIL ON SCIENTIFIC AFFAIRS

CSA Report 1 - I-03

Subject: AMA National Disaster Life Support Program

Presented by: J. Chris Hawk, III, MD, Chair

Referred to: Reference Committee K  
(Ruth M. Covell, MD, Chair)

---

1 In December 2002, in response to policy recommendations advanced by the Council on Scientific  
2 Affairs (CSA), our American Medical Association (AMA) established the Center for Disaster  
3 Preparedness and Emergency Response to develop and disseminate a comprehensive disaster  
4 management education and training program for physicians and other health professionals. This  
5 report describes our AMA's involvement in developing a National Disaster Life Support (NDLS)  
6 program through which all health professionals can acquire a fundamental understanding and  
7 working knowledge of their potential contributions to disaster management at the clinical and  
8 public health response levels and become aware of their integrated professional roles and  
9 responsibilities inherent in a community, state, or regional response. This new initiative builds on  
10 and advances years of work by the CSA and others to enhance physicians' awareness of their  
11 important role in responding to terrorism and other public health emergencies. Recommendations  
12 in the report underscore this important role as well as support critical learning objectives and  
13 competencies identified recently by the Association of American Medical Colleges (AAMC).

14

15 **Introduction**

16

17 The increasing likelihood of the use of weapons of mass destruction (WMD) on large civilian  
18 populations has been described in many venues, from professional journals to Congressional  
19 hearings to media documentaries. Concern continues about the security of the enormous  
20 worldwide arsenal of nuclear, chemical, and biological agents, as well as the recruitment of persons  
21 capable of manufacturing or deploying them. While the likelihood of a successful chemical,  
22 biological, or nuclear attack may seem remote compared to other known health risks, the  
23 catastrophic nature of such events demands that health professionals and their communities be  
24 prepared. Natural disasters such as tornadoes, hurricanes, floods, and earthquakes, as well as  
25 industrial and transportation-related catastrophes, are far more common and also have the potential  
26 to severely stress existing medical, public health, and emergency response systems. The  
27 emergence of the West Nile virus and SARS, as well as the recent arrival of monkeypox in the  
28 Western hemisphere reinforce to health care professionals that they also must be prepared to  
29 respond to novel and unexpected public health emergencies.

30

31 A critical component in dealing with disasters is a strong public health infrastructure. Investment  
32 in public health systems will enhance capacity to detect and contain rare or unusual disease  
33 outbreaks, whether deliberately induced or naturally occurring. Establishing more effective  
34 strategies against bioterrorism, for example, will have the benefit of improving response to natural

1 epidemics and new or emerging diseases. Capacities needed to cope effectively with the  
2 consequences of an act of bioterrorism could therefore build on the systems used to respond to  
3 natural disease outbreaks. This allows for a dual-use response infrastructure that improves the  
4 capacity of physicians and public health agencies to respond to multiple hazards while taking into  
5 account the unique and complex challenges presented by a WMD event.

### 6 7 **Filling the Gaps in Emergency Preparedness and Response Training**

8  
9 The events of the past two years have made clear that the nation's public health and health care  
10 systems are underprepared to address the full scope of health, safety, and security consequences  
11 that can result from catastrophic events.<sup>1</sup> Findings of a study by the American College of  
12 Emergency Physicians (ACEP) Task Force are typical of others that have attempted to assess the  
13 emergency response capabilities of the health workforce.<sup>2-7</sup> In an extensive review of the readiness  
14 of emergency physicians, emergency nurses, and emergency medical technicians to respond to the  
15 health consequences of the use of WMD (which was performed prior to the terrorist events of  
16 September 2001), ACEP found that "little or no WMD-based expertise existed among the three  
17 audiences..."<sup>2</sup> Even among emergency physicians – specialists whom the public most expects to  
18 be well-trained to respond to WMD-related events – WMD training was lacking. Such training  
19 was not part of the core content of medical schools and is only a small part of training in residency  
20 programs. This finding is echoed by the Liaison Committee on Medical Education's annual survey  
21 of medical schools, which found that while 88 of 126 medical schools required students to take  
22 course work in biological and chemical terrorism, most of them required less than 6 hours of course  
23 work over the four-year curriculum.<sup>8</sup>

24  
25 Among hospitals, a 2001 survey suggests that 100% of hospitals surveyed were inadequately  
26 prepared for a biologic incident and 73% were inadequately prepared for a chemical or nuclear  
27 event.<sup>9</sup> A different survey of more than 180 emergency departments found that fewer than 20% of  
28 hospitals had plans for biological or chemical weapons events.<sup>10</sup> This lack of preparedness further  
29 suggests a lack of training.

30  
31 Recognizing that much needs to be done to improve the public health and health care capacity of  
32 the nation to respond to acts of terrorism and other catastrophic disasters, the US Congress is  
33 providing unprecedented financial support to states to train the nation's health workforce and  
34 strengthen public health and emergency response systems. With federal support, state and local  
35 public health agencies are improving disaster response programs and services, and hospitals are in  
36 the process of upgrading their ability to respond to acts of bioterrorism and outbreaks of infectious  
37 disease, as well as natural disasters and other public health emergencies.

38  
39 Through the Health Resources and Services Administration (HRSA) and the Centers for Disease  
40 Control and Prevention (CDC), the Department of Health and Human Services has moved  
41 aggressively to fill important infrastructure and education gaps. HRSA is supporting education and  
42 preparedness training and addressing regional surge capacity, emergency medical services, and  
43 hospital linkages to public health agencies. The CDC is funding efforts to improve surveillance  
44 and epidemiology, laboratory capacity for biological and chemical agents, health communications  
45 and information technology, and health information dissemination. In 2000, the CDC established a  
46 national system of Centers of Public Health Preparedness (<http://www.phppo.cdc.gov/owpp>) to  
47 improve the capacity of front line public health and health care workers to respond to terrorism and  
48 other public health threats and emergencies. Published data are not yet available to assess the  
49 accomplishments and effectiveness of this training network.

1 Since the September 11th attacks, associations representing health professionals of all disciplines  
2 have responded quickly and impressively to provide health care workers with skills and  
3 competencies to respond to acts of terrorism.<sup>2,11-15</sup> Specialties of family practice, preventive  
4 medicine, pediatrics, emergency medicine, internal medicine, psychiatry, and radiology, to name  
5 but a few, have developed excellent training materials to educate their respective constituencies.  
6 Training programs have been created in various formats, such as didactic lectures, Web-based  
7 tutorials, video and lecture tape series, workshops, and conferences. Many programs are more  
8 narrowly targeted (eg, to infectious disease specialists, emergency physicians, pediatricians,  
9 psychiatrists, radiologists) and do not necessarily reach a broad spectrum of health care students  
10 and professionals. To date, most efforts focus almost entirely on clinical and technical material,  
11 while not adequately addressing public health and emergency management system response  
12 requirements. Few national programs have been developed to address the important skills and  
13 educational needs in disaster management and response, in an “all-hazards” approach, that are  
14 common to multiple disciplines.

15  
16 The Web site of the Public Health Foundation (<http://www.trainingfinder.org>) reveals a plethora of  
17 educational opportunities for practicing health care professionals. A search for  
18 “bioterrorism/emergency preparedness” training materials revealed 96 unique resources, most of  
19 which are Web-based or available on video tape. Few of these are targeted at students in health  
20 professions schools. For medical school students, the AAMC has compiled a list of model training  
21 programs across the country.

22  
23 The CDC has assembled perhaps the widest assortment of readily available training materials and  
24 modules, nearly all of which are available through its Web site (<http://www.bt.cdc.gov>). This is a  
25 valuable resource on public health emergencies and includes fact sheets on a variety of biological,  
26 chemical, and radioactive agents, clinical and infection control guidelines, the types of injuries  
27 resulting from mass trauma, and pharmaceutical stockpile information. These materials generally  
28 focus on responding to a specific type of terrorism, often targeting a specific hazard. The  
29 educational materials and modules are often not suitable for introductory education about the health  
30 worker’s role in the public health system, public health surveillance and reporting, the organization  
31 of incident command centers, overarching information about major categories of WMD agents,  
32 fundamental clinical concepts for managing WMD-related events, and strategies for dealing with  
33 mass casualties.

### 34 35 **The Need for Standardized, Multidisciplinary Training**

36  
37 Since the terrorist attacks in 2001, interest has increased for a nationally recognized course in “all-  
38 hazards” training to better prepare health and safety professionals for mass casualty incidents.  
39 While each discipline brings a unique and valuable knowledge base and skill set that contributes  
40 importantly to the nation’s readiness, the multitude of responders including emergency medical  
41 technicians, paramedics, fire fighters, law enforcement personnel, physicians, nurses,  
42 administrators, military personnel, and others who arrive at a disaster scene typically have very  
43 different definitions of terms, standards, operation methods, and classifications, as well as  
44 experiences and training.

45  
46 Through recent grant programs, federal agencies such as HRSA and the CDC recognize the need to  
47 teach the important skills, competencies, and knowledge bases that cut across individual health  
48 professions and are important for all health workers to acquire. The multidisciplinary response that  
49 communities and the nation as a whole must implement in a public health emergency makes it  
50 critical that health professionals be trained in multidisciplinary settings.

1 A key finding of the ACEP Task Force was the lack of any “approved” standard content literature  
2 on which to base a WMD course.<sup>2</sup> The Task Force identified discipline-specific core content for a  
3 national training program to detect and respond to chemical, biologic, and radioactive agents. This  
4 includes core objectives and principles for preparing emergency physicians, nurses, paramedics,  
5 and students in these disciplines to respond to terrorism involving WMD. The ACEP task force  
6 addressed barriers to professional training and curricula enhancement, and acknowledged the  
7 difficulty in implementing new course material into the already crowded core content of  
8 undergraduate and graduate medical and nursing education programs. Recently, the AAMC  
9 published guidance on the content and teaching methods that would be most appropriate for  
10 incorporating this content into medical school curricula.<sup>11</sup>

11  
12 Some of the disaster management skills needed by health care providers are clinical in nature;  
13 others relate to their role in the larger public health system. When encountering disaster victims,  
14 physicians must be able take medical histories and conduct physical examinations to rule out signs  
15 and symptoms characteristic of exposure to various chemical, biological, and radioactive agents.  
16 They must also be able to order appropriate procedures and laboratory studies to confirm or refute  
17 possible diagnoses. Health care providers also must employ appropriate procedures to prevent  
18 exposure to themselves and others. Clinicians must be able to prescribe treatment plans that may  
19 include management of psychological as well as physical trauma. Finally, they must understand  
20 the basics of risk communication so that they can communicate clearly and nonthreateningly with  
21 patients, their families, and the media about such things as exposure risks and potential preventive  
22 measures (eg, smallpox vaccination).

23  
24 An integral component of any WMD-based curriculum should be focused on physicians’  
25 interaction with the public health system in order to facilitate effective and coordinated medical  
26 and public health responses to WMD, as well as to more common health threats, including chronic  
27 and infectious diseases, injuries, and substance abuse.<sup>11</sup> Most health professions curricula do not  
28 address either the role of the public health, emergency medical services, and emergency  
29 management systems or the individual health professional’s role in these systems. Interventions  
30 that must be considered following the onset of a disaster (terrorism-related or not) include  
31 quarantine, mass immunization, mass triage, public education about preventing exposures,  
32 environmental decontamination and sanitation, and epidemiological surveillance and investigation.  
33 Health professionals who have direct involvement in a disaster event may need to understand  
34 procedures used to collect patient information for surveillance as well as the rationale and  
35 procedures for reporting cases and patient information. Furthermore, clinicians will need to  
36 understand the incident command structure and their role within that structure.

37  
38 Another important set of issues involves professional ethics and disaster response.<sup>11</sup> This  
39 encompasses responders’ responsibility to treat patients (including those with potentially  
40 contagious conditions), responders’ rights and responsibilities to protect themselves, issues  
41 surrounding their responsibilities and rights as volunteers, and associated liability issues.

42  
43 While there is no nationally recognized, standardized, multidisciplinary curriculum for training  
44 health professionals about the medical and safety implications of disasters and other public health  
45 emergencies, considerable interest and activity exist nationally in this regard. As described below,  
46 our AMA is actively involved in the development and fielding of three standardized disaster life  
47 support courses aimed at medical and nonmedical responders. In September 2003, HRSA awarded  
48 \$26.6 million in 23 states to support continuing education programs for health professionals and  
49 curriculum development in health professions schools.<sup>16</sup> Comprehensive training manuals and  
50 textbooks are being published on which to base course development.<sup>17-20</sup> In April 2003, Columbia

1 University created a National Center for Disaster Preparedness in the Mailman School of Public  
 2 Health. A stated goal of the Center is to develop curricula for health professionals and to “serve as  
 3 a national resource and training ground for community and public health emergency  
 4 preparedness.”<sup>21</sup> A National Health Professions Preparedness Consortium, founded by Louisiana  
 5 State University, the University of Alabama, and the Vanderbilt School Nursing, has been formed  
 6 to facilitate the development of curricula and training programs to address preparedness of  
 7 physicians and other health care workers to respond to WMD-incidents.<sup>22</sup>

8  
 9 Perhaps the best examples of standardized training programs targeted at multiple health professions  
 10 focus on cardiac arrest and trauma support. Over the past three decades, nationally recognized and  
 11 validated programs for advanced cardiac life support (ACLS, sponsored by the American Heart  
 12 Association) and advanced trauma life support (ATLS, sponsored by the American College of  
 13 Surgeons) have become a standard part of civilian and US military medical curricula and  
 14 continuing medical education (CME).

15  
 16 Even before the terrorist attacks in 2001, experts in emergency and disaster medicine saw the need  
 17 for a nationally recognized course similar to ACLS and ATLS but directed at the recognition and  
 18 management of “all-hazards” threats (ie, nuclear, biological, chemical, explosive, and natural  
 19 disasters). With CDC support, the National Disaster Life Support Education Consortium  
 20 (NDLSEC) was established to better prepare health care professionals and emergency response  
 21 personnel for mass casualty incidents by assimilating pre-existing disaster educational programs  
 22 into a cohesive all-hazards manual and continuing education program (Appendix A lists current  
 23 NDLSEC members). Like ACLS and ATLS, these courses were offered in a didactic and skills lab  
 24 format, in a schedule that could be accomplished in a weekend. Courses targeted resident  
 25 physicians, critical care/emergency nurses, paramedics, primary care physicians, and medical  
 26 students.

27  
 28 **The National Disaster Life Support (NDLS) Program**

29  
 30 At the 2001 AMA Interim meeting, the House of Delegates mandated that our AMA develop a  
 31 major national initiative to rebuild the nation's public health infrastructure and ensure that  
 32 physicians, in partnership with public health agencies, have the capacity to respond to future  
 33 medical disasters. It was through this action that the Center for Disaster Preparedness and  
 34 Emergency Response (CDPER) was created to manage a comprehensive disaster management  
 35 education and training program. Directed by James James, MD, DrPH, MHA, the CDPER resides  
 36 within the Group on Science, Quality, and Public Health.

37  
 38 In 2003, our AMA signed a Memorandum of Understanding with the four NDLSEC founding  
 39 institutions (the Medical College of Georgia, University of Georgia, University of Texas  
 40 Southwestern Medical Center at Dallas, and University of Texas at Houston School of Public  
 41 Health) and established a steering committee to coordinate efforts and resources of the AMA and  
 42 the NDLSEC to enhance the education and training of health care professionals and others in  
 43 disaster preparedness and emergency response.

44  
 45 The overarching purpose of NDLS program is to provide the basic information and skill set that all  
 46 health and safety workers need to competently respond to an intended or naturally occurring public  
 47 health emergency. This will be accomplished through the development and dissemination of three  
 48 stand-alone courses, Basic Disaster Life Support (BDLS), Advanced Disaster Life Support  
 49 (ADLS), and Core Disaster Life Support (CDLS), which can be incorporated into various training  
 50 curricula, including but not limited to medicine, nursing, pharmacy, dentistry, public health, and

1 the allied health sciences. It should be noted at the outset that these courses are not intended to  
2 displace existing curricula or training programs but to complement them (see Appendix B for  
3 course descriptions). Course participants are expected to gain a fundamental understanding and the  
4 working knowledge needed for effective contributions to medical disaster management at the  
5 clinical and public health response levels and become knowledgeable of their integrated  
6 professional roles and responsibilities in emergency response efforts.

7  
8 Strategic goals of the NDLS program are:

- 9
- 10 • To provide a comprehensive and consistent overview of disaster management topics
  - 11 relevant to all health and safety professionals regardless of discipline or specialty.
  - 12 • To be recognized nationally as the definitive basic training resource for disaster
  - 13 preparedness and response for both civilian and military providers.
  - 14 • To promote AMA leadership in protecting public health, safety, and security.
- 15

16 When fully developed, courses will be “packaged” to include a basic text; an “Instructor’s Manual”  
17 containing the course syllabus; accompanying audiovisuals; and an examination, evaluation, and  
18 verification process to allow the stand-alone course to be offered throughout the country. Course  
19 participants are eligible for CME credit. The packaged product includes access to a faculty  
20 development program to prepare course directors to offer the courses at their institution. Key  
21 features of the NDLS program are provided in the Table.

22  
23 An additional benefit will be the establishment of a central database or registry to allow rapid  
24 identification by discipline and specialty of individuals who have successfully completed the  
25 courses. This central database or registry could be used for an expanded Medical Reserve Corps of  
26 volunteer health care providers who might be willing to contribute expertise beyond their local  
27 community.

### 28 29 **AMA Leadership in Action**

30  
31 Much more still needs to be done to fully integrate the public health community, physicians,  
32 pharmacists, nurses, police, firefighters, emergency medical service providers, and hospitals into a  
33 cohesive emergency response system. This will require coordinated and sustained efforts from  
34 many groups across many disciplines. Implementing a national education and training program  
35 requires a strong advocate for the importance of including content integration as a priority into  
36 existing medical and public health education. As the umbrella for organized medicine and the  
37 nation’s leading voice for individual physicians, our AMA is ideally positioned to provide  
38 leadership and advocacy in this regard. This important role of the AMA was underscored by the  
39 National Advisory Panel to Assess Domestic Response Capabilities for Terrorism Involving  
40 Weapons of Mass Destruction (also known as the “Gilmore Commission”),<sup>23</sup> which has advised  
41 Congress to fully implement the recommendations in CSA Report 11 (I-00), “Medical  
42 Preparedness for Terrorism and Other Disasters.”

43  
44 Recognizing that various potentially competitive programs have been developed or are under  
45 development, it is imperative that our AMA move forward expeditiously with this program.  
46 Currently, our AMA is working with the American College of Preventive Medicine to identify  
47 important public health-related elements in the NDLS courses and procure funding for the further  
48 development and fielding of the courses. Through its convening capacity, our AMA and the Center  
49 for Disaster Preparedness and Emergency Response must reach out immediately to other potential  
50 partners including:

- 1 • Medical specialty societies
- 2 • State and local medical societies
- 3 • Public health agencies, emergency management agencies, and emergency medical services
- 4 organizations
- 5 • Federal agencies (eg, Department of Homeland Security, Department of Health and Human
- 6 Services, Department of Defense, Veterans Administration)
- 7 • Other medical and public health organizations (eg, Association of American Medical
- 8 Colleges, American Hospital Association, National Association of EMS Physicians,
- 9 American Public Health Association, American Nurses Association, American Osteopathic
- 10 Association, National Medical Association, Association of Schools of Allied Health
- 11 Professions, Joint Commission on Accreditation of Healthcare Organizations, National
- 12 Association of County and City Health Officials)
- 13 • Academic institutions (eg, CDC- and HRSA-funded Centers for Bioterrorism/Public Health
- 14 Preparedness, Uniformed Services University for the Health Sciences)
- 15 • Private foundations and voluntary organizations

16

17 Developing comprehensive curricula to train health care professionals for a disaster event presents  
18 a daunting challenge. That is because disasters can occur in multiple scenarios, with diverse  
19 clinical and public health outcomes, many of which are not addressed in current health professional  
20 student education. Current knowledge gaps cut across the continuum of emergency events and  
21 point to the important need to train all health care workers to:

22

- 23 • Recognize the potential for a mass casualty incident and identify quickly when a dangerous
- 24 incident has occurred;
- 25 • Rapidly alert the public health and emergency response systems;
- 26 • Participate in a multidisciplinary, coordinated response;
- 27 • Cope with the unusual search, rescue, triage, and treatment challenges that occur in disaster
- 28 situations;
- 29 • Protect themselves and others from harm;
- 30 • Recognize their roles and limitations in disaster response efforts;
- 31 • Communicate confidently with the public and the media about the response plans and
- 32 capabilities; and
- 33 • Seek additional information and resources.

34

35 All health care personnel have an obligation to their patients, their profession, and to the health,  
36 safety, and security of their communities. Health professionals, regardless of specialty or area of  
37 concentration, must understand the roles of each segment of the response system and must be  
38 trained to detect and respond to all types of potential disasters in a coordinated and integrated way.  
39 To support these obligations, our AMA has a duty to ensure that physicians and other health care  
40 professionals have the requisite knowledge and skills to function effectively in a disaster or other  
41 public health emergency. Through the NDLS program, our AMA can be recognized as an  
42 important national resource for enhancing disaster preparedness and response capabilities of both  
43 civilian and military providers. By institutionalizing training in emergency preparedness and  
44 response throughout the health system, our AMA can better ensure that readiness remains high  
45 even during periods of seeming safety and stability. Building a well-trained and well-prepared  
46 health workforce through an all-hazards approach provides the dual benefit of bolstering medical  
47 and public health systems to respond to terrorism and other public health emergencies, which will  
48 truly strengthen the public health infrastructure.

1 **RECOMMENDATIONS**

2  
3 The Council on Scientific Affairs recommends that the following recommendation be adopted and  
4 the remainder of this report be filed:

5  
6 That AMA Policy H-130.946, “AMA Leadership in the Medical Response to Terrorism and Other  
7 Disasters” (AMA Policy Database), be amended by insertion and deletion to read as follows:

8  
9 Our AMA:

- 10  
11 1. Condemns terrorism in all its forms and will provide leadership in coordinating efforts to  
12 improve the medical and public health response to terrorism and other disasters.  
13  
14 2. Will work collaboratively with the Federation in the development, dissemination, and  
15 evaluation of a national education and training initiative, called the National Disaster Life  
16 Support Program, to provide physicians, medical students, other health professionals, and other  
17 emergency responders with a fundamental understanding and working knowledge of their  
18 integrated roles and responsibilities in disaster management and response efforts.  
19  
20 23. Will join in working with the Department Office of Homeland Security, the Department of  
21 Health and Human Services, the Department of Defense, the Federal Emergency Management  
22 Agency, and other appropriate federal agencies; state, local, and medical specialty societies;  
23 other health care associations; and private foundations to (a) ensure adequate resources,  
24 supplies, and training to enhance the medical and public health response to terrorism and other  
25 disasters; (b) develop a comprehensive strategy to assure surge capacity to address mass  
26 casualty care; (c) implement communications strategies to inform health care professionals and  
27 the public about a terrorist attack or other major disaster, including local information on  
28 available medical and mental health services; (d) convene local and regional workshops to  
29 share "best practices" and "lessons learned" from disaster planning and response activities; (e)  
30 organize annual symposia to share new scientific knowledge and information for enhancing the  
31 medical and public health response to terrorism and other disasters; and (f) develop joint  
32 educational programs to enhance clinical collaboration and increase physician knowledge of  
33 the diagnosis and treatment of depression, anxiety, and post traumatic stress disorders  
34 associated with exposure to disaster, tragedy, and trauma.  
35  
36 4. Believes all physicians should ~~be~~ (a) be alert to the occurrence of unexplained illness and death  
37 in the community; (b) be knowledgeable of disease surveillance and control capabilities for  
38 responding to unusual clusters of diseases, symptoms, or presentations; (c) be knowledgeable  
39 of procedures used to collect patient information for surveillance as well as the rationale and  
40 procedures for reporting patients and patient information; and (d) be familiar with the clinical  
41 manifestations, diagnostic techniques, isolation precautions, decontamination protocols, and  
42 chemotherapy/prophylaxis of chemical, ~~and~~ biological, ~~and~~ radioactive agents likely to be used  
43 in a terrorist attack; (e) utilize appropriate procedures to prevent exposure to themselves and  
44 others; (f) prescribe treatment plans that may include management of psychological and  
45 physical trauma; (g) understand the essentials of risk communication so that they can  
46 communicate clearly and nonthreateningly with patients, their families, and the media about  
47 issues such as exposure risks and potential preventive measures (eg, smallpox vaccination);  
48 and (h) understand the role of the public health, emergency medical services, emergency  
49 management, and incident command systems in disaster response and the individual health  
50 professional’s role in these systems.

- 1 5. Believes that physicians and other health professionals who have direct involvement in a mass  
2 casualty event should be knowledgeable of public health interventions that must be considered  
3 following the onset of a disaster including: (a) quarantine and other movement restriction  
4 options; (b) mass immunization/chemoprophylaxis; (c) mass triage; (d) public education about  
5 preventing or reducing exposures; (e) environmental decontamination and sanitation; (f) public  
6 health laws; and (g) state and federal resources that contribute to emergency management and  
7 response at the local level.  
8
- 9 6. Believes that physicians and other health professionals should be knowledgeable of ethical and  
10 legal issues and disaster response. These include: (a) their professional responsibility to treat  
11 victims (including those with potentially contagious conditions); (b) their rights and  
12 responsibilities to protect themselves from harm; (c) issues surrounding their responsibilities  
13 and rights as volunteers, and (d) associated liability issues.  
14
- 15 57. Believes physicians and medical societies should participate directly with state, local, and  
16 national public health, law enforcement, and emergency management authorities in developing  
17 and implementing disaster preparedness and response protocols in their communities, hospitals,  
18 and practices in preparation for terrorism and other disasters.  
19
- 20 38. Urges Congress to appropriate funds to support research and development (a) to improve  
21 understanding of the epidemiology, pathogenesis, and treatment of diseases caused by potential  
22 bioweapon agents and the immune response to such agents; (b) for new and more effective  
23 vaccines, pharmaceuticals, and antidotes against biological and chemical weapons; (c) for  
24 enhancing the shelf life of existing vaccines, pharmaceuticals, and antidotes; and (d) for  
25 improving biological, ~~and~~ chemical, and radioactive agent detection and defense capabilities.  
26 **(Modify Current HOD Policy)**

**Table. Key Features of the NDLS Program**

<p>National in scope and designed to meet diverse audience needs and requirements (medical, public health, law enforcement, fire, emergency management, emergency medical services)</p>
<p>Emphasis on multidisciplinary all-hazards training, with focus on general improvement of public health preparedness and response infrastructures, to build an overall response force that is prepared at individual and system levels</p>
<p>Courses provide didactic and practical "hands-on" experiences using simulation and other proven educational modalities</p>
<p>Courses were developed by medical professionals (in public health and clinical specialties) with direct experience and solid academic credentials in disaster management</p>
<p>Development, validation, and fielding of course materials has the commitment and active participation of disaster medicine experts and key stakeholder organizations including the AMA, CDC, and US military</p>
<p>The AMA will involve all interested medical societies in the further development, fielding, and evaluation of the NDLS courses</p>
<p>The courses utilize a user-friendly and recognizable concept that fits current ACLS/ATLS templates in terms of:</p> <ul style="list-style-type: none"><li>• targeted audience</li><li>• scheduling logistics</li><li>• space allocation</li><li>• format (didactics and drills)</li><li>• suitability for Web-based training (distance learning component)</li></ul>
<p>As stand-alone courses, BDLS and ADLS can be incorporated into the curriculum of health professions schools or presented as workshops or continuing education programs at meetings and symposia.</p>
<p>Courses soon will be adapted for distance learning</p>
<p>A steering committee has been formed comprised largely of academicians in disaster medicine who also serve as medical directors or special consultants to various state and federal agencies on the subject material. The AMA serves as chair of this committee.</p>
<p>The AMA is the sponsoring and CME-accrediting organization for the NDLS courses.</p>

## References

1. Institute of Medicine. *Biological Threats and Terrorism: Assessing the Science and Response Capabilities: Workshop Summary*. Washington, DC: National Academy Press; 2002.
2. NBC Taskforce. *Developing Objectives, Content, and Competencies for the Training of Emergency Medical Technicians, Emergency Physicians, and Emergency Nurses to Care for Casualties Resulting From Nuclear, Biological or Chemical Incidents*. Dallas, Texas: American College of Emergency Physicians; 2001. Available at: <http://www.acep.org/library/pdf/NBCreport2.pdf>. Accessed October 2003.
3. Institute of Medicine. *Who Will Keep the Public Healthy? Educating Public Health Professionals for the 21<sup>st</sup> Century*. Washington, DC: National Academy Press; 2002.
4. Council on Scientific Affairs, American Medical Association. *Medical Preparedness for Terrorism and Other Disasters*. CSA Report 11 (I-00). Chicago, IL: AMA; 2001. Available at: <http://www.ama-assn.org/ama/pub/article/2036-5419.html>. Accessed October 2003.
5. Alexander GC, Wynia MK. Ready and willing? physicians' sense of preparedness for bioterrorism. *Health Affairs*. 2003;22:189-197.
6. Chen FM, Hickner J, Fink KS, Galliher JM, Burstin H. On the front lines: family physicians' preparedness for bioterrorism. *J Fam Pract*. 2002;51:745-750.
7. Ghilarducci DP, Pirrallo RG, Hegman KT. Hazardous materials readiness of United States Level I trauma centers. *J Occupat Environ Med*. 2000;42:683-692.
8. Liaison Committee on Medical Education. *2002-2003 Annual Medical School Questionnaire*. Chicago, IL: American Medical Association, 2003.
9. Treat KN. Hospital preparedness for weapons of mass destruction: and initial assessment. *Ann Emerg Med*. 2001;38:562-565.
10. Wetter DC, Daniel WE, Treser CD. Hospital preparedness for victims of chemical or biological terrorism. *Am J Public Health*. 2001;91:710-716.
11. Association of American Medical Colleges. *Training Future Physicians About Weapons of Mass Destruction: Report of the Expert Panel on Bioterrorism Education for Medical Students*. Washington, DC: AAMC;2003.
12. Association of Departments of Family Medicine, Association of Family Practice Residency Directors. *Disaster Medicine: Recommended Curriculum Guidelines for Family Practice Residents*. Available at: <http://www.aafp.org/x16647.xml?printxml>. Accessed October 2003.
13. International Nursing Coalition for Mass Casualty Education Competency Committee. *Educational Competencies for Registered Nurses Responding to Mass Casualty Incidents*. Available at: <http://www.aacn.nche.edu/Education/INCMCECompetencies.pdf>. Accessed October 2003.

14. American College of Radiology, American Association of Physicists in Medicine, American Society of Therapeutic Radiology and Oncology. *Disaster Preparedness for Radiology Professionals: Response to Radiological Terrorism*. Available at: [http://www.acr.org/publications/mnp/mnp\\_primer.html](http://www.acr.org/publications/mnp/mnp_primer.html). Accessed October 2003.
15. Center of Health Policy, Columbia University School of Nursing. *Bioterrorism and Emergency Preparedness: Competencies for all Public Health Workers*. Available at: <http://cpmcnet.columbia.edu/dept/nursing/institute-centers/chphsr/btcomps.pdf>. Accessed October 2003.
16. *HHS Awards \$26.6 Million in New Program to Provide Bioterrorism Training and Curriculum*. News Release September 12, 2003. Available at: <http://www.hhs.gov/news/press/2003pres/20030912d.html>. Accessed September 2003.
17. Landesman LY. *Public Health Management of Disasters: The Practice Guide*. Washington, DC: American Public Health Association; 2001.
18. Hogan DE, Burstein JL. *Disaster Medicine*. Philadelphia: Lippincott Williams & Wilkins; 2002.
19. Briggs SM, ed. *Advanced Disaster Medical Response: Manual for Providers*. Boston: Harvard Medical International, Inc; 2003.
20. Veenema TG, ed. *Disaster Nursing and Emergency Preparedness for Chemical, Biological, Radiological Terrorism and Other Hazards*. New York: Springer Publishing; 2003.
21. *Columbia University's Mailman School of Public Health Creates National Center for Disaster Preparedness: Names Irwin Redlener, MD, to Head New Center*. Press Release. April 28, 2003. Available at: <http://www.mailman.hs.columbia.edu/news/redlener.html>. Accessed October 2003.
22. *The National Health Professions Consortium*. Available at <http://www.mc.vanderbilt.edu/nursing/coalitions/INCMCE/nhppcoverview.pdf>. Accessed October 2003.
23. National Advisory Panel to Assess Domestic Response Capabilities for Terrorism Involving Weapons of Mass Destruction. *Third Annual Report to the President and the Congress of the Advisory Panel to Assess Domestic Response Capabilities for Terrorism Involving Weapons of Mass Destruction*, III. Arlington, VA: RAND; 2001.

## **Appendix A**

### **The National Disaster Life Support Education Consortium (NDLSEC)**

#### **NDLS Steering Committee**

**Robert R. Bass, MD, FACEP**, Executive Director, Maryland Institute for Emergency Medical Services Systems, Baltimore, Maryland

**Phillip L. Coule, MD** Associate Director, Center for Operational Medicine, Assistant Professor of Emergency Medicine, Department of Emergency Medicine, Medical College of Georgia; Chairman, Georgia EMS Medical Director's Advisory Council

**Cham Dallas, PhD** Special Consultant to the US Air Force Surgeon General on Weapons of Mass Destruction; Head, CLEARMADD and University of Georgia Toxicology Program

**James J. James, MD, DrPH, MHA** Director, AMA Center for Disaster Preparedness and Emergency Response; Steering Committee Chair.

**Scott Lillibridge, MD** Special Assistant on Bioterrorism to the US Department of Health and Human Services (DHHS) and the CDC; in-coming Professor and Director of the Center for Bioterrorism and Disaster Preparedness, School of Public Health at the University of Texas Health Sciences Center, Houston, Texas

**Paul E. Pepe, MD, MPH** Professor of Surgery, Medicine, and Public Health and Chair, Emergency Medicine, University of Texas Southwestern Medical Center at Dallas; national spokesperson for the American Heart Association (AHA) and longstanding member of AHA Basic Life Support and Advanced Cardiac Life Support Committees

**Richard Schwartz, MD** Vice-Chair Emergency Medicine Department, Director of Center of Operational Medicine, Medical College of Georgia; Federal Bureau of Investigation Emergency Medical Support Program

**Raymond E. Swinton, MD** Assistant Professor, Division of Emergency Medicine, University of Texas Southwestern Medical Center at Dallas

#### **Participating Agencies and Organizations**

**American College of Emergency Physicians**, Dallas, Texas

**Center for Disaster and Humanitarian Assistance Medicine (CDHAM)**, Department of Military and Emergency Medicine, Uniformed Services University of Health Sciences, Bethesda, Maryland (Specifically, the Medical Director of CDHAM is a collaborating representative to the NDLSEC from the Uniformed Services Health Sciences University)

**Centers for Disease Control and Prevention**, Atlanta, Georgia (Original sponsoring agency for BDLS/ADLS development)

**Center for Leadership in Education and Applied Research in Mass Destruction Defense (CLEARMADD).** A collaborative center of the University of Georgia and the Medical College of Georgia, which has been designated by the CDC as a Specialty Center for Public Health Preparedness and funded under a directed congressional appropriation in 2002 to develop medical education programs in mass casualty management for emergency care personnel.

Collaborative partners of CLEARMADD include:

*Center for Total Access, Southeastern Regional Medical Command, Fort Gordon*

A medical informatics research and development laboratory and testing facility in support of the Southeast Regional Command 's integrated Tri-Service medical support mission, providing technology solutions and support through concept development, demonstrations, military utility assessments, modeling, interactive multimedia applications, data analysis, peer review, and publication

*Major US Urban Centers' EMS Medical Directors' Consortium (Eagles group)*

Multiple members of the so-called "Eagles" group - an education coalition of EMS medical directors from large metropolitan centers (Seattle, San Francisco, Los Angeles, San Diego, Boston, Chicago, Philadelphia, Richmond, Nashville, Austin, Columbus, Houston, Dallas, and others)

*Research Triangle Institute*

A nonprofit research corporation that provides expertise in computer-based simulation as well as in administrative and grant support for the NDLSEC

*Texas Department of Health (TDH)*

Members of various committees of the State of Texas Governor's Emergency-Trauma Advisory Council, managed by the TDH, are part of the NDLSEC, and plans are underway to provide a course rollout at the TDH's state EMS conference

*US Air Force, Office of the US Air Force Surgeon General*

Specifically, the Civilian Consultant to the Air Force Surgeon General on Weapons of Mass Destruction is a collaborating representative to the NDLSEC

**Academic Centers**

Johns Hopkins University  
Medical College of Georgia  
Parkland Health and Hospital System, Dallas  
Uniformed Services University Health Sciences University  
University of Georgia  
University of Massachusetts Medical School  
University of Texas School of Public Health, Houston  
University of Texas Southwestern Medical Center

**Participating Individuals**

Richard Aghababian, MD Professor and Chair, Emergency Medicine, University of Massachusetts Medical Center, Worcester, MA; Past-President, American College of Emergency Physicians; developer of the Pediatric Disaster Life Support course

Erik Auf der Heide, MD, MPH Disaster planning and training specialist, Agency for Toxic Substances and Disease Registry, US Department of Health and Human Services  
Ronald Blanck, DO Past Surgeon General of the US Army and President of the University of North Texas Health Sciences Center, Special Consultant on Homeland Defense to the Bush Administration

Raymond A. Fowler, MD Assistant Professor, Division of Emergency Medicine, University of Texas Southwestern Medical Center at Dallas; Past-President National Association of EMS Physicians; founding Program Director for Basic Trauma Life Support

Chris Keyes, MD, MPH Associate Professor and Chief, Section of Toxicology, University of Texas Southwestern Medical Center at Dallas

Robert Suter, DO Attending Physician, Parkland Memorial Hospital, Dallas, TX; Associate Professor, Department Emergency Medicine, Medical College of Georgia; national Secretary-Treasurer, American College of Emergency Physicians

Nelson Tang, MD Medical Director, US Secret Service; Assistant Professor, Johns Hopkins University Department of Emergency Medicine

John M. Wightman, EMT-P, MD Chair, Disaster Medicine Interest Group, Society for Academic Emergency Medicine; Associate Professor and Medical Director, Center for Disaster and Humanitarian Assistance Medicine, Department of Military and Emergency Medicine, Uniformed Services University of Health Sciences

**Appendix B**

**The National Disaster Life Support Program**

*Basic Disaster Life Support (BDLS)*  
*Advanced Disaster Life Support (ADLS)*  
*Core Disaster Life Support (CDLS)*

**Course Descriptions**

**Basic Disaster Life Support (BDLS)**

BDLS is delivered through in-person didactic and interactive lectures with standardized slide sets and an accompanying text. Information can be delivered over 1 day or over multiple days. In the future, the BDLS course also will be available in a distance-learning model via the Internet. Computer generated simulation will be used to enforce concepts learned in each chapter.

The BDLS course is a review of the all-hazards topics including natural and accidental man made events; traumatic and explosive events; nuclear and radiological events; biological events; and chemical events (Box 1). Also included, is information on such critical areas as the health care professional’s role in the public health and incident management systems, community mental health, and special needs of underserved and vulnerable populations.

<b>Box 1 BDLS Course Topics</b>	
<ul style="list-style-type: none"> <li>• <b>DISASTER Paradigm</b></li> <li>• <b>Natural Disasters</b></li> <li>• <b>Traumatic and Explosive Events</b></li> <li>• <b>Nuclear and Radiological Events</b></li> </ul>	<ul style="list-style-type: none"> <li>• <b>Biological Events</b></li> <li>• <b>Chemical Events</b></li> <li>• <b>Public Health Implications of Disasters</b></li> <li>• <b>Psychosocial Aspects</b></li> <li>• <b>Evaluation and Testing</b></li> </ul>

The recognition and management of the disaster scene and victims is reinforced through a unique approach called the *D-I-S-A-S-T-E-R* paradigm (Box 2). The *D-I-S-A-S-T-E-R* paradigm organizes the students’ preparation and response to disaster management. It emphasizes an all-hazards approach to mass casualty incident management and facilitates ongoing qualitative and quantitative assessment of an incident.

<b>Box 2: <i>D-I-S-A-S-T-E-R</i> Paradigm</b>
<p><b>D – Detect</b>  <b>I – Incident Command</b>  <b>S – Scene Security and Safety</b>  <b>A – Assess Hazards</b>  <b>S – Support</b>  <b>T - Triage and Treatment</b>  <b>E – Evacuation</b>  <b>R – Recovery</b></p>
<p>The <i>D-I-S-A-S-T-E-R</i> paradigm organizes the providers’ preparation and response to disaster management.</p>

The triage system for BDLS is the *M.A.S.S. Triage* model (Box 3). *Id-me!* Is a simple mnemonic for sorting patients during triage of mass casualties, which is used effectively in the *M.A.S.S. Triage* model (Box 4). A detailed discussion and application of these assessment tools is discussed and reinforced throughout the BDLS and ADLS courses.

Box 3. <i>M.A.S.S. Triage</i>	Box 4. <i>“Id-me”!</i>
<p style="text-align: center;">M – Move A – Assess S – Sort S – Send</p> <p><i>M.A.S.S.</i> Triage is a disaster triage system that utilizes US military triage categories with a proven means of handling large numbers of casualties in a mass casualty incident (MCI).</p>	<p style="text-align: center;">I – Immediate D – Delayed M- Minimal E - Expectant</p> <p><i>Id-me!</i> “Id me” is an easy to remember phrase that incorporates a mnemonic for sorting patients during MCI triage. It is utilized effectively in the <i>M.A.S.S. Triage</i> model.</p>

Course Duration

6.5 hours of didactic teaching (excludes breaks and lunch)

Training Schedule

BDLS can be delivered in 1 day or separated into modules and delivered over multiple days

Target Audience

Physicians, physician assistants, nurses, dentists, pharmacists, public health professionals, medical examiners, veterinarians, allied health professionals, health professions students, emergency medical technicians, paramedics, mental health professionals, police, firefighters, emergency management workers, social workers, disaster relief workers

Class Size

BDLS can be provided to large audiences (eg, more than 100 participants) and is limited only by the size of the classroom

Certificate of Training

All students who successfully complete BDLS (as measured by minimal scoring on a course competency examination) receive a “Certificate of Training” and course completion card. Certificates and course completion cards are valid for 4 years from the course completion date.

Database/Registry

All students who successfully complete BDLS will be entered into an AMA database, which will serve as registry of BDLS-trained professionals by discipline, specialty, geographic location, and level of NDLS training. This database will provide a potential reserve pool of trained personnel who can be called upon for large scale disasters or other public health emergencies.

Continuing Education Credit

The AMA is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians. The AMA designates this educational activity for a maximum of 6.5 category 1 credits toward the AMA Physician’s Recognition Award. Each physician should claim only those credits that were actually spent in the activity. The AMA has

determined that physicians not licensed in the United States who participate in this activity are eligible for AMA PRA category 1 credit.

#### NDLS Course Coordinator Training

Persons who are BDLS- and ADLS-trained are eligible to become NDLS Course Coordinators for their respective states, communities, or institutions. This requires 70 minutes of additional training, which is included as part of the ADLS course. Coordinators are responsible for course marketing and registration, securing training sites, and associated planning and logistics. They will work with AMA staff to assure appropriately trained faculty to present NDLS courses.

#### BDLS Course Instructor Training

Participants interested in becoming BDLS course instructors must successfully complete the BDLS course and be approved by the AMA and an NDLS Course Coordinator.

#### Course Scheduling

To schedule a BDLS course, contact the AMA or an NDLS Course Coordinator.

### **Advanced Disaster Life Support (ADLS)**

ADLS is a more advanced practicum course for the trained BDLS provider. It is an intensive 2 day course that allows students to demonstrate competencies in casualty decontamination, essential skills lab, and mass casualty incident information systems/technology applications (Box). Using simulated all-hazards scenarios and mass causality incidents, it makes use of four interactive sessions in which participants treat simulated patients in various disaster drills and situations. Training is focused on the development of "hands on" skills to allow participants to apply the knowledge learned in BDLS.

During ADLS, the interactive scenarios and drills utilize high-fidelity manikins and volunteer patients to gain a realistic experience in treating those pathologic patient conditions not routinely encountered by the responders and health care providers. Hands-on exercises teach practical skills, such as decontamination and use of protective equipment, and provide instruction in topics that traditionally are not addressed in the education of most health care professionals.

#### **Box. ADLS Core Training Areas**

**An advanced practicum course demonstrating competencies in these areas:**

- **Medical decontamination (PPE and Decon)**
- **MASS Triage**
- **Media and communications**
- **Healthcare facilities and community disaster planning**
- **Local, state, and federal disaster resources**
- **Mass fatality management**
- **Essential skills laboratory**
- **All-hazards training scenarios**

#### Course Duration

Day 1: Six hours of didactic lectures (excludes breaks and lunch)

Day 2: Seven hours of “hands-on” training distributed among 4 ADLS stations (excludes lunch)

#### Suggested Training Schedule

Day 1: BDLS (6.5 hours of instruction, 1 hour lunch, two 15 minute breaks)

Day 2: ADLS (6 hours of instruction, 1 hour lunch, two 15 minute breaks)

Day 3: ADLS (7 hours of instruction, 1 hour lunch)

Days 2 and 3: Optional NDLS Course Coordinator training (70 minutes total)

#### Target Audience

Physicians, physician assistants, nurses, paramedics (others may audit the course but will not receive “Recognition of Training” certificate or ADLS course completion card)

#### Class Size

ADLS is limited to 60 BDLS-trained participants

#### Certificate of Training

“Certificates of Training” and ADLS course completion cards will be distributed only to physicians, physician assistants, nurses, and paramedics who have successfully completed the course. Other professionals can audit the course and will receive a “Certificate of Attendance.” All ADLS certificates and course completion cards are valid for 4 years from the course completion date.

#### Database/Registry

Physicians, physician assistants, nurses, and paramedics who successfully complete the course will be entered into an AMA database, which will serve as registry of ADLS-trained professionals by discipline, specialty, and geographic location. This database will provide a potential reserve pool of trained personnel who can be called upon for large scale disasters or other public health emergencies.

#### Continuing Education Credit

The AMA is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians. The AMA designates this educational activity for a maximum of 13 category 1 credits toward the AMA Physician’s Recognition Award. Each physician should claim only those credits that were actually spent in the activity. The AMA has determined that physicians not licensed in the United States who participate in this activity are eligible for AMA PRA category 1 credit.

#### NDLS Course Coordinator Training

Persons who are BDLS- and ADLS-trained are eligible to become NDLS Course Coordinators for their respective states, communities, or institutions. This requires 70 minutes of additional training, which is included as part of the ADLS course. Coordinators are responsible for course marketing and registration, securing training sites, and associated planning and logistics. They will work with AMA staff to assure appropriately trained faculty to present disaster life support courses.

#### ADLS Instructor Training

Persons who wish to become ADLS course instructors or establish an ADLS Training Center should contact the AMA to discuss opportunities and requirements.

#### Course Scheduling

To schedule an ADLS course, contact the AMA or an NDLS Course Coordinator.

## **Core Disaster Life Support (CDLS)**

CDLS is an introduction to “all-hazards” preparedness for basic first responders, community officials, business owners, and other concerned citizens. It is delivered over 4 hours through in-person didactic and interactive lectures with standardized slide sets and an accompanying text. The course provides a brief overview of natural and accidental man made events; traumatic and explosive events; nuclear and radiological events; biological events; and chemical events. The focus of the course is discussion and application of a unique approach to disaster management called the *D-I-S-A-S-T-E-R* paradigm (Box). The overarching aim of the course is to introduce participants to basic concepts and terms that are reinforced in greater detail throughout the BDLS and ADLS courses.

In the future, the CDLS course also will be available in a distance-learning model via the Internet. Computer generated simulation will be used to enforce concepts learned in each chapter.

### **Box. Course Topics**

**Overview of Disasters**

**The D-I-S-A-S-T-E-R Paradigm**

**The Disaster Team**

**Coping with Disaster**

### **Course Duration**

4 hours of didactic teaching

### **Target Audience**

Non-medical first responders (eg police, fire, HAZMAT responders), government officials, facility managers, safety officers, hospital administrators, corporate security, community groups, business groups, schools, disaster volunteer groups

### **Class Size**

CDLS can be provided to large audiences (eg, more than 100 participants) and is limited only by the size of the classroom

### **Course Instructor Training**

Participants interested in becoming CDLS course instructors should successfully complete the BDLS course and be approved by an NDLS Course Coordinator and the AMA.

### **Course Scheduling**

To schedule a CDLS course, contact the AMA or an NDLS Course Coordinator.

### **AMA Contacts**

**James J. James, MD, DrPH, MHA**

Director, Center for Disaster Preparedness and Emergency Response

American Medical Association

Chicago, IL

312 464-5719 (phone)

312 463-5841 (fax)

[james\\_james@ama-assn.org](mailto:james_james@ama-assn.org)

**Ruth Steinbrecher, MPH**

NDLS Program Administrator

Center for Disaster Preparedness and Emergency Response

American Medical Association

Chicago, IL

312 464-4149 (phone)

312 464-5841 (fax)

[ruth\\_steinbrecher@ama-assn.org](mailto:ruth_steinbrecher@ama-assn.org)

Fiscal Note: \$1,291. Send Email to all Federation members requesting willingness to review current manuals. Mail review copies to persons identified by respective societies. Collate comments for NDLS Steering Committee.