Government Services Chapter ACEP

Spring 2003

The EPIC

DEPLOYMENT: A Special Edition

Government Services Chapter
American College of Emergency Physicians
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February 2003

Dear GSACEP Member,

As military emergency physicians we are experiencing one of the most challenging times our specialty has ever encountered. For the past two decades we have struggled to define our specialty within the military. Our success can be clearly measured by the high op tempo emergency physicians are experiencing since Sept 11, 2001. It is no longer a question IF you will be deployed but WHEN.

Our specialty training has prepared us well to succeed in the austere operational environment and the military line and medical leadership know this fact. However, while we all may have the medical skills to perform our job, the ability to treat both battle injuries and non-battle disease injuries, and the ingenuity to adapt to remote environments, deployments can still be very stressful to each of us and our families. While the GSACEP Board of Directors was distressed to have to cancel the 2003 Joint Service Symposium due to the heightened op tempo they wanted to do something to help members. The following has been prepared in an effort to help members who may be deploying.

The articles you will find are practical tools to help you get ready. Websites for more information on medical care aspects will be available in the future on the GSACEP website. There is a wealth of resources easily accessible on medical management of combat casualties. Thus the focus here is to help one get out the door and spend those final moments with your families and friends. Also a couple of articles have been included on new training opportunities and detainee medicine.

The enclosed information will also be placed on the GSACEP website. The goal is to see this website grow. Please share with us articles, case reports, pictures or anything else from your deployment experiences you think may be of benefit to your military emergency medicine colleagues. Please contact Ms Bernadette Carr, GSACEP Executive Director at gsacep@aol.com if you have something to share.

On behalf of the GSACEP Board of Directors we hope you find this resource helpful. We applaud each and every one of you for the courage and sacrifice you have made and will make in the future as military emergency physicians. We pray that God watches over you and your families during these challenging times and keeps us all safe and healthy.

Sincerely,

LtCol Linda Lawrence, USAF, MC

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Packing Tips for Exercises and Deployments

by CPT Ilse Alumbaugh, RN

Editor's Note: The following was prepared by CPT Ilse Alumbaugh, a student in the Graduate School of Nursing at Unformed Services University. These lessons learned were shared with the medical students as they prepared for their senior one-week field exercise. Whether you are a novice field goer or seasoned veteran I am sure you will find a pearl or two among these that will make a huge difference in your future field experiences. Even if you won't be residing in a tent there are several helpful hints that can apply to all of us. I have added a few commentaries in italics from my field experiences. Yes even us Air Force type sometimes find ourselves away from the club.

This list of tips is written for general field survival and deployments. It's based on 20 years of field experience, deployments and humanitarian missions. Must do items for this exercise have been underlined. Store the rest away for later reference.

Packing Tips:

Tip #1: Line your duffle bag with a 33 gallon garbage bag. Invest in a strong lawn/leaf bag that resists punctures. If you don't normally buy large garbage bags, get together with friends and share a box. Take at least 1-2 extra bags for whatever.

Tip #2: Line your sleeping bag cover with another bag. The waterproof bags (aka, the Willie P) can sometimes come with holes – even the new ones.

Tip #3: Line your ruck sack with a 3rd bag. Take at least 1-2 extra bags for whatever. *Bring extra of all kinds of bags – garbage, gallon ziplock, quart ziplock. Don't take much room and great to keep dry things dry, wet things away from dry and storing those coveted snacks from predators. At the end of the exercise when heading home there is the temptation to toss everything together but if you bag the mud it makes it easier at the cleanup.*

Tip #4: Pack an A bag and B bag. In most units, the hospital command determines which bag will be which for shipping and storing purposes. The A bag is usually your ruck sack and should contain stuff you need quickly. A change of clothes, three days of socks, underwear, and t-shirts (may increase based on your unit's mission and travel time), a toiletry bag, 2-3 days of MRE's, and gas mask and LBE if you're not carrying it. Also pack your woobie (poncho liner) and a pillow on the top. These will be handy in intemperate hangers waiting for transportation for chilly weather and a quick nap.

The B bag is usually your duffle bag and contains the majority of your supplies and clothes. This includes an off weather gear for long deployments.
a. Pack pt clothes, military and civilian for off duty time. Take at least three t-shirts on deployments.
b. For deployments, pack 2-3 sets of civilian clothes NO MATTER WHAT THEY TELL YOU regarding actual need. You will be told you don't need them. You won't, everyday. But you will need them for R&R. Take them. At some point you will need them. *Even if you don't get to go anywhere it feels great to wear something different for a change. Nothing like wearing those favorite comfy jeans and shirt to pick up your spirits.*

The C bag is often authorized for long deployments and may be shipped. This is where your survival stuff will go. Pack your lawn chair, plastic shelves, etc. in here. Do not pack anything in this bag you can't live without. That includes cold or hot weather gear even if you THINK you're going to a hot or cold weather climate. If your gear is shipped it can take up to three months to get to you and things change quickly during deployments.

The Double Duffle Bag Theorem:
A. Whatever you need the most will sift to the bottom of your duffle bag.
B. Whatever you needed the last time you looked and no longer need will always be on the top of the duffle bag until you need it again, in which case it will mysteriously sink to the bottom again.

Tip #4: Pack three days of under items in a bag. Pack as many bags as you need for the deployment or field exercise. For long deployments, laundry may be scarce for the first couple weeks. Bring at least 14 days of under things. Pack one bra, three t-shirts, three socks, and three pairs of undies into a 1 gallon bag, or a long plastic newspaper bag. I highly recommend the latter. When you're reaching around blindly in your duffle bag, they will be the easiest to find. This tip is helpful for anything you think may be hard to find. Put 1-2 bags of under items in your A bag as needed.

Tip #5: How to Organize Your Duffle:
a. Make 3-5 day layers in your duffle bag. Fold or roll your uniforms and place them in 3-5 day layers, alternating uniforms with long underwear/sweaters/thermo in cold environments.
b. Place boots around the sides toward the top for quick retrieval.
c. Pack the long bags with T-shirts etc., last, and slide them around the edges of your duffle bag.
d. For flights and travel, ALWAYS set up and fold your LBE and place it on top. Ideally this would be in the ruck sack if you have one. Then your mop gear, then your gas mask. Leave the mask on top regardless of whether you think you'll ever need it. You probably never will, but if you got into a hostile environment, this advice may pay off.

Tip #6: Pack a sandwich bag with three pairs of socks, a bottle of powder and a few candies. Place the bag in the outside pocket of your rucksack (or gym bag). This great for road marches, or wet weather. The powder is

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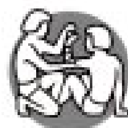

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Keeping Warm and Dry:

Tip #1: Keep your extra boots in your ruck and place your daily boots **under your cot** to air out at night. You can cover the openings with socks if the insides aren't soaked from sweat or water. Carefully check for critters the next morning. But always put them under your cot. The tents tend to leak.

Tip #2: Keeping your bunk dry. Pack a 3-pack roll of painter's drop cloths or inexpensive plastic shower curtain liners, 550 cord and clothes pins. When your tent is set up, attach the 1st cloth to the side of the tent at an angle suspended over the 550 cord. Attach the other two cloths to the first cloth, draping the edges over the string and clipping into place assuring the water runs away from your bed. Roll the sides up and clip into place. Drop sides on rainy nights.

Tip #3: Invest in a gator. A gator is an 8x8, square hood you can purchase at clothing sales. It is most handy in cold weather. It can be worn over your head like a scarf to keep your neck, face and chin warm, or bundled around your neck between your parka and your helmet. When worn this way, it keeps the rainwater from dripping onto your neck, down the back of your sweater and jacket while you're bending over working.

Creating a Cozy Camp Environment:

Tip #1: Bring toilet paper. Share among friends if you must, but make sure you have it. It oddly becomes a hot item in the field if the supply people didn't bring enough. Include hand sanitizer.

Tip #2: Privacy: After a few days in the field, you will long for privacy. Attach a poncho, or shower curtain over the line for a secure changing or rest area.

Tip #3: Invest in a down pillow. If you need a full sized pillow, consider buying a small full-sized down pillow versus a fiber fill pillow. It fits nicely in a two gallon bag that fits perfectly on the top of your ruck sack for quick retrieval, and provides good back support while waiting for transportation. It crushes down and stuffs nicely around your duffle. It can fill in cracks without taking much room. *If space is at a premium take a pillow case and fill it with clothing. While not as nice as a down pillow it is better than nothing. Plus sleeping with your clothes keeps them warm and makes getting dressed in a cold tent all the more appealing in the early dark cold AM.*

Another option is an inflatable bathtub pillow. It launders well in the washer and dryer. Bring two pillow cases for deployments and long exercises.

Also bring two sheets. This is great for hot climates in coed tents. You can roll the edges of your sleep bag, lie on your sleeping bag and cover with a sheet, which rests on the elevated rolls. This keeps the sheet off of you and air circulating. Applies to tiny people best. *A flannel sheet or light fleece blanket are great for lining your sleeping bag during cold trips. No matter how cold they always feel warm and great to wrap around your head/neck to keep the draft out.*

Tip #4: Invest in a snake light with a battery pack. The snake light is handy for everything, to include reading at night. In most exercises or deployment, you'll have electricity so you can charge your snake light when not using it. Keep it dry. Watch Home Depot, Lowe's and K-mart for sales to get a good price.

Tip #5: For long field exercises and deployments, invest in an inexpensive plastic set of drawers. Pack the drawers with snacks and extra supplies and books. Pack a plastic box with extras and ship it with your section's MIL van. At destination, put your snacks in the critter and moisture proof box and place under bunk. It doubles as a card table and dressing table. Put your often used items (toiletries, etc.) in the plastic drawers and use for a night stand. Determine if your drawers are water proof first. If not, elevate it on your box or pallet, and cover with plastic in rain. If you suspect they are not air tight, DO NOT store food items in them unless you like critters visiting you at night.

Tip #6: Invest in a camp chair. For a quick exercise, buy an aluminum folding chair. It fits perfectly in your ruck sack and provides back support – like a back pack frame if padded properly. For longer deployments, buy the folding chairs/recliner/couch and ship it with the hospital. They also have folding tables now. You can find these at K-mart and Wal-Mart.

Tip #7: Pack a couple sports bras and running shorts/tights. This will make changing in a co-ed tent slightly more palatable.

Tip #8: Bring sweats or neutral pajamas to sleep in. I don't recommend crawling into bed with the long underwear you plan to wear the next day because you'll sweat in them while you sleep. Deciding to wear the ones you wore that day is up to you.

General Survival Tips:

Tip #1: Always bring leather gloves with liners for setting up tents, filling sandbags, etc. regardless of the weather and regardless of whether you normally wear work gloves. Keep them handy in your ruck sack for quick retrieval.

Tip #2: Keep hand sanitizer, toilet covers and emergency toilet paper in your ammo pouch. You can find the mini-packs of toilet covers (5/pack), sanitary hand wipes, and a tiny TP roll for .78 cents apiece at Wal-Mart in the sample items aisle.

Tip #3: Surviving the Porta John Lifestyle: Team up with a buddy to watch your stuff. If security is an issue, take it in with you with the following guidelines: Go into stall, lock door, close lid to commode. Unhook your gear and hang it up on door. Close toilet lid and re-don gear. Don gear outside the John if there is a long line. You laugh but there are many flash lights, gas masks, and weapons in latrines all over the world. Nothing alarms one more than the sight of a glowing outhouse – for days if Duracell batteries were used.

The Cycle Theorem:
If it's inconvenient, your cycle will start.
If you don't care it won't.

Tip #4: If deployed, pack a three months supply of feminine hygiene items with you. It may take that long to get your gear shipped to you or for AAFES to set up shop. If you don't have regular cycles, you may be surprised that they suddenly get regular. If you take OCP's, you can skip your odd colored pills (green, white) and start a new pack. This will suppress a cycle. Do this no more than three months. Keep current on GYN guidelines in case this changes.

Staying Fresh and Tidy

Tip #1: No shower? No problem. Baby wipes are great. Select a smell you can stand. Don't be ashamed to wander through Wal-Mart and the Commissary opening packages and sniffing. By the end of the exercise, you will HATE the smell if you don't choose wisely. This will be a problem when you have children, change their diapers and think of the field. For the day, you can purchase travel packs for your ammo pouches or select about five, fold them, and place them in baggies. They're refreshing and keep the grime down. See Tip #5 too.

Tip #2: A basin is better. The plastic surgical basin is the perfect size if you can get your hands on one. Pack your items into it to save room.

Tip #3: Befriend the OR staff in a CSH – they are sometimes the only ones in the hospital with hot water and a sink big enough to wash long hair properly. Bring easy rinse shampoo and cream rinse.

Tip #4: Use bar soap. Consider Irish Spring, it rinses better and leaves you feeling cleaner. Liquid soap is wonderful – in garrison, and feels soft and luxurious. However, it doesn't rinse well and tends to leave you feeling slimy in the field. Again, select the scent carefully.

Tip #5: Bring a pack of Pond's face cleaning cloths – they're pre-moistened, and designed to remove make up. They're great for removing camouflage makeup. Good for sensitive skin and less harsh than baby wipes. An alternate, if you battle adult acne, is Noxzema face cleansing cloths you can rinse

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under your canteen. They're refreshing and designed to keep acne at bay which creeps out with chin straps and having your face grimy all day. You can pack a few or invest with friends and share a pack.

Tip #6: Buy slightly elevated but stable shower shoes. This will keep your feet out of mud and the water that invariable pools in the shower and creeps you out – especially if you see hair and foreign objects floating around in it. New styles allow you to go up to 3 inches out of the water. Stop at about 1.5 inches. $12.00 at Kohl's and K-mart.

Tip #7: Women Only – Men won't care: Buy underwear for deployments and the field. Your overriding desire when you return from a trip longer than a week is to immediately burn your underwear because you are so sick of looking at it. Invest in cotton underwear and bras in fun colors from K-mart, Wal-Mart, or Target. White gets really grimy looking. Don't bring the Body by Victoria for $12.00 a pair.

Keeping Entertained

Tip #1: Confer with a group of friends who have similar reading interests. Everyone bring three different paperbacks. Trade off. Pack more in the mil vans. *If your camp doesn't have an exchange library start one. I greatly expanded my reading interests while deployed.*

Tip #2: Invest in a Game boy. Bring lots of batteries for them. If you like to play competitively, find a buddy who has a Game boy and invest in a connecting cord.

Tip #3: Computer – Risky in sand! But, worth it. If you're shopping for a travel lap top, find one that will connect into your LAN line. Many computers have wireless capability, but you may not have a signal center at your destination. When you get to the field, befriend the signal guys – feed them quality snacks and promise them all the medical care they desire (may have to get the NP's or FP docs to help you carry this out) and ask them to configure your phones with your computers in mind. They'll know what to do. Expect EVERYONE in the hospital to ask to use your computer. Make a decision before you deploy if that is acceptable. If so, remove all private data, Quicken, letters, etc. from the computer because people get bored at night and go snooping through your computer. In El Salvador we swiped each other's pictures from the MEDCAPs and emailed them home. Make sure your picture collection is G rated. That goes for email as well. Let your friends and family know this.

Tip #4: Digital Camera – Again, risky in sand, but worth it. It is amazingly satisfying to send real time photos home. If you don't want to risk a digital camera, buy no less than 5 disposable cameras. When full, mail them home to family to develop onto a disc and email back to you to share with friends. *Know the local rules before you click. Pictures of the front gate were off limit at Incirlik AFB Turkey – with the armed guards who had no sense of humor compliance was a 100%. One of my colleagues incited what almost turned into an international event at another Middle East base when he took pictures of a base sign several miles away from camp as they returned from taking a patient downtown. And do be careful of what you email – big brother is watching and what we may accept as okay in our country can be offensive in other countries. On the bright side a digital camera can be very helpful as you shop. I used to send my husband pictures of the rugs I thought of buying so he could tell me his preference and remind me what my home looked like – funny how quickly one can forget the colors of the walls.*

Tip #5: Cards and games will appear mysteriously and everyone will play. Bring what you enjoy. Crafts – cross stitch and knitting. *We even got the orthopedic surgeon deployed with us to cross-stitch something for his soon to be new baby.*

Fine Dining in Austere Conditions:

Tip #1: See MRE menus. Learn to barter. Know your buddy's weakness. Most people can be divided into: hate cheese, love peanut butter, hate Tabasco, need more sugar, hate pound cake, must have M&M's. Use the heater – but don't open the package before you warm your food. The water will spill into the MRE and spoil the taste.

Tip #2: Dealing with nausea – Try to take antimalarials at bedtime if you aren't required to take them in formation. If required to take them in formation, eat a handful of Cheezits first. They coat the stomach and prevent nausea. Ginger snaps are great for general nausea related to change of environment and strange foods, but Cheezits are better for nausea associated with Primaquin and Doxycycline.

Tip #3: Speaking of anti-malarials – never, NEVER take an antimalarial tablet with a carbonated soda. Never. It comes back up quickly and violently.

Tip #4: This isn't the time to diet. You'll lose weight naturally by working like a dog, being too anxious to eat and of course, the trots associated with traveler's diarrhea. If trots aren't your problem… See Tip #5. Eat what you want and drink lots of fluids. If you don't have patients, you'll find yourself spontaneously exercising regularly out of boredom.

Tip #5: Take a fiber supplement in tablet form if MRE's are rough on you. Bear in mind that most constipation occurs when people don't feel like facing the smelly latrine. If this is the case, take a toilet cover, a good book, and a clothespin for your nose. Don't forget the hand sanitizer and toilet paper. I continue to be STUNNED by the lack of hand washing stations in a field hospital.

Tip #6: Facing caffeine addiction: The first step is acknowledging your powerlessness over caffeine. The second step is to fight signs of physical addiction. If your hospital is shipped, you may not have hot meals or real coffee for several weeks to months or the heat makes the thought of hot coffee seem, well, hot. This scenario can be a disaster for the caffeine addicted. The fix: Mix 1/2 strength lemon flavored iced tea with water. This prevents caffeine withdrawal headaches and temperament changes usually associated with heat injuries. It's important to know the difference. You don't want sepsis from an IV over caffeine withdrawal. The signs are the same. Really.

Tip #7: Handling Chlorinated Water: The PM guys kinda over do it - for good reasons of course. Warm chlorinated water is even more awful. To motivate myself to stay hydrated; I mix 1/2 strength Capri Sun or Gatorade in my water in a separate water bottle I keep in my cargo pocket. I make a couple batches a day. Adjust the amount of mix for the heat. Dilute in hotter weather or less if you aren't eating regularly. Other options: Boxed concentrated juices such as grape, apple, cranberry. Be cautioned that you may not be able to refrigerate these once opened, but if refrigerators are an option, go for it.

Tip #8: Bring a slender water bottle that fits into your cargo pocket for this purpose. Each night, empty it out, rinse it with chlorinated water and let it drain. Do not reuse fluids from day to day because of the sugar content.

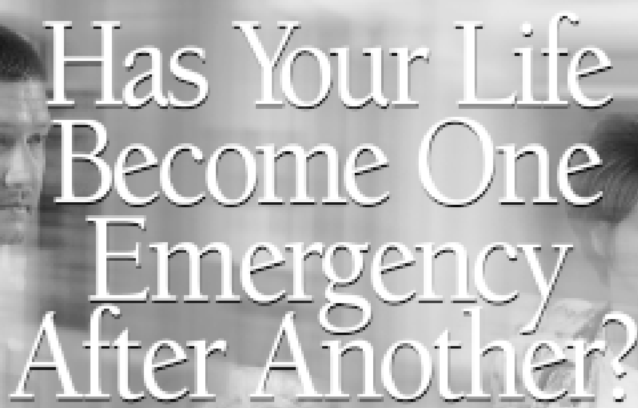
Do not, do not, DO NOT, put anything other than water in your canteen. This is an offense punishable by UCMJ for the enlisted soldiers. They'll be watching you. Set the example. Mix your juice in a water bottle and keep your canteens filled with fresh water even if you only consume from your water bottle. As a medical professional you can make an educated choice about your fluid and electrolyte choice. The 11B sharing your camp site may not be able to make that same educated choice.

Tip #9: Still No Hot Coffee: If you're lucky, you have hot water, but can't stand instant coffee another day or you can't imagine life without Starbucks. The fix: Bring flavored teas and flavored creamers to dress up your caffeinated beverages. Don't forget your private stash of sugar. Like toilet paper, it can quickly become a premium item.

Tip #10: If you have more than 1 MRE a day, bring snacks. You'll be profoundly tired of MRE's in no time.

Special Thanks to my Nursing colleagues who reviewed this list and offered their suggestions:Major Tammie Boeger, Major Joe Candelario, CPT Lisa Ford, CPT Tony Leonard, CPT Jana Ortiz, CPT Meryia Windisch

And extra special thanks to my Mom who taught me how to tell when it's going to rain; and my parents who dragged me out on my first hike when I was three and encouraged us to hike the Grand Canyon every Spring Break.



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Elevated shower shoes

Hand lotion – choose scent wisely
Bug Spray
Sun Screen
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Hand Sanitizer
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Extra glasses
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First Aid Kit:
- Mole skin
- Bandages
- Ankle brace
- Tylenol/Motrin
- Cortisone cream

Hair cutting items
Hair implements – pack extras

Sunflower seeds – keep you awake on guard duty
Coffee beans

Good clinical pocket references. *Consider a computer and then you can bring a reference library on CD-ROM. Don't expect much where you are going.*

[1] On the first night of a deployment to El Salvador, I went to bed to the sound of demonstrations in a nearby city. I was awakened a short time later choking from smoke rolling into the tent. Thinking we had been involved in a riot and were under attack, I jumped up, donned my gas mask and awakened and evacuated the tent. We were disoriented and confused. When the smoke cleared, we found an MRE bomb under the cot of the Chief Nurse who was next to my cot. The prankster was never found and no one was hurt. But it taught me not to pack my gas mask too far away and the mask allowed me to quickly and safely evacuate the tent.
[2] I woke up one morning and found that one boot had crept out from under my cot in the night. It was filled with two inches of water!
[3] Don't let anyone tell you it NEVER rains where you are. In El Salvador we got to experience the only rain they've ever had in December in 20 some odd years. It lasted 15 minutes, but soaked everything because no one (except me) was prepared. How did I know it was going to rain? When the barometric pressure changes, leaves will flip up, curl over and take on a silver appearance, even if there isn't a cloud in the sky. Look at the trees. If they appear silver from a distance, look closely and immediately secure your site. It WILL rain within three hours. My tent mates who thought I was crazy when I started dropping my tent flaps, thought I was magic when they had to dry their gear. It's not magic, just science, but they pestered me every day for the rest of the deployment for a weather report! It was 80, sunny and warm. It never rained again.

Just Do It!
Survival Tips for PROFIS Officers

by CPT Ilse Alumbaugh, RN

You may have the experience of being assigned to a unit as a PROFIS officer. This will happen just when you think your life will be all clinical and you're well established in your practice. Then you'll get that email or phone call – you've been assigned to a CSH or FH. While your initial instinct will be to hide in your clinic and pray the phone never rings for an FTX or deployment, resist!! Accept your assignment, and do some research to find out what your role will be.

Tip #1: **Know your mission.** Find out what your unit's mission is, who they typically support, what geographic region your tactical unit supports, how often your medical unit trains, and how many times the unit has been deployed in the last five years.

Tip #2: Take the time to get to know your team. Don't slink away and bury yourself with appointments when you hear an exercise is coming up. Use the opportunity to go to the field to meet your team; most helpful if your unit isn't in your state.

Tip #3: Befriend the NCOs. If you're lucky enough to be in the same location as your unit, find out who the NCO's are that support your section. Befriend them. Feed them quality snacks, and train them. They will love you for it. Train them to the level you expect from your support staff. Your expectations and their experience will be surprisingly different. Teach them ATLS, especially primary and secondary assessment, resuscitation, mascals, and how to manage specific cases appropriate to your unit. Coordinate with your Nurse Corps staff and senior NCO's who may already be training. Evaluate and join in the training.

Tip #4: Befriend your professional colleagues in the unit. Remember, you'll be spending long hours in a tent with them, possibly in war. This is time to find out whom to avoid, who to befriend, and who to play chess, run or swap books with. This doesn't seem important now, but it will be.

Tip #5: Learn how to procure. If assigned to a ward or unit, get to know your Ward Master and Head Nurse. Go with them at least quarterly to unpack and inventory the chests. You will be stunned at how outdated your equipment is. Ask for supply input from the head nurse. She is working full time on the ward and knows the latest supplies and equipment. Your NCO is likely to have spent the last 8-15 years in a tactical unit and hasn't touched a patient in three years but he/she knows exactly how to get their hands on the supplies you need. They may ask you to use your authority to request and justify the supplies. Make the time to do it. Encourage your senior NCO's to rotate supplies about to expire and keep current with technology. If have problems with getting current supplies, make a wish list, give a copy to your NCO and Head Nurse and bide your time. During deployments, coffers dramatically fly open and money will suddenly be available for all the supplies you need.

Tip #6: Packing snacks. When getting deployed, collect quality snacks and bulky supplies such as a chest and pack them in the chests being shipped to your deployment area. Get a plastic chest with drawers and pack the drawers with snacks you'll need for a long deployment. It doubles as a water proof night stand to store your things in when you get to your assignment.

Live out of state from your unit? Remember the friends you made? This is the time they'll help you. You're assigned to Walter Reid and you're told your unit, stationed in New York, North Carolina, Georgia or Kentucky is being deployed. How to get your snacks packed? Quickly purchase and ship your box to your friend, or call them, send them a check and ask them to purchase and pack the items for you. See, you need good friends for these kinds of favors. Remember, these items may be shipped and can take MONTHS to get to you. Do NOT ship anything you don't need within two months. This includes intemperate weather clothing.

Tip #7: Lead by example. When deployed or training, never be heard complaining by a subordinate. Ever. It decreases morale (including your own) and quickly establishes you in the minds of the unit regulars as a whiny, spoiled PROFIS officer. When setting up sleep tents and the hospital, do not hide, be the first to pick up a mallet. Do not reason about the necessity of filling, emptying and refilling sandbags. Just do it. Be first to do it. Step forward and lead by example with a positive spirit. This can be surprisingly hard. Especially when you're tired, hot, cold, sleep deprived or scared. However, a positive attitude quickly becomes contagious. Leadership by example is one of the most effective methods of leadership. This will most be most important when you've set up your 12th sleep tent or filled your 25th sandbag or been sitting in your empty CSH wondering where the heck the patients are and reflecting sadly on the backlog of patients in your clinic. Patients in your clinic will fill your head with woe before you leave – "But gosh Doc! Who's going to take care of me while you're gone? You're a ______ist, why do YOU have to go? You should be here taking care of me. I need you more." At the moment, you may feel glad for the break. Within days or weeks, you'll be thinking fondly about that patient and wishing you were home.

Tip #8: Choose who sleeps next to you very carefully. You do not want to be next to the unit commander, chief nurse, or first sergeant. You also don't want to be next to your NCOIC, OIC, or anyone that quite frankly annoys you. Oddly, these people can be your bunk mates and you need to let your hair down at some point and vent. Avoid snorers. Prior to deployment, liberally write referrals to ENT for people you suspect may have a snoring problem. Think I'm kidding? Nights can be very long.

Tip #9: Understand heat categories and be an advocate for your soldiers and staff. Bring up the question of limiting training in extreme hot weather. Sometimes your MSC officer is inexperienced and isn't aware that such a thing as a wet bulb exists. They take the news more seriously from a physician.

Tip #10: Bring your own role of toilet paper and hand sanitizer. Oddly enough, you can't count on a hand washing station even in a hospital!

RECIPES TO ENHANCE YOUR MRE'S

by CPT Ilse Alumbaugh, RN

Ranger Pudding

1 MRE cocoa beverage powder
1 MRE creamer packet
1 MRE sugar packet
water.

Directions: Mix creamer, powder and sugar. Add water and stir to desired consistency.

Ranger Bread Pudding

1 batch Ranger Pudding
1 half MRE pound cake.

Directions: Crumble pound cake into Ranger Pudding

Peanut Butter Cup Poundcake

1 MRE cocoa beverage powder packet
1 MRE creamer packet
1 MRE sugar packet
1 MRE peanut butter
1 MRE vanilla pound cake
1 MRE coffee (optional)

Directions: Divide poundcake. Slice top of peanut butter packet open. Add cocoa, creamer, sugar, and coffee to the peanut butter one at a time, mixing well. Spread onto _ pound cake and top with other half.

If you need the caffeine, mix a tiny amount of coffee into the peanut butter mix.

Mocha Frosting

1 pouch of MRE cocoa
1 packet of instant coffee (optional)
Water as needed.

Directions: Add just enough water to the cocoa mix to resemble frosting. Add coffee granules as you wish to create a mocha flavor. Spread this frosting on such items as MRE pound cake, cookies and crackers.

Ranger Cobbler

1 MRE pouch of peaches or apples or strawberries
1 packet of sugar
2 crackers,
Water as needed (hot water makes it more cobbler-like)

Directions: Add more water to the pouch of peaches than usual. Add the packet of sugar and stir. Crumble the crackers and add to the contents of the pouch. Add more water if necessary and gently stir.

Ranger Mocha Latte

1 pouch of MRE cocoa
1 packet of instant coffee
1 packet of sugar
2-3 packets of cream
Hot Water

Directions: Stir ingredients together in hot water and enjoy.

Cheese Dogs

1/2 packet of cheese
1 packet of hot dogs

Warm hot dog bag. When able to safely handle, slice hot dogs lengthwise with a clean knife and pour in cheese. Accompany with crackers. Season with Tabasco.

Hint: Reserve rest of cheese and a cracker for a late night snack.

Peanut Butter and Jelly Sandwich

1 packet of peanut butter
1 packet of jelly/jam
1 packet of A rat bread (snag at breakfast and put in pack)

General MRE Guidelines

Adding cheese, crackers to any meal immediately enhances the flavor and texture.

Learn to barter. Know your buddy's weakness – find out who hates or loves cheese, coffee, tea, sugar, peanut butter, pound cake, crackers, and that yummy gum.

Detainee Medical After-Action Report

by CDR. James Ritchie, MD, MC, USN

Editor's Note: While this article is a little on the longer side long I believe a condensed version would not be as beneficial. This may be a new area for many of us being deployed. If time is of the essence then skip to the end to the special issues section to view some critical lessons learned. Otherwise I encourage you to read this very interesting and highly educational after action report in totality.

The 26 MEU Medical team, consisting of command element, MSSG, and augmentee personnel, was tasked on arrival with providing medical care for incoming detainees to be received at the Kandahar Airport Temporary Holding Facility (KATHF). Many lessons were learned, as no written guidance was available to us, and from the outset, the detainee medical tasking was to be accomplished with no additional personnel or material. This AAR is arranged as following: first, a basic sequence of events regarding the initiation of detainee medical service; second, a description of the team's parts, functions, and interactions; third, a compilation of various statistics regarding detainee illnesses and injuries; fourth, a consideration of selected issues likely to impact future similar operations. Medical issues not germane to detainee care are included in a separate AAR. However, for perspective, the reader should be aware that the 26 MEU Medical team was selected and fielded to provide combat casualty support. This remained the primary mission, and casualties were received, treated, and medevac'd throughout the deployment. Nonetheless, due to sheer volume of need, the great preponderance of medical effort was spent in detainee care.

SEQUENCE OF EVENTS

December 16-18: Three medical personnel, the MEU Surgeon, an Emergency Physician, and an Intensive Care Nurse, arrived at Kandahar. No medical facilities exist. The BLT physician, a GMO who had arrived two days prior, has established a Battalion Aid Station in an alcove in the terminal. First word is received that Kandahar will be receiving as many as 200 detainees, and orders are received to prepare a holding facility. Medical planning begins, with plans to obtain large amounts of medical information from each detainee, including lab samples. Plans were made to contact the Red Cross and CDC to ascertain their interest in medical data. However, these plans were halted by higher authority, due to more pressing needs, such as expeditious ingress, security, and interrogation requirements.

No information existed regarding any medical needs the detainees might have. Medical screening was the only service known to be needed. A data set for screening was agreed upon by the medical staff. Each detainee would be asked if he was ill, and whether he wanted to see a doctor. He would be assessed for general nutritional status and state of dental repair. His pulse would be counted. He would be examined visually, and any lesions, marks, scars, or other identifying information would be recorded. Based on the detainee's requests and any findings apparent on visual exam, further examination could be carried out at the discretion of the provider on the screening team. Should any detainee be found to be seriously ill, another team would be summoned to care for him while screening continued.

The Medical Team is seriously concerned about the ability of our small group to care for a large number of potentially medically needy detainees while continuing our primary mission of casualty support. The Team also was transported with a very limited medical equipment supply. Resupply was questionable. Issues of triage of medical equipment between detainees and U.S. casualties were debated. (See special issues, below.)

December 18. Received first 15 detainees. Approximately two hours before arrival, the screening team spoke with personnel who had visited the prisons from which the detainees were being shipped. These personnel told us of many seriously wounded and critically ill prisoners who might be sent to us. The screening team obtained a supply of dressing materials.

Two of the first 15 detainees were wounded. The first was very malnourished, and had sustained a gunshot wound to the upper right humerus approximately one month prior. The wound was infected, and the fracture had not healed. The second injury was a simple gunshot wound to the posterior thigh, which was granulating well and healing. Both detainees' wounds were dressed appropriately. The remainder of the detainees had no active wounds, though two had complaints or findings requiring further evaluation.

The wounds of the first detainee could not be definitively treated at KATHF. Orthopaedic operative intervention would be necessary. A debate ensued regarding the proper course of action in keeping with the Geneva convention. See the "Medevac Controversy" section below. Ultimately, we provided the best care available to us within KATHF, but did not medevac detainees until their trip to the holding facility at Guantanamo Bay, Cuba.

December 19. Recognizing that, should we receive injured detainees in the same proportion as our first shipment, a large daily medical effort would be necessary, we began to prepare. KATHF commanders were asked for dedicated medical space within the camp. Some suggested that we bring injured detainees out of the camp to casualty receiving area to treat. We rejected that suggestion due to difficulty of movement, potential interference with receiving U.S. casualties, and potentially providing the enemy with weapons, as the treatment tent was full of instruments, needles, scalpels, etc.

Concerned about the cold nights (lows in the upper 30's, Farenheit) and the poor nutritional status of the first detainee, warmer blankets and more meals were provided.

December 20. General Surgeon and Anesthesiologist arrive from Rhino. Daily, we are encountering difficulty in obtaining guard and translator support to conduct sick call. Priority is being given to interrogation, and we often have to wait hours to treat a few patients. The detainees begin asking to see physicians, and the guards begin passing their requests to us.

December 21. Single detainee arrives, healthy.

December 23. Single detainee is brought from Kandahar Hospital, where we learn that approximately nine Al Qaeda are barricaded in a seige. They are all hospitalized, significantly ill patients. This detainee has a head injury and a femur fracture, which has been treated with traction by way of Steinman pin. He was initially delirious, but after resuscitation, pain control, and building a new traction apparatus out of available materials, his thoughts become coherent. A separate room in a small adobe building in the detainee facility is commandeered to house this detainee, as he is litter-bound.

Again, requests are made for a dedicated medical treatment area within the compound. We calculate that if we receive all nine of the hospitalized patients, plus a similar percentage of ill patients scattered among the 200 detainees planned to be housed here, we can expect 40 daily medical contacts. Medical planner asks for more personnel and more equipment. We are husbanding supplies. Through our persistence in reliably requesting guard and translator support, the guards have begun arranging for our support.

December 26 and 27. Forty-five detainees arrive, eight with significant injuries. One had sustained a penetrating wound to the head, which had been treated by craniotomy, but the wound was infected. The medical team was concerned about a possible epidural abscess, and issues regarding medevac were revisited. We had no neurosurgeon. We were directed to provide the best care available within the facility, but were again told that no detainee would be medevac'd. Seabees began construction of "hardback" tents, one of which was designated as our treatment area. We request a second tent to shelter litter patients. Some detainees complain of lice, and the diagnosis is confirmed. We inform the camp commander, and recommend shaving and de-lousing the detainees.

The Army 250th Forward Surgical Team arrives. They are willing to help out with surgical cases with the detainees, but otherwise "have not been tasked" with detainee care.

December 29. Surgical "Grand Rounds," with the entire team evaluating

injured patients, debriding as possible, and selecting patients likely to benefit from surgical debridement or washout under anesthesia.

December 30. An operating table and anesthesia machine are moved into the KATHF, and plans are set to provide operative intervention the following day.

December 31. Four surgical cases are carried out in the KATHF medical tent. The suspected epidural abscess is explored and found to be a subcutaneous small infection. One hand and two leg explorations, debridements, and washouts are performed.

Heading Out of Town – What Needs to be Done

by CPT. Robert Blankenship, MD, MC, USA

Editor's Note: CPT Blankenship shared the following tips as he prepared in Feb 2003 to deploy with his unit for an unknown amount of time. While the success of these tips has yet to be personally measured, those with prior experience found them to be all reasonable and many essential. Given the short notice you may get prior to a deployment it is probably good to complete some of these tasks now as those final days before leaving can be quite stressful and all you want to do is spend them with family.

1. Get a hard-shelled case / footlocker to pack coffee pot, extra food, books, etc. ENSURE YOU CAN LOCK IT! I packed a coffee pot, soup cooker, tea pot to boil water, snacks, pasta, extra soup, razors, toothbrushes, books, music CDs, extra socks, t-shirts, etc.
2. Get a protective case for you laptop. I recommend ruggedcases.com
3. Consider palm books from Handheldmed.com
4. Will, Power of Attorney, Special Power of Attorney
5. Pay as many bills as you can via electronic bill pay. Less stamps, no thought needed, it is automatic.
6. Ensure you do not have a leased car that will need to be turned in while you are away.
7. Consider changing you insurance policy from what you have to storage only. I am doing that and will save about $300 / 6 months.
8. Ensure your bank card will not expire while you are gone.
9. Paperback books.
10. Ensure you give out your deployment address to your buddies who will send you stuff each month...like more paperback books.
11. Rosen, Tintinnali, and other medical texts come on CD-ROM and they are easier to carry than the real texts.
12. Some airlines are offering discounted tickets for your parents to visit before you deploy. Mine saved $400 last weekend by using that policy. I am unsure if everyone is offering it, but Delta was.
13. Increase your life insurance. USAA and USPA IRA life-insurance companies allow the clause of war - ENSURE YOURS DOES. If not, you will pay and then get nothing if something happens during war. I know not fun to talk about, but ensure you look into it fully.
14. Ensure your taxes are filled before you go. If not, when you deploy you are automatically granted an extension.
15. Save all your receipts for items you buy to deploy with. They are considered a job expense and are therefore tax deductible.
16. Security system. May wish to get your home monitored while away by friends, family, or a security company.
17. Ensure you plan for someone to keep up your house and yard while away.

December 31-January 02. Detainees pour in, up to 62 in one night. Total number is 225. Some groups of detainees arrive in good physical condition. Some arrive with multiple old battle wounds, having received little treatment. Some arrive with prior treatment, even Orthopaedic external fixeters, having been transported from prison hospitals.

Previously, the "Detainee medical team", consisting of four or five people, was able to provide all necessary care every day. During this influx, the team was overwhelmed, and during one short period, dressings were not being changed regularly. A multiple-team approach was adopted, including dressing change, medication administration, sick-call, and ingress teams, with a surgical team as needed. Obviously, more personnel were required, but prompt, effective care was returned.

Medics attached to the Military Police company are recruited to begin dispensing medications.

During sick-call, a 58-year-old detainee is found to be unable to rise due to illness. He is diagnosed with pneumonia and is kept in the medical tent overnight receiving IV antibiotics and fluids. The following day he is greatly improved, and is returned to his cell.

January 02. Fifteen operative cases are performed in the KATHF medical tent. An assembly-line approach proved very effective. IV anesthesia, primarily with ketamine, greatly facilitates efficient evaluation and treatment. Wounds are cleaned, debrided, washed out, and redressed. The patients are recovered for a short time, then returned to their cells. During recovery, the next case is begun.

The International Committee of the Red Cross inspects KATHF, and is very impressed with the level of care provided the detainees. One of the ICRC inspectors is an Anesthesiologist, and actually helps us with our surgical effort, finding charts and assisting with patient movement. He is ebullient.

One very debilitated patient, almost skeletal in appearance, does not regain consciousness after debridement of his foot and perineal injuries. He remains comatose hours after his procedure. Due to his general level of nutrition, a consolidated left lung, and unresponsiveness, the commanders are advised that he may expire. IV fluids, antibiotics, and enteral nutrition by NG tube are begun and carried on through the night. The following day, he awakens and participates in feeding himself.

A corpsman is assigned as "ward clerk," managing charts and assembling medication lists daily.

January 05. The Army Orthopaedist arrives. He examines multiple detainees with orthopaedic injuries, fractures, and non-unions. Unfortunately, since we have no radiology support, he advises that the patients would be better off waiting until they arrive in Guantanamo Bay for definitive care.

January 07. 300 detainees are present. The 555th Forward Surgical Team arrives, in response to the prior request for help with the detainee medical mission. They arrive without any medical supplies, and have been told by their superiors that their mission is to de-louse the detainees. They begin preparations to start de-lousing. They begin to integrate into the daily care of detainees, helping with sick call and surgical cases.

January 07-13. Preparations begin to send detainees to Guantanamo Bay, where a longer-term facility awaits. The medical team collates a list of injured or ill detainees, and prioritizes them for transfer. The KATHF staff attends the sickest detainees first. However, Guantanamo Bay contends that they are not ready to receive these casualties. We argue that we do not have radiology, lab, extended pharmacy, and the ability to treat the suspected malaria and leishmaniasis in some of the detainees. Most telling, the nights in Kandahar are often freezing, and many of our patients have frostbite or other cold injuries. Their injuries may worsen in Kandahar, and would not in Cuba. Even if no further medical action were to occur in Cuba for a few weeks, these detainees would be better off there due to the weather.

The medical effort for the detainees peaks. Dressings are changed every other day for the most part, on about 40 patients daily. Approximately 100 medications are dispensed three times a day. After initial arrival of injured detainees, they are assessed in the Operating Area and debrided or washed out as appropriate. One patient, the debilitated detainee who almost died, has daily dressing changes and packs under anesthesia in the tent.

January 13. 391 detainees are present, the highest number during our tenure. Thirty depart for Guantanamo Bay, Cuba. Those departing are healthy. The next several flights are to have healthy detainees.

January 16. 40 detainees are repatriated to Pakistan. Flights to Guantanamo continue. Also, detainees continue to arrive.

January 20. 15 litter patients depart for Cuba on the 6th flight. The 5th flight contained 30 "walking wounded." The number of dressings to be changed and medications to dispense drops dramatically. The debilitated detainee is not transported to Cuba. He is to be held in Kandahar, expecting repatriation to a hospital in Afghanistan.

> ***"Despite life-threatening conditions and serious injuries present on arrival... all patients have improved, and no fatalities have occurred."***

January 22. Give passdown to three representatives of "Charlie Med," the 101st Airborne's medical company. They are introduced to all aspects of the detainee medical effort. As these four are the advance party, they do not plan to take over all care themselves, but do learn the processes and participate in the care.

The supplies ordered to help in detainee care arrive, one month after being requested.

Approximately half of Navy medical team departs Kandahar.

January 24. The remainder of the Navy medical team departs Kandahar. The Army 250th FST personnel join Charlie Med in daily detainee care and data collection. A total of 431 detainees were screened since the beginning. Despite life-threatening conditions and serious injuries present on arrival and profoundly spartan treatment conditions, all patients have improved, and no fatalities have occurred.

DETAINEE MEDICAL TEAM S

Several teams and individual jobs were defined in providing care to such a large number of detainees daily. The teams included: sick call, dressing change, medication administration, ingress screening, egress screening, and surgical. Individual jobs included data manager, ward clerk, and medical director. Descriptions of function and interaction follow:

1. Sick Call Team. Detainees presented a wide variety of medical complaints (see list below), upon initial screening and during their stay at KATHF. A sick call team addressed these complaints promptly. During ingress screening, when a medical concern was identified, the number of the detainee was recorded on a list. This list was placed in a designated area in the MTT (medical treatment tent), where the sick call team would find it next day. Also, when a detainee made a medical concern known to the guards, the guards would leave that sick-call request in the same place.

Typically, when making rounds through the camp, the sick-call team would receive solicitations for care from additional detainees. These were handled as time allowed, as at times virtually every detainee in a cell would have a request, usually regarding a chronic low-acuity condition. Some sick-call providers preferred to accompany the medication administration team during morning rounds, and take requests for care at that time. This method facilitated the addition of prescriptions to the medication administration list. Usually, the provider would ask for the two sickest detainees in the cell, rather than allow everyone to bring their concerns.

Often, the provider could perform sick-call without entering the cell. Many cases of simple diarrhea and constipation, myalgias, or similar complaints could be treated without a physical examination, knowing that followup was guaranteed. In no case did this policy result in an adverse outcome. Due to the prevalence of diarrhea and constipation and the sheer volume of sick call requests, standard prescription packs were prepared and prescribed as a unit. Ciprofloxacin and imodium were prescribed for simple diarrhea, and bisacodyl was prescribed for constipation.

Medical records were maintained on detainees with significant injuries or medical complaints. If a detainee was healthy, no medical record was generated, due to a very limited supply of record folders (80 were brought from the ship) and progress note forms. When a sick-call complaint history was entirely consistent with an uncomplicated case, a note was not generated, but a count was recorded on the medication sheets. The new notes and counts of uncomplicated complaints were reviewed daily by the data entry personnel, and diagnoses were entered into the database. In retrospect, a more complete record-keeping system would have helped significantly in following trends and tallying diagnoses.

When a physical exam was indicated, the cell was opened and either a guard accompanied the provider into the cell (with all other detainees moving to the other side of the cell), or the ill detainee was brought out of the cell for examination.

Few detainees spoke English. However, the MP's tried to place at least one English-speaking detainee in each cell. This English-speaker could be called to translate, in most cases. Periodically, this English-speaker would be unable to translate, as the detainees came from many different countries and spoke different languages. In this case, either a three-way translation was set up with other detainees or a military translator was provided. Very rarely, evaluations occurred without translation.

2. Dressing Team. Upon ingress screening, detainees requiring wound care were identified and placed on a list. Their dressings were changed during screening, as well. The list was delivered to a specified location in the MTT for the Dressing Team to find the next day. The team leaders would manage the list, adding and dropping detainees as their wounds healed. Typically, dressings were changed every other day, with a few exceptions.

All wounds were initially evaluated next day by the surgeons. The management of most wounds was handed over to the Dressing Team. Wounds needing debridement or washout were treated initially in the MTT OR, and followed by the Surgical Team as appropriate, with the Dressing Team's daily involvement.

The MP's were asked to concentrate detainees needing wound care in as few cells as possible. At one time, two cells were full with detainees needing dressing changes. This greatly facilitated the efficiency of the Dressing Teams.

(Detainee Medical Report Continued on page 14)

Coming Soon to Military Emergency Medicine: Basic and Advanced Disaster Life Support Courses

LTC Bruce D. Adams, MD, MC, USA & Richard B. Schwartz, MD

Introduction:
Inspired by the events of 11 September 2001, a consortium of academic and governmental agencies has produced two important new programs: Basic Disaster Life Support (BDLS™) and Advanced Disaster Life Support (ADLS™). Several of these courses have already been presented at national disaster, EMS and emergency medicine conferences. This article outlines the purpose and scope of the courses, and their potential application to military emergency medicine.

Background on ADLS™:
Over the past three decades, nationally recognized and validated training programs for Advanced Cardiac Life Support (ACLS) and Advanced Trauma Life Support (ATLS) have become a standard part of civilian and U.S. military medical training curricula and continuing medical education (CME). During the 1990's, understanding the evolving need for similar advanced training in the recognition and management of "all-hazards" threats (nuclear, biological, chemical, explosive and natural disasters), several academic institutions developed analogous Advanced Disaster Life Support (ADLS)™ courses. These courses target resident-physicians, critical care/emergency nurses, paramedics, primary care providers, and medical students. Like ACLS and ATLS, these courses are designed with both didactic and skills lab format in a schedule that can be accomplished in a weekend.

After the events of the fall of 2001, the demand for a nationally recognized course in all-hazards training increased. A consortium of academic and governmental institutions agreed to assimilate their pre-existing ADLS™ educational programs under a federal appropriation managed by the Centers for Disease Control and Prevention (CDC). To meet this established need, the National Disaster Life Support Educational Consortium was formed. The advisory board consists of international and domestic leaders in disaster management.

Overall Course Concept:
Like its ACLS and ATLS counterparts, the BDLS™ course is primarily didactic in nature and may be presented in lecture form or through distance learning and computer simulation. ADLS™ makes use of interactive scenarios and drills in which the participants treat simulated patients in a disaster. Through the use of high fidelity mannequins the student can gain experience in treating conditions that they would normally not treat even with years of experience. Hands on labs to practice skills such as decontamination will provide education in areas traditionally lacking in healthcare provider education. The training scenarios will reinforce information presented in BDLS™.

BDLS™
BDLS™ (Basic Disaster Life Support) is the didactic component of the training. The BDLS™ curriculum is developed with an all-hazards approach (recognition and management) to disaster response. Individual chapters remain cohesive by the incorporation of a unifying algorithm called the "D-I-S-A-S-T-E-R paradigm*". Also, the concepts of "MASS Triage**" and Disaster Casualty Zones will also be reinforced continually throughout the chapters. Unlike ACLS and ATLS, participants can receive certification for completion of this didactic portion of the course. Those completing the BDLS™ didactic course can then participate in ADLS™.

This BDLS™ (didactic) part of the course can be delivered in two separate formats. The first format follows the typical ACLS/ATLS model utilizing in-person didactic and interactive lectures with standardized slide sets and an accompanying text. The information can be delivered over two days or over multiple days. The material will also be presented in a distance-learning model via the Internet. Computer generated simulation will be utilized to enforce concepts learned in each chapter.

ADLS™
The ADLS™ training program is focused at the "certified" BDLS™ provider. The ADLS™ training will consist of an intensive single day course. This training is focused on the development of "hands on" skills and allows the provider to apply the knowledge learned in BDLS™ using simulated disasters. The ADLS™ core curriculum includes: Casualty Decontamination and Protective Equipment, Essential Disaster Skills Lab, Clinical Scenarios utilizing high fidelity simulation, and a Table Top Disaster Exercise.

*The Disaster Paradigm™ is a mnemonic that organizes the providers' response and planning of a disaster:
D - Detect
I - Incident Command
S - Scene Security and Safety
A - Assess Hazards
S - Support
T - Triage/Treatment
R - Recovery

** M-Move; A-Assess; S-Sort; S-Send: MASS™ Triage is a disaster triage system that utilizes US military triage categories with a system to triage large numbers of casualties quickly in a mass casualty incident.

Target Audience: The target audience for BDLS and ADLS includes: emergency and critical care physicians and nurses, EMT's, paramedics, pharmacists, allied health professionals and medical students.

Conclusions:
How might BDLS/ADLS impact military emergency medicine in the future? With the formation of the DOD Northern Command with the mission of Homeland Security there exists the potential for increased military presence in civilian disasters. This presence represents new challenges in the coordination between military and civilian systems. As the threat of the use of WMD on civilian populations increases there are data that suggests a significant lack of hospital preparedness to meet this threat. A recent survey (Treat, 2001) suggests that 100% hospitals surveyed were inadequately prepared for a biologic incident and 73% were inadequately prepared for a chemical or nuclear incident. It is also evident that adequate training is lacking in our current educational process for the target groups faced with a WMD incident (Waeckerle, et al, 2001). These data suggest that there is a critical need for these kinds of training programs focused at the responders to mass casualty disasters. Additionally, training focused for hospital and municipality administrators is required to develop a uniform approach to mass casualty management. Military physicians regularly prepare for mass casualty scenarios, and possess advanced knowledge of nuclear, biological and chemical disaster management. .The BDLS/ADLS courses effectively bring together the management strategies of all disaster medicine into a consolidated training platform. Just as ATLS provides a "common language" for trauma professionals to communicate treatment plans, BDLS/ADLS will improve communication between military medical personnel and other governmental relief agencies. The implementation of BDLS/ADLS within the military is still in development. However, the US Army's newly conceived Special Medical Augmentation Response Teams (SMART) are one potential mechanism of applying ADLS to the military. One of the primary SMART missions is to provide expertise in disaster response and augmenting existing clinical resources. The BDLS/ADLS program may streamline this process in the near future.

(Detainee Medical Report Continued from page 12)

When a detainee needing dressing change was placed in another cell, the Dressing Team would ask the MP's for his location, then a special trip was necessary, requiring the other detainees to move to the other side of the cell, bringing the injured detainee out for the team to address the wound. When multiple detainees were scattered in this way, efficiency was greatly reduced.

Because of very limited supply and great demand, dressing supplies were carefully husbanded. The wounds were appropriately dressed, but only the minimum adequate supplies were used. For instance, one roll of Kerlix could typically be divided among three wounds.

3. Medication Administration Team. All teams with providers (Ingress Screening, Sick Call, and Surgical) could prescribe medications. When a note was generated with a medication order, it was given to the Ward Clerk, who would then amend the medication list. Also, when the Sick Call provider accompanied the Medication Administration Team, he could amend the list on the spot for uncomplicated conditions.

The Medication Administration Team dispensed medications three times daily, receiving the list from the Ward Clerk. Initially organized by nurses on our Navy team, this team responsibility was turned over to Army MP medics, who performed admirably.

Whenever possible, prescriptions were written for a defined period, to decrease workload on the team.

4. Ingress Screening Team. Detainees were brought to Kandahar from other prisons via aircraft. Upon arrival, they underwent extensive processing, including a strip search, medical screening, brief interrogation and identification gathering, etc. Afterwards, they were provided with new clothing and blankets, and were moved to their cells. Medical screening consisted of ascertaining the need for medical care, recording identifying marks, scars, and lesions, and recording nutritional status and repair of dentition. The team consisted of one provider and one or two corpsmen or techs.

Screening information was recorded on standardized data sheets. For a brief period, directly inputting the information into a laptop computer was attempted. However, due to lack of backup and a loss of files in another part of the operation, the written data sheets were re-instituted. After screening was complete for the night, the data sheets were taken to the data manager for entry into the database. During the first few screening sessions, three reports were generated. Medical record sheets were kept, a tallied list was provided to the MP's, and a narrative report was generated for the intelligence community. This duplication of effort was streamlined into the single database, distributed to whomever needed the information. Medical record sheets were not begun for healthy detainees. Ill and injured detainees were seen the following day, and records were generated at that time.

When detainees presented with wounds, any dressings were completely taken down, for evaluation of the wound as well as to ensure no weapons were present in the dressing. After assessment, the wound was re-dressed appropriately, but debridement or other intervention was not begun at that time. A list of wounded or ill detainees was maintained during screening, and the list was later placed in the MTT for the surgical, wound care, and sick call teams to see the following day and add to their lists.

Rarely, a detainee would be found to be seriously ill upon presentation. At that time, the screening team would either call another team to treat the detainee, or would treat him themselves after completing screening.

Of note, this team worked almost exclusively at night, on little or no notice, for hours at a time. As often as not, advance information on numbers or medical condition of inbound detainees, or even whether any would be coming that night, was very inaccurate. Occasionally, detainees would be brought in by patrols with no warning at all. As many as 62 detainees were delivered in one night, requiring many hours of work. Consequently, the Ingress Screening Team typically was not scheduled for duties during the day.

5. Egress Screening Team. When detainees were transported from KATHF to Guantanamo Bay, a similar screening process was conducted. Additionally, the detainees were de-loused. Members of the Army's 555th FST sprayed new clothing with permethrin several days in advance, and shaved hair and beards during egress. Detainees to be transported would be identified on the prior day, and their medical records would be collected by the ward clerk and brought to the egress area. During egress, after strip search, a screening exam was again conducted and recorded, and the patient's medical records were added to the other documentation accompanying them. If the detainee had been healthy and no record existed, the screening provider wrote a summary note instead.

6. Surgical Team. Many detainee wounds required surgical evaluation, debridement, exploration, and washout. Most of the wounds had been sustained from two to four weeks prior to arrival in Kandahar, and many were infected or had necrotic material present. A few had come from prison hospitals, and had been treated with external fixeters, some of which were infected as well. Many fractures had not healed. Two patients arrived with surgically debrided below-knee amputations that had not been closed.

On the day after arrival, the surgical team would review information from the screening team. Patients with wounds would be brought into the MTT OR for dressing change and evaluation. If the wound warranted surgical intervention, this would be performed on the spot. The Anesthesiologist or Anesthetist would provide intravenous anesthetic, usually with ketamine, and the Surgeons and OR Techs would perform necessary procedures. Dressings were re-applied while the patient was still anesthetized. Anesthesia recovery occurred inside the MTT, under the care of an Intensive Care Nurse. A highly organized Circulating Nurse proved indispensable, in having the next detainee ready, with chart present, and moving the patients and records through accurately and expeditiously. Records were completed by the Surgical Team and given to the Ward Clerk for filing.

The Surgical Team followed their post-operative patients, all of whom were housed in the medical ward tent. They re-assessed these patients regularly with the Dressing Team during their rounds. Three patients had non-union of both-bones fractures of the forearm or lower leg with significant tissue defects, and the Surgical Team recommended amputation. All of these patients refused amputation.

An Orthopaedic Surgeon was available for consultation from the Army's 250th FST. Due to absence of radiologic support, he felt that surgical intervention for the variety of fractures and non-unions should wait until the patients were transferred to Cuba. The only exception was one patient with a tibia fracture, which the Orthopaedist externally fixed.

7. Data Manager. An individual received data sheets from the Ingress Screening Team, and entered the information into a database. The database contained: detainee number; pulse; dentition repair; level of nutrition; medical requests or injuries; marks, scars, or lesions; need for followup. Daily sick-call complaints were recorded on a separate database, but in the future, this information would be best managed by the data manager. The database was provided to the KATHF staff and Military Intelligence officers to include in their information. The database was used to provide current information to a variety of commanders, and served in prioritizing detainees for transport to Guantanamo. Computers were in short supply during our tenure, and officers of the Air Force AirEvac Liaison Team volunteered to manage the database on one of their computers.

8. Ward Clerk. An individual was given the job of managing the charts and documentation of detainee medical care, as well as preparing the daily medication dispensing sheets. He organized the charts, pulled them for surgeries or when the detainees were scheduled for departure, and filed new notes. When notes were generated during sick call or surgery, he would review them, note new prescriptions, and transcribe them onto the medication sheets. He also was responsible for maintaining an adequate supply of consumables and pharmaceuticals in the MTT. As detainee medical care did not have a separate supply chain, he obtained these materials from the combat support supplies.

9. Medical Director. An individual senior officer coordinated medical efforts and relationships with interested parties. He negotiated appropriate workspace and ward space. He served as liaison with MP's to reliably obtain guard support and establish reasonable practices by guards when accompanying medical teams. He also served as liaison with interpreters. The Medical Director represented the medical needs of detainees to policymakers, and recommended actions such as medevac to the MEU Surgeon. He was responsible for prioritizing detainees for medevac and working with airevac planners as the schedule and priorities changed daily. He maintained a "low tech" paper database of medical conditions upon ingress and from sick call according to detainee number, which backed up the computer database and served as a more accurate, if more cumbersome, record of medical conditions. The data below are from this database.

STATISTICS

These statistics apply for the period of 18 December 2001until 20 January 2002

Number of incoming detainees screened: 431
Number of wartime penetrating, blunt, or environmental injuries: 116
Patients with medical complaints on ingress screening: 184
Patients with traumatic findings on ingress screening: 75
Approximate number of dressing changes: 1,500
Approximate number of medications dispensed: 3,000
Total number of "detainee days" (each detainee's duration of stay was calculated, and these were summed): 6,638
Litter patients: 15

The following table reports numbers of traumatic or environmental injuries found during detainee ingress screening. "Penetrating" injury is one caused by a missile or knife, penetrating the skin. Gunshot wounds and fragmentation injuries are included. "Blunt" injuries are sustained by falls, automobile accidents, or other non-penetrating causes.

Traumatic Injuries on Ingress Screening

Anatomic Location	Penetrating	**Penetrating (% of total)**	Blunt	**Blunt (% of total)**	Total
Lower Extremity	**42**	**42.4**	**4**	**4**	**46**
Upper Extremity	**20**	**20.2**	**5**	**5.1**	**25**
Back/Flank/Buttock	9	9.1	0	0	9
Chest	8	8.1	0	0	8
Head	1	1	5	5.1	6
Abdomen	3	3	0	0	3
Eye	2	2	0	0	2
Total	85	85.6	14	14.2	99

Fractures (penetrating)	17
Fractures (blunt)	7
Amputations	4
Neurologic injury	4
Wound infections	18
Prior operative ortho intervention	6
Fracture non-union (not including fractures with hardware)	5
Cold injuries	16

Regarding the table, gun shot Wound's (GSW's) with entry and exit wounds were counted as one wound. If the GSW traversed two anatomic regions, the entry wound was listed. If the bullet reentered, a second wound was counted. Both bone fractures of the forearm or of the lower leg were counted as a single fracture. Multiple fragment wounds to one region were counted as one wound. Isolated pain or sprains were not counted. Significant abrasions and lacerations were counted. Incidental abrasions were not counted. Amputations were not counted as fractures.

The following table reports numbers of non-traumatic, non-environmental conditions found during detainee ingress screening.

Nontraumatic Conditions on Ingress Screening

Complaint	Total
Somatic Pains/ "Rheumatism"	34
Abdominal Pain/PUD/Dyspepsia	16
Diarrhea	13
EENT Complaints (Headache, Nose Bleed, etc)	11
Chest Pain	4
Fever	4
Episodic fever consistent with malaria	4
Kidney Pain	4
Constipation	3
Skin Lesions consistent with leishmaniasis	3
Mental instability, psychiatric disturbance	2
Weakness/fainting	2
Diabetes	2
Hemorrhoids	2
Dental pain	1
Fleas	1
Hypertension	1
Dysuria	1

Detainees complained of a large number of medical conditions during their stay at Kandahar. Every complaint was addressed by the Sick Call team. Evaluations of medical conditions requiring followup or further evaluation, or those of interest, were recorded in the patient record. Conditions that were found to be routine, with no likelihood of further intervention, were usually not recorded, especially if no intervention was begun at all. This was done due to the sheer volume of complaints and paucity of supplies and personnel. Unfortunately, this practice precluded an accurate count of sick-call complaints, especially very common ones such as somatic aches and diarrhea. However, all significant conditions were recorded.

Of conditions recorded, the largest category was somatic pain, accounting for 31%. Some complained of generalized aches, especially when cold. Others had localized pain in joints, muscles, chest, or abdomen. These patients were evaluated carefully, especially when complaining of abdominal or chest pain. Every detainee with chest pain was found to have history and physical findings entirely consistent with chest wall pain. However, neither radiography nor electrocardiography were available at Kandahar. No adverse outcomes were noted. One detainee with abdominal pain was felt to have possible biliary disease. Our general surgeon evaluated and followed this patient. The pain resolved slowly over the course of several days with symptomatic treatment.

The second most common symptom recorded was diarrhea, accounting for 15%

of complaints. Very widespread among inbound detainees, this condition was promptly treated with three days of ciprofloxacin and imodium as needed. The prevalence of diarrhea gradually decreased, and by January 19, no further cases were brought to our attention. Approximately 8% of recorded complaints were of constipation. This was treated with bisacodyl with near-universal success.

One detainee was found to be too ill to rise during morning rounds. He had arrived two days prior and had no complaints at that time. On evaluation he was weak and breathing rapidly, with a pulse of 140. This detainee was diagnosed with pneumonia and was treated with IV antibiotics and hydration in the medical treatment tent overnight. He was dramatically improved the following day, and was returned to his cell. He continued to improve on followup.

SPECIAL ISSUES

1. Medevac. Several detainees had medical conditions exceeding our ability to definitively treat. For instance, several had fracture non-unions requiring operative Orthopaedic intervention. We had no radiology support, and our operating area was located in an open-air tent. Medically, these detainees rated evacuation to another facility able to perform the indicated procedures. Medevac was not time-critical, as the injuries had occurred about a month prior to arrival, on average. The wounds were treated with immobilization and standard wound care, and the soft tissues continued to heal. One patient was critically ill upon arrival, and we expected him to expire. In every instance, upon recommending evacuation to treat, we were directed to provide the best care using available assets, but were denied permission to medevac. Rationale was based on the dangerous behavior of prior similar prisoners in other facilities, stabbing guards and physicians, and detonating hidden explosives. As no secure transport or medical facility was available, the detainees were kept at KATHF until such transport and facilities became available.

> ***"Predictions of how many detainees we would receive in any given night were notoriously unreliable."***

2. Ethics of treating detainees. Upon being notified of the detainee medical mission, some members (a minority) of the medical team expressed a reluctance, or even resistance, towards "using our gear to treat those people instead of our guys." Some did not wish to treat enemy personnel at all. Others were very concerned about expending our very limited supply of dressings and medications, leaving us with little or nothing for U.S. or coalition casualties. Some also were willing to use the designation of "detainee" as an excuse to ignore Geneva Convention requirements for medical care.

   The final decision: the detainees would be treated appropriately using available medications and supplies in a frugal fashion. For instance, no extra gauze would be used for padding. Non-soiled elastic wraps would be re-used on the same patient. Medications would be prescribed for limited duration when appropriate. Resupply was requested right away, anticipating rapid supply use. Personnel were informed of Geneva Convention requirements, and were instructed in the ethics and pragmatic benefits of treating enemy personnel with compassion. We're the good guys, after all.

3. Detainee "Doctors". Three detainees identified themselves as "doctors." These individuals were questioned regarding their training and experience, and were questioned regarding their approaches to certain conditions common to the detainees. One individual was evasive about his formal training, and when asked how he would treat an infected gunshot wound, responded that he would use accupuncture. If that wasn't successful, "In Shallah." The second "candidate" did not wish to participate in medical care. The third had some months of formal training and verbalized a competent functional knowledge in basic outpatient care.

   The Geneva Convention was reviewed. This document stated that prisoners who were medical personnel could be required by the detaining authority to treat other prisoners. The Convention did not require the detaining authority to allow these personnel to treat other prisoners. Neither the KATHF commanders nor we wished to allow the detainee to walk the camp going from cell to cell. As he could then only be allowed to treat personnel in one cell and not others, we determined that the potential benefit would be insignificant and could even cause disquiet in the other cells. Therefore, we did not allow detainees to act as medical personnel.

4. Use of assets. As mentioned above, medical supplies were very limited. Though we were frugal with supplies, they were consumed at a rapid rate. Some medications and bandaging materials were completely expended in approximately three weeks. Though we requested expeditious resupply, these supplies arrived almost exactly one month after request, after most of the medical effort was completed. The Army's 250th FST provided supply for U.S. and coalition combat casualties, when necessary.

   To supply a similar effort in the future, we recommend a surgical and anesthesia block, and a BAS block. Our detainees came from other facilities, and no fresh traumatic wounds were encountered. Consequently, the trauma-receiving emphasis present in STP blocks would be unnecessary to supply a detainee medical system.

5. Predictions of detainee number and injury. Predictions of how many detainees we would receive in any given night were notoriously unreliable. On some nights, anticipated flights wouldn't show up at all. On other occasions, large numbers of detainees would arrive without warning. Similarly, number and type of injury anticipated in an incoming group usually had little accuracy. Therefore, our detainee ingress screening teams stood watch regardless of anticipated ingress, and would proceed to the ingress tent only when the detainees had physically landed at the field. Also, they always brought bandages and similar supplies.

6. Body Cavity Search. During ingress screening, every detainee was strip-searched. As part of this search, a body-cavity search (rectal) was carried out. Initially, the security personnel understood that this was not a medical examination; it was a security exam. We were not looking for prostate cancer; we were looking for grenades. Security personnel were briefed on appropriate methods of examining the rectum by the medical provider, and performed the exam under observation of the provider and security officers.

   When the Army took over security screening, their personnel refused to perform the rectal search, and our medical personnel were required to perform this search. Finally, after many discussions about this issue, a compromise was reached; the medical personnel would perform the search on ingress, and the Army security personnel would conduct the exam on egress. Soon afterwards, the exam was no longer required on egress.

   This exam is entirely appropriate in screening potentially hostile detainees who have been known to conceal weapons. However, for perspective, none of the 431 detainees had any objects in their rectums, and the reaction displayed by most of them during the exam suggests that the rectum is not likely to be used by them for smuggling weapons. Further debate and decision is requested on this issue.

7. Security Concerns. Opinion varied among both medical and security

personnel regarding safe conduct of medical personnel during care of detainees. Some were willing to have medical personnel moving freely among a large number of detainees with minimal guard. Others preferred to have every detainee removed from the cell by two guards and brought to a secure location for medical evaluation and care. Ultimately, a compromise was reached. When caring for detainees in the Ward Tent, who required regular dressing changes and many of whom were not able to walk, medical personnel were allowed to move freely among the detainees, with two guards standing by. However, when caring for ambulatory detainees from another cell, all other detainees were sent to the far end of the cell and the one to be treated walked to the gate and knelt. At that time, either the provider entered the cell, or the detainee was brought outside for evaluation or treatment. When another detainee was used to translate, he was allowed to stand close enough in the cell to allow communication.

With this method of insuring secure care, no detainee attempted to harm any medical personnel. We cannot know whether they would have done so if given the opportunity, but one prisoner at another facility is known to have attacked and killed a physician caring for him. Further, a variety of sharpened sticks or pieces of metal were occasionally found among the detainees at Kandahar.

Respectfully submitted,

CDR James V. Ritchie MC

With input from LCDR Michael Harrison, MC, CDR Robert Hinks, MC, LCDR Gus Carreno, MC, LT Timothy Wilks, MC, LT Paul Villaire, NC, LT Michael Pike, NC, LT Alan Heffner, MC, LT Bradley Buchanan, NC, LTJG Michael Terp, MSC , and LTJG Michael Oviatt, NC.

Legal & Financial Planning

By LtCol. Linda Lawrence, MD, USAF, MC

One of the most stressful aspects about preparing to deploy can be making all the necessary financial and legal arrangements necessary. The best time to prepare is NOW. Yes I say that for those of you who don't even have orders in hand. Deployment is a fact of life for the military and none of us ever know for sure when we may be called to serve. I can also tell you those final days you will not want to spend making these arrangements.

I have gathered the following information from personal experience, USAA website and Military.com website. For those of you who are new to the military and not familiar with USAA insurance and financial services company I encourage you to check it out. Only military members and their families are eligible. Because the company deals only with military members they are deeply familiar with the unique aspects of military life and tailor programs to support military members. In addition I have to personally say I have been impressed over the years with their customer service. I say this not as an add for USAA but just my two cents for what it is worth – yes some who know me may say two cents is over priced. Check them out at www.usaa.com .

Another resource you may want to become familiar with is the Military.com a website with wide variety of military information to include military benefits and recent news. I registered at work and get weekly emails with headlines. Amazing what deals you may find in the civilian sector that you didn't know you were eligible for while in uniform. In addition there are updates on issues and news that don't seem to trickle down the information chain that well. You can register for free at www.military.com .

Now for the nuts and bolts of what you need to do pre-deployment to get your affairs in order. At the end I have attached the USAA pre-deployment and deployment checklist from their website.

Make a Will: The military has already required you to name beneficiaries in the event of your incapacity or death in the line of duty. However, this is not meant to replace a legal will which is much more detailed and inclusive. Some units require those who are eligible to be deployed to create a will just in case. Makes good sense as this can take a little time and at least two trips to the legal office. Plus discussing such issues with your spouse on the eve of the deployment can be quite a downer. If you have children hopefully you and your spouse have already created a will.

Power of Attorney: Unlike a will you often will not have an open standing power of attorney for all your financial and legal affairs. Whether you will need one while gone depends on how you have your finances established and what may occur during your absence – such as selling a home or car. A power of attorney document can be very specific or more general but basically gives an agent authority to act on your behalf in your absence, depending upon the scope and terms of the document.

This agent or "attorney-in-fact" can be your spouse, a relative or a trusted friend. Best to do this under the guidance of your local military legal office who can draw up the forms for you and provide you with legal advice to suit your situation. USAA provides a limited power of attorney restricted for USAA business and transactions only that can be downloaded from website and completed under notary signature.

Taxes: While the word taxes makes many of us want to run screaming and can lead to staffing shortages on April 15 when it comes to deploying there is a lot of good news. While you still have to eventually pay taxes you will be pleased to learn there are a lot of exclusions you qualify for while deployed. You also can be eligible for an extension if your deployment is over the mandatory Apr 15 deadline. Definitely take the time to speak to the representative at your base legal office who can outline all your benefits and responsibilities. Also if you didn't read your LES monthly before most definitely start reading them once you are deployed and be sure you are getting everything you are entitled.

Here are a few of the exclusions from your taxable income while serving in a combat zone. These apply for each month you are in the combat zone even if only for one day that month. Took me awhile when I was deployed to figure out why so many VIPs visited our base at the end of the month and it can make that week delay returning all the more palatable if you have to flip the calendar to the next page to find your departure date.

- Active-duty pay
- Imminent-danger or hostile-fire pay
- Your re-enlistment bonus (if it occurs in a month you serve in a combat zone). A part of medical pay bonuses may be eligible and amount depends on your rank – see below.
- Awards for suggestions you made when you served in a combat zone.
- You can also exclude military pay earned while you are hospitalized as a result of wounds, disease, or injury incurred in the combat zone. The exclusion of your military pay while you are hospitalized does not apply to any month that begins more than 2 years after the end of combat activities in that combat zone. Your hospitalization does not have to be in the combat zone.

As commissioned officer, you may exclude your pay according to the above rules. However, the amount of your exclusion is limited to the highest rate of enlisted pay (plus imminent danger/hostile fire pay you received) for each month during any part of which you served in a combat zone or were hospitalized as a result of your service there. Currently the highest is $4757.40 for an E9 with 26+ years and $5703.30 for warrant officer. I am not clear which

they use to calculate. More information can be found at www.military.com .

Paying Bills: At this point in our careers most if not all of us have established bank accounts, credit cards and significant loans and bills. While you probably won't need to run out and open a credit card account for personal expenditures you will need to worry how to pay your bills. You may want to consider paying your bills online. There are services that allow you to do this for automatic payment.

Banking: If you don't regularly use an ATM card be sure you know how to when deployed. Not a time to forget the pin # or how to access. The fees for a cash advance off your government credit card or ATM card can be filed on your travel voucher. Check your account to see if you can perform electronic fund transfers. It is more and more common to have computer access while deployed. Also may want to consider obtaining a debit card. It is like a plastic check and one less bill to pay. Also USAA gives members cash back on qualified purchases.

USAA credit card lists some special advantages when deployed.

- When you're deployed on a military campaign, USAA will rebate all the interest on your card for the entire length of your involvement.
- On all other deployments, even training exercises or sea duty, we'll lower the annual percentage rate (APR) on your card to 6% for up to nine months.

If you are going to an established base you may find banking services available. You will need a personal check to open an account. This can be very beneficial as ATM machines aren't as reliable away even on military bases as in the US. Always save your ATM receipts and be sure to count your money when you do get it from a machine. And don't wait until you are down to your last five dollars – for sure that will be the week the machines don't work.

Life Insurance: Many insurance benefits are available while deployed or opportunities to reduce expenses. To begin with you want to ensure you have adequate life insurance coverage before you depart and benefits are eligible if event occurs as a result of war.

The military provides life insurance, up to the limits of your Servicemembers' Group Life Insurance (SGLI) policy, usually $250,000 for you, $100,000 for your spouse and $10,000 for each child. In addition, your family is eligible for a monthly benefit paid to your spouse and minor children by the Veteran's Administration if you die while on active duty. This benefit is called Dependency and Indemnity Compensation (DIC). (Taken from USAA website)

Does this amount seem adequate for your family if you fail to return? It might be a good time to sit down with a representative and learn more about what is considered appropriate coverage. USAA has contracts that do not have war exclusions in their base contracts. The number for more information is USAA Life at 1-800-531-8685. Check your contract if you use another carrier.

Property Insurance: Whether you live in government quarters, rent or own a home, you may need to make changes to your property insurance coverage before you leave on deployment. This is especially important if you are single or your spouse spends time away from home, leaving your possessions vulnerable to theft. If you are single and concerned about leaving your home unattended consider having one of the techs or nurses you trust live in your home while you are gone. This can also be a way to take care of your pet while gone. If you do this be sure you have appropriate property and casualty insurance coverage in case someone has an accident in your home and is injured.

Might also be the time to get that home security system you have debated about purchasing. Homes that are protected by professionally monitored security systems are three times less likely to be the target of a burglary per USAA. In addition installing a monitored home security system can also make you eligible for a credit of up to 15% on your property insurance.

Auto Insurance: If you're putting your car in storage during your deployment, or lending it to a friend or relative, be sure to contact your carrier to see what coverages apply. Since some storage facilities carry their own insurance, you may need less coverage. If the storage facility does not carry insurance you may want to continue your own coverage to protect your vehicle. Also, in some states you may reduce or delete your liability and collision coverage if the vehicle will not be driven for an extended period of time.

Another auto benefit I found while deployed was access for my spouse to have free oil change at the base auto garage. Be sure you attend the family services outbrief before you depart to find out what benefits like these and others your family may be eligible for regardless of whether you reside in base housing or off base.

Medical Benefits: While yours will be taken care of while you are deployed be sure your family is properly enrolled in DEERS and TRICARE before you depart. If you haven't accessed the system recently probably best to check status prior to departure. I know in my region we have had many problems the past several months and several who thought they were enrolled found themselves no longer enrolled or not where they planned. Also if your family plans to move away to be closer to other family members while you are gone be sure you switch them to the new region.

On a medically related note go ahead and learn about medical retirement for imminent death if you aren't already aware of how it works. As emergency physicians we should all know about this but I learned about it while deployed. If an active duty member appears they are going to die you can through the local chain of command get them medically retired so there family receives better benefits. There are exclusions and rules and don't assume those around you will know all the details.

While the above is by no way an all-inclusive guide hopefully it provides some things to think about. Attached are checklists from USAA, which you can use to help you with some other details. GSACEP is developing an operational medicine web page and this and other information will be placed on that web page. If you have other information that would be beneficial to be included or pearls of wisdom please share them by contacting the chapter at webmaster@gsacep.org .

Pre-Deployment Checklist

Copied from USAA website at www.usaa.com

___ Set up a folder to hold receipts and financial documents in your absence.
___ Consider developing a financial plan to make sure your legal, financial and insurance needs are in order.

Legal

___ Consider giving your spouse, relative or trusted friend a legal power of attorney to handle affairs in your absence.
___ See your legal office about making a will.
___ Consider a living will for you and your spouse and make sure your spouse, relative or friend is aware of its contents and location.
___ Place valuable documents that you don't use regularly in a safe-deposit box.

Financial

___ Review your financial arrangements and, if necessary, make sure all financial accounts are shared with your spouse.
___ Record financial account numbers and be prepared to bring that record with you when you deploy.
___ Review your financial needs now and ensure that any loans that may be needed are pre-arranged.
___ Review investment options and consider tax-exempt income from deployment.

See pneumonia. Think ROCEPHIN.

Adverse clinical effects in adults occur at levels similar to those of other cephalosporins: diarrhea (2.7%), rash (1.7%) and local reactions (≤1%). ROCEPHIN is contraindicated in patients with a known allergy to cephalosporins and should be used cautiously in penicillin-sensitive patients.

Please see adjacent page for summary of complete product information, which includes a list of indications, susceptible organisms and adverse reactions.

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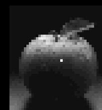

Once-a-day

Rocephin® IV·IM

ceftriaxone sodium

Usual adult daily dosage: 1 to 2 g once a day

Strength. Longevity. Trust.

Rocephin® IV·IM
ceftriaxone sodium

Before prescribing, please see complete product information, a summary of which follows:

INDICATIONS AND USAGE: Rocephin is indicated for the treatment of the following infections when caused by susceptible organisms:

LOWER RESPIRATORY TRACT INFECTIONS caused by Streptococcus pneumoniae, Staphylococcus aureus, Haemophilus influenzae, Haemophilus parainfluenzae, Klebsiella pneumoniae, Escherichia coli, Enterobacter aerogenes, Proteus mirabilis or Serratia marcescens.

ACUTE BACTERIAL OTITIS MEDIA caused by Streptococcus pneumoniae, Haemophilus influenzae (including beta-lactamase producing strains), and Moraxella catarrhalis (including beta-lactamase producing strains).

NOTE: In one study lower clinical cure rates were observed with a single dose of Rocephin compared to 10 days of oral therapy. In a second study comparable cure rates were observed between single dose Rocephin and the comparator. The potentially lower clinical cure rate of Rocephin should be balanced against the potential advantages of parenteral therapy.

SKIN AND SKIN STRUCTURE INFECTIONS caused by Staphylococcus aureus, Staphylococcus epidermidis, Streptococcus pyogenes, Viridans group streptococci, Escherichia coli, Enterobacter cloacae, Klebsiella oxytoca, Klebsiella pneumoniae, Proteus mirabilis, Morganella morganii,* Pseudomonas aeruginosa, Serratia marcescens, Acinetobacter calcoaceticus, Bacteroides fragilis* or Peptostreptococcus species.

URINARY TRACT INFECTIONS (complicated and uncomplicated) caused by Escherichia coli, Proteus mirabilis, Proteus vulgaris, Morganella morganii or Klebsiella pneumoniae.

UNCOMPLICATED GONORRHEA (cervical/urethral and rectal) caused by Neisseria gonorrhoeae, including both penicillinase- and nonpenicillinase-producing strains, and pharyngeal gonorrhea caused by non-penicillinase-producing strains of Neisseria gonorrhoeae.

PELVIC INFLAMMATORY DISEASE caused by Neisseria gonorrhoeae. Rocephin, like other cephalosporins, has no activity against Chlamydia trachomatis. Therefore, when cephalosporins are used in the treatment of patients with pelvic inflammatory disease and Chlamydia trachomatis is one of the suspected pathogens, appropriate antichlamydial coverage should be added.

BACTERIAL SEPTICEMIA caused by Staphylococcus aureus, Streptococcus pneumoniae, Escherichia coli, Haemophilus influenzae or Klebsiella pneumoniae.

BONE AND JOINT INFECTIONS caused by Staphylococcus aureus, Streptococcus pneumoniae, Escherichia coli, Proteus mirabilis, Klebsiella pneumoniae or Enterobacter species.

INTRA-ABDOMINAL INFECTIONS caused by Escherichia coli, Klebsiella pneumoniae, Bacteroides fragilis, Clostridium species (Note: most strains of Clostridium difficile are resistant) or Peptostreptococcus species.

MENINGITIS caused by Haemophilus influenzae, Neisseria meningitidis or Streptococcus pneumoniae. Rocephin has also been used successfully in a limited number of cases of meningitis and shunt infection caused by Staphylococcus epidermidis* and Escherichia coli.*

*Efficacy for this organism in this organ system was studied in fewer than ten infections.

SURGICAL PROPHYLAXIS: The preoperative administration of a single 1 gm dose of Rocephin may reduce the incidence of postoperative infections in patients undergoing surgical procedures classified as contaminated or potentially contaminated (eg, vaginal or abdominal hysterectomy or cholecystectomy for chronic calculous cholecystitis in high-risk patients, such as those over 70 years of age, with acute cholecystitis not requiring therapeutic antimicrobials, obstructive jaundice or common duct bile stones) and in surgical patients for whom infection at the operative site would present serious risk (eg, during coronary artery bypass surgery). Although Rocephin has been shown to have been as effective as cefazolin in the prevention of infection following coro-nary artery bypass surgery, no placebo-controlled trials have been conducted to evaluate any cephalosporin antibiotic in the prevention of infection following coronary artery bypass surgery.

When administered prior to surgical procedures for which it is indicated, a single 1 gm dose of Rocephin pro-vides protection from most infections due to susceptible organisms throughout the course of the procedure.

Before instituting treatment with Rocephin, appropriate specimens should be obtained for isolation of the causative organism and for determination of its susceptibility to the drug. Therapy may be instituted prior to obtaining results of susceptibility testing.

CONTRAINDICATIONS: Rocephin is contraindicated in patients with known allergy to the cephalosporin class of antibiotics.

WARNINGS: BEFORE THERAPY WITH ROCEPHIN IS INSTITUTED, CAREFUL INQUIRY SHOULD BE MADE TO DETERMINE WHETHER THE PATIENT HAS HAD PREVIOUS HYPERSENSITIVITY REACTIONS TO CEPHALOSPORINS, PENICILLINS OR OTHER DRUGS. THIS PRODUCT SHOULD BE GIVEN CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. ANTIBIOTICS SHOULD BE ADMINISTERED WITH CAUTION TO ANY PATIENT WHO HAS DEMONSTRATED SOME FORM OF ALLERGY, PARTICULARLY TO DRUGS. SERIOUS ACUTE HYPERSENSITIVITY REACTIONS MAY REQUIRE THE USE OF SUBCUTANEOUS EPINEPHRINE AND OTHER EMERGENCY MEASURES.

Pseudomembranous colitis has been reported with nearly all antibacterial agents, including cef-triaxone, and may range in severity from mild to life-threatening. Therefore, it is important to consider this diagnosis in patients who present with diarrhea subsequent to the administration of antibacterial agents.

Treatment with antibacterial agents alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by Clostridium difficile is one primary cause of “antibiotic-associated colitis.”

After the diagnosis of pseudomembranous colitis has been established, appropriate therapeutic measures should be initiated. Mild cases of pseudomembranous colitis usually respond to drug discontinuation alone. In moderate to severe cases, consideration should be given to management with fluids and electrolytes, protein supplementation and treatment with an antibacterial drug clinically effective against Clostridium difficile colitis.

PRECAUTIONS: General: Although transient elevations of BUN and serum creatinine have been observed, at the recommended dosages, the nephrotoxic potential of Rocephin is similar to that of other cephalosporins.

Ceftriaxone is excreted via both biliary and renal excretion. Therefore, patients with renal failure normally require no adjustment in dosage when usual doses of Rocephin are administered, but concentrations of drug in the serum should be monitored periodically. If evidence of accumulation exists, dosage should be decreased accordingly.

Dosage adjustments should not be necessary in patients with hepatic dysfunction; however, in patients with both hepatic dysfunction and significant renal disease, Rocephin dosage should not exceed 2 gm daily without close monitoring of serum concentrations.

Alterations in prothrombin times have occurred rarely in patients treated with Rocephin. Patients with impaired vitamin K synthesis or low vitamin K stores (eg, chronic hepatic disease and malnutrition) may require monitoring of prothrombin time during Rocephin treatment. Vitamin K administration (10 mg weekly) may be necessary if the prothrombin time is prolonged before or during therapy.

Prolonged use of Rocephin may result in overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Rocephin should be prescribed with caution in individuals with a history of gastrointestinal disease, especially colitis.

There have been reports of sonographic abnormalities in the gallbladder of patients treated with Rocephin; some of these patients also had symptoms of gallbladder disease. These abnormalities appear on sonography as an echo without acoustical shadowing suggesting sludge or as an echo with acoustical shadowing which may be misinterpreted as gallstones. The chemical nature of the sonographically detected material has been determined to be predominantly a ceftriaxone-calcium salt. **The condition appears to be transient and reversible upon discontinuation of Rocephin and institution of conservative management.** Therefore, Rocephin should be discontinued in patients who develop signs and symptoms suggestive of gallbladder disease and/or the sonographic findings described above.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Carcinogenesis: Considering the maximum duration of treatment and the class of the compound, carcinogenicity studies with ceftriaxone in animals have not been performed. The maximum duration of animal toxicity studies was 6 months.

Mutagenesis: Genetic toxicology tests included the Ames test, a micronucleus test and a test for chromosomal aberrations in human lymphocytes cultured in vitro with ceftriaxone. Ceftriaxone showed no potential for mutagenic activity in these studies.

Impairment of Fertility: Ceftriaxone produced no impairment of fertility when given intravenously to rats at daily doses up to 586 mg/kg/day, approximately 20 times the recommended clinical dose of 2 gm/day.

Pregnancy: Teratogenic Effects: Pregnancy Category B. Reproductive studies have been performed in mice and rats at doses up to 20 times the usual human dose and have no evidence of embryotoxicity, fetotoxicity or teratogenicity. In primates, no embryotoxicity or teratogenicity was demonstrated at a dose approximately 3 times the human dose.

There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproductive studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nonteratogenic Effects: In rats, in the Segment I (fertility and general reproduction) and Segment III (perinatal and postnatal) studies with intravenously administered ceftriaxone, no adverse effects were noted on various reproductive parameters during gestation and lactation, including postnatal growth, functional behavior and reproductive ability of the offspring, at doses of 586 mg/kg/day or less.

Nursing Mothers: Low concentrations of ceftriaxone are excreted in human milk. Caution should be exercised when Rocephin is administered to a nursing woman.

Pediatric Use: Safety and effectiveness of Rocephin in neonates, infants and pediatric patients have been established for the dosages described in the DOSAGE AND ADMINISTRATION section. In vitro studies have shown that ceftriaxone, like some other cephalosporins, can displace bilirubin from serum albumin. Rocephin should not be administered to hyperbilirubinemic neonates, especially prematures.

ADVERSE REACTIONS: Rocephin is generally well tolerated. In clinical trials, the following adverse reactions, which were considered to be related to Rocephin therapy or of uncertain etiology, were observed:

LOCAL REACTIONS—pain, induration and tenderness was 1% overall. Phlebitis was reported in <1% after IV administration. The incidence of warmth, tightness or induration was 17% (3/17) after IM administration of 350 mg/mL and 5% (1/20) after IM administration of 250 mg/mL.

HYPERSENSITIVITY—rash (1.7%). Less frequently reported (<1%) were pruritus, fever or chills.

HEMATOLOGIC—eosinophilia (6%), thrombocytosis (5.1%) and leukopenia (2.1%). Less frequently reported (<1%) were anemia, hemolytic anemia, neutropenia, lymphopenia, thrombocytopenia and prolongation of the prothrombin time.

GASTROINTESTINAL—diarrhea (2.7%). Less frequently reported (<1%) were nausea or vomiting, and dysgeusia. The onset of pseudomembranous colitis symptoms may occur during or after antibacterial treatment (see WARNINGS).

HEPATIC —elevations of SGOT (3.1%) or SGPT (3.3%). Less frequently reported (<1%) were elevations of alkaline phosphatase and bilirubin.

RENAL—elevations of the BUN (1.2%). Less frequently reported (<1%) were elevations of creatinine and the presence of casts in the urine.

CENTRAL NERVOUS SYSTEM —headache or dizziness were reported occasionally (<1%).

GENITOURINARY—moniliasis or vaginitis were reported occasionally (<1%).

MISCELLANEOUS—diaphoresis and flushing were reported occasionally (<1%).

Other rarely observed adverse reactions (<0.1%) include leukocytosis, lymphocytosis, monocytosis, basophilia, a decrease in the prothrombin time, jaundice, gallbladder sludge, glycosuria, hematuria, anaphylaxis, bronchospasm, serum sickness, abdominal pain, colitis, flatulence, dyspepsia, palpitations, epistaxis, biliary lithiasis, agranulocytosis, renal precipitations and nephrolithiasis.

OVERDOSAGE: In the case of overdosage, drug concentration would not be reduced by hemodialysis or peritoneal dialysis. There is no specific antidote. Treatment of overdosage should be symptomatic.

DOSAGE AND ADMINISTRATION: Rocephin may be administered intravenously or intramuscularly.

ADULTS: The usual adult daily dose is 1 to 2 grams given once a day (or in equally divided doses twice a day) depending on the type and severity of infection. The total daily dose should not exceed 4 grams.

If *Chlamydia* trachomatis is a suspected pathogen, appropriate antichlamydial coverage should be added, because ceftriaxone sodium has no activity against this organism.

For the treatment of uncomplicated gonococcal infections, a single intramuscular dose of 250 mg is recommended.

For preoperative use (surgical prophylaxis), a single dose of 1 gram administered intravenously 1/2 to 2 hours before surgery is recommended.

PEDIATRIC PATIENTS: For the treatment of skin and skin structure infections, the recommended total daily dose is 50 to 75 mg/kg given once a day (or in equally divided doses twice a day). The total daily dose should not exceed 2 grams.

For the treatment of acute bacterial otitis media, a single intramuscular dose of 50 mg/kg (not to exceed 1 gram) is recommended (see INDICATIONS AND USAGE).

For the treatment of serious miscellaneous infections other than meningitis, the recommended total daily dose is 50 to 75 mg/kg, given in divided doses every 12 hours. The total daily dose should not exceed 2 grams.

In the treatment of meningitis, it is recommended that the initial therapeutic dose be 100 mg/kg (not to exceed 4 grams). Thereafter, a total daily dose of 100 mg/kg/day (not to exceed 4 grams daily) is recommended.The daily dose may be administered once a day (or in equally divided doses every 12 hours). The usual duration of therapy is 7 to 14 days.

Generally, Rocephin therapy should be continued for at least 2 days after the signs and symptoms of infection have disappeared. The usual duration of therapy is 4 to 14 days; in complicated infections, longer therapy may be required.

When treating infections caused by Streptococcus pyogenes, therapy should be continued for at least 10 days.

No dosage adjustment is necessary for patients with impairment of renal or hepatic function; however, blood levels should be monitored in patients with severe renal impairment (eg, dialysis patients) and in patients with both renal and hepatic dysfunctions.

Revised: September 2000
ROB1

Rx only

Pharmaceuticals

Roche Laboratories Inc.
340 Kingsland Street
Nutley, New Jersey 07110-1199
www.rocheusa.com

___ Set up automatic deposit and payment services in your absence.
___ Consider obtaining a calling card with preferred country rates.
___ Discuss budgets for home and deployment expenses.

Property
Review your insurance needs:

___ Homeowners or condominium insurance
___ Renters insurance (includes liability and personal property)
___ Personal Articles Floater
___ Fire insurance
___ Flood insurance
___ Auto insurance. (Check to see if rates can be lowered.)
___ Life insurance
___ Arrange for a home security system which may reduce your homeowners insurance rates.
___ Update your property inventory by recording all serial numbers.

Medical

___ Make your living will part of your medical records.
___ Make any necessary changes to your TRICARE program option if family members are away from a military installation.

Deployment Notification Checklist

Copied from the USAA website at www.usaa.com. This is meant to complement the pre-deployment checklist above.This checklist should help you tie up those loose ends before you deploy.

___Finalize financial, legal and insurance decisions.

Financial

___ Notify your credit card company if you will be taking your card overseas.
___ Make sure your spouse is aware of financial and computer passwords and, if necessary, write them down and store them in a safe place.
___ Notify creditors who may offer deployment benefits.
___ Contact your financial planner to discuss issues concerning your deployment.

Medical

___ Make sure your Defense Eligibility Enrollment Reporting System (DEERS) form is updated.
___ Make sure your spouse understands the military's Family Member Dental Plan.
___ Verify the TRICARE status for your family.

Property

___ Check your major appliances — stoves, washing machines, dryers and so on — to make sure they are in good working order.
___ Replace filters on heating and air-conditioning systems.
___ If there are any repairs needed to your electrical, climate-control and water systems, have them done now.
___ Make sure your spouse knows how to turn off the well pump, the water heater, water and gas mains and any other major systems. Leave written instructions, just in case.
___ Check your smoke detectors.
___ Label fuses and circuit breakers and show your family members how to use them.
___ Make an extra set of house keys.
___ If you have a home security system, make sure it works properly.
___ Complete a temporary change-of-address form if your home will be unoccupied.
___ If you are renting a home or apartment, notify your landlord that you will be gone.
___ Cancel your newspaper delivery if your home will be unoccupied.

Have the following on hand for household emergencies:

___ Flashlight
___ Extra batteries
___ Candles
___ Matches
___ First-aid kit
___ Electrical tape
___ Fire extinguisher
___ Bottled water

Auto

___ Notify your insurance company if your car will be placed in storage while you are deployed. Adjust your coverage as necessary.
___ Make sure your registration, insurance and inspection stickers are up to date.
___ Ensure car systems have been serviced.
___ If you use any special gas and oil, make sure your family knows about it.
___ List repair facilities, including tire and body shops.
___ Make a maintenance schedule for oil changes and tire realignments.
___ Prepare an emergency kit:
___ Flares
___ A spare tire
___ A jack
___ Flashlight or lantern and spare batteries
___ Jumper cables and directions on how to use them
___ A tool kit
___ A first-aid kit
___ A snow and ice scraper
___ A tire gauge
___ Maps
___ Some way to seek help, like a cell phone, calling card or proper change
___ Blanket or plastic sheet

Personal

___ If your deployment is international, notify your calling card provider.
___ For members using the USAA/Sprint card, call 1-800-755-8722.
___ Make sure your family's military identification cards are current and will not expire while you are gone.
___ Notify your children's school of your deployment.
___ Contact your place of worship.
___ Secure any weapons you may have in your home.
___ Make a list of important e-mail addresses to bring with you.

Arrange care for your pets:

___ Make sure all shots are up to date.
___ Notify your veterinarian that someone will be taking care of your pet.

Notify your credit card company if you will be taking your card overseas.

Saying Goodbye - Leaving the Family

By LtCol. Linda Lawrence, MD, USAF, MC

One of the hardest things about being deployed is saying goodbye to family. Both sides have concerns and these can put a strain on even the healthiest of relationships. Here are a few tips to help survive. You may also receive information from your local Family Support Center and be briefed by Mental Health staff. Even if you don't think you need help, take the time to listen. The rest of it seems to fall into place but your family will always remember how this was handled and for already strained relationships it can be the final straw.

Sit down and talk about the new responsibilities your spouse will have with your absence. Develop a plan to cover these duties...

1. **Start talking to your spouse today.** Yes I mean today even before you may be tasked to deploy. It is not a matter of IF but WHEN. You and your spouse should expect for you to be deployed and a plan to handle it. This is especially true if you will need to add additional childcare support.

2. **Identify what your spouse needs to know to manage without you.** Sit down and talk abut the new responsibilities and duties your spouse will have with your absence. Develop a plan to cover these duties and don't just assume he/she can do everything. Think of things you can get other family or friends to help with or consider hiring out some duties. If you have small children, consider extra childcare.

3. **Keep routines and don't let go of discipline.** Especially when children are involved it is important to keep the same routine at home even when one parent has departed. Also keep discipline – that is part of the kids routine. Still celebrate holidays and birthdays. You can always do them again on your return. My family still went on scheduled vacations while I was gone and made a videotape for me. The kids also sent postcards each day of the trip – of course they arrived weeks later and out of sequence. I almost felt like I was there and they felt I was still part of their experience.

4. **Encourage your spouse to take private time while you are away.** When children are involved the tendency is for the spouse to think they have to always be available for the children. If you went out as a couple before the deployment, encourage your spouse to do the same. Encourage him/her to go out to see a movie, dinner with friends or shopping. The feeling can be:Hhow can I go out and enjoy myself when my husband/wife is working hard and doesn't have the same options? This isn't true. You will have some R&R time while deployed. While maybe not much, there will be activities planned as well as all the impromptu gatherings you and your colleagues will have to help blow off steam.

5. **Communicate with your family.** There are the standard ways to communicate – phone, email, letters. Also consider ahead of time writing out some letters to be opened throughout the deployment in case there are periods you won't be able to contact family. This way they can open a card and be reminded of your expression of love. I had a 2 & 3 yr old I left behind. Before I left, I bought several small toys. Then I would have my husband pull one out the next day after a call when the kids got up from a nap. They were always so excited to know that Mommy sent them something from Turkey. We also shared pictures through email and tons of the email cards. One website is www.bluemountain.com . My kids would send me pictures they drew. By the time I returned, my walls were papered with their artwork.

6. **Making the transition back home.** Start talking about it before you return. Remember your family's life went on and your spouse may not have been able to keep you apprised of every detail. Don't be surprise to see some changes you didn't expect. For some it can be hard to realize their family did just fine without them. When I returned, one thing I found especially hard was having to reassure my daughter every time I walked out the door that I wasn't leaving "forever" as she feared and not be overcome with guilt. Talk to your children and spouse about what their concerns are and don't feel guilty about being gone.

7. **Remember people will come and go in the military and the military will do just fine, but our families are with us forever.** Take time before, during and after to prepare your family and talk about your concerns. We spend so much time on the military planning yet forget the family planning aspect of a deployment. Make this a family event, not a personal event.

Revised ACEP Status for Reservists

In early 2002, The ACEP Board approved a recommendation from Dr. Brian Baxter, who was then ACEP Membership Committee Chair, to include reservists called to active duty in the category of inactive members.

Dr. Baxter submitted the following recommendations to the Board: "That the Board of Directors amend the Guidelines for Inactive Members to include members in the reserves called to active duty for 90 days or greater as a result of war or other national security issues, whether for stateside or overseas service."

Active membership dues are presently $515.00; inactive dues are $172.00. GSACEP agues that reservists called to active duty for an extended period can anticipate a reduction in personal income. During Operation Desert Storm in 1991, the ACEP Board also approved a one-time reduction for reservists called to active duty.

Dealing With Stress and Deployment: How Will I Cope?

by MAJ John McManus, MD, MC,USA

Critical Incident (CI):

"any significant emotional event that has the ability to produce unusual distress in a healthy person"

Working as a professional dedicated to physical, mental or spiritual health has never been more challenging. Caring for a diverse population of patients who are feeling ill from the stresses of separation, uncertain safety, the unfamiliar risks of war and terrorism, etc. can easily cause burnout or compassion fatigue in the well-meaning professional who keeps striving to meet the needs of his or her patients, without taking time to meet his or her own needs for rest and nourishment of body, soul and mind. There are many ways to cope with stressors and to relieve the pressures of a demanding and inherently stressful situation and position. Here are a few tips to help deal with these stressors and keep one on the right track.

1. Modify your time management and work habits. Although, not completely in control of your schedule, it may be wise to change your routine up to break up monotony. Also, have colleagues send you teaching aids to help in peer and subordinate medical teaching (pulling 'sick-call" shouldn't be your only duty).
2. Be flexible and prepared for change. This is a must in the deployment situation. Rather than complain about the lack of information and constant change, try to make the best of it and expect the unexpected. The soldiers look to you for leadership and helping set the morale.
3. Practice what you preach to your patients! Get enough sleep and eat a well balanced diet (this is possible even in the field). Avoid the deployment junk food.
4. Commit to or revitalize an exercise program that involves activities 20-30 minutes daily. I can't recall how many times I walked around the sands of Kuwait in full gear. It's hard to get started, but getting the routine down becomes second nature.
5. Schedule daily leisure time and protect it! Have family and friends send you non-job-related books, music, movies, etc to break up work-related topics. This is a great opportunity to finish a correspondence course or polish up the foreign language you always wanted to perfect.
6. Write frequent letters to friends and family (don't assume they know you are fine). The mail service does do a great job and people love to hear how things are going.
7. Commit to one or two goals that you want to accomplish while deployed.
8. Remain upbeat and focus on the positive. Acknowledging any negative feelings you might be harboring does improve your ability to remain optimistic. However, do this privately among peers.
9. Get creative! One of the best ways to improve morale and cope with the deployment is to "rev up" your natural powers for creative intervention.
10. Learn from the experience of others. Two very common mistakes people make when undergoing change are: 1) they try to cope on their own; and 2) they fail to benefit from the experience of others.

Finally, it is important to remember that feeling out of control or experiencing stress is not uncommon. Nor are they signs of weakness or failure. Physicians who commit to improving their own well-being, not just that of their patients, can prevent excessive stress from diminishing their professional performance, their satisfaction with work, and their personal lives. Good luck and God speed a safe return to your family and friends.

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(fluticasone propionate and salmeterol inhalation powder)