EMERGENCY MEDICINE®

EDITORIAL

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MCIs and the Orlando Nightclub Shooting

While most Americans were still reacting in horror and disbelief to news of a mass shooting at the Pulse nightclub in Orlando, Florida in the early morning hours of June 12, 2016, the thoughts of most emergency physicians (EPs) were probably focused on the ongoing efforts to save as many victims as possible: What was the closest Level 1 trauma center, and how deep was the ED staffing there that night? Was there a need for additional resources, and perhaps even, could they get there in time to help? In this issue of *Emergency Medicine* (*EM*), Residency Program Director Salvatore Silvestri, MD, and his emergency medicine colleagues masterfully recount events from that night as they unfolded, both at the scene and two blocks away at the Orlando Regional Medical Center (ORMC) ED, in the minutes and hours following the first reported shootings.

Being prepared for a mass-casualty incident (MCI) is an extraordinarily expensive requirement of a hospital: It must acquire and maintain adequate resources and communication capabilities; periodically perform unannounced drills that disrupt other hospital activities; and ensure that all EPs and staff are not only able to perform their own day-to-day roles as attending physicians, residents, nurses, etc, but are also capable of taking on even greater responsibilities during an MCI—depending on the day and time it occurs. As you will read in the pages that follow, in the early morning hours of June 12, many of the practiced exercises and rehearsed procedures proved useful, even life-saving, while others had to be discarded or ignored in favor of improvised solutions to rapidly transport and treat the large number of victims with unanticipated needs, under unique conditions.

In any MCI, saving the largest number of victims invariably depends on rapidly instituting some deviations from standard operating procedures (SOPs) and standards of care (SOCs). As described by the ORMC EP authors, "...law enforcement vehicles and ambulances would make the two-block drive from the scene to ORMC carrying as many patients as they safely could, and return immediately after offload....minimal interventions were performed and unlike standard procedure, EMS could offer no prearrival report to the hospital."

Deviations from SOPs and SOCs during an MCI are not confined to prehospital care, but often extend into the ED and beyond. Most difficult for an EP participating in an MCI is the moment of realization that the sheer number of seriously injured and dying patients arriving en masse mandates a change from "ED triage" to "battlefield triage." As Dr Ponder recalled, "One of the first few patients I saw was pulseless, and as I went to start chest compressions, I was stopped by a trauma surgeon who said, 'He's gone, focus on the ones we can help.'"

In EDs, dying patients are attended to first with extensive staff and resources, while, as a result, less seriously ill patients must sometimes wait longer for care. The opposite is true on the battlefield, where near-death victims of lethal injuries are provided only with comfort care, at most, in order to save those who have a chance of surviving their extensive or serious injuries.

For hospitals and staff, the costs incurred by disaster preparedness are great and invariably exceed government funding provided for these efforts, but how much greater would be the human toll from an MCI without such efforts? All EPs should be proud of what our colleagues at ORMC accomplished on June 12. Though most EPs may never have to deal directly with an MCI, the Orlando nightclub shooting incident was only one of the latest MCIs, certainly not one of the last. ■

Previous editorials on MCIs may be found in EM *September 2006 (9/11), June 2011 (first responders), September 2011 (9/11), November 2011 (surge capacity), and September 2012 (surge capacity/Hurricane Sandy).*

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