CIVILIAN CASUALTY CARE
AND DISASTER PREPAREDNESS

Iranian and Israeli collaboration
Simulation training and community response

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MD, PhD, MBA | First edition 2026

About this book

First edition • 31 October 2026

Civilian Casualty Care and Disaster Preparedness
An Iranian and Israeli framework for simulation training and community response

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This book brings together my philosophy of major trauma care, my civilian emergency-care teaching, and selected published work by Dr Debra Gershov-West and colleagues. Its purpose is to help Iranian and Israeli doctors build a shared training programme and then teach practical early care to communities in the United Kingdom, United States, European Union and elsewhere.

The clinical focus is the period from recognition of danger to professional emergency care, with continuity into trauma services and rehabilitation. The organisational focus is a proposed collaboration: a common curriculum, local accountability, assessed practice and continuing improvement. The programme described here has not yet been independently validated or accredited.

This is an educational and simulation manual. Reading it does not confer clinical competence, professional registration or authority to respond. Local emergency-service instructions, clinical protocols and the responsible clinical lead govern practice. Before running a course, the host must review its clinical content, equipment, instructors and escalation arrangements. An independent specialist review of this complete edition has not been recorded.

Dr Gershov-West is cited as a source author, not as a co-author, reviewer or confirmed partner. No endorsement by FEM, Magen David Adom, WHO, ICRC, NHS, a university or government is claimed. External papers are discussed in original summaries; their text, proprietary course materials and figures are not reproduced.

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Preface

Friendship expressed through responsibility

I want the friendship between Iranians and Israelis to become something practical. Doctors from our two nations can learn together, test their decisions together and teach the people around them how to respond when ordinary life is interrupted by violence or disaster.

My starting point is the injured person. A casualty may be frightened, bleeding, struggling to breathe or separated from family. That person needs a prepared response. Nationality, religion and political opinion must not determine the care they receive. Our professional responsibility is to recognise need and respond with competence and dignity.

I am concerned about threats directed at Iranian and Israeli communities, including hatred and violence from Islamist extremists. Preparedness should strengthen confidence and mutual support without encouraging suspicion of a religious or ethnic community. We must recognise threatening behaviour, take credible concerns seriously and work with the appropriate authorities. Medical education is a peaceful response to vulnerability.

In my work on major trauma, I have emphasised physiology, priorities and coordinated care. I use the Formula One team as a teaching analogy: each person understands a task, the team communicates and the sequence matters. The analogy has limits. A patient is a person with a history and a future, and success means more than completing a procedure quickly. [1]

Disaster medicine asks us to extend that discipline beyond one resuscitation bay. Who calls for help? Who knows whether the scene is safe? Who notices the quiet casualty who is deteriorating? Who records a treatment and ensures that the next team receives the information? Who protects the exhausted responder?

This book proposes a structure for answering those questions through practice. I want Iranian and Israeli clinicians to share knowledge without competing over national ownership of good medicine. The first shared achievement can be modest: a carefully run course, a measurable improvement in a skill and a community that knows how to ask for help.

The longer ambition is a durable professional relationship, capable of supporting civilian care in future crises and improving everyday emergency readiness. We should begin with what we can teach safely, measure honestly and maintain over time.

How to use the manual

Two learning tracks and one shared purpose

Community learners should use Chapters 1, 3, 4 and 8, the community-course page, the community scenarios and the action card. Clinicians should read the whole manual, with particular attention to Chapters 5 to 7, simulation design, professional scenarios and local implementation.

Educators should complete the course-readiness sheet before teaching. Select the scenarios appropriate to the learners rather than trying to teach every topic in one session. The recommended timings, group sizes and assessment criteria are proposals for this programme, not requirements issued by a national training body.

Community track: recognise danger; call for help; control visible life-threatening bleeding within training; recognise abnormal breathing; begin CPR and use an AED; preserve warmth and dignity; provide a clear handover. No invasive procedures or injectable medicines are taught to the general public.

Clinician track: apply a structured primary survey; distinguish individual resuscitation from mass-casualty triage; communicate priorities; work within a declared incident structure; reassess; coordinate transfer; identify the need for definitive care. Procedural stations require appropriately qualified instructors, approved equipment and task trainers.

Facilitator track: prepare an exercise, prebrief participants, observe performance, manage distress, debrief without blame, document learning and organise reassessment. A doctor who is clinically experienced may still need instruction in simulation facilitation.

Use the numbered references to distinguish published evidence from this book's proposed curriculum. The scenarios, timetables, role cards and forms are original teaching designs. They are deliberately adaptable; they are not a replacement triage algorithm or a claim of certification.

English is the common working language of this edition. Persian, Hebrew and other teaching versions should undergo bilingual clinical review, including checking numbers, negation, emergency contacts and right-to-left layout. Translation alone is not localisation. Learners should practise the words they will actually use with local emergency services.

For a real emergency, use the local emergency number and follow the dispatcher. Do not attempt to consult a long chapter while a person requires immediate care. The concise action card is a reminder for trained practice, not a substitute for hands-on instruction.

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Linked chapter and exercise guide

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1 A joint humanitarian framework

Purpose and boundaries

The proposed programme has three linked aims: improve early civilian casualty care; establish reliable professional relationships between Iranian and Israeli doctors; and help diaspora communities act safely and effectively during emergencies. It also applies to road collisions, workplace injuries, sudden cardiac arrest, fires and natural disasters. Preparedness should be useful even when the feared conflict never occurs.

The founding medical principle is care according to need. Participants may have different political views and personal histories. The teaching environment should permit respectful disagreement while keeping bedside decisions free from discrimination. No casualty should have to express a political opinion, consent to publicity or prove community membership to receive help.

The collaboration should be described publicly as proposed until partners accept defined roles. Hosting a book on a charity or personal website does not establish institutional sponsorship, registered charitable status, an operational medical team or permission to deploy abroad.

For an initial pilot, I propose equal Iranian and Israeli participation in curriculum development, with a host-country clinical lead responsible for local clinical standards. Include emergency medicine, trauma surgery, anaesthesia or critical care, nursing, prehospital care, simulation education and community representation. Expertise and availability should determine teaching roles.

Agree in writing who owns the teaching material, who may use an organisation's name, how expenses are approved, how concerns are raised and how clinical changes are authorised. Invitations, faculty appointments and partnership announcements should follow explicit agreement rather than inference from a meeting or a citation.

Personal encounters can build trust, but a dependable programme requires records: an approved curriculum, an instructor register, a version number, a local emergency plan and an improvement log. The collaboration becomes credible when another team can understand and reproduce the training.

Keep public information focused on educational aims, registration arrangements and broad outcomes. Keep participant lists, emergency contact trees, venue vulnerabilities and detailed security arrangements in appropriately restricted records. Community confidence should not come at the cost of unnecessary exposure.

2 Evidence informing the programme

What the source works contribute

My Philosophy of Major Trauma connects resuscitation with definitive treatment and rehabilitation. It places physiology before diagnostic completeness, describes the primary survey as a repeated process and treats teamwork as part of clinical care. My Persian civilian first-aid guide brings those priorities into public education: safety, bleeding control, airway and breathing, warmth, communication and transfer. This book adapts those educational principles into a proposed training system. [1,2]

Alpert, Gershov West and colleagues describe professional community emergency response teams in Israel, including MDA and FEM approaches. Their account supports locally organised training, on-site simulation, assessment and integration with emergency services. It also identifies limits in evaluation; not all participants were formally tested. It is descriptive programme evidence, not a controlled demonstration of reduced mortality. The practical inference for this book is to assess what learners do and to test the interface with local services. [3]

Gershov West, Alpert and Braitberg discuss two hospitals' response to the 7 October 2023 attack through a disaster-management framework incorporating command, control, coordination, communication and community consequences and connection. The relevant lesson is to rehearse the organisation around care, including reliable information and links with the community. This disaster-management use of “six C's” should not be confused with a separate psychological-support model using similar terminology. [4]

The NICEM publication describes a national emergency-medicine course using simulation, skill stations, case-based learning and crisis resource management. It supports combining preparatory study with supervised practice. Positive feedback and proposed impact do not establish the effectiveness of our new programme. [5]

Nerlander, Rose and Gershov West interviewed 19 emergency-department staff about operating a wartime mass-casualty plan. Reported themes included threats to staff safety, prolonged uncertainty, incomplete information and the contribution of frequent drills. This qualitative study provides useful planning questions, with limits inherent in one setting and retrospective accounts. [6]

FEM's official description confirms Dr Debra Gershov-West's role in founding its mobile training project. This edition draws on published research and publicly described educational approaches; it is not an authorised FEM course. [7]

2 From evidence to teaching

An explicit source map

Use evidence for the claim it can support. A publication describing a training programme can inform curriculum design. It cannot, by itself, prove that another programme will save lives. A clinical guideline supports a clinical recommendation within its population and setting. An author's reflection explains a philosophy; it is not an outcome study.

Source family	Contribution here	Boundary
Bakhshayesh books [1,2]	Clinical priorities and community teaching	Adapted educational synthesis
Gershov-West and colleagues [3–6]	Community teams, education and incident organisation	No endorsement or proven effect of this course
WHO and ICRC [8–10]	Structured emergency care and exercise planning	Use the actual course and local protocols for certification
RCUK and NICE [11–13]	Current UK first aid, CPR and trauma checks	Localise to other jurisdictions
NHS England and JESIP [14–16]	Triage selection and incident reporting	Do not merge algorithms

Before each course, assign a clinician to check whether a relevant guideline has changed. Record the source, date accessed, local adaptation and reviewer. If a recommendation differs from an older edition of my teaching, use the current approved approach and explain the change to instructors.

The most important updates are often small but consequential. For example, the 2025 UK adult basic-life-support guidance directs an immediate emergency call for an unresponsive person, followed by breathing assessment while awaiting the call handler. A learner should not delay the call while attempting a pulse check. [12]

This book does not reproduce ATLS, WHO, RCUK, MDA or other proprietary teaching packages. It points readers toward the organisations responsible for those materials. Official courses and competency requirements remain distinct from this independent curriculum.

Suggested scholarly use: cite this book for its proposed collaboration framework and original exercise designs; cite the original papers and guidelines for their findings and recommendations. Keep a clear record when changing a scenario or adding a clinical intervention.

3 Preparedness before an incident

Vigilance without profiling

Preparedness begins with ordinary knowledge of a place: exits, a precise address, how to contact emergency services, where the AED and first-aid equipment are kept, who can provide assistance and how people with mobility or communication needs will leave safely. A plan that depends on one person's telephone or memory is fragile.

For diaspora events, appoint a welfare lead and a person responsible for liaison with venue management. Identify a safe meeting point and an alternative if conditions change. Confirm how emergency vehicles will gain access. These details belong in a local plan; they should not be improvised after casualties arrive.

Threat awareness should focus on observable conduct and credible information. A specific threat, violence, a suspicious abandoned object or an attempt to obstruct an exit may require reporting. A person's language, dress, nationality or religion is not evidence of hostile intent. Do not confront a person, investigate a suspicious package or circulate unverified accusations.

In a firearms or weapons attack in the UK, official public guidance is RUN HIDE TELL. Escape by a safe route if possible; otherwise hide, secure your position as appropriate and contact police when safe. Leave belongings, avoid filming and follow police instructions. Medical volunteers should not move into an active threat to reach casualties. [17]

Use a brief opening announcement at suitable events: identify the welfare team, show exits and explain how to request help. Do not create alarm or present a training session as evidence that an attack is expected. An accessible venue and a calmly rehearsed plan improve readiness for many emergencies.

A monthly readiness check can inspect access to equipment, battery status, expiry dates, staff changes and contact details. A short quarterly rehearsal can test whether a new volunteer can find the address, call procedure and equipment without coaching. These intervals are proposed starting points; local risk and requirements may justify others.

Exercise communication failures deliberately. Ask what happens if the internet fails, the main entrance is unavailable or the named lead is absent. Use printed instructions and clear role substitution. Never place a test call to a real emergency number unless formally arranged with the service.

4 Community first response

The first few minutes

The community responder's task is to bridge the time until professional care. Begin from a position of safety. Call early, give the location and describe the immediate problem. Ask a specific person to bring the AED or first-aid kit and another to guide responders, when this can be done safely. [2,11]

For visible life-threatening external bleeding, apply firm direct pressure. Trained responders can escalate to an appropriate dressing or limb tourniquet when pressure does not control bleeding. Record the application time and do not loosen or remove a tourniquet. A tourniquet is for a limb, not the neck or trunk. [2,11]

If someone is unresponsive, call emergency services immediately. If breathing is absent or abnormal, begin CPR and follow dispatcher and AED instructions. For an adult, compress at 100–120 per minute to a depth of 5–6 cm, allowing recoil. Give 30 compressions and 2 breaths if trained and able; otherwise give continuous compressions. [12]

Watch for change. A person who was speaking may become drowsy. A dressing may begin to leak. A casualty who walked initially may develop breathing difficulty. Reassessment after an action or movement is a central lesson from my civilian first-aid guide. [2]

Preserve warmth with insulation beneath and over the person, while keeping necessary access for care. Explain what you are doing, protect privacy and keep an appropriate companion nearby. Do not offer food or drink to a severely injured or drowsy casualty. Do not remove embedded objects or push exposed bone back into a wound. [2]

An open chest wound needs urgent professional help. Do not improvise an airtight seal. The 2025 UK guidance advises leaving it uncovered; trained providers with suitable equipment may use a specialised non-occlusive or vented dressing and monitor it. [11]

Airway and breathing needs take priority over rigid positioning rules. Avoid unnecessary movement after trauma, but do not allow blood or vomit to obstruct breathing because of fear of moving the neck. Learn assisted positioning in a supervised practical session and follow dispatcher advice. [2]

The community course must teach these skills on task trainers. Reading a tourniquet description or watching a demonstration is not equivalent to demonstrating effective bleeding control.

4 Boundaries of community care

Recognise and escalate

My civilian guide separates public actions from skills requiring training. The same separation is essential in a mixed Iranian and Israeli programme. A confident volunteer must know when to ask for help, and an experienced doctor must recognise when the environment or available equipment makes a familiar intervention unsafe. [2]

Do not teach needle chest decompression, surgical airways, intravenous treatment, injectable drugs or wound closure in the community course. Such procedures require professional scope, current competence, suitable equipment and a system for monitoring and rescue. A medical degree alone does not establish current competence in every emergency procedure.

Do not enter unstable buildings, smoke-filled spaces or suspected contaminated zones. Ordinary face coverings do not make an unknown chemical atmosphere safe. Report exposure concerns before a casualty enters a clean treatment area or vehicle. Specialist rescue and decontamination are separate capabilities. [2]

Burns, crush injury, eye injury, head injury and penetrating wounds may appear deceptively limited. Avoid judging severity from the size of a skin wound. Arrange professional assessment for serious mechanisms or concerning symptoms. A person who can walk should remain within the assessment and tracking system. [1,2]

Children need age-appropriate assessment and equipment. Pregnancy, anticoagulant treatment, frailty, diabetes and cardiopulmonary disease may change risk and management. Identify these factors and communicate them. A general adult course should not imply competence in paediatric resuscitation or obstetric emergencies; provide dedicated modules with suitable instructors. [1,2]

When help is delayed, continue reassessment, warmth, communication and appropriate support within training. Do not interpret delay as permission to begin unfamiliar invasive treatment. Document a changing condition and renew the request for assistance when possible. Keep one person responsible for communicating the latest information.

Avoid turning the classroom into a contest of bravery. A safe decision to withdraw, stop or request expertise can be the correct performance. Assess judgement as well as manual skill, and reward recognition of limits.

5 The clinician and the primary survey

A repeated process of assessment and action

The primary survey provides a shared sequence under pressure. In my major-trauma text, catastrophic external haemorrhage precedes airway, breathing, circulation, disability and exposure. These priorities organise simultaneous team activity; they do not require everyone to wait while one clinician recites the alphabet. [1]

At x, identify and control catastrophic external bleeding. At A, assess airway patency and the need for airway support while managing spinal risk. At B, determine whether ventilation and oxygenation are adequate and recognise immediate thoracic threats. At C, assess perfusion and haemorrhage, including sources not visible externally. At D, assess consciousness and neurological change. At E, examine sufficiently while preventing hypothermia and preserving dignity. [1]

Each intervention requires a response check. Has pressure controlled bleeding? Has an airway manoeuvre improved ventilation? Has a transfer changed the casualty's condition? A recorded blood pressure or oxygen saturation is one part of the picture. The trajectory, mechanism and examination remain important. [1]

Use the simulation to make reasoning audible. A team leader might say: “The external bleed is controlled, but perfusion remains poor. We need to reassess for another source and organise definitive care.” This allows the team to recognise a changing problem rather than assume that completing one task has stabilised the patient.

Clinical teaching must match the host's protocols. NICE NG39 supports direct pressure for external bleeding, tourniquet use when pressure fails in life-threatening limb haemorrhage, and early intravenous tranexamic acid for major trauma with active or suspected active bleeding. It advises against administration more than three hours after injury unless there is evidence of hyperfibrinolysis. Drug selection, dose and administration belong to the approved clinical protocol and appropriately authorised staff. [13]

In the exercise, use simulated medicines and state clearly that no treatment is given to actors. Faculty should verify the prescription and administration process against the host protocol. The learning objective is a safe, timely decision and closed-loop communication, not memorising a dose from this book.

5 Trauma decisions beyond the checklist

Physiology and destination

My major-trauma philosophy treats early surgery as a continuation of resuscitation. The immediate purpose may be haemorrhage control, control of contamination and physiological stabilisation. Definitive reconstruction must be proportionate to the person's capacity to tolerate it. [1]

A scan can be valuable and still be the wrong next destination for a patient with uncontrolled haemorrhage and persistent instability. The exercise should ask what information is essential for the next decision, whether obtaining it introduces delay and what care can continue during transfer. Learners must explain their decision using the clinical situation and local capability. [1]

Avoid making a dramatic fracture the sole focus of a scenario. Add a physiological clue that requires reassessment: altered consciousness, increasing respiratory effort or deteriorating perfusion. The purpose is to test whether the team can reconsider its working diagnosis and seek the appropriate specialist support.

For limb injury, include a documented neurovascular assessment before and after an intervention, appropriate splintage and early escalation where perfusion is threatened. Open fractures require a coordinated pathway for antibiotics, wound management, fixation and soft-tissue coverage. These are professional decisions; the public responder's role is protection and timely transfer. [1]

Build rehabilitation into the final handover. Record injury-related function, pain, communication needs, family contacts and likely follow-up requirements when the emergency phase permits. Survival creates a continuing duty to support recovery. A simulation can end with an agreed destination and responsibility for the next step rather than with an artificially complete recovery. [1]

The professional course should teach the interface between prehospital care, emergency departments, theatres, critical care and rehabilitation. It should not suggest that a community casualty point can substitute for definitive trauma care. Its purpose is to organise appropriate early help and onward movement when the normal system is strained.

For procedural extensions, use separate supervised courses and credentialing. Advanced airway techniques, thoracic procedures, transfusion, ultrasound and operative interventions should be taught by competent faculty under the relevant institutional arrangements.

6 Mass casualty organisation

One patient and many patients require different systems

A mass-casualty situation occurs when needs exceed the resources immediately available. The number alone does not define the challenge. A small team with limited transport may be overwhelmed by a few severely injured people, while a prepared centre can absorb a larger number. The exercise must specify the resources and the point at which help is requested.

Individual resuscitation asks what one patient needs. Incident triage asks how to prioritise limited assessment, treatment and transport across many people. These processes interact, but they are not interchangeable. Reassess priorities as conditions and resources change. Use the locally adopted triage system without inventing a hybrid.

In England, NHS guidance distinguishes the Ten Second Triage tool, intended for initial responders before the NHS clinical response, from the Major Incident Triage Tool for NHS responders. The original tools include instructions and exceptions that cannot safely be replaced by a colour chart alone. Faculty must obtain the current official tool and teach its complete local application. [14,15]

For an international course, use one host system for each assessed exercise. Explain other systems in a comparative discussion after assessment. A participant should never have to guess which algorithm a facilitator expects. Do not substitute a national triage system's restrictive resuscitation rules into ordinary single-patient community CPR teaching.

Appoint an incident lead, clinical lead, triage lead, treatment-area leads, transport coordinator and documentation function as resources permit. In small teams one person may combine roles, but the responsibilities must remain visible. Unannounced duplication of command is a useful scenario challenge because it exposes unclear authority.

Maintain a casualty register using unique identifiers, location, priority, key intervention, destination and handover time. Avoid recording unnecessary personal details. Walking casualties require a supervised route for reassessment and registration, not automatic release.

The team must know who authorises movement and how destinations are selected. Sending everyone to the nearest door can overload a single facility. Coordinate with the official response and receiving services rather than self-deploying a parallel transport network.

6 Communication and continuity

A short message that changes the response

JESIP's M/ETHANE framework structures incident information: major-incident status, exact location, type of incident, hazards, access, number of casualties and emergency services present or required. Update the message as information changes. A community caller can provide the same useful facts in plain language without claiming authority to declare an incident. [16]

Teach three different communications. The initial call establishes the scene and need for help. A clinical handover transfers responsibility for one patient. A command update describes the evolving incident. Mixing all three into a long narrative makes critical information harder to recognise.

A practical handover can state the casualty identifier, mechanism and time, important injuries, physiological findings, treatment with times, response and outstanding concern. Repeat a time-critical detail such as tourniquet application. Give the receiver an opportunity to ask questions and confirm that responsibility has transferred. [1,2]

Closed-loop communication means naming a person, specifying a task, receiving acknowledgement and hearing completion or a barrier. “Someone call an ambulance” is weaker than assigning a named caller who reports that contact has been made. In a bilingual team, choose a shared working language for commands and use short, familiar words.

Separate confirmed facts from reports. A rumour about a second incident may require checking; it should not silently become the basis for moving all casualties. The command log should record the source, time and degree of confidence. Do not delay an urgent protective action when the available evidence is already sufficient.

Train a fallback when radios or mobile data fail: an agreed runner within a safe area, a whiteboard, a written casualty card and a predefined reporting location. Avoid unnecessary broadcasting of names or clinical details. If connectivity returns, reconcile paper and electronic records using the unique identifier.

Continuity also includes responders. Plan relief, breaks, hydration and a way to report fatigue or distress. A long incident can degrade attention after the initial surge. The hospital staff-experience study makes this a useful concern for an extended exercise, not just a closing welfare statement. [6]

7 Injury patterns and special circumstances

Teach recognition and escalation

Blast and penetrating mechanisms can produce several injuries in the same person. External wounds may underestimate internal damage, and apparent stability can change. In the simulation, require a mechanism-based concern, repeated assessment and a destination decision. Do not use a single dramatic image as a diagnosis. [1,2]

For a breathing problem after chest injury, teach clinicians to consider life-threatening thoracic injury and call for the relevant expertise. For community participants, teach recognition, emergency contact, appropriate positioning and avoidance of harmful improvisation. The public and professional endpoints differ even when the opening vignette is the same. [1,2]

Head injury scenarios should include change over time and a search for reversible causes of deterioration. Avoid treating all reduced consciousness as psychological distress. A casualty who is frightened can also be hypoxic, bleeding or have a brain injury. [1]

Burn and smoke scenarios should test safe access, early escalation and prevention of further exposure. Crush scenarios should distinguish support from a safe position from technical rescue. Contaminated casualties require appropriate notification and specialist direction before entering clean care pathways. These are recognition exercises, not instruction in hazardous-area rescue. [2]

Include pregnancy, childhood, disability and frailty in the curriculum without using them as surprise traps. Give faculty appropriate expertise, equipment and age-specific protocols. Assess whether the learner seeks assistance and adapts communication, rather than expecting an untrained clinician to perform a specialist intervention.

Communication disability, autism, dementia, hearing impairment or limited shared language can affect the encounter. Offer a quieter space when feasible, simple explanations, interpreters and trusted support. Do not mistake unfamiliar behaviour for aggression or refusal. Obtain consent where possible and follow the applicable emergency-care framework.

Pain and distress deserve attention alongside life threats. In clinical exercises, analgesia planning should follow the host protocol and include monitoring. In community exercises, reassurance and protection should not delay urgent transfer. Document the effect of an intervention and the next assessment point.

WHO-ICRC Basic Emergency Care provides an established structured resource for first-contact clinicians, including conflict-related injury materials. Use it as a further learning pathway, with its own course requirements and current materials. [8]

8 Psychological support and respectful care

Support without coercion

The first useful psychological intervention may be practical: a calmer place, a blanket, a clear explanation, help locating a trusted person or a reliable account of what will happen next. WHO's psychological-first-aid guidance describes humane support that respects dignity, culture and abilities. It is not compulsory emotional disclosure or an immediate diagnosis. [18]

Introduce yourself and explain your role. Ask what the person needs now. Listen without demanding a detailed account of the event. Give honest information and avoid promises that you cannot keep. A simple choice can restore a degree of control: whether a trusted companion sits nearby, or which language is most comfortable. [2,18]

Do not assume distress explains altered consciousness or breathing difficulty. Assess medical threats first. In training, the actor may appear panicked, but the facilitator should also provide clinical observations so the learner must consider both physical and psychological needs.

Keep children with a safe, appropriate caregiver where possible and follow safeguarding arrangements. Do not use an unverified stranger as a family contact. Record essential identifying information privately and use the official reunification process. Avoid public photographs of children or casualty lists.

A technical debrief is a structured review of performance. Psychological support is care for the person. Participation in one should not require public disclosure in the other. Offer a private route for help and allow an observer role or withdrawal from an emotionally difficult scenario.

Faculty must not use surprise gunfire, simulated explosions, graphic imagery or coercive role-play to make a session feel realistic. Realism should serve a learning objective. A quiet written inject can test decision-making without recreating a participant's trauma.

After an actual incident or distressing exercise, signpost appropriate local support and arrange follow-up where needed. Persistent symptoms, impaired functioning or immediate concerns about safety need professional assessment. This book does not promise that a brief intervention prevents post-traumatic stress disorder.

Compassion also shapes professional collaboration. Iranian and Israeli participants may carry different losses and fears. Make room for respectful listening while keeping the exercise focused on shared clinical duties.

9 Building the faculty

Governance before delivery

For the pilot, appoint a programme lead, host clinical lead, simulation lead, community liaison, safeguarding and welfare lead, and a data lead. Some functions may be combined in a small programme, but each must have an accountable person and a substitute.

Role	Main responsibility	Evidence before the course
Programme lead	Scope, partners and resources	Agreed course plan
Host clinical lead	Clinical content and local pathways	Signed clinical review
Simulation lead	Scenarios, equipment and faculty calibration	Rehearsal record
Welfare lead	Accessibility, consent and distress response	Participant information
Data lead	Assessment records and confidentiality	Access and retention plan

Verify instructors' identity, current professional standing where relevant, competence for the station they teach and suitable arrangements for the activity. A visitor's overseas registration does not automatically authorise clinical practice in the host country. For patient-facing activity, obtain advice from the relevant regulator and host institution; this manual does not determine legal permissions.

Before teaching, faculty should run each station themselves. Agree what constitutes adequate performance, which prompts are allowed and which errors require stopping. Use the same case information across groups unless variation is intentional and documented.

Co-teaching can support the collaboration: pair instructors with different national or professional backgrounds, then review the session together. Do not assign expertise by nationality. Invite community feedback on language and accessibility without asking community representatives to approve clinical content outside their competence.

Publicity should name only confirmed faculty and partners. The proposed collaboration with Israeli educators, including possible engagement with FEM, requires direct agreement before using names or logos as partners. Referencing a paper is sufficient for scholarly attribution and does not confer programme affiliation.

Use a local review cycle after the first pilot, after a significant incident and whenever guidance changes. Keep a version-controlled master, record what changed and remove superseded handouts from teaching kits.

10 The professional course

A proposed two-day pilot for 12 clinicians

Prepare learners with the relevant book chapters, the host triage tool, emergency plan and a short knowledge check. Ask about prior trauma training, language needs and accessibility. Use three groups of four, with a competent facilitator for each active station and additional support for equipment and welfare. Adjust group size to allow each participant observed practice.

Day 1	Session	Purpose
09:00–09:30	Welcome and prebrief	Shared expectations and safe simulation
09:30–10:15	Trauma priorities	Physiology and repeated primary survey
10:15–10:30	Break	Reset
10:30–12:30	Three skill rotations	Bleeding, airway and structured assessment
12:30–13:15	Lunch	Faculty review
13:15–14:00	Incident organisation	Host triage and communication
14:00–15:30	Single-casualty scenarios	Role rotation and feedback
15:30–15:45	Break	Reset
15:45–16:30	Transfer and handover	Continuity of responsibility
16:30–17:00	Review	Individual learning goals

Day 2	Session	Purpose
09:00–09:30	Retrieval practice	Revisit yesterday's priorities
09:30–10:45	Two professional scenarios	Deterioration and limited resources
10:45–11:00	Break	Reset
11:00–12:30	Incident exercise	Command, triage and casualty tracking
12:30–13:15	Lunch	Faculty scoring calibration
13:15–14:15	Community teach-back	Explain and demonstrate safely
14:15–15:30	Observed assessments	Individual performance and remediation
15:30–15:45	Break	Reset
15:45–16:30	Retest and implementation	Local course plan
16:30–17:00	Review and commitments	Assign actions and follow-up

Completion means documented participation and the assessed skills specified by the course. It does not confer specialist status, national accreditation or unrestricted authority to respond. Record incomplete stations and any further supervised practice required.

10 The community course

A proposed four-hour practical session

Invite adults from Iranian and Israeli communities and other interested neighbours. Use plain language and small practice groups. The host should offer adapted sessions for children or people requiring additional support rather than assuming this adult course meets every need.

Time	Activity	Observable endpoint
00:00–00:20	Safety and calling for help	Gives location and immediate concern
00:20–01:10	Bleeding control	Demonstrates pressure on a trainer
01:10–01:20	Break	Questions and welfare check
01:20–02:20	CPR and AED practice	Recognises abnormal breathing and acts
02:20–02:50	Positioning, warmth and handover	Explains safe support and reassessment
02:50–03:00	Break	Reset
03:00–03:40	Two short scenarios	Combines skills within scope
03:40–04:00	Individual check and next steps	States limits and further learning needs

Add tourniquet or wound-packing practice only where suitable trainers, equipment and an instructor who can assess each learner are available. Do not compress all advanced bleeding skills into a demonstration that leaves participants unobserved. For a shorter session, reduce the advertised scope rather than claiming the same competence.

Start with a familiar emergency such as an injury at a community event. Introduce a simulated threat or multiple casualties only after participants understand safety and emergency activation. Learners should leave knowing that withdrawing from danger can be the correct action.

Use teach-back: ask the learner to show or explain what they would do, then correct one issue at a time. A person who struggles with terminology may still perform a useful action well. Do not use a language-heavy quiz as the sole assessment of practical ability.

Provide the action card, the correct local emergency number and a route to recognised first-aid training. Suggested follow-up is a brief practice session at three months and observed reassessment at six to twelve months, adapted to local requirements. These are proposed programme intervals, not national certification rules.

Invite feedback privately. Ask whether participants could hear, understand, practise and opt out. Publish only aggregate learning outcomes and no identifiable assessment results without an appropriate basis and consent arrangements.

11 Designing a safe simulation

Prebrief before performance

WHO distinguishes discussion-based exercises from operational drills and larger functional or field exercises. Choose the smallest format that can test the objective. A tabletop can reveal an unclear command structure; a task trainer is better for observing bleeding control. Expensive equipment is not a substitute for a clear learning question. [9,10]

Every exercise needs an objective, learner group, setting, resources, initial information, timed or conditional injects, expected actions and an end point. The facilitator must know what happens if the learners act correctly, delay or choose an unsafe action. Use physiological changes as teaching cues, not as punishment.

Read a prebrief aloud: “This is a learning exercise. The people and events are fictional. You may pause at any time. Say STOP SIMULATION for a real safety concern. Treat equipment according to the instructions. No medicines or invasive treatment will be used on a person. We will discuss decisions respectfully and keep individual performance confidential within the agreed process.”

Explain what the mannequin can and cannot show. Agree how to request examination findings and how to verbalise actions that cannot be performed. Label all mock medicines and equipment. Keep live sharps, electrical hazards and clinical stock outside the exercise area unless a controlled professional station specifically requires them.

No chest compressions, defibrillator shocks, invasive procedures or tourniquet tightening should be performed on actors. Use dedicated trainers for these actions. Obtain consent for any permitted non-invasive examination or handling. Use a safe alternative for participants with physical limitations.

Appoint an independent observer where possible. The observer records behaviour and times; the facilitator runs the case. In a small course these roles may combine, but faculty should acknowledge the limitations. Do not make the actor responsible for detecting unsafe clinical behaviour.

Brief venue staff and neighbours where an exercise might be mistaken for a real incident. Use clear exercise signage and simulated calls. Agree an actual emergency plan, first-aid provision and evacuation arrangements before beginning.

11 Observation and debriefing

Make the learning visible

Begin the debrief with a short reaction check and a shared account of events. Then examine two or three important decisions. Ask what the learner noticed, what they believed was happening and what made the task difficult. Avoid treating an error as proof of carelessness before understanding the situation.

A useful facilitator statement connects an observation with a question: “I noticed the team moved the patient before confirming who would monitor breathing. What was the plan at that point?” This invites explanation while keeping the clinical concern explicit.

Distinguish a knowledge gap from an equipment problem, a communication failure or an unrealistic exercise cue. The correction differs. Teaching a manoeuvre again will not fix an inaccessible kit or two competing leaders.

Finish with a specific action: who will change what, by when, and how will the change be checked? Repeat a short segment if the learner can benefit from immediate practice. Retesting is part of learning, not an embarrassment.

Observation domain	What to record
Safety	Recognised hazard and stayed within the safe boundary
Prioritisation	Identified the immediate threat before lower-priority tasks
Action	Performed the relevant skill effectively on the trainer
Communication	Named task owner and confirmed completion
Reassessment	Checked response after action or movement
Continuity	Gave a clear handover and transferred responsibility

For each domain, record observed, prompted, not yet demonstrated or not applicable. Note the actual behaviour rather than a vague personality judgement. A global “good teamwork” score cannot explain what to improve.

Confidence and satisfaction can be collected separately. They are useful but should not be treated as equivalent to competence. The professional-community-team publication's evaluation limitations reinforce the need for observed performance in this proposed programme. [3]

Use a supportive technical debrief; do not require participants to recount personal trauma. Offer a private follow-up if the exercise causes distress. Close by restating what the group can now do and what still requires supervision.

12 Scenario bank

Instructions for every case

All cases are fictional teaching exercises. Numbers are simulated observations, not diagnostic thresholds. Faculty must approve the case against the host protocol and learner scope before use. The suggested run times exclude a ten-minute prebrief and fifteen- to twenty-minute debrief.

Prepare the equipment and casualty cards before learners enter. Give only information that would be available at that stage. If the mannequin cannot show a finding, supply it when the learner appropriately asks or examines. Do not hide a critical finding merely to force failure.

Each case has a community or professional endpoint. A learner may verbalise a request for a procedure beyond the station's scope; no invasive procedure is performed on a person. Use a task trainer if a separately approved procedural skill is being assessed.

The observer records the first recognition of danger, emergency activation, first appropriate action, response check and handover. Timings support discussion; they are not universal pass thresholds. Patient care should not become a speed competition that rewards unsafe shortcuts.

Stop immediately for a real injury, participant distress requiring help, unsafe equipment use or confusion between simulation and reality. For a purely simulated clinical error, the facilitator may pause, coach and restart if that better serves learning.

Case	Audience	Main learning objective
1 Bleeding at a community event	Community or clinicians	Act and reassess
2 Collapse during a meeting	Community	Emergency call, CPR and AED
3 A quiet casualty after an explosion	Clinicians	Recognise deterioration
4 Airway threat after a fall	Clinicians	Prioritise airway with spinal precautions
5 Several casualties at a venue	Clinicians and command team	Triage, tracking and transport
6 Delayed transfer	Clinicians	Maintain care and communicate change
7 A frightened parent and child	Community or clinicians	Respectful communication and safeguarding
8 Hospital surge tabletop	Senior clinicians and organisers	Capacity, uncertainty and continuity

After each case, choose one individual learning goal and one system change. Re-run a short section to test the correction. Keep the record with the course evaluation rather than publishing individual performance.

Scenario 1 Bleeding at a community event

Community track • 8 to 10 minutes

Purpose: recognise life-threatening bleeding, activate help, demonstrate effective action on a trainer and give a concise handover. Clinical foundations: my civilian guide and current local bleeding-control teaching. [2,11]

Setting and equipment: a safe indoor community venue; adult actor beside a simulated lower-leg wound trainer; gloves, dressings, training tourniquet if included in the course, blanket, marker and casualty card. Three learners take responder, caller and support roles. Never tighten a tourniquet on the actor.

Opening information: “A visitor has sustained a deep leg wound from broken glass. The immediate hazard has been isolated. Blood is flowing continuously and rapidly soaking clothing. The person is alert and frightened.” If asked, the caller knows the venue address and access point.

Expected actions: confirm that approach is safe; identify the bleeding as urgent; delegate an emergency call; apply effective direct pressure on the trainer; escalate within assessed training if bleeding continues; arrange warmth; reassess breathing, responsiveness and bleeding; record important treatment times; prepare a handover.

Inject at two minutes: if pressure is effective, say that bleeding has reduced but the person feels faint. If pressure is ineffective or repeatedly released, show continued simulated bleeding. The learner should reassess and seek further help, not merely add layers without checking the source.

Inject at five minutes: a bystander asks whether the dressing or tourniquet can be loosened because it hurts. The responder explains the appropriate action and communicates concern to the incoming clinical team. If a tourniquet was applied, it remains visible and its time is handed over.

Critical errors: entering an unconfirmed hazard; leaving serious bleeding unaddressed; tightening a device on a real limb; removing an embedded object; loosening a tourniquet; treating a verbal statement of competence as proof that bleeding is controlled.

End point: effective simulated control, continued observation and an organised transfer of responsibility. The actor does not become fully well simply because bleeding is controlled.

Debrief: What made the bleeding urgent? Who confirmed the emergency call? How did the team know its action worked? What information would the next clinician need? Repeat the pressure or device step if necessary before recording competence.

Scenario 2 Collapse during a meeting

Community track • 8 minutes

Purpose: recognise an unresponsive person, call promptly, identify abnormal breathing, start adult CPR and use a training AED. Use the current host-country basic-life-support teaching. [12]

Setting and equipment: adult CPR mannequin, training AED, telephone prop, disposable barriers and a clearly marked safe floor space. Four learners rotate through rescuer, caller, AED retrieval and observer roles. No compressions or shocks are applied to an actor.

Opening information: “An adult suddenly collapses during a meeting. There is no ongoing environmental danger.” The mannequin is unresponsive. When breathing is assessed, the facilitator describes intermittent gasping, not normal breathing.

Expected actions: ensure safe approach; check response; call or assign an immediate emergency call; assess breathing while help is being activated; recognise gasping as abnormal; begin CPR; request and use the AED; ensure no one touches the mannequin during simulated analysis or shock; resume CPR as directed.

Inject at two minutes: the caller says the dispatcher is asking whether the person is breathing normally. The team should give a clear answer rather than equate any movement with effective breathing.

Inject at four minutes: the AED arrives. The learner follows its prompts, exposes the mannequin chest appropriately and communicates clearly. The observer records any unnecessary interruption in compressions and whether hands-off safety was stated and checked.

Inject at six minutes: the compressor reports fatigue. The team arranges a change with minimal disruption. If the course has no rescue-breathing competence assessment, the expected response remains compression-focused with dispatcher support, rather than unpractised ventilation.

Critical errors: delaying the call for a pulse check; accepting gasping as normal breathing; applying a live defibrillator to a participant; continuing contact during simulated shock; lengthy pauses for discussion while no one performs CPR.

End point: a coordinated cycle of CPR and AED use followed by a simulated professional handover. Use mannequin feedback when available, with instructor observation; an attendance record alone is insufficient.

Debrief: What did “abnormal breathing” mean in this case? How did the AED change the team's work? Could each learner find the real venue AED? Arrange further practice for anyone who has not demonstrated the agreed skills.

Scenario 3 The quiet casualty

Professional track • 12 minutes

Purpose: identify a deteriorating casualty whose external injury appears small, reassess priorities and arrange appropriate definitive care. Clinical foundations: trauma physiology and regional injury assessment. [1,13]

Setting and equipment: safe simulated reception area after an explosion; adult mannequin or actor; monitor cards, examination cards, casualty record and simulated communication equipment. A small chest wound is represented without graphic imagery. No thoracic procedure is performed on a person.

Opening information: the casualty is seated, speaking briefly and says, “I am all right; help the others.” Initial simulated observations: respiratory rate 24/min, heart rate 112/min, blood pressure 108/72 mmHg, oxygen saturation 94% on room air. These values are prompts for clinical interpretation, not a prescribed triage result.

Expected actions: assess the mechanism and complete a prioritised survey; recognise the importance of breathing and perfusion findings; seek examination details; identify possible serious internal injury; provide support within the local protocol; request senior or specialist help and organise urgent transfer; reassess after intervention.

Inject at four minutes: increasing breathlessness, respiratory rate 32/min, heart rate 128/min, blood pressure 90/60 mmHg and reduced ability to speak. Supply additional clinical findings according to the faculty-approved diagnosis when asked. Do not make the learner infer a specific chest condition from vital signs alone.

Inject at seven minutes: a colleague proposes sending the casualty to routine imaging because the skin wound is small. The team must explain whether the patient can safely tolerate that pathway and identify the capability needed now. If a procedure is indicated under the local protocol, the learner states the indication, competence requirements and immediate plan.

Critical errors: treating the ability to walk as clearance; ignoring worsening physiology; packing the chest wound; attempting an invasive procedure on an actor; delaying escalation solely to complete documentation or obtain a perfect diagnosis.

End point: a clear working assessment, resuscitation priorities, destination decision and handover. The facilitator should not reward a memorised diagnosis when the team has failed to assess the patient.

Debrief: Which finding changed your priority? What uncertainty remained? What could safely occur in parallel? How did you communicate that the patient needed a different pathway?

Scenario 4 Airway threat after a fall

Professional track • 10 minutes

Purpose: manage an immediate airway problem while minimising unnecessary spinal movement and maintaining team coordination. This case uses principles from the major-trauma and civilian-care books. [1,2]

Setting and equipment: airway mannequin with simulated secretions, suction trainer if available, monitoring cards, appropriate non-invasive airway-training equipment and a trolley. Four learners take airway, assistant, assessment and team-leader roles. Perform all airway procedures on the mannequin.

Opening information: “An adult fell during an evacuation. The person responds only to voice, has blood in the mouth and makes a gurgling sound. Neck injury is possible.” Breathing is present. The facilitator supplies findings when the team examines appropriately.

Expected actions: call for help; recognise the airway threat; use appropriate airway measures within competence; maintain suitable spinal precautions without allowing obstruction; coordinate necessary movement; assess breathing and circulation; reassess after suction or positioning; arrange definitive airway support and transfer when indicated.

Inject at three minutes: the assistant says, “We must not move anything because the neck may be injured.” The leader should explain how the team will protect the airway and reduce unnecessary movement together. The exercise tests prioritisation rather than a choice between caring about the airway and caring about the spine.

Inject at six minutes: after an effective manoeuvre, the gurgling improves but the casualty remains drowsy. The team should continue reassessment and plan ongoing airway protection rather than declare the problem resolved permanently.

Optional advanced extension: a qualified airway instructor may add a separate task-trainer station under an approved protocol. Advanced techniques are not assessed merely by verbal description in this core case.

Critical errors: allowing persistent obstruction while discussing immobilisation; blind finger sweeps; uncoordinated movement; assuming one successful manoeuvre eliminates future risk; continuing beyond current airway competence without calling for assistance.

End point: an effective temporary airway strategy, repeated assessment and an explicit plan for the next level of care.

Debrief: What did each team member understand the immediate threat to be? What was the trigger for further help? Who would monitor the airway during transport? Repeat the coordinated movement sequence if needed, using safe mannequin handling.

Scenario 5 Several casualties at a venue

Professional and command track • 20 minutes

Purpose: apply one approved triage system, maintain a casualty register, allocate roles and coordinate transport. Use the host's current official tool. The casualty descriptions below do not supply universal colour labels. [14–16]

Setting: a fictional event venue after an incident. Police or relevant authorities have designated a safe treatment area for the exercise. Give the team four responders, one communication link, limited equipment and an initially delayed ambulance response. Faculty provide the approved triage decision card.

ID	Initial presentation	Planned inject
A01	Major leg bleeding, alert, unable to walk	Bleeding response depends on effective trainer action
A02	Walking, chest discomfort after blast exposure	Becomes breathless at six minutes
A03	Drowsy after head impact, breathing	Requires reassessment and airway attention
A04	Ankle injury, alert, stable breathing	Asks to leave without registration
A05	Frightened adult, no obvious injury	Reports a missing child
A06	Child with caregiver, observations supplied by faculty	Apply age-specific host protocol

Expected actions: establish a lead; confirm safe boundaries; send an incident report; address immediate lifesaving needs within scope; assign identifiers; apply and document the chosen triage tool; create treatment and reassessment responsibilities; coordinate transport priority with the official response; account for walking casualties.

At five minutes, introduce a second volunteer who gives conflicting instructions. At eight minutes, change the ambulance arrival estimate. At twelve minutes, give a report of a blocked access route. The team should verify information, update the plan and communicate it rather than continue silently with the original assumptions.

Critical errors: unrecorded departures; treating triage as a single permanent label; sending casualties into an unsafe route; creating an unauthorised parallel command; abandoning clinical reassessment while completing the register.

End point: all six casualties accounted for, urgent needs addressed or escalated, priorities reassessed, destinations coordinated and outstanding risks handed over.

Debrief: Did the register match the actual locations? Who noticed A02's change? Was authority clear? What resource or information gap most affected care? Retest one failed communication link.

Scenario 6 Delayed transfer

Professional track • 15 minutes with a time jump

Purpose: maintain a coherent care plan when transfer is delayed, recognise deterioration and protect the responder team. This is a rehearsal of early-care continuity, not a prolonged field-care qualification. [1,2,6]

Setting: a safe local treatment room. The patient has a controlled limb bleed and a significant injury requiring hospital care. A tourniquet was applied by a trained responder; its time is recorded. Provide a handover, monitor cards and the host's relevant clinical protocol. No device is applied to a real limb.

Opening information: “Transport is delayed. The casualty is alert but in pain. The first team is tired and wants to hand over.” The learners must establish what has happened, what remains uncertain and who now holds responsibility.

Expected actions: confirm treatment history and times; repeat assessment; check bleeding control and warmth; plan monitoring; arrange analgesia and other treatment only within authorised clinical scope; communicate urgency and changing findings; document the next review; arrange staff relief and supplies.

At four minutes, announce a simulated passage of thirty minutes and provide new observations. The casualty becomes more drowsy and perfusion worsens. The team should investigate the change and renew escalation rather than assume the original injury explains everything.

At eight minutes, a bystander suggests loosening the tourniquet because the delay is long. The team should maintain the appropriate protocol and seek suitably competent clinical direction. Delay alone is not an instruction to release a tourniquet.

At eleven minutes, communication fails. Learners should use the agreed fallback and preserve a reliable paper record. A fatigue inject asks whether the monitoring role can be transferred safely rather than simply abandoned for a break.

Critical errors: unplanned gaps in monitoring; losing treatment times; undertaking unfamiliar invasive treatment because transport is delayed; assuming stable bleeding control excludes another cause of shock; handing over without confirming acceptance.

End point: an updated clinical and transfer plan, named monitoring responsibility, documented deterioration and an effective handover to relief staff or transport.

Debrief: What changed the urgency? How did the team distinguish delay from clinical stability? What preparation would reduce the burden next time? Discuss resource limits without promising that a small team can replace hospital care.

Scenario 7 A frightened parent and child

Community or professional track • 10 minutes

Purpose: combine medical vigilance with supportive communication, language assistance and safeguarding. No child needs to act in this scenario; use an adult role-player and a child mannequin or written card. [2,18]

Setting: a safe area after a confusing evacuation. The parent speaks limited English and is visibly distressed. They believe their child is injured but cannot explain the mechanism clearly. An interpreter role is available if requested.

Opening information: the child is awake and crying. Faculty provide age-appropriate observations and injury findings when requested. The parent repeatedly asks whether they can leave and says another family member is missing.

Expected actions: introduce the responder; assess immediate clinical needs; use short explanations and language support; identify an appropriate caregiver relationship; maintain dignity; explain the next step; arrange medical assessment if indicated; direct family-reunification concerns to the agreed process.

Inject at three minutes: a bystander starts filming. The learner should protect privacy and request that filming stop without escalating confrontation or abandoning care. The facilitator tests whether the team can maintain clinical attention while another member handles the bystander.

Inject at six minutes: an unfamiliar person says they can take the child to a relative. The team should use the host safeguarding process and avoid an unverified handover. A community learner is expected to seek the responsible professional, not conduct an independent investigation.

Optional professional extension: add a changing observation that requires a repeat primary survey. The objective is to avoid explaining all distress as anxiety. Do not use an obscure paediatric diagnosis as a hidden test.

Critical errors: separating the child from a safe caregiver without reason; using threats to obtain cooperation; overlooking a medical problem; publishing identifiable details; allowing an unverified departure; coercing a trauma narrative.

End point: medical needs assessed or escalated, an understandable plan communicated and a safe continuity arrangement established.

Debrief: What helped the parent understand? How did the team check comprehension? What information was necessary to record? Which local safeguarding and interpreter arrangements need to be in place before a real event?

Scenario 8 Hospital surge tabletop

Senior clinical and organising teams • 30 minutes

Purpose: test organisational decisions when demand grows, information is incomplete and staff safety affects capacity. This original tabletop is informed by published disaster-response accounts, without reproducing their events. [4,6,9]

Setting: a fictional civilian hospital or network. Give participants a simple capacity sheet listing staffed treatment spaces, available senior staff, theatre readiness, blood-bank contact, transport coordination and current routine activity. Use simulated numbers chosen by the host; do not circulate actual vulnerabilities publicly.

Opening information: emergency services report an incident with an uncertain casualty count. Some patients may self-present. Participants must decide who activates the plan, how information is confirmed, where arriving patients are assessed and how ongoing routine emergencies continue to receive care.

At five minutes, the reported casualty number doubles but the source is unverified. At ten minutes, staff report difficulty travelling safely. At fifteen minutes, a second receiving area is proposed without confirmed staffing. At twenty minutes, families arrive seeking information and a social-media rumour spreads.

Expected actions: maintain a clear command structure; distinguish staffed capability from physical space; obtain and update reliable information; protect staff; assign triage and patient-flow responsibilities; coordinate with other facilities; manage family communication; plan relief and continuity beyond the first surge.

Ask the group to state what it will stop or defer, who authorises that decision and how risks to other patients will be managed. Capacity is not created merely by opening a room. Identify staff, supplies, monitoring and escalation arrangements for every new care area.

Critical errors: basing all decisions on an unverified casualty count; calling staff into an unsafe route; treating volunteers as automatically credentialed; accepting patients into an unstaffed area; publishing casualty identities; overlooking routine emergency care.

End point: a written decision log, current capacity picture, named responsibilities, escalation requests and a plan for the next operational period.

Debrief: Which assumption failed first? What information was indispensable? What could the hospital change before the next exercise? Assign each improvement an owner and a test date. The staff-experience literature informs these questions; it does not provide a universal hospital plan.

13 Assessment and course records

Participation and competence are different records

Use direct observation for practical skills, a short knowledge check for key concepts and a team exercise for coordination. Record each separately. A learner can attend the whole course and still need further practice in a particular skill.

Suggested individual assessment: one bleeding-control task, one relevant resuscitation or primary-survey task, one concise handover and a short explanation of personal limits. Community learners should not be tested on professional interventions. Clinicians should be assessed only on skills included in the approved course and within scope.

Use three outcomes: demonstrated without prompting; demonstrated with prompting and further practice needed; not yet demonstrated. A critical safety error requires the station to stop or be corrected, followed by reassessment. The host faculty must define critical errors before the course; do not invent a pass mark after seeing the results.

Record	Minimum fields
Learner	Identifier, course date and track
Station	Objective, equipment and protocol version
Observation	Action seen, prompts and critical errors
Outcome	Demonstrated or further practice required
Remediation	Specific practice and reassessment date
Assessor	Name, role and signature

Knowledge prompts can ask: What is the first action when the scene is unsafe? What should trigger an emergency call? Why must a casualty be reassessed after movement? Why does walking not prove absence of serious injury? Who determines the triage system? What information must accompany a tourniquet? Discuss answers before the practical assessment, then use a different vignette to check understanding.

The completion statement should list the actual assessed competencies and limitations. Avoid wording such as “qualified disaster physician” or “certified emergency responder” unless a recognised awarding body has granted that status through its own process.

Keep individual results private and accessible only to appropriate course staff. Agree retention and correction arrangements with the host. Do not collect passport details, political affiliations or sensitive medical histories when they are unnecessary for the training purpose.

Invite an independent clinical educator to review a sample of assessments and the curriculum before wider rollout. Document the review and changes; do not imply that publication of this manual itself completes that process.

14 Implementation across countries

A local system for a shared curriculum

Use a common educational core and a local implementation sheet. The core establishes safety, early care, reassessment, communication and dignity. The local sheet establishes the emergency number, services, triage tool, clinical protocols, faculty authority, equipment and referral pathways.

Location	Emergency contact for teaching	Required local adaptation
United Kingdom	999 or 112	Host service pathways and current UK guidance
United States	911	State and local EMS protocols and instructor requirements
European Union	112	Country-specific language, EMS and clinical arrangements
Israel	MDA 101 for medical emergencies	Host MDA and local clinical arrangements
Elsewhere	Verify before the course	National and local emergency arrangements

These numbers were checked against official sources for this edition. The same number can mean something different elsewhere: 101 is not the UK ambulance emergency number. Teach the number for the location in which the learner will act. Do not assume that text, app or accessibility features work identically across countries. [19–22]

For each location, identify the service that will receive an emergency call, how the venue is described, where responders enter and how a patient is handed over. Use the host's agreed approach for triage, medicines, paediatrics, safeguarding, consent and information handling. Obtain appropriate local professional advice for permissions and insurance rather than treating this book as legal guidance.

Translation requires a bilingual clinician and a second checker. Verify imperative verbs, “do not” statements, units, times and emergency numbers. Test the translated handover aloud. Right-to-left material should retain readable numerals and unambiguous sequencing. Keep a version link to the English master.

Diaspora education can begin with accessible local events. International visits or programmes in Iran and Israel require separate arrangements for travel, institutional hosting and clinical activity. A successful classroom course does not establish an emergency deployment service.

Maintain a small set of common outcomes across countries, such as effective simulated bleeding control and complete handover, while allowing local methods. Compare learning honestly, accounting for differences in participants and resources. Avoid national league tables that undermine cooperation.

15 A practical pilot and improvement plan

Proposed first ninety days

The first pilot should be small enough to supervise well. A twelve-clinician course with a subsequent community session offers a manageable starting point, provided the host can supply the faculty and equipment. The numbers are planning assumptions, not evidence-based optimal group sizes.

Period	Work	Completion evidence
Days 1–15	Confirm host, leads and willing partners	Written scope and responsibilities
Days 16–30	Review curriculum and local pathways	Clinical approval and equipment list
Days 31–45	Faculty rehearsal and participant preparation	Tested scenarios and accessible materials
Days 46–60	Deliver professional pilot	Attendance, assessment and issue log
Days 61–75	Deliver adapted community session	Observed skills and participant feedback
Days 76–90	Review, revise and plan reassessment	Action register and revised version

Budget by activity rather than assuming donated time is unlimited. Include venue, instructor time, travel, task trainers, consumables, cleaning, accessibility, interpretation, insurance arrangements, administration and follow-up. Seek quotations before publishing a fee or promising a free programme. Do not commit an organisation's funds without its approval.

Measure what the pilot can establish: attendance, proportion of learners observed, skills demonstrated after remediation, completeness of handover, equipment failures and actions closed. Report the denominator and the assessment method. Confidence scores may be included but should not be presented as evidence of clinical competence or survival benefit.

At follow-up, repeat a small sample of practical assessments using comparable conditions. Record loss to follow-up. If the programme later studies real clinical outcomes or collects data beyond service improvement, obtain the appropriate ethics, governance and data advice before collection.

The collaboration itself needs evaluation. Ask whether both communities had meaningful participation, whether teaching roles matched expertise, whether language barriers were addressed and whether participants would work together again. Use anonymous feedback where practical.

Publish a concise aggregate report after the pilot, including limitations and unresolved actions. Maintain a corrections contact and version date for the book. A programme earns trust by showing what it learned and what it changed.

Appendix A Course readiness sheet

Complete locally before teaching

Course title and version: _____
Host organisation and venue: _____
Date and track: _____
Programme lead and substitute: _____
Clinical lead and review date: _____
Simulation lead and welfare contact: _____

Confirm each item and record evidence or an action owner.

Readiness item	Confirmed or action required
Audience and advertised competencies are defined	_____
Clinical content and host triage tool reviewed	_____
Faculty competence for each station verified	_____
Emergency number, address and access route checked	_____
Real emergency plan and stop phrase agreed	_____
Training and clinical equipment clearly separated	_____
Actors consented and unsafe actions excluded	_____
Accessibility, interpreters and welfare provision arranged	_____
Assessment criteria and remediation agreed	_____
Data access, retention and photography rules agreed	_____
Partner names and publicity authorised	_____
Post-course review and follow-up scheduled	_____

Local clinical protocols and versions: _____
Equipment checked by and date: _____
Outstanding issue that prevents delivery: _____
Decision and responsible lead: _____

This sheet records a local decision. It does not constitute accreditation or replace the host's governance requirements. Keep completed copies in the course record; do not publish personal contact details or security arrangements by default.

Appendix B Community action card

Use alongside practical training

1 Stay safe
Do not enter an active attack, fire, unstable structure or unknown contamination. Move to safety and follow official instructions. Your first duty is not to create another casualty.

2 Call early
Give the exact location, what happened, continuing hazards and the most urgent casualty problem. Assign a caller if others are present. Use the local emergency number and follow the dispatcher.

3 Deal with immediate threats within your training
Control visible life-threatening bleeding. For an unresponsive person, activate emergency help and assess breathing; if it is absent or abnormal, start CPR and use an AED. Use the techniques practised in the course. [2,12]

4 Watch for change
Recheck after an action or movement. Keep the person warm, explain what you are doing and protect privacy. Do not assume that walking or speaking means the injury is minor. [2]

5 Hand over
Give the mechanism and time, main concern, changes, treatments and their times. Keep a tourniquet visible and report when it was applied. Confirm that the next responder has accepted responsibility. [2]

Local emergency number: _____
Venue address and access point: _____
AED location and access: _____
First-aid kit location: _____
Safe meeting point and alternative: _____

This card is for community first response. It does not authorise hazardous-area rescue, invasive procedures, injectable medicines, wound closure or independent clinical triage decisions outside training. Do not delay emergency care to complete a form.

For use in the UK: 999 or 112. For use in the US: 911. In the EU: 112. In Israel, medical emergencies: MDA 101. Verify the location and local arrangements before distributing the card. [19–22]

Appendix C Casualty handover record

One record per casualty • fictional data only during exercises

Casualty identifier: _____ Approximate age: _____
Incident time and location: _____
Mechanism and exposure concern: _____

Assessment	Finding and time
Catastrophic bleeding	_____
Airway	_____
Breathing	_____
Circulation and perfusion	_____
Consciousness or neurological change	_____
Other important injury and warmth	_____

Treatment or action	Time	Response
_____	_____	_____
_____	_____	_____
_____	_____	_____

Tourniquet site and application time if used: _____
Relevant symptoms, allergies, medicines and history: _____
_____
Pregnancy or other special consideration if relevant: _____
Change since initial assessment: _____
Outstanding concern or required capability: _____
Destination and transport arrangement: _____
Handover to and time accepted: _____
Responder name or service identifier: _____

Use the host's authorised record in real care where available. Record only information necessary for care, keep it with the casualty through the approved process and protect confidentiality. Completing the sheet must not delay a lifesaving action or urgent transfer. [1,2]

Appendix D Exercise observation sheet

Record behaviour and the next learning step

Exercise and version: _____
Learner or team identifier: _____
Date, observer and protocol: _____

Mark O = observed without prompt; P = prompted; N = not yet demonstrated; NA = not applicable.

Behaviour	Mark	Evidence or comment
Recognised hazards and safe boundary	____	_____
Activated help with useful information	____	_____
Identified the immediate clinical priority	____	_____
Performed the relevant skill effectively	____	_____
Allocated roles and confirmed tasks	____	_____
Reassessed after action or movement	____	_____
Escalated beyond competence appropriately	____	_____
Maintained dignity and communication	____	_____
Recorded key treatment times	____	_____
Completed handover and continuity	____	_____

Critical safety concern and action taken: _____
_____
First appropriate action time and context: _____
What helped the learner succeed: _____
One individual learning goal: _____
One system improvement: _____
Remediation and reassessment plan: _____
Outcome and assessor signature: _____

Timing is descriptive unless a locally approved standard defines a threshold. This original sheet is a proposed educational tool and has not been validated as a competency instrument. Use it with trained assessor judgement and the host's assessment requirements.

Appendix E Equipment and improvement records

A workable kit and an accountable follow-up

Plan equipment against the skills being taught. Community teaching commonly needs gloves, dressings, bandages, blankets, a telephone prop, an adult CPR mannequin and a training AED. Add bleeding trainers and clearly designated training tourniquets for those assessed stations. Clinical teaching may require airway trainers, monitoring cards and protocol-specific simulation equipment. [2]

Equipment check	Record
Item and quantity	_____
Training or clinical designation	_____
Condition, expiry and cleaning status	_____
Owner and access arrangements	_____
Replacement or maintenance needed	_____
Checked by and date	_____

Do not place specialist equipment in a public kit merely because it appears useful. Match equipment to authorised skills, maintenance and replenishment. Use a recognised local specification for operational kits. A training inventory is not automatically a clinical stock list.

Improvement action	Owner	Due date	Evidence of completion
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Suggested review questions: Was every learner observed? Which action was most often prompted? Which equipment was unavailable or confusing? Did the language support work? Was anyone distressed? Did the team know when to stop? Which change will be tested next?

Version record: identify the edition, the date, the change, its reason and the approving clinical lead. Retain the previous version for traceability while clearly withdrawing it from active teaching.

Closing reflection: cooperation becomes durable when it survives beyond an event. A shared lesson, a corrected error and a reliable follow-up are practical expressions of the friendship this programme seeks to build.

References

Sources checked for this edition on 31 October 2026

1. Bakhshayesh P. Philosophy of Major Trauma. First edition, 13 October 2026. Author-published. Source read from the author's Google Drive; public book page.
Open source

2. Bakhshayesh P. Immediate Help for Casualties in Crisis [Persian civilian first-aid guide]. Version 1, 12 October 2026. Source: Iran_Civilian_First_Aid_Peyman_Bakhshayesh_FA.docx, author's Google Drive. English title here is descriptive.
Open source

3. Alpert EA, Gershov West D, Sasson M, Berzon B, Nerlander M, Weiss I, Jaffe E. Preparing Local Professional Community Emergency Response Teams for Mass Casualty Incidents: Lessons Learned from Israel Since October 7, 2023. Disaster Med Public Health Prep. 2026;20:e84.
Open source

4. Gershov West D, Alpert EA, Braitberg G. Integrating the six C's of disaster response: Lessons from the mega terrorist attack on October 7, 2023. Am J Disaster Med. 2024;19(2):175–178. Abstract consulted.
Open source

5. Gershov-West D, Alpert EA, Kesari S, Lipsky AM. Integration of an advanced graduate medical education program for a new specialization in Israel: the National Israeli Course in Emergency Medicine (NICEM). Harefuah. 2025;164(7):456–462. Hebrew article; English abstract consulted.
Open source

6. Nerlander MP, Rose AJ, Gershov West D. Wartime Mass Casualty Incident Plan Operation: Staff Experiences from a Civilian Hospital in Southern Israel on October 7, 2023. Disaster Med Public Health Prep. 2026;20:e135. Abstract consulted.
Open source

7. Frontline Emergency Medicine. Official project description and team.
Open source

8. WHO and ICRC. Basic Emergency Care: approach to the acutely ill and injured. 2018; official resource page includes subsequently updated teaching materials and conflict-related injury modules.
Open source

9. WHO. Simulation exercises: exercise types, purposes and programme resources.
Open source

10. WHO. Mass gathering practical guide for simulation exercises and after action reviews. 10 July 2025.
Open source

11. Resuscitation Council UK. First Aid Guidelines. Published 27 October 2025.
Open source

12. Resuscitation Council UK. Adult Basic Life Support Guidelines. Published 27 October 2025.
Open source

13. NICE. Major trauma: assessment and initial management. NG39. Recommendations.
Open source

14. NHS England. Ten Second Triage tool. Updated 4 August 2025. Use the official complete tool.
Open source

15. NHS England. NHS Major Incident Triage Tool (MITT). 11 April 2023. Use the official complete tool.
Open source

16. JESIP. M/ETHANE incident reporting framework.
Open source

17. ProtectUK and Counter Terrorism Policing. RUN HIDE TELL. Official public guidance, 21 May 2026.
Open source

18. WHO, War Trauma Foundation and World Vision International. Psychological first aid: Guide for field workers. 2011. Official overview and language resources consulted.
Open source

19. UK Government. 999 and 112: the UK's national emergency numbers.
Open source

20. National 911 Program. Calling 911.
Open source

21. European Commission. 112 - the EU's emergency phone number.
Open source

22. Magen David Adom. Emergency contact and first-aid resources: medical emergency number 101.
Open source

Source note: the author's Drive manuscript and civilian-care guide were read as source texts. Public professional and community websites informed the author profile and collaboration context. Abstract-only sources are labelled above. This is a selective educational synthesis, not a systematic review.