# SPECIAL EDITION

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# Deploying Health Care Provider

## Operations Iraqi Freedom and Enduring Freedom

*Tactics, Techniques, and Procedures*

Center for Army Lessons Learned (CALL)
Fort Leavenworth, KS 66027-1350

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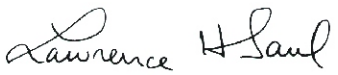
# Foreword

In today's Army, all newly graduated physicians should expect to deploy in support of the Global War on Terrorism within the first one to two years after residency. Though they may not know their specific assignment or in what capacity they are expected to perform until right before they deploy, the expectations of their gaining unit is that they are technically and tactically proficient in their abilities to save the lives of the injured Soldiers.

This guide is a one-stop source for the operationally inexperienced medical provider who needs to understand the tactics, techniques, and procedures (TTP) required to be successful as an Army PROFIS (Professional Filler System) provider. The purpose of this guide is to augment **AR 601-142,** ***Army Medical Department Professional Filler System*** in the preparation of the inexperienced deploying physician. This guide is just that, a guide, and should not replace advice of experienced medical and non-medical, noncommissioned and commissioned officers who have extensive deployment and combat experience.

Lessons learned can be hard at times and this guide focuses on many key aspects of deployment preparation, operational planning, and casualty treatment TTP in the hope that these new physicians do not repeat the same mistakes their predecessors made during the early deployments in support of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF). Though this guide was mainly prepared by experienced physicians, the principles contained within are applicable to most any inexperienced medical person.



Lawrence H. Saul
COL, FA
Director, Center for Army Lessons Learned

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Unless otherwise stated, whenever the masculine or feminine gender is used, both are intended.

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# Prologue

I had always respected doctors before, but somehow lying there wounded in the hospital in South Vietnam, looking up at them as they approached my stretcher, I quickly formed an overwhelming affection for them.

With the resiliency of a youthful body, and the blessing of the physician's excellent skills, it was not long before they had me back out in the jungle leading troops, a little sore, but ready to "mix it up" some more. Unfortunately for me, these warm feelings for my Army physicians were repeated again, very soon thereafter, when I was wounded a second time.

Now, thirty years later, I see much has changed for military doctors. Yet at the same time nothing has changed. Last year, as Commander of United States Southern Command, I toured a Colombian medical battalion and a forward surgical team (FST). I spoke to the doctors, and I saw the Soldiers who had been wounded in action. There they were, just like we were . . . Young men lying on gurneys, probably looking up at their Army doctors with the same pained, scared eyes we had in Vietnam. From the critical eye of the physician it is probably not too different, either—amputations, bullet wounds, burns, missing eyes, and lots of candidates for physical therapy—in fact, it is probably not too different from what our physicians see in Iraq today.

What is different is the survival rate of Colombian Soldiers wounded in combat. The Colombian military has consistently sustained a 30-40% "died of wounds" rate over the previous four years. When their troops get hit out in the bush, their chances of making it out alive were, up until recently, not too much more than the flip of a coin. Drawing on lessons from our earlier conflicts, the arts you've polished, the methods and techniques and procedures you've institutionalized, we have offered the Colombians a new way to care for the wounded. Their Health Service Support leadership and two of their young military trauma surgeons have visited our Command, and together we have formed a process which they now implement as their own FST concept. Fortunately, just like you, Colombian medical professionals are a pretty bright group, and they have snatched our ideas right up. They have formed four FSTs, three of which were immediately deployed. They effectively perform casualty evacuation (CASEVAC) for a large number of casualties to the FSTs, they have a significantly reduced combat death rate, and they return to duty hundreds of Soldiers that otherwise would have been lost for months obtaining surgical care. They have totally changed the face of caring for their combat wounded. The survival chances of their wounded have gone from what was basically a coin flip to some pretty solid odds today, and all due to the combat experience and expertise of US Army medical professionals.

In between my visits to those casualty wards in South Vietnam and Colombia, during my time as a peacetime Army officer, I've been in some of the best, most modern hospitals, and among some of the best physicians and specialists in the world. And they were Army too.

In 1978, our infant daughter was diagnosed with multiple disabilities, We soon became involved in a highly specific medical protocol of treatments, specialists, and equipment, and all this in a variety of geographic locations over the years. Thankfully, despite the complexity of her

disabilities, the Army never failed to provide for the medical requirements she faced. We were never at a loss for a knowledgeable physician or highly focused specialist, and we were never at a loss for a modern, well-equipped hospital.

I've seen you in both lights. I've seen you there myself, working your art with skilled hands and brilliant knowledge, and I've seen you doing it in both the mud of the jungle and the fluorescent light of high-tech hospitals. I'm in a position to make the following statement, and with all the certitude that personal experience assures: Thank God our Army physicians have the medical skills and sense of selfless service they do, so they can operate in both of these diametrically opposed worlds, that they are Soldiers as well as doctors.

You may be working in a world-class medical center, or you may be hunkered down in a steamy tent in a combat zone. You may be utilizing a computer-based laser procedure, or a traditional surgical knife. The eyes that look imploringly up at you may come from a service member's little child at Walter Reed, or they may come from a 25-year old infantryman in Iraq. But regardless of your environs, whatever the equipment, whomever the patient may be, whatever your specialty may be, one thing you will know: You are essential to the readiness of the Army; you are essential to the preservation of our freedom . . . because you are doctors and because you are Soldiers.

General James T. Hill
United States Army

# Introduction

As a young captain at Walter Reed, I recall an animated discussion with a now retired colonel regarding the conflict inherent to being a physician in the military.

"One day," he argued, "You are going to have to choose. Are you a doctor or are you a Soldier? You can't be both."

His comments would likely have been echoed by a number of military doctors twenty years ago. Unfortunately, in many cases he was right. Commanders from every service talk with frustration about the difficulty they have had in getting providers to respond to the needs of the line units. At the conclusion of one of my JRTC rotations deployed as a field surgeon with the forward support battalion, the battalion commander told me that his sole experience with docs to that point had been one of "low-quarter skid marks all the way down the Medical Department Activity (MEDDAC) hallway." Not a glowing endorsement. But it confirms what the colonel told me more than twenty years ago. For many of us, there is an inherent conflict between our roles as hospital or clinic based specialists and "field surgeons."

In the forties and fifties, more than 50,000 physicians deployed with the military to World War II and the Korean conflict. Most who served returned to civilian life after the conflict was finished. Similarly, in the sixties, the majority of physicians who worked with the military served tours in Vietnam that were temporary interruptions of their civilian pursuits. These were true citizen-Soldiers who brought their medical practice, private and academic, into the military service for a specific, limited period of time then returned home.

Through the years, a core of uniformed providers has made the military their full-time job. In the past decades, military medicine has blossomed into medical academics with large medical centers, a medical school and a myriad of graduate medical education in every specialty. By the time of Operation Desert Storm/Desert Shield in 1990, military medicine was hospital and clinic focused in garrison and in the field. Uniformed providers performed admirably in the desert, or on brief exercises to the combat training centers (CTC), then returned home to their garrison hospitals and training programs.

Through the past five decades there has been a small core of professional, full time physician/Soldiers whose focus has primarily been the support of operational missions. These warriors are Soldiers who also happen to know and practice excellent medicine. They have played and will continue to play key leadership roles in the military and in military medicine; a system whose primary focus is to care for Soldiers and their families. They have been considered by some to be outside the "mainstream" of military medical practice. Now we are learning that they are the mainstream.

A new picture is evolving for military medicine. As the present conflicts in Southwest Asia enter their third year, it has become clear that the global war on terrorism will not have a clear ending, at least not soon. Uniformed physicians in every specialty and service have begun to realize that they will deploy at least once during their period of obligated military service. If they stay on active duty or in the inactive service with the guard or reserves, they will likely deploy

more than once. It is no longer a matter of if they will deploy. It is not even so much a question of when. It is more a matter of "how many times."

A young captain graduating from residency may deploy soon after graduation as a Professional Filler System (PROFIS) physician supporting a division, then perhaps again as a major either in a PROFIS role or as a brigade or flight surgeon. After promotion to lieutenant colonel, he or she might deploy to lead or practice in a combat support hospital or forward surgical team, then again as a colonel to command or staff a medical brigade. Several deployments in a career will likely become the norm. In essence, "going home" will no longer be a simple, one time event for those who stay in uniform.

As a result of these demands, we have a greater challenge than any other medical system in the U.S. today. Can we maintain the strong tradition of academic medicine that has emerged over the past decades and has produced leaders throughout military and civilian medicine today, and at the same time learn from those warriors among us whose focus has always been the care of the Soldier, in war and in peace?

The purpose of this newsletter is to take the lessons learned by providers who have deployed in Operation Iraqi Freedom and Operation Enduring Freedom as well as lessons learned from the veterans of previous deployments, and crystallize them into one place as a reference to help prepare the providers who will follow us. It is a compilation of the recommendation of scores of experienced physicians and other health care professionals who have done what you are about to do. The replies have come from conference seminars, interviews, and through email. This newsletter is not an attempt to present or review doctrine. There are other places you can find that information. In this book, you will hear the voices and stories of your colleagues. They have reason to speak. They have done what you are about to do with overwhelming success. You will be just as successful.

Young providers in any color uniform just out of training, or in hospital practice, must concentrate first and foremost on becoming and staying experts in their practice specialty. But they must also be ready to deploy. While he was the Acting Secretary of the Army, Mr. Les Brownlee observed the following sobering truth, "Our Army has passed from a time of contingency operations into an undetermined period of continuous operations." If he is correct, and every indication suggests that he is, many of us will have the occasion to serve with Soldiers in the field. I sincerely hope that this book will help you to be prepared when the time comes for you to deploy.

*Pro cura militis – For care of the Soldier.*

COL Chuck Callahan
8th Medical Brigade (Forward)
Camp Arifjan Kuwait

# Chapter I: Survival Tips for the New Army Doctor

## Introduction

***"America is a Nation at war." We can expect "a foreseeable future of extended conflict in which we can expect to fight every day, and in which real peace will be the anomaly."***

*General Peter J. Schoomaker, United States Army Chief of Staff*

We are an "expeditionary Army." We all must be ready to deploy at any time. This is the implication behind General Shoomaker's question: "Do you have your dog-tags on?" The changes in the Army require us to examine the steps we have taken throughout our career to prepare to serve as officers on deployment when the time comes. It begins with our knowing the fundamentals of leadership. Retired General William Cohen, in his book ***The Stuff of Heroes,*** writes that the first principle of leadership is to maintain absolute integrity. Integrity begins with being true to the core values of the Army.

**Loyalty:** Loyalty is being true to ourselves and to others. We must first be true to ourselves and to the life-long process of "becoming." Even on deployment, loyalty to oneself means that you take time to do the things that make you who you are. You have to take time to "play and pray," and to cover the essentials. Whether in garrison or in the field, take time for exercise, hobbies, and for worship.

If we do our jobs right, there will be time to demonstrate loyalty to our spouses and children while still supporting and caring for colleagues. Also, we must be loyal to our patients. The men, women, and children who come to us for care are looking for someone who will share ownership of their health. They are looking for someone to bear their burdens with them, and they know immediately when we are just going through the motions in any setting.

**Earn the Respect of Others:** The "Officer Image" is a critical part of who we are as leaders. The practicalities of the officer's image are stressed in ***The Officer's Guide*** (Crocker LP, Stackpole Books, 1993.) This is a book every officer should own. Buy it and page through it on the plane to your next TDY. The officer should be strong on principle. The officer should be cool-headed and not given to temper tantrums. He or she should be flexible in working for an organization where the rules of engagement can change overnight. Leaders should avoid the use of first names for superiors and for subordinates. Remember that "rank has its privileges," but do not assume the privileges for yourself. Be liberal in the use of "Sir" and "Ma'am" in addressing superiors whether they ask for it or not. Do not offer excuses for jobs not done or not done well. Avoid servility, slander, and coarse language. Know how to wear the uniform and know the rank structure of officers and enlisted, for all the services if possible. Use the correct rank titles to address your active duty patients or their parents and you will take immediate steps to securing their trust. An all service rank chart follows this chapter for you reference.

Do not just sit in the clinic or hospital. Get out and visit Soldiers in field units when you can. Be proactive instead of reactive. The American Soldier is remarkably resourceful. Soldiers will make things happen no matter the cost, many times to the neglect of seeking medical treatment if

it means time away from the mission and their duties. The best way to keep tabs on the health of Soldiers is to visit and spend time with troops where they work, not where you work (i.e. the clinic or hospital). Peabody's advice, "The secret of the care of the patient is caring for the patient…the good physician knows his patient through and through." The rule applies to the health of Soldiers, beyond the walls of the hospital clinics and wards.

Soldiers rarely fake their problems or malinger. In reality, they are more like professional athletes who too often they ignore legitimate problems. Units often require Soldiers to train despite ongoing overuse injuries, and being an advocate for patient-Soldiers will help not only the Soldier's but the unit's effectiveness.

Bottom line, involve yourself with the real Army: it is an amazingly complex and interesting organization and time with line Soldiers is time well spent. You will never forget why you wear the uniform. Take the opportunities offered to you to go to military schools (airborne, air assault) or work on skills badges (expert field medic badge.)

With that said, the commanders and other troops have a tremendous amount of respect for what we do. They fully understand our role in "getting them home" from the battlefield. You will earn their respect by being respectful to them and their profession of combat arms. You should be in as much awe of their work as they are of yours. Just accept the fact that you are not in charge but that your opinion will be considered. Docs often hide behind the guise of advocating for "patient care" when really they are just defending turf or battling the loss of control. Be professional in everything, and remain flexible.

When you do go to the field or deploy with them, do not whine. You will have a hard time regaining "respect points" if you start out complaining about living conditions, work space, and inconveniences that you feel are "beneath you." Expect to receive the basic necessities just like every other Soldier, but expect to procure your own "creature comforts." This is especially important if you are a PROFIS provider- they do not expect you to be a "hard" infantryman, but they do not expect you to be so "soft" either. Know the proper wear of both the utility uniform and the field gear- to include the helmet (buckle your chin strap). If you look like a Soldier, they will treat you like one. If you look like a "ragbag," you will always have that barrier between you and the Soldiers.

The needs of the unit dictate, like it or not, that you cannot always be the "good doctor" when it comes to the disposition of sick and injured Soldiers. You truly must weigh the needs of the unit with what truly can or cannot be accomplished by the Soldier. There is a limit to the number of Soldiers to accomplish any given mission. If out of sympathy for the Soldier, you give everyone quarters or recommend light duty for everyone, then you will lose the respect of the command, and they will often be forced to ignore your recommendations in order to complete the mission. If you reserve these for Soldiers truly in need, then the commanders are more likely to follow your recommendations and will even attempt to accomplish the mission with fewer Soldiers.

**First Assignment:** Your first military assignment is likely to be in a table of distribution and allowance (TDA) hospital. This is the term the Army uses to refer to fixed "brick and mortar" facilities. When you arrive at this assignment, it is wise for you to make an appointment to meet

the Hospital Commander and the Deputy Commander for Clinical Services (DCCS). This deputy commander is the "doctor's boss." It is an old Army tradition, to have a simple card made with your name, rank, corps and perhaps specialty, and leave it with the Commander's secretary when you make your office call (there is usually a dish for the cards on the secretary's desk). Make sure that your haircut, shoes, and uniform are all appropriate before you show up. Bad first impressions are tough to undo.

As silly as it sounds, look at your hand salute in the mirror, and practice getting it right. Your salute tells Soldiers and other officers what you think of them. A departing pharmacy officer stopped me at graduation several years ago and thanked me for the way I returned his salutes on the way to and from the parking garage. He told me that taking time to come to attention, make eye contact and return the salute demonstrated my respect for him. I did not even know it was happening.

When you are assigned to a field unit, and you first meet and work with the officers, some clear differences will become immediately apparent. Although the medical officers and the combat arms officers are in the same Army, we come from completely different working environments that shape the way we conduct business on a daily basis. There seems to be an initial "love-hate" relationship with the "line guys" and the "docs." This can help you or hurt you depending on your initial interactions with them. A good place to review your military bearing and military etiquette is with your squared away noncommissioned officer (NCO) or experienced physician assistant (PA). The combat arms commanders do not always interact in the same social manner as we sometimes do in the medical arena.

Be humble. They know you are a doctor - but you have to accept the fact that you are an adviser to the command. Help them make good decisions about medically related issues, but do not presume that your opinion or recommendation is necessarily in the best interest of the unit. Accept that you will occasionally be overridden. Show a genuine interest in learning about the unit, its history, the customs/courtesies of the Army. Learn the proper way to address your superior officers and commanders. Learn their language of acronyms and phrases. We have significantly more acronyms than they do so try to minimize "doc speak" and talk to them in intelligent lay terms.

**Career Enhancement:** No one will look out for your career if you do not. Get in the habit of reviewing your Officer's Record Brief, or your career file. Know what the boxes mean. Get an appointment with the troop commander at your hospital or clinic if you cannot figure it out. Stay in touch with your specialty consultant and keep him informed of your long-range plans. While in your "utilization tour" make it your highest priority to become an excellent provider. Become board certified and develop a plan to stay current and sharp in your field. Most of the MEDDACs have training programs where primary care providers have opportunities to teach. You will also have chance to serve on hospital committees and to help run the clinic or practice. All these skills make you more marketable when you leave the service.

**Deployment:** In the "TDA world" medicine is not that different than what our civilian counterparts practice. The biggest differences come when assigned to a field unit. The PROFIS system has not done a very good job of getting doctors ready to serve in a field unit in a combat

zone, but there are specific steps to take to ease that transition before you deploy while you are still in garrison.

- Get in physical shape and stay there. The average deployment workday is 16-18 hours, with no days off, for months at a time. You will need increased stamina to handle the rigors of your job.

- Always be a team player. Be willing to take on additional duties, even if you have never done them before. There are many things that need to be done to accomplish the mission when deployed, and someone has to do them. If you can offer your assistance (even better if you offer before you are asked), the unit will only benefit, and you will gain the respect of those around you and be viewed as more than just "that PROFIS doc." There are clearly some duties that you cannot do based on the Laws of Land Warfare, but if all you do is conduct sick call and hang out in the aid station, you will just be "that PROFIS doc."

**Soldier Skills:** Refresh your memory and repeatedly practice basic Soldier skills such as properly clearing your weapon. This is a simple thing you can review every time you handle a pistol. The single most common mistake made by officers with the 9mm pistol leading to accidental discharge is failure to drop the magazine before pulling back the charging handle. In this scenario we have all seen the doctor who is not paying close attention or is in a hurry to get into the chow hall, forgets that there is a full magazine in the weapon, charges it, does not look at the chamber, then flips off the safety, and accidentally fires the weapon. It is amazing how frequently this happens. The worse case scenario is obviously injuring or killing a fellow Soldier. In many places it is an automatic Article 15: a career "ender" or the justification for a relief from command or responsibility. The solution is simple. Perform the "pistol-butt rectal exam." Get in the habit of putting your finger into the butt of the pistol as the first step in clearing the weapon. You cannot do it unless you drop the magazine first. If you want to talk about losing the respect of your unit, try firing a round into the clearing barrel in front of the Soldiers.

The very best thing you can do for the unit and for the Soldiers, even before you get to know them well, is to be the best Soldier and clinician you can be. The Army medical officer is a Soldier who practices medicine, not just a doctor in a uniform. Soldier skills and field experience are essential elements of training for military physicians. Knowing and embracing these simple truths will ago a long way towards a smooth transition to the PROFIS or field unit assignment.

**Leadership:** One of the thorny issues which medical corps officers will encounter is that they will often be the senior ranking officer in the medical platoon, company, or even a battalion. This can result in anything from an uncomfortable truce to overt hostility if the limits of authority are not established from the start. Historically, the brigade surgeon has become the medical company commander in time of war, and the medical service corps captain, the executive officer. This led to an uneasy situation where the most experienced leaders were not in the position of command where they could have the greatest impact, thus this practice ended after Desert Shield/Desert Storm and is now decided by the "most fit to command" principle and usually allows the Medical Service Corps officer to remain as the company commander. Doctors

do not generally like to be told what to do, especially regarding patient care or procedures, and this is especially true when the doctor outranks the individual in charge.

In practical terms, the physician is wise to recognize and work through the established lines of leadership. In most cases, the physician's authority extends only to those things that specifically affect the care of patients. This does not necessarily mean assigning personnel to various duties, one of the most common areas of conflict. The personnel belong to the company commander. Doctors are generally "take-charge" individuals by nature, and personal restraint will be a recurring challenge. It is well worth the effort, and it is the responsibility of more senior officers, to be sensitive to potential conflicts and to intervene when necessary.

**Principles of Leadership:**

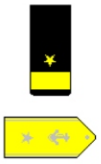
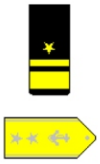
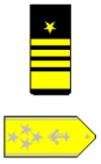
- Know yourself and seek self-improvement
- Be technically and tactically proficient
- Seek responsibility and take responsibility for your actions
- Make sound and timely decisions
- Set the example
- Keep your subordinates informed
- Know your Soldiers and look out for their well-being
- Develop a sense of responsibility in your subordinates
- Ensure the task is understood, supervised, and accomplished
- Build the team
- Employ your unit in accordance with its capabilities

**New Doc Survival Tips:**

- Be a leader and study leadership
- Be a Soldier
- Be professional
- Become an outstanding doctor (nurse, PA, etc.)
- Be humble
- Do not whine
- Be flexible
- Remember the needs of the unit and the team come first
- Know your weapon
- Learn how to wear the field uniform (Kevlar, etc.)
- Understand that you will deploy

| Enlisted | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Rank Level | Army | | Navy / Coast Guard | | Air Force | | Marines | |
| E-1 | Private | (no insignia) | Seaman Recruit (SR) |  | Airman Basic | (no insignia) | Private | (no insignia) |
| E-2 | Private |  | Seaman Apprentice (SA) |  | Airman |  | Private First Class |  |
| E-3 | Private First Class |  | Seaman (SN) |  | Airman First Class |  | Lance Corporal |  |
| E-4 | Specialist, Fourth Class |  | | | | | | |
| | Corporal |  | Petty Officer Third Class (PO3) |  | Senior Airman |  | Corporal |  |
| E-5 | Sergeant |  | Petty Officer Second Class (PO2) |  | Staff Sergeant |  | Sergeant |  |
| E-6 | Staff Sergeant |  | Petty Officer First Class (PO1) |  | Technical Sergeant |  | Staff Sergeant |  |
| E-7 | Sergeant First Class |  | Chief Petty Officer (CPO) |  | Master Sergeant |  | Gunnery Sergeant |  |
| | | | | | Master Sergeant 1st Sergeant |  | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| E-8 | Master Sergeant |  | | | Senior Master Sergeant |  | Master Sergeant |  |
| | First Sergeant |  | Senior Chief Petty Officer (SCPO) |  | Senior Master Sergeant 1st Sergeant |  | First Sergeant |  |
| E-9 | Sergeant Major |  | | | Chief Master Sergeant |  | Master Gunnery Sergeant |  |
| | Command Sergeant Major |  | Master Chief Petty Officer (MCPO) |  | Chief Master Sergeant 1st Sergeant |  | Sergeant Major |  |
| E-9 (special) | Command Sergeant Major of the Army |  | Master Chief Petty Officer of the Navy (MCPON) |  | Chief Master Sergeant of the Air Force |  | Sergeant Major of the Marine Corps |  |

| Officers | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Rank Level | Army | | Navy / Coast Guard | | Air Force | | Marines | |
| O-1 | Second Lieutenant (2LT) |  | Ensign (ENS) |  | Second Lieutenant (2Lt) |  | Second Lieutenant (2LT) |  |
| O-2 | First Lieutenant (1LT) |  | Lieutenant, Junior Grade (LTJG) |  | First Lieutenant (1Lt) |  | First Lieutenant (1LT) |  |
| O-3 | Captain (CPT) |  | Lieutenant (LT) |  | Captain (Capt) |  | Captain (CPT) |  |
| O-4 | Major (MAJ) |  | Lieutenant Commander (LCDR) |  | Major (Maj) |  | Major (MAJ) |  |
| O-5 | Lieutenant Colonel (LTC) |  | Commander (CDR) |  | Lieutenant Colonel (LtCol) |  | Lieutenant Colonel (LTC) |  |
| O-6 | Colonel (COL) |  | Captain (CAPT) |  | Colonel (Col) |  | Colonel (COL) |  |
| O-7 | Brigadier General (BG) |  | Rear Admiral, Lower Half (RDML) |  | Brigadier General (BGen) |  | Brigadier General (BG) |  |
| O-8 | Major General (MG) |  | Rear Admiral, Upper Half (RADM) |  | Major General (MGen) |  | Major General (MG) |  |
| O-9 | Lieutenant General (LTG) |  | Vice Admiral (VADM) |  | Lieutenant General (LtGen) |  | Lieutenant General (LTG) |  |
| O-10 | General (GEN) |  | Admiral (ADM) |  | General (Gen) |  | General (GEN) |  |
| (special) | General of the Army |  | Fleet Admiral (FADM) |  | General of the Air Force |  | | |

# Chapter II: Life in the Real Army

## Introduction

All Medical Corps Officers, and for that matter, members of the Army Medical Department, will at some time likely be a part of a brigade or battalion table of organization and equipment (TO&E) or "field" unit. There are equivalents in all the services. In the Army, some doctors will take brigade, battalion, or flight surgeon slots right out of training and will serve as full-time docs in the unit, others will be assigned in a Professional Officer Filler System (PROFIS) slot. These are slots with "regular" Army units where the doctor is named, but only joins the unit when the unit has extended training or deployments. Normally, the incoming doctor will occupy the "surgeon" slot in the brigade or battalion medical platoon. He will be assigned to the unit Headquarters and Headquarters Company (HHC) in the role of a special staff officer. As a special staff officer, the brigade or battalion surgeon works for and reports directly to the battalion or brigade commander, but also serves as a member of the staff under the direction of the executive officer. Depending on the unit of assignment, medical annexes to operations orders can be found in the S1 or S4 sections, but frequently will be found standing alone as well.

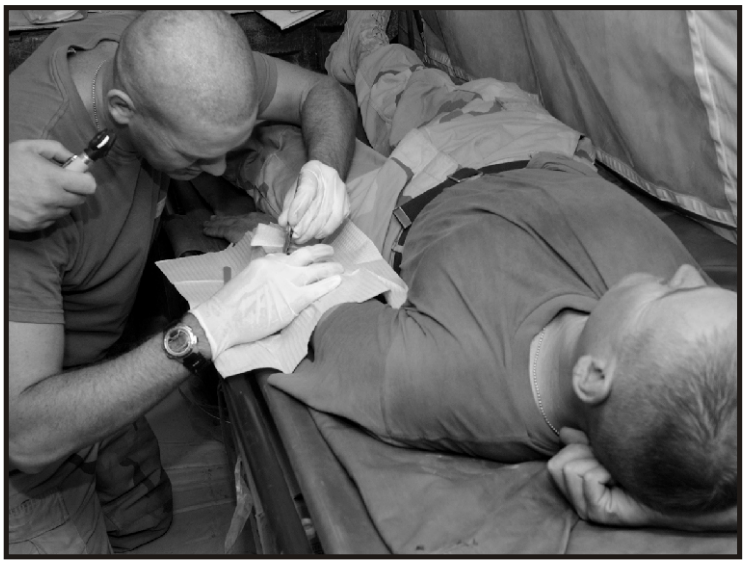


**Figure 1**

For those initially heading to TDA hospitals or clinics, a PROFIS assignment is almost inevitable. It is a mistake to wait to get to know your PROFIS unit until you are tasked to go to the field or to war with them. The assignment is usually made by the department chief or hospital deputy commander. Hopefully, your service or department chief will delay your assignment six months or so to make sure that you are well established in your practice before you join the PROFIS unit. The delay in assignment allows for the doctor to devote the necessary attention and take an active role with the PROFIS unit when the assignment comes. Prepare

yourself for your PROFIS duties first by finding out all you can about the unit and its mission. Read the field manual that pertains to the unit's mission.

When you become part of a TO&E "field unit" you become a part of a team. You and your medics are responsible for saving lives. Make sure that they get the best training possible while they are still in garrison. Your medics will be closest to the fight. Get to know the medics. Make time to train, talk to, and encourage your medics. You owe it to them to make sure they are properly trained. In the rear, you may only be the PROFIS doc and these medics may be someone else's responsibility. But in combat you are their doc. You are the one who can help them save their buddies. Make it a personal mission not to let them down.

Flight Surgeon: Flight surgeons deserve some special notice. They are normally assigned to and work with the aviation units prior to deployment. However, in garrison there are conflicting issues. In the garrison, the flight surgeon is unable to spend time on the key non-clinical duties that keep the unit healthy. Too often the flight surgeon is just a clinician who also knows how to fill out the various forms necessary to complete the annual Flight Duty Medical Exams. The flight surgeon is not only a clinician, he or she is also a practitioner of preventive medicine and occupational medicine. Army Regulations (AR) outline the duties and responsibilities of the flight surgeon (AR 40-3, AR 40-8, AR 40-501, AR 95-1, AR 385-40, AR 385-95, AR 600-105) covering medical, aviation, and safety areas of expertise.

In order to ensure that the flight surgeon is afforded the opportunities to perform the mandated non-clinical duties, it is important to make the aviation brigade or task force commander your advocate. Do this by actively promoting your capabilities to optimize the unit's operational and combat readiness. Speak in terms that an intelligent but non-medical individual can understand. Communicate regularly with the next higher physician, typically the division surgeon. Get to know the flight crews and convince them that you are their advocate. It is rare for an aviator to voluntarily seek medical advice when he or she suspects that the encounter will lead to a "down slip." Unfortunately, it is difficult to know the true health status of the unit by monitoring the sick call log. There are other issues out there that need to be investigated, but it requires that the crews trust you as someone who will look out for their well being and often takes more than just a professional relationship, it takes their respect.

**TO&E Unit Key Leaders and Staff Officers**

When you receive your PROFIS assignment, find out where the unit area is located and schedule introduction meetings with the key unit personnel. Below is a listing of key TO&E commanders and staff you should meet and get to know early.

**Unit Commander:** This senior officer will normally be a colonel at the brigade level or a lieutenant colonel at the battalion level. They are the ultimate authorities in those units. He will probably be your rater or senior rater. The commander may well have already developed a negative attitude toward docs from his or her time as a platoon leader or company commander in previous assignments. You will know early on in the initial interview is this is the case. If so, you may have an uphill battle until you change that perception. Make an office call. Introduce yourself. Get an idea of what the commander expects of you as a physician. Ask the question.

Make yourself available to him/her at any hour for advice on any medically related issue. Be loyal to the unit and advocate for the troops. The commander will appreciate your input on issues, especially if you are advocating for the welfare of the troops. However, the commander is not the person to complain to about little grievances. Begin by using your company chain of command and the other staff sections, the commander has enough to deal with.

Offer to take on additional duties and staff roles as needed. There will be plenty of extra jobs in a deployment situation. Preventive medicine duties, environmental safety issues, and humanitarian and civil-military operations are just a few of medically related additional duties that you will be asked to perform. Medical capability exercises (MEDCAPs) are no longer solely missions for special forces medics, your commander will want you to win the hearts and minds of the enemy. The commander will appreciate your being a team player. Make a positive first impression.

**HHC Company Commander:** This officer will be a captain, so every PROFIS physician will either be of the same rank or higher. However, understand that as the senior officer of the medical platoon, you are not in command, but you are a leader none-the-less. Salutes to others of equal rank are not appropriate, but you should give the same respect to that company commander that you would give to someone of higher rank. The success or failure of the unit depends on the commander's relationship with his/her troops. Never show disrespect to the company commander or disobey the company rules and regulations. It is appropriate to respectfully disagree with the commander in private, but never in public. Do not adopt the attitude that line officers presume docs will have: that the Commander's rules do not apply to you. They do.

**HHC First Sergeant:** This is the NCO who will get things done for you when it comes to mobilizing manpower. NCOs run the Army, and anything you can do to earn their respect and loyalty will pay large dividends later. However, do not assume that you are special in the 1SG's eyes just because you are a doctor. Their first priority is the welfare of their Soldiers - and they are good at it. They will afford you the respect you deserve based on your rank, but they will not tolerate an expectation of special treatment. They can certainly help you to acquire additional creature comforts, but you will only get that help if you treat the 1SG with all the respect due to the senior NCO in the unit. It would be very bad to start off on the wrong foot with this NCO. He or she will be looking at you and your uniform the very first time you meet.

**Medical Platoon Leader:** This officer will be a Medical Service Corps second or first lieutenant. He might be intimidated by your rank, but do not abuse the relationship. You should utilize him as the first step in your chain of command in order to get the mission accomplished. You should develop a close working relationship with the platoon leader and address issues with him. Make sure that all your concerns regarding the functioning of the treatment areas are discussed with the platoon leader first. If your complaint or concern gets to a higher level, you can be sure that the platoon leader will be taken to task for the problem, not you.

**The S4 or SPO:** This is the unit logistics officer. This person will become your very best friend in the field as he or she knows how to get you the things you need. Medical officers are notoriously ignorant of the way the supply system works. The logistician has an essential role,

as one senior medical logistics officer says, “forget logistics and you lose.” Nine times out of ten, their attitude will be “the answer is ‘yes’ now what is the question?” But you have to get to that point with them. Begin by building a relationship early. If you go out of your way to learn the unit’s medical equipment and supply (medical supply is designated Class VIII), you will score points early with the logistics officer.

**The Other Staff Officers (the “S’s”):** The personnel officer (the “S-1”) will help you negotiate the nuances of life with a field unit: forms to complete, orders, etc. The intelligence officer (S-2) will be the one who usually has the inside scoop on what is happening “outside the wire.” The operations officer (S-3) will be the one to write you into plans to go on medical civil action missions and other unit operations. The S-3 is a good person to get to know. For all these officers, you may not think you need them now, but eventually you will.

**The Chaplain:** Regardless of your religious affiliation, you will work hand-in-hand with the chaplain. The chaplain will provide comfort to the Soldiers when you cannot help them medically. Encourage the chaplain and the chaplain’s assistant (usually a junior enlisted) to participate in ALL casualty encounters, even the minor stuff. Ask them and help them to talk with every wounded Soldier. The chaplain will become a resource for the more critical patients. Some chaplains will even pitch in and help with simple medical duties, so encourage them to become EMT-Bs or combat lifesavers at a minimum. And equally important, the chaplain becomes the unit pastor as he or she is a source of comfort for the providers as well. Taking care of combat casualties is a tough job. It is physically and emotionally draining. We are only beginning to figure out ways to help health care providers who have cared for fellow Soldiers with severe trauma to cope with what they experience after they come home. Being aggressive about maintaining your mental and spiritual health while you are deployed is a first step. The chaplain can be there to recognize when you are starting to show the strain and can sit and help you talk it out. Again, encourage the chaplain to become an integral part of the aid station.

**The Troops:** These young warriors, whether members of the medical platoon or the unit as a whole, only represent themselves. Though they do not hold sway over you in any way, it is essential that over time you try to meet all of the Soldiers in the unit. You will likely be depending on them for your protection, food, supplies, etc. and will be caring for them should they become a casualty or on sick-call. Introduce yourself to them, (rank, first name, last name) and telling them a little about yourself. Explain your role within the unit (especially if you outrank the company commander.) These things will help you to establish a greater bond with the unit. Do not allow junior officers or enlisted to call you by your first name, and be very careful about calling them by their first name. In general, a safe rule is to always use rank and last name in public, and perhaps save first name for church or for private, social settings.

**Your First Day:** When you show up for the field assignment, or the day you report for the brigade/battalion surgeon’s job, wear the unit patch on your left shoulder, not the Army Medical Command (MEDCOM) patch. Patches on the right shoulder are reserved for patches of those units in which you serve in combat. Do not worry, you will likely earn one of these soon enough and probably several times in your military career. It says to the unit that you know who you belong to and you are ready to be part of the team. Soldiers you serve with will appreciate that their "doc" wears the same patch they do. It is an important first impression.

**Profiles:** Learn how to write a profile, but do not write a single profile for anyone until another doc or PA from the unit has sat you down and explained the command's policy. Profiles are like lightening rods and the Soldiers are smart enough to sometimes come to the new doc to try to get their profile "rewritten."

**Tactical Equipment:** While you are in garrison, take time to familiarize yourself with the different medical vehicles. Get a feel for what it is like to treat casualties in them and get a basic idea of what supplies and pieces of equipment are on board. The M997 (field litter ambulance [FLA] or just "ambulance") is rather roomy compared to the other vehicles; however, space is limited and the sides are NOT made of Kevlar, but fiberglass. The M113 is the smaller track vehicle. It is an extremely tight space and not a very comfortable ride. If you want to put your skills to the test, try putting in an IV while driving 40 mph over a dirt road. You should try it at some point in garrison, because one day you may have to do it for real. Make sure your medics pack the essentials for saving lives in these vehicles. The M577 command post vehicle is the other track vehicle. It is not really an "evac" vehicle because it is pretty slow. It is very roomy but is used mainly as a mobile aid station.

**Figure 2. M997 Field Litter Ambulance (FLA)**

The **high mobility multipurpose wheeled vehicle (HMMWV)** is a light, highly mobile, diesel powered, four wheel drive tactical vehicle that uses a common 1-ton payload chassis. The HMMWV can be configured to fill a number of missions on the battlefield.

**Figure 3. M998 High Mobility Multipurpose Wheeled Vehicle (HMMWV)**

**The M577A3 Tracked Command Post Carriers** are full-tracked lightweight vehicles used as an operational staff office and command post.

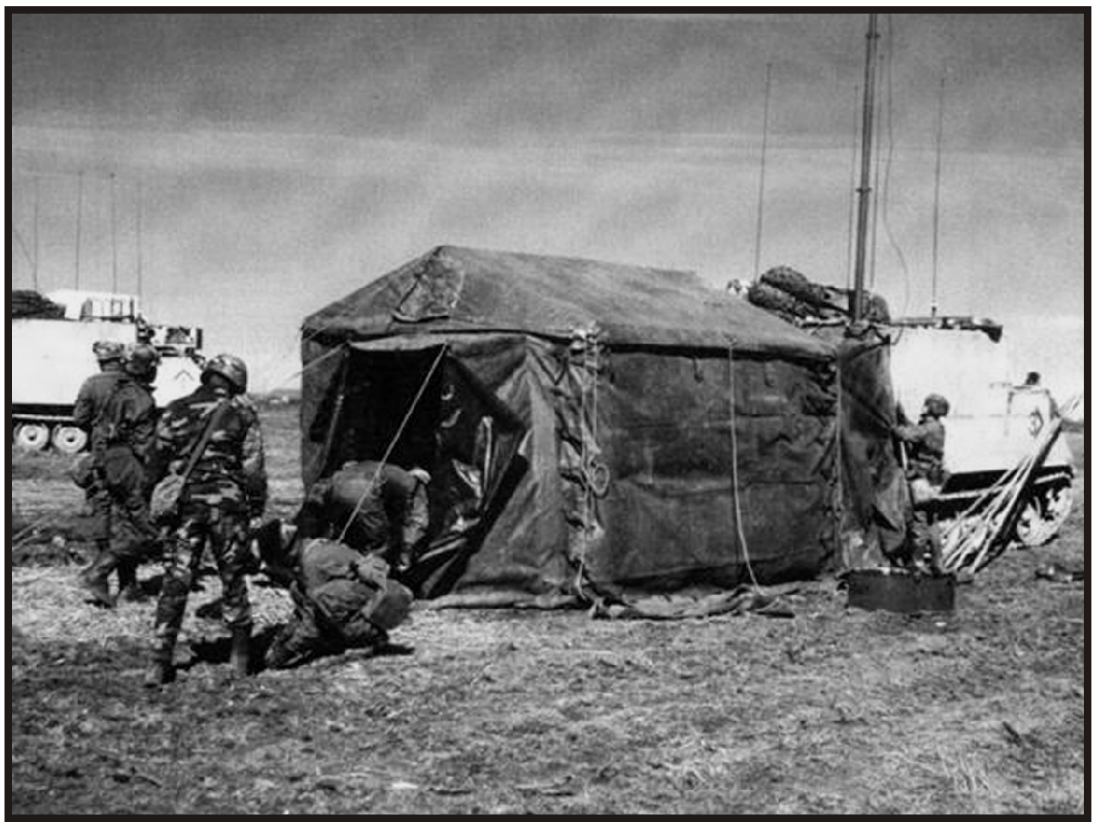


**Figure 4. M577A3**

### M2A0 Armored Medical Evacuation Vehicle (AMEV)

The M2A0 Bradley chassis is modified by removing the turret, raising the roof, moving fuel tanks to the exterior, installing Bradley M2A2 armor protection, and transmission electronic controller (TEC) upgrade. The vehicle is further modified to meet medical requirements by incorporating 1) an oxygen distribution system, 2) litters for up to four personnel, 3) seating for up to eight ambulatory patients, 4) medical lighting, and 5) stowage for medical equipment.

**Figure 5. M113A AMEV**

## M113A4 AMEV

The M113A4 AMEV provides the means to treat and evacuate combat casualties from armor and mechanized infantry battalions on the 21st Century battlefield, while providing a standard of care similar to that in other modern medical evacuation vehicles and aircraft. The M113A4 Armored Medical Evacuation Vehicle supports the required mission profile including:

- accommodations for four litter or eight ambulatory patients
- movable attendant's seat
- an over pressure nuclear, biological, chemical (NBC) air filtration system
- patient support systems
- engine noise reduction
- Geneva Convention markings


**Figure 6. M113A4 AMEV**

You should become familiar with the items of medical equipment and supplies the Army prescribes for the unit to which you will be attached. Further, you should become familiar with the items of equipment in the organizations forward of your own, to which you might be further attached. You can find these lists on line. Another detailed source for this information is at <https://webtaads.belvoir.army.mil/usafmsa>. (The acronym TAADS stands for The Army Authorization Document System.)

Each unit has a Unit Assemblage List (UAL) off of which they work. This contains a listing of all the medications and pieces of equipment that the unit is "authorized." A computerized list should be available at the company level that will even list what is in the individual medical equipment sets (MES) chests. The year group of the UAL (1999, 2000, etc.) determines the actual supplies authorized. Check with your unit to see which UAL they are authorized. You can then visit <www.usamma.army.mil>.

**Train As You Will Fight:** Despite the impact that it may have on the physician's clinic schedule, every opportunity should be provided for PROFIS assigned physicians to gain

experience with the assigned unit. The key to success of a medical operation is training with the assigned unit. This has been shown over and over again in trauma centers across America. Before a deployment, there is often time, although any opportunity taken ahead of the pre-deployment schedule will be time well spent. One of the most difficult transitions is the new doctor to the field unit. While some think that the average doc can learn the unit on the fly, many agree that there is no substitute for training alongside the officer and enlisted personnel of these units in site selection, facility, and equipment set-up and in treatment battle drills. In particular, clinicians who do not train with the unit are often unfamiliar with the sets, kits, and outfits of that unit.

Although opinions vary, most agree that the medical staff should spend a minimum of 10-14 days training with the unit a year. This is barely enough time to establish a rapport with the troops and the other providers. Attending at least two field exercises a year with the unit and at National Training Center (NTC) or Joint Readiness Training Center (JRTC) rotation at least once every two to three years is ideal. Longer deployments (JRTC and NTC) are great opportunities for bonding with the troops who will likely be with the unit longer that the company commanders and platoon leaders. These training center rotations are usually between 14 and 30 days depending on unit assigned and training location. Plus, the exercises are the best way to become familiar with unit operating procedures in the field. In this regard, the reserves and guard may be better off than the regular army because, at least annually, the reserve or guard unit deploys and practices for their mission.

A deploying physician can learn the basics about the unit off their web page, but you learn a lot more by training with them. When in the field, go through every drawer of the chest and through every chest with the senior medic or PA. The doctor's usual, favorite drugs will often not be available, and they may not be in the supply system. In these cases, learning to use the medications that are available will save a great deal of grief for you with the unit logistics officer. (It is a theme one hears often from the medical logistics community.) For that matter, learning as much as you can about the way the medical logistics system works will also be time well spent.

**Real Army Life**

- Aggressively seek to meet and know your field PROFIS unit.
- Get to know the unit's key personnel.
- Wear the unit's patch.
- Train in the field with the unit.
- Learn the unit's authorized load (UAL).
- Use the chain of command.
- Avoid command conflict.
- Become a part of the team.
- Train the medics.

# Chapter III: Imperatives for Deployment to a Combat Zone

## Introduction

Two days after Easter, the Chief of the Medical Corps called me to ask for a list of names from my specialty. He had to present them to the Surgeon General as options for a slot that had come open. The reserve medical brigade in Kuwait had lost their chief of professional services and the brigade commander had asked the Surgeon General for a replacement. I was told I needed to provide a list of senior docs, and preferably ones who had not yet deployed.

"Well, that includes me, then," I told him. "We are getting thin on the bench and we're down to consultants and department chiefs."

The phone was quiet for a moment, "Well, since you mentioned it," he finally said, "I thought you might be a good choice for this position." I thanked him and suggested three other names.

I told my wife about the strange conversation when I called her at lunch. She was quiet for a moment. "It won't happen," I told her. "He was just fishing for names."

"How do you know?" she asked me. By that weekend I got the word I was deploying, and within a few more days I had orders. She said she knew the moment I told her on that first phone call.

As a supervisor, I have had to select physicians for PROFIS taskings and send them on deployment or to combat. It was the hardest thing I ever had to do. I wrote letters to the families of the physicians I deployed telling the spouse and children that the decision was mine, that their spouse had not volunteered, and that I wanted to do all I could to support them while their spouse was away. It is different for the medical folks, because not everyone deploys and until very recently it was a relatively rare event.

Then I had to go myself; then I had to climb into my car on a Saturday night in May and leave them without knowing when I would be back. Leaving my children crying in the parking lot now tops the list as the single, hardest thing I have ever done. We need to remember that for our families and especially for our civilian friends, deployment is a tragic event. Fortunately, for our extended military family, deployment is a way of life. That perspective has been very helpful for my wife and children, who have been surrounded and supported by military families while I have been gone. My wife has developed deep friendships with other military wives. Church and other especially close friends have also been a tremendous support. They are ones who will also celebrate the most with you, when you do finally return home.

**Breaking the News:** There seems to be no single, right way to break the news of a deployment to loved ones. Each person seems to have his or her own story of those difficult moments when the news came out and the family's reaction. One of my daughters started crying at the dinner table when I gently suggested that I might have to deploy. Two others left the room to cry. The less notice you have (and some of our colleagues had less than a week) the harder it is on you and your family. That seems to be a consistent theme.

Some believe that breaking the news slowly if you have the time makes the process easier. That worked for my family. When I first broke the news to my children, I told them that it still was not definite, but that deployment looked likely. I was able to break the news slowly, and it made it easier on them. Give your family a brief situation background of the war/operation, the unit you will be with, where you are going, and the importance of the mission. Your "spin" on things has a huge impact. The fact that you are proud to go, but would always rather be with them if circumstances permitted, goes a long way. For some, the notice came through CNN, when news broke that a unit was deploying. In these cases, it is crucial to talk about the deployment with your spouse as soon as possible. Bad news never gets better with age.

**Family Concerns:** If you are married, make time to talk. Be open and honest with your spouse about your fears about the deployment and listen to hers/his. You are both probably worried about your safety. Naturally, you will see the same concerns from a different perspective, and there will be a host of smaller issues regarding your personal situations during the deployment. Your spouse will have fears about finances and how to take care of the children alone. The spouse staying home will worry whether anyone will be available for support. You will have concerns about how you will perform in the new environment, whether you will you be able to handle the stress of combat and casualty care. You will have a lot of ideas about how you will be living, whether you will be miserable or comfortable.

The deploying partner may at some point begin to feel excited about the upcoming deployment. If you have been in the military for any length of time, this is for some like the "big game" for which we have been practicing. Perhaps we have watched folks head off and have felt twinges of guilt or envy that even we find confusing. I have spoken to many officers and enlisted who confess to these feelings, and they have mentioned how difficult it is for the spouse or partner to understand. Now, faced with the deployment, there may be feelings at times of relief or anticipation on the part of person leaving. These will be very difficult for the remaining spouse to understand. The couple has to work through this area. And this raises another truth many have observed. People who have marital problems while on deployment tend to be the same people who have marital problems prior to deployment. A strong marriage can grow even stronger during a deployment. If there is time before deployment and the need, establishing a relationship with a family and marriage counselor who will be there when you return may be a worthwhile investment that will pay dividends on the other side of the deployment.

Both of you will at least have fleeting thoughts or fears of whether the spouse or partner will be faithful, whether they are at home or overseas. We have all heard stories. These are natural reactions to the unknown. This issue is worth discussing because both sides may feel guilty for even thinking about it, and thus embarrassed to talk. It may be a bigger fear if faithfulness for whatever reason has been an issue in the relationship. Regardless, silence will only fertilize fears that may be unfounded, and make the fears even harder to talk about. Talk to your spouse, to your fiancé, or partner. Really listen to what he or she is saying with an effort to hear the feelings behind the words. Understand that you both are under a great deal of stress and that you will each deal with the stress in a different way. This will be harder to do than perhaps any other time in the relationship because of the feelings involved. Do not assume that just because it is you that is deploying that you are the only one suffering. Some couples choose this time to renew their marriage vows either formally or informally, and to have their marriage "blessed"

and prayed for by their pastor or religious leader. Some couples exchange small items of jewelry as reminders of fidelity. The time before deployment is a great time to re-declare commitment to one another.

**Personal Preparations for Deployment:** You owe it to your spouse and your family to prepare them for potential negative consequences of deployment including the fact that you may come back wounded or not at all. Think about what they would experience if you did not come back. Think about making some preparations for that possibility.

**Soldier Readiness:** It is always in your best interest to keep your "Soldier readiness" issues current. These are things you will need to make sure you take if you ever have to deploy. If you have to accomplish these things in the weeks before deployment, you will lose time with your family. Do as much as you can early and keep these items up to date. To find references for all these issues go to the OP READY Web site at:
<http://www.armycommunityservice.org/vacs_deployment/data/modules/pbm/rendered/operation_ready.asp>

**Personnel Requirements:** Active duty Soldiers need a physical examination every five years after age 30 and reserve Soldiers require one every five years regardless of age (AR40-501 Standards of Medical Fitness). Different services have different requirements. The physical examination is one of the most common things to delay medical readiness. Keep your physical examination records current, along with your will, your durable power of attorney, I.D. and TriCare cards for family members, and the family care plan (AR 600-10.) Also, keep your immunizations up to date. One colleague of mine needed eleven different immunizations when he came though the mobilization site.

**Will/Power of Attorney (POA):** Make sure you have a will. Yes, the Judge Advocate General (JAG) folks can help, but make sure you are careful about who will help your spouse execute your will. Make sure that you have general/special power(s) of attorney as well durable power of attorney for health care. Assemble all these documents and make sure that someone you love and trust, in addition to your spouse, knows where all the information is. Ask for examples of all POA's that they routinely provide to Soldiers, not just settling on a general POA, this will ensure that you do not forget something that may be needed after you deploy.

**Special Instructions:** Some officers have gone as far as to do legwork for funeral arrangements and jotted those notes down. Some people leave notes in sealed envelopes with friends to be passed on if they do not make it back. You can always tear them up when you get home. But it will be a sign of your love for your family that you took the time to address the issue ahead of time.

**Medical Care:** Sometimes the deploying spouse has been the one who accessed the medical care system and the family remaining at home will have no idea how to negotiate through the clinic or hospital. Leave specific instructions about the family member's providers, and what information will be needed to get medical care. If you have a regular provider, make arrangements ahead of time and let your spouse know how to access care. We know how intimidating the system can be, and how much different it will be for our family members when we are not there to smooth things along. There are stressors in a deployment that are unique and

may require that family members access mental health care. Stress and episodic depression may be normal. If it lasts more than two weeks, or is associated with the signs and symptoms of severe depression, professional mental health care is needed.

**Red Cross:** Family members should also know about Red Cross and the information they would need to send an emergency Red Cross message (name, social security number, unit, current address, and phone number.) It may be a good idea to provide them with an example format that only needs the blanks filled in for completeness. If the Red Cross message is not specific enough, with the right information, the command may waste time trying to get all the details before sending you to the location desired in the message.

**Insurance:** Make sure that you have the maximum amount of Serviceman's Group Life Insurance and enough life insurance to take care of your family's needs. Update all your life insurance beneficiaries. Make sure you read the fine print on your commercial insurance policies. Many "private" company policies have a "war clause." This clause essentially negates the policy if you are killed while in uniform or in combat. The agent may not know or may elect not to tell you. I was surprised by the big name insurance companies that simply will not cover you if you die in a war zone. Check your policies. (Obviously, with the Uniformed Services Automobile Association this is not a problem, as they were initially founded with these circumstances in mind.)

**Finances:** Square your finances away before you go. Make sure whoever is handling your finances has access to your accounts and instructions on paying bills. If you plan on filing taxes while deployed, your spouse or designated other must have separate arrangements with the IRS to file your taxes. Usually a POA can be used to take care of your taxes if desired, otherwise an extension can be filled. Pay down credit cards to reduce debt. Research and understand the special pays and allowances before you deploy (i.e. hazardous duty pay, family separation pay) so that both you and the person handling your finances are aware of your proper entitlements. The Soldier readiness processing (SRP) site is not the place to research these benefits, as the folks working there may not know. For the record, doctors are entitled to all their specialty pays while deployed. Execute the contracts before deployment with your home duty station or immediately after you activate if you are reserve or guard. Folks in theater may not always know how to do this. Unlike your base pay, this specialty pay is not tax free.

**The Home:** Get as much taken care of at home as possible (the "honey-do list") before you go so that it is not left for your spouse or children to figure out. Gather information about resources you normally handle (plumber, electrician) for the family while you are gone. For many husbands in particular, this is a sore point. We are the ones who manage "the fleet" of vehicles and the mechanical, practical issues at home (refilling the propane on the BBQ, mowing the lawn, getting cars inspected or registered.) These things will still break down and need work while we are away. Can you trust your spouse to make the right decisions? If not, can you educate him/her to do so? It is a pretty common source of tension for people in theater and a recurring source of frustration: the car breaks down, and the spouse takes it to a mechanic to get fixed for something the deployed husband or wife would normally take care of. There are some things we just have to let go of for the time we are deployed. You can always fix or replace the car or the motorcycle. Damaged trust or lack of respect in a marriage is harder to repair.

**Medical Practice:** Deployment has a big impact on our medical practices as well. For physicians, especially for the reserve and guard, the deployment has almost as much impact on the lives of medical partners as it does on the immediate family. The office staff, hospital staff, and partners need to be brought in the loop as soon as practical, as often schedules will need to be changed and their lives rearranged as well. Someone has to take over all the committees and administrative issues with which you are involved. Someone may need to finish your research protocols or the work on a process improvement initiative. Spend time making a list of patients you need help managing while you are away and make sure that you find a way to contact them, even if it is as simple as a "form" letter you sign and have an administrator send. For select patients, it will be essential that you make a "hand-off" to another provider. Make that list early, then work though the medical record hand off as soon as you can so you can maximize the time you need socially with your practice or department family, and your family at home.

**Deploying Unit:** While we discuss the impact of the deployment on the Soldier and the family, it is worth remembering if you have limited advanced notice, that the unit was almost certainly not to blame for failing to give you advanced notice. Do not take it out on the command by pouting or whining. The unit has a mission to accomplish; everyone has a role in the unit; your position needed to be filled to save lives. That's all. It was nothing personal. Chances are the unit had been asking for a PROFIS doc for a while to fill the empty slot and had been stressed about the prospect of not having the position filled for deployment. You can guarantee that there is a fair amount of anxiety regarding the assignment of docs to the unit, so you are actually a welcomed asset. But you can sour that appreciation by blaming (through actions or words) the unit. Be cautious of the way you come across to your new unit after you receive deployment orders.

**Communications:** We are fortunate at our ability to stay in touch with our families and friends while we are gone. Even as recently as Desert Storm/Desert Shield there was no email. Folks wrote letters and phoned now and then. Today, I get email multiple times a day from my wife, my children, and extended family. Packages and letters come pretty regularly. Many docs use "web-cams" and instant messaging (although it is discouraged in some places with limited bandwidth.) Regular, scheduled video visits are available in all theaters. It is easier to stay a part of your spouse and children's lives than it ever has been. Ensure that your spouse and family understand that morale lines and computers may be turned off if there is an emergency or death in the unit. Explain to them that this frequently occurs so that the casualty notification process can be conducted properly and is not inadvertently sabotaged by another well-intentioned unit spouse.

Some families elect to withhold the "bad stuff" until you are home from the deployment. They try to focus on positive things in emails while deployed. Some share everything because that has always been the nature of the relationship. In either case, many deployed Soldiers and spouses at home talk about the importance of writing a journal so the difficult times can be worked through later.

**Operational Security (OPSEC):** Remember that you will need to practice good OPSEC. Your family cannot know everything about where you are and what you are doing. Know the specific requirements of your unit's OPSEC and do not violate them. Prepare your family for good

OPSEC by letting them know before you depart what you can and cannot discuss on a deployment, such as your unit's location, your unit missions, when you will be redeploying, and unit casualties.

**Deployment Imperatives**

- Be ready to go at any time.
- Break the news gently, and as soon as you can.
- Talk openly and honestly with your family.
- Invest time in your family and marriage.
- Make arrangements for event that something happens to you.
- Ensure you have a viable family care plan.
- Check your life insurance and your will.
- Take care of finances.
- Take care of your "to-do's" at home.
- Inform your patients and partners of your pending absence.
- Plan how you will stay in touch (email, web-cam, etc.).

# Chapter IV: Packing and Preparation for Deployment

## Introduction

Face it. Very few of us practice the kind of medicine that we will need to know when we get deployed to the field environment. We used to characterize the pace in the field as "hours of boredom punctuated by minutes of bedlam." The practice is a blend of boredom and bedlam. The kinds of diseases you will need to know about are different. There are the exotic diseases you have never seen before like leishmaniasis. In addition to the scope and breadth of combat injuries (topic of another chapter) pediatricians will need to know how to take care of a contractor with chest pain and internists will need to know about the causes of diarrhea in a host nation child. Surgeons will need to know how to provide primary care, not just operate. Some surgeons will not even be in a surgical slot, they may be assigned as a battalion surgeon. These are some of the areas to focus on during the pre-deployment preparation.

The deploying provider needs to learn the management of coronary artery disease and the management and assessment of chest pain. Routine medical problems follow service members to the combat environment. Hypertension and non-insulin dependent diabetes mellitus management are also important skills, not so much for the deploying service members, but so you can take care of the contractors who deploy alongside the Soldiers, this includes reserve component, national guard, and Department of the Army Civilians. You will be caring for them at every level facility. Many are retired military, but regardless, they very often do not have the same health screening scrutiny for a variety of reasons.

**Fundamental Medical Skills:** Stay current in the skills you need for the field, no matter what your specialty. Keep up with Advanced Trauma Life Support (ATLS) and Advanced Cardiac Life Support (ACLS) as well as the basic orthopedic evaluations and treatments. If you do not know what Tactical Combat Casualty Care is, seek out training on the topic, or at least read Captain Frank Butler's *Tactical Combat Casualty Care in Special Operations*. ***Military Medicine*** 161(August 1996): Supplement 1-16 or *Chapter 17: Military Medicine,* in ***The Prehospital Trauma Life Support Manual***, Fifth Edition. This information is different than what most of us were taught as medics, medical students, in the Officer Basic Course or in the Combat Casualty Care Course (C4) in the past. Learn the basics of preventive medicine and field sanitation. If at all possible, spend time in an orthopedic clinic and/or dermatology clinic. The AMEDD will need to come to terms with the fact that the Residency Review Committee (RRC) does not allow enough time in any residency to cover all the skills that a field doc should acquire. One thing that will usually save you is that you can almost guarantee that you will have a wide variety of expertise deploying with you. The physician assistants (PAs) and family practice (FP) docs, for instance, tend to have a better understanding of orthopedics than most other non-surgical docs.

Take the time to learn and understand the different "disease non-battle illness" (DNBI) categories. Know the air evacuation and triage categories (they are different and frequently confused by doctors.) Learn how to write a nine-line medical evacuation (MEDEVAC) request.

If you are a non-family physician, prepare yourself for general practice issues. Non-pediatricians should take the time to attend Pediatric Advanced Life Support (PALS) and Neonatal Resuscitation Program (NRP) if at all possible. You will be caring for infants and children regardless of your specialty if you are assigned to Afghanistan or Iraq. Become familiar with obstetric/gynecology OB/GYN subjects. Especially if you are a female, you may very well find yourself delivering pregnant women and treating various GYN issues. Familiarity with the basic use of psychotropic drugs and the approach to treatment for smoking cessation are also very helpful. Be prepared to work out of your comfort zone.

**Orthopedics:** A useful part of the preparation, if there is time, is to work in the troop medical clinic with the unit's PAs or brigade surgeon. Part of the focus of that training should be on the care of orthopedic injuries. The number and scope of orthopedic injuries one will encounter is impressive. Some of these are directly related to improvised explosive devices (IEDs) or vehicle-born explosive devices (VBEDs) and their associated battle injuries; others will be battle and non-battle injuries related to musculoskeletal injuries. Typically, these are severe enough to be seen by the orthopedic surgeon for definitive management. Thus, Soldiers with these injuries will either over-fly the lower levels of care, or will be stabilized and then air evac'd out.

However, the majority of orthopedic injuries are simply related to day-to-day activities. Soldiers twist ankles jumping out of their trucks, and mechanics routinely injure their hands. The number of recreational injuries will also amaze you. When they are not fighting or working, Soldiers play. Basketball accounts for a high percentage of injuries: sprained ankles, injured knees, complete ankle subluxation, achilles tendon rupture, shoulder injuries, etc. Prior to deployment, it would be helpful to spend a time with a radiologist, reviewing a variety of bone x-rays. It would also be helpful to spend time with the physical therapist in order to learn about stretching and strengthening exercises for shoulder, knee, and ankle injuries.

**Professional References:** There is a lot of discussion about gathering professional references for the deployment and a list of a few suggestions is at the end of this newsletter. Many people mentioned that their favorite reference has been <www.google.com>. It certainly has been mine here. Enough information on just about every subject can be found through Google, as well as pretty much any military regulation or field manual. Most every site you could be stationed at has internet connectivity, some better than others. More than one person has wondered how anyone fought a war in the days before docs emailed questions to each other, checked drug-doses on the Internet or completed web-based continuing medical education. The single most frequent solution to any staffing problem in any headquarters usually begins or ends with, "I'll email you."

**Exercise:** People work pretty much every day or at least six days a week. And most folks are in their workplace twelve hours a day a least. In our staff headquarters it is probably fifteen hours on average. Nearly everyone talks about the importance of exercise, and you need to carve time out of your schedule for it. Deployments are a great time to lose weight, tone muscle, or sculpt that perfect body. Come prepared for two-a-day workouts involving not just running but lifting, and in many locations aerobicycles, ellipticals, stairmasters, and muscle fitness machines.

**Laptop Computers:** Take creature comforts with you or get them when you get to country. A practically universal recommendation is that you bring your own laptop computer. Most can be charged at 220 or 110 volts (Iraq and Kuwait are 220V, Afghanistan is 110V) but check your charger. For medical practice, there are invaluable references you can load on the laptop including Micromedix and the Special Operation Medical Forces Handbook, as well as a host of other compact disk textbooks and references. People use the laptop for the same things they do at home: to type messages, work with pictures, keep a journal, play computer games, listen to music or watch DVDs. Some who deploy may be able to obtain the laptop on loan from the military, usually though their unit supply. It will only be the very rare situation where the surgeon does not have his own computer.

If you buy a personal laptop for deployment, consider getting it at some place like Best Buy and take out the extended warranty. Then when you return with it trashed from the heat and dust, you can have them refurbish it. Bring CDs and DVDs in a portable multi-disc holder. The movies are very popular to swap around-but make sure you label yours. It is also not a bad idea to buy a specialized "combat proof" case for the computer, like those made by Pelican <www.pelican.com>. If something happens to the computer, you will have to ship it home for repairs, so again, an extended maintenance warranty is essential. Many people also use and swear by their personal digital assistants (PDAs.) But again, get a hardy case for it.

Nearly everyone also has one or two USB "thumb-drives" to store pictures and documents. Again, they are available in theater, but not always compatible with every computer. Buy one at home before you come and then request through supply another one or two before or immediately upon deployment.

**Local Culture:** "Haji" is a term you will hear a lot in theater. "Haji" is derived from an Egyptian name meaning "born in the pilgrimage." Some folks think that its use derives from the turban-clad boy in the old cartoon Johnny Quest. It has evolved to become a derogatory term used to refer to all things local, in Iraq, Afghanistan, and Kuwait (Haji CDs, Haji DVDs, Haji thumb-drives, etc.). It has taken on the air of a racial slur, and is interpreted by some local folks that way. Be careful or avoid letting it become part of your vocabulary all together.

**Packing:** You are limited in what you can bring, unless you are assigned to the unit early enough to get stuff into their internal airlift/helicopter slingable unit (ISU) or connex container for shipping. In any case, do not take a suit case with you. If you have personal cold-weather gear and are deploying in the summer, leave it in a box at home, and have your spouse or a friend ship it at the appropriate time (in September or October.) Bring a change or two of seasonally appropriate civilian clothes and several sets of PT uniforms. Rules differ on different posts and operating bases.

The use of Ziploc® bags is very popular with some deployed personnel. Using plastic bags, one or two duffle bags, and the ruck-sack, you can be pack "bags in bags." For example, in the duffle bag, organize one of your issued green water proof bags with a bunch of quart-sized bags. Each one contains one set of underwear, t-shirt and socks. If you are in a dirty environment (most of the time) you only have to grab a Ziploc bag and take it to the shower point to change. Put your dirty underwear/socks back into this same zip-lock bag, squeeze all the air out, seal it

and put back in your laundry bag. With no air in the bag, the sweaty clothes are less likely to get mildewed before you can get to the laundry with them. Use other zip-locks bags for books, electronics, or anything else you need to keep dry.

It is remarkable how many things I thought I would need that I have not really ever used here. I did not appreciate how available things would be through the Post Exchange or the internet and mail. I mentioned to a friend in Afghanistan that I had ordered a guitar and had it delivered so I could play in church. He reached around the corner of his desk and picked up a Martin back-packing guitar he had ordered and was learning as well. You do not have to bring everything you think you will need when you first come. Travel with as little as you can initially. Then have things shipped once you get a feel for your location and capabilities. You may be in a hurry, but you will have time.

**Creature Comforts:** In addition to preparing professionally for the deployment, it is also important to prepare personally, to make sure that you are comfortable and that you have something you enjoy doing when you are not in the hospital or troop medical clinic (TMC). Travel light. You can pretty much buy whatever you need through the internet. And just about every company delivers, including the Soldier's favorite library, <www.amazon.com>. The kinds of things you might want to bring or buy is obviously personal and reflects the same kinds of things you might be interested in home. The "battle rhythm" is different than home.

If you are in a relatively stationary location, the Post Exchange is there. You can usually get things delivered to round out what creature comforts you want and did not bring. For example, <www.aafes.com> or <www.walmart.com> are reasonable places to order whatever comfort items you might want if the PX does not have it: TV, DVD player, antenna, microwave. The companies generally send through regular mail, so expect possible damage en-route. Companies shipping via UPS cannot send overseas. Actually, you will be surprised at how much "stuff" the PX has in most locations.

It seems like pretty much everyone has a digital camera. (Again, the PX carries them.) The camera is useful for both personal reasons as well as for medical documentation and transmission of images over the internet for telemedicine purposes. (Dermatology consults are available from anywhere 24/7 through email at <derm.consult@us.army.mil>. Ophthalmology consults are available at <eye.consult@us.army.mil>.) Inexpensive video cameras are also available so you can exchange videos back and forth with home. Service members also seem to favor MP3 players of all varieties.

Playing music as well as listening to it is a way people use their spare time. Unless you have an older instrument you do nt care about getting dusty, dirty, heat-shocked or broken, leave your instrument at home and order one. There are a number of companies that will ship to the desert (<www.music123.com> is used a lot). Folding chairs are great to have. They are also cheap (often less than ten bucks) and ubiquitous in theater. If you have a favorite brand of running shoes, bring an extra pair with you so you do nt have to search for them on line or in the Post Exchange. The heat and rough ground conditions are hard on all footgear; trail running shoes are probably well worth the money.

Wet wipes are widely used, especially before you can get reliable latrines. Some of the most sought after and requested items are the Under Armor and Duofold undershirts. These perspiration-wicking t-shirts do an amazing job. Headlamps are considered essential in field medicine, and some recommend bringing more than one. These can be obtained from most sporting good stores and most supply systems in theater. They frequently have the option of red, blue, or green light filters as well. I would not recommend the red filter as it makes it very difficult to see blood under that filter in the dark. Having an aid bag you can stock or, if you are coming with troops, one that is stocked ahead of time with first aid and sick call items is the best way to take care of the troops en route, including meds for upper respiratory infections (URIs), gastroenteritis, and musculoskeletal injuries, and a suture kit for cuts obtained along the way. Unlike earlier deployments, excellent cold weather ("snivel") gear is issued now including gloves, "neck gators" and Special Operations Forces Equipment Advanced Requirements (SPEAR) Extended Cold Weather Clothing System. Aviator gloves are very popular. They are one of the items in the "rapid fielding initiative;" an effort to get the latest gear to the Soldiers, but the gear has not made it everywhere. Other important items include Ballistic Wiley-X and Oakley goggles and glasses. These may be issued when you come or once you get there. Considering that these are quite expensive, you may want to wait until your unit issues them.

Coffee seems to be a very important creature comfort here and it is an easy thing for friends and family to ship. Many people have coffee makers, grinders, and even cappuccino makers or espresso machines depending on the location. If you bring electronic items, remember that you may need a power-transformer to use 110V appliances in Iraq or Kuwait. They are usually available at the PX in theater for twenty or thirty bucks.

**Deployment Packing and Preparation**

- Expect to deploy.
- Be prepared.
- Cross train to broaden clinical capabilities.
- Keep life-saving training current: ATLS, ACLS, PALS, NRP, TC3.
- Learn from the unit physician assistant.
- Know your orthopedics.
- The internet is your best reference (<www.google.com>).
- Travel light.
- Pack smart.
- Most commonly cited "necessities:" a laptop computer and digital camera.
- Order "niceties" on-line.

# Chapter V: Basic Field Items

## Introduction

During your preparation for deployment, you will be issued many items that you will not need. Do not ditch these items, as you will be billed for it when you get home. Pack things you are unlikely to use in one bag (cold weather gear if it is summer in Iraq, chemical gear, etc.) Lock that bag, label it and set is aside. It is sometimes helpful to put a piece of paper on the top inside the bag with a list of all the bag contains. That same list is something you might want to keep elsewhere, in case the bag is lost in transit.

Have one bag that is your go-to bag while the unit is moving. You should have everything you need at the top of that bag. Do not divide your essentials between different bags. Pack light and have things shipped later if you need them. Most folks have found that using plastic storage or clothes vacuum bags make packing and moving much easier. For example, some have used the large-sized clothing vacuum bags you can buy for about ten to fifteen dollars each. These can be used to condense clothes and sleeping bags so that they take up much less space. The plastic bags also slide over each other more easily in a tight duffel bag, making packing easier.

**TA-50 Issue:** In garrison, the day you get your issue of TA-50 may be the first indication that you are in the "real Army." (The name "TA-50" derives from the "table of allowances 50-901" for clothing. The document outlined the clothing and gear you deployed with.) The TA-50 equipment will either be picked up at the central issuing facility ("CIF") at the home station, or will be issued as part of the preparation at the mobilization site. If you have the luxury of getting the issue ahead before the deployment, ask an experienced noncommissioned officer (NCO) to take you through the assembly of the load-bearing equipment and the ruck-sack in particular. In most cases, the NCO will jump at the chance to help the doc make a positive impression. That same NCO can also help to coordinate the purchase of essential items for the field, including 550 parachute cord, a roll of "100-mile-an-hour" green tape, several green bungee cords and numerous other little items. Take a trip with him or her to clothing sales, then spring for lunch.

**Body Armor:** You will have to wait until you get to your unit before you know what the standard uniform is for your place of deployment. Some locations wear individual body armor (IBA) and helmet all the time, and do not use the load-bearing equipment (LBE). You are best advised to assemble the equipment and wait to see the standard when you get to your unit's location. Ask a senior NCO if you have a question. Learn how to wear and use ballistic eye protection and combat ear plugs. Get them for yourself. Again, the supply sergeant may be your best friend.

**Personal Weapons:** However, the physician in a combat environment is armed with the nine-millimeter pistol. While the practitioner should be an expert in the care and use of the firearm, its minimal firepower underscores the doctor's role in a fire-fight: survival and personal protection. The idea that survival and evasion should be a priority for a doctor flies in the face of our occasionally macho culture. However, a dead or wounded physician cannot treat patients, and thus cannot accomplish his or her primary mission. Depending on the mission, it may be a good idea for you to have an M-4 or M-16. There is an old saying, "By the time I need to have a

long rifle, there will be plenty lying around." I would not count on it. I have talked with more than a few docs who either could not get to an abandoned M-16 because of enemy fire, or when they did, they discovered that the now injured or dead Soldier that originally carried the weapon has expended all his ammunition.

One of the things rarely mentioned before you deploy are holsters. You will be issued the standard (Bianchi UM84-1) holster for your 9mm pistol. It is not very convenient. Most officers buy a "drop holster" or holster extension, so the pistol is lower on the leg while wearing the IBA. The Bianchi M1425 is an example that uses the issued holster, but people wear all different brands. Shop the internet. You will see green, black, and desert color commonly worn in theater. In addition, for times when not wearing the IBA, most use a shoulder harness of leather or nylon webbing. The leather ones are available in theater, but the better ones can be ordered on the internet. People wear black and light or dark brown. Finally, a number of folks recommend a third holster to wear when running; an elastic one with Velcro has been mentioned. Fire every weapon you get the chance to ahead of time. Qualify with the M-16 and M-4 if you can. One doctor mentioned that he wished he was better with the AK-47, so he could pick one up and use it in an ambush. Be familiar with any weapon system that is typically assigned within your unit. You never know when you may need it to defend yourself or your patients.

**Other Misc Items:** A durable flashlight (or two) is an important piece of equipment in addition to the head-lamp recommended elsewhere. The Micro-Light type are often hung on the uniform or LBE. Many also recommend the SureFire tactical lights, but they are expensive. These also come in numerous colors. In addition to the parachute cord and "100-mile-an-hour" tape, basic tools will be helpful: a screwdriver, small hammer, adjustable wrench. These are heavy, so try to ship them ahead with the unit. In any case, you can usually scrounge some to borrow from the post "DPW" or Maintenance Company. Everyone carries a knife of one kind or another. It is easy to get carried away with these to the point there they become a liability rather than an asset. (Ask a doc who has been "downrange" how many Soldiers he or she has sutured with accidental, self-inflicted knife wounds.) Something that folds and fits in the desert camouflage uniform (DCU) pants pocket is probably more than adequate. If nothing else it helps with opening meals, ready to eat (MREs). Crews on the charter plane you will deploy on get a bit nervous about big blades, and may ask you to check anything with a blade longer than 3 ½ inches. Make sure you pack and lock all these things if you travel commercial. In addition, almost everyone has a Leatherman or similar type tool. You will find yourself using it regularly.

If you are unclear about your eventual living arrangements, take a small "back-pack" tent. They are light and easy to pack. You may have to share living space in a very big tent with lots of people. For many people, personal space is important for sanity. In general, no one will care if you set up a pup tent instead of sleeping on a cot. With the tent, a self-inflating or air-mattress is an important comfort item. Early in the conflict, people swore by shower bags, although this is unnecessary in most locations now. Pretty much everyone is sleeping/living in at least "force protection tents" on cots and has access to shower facilities.

Another recommended personal item is the poncho liner. It is not always issued, but you can buy one for less than thirty dollars. It is the ideal field blanket: easy to clean, light, warm and

durable. It is definitely worth the purchase. A small mirror and a cheap, plastic travel mug in subdued colors are both frequently used (available in the Post Exchange if you want to wait until you arrive). Bring extra packages of subdued "desert" rank, branch insignia, unit patches, and badges. No one wears pin-on. It is easy to get them sewn on, with tailors on most posts. Bring them from home as it is not always easy to find the patch or insignia you need at every location. Worst case scenario, you can give the extras you bring back to friends as souvenirs. Tell them that you carried them to war. Bring a sewing kit just in case you do not have access to a tailor. Battle dress uniforms (BDUs)/DCUs get torn all the time and you may not be able to direct exchange (DX) your damaged clothing for a while.

**Temperature Extremes:** It is hard to overestimate the extremes of climate in the desert. In Kuwait and Iraq, it is routinely above 120 degrees during the day. If you are deploying in the summer, taking the time to acclimatize before you leave is important. Try to exercise in the heat of the day for up to ninety minutes for the two or three weeks prior to deployment. The new "under armor" t-shirts are very effective at wicking away the sweat and keeping you cool. Try this simple exercise to demonstrate the power of evaporative heat loss to medics and Soldiers: Take a cold bottle of water or IV fluids. Put it in a wet sock, and hang it to air-dry. Even on the hottest days, the temperature of the fluid will only rise a few degrees if the sock stays wet, if it is suspended so it can air dry. (The air is hot here, but very dry with relative humidity usually less than 15%.) People will laugh at first, but see how quickly they duplicate the experiment and apply it. I have seen civilian contractors with insulin dependent diabetes keep their insulin "refrigerated" this way for weeks. This is the way to stay cool when you do not have coolers or air conditioners. It is a great way to augment cooling when treating heat casualties. Stay cool by wetting your helmet liner or "neck-scarf" (check with commanders for local rules on this one).

**Personal Safety:** The best piece of field advice is to be cautious and to stay safe. Never let your guard down. All of the places you can be deployed are always potentially dangerous, all the time. Do not get careless. If you are aware of something that looks, acts, and/or smells like something that could kill you (i.e. bullets, mortars, rockets), react quickly with the proper training. Do not get casual no matter how anyone else seems to react. Chances are that someone is trying to kill you, and if you do not do the right thing quickly, you will be hit. As Winston Churchill once remarked, "There is nothing as exhilarating as being shot at and missed."

**Basic Field Craft**

- Assemble your TA-50 ahead of time.
- Pack smart.
- Know and wear individual protective equipment.
- Bring: holster(s), flashlights, Leatherman , knife.
- Make sure you have a poncho liner.
- Bring 550 cord, "500 mile-an-hour" tape, and bungee cords.

# Chapter VI: Army Units and Levels of Medical Care

## Introduction

Levels of care are so basic to the concept of battlefield health care that in the combat environment, the level of care provided becomes the name of the facility.

> "The patient was transported to the Level III for surgery."
> "The x-ray is down in the Level II."
> "The Soldier was MEDEVAC'd to the Level IV to get the surgery."

In order to be able to speak the language on the battlefield, the deploying doctor or provider has to understand these basic levels, or echelons, of care. They are not unique to any one service. With minor variations, the terms are used across by all services across the military.

**Level I:** At this level, care is provided by designated individuals or elements that are organic to combat units, and by elements of the area support medical battalion. Typically, this care is provided by a treatment platoon attached to the battalion. It is led by a second or first lieutenant medical service corps officer. Depending on the battalion commander's preference, in some cases the battalion surgeon (the attached doctor) will assume command of the medical treatment platoon. Level I care focuses major emphasis on those measures necessary to stabilize the patient and allow for evacuation to the next level of support. The elements of this care are not limited to the battalion aid station, but in fact begin with the Soldier at the point of injury.

At the point of injury, Level I care begins with self-aid, buddy aid, and first responder aid. Great strides have been made in self-aid during Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF), especially with the universal recommendation for tourniquet use. Ideally, each Soldier deploys with a tourniquet for self-use. Often, it is the division or brigade surgeon who ensures that the Soldiers are issued these prior to deployment. They are only recently becoming part of the basic issue.

The next higher Level I care is the combat lifesaver in the Soldier's unit. These Soldiers receive roughly forty hours of training in basic first aid and stabilization. Though currently under revision, the combat lifesaver bridges the gap between the first responder and the combat medic. A combat medic is assigned to each platoon. These 91Ws are trained and certified as emergency medical technicians (EMT) in their basic and advanced training. Medics are trained as "EMT-Basic" or "EMT Level I." The EMT-1 has the emergency skills to assess a patient's condition and manage respiratory, cardiac, and trauma emergencies. For reference, the EMT-Intermediate medic (EMT-2 and EMT-3) has more advanced training that allows the administration of intravenous fluids, the use of manual defibrillators to give lifesaving shocks to a stopped heart, and the application of advanced airway techniques and equipment to assist patients experiencing respiratory emergencies. EMT-Paramedics (EMT-4) provide the most extensive prehospital care. In addition to carrying out the procedures already described, paramedics may administer drugs orally and intravenously, interpret electrocardiograms (EKGs), perform endotracheal intubations, and use monitors and other complex equipment. Though they usually lack the formal certification, many medics, by nature of their experience and informal

training, are capable of skills across this spectrum. Though combat medics are only trained to the EMT-B level in Advanced Individual Training (AIT), we must encourage and support them in pursuing higher levels of medical training through motivation or re-enlistment contracts.

The first formal treatment capability at Level I occurs at the treatment squads or the battalion aid station (BAS). Typically, the BAS is staffed by a physician assistant and/or a physician, as well as a number of junior and more experienced medics. The physician also typically functions as the battalion surgeon, acting as a staff officer for the lieutenant colonel battalion commander. At this level, a provider is expected to be able to function independently in providing basic sick call and acute trauma life support for casualties. It is worth stressing that today's Soldiers are really professional athletes. The physicians selected for this position are almost always PROFIS physicians. For combat arms units, these physicians are generally men. It is very common for PROFIS physicians to complain that their medical skills are not utilized well in Level I settings. And in truth, that may be the case. However physicians assigned at this level need to have specialized knowledge and ability unique for the care they will be required to provide. For example, providers must have expertise in the recognition, treatment, and rehabilitation of musculoskeletal injury. This is, in fact, a skill set identified by nearly all deploying docs as one they wish they had spent more time developing.

**Level II:** At Level II, care is rendered at the medical company. Level II care is typically performed by company-size medical units organic to brigades, divisions, and area support medical battalions. The support battalion's medical company is an example of this type of a unit at the brigade level. At this level the casualty is examined and his wounds and general status are evaluated to determine his treatment and evacuation precedence. Emergency medical treatment, including basic resuscitation, is continued. If necessary, additional emergency measures are instituted. Additional emergency measures do not generally go beyond the measures dictated by the immediate necessities. Known as the division clearing station, it is the first place in the levels of care that has a whole blood capacity. There is also limited x-ray and dental services. It is also typical for the Level II facility to have a patient hold capability that is supervised by a nurse attached to the unit. Patients who can return to duty (RTD) within seventy-two hours are held at this level for observation and treatment.

The medical company generally includes a number of providers including the brigade surgeon. The brigade surgeon is often a senior captain or major assigned to the unit for two years or longer. Formerly, this position was generally occupied by a general medical officer. More recently, board-certified specialists are assigned these tours. Typically, the brigade surgeon is a family practitioner, internist, emergency medicine physician, or pediatrician. The brigade dental officer is also assigned to the medical company. In garrison, the dentist works in the post dental clinic, but he or she deploys when the unit goes to war. In a mass casualty situation, the dentist by doctrine is supposed to act as the triage officer. In practice, the triage officer should really be the most experienced and most skilled of the medical staff, this is usually not the dentist. Dentists are best utilized by helping the senior NCO monitor flow, track casualties, and coordinate MEDEVAC. There may be two to three additional PROFIS physicians or PAs assigned to the medical company to provide Level II care.

**Level III:** At this level, the patient is treated in a fixed medical treatment facility staffed and equipped to provide resuscitation, initial wound surgery, and post-operative treatment. In the Army system under the recent medical reform initiative, the combat support hospital (CSH) is the prototype of the Level III facility. The CSH generally has the full capability one would expect from a community hospital and trauma center, including medical and surgical specialists. The hospital cares for trauma patients and patients with non-battle injuries who are expected to recover within two weeks. Those who need a more extended hospitalization or rehabilitation are generally evacuated to the next higher level of care. There are more than three dozen CSHs in the Army inventory. These hospitals are typically staffed by PROFIS physicans: surgeons and surgical specialists (including gynecologic surgeons), internists who also function as intensivists, family practitioners, radiologists, and occasionally pathologists. Mental health professionals are also well represented. In specific circumstances, a pediatrician or family practitioner with extensive pediatric experience will be requested, as with the hospital at Bagram Air Base in Afghanistan, where a significant number of critically-ill pediatric patients have received care. In addition, a pediatric intensivist has provided extensive support to the intensive care unit (ICU) of the hospital in Baghdad, where critically ill pediatric patients regularly receive care. Over the last ten years, CSHs have been "manned" by mission-driven requirements and providers specifically picked to fill billets based on likely patient/casualty types. This frequently results in not deploying an entire CSH into theater, especially once stability operations begin.

If an injured Soldier receives advanced medical care within the first hour after injury, the chances of survival and recovery go up exponentially. Historically, ten to fifteen percent of those wounded in action require surgical intervention to control hemorrhage and provide stabilization before evacuation. Forward surgical teams (FST) are highly mobile units deployed far forward near the fighting to allow for early intervention. The FST provides versatility, expandability, and deployability. Typically, the team deploys in the area of a maneuver brigade or armored cavalry regiment and includes 20 staff members organized into four functional areas: triage-trauma management, surgery, recovery, and administration/operations. The unit's mission is to provide initial surgery on two operating tables, and up to six hours of postoperative care for a maximum of eight patients at a time. When properly staffed, the unit can treat major chest and abdominal wounds, continuing hemorrhage, severe shock, compromised airway or respiratory distress, amputations, major organ fractures, crush injuries, and acutely deteriorating consciousness with closed head wounds. Occasionally, the FST may be attached to a CSH to provide additional surgical capability, but more recently they have been pushed down to the brigade level and are more frequently co-located with elements of the brigade-assigned medical company.

**Level IV:** At this level of medical care, the patient is treated in a hospital staffed and equipped for general and specialized medical and surgical care and reconditioning and rehabilitation for return to duty. For OIF/OEF, the Level IV facility is Landstuhl Regional Medical Center in Germany. Many providers from all services have been assigned to this institution to supplement and support the dedicated staff who are providing medical and surgical care for literally hundreds of service members weekly. In general terms, patients remain at this level of care if there is an expectation that they will be able to return to duty in theater.

**Level V:** For operations OEF/OIF, the Level V facilities include medical centers and medical/dental activities across the Continental United States (CONUS). Care delivered at this level includes reconditioning, rehabilitation, and long term support for those who are not expected to return to duty. Every effort is made to return the service member to the facility closest to his or her major source of support, whether it is the home station or another medical facility close to extended family. These CONUS-based support facilities represent the most definitive medical care available within the Health Services Support system, and increasingly they are the facilities were we live and work on a daily basis in garrison. Walter Reed and Brooke Army Medical Center are two well known Level V facilities in CONUS.

**Levels of Medical Care**

- Level I: The Battalion Aid Station
  - » Tactical Combat Casualty Care
- Level II: The Medical Company
  - » The Field Troop Medical Clinic
- Levle III: The Combat Support Hospital
  - » Specialty-based "hospital" care
- Level IV: Theater Hospital
  - » Rehabilitate and return to duty
- Level V: Home Station Hospital
  - » Long-term recovery

# Chapter VII: The Physician in the Battalion Aid Station (Level I)

## Introduction

Soldier care at the level of the battalion aid station (BAS) is "warrior medicine," especially during the combat/maneuver phase of war. Providers at the BAS move with the maneuver unit along side the Soldiers. In the opening phases of OIF and OEF, these doctors, many of whom were PROFIS fillers, performed magnificently. They were constantly in or close to firefights. To read what they have written and to listen to their stories is to hear of experiences that changed their lives, and how they became bonded with the Soldiers with whom they served.

**Warrior Ethos:** More than any other place, assignment to a BAS (or its equivalent with Marine combat units) requires that the doc be a warrior. Good physical conditioning and the ability to operate in austere conditions are essential. Weapon skills, comfort with all the personal protective equipment and knowledge of field craft are requirements. If you get the chance, get your license to drive military vehicles, especially the high mobility multi-purpose wheeled vehicle (HMMWV). When you get to the unit, show up in the right uniform with the right patches and the right equipment. Wear the uniform and equipment correctly, all the time (AR 670-1). Remember that in so doing you are not doing your company commander "a favor." This is the expectation for all the Soldiers in the battalion. You are one of them.

**Fitting In:** Pay careful attention to rank. It tends to mean a lot more in the battalion than it does in the hospital. Captains, majors, and sometimes lieutenant colonels may all be staffed together and address each other by first name in the Medical Department Activity (MEDDAC). It is not the case in the battalion. Do not get lazy or cut corners with regulations or standards, especially when it impacts on your safety or the safety of the medics with whom you are working. Because you are a doctor, you will be more closely scrutinized, especially early on before you become "their" doc. And becoming their doc is your goal.

**Organization:** If you go to a forward operating base (FOB) get to know the FOB commander. After the battalion commander, this officer is your most important ally. He can also be your greatest enemy if you start out on the wrong foot. Meet the FOB staff. In fact, befriend them. Theirs is a lonely job and they are the ones who will be in the best position to support you. Be wary of those above you in the chain of command who do not seem to do their job and resolve never to be thought of the same way by others. Watch out for people who make rules for the sake of uniformity and for those who seem to make decisions without regard for the consequences.

Your most likely source of conflict will be with the medical platoon leader. One of the questions you need to resolve up front with the battalion commander is the question of who commands the medical platoon. Stories abound of difficulties both ways. As the doc filling in at a BAS, you will often be the senior medical officer. However, you may not be in the chain of command. This leads to inevitable conflict because the very junior will likely be uncomfortable with your rank and position. At best he or she will be threatened by it. It is exacerbated in some situations because the doc is the medical leader that the medics look to for anything resembling a medical decision, which is almost every decision when you are deployed. In garrison, it is simpler for the

lieutenant to command because the issues are more training and equipment maintenance. In the field, however, the business is medical, whether it is sick call or mass casualty (MASCAL). Get your commander's intent early, and develop a close relationship with the platoon leader. Look at it as an opportunity for mentoring, or at least mutual growth and education. This young lieutenant can teach you a lot about the Army. And you can teach him or her much about medicine.

**Mission Planning:** It is useful to know when the Soldiers of the battalion are going "outside the wire" on a mission or when they are going to be firing their weapons. It allows you to prepare for possible casualties. In this regard, knowing the company commanders and gaining their trust is essential. Many times your medics and an FLA will accompany the infantry on their mission and the company commander will look after your people. While the provider typically stays back at the aid station, it is worth going with the infantry on a mission at least once so you can appreciate what they go through. Obviously, it is a decision for your commander and there is a possibility that both the doc and PA get sliced down to the maneuver company level or below, depending on the mission. But if there is a civil affairs medical mission that involves treating the local population, chances are you will be included. In both Iraq and Afghanistan, female medics and doctors tend to be in high demand for these missions, because in the Muslim culture, the women do not receive care from male medical personnel without resistance.

**Operations:** In garrison, it is easy to send someone to "the specialist" for minor procedures like toenail removal or incision/drainage of an abscess. These are skills the BAS physician needs to have for a number of reasons. One of the goals of field medicine is to treat the Soldier as closely to his unit as possible. In the BAS that means you keep the Soldier close to the front. It is dangerous in some cases, impossible in others to refer some cases. In Iraq, you really cannot do frivolous ground evacuations back to the forward support battalion or hospital. Patient movement requires arranging a convoy, and always puts people at risk with exposure to improvised explosive devices (IEDs) along the way. In Afghanistan, all patient evacuation is by air. Ground evacuation from some FOBs takes up to seventeen hours. It is simply not an option. Also understand that extreme weather conditions abound. Dust, wind, snow, and clouds can force you to hold a casualty for up to 72 hours.

Always do what is medically right for the Soldier, but know that sometimes you will have to adjust how you do it. For instance one doc reports the ambulatory treatment of cellulites of the hand by bringing the Soldier back to the BAS several times a day. The medics started a new intravenous line each time and hung antibiotics (cefazolin) for several says, until treatment could be changed to an oral medication (cephalophin.) Needless to say, the Soldier and his chain of command were thrilled because he did not need to be evacuated and could receive care and still support the unit's mission.

The job of battalion surgeon is not too difficult to learn. Much of what you will be called to do is not difficult medically, with the exception of trauma medicine. The most common, recurring challenge will be in being a military leader in this setting. This should be a big part of your focus. Meet every first sergeant in the battalion, and every NCO down to E-6. Make sure that you provide medical care to everyone in the unit if you can, without regard to time of day (difficult for those used to fixed sick-call hours.) Live and work alongside your medics. Respect

their opinions. Let them make decisions as often as possible. Learn their spouse and children's names and ask about them regularly. Take their problems and concerns seriously. Be extremely clear with instructions and praise them liberally for their successes. Treat them better than you think they need to be treated.

**Teamwork:** Live with your medics, if possible. If your medics do not have air conditioning, neither should you. Promote re-enlistment. Counsel your medics on career options; help them dream, and help them realize those dreams. If you are tasked with a job that is not inherently medical, do not balk. "Not my job" should never grace your lips. Do physical training (PT) with your medics often. If they see you doing it, they will follow your example.

**Training:** Training and development of medical battle-drills with medics or corpsmen assigned to the unit should be part of your preparation. As teacher, you must know advanced trauma life support (ATLS), tactical combat casualty care (TC3), and suturing skills. Spend some time in your hospital emergency room (ER) or orthopedics clinic if you need to brush up.

**Supplies:** Know the treatment of and check to make sure you have enough supplies for the treatment of orthopedic injuries. Remember you are caring for what are essentially professional athletes. Have the unit order a plethora of Velcro wrist splints, several knee immobilizers, ankle braces that lace and fit well in the combat boots, and some weight belts for Soldiers on details that require a lot of lifting.

**Geneva Convention:** Act like a field grade officer and be a leader for the medical unit. Your battalion commander may try to waive your unit's Geneva Convention rights if he needs to. He may not know any better, so medical officers need to know the rules ("The Laws of Armed Conflict" from **FM 27-10, *The Law of Land Warfare*** ). Individuals protected under the Geneva Convention as medical personnel are not allowed to voluntarily give up (in part or in total) their protective status. They also cannot be ordered to violate the rules. Once you do something that causes you to forfeit your protective status, you are not allowed to regain it (it is not an on/off thing). The example that comes to mind is guard duty. The medics and docs are not permitted to pull perimeter guard duty for the FOB due to its inherent offensive duties. They can, however, pull guard duty in small patrol settings or guard patients from enemy actions. The perception is often "those medics don't pull guard duty or do anything but sit around in the aid station." It is important for the medics and medical folks to be seen doing other non-guard-duty jobs around the FOB. The key is to make sure that you and your medics pull your weight. The fact that the enemy will disregard the Geneva Convention is not an excuse. We signed the agreement. We are bound by it, and we would hope our enemy would follow the rules as well.

**Miscellaneous:** Counsel your NCOs early and often. Do "curbside" sick call for the command group and their staff. Keep the unit's immunizations up to date. This is one of the "metrics" that reflects on your commander's leadership. You can easily help him out, and keep it off his radar. Find out which medics are not receiving packages from home and have something sent to them. Learn about awards, especially Combat Medical Badge and Purple Heart criteria. You will be looked at as the "expert" on these and asked to advise the command on whether Soldiers have met the criteria. Be aggressive about writing awards for your Soldiers.

In the battalion where you live with Soldiers, being a Soldier is what counts most. Be an officer first. Mentor military development in yourself and others. You will be working with warriors. Walk humbly, and become a warrior too.

**The Physician in the Battalion Aid Station**

- Practice Warrior Medicine.
- Know field craft.
- Be an excellent Soldier.
- Drill for MASCAL.
- Train to practice field orthopedics and sports medicine.
- Get to know the battalion commander and battalion staff.
- Walk carefully through the "command minefield."
- Routine evacuation will be near impossible at times - learn to make due.
- Know your Soldiers.
- Work and walk with the warriors.

# Chapter VIII: The Physician in the Support Medical Company (Level II)

## Introduction

In the combat and maneuver phase of an operation, all the same advice given to a doc deploying with a battalion aid station (BAS) applies to one assigned to a medical company. The medical company is truly the deployed troop medical clinic, providing the range of acute minor illness care to resuscitation following severe trauma. Docs at this level need all the skills of the Level I doc, as well as the range of skills they have developed in caring for Soldiers in garrison.

When the unit is moving, you provide basic, Level I care: sick call and trauma resuscitation. The biggest differences are the unit size and Level II capability once the maneuver stops and sets up shop either in tents, in a fixed facility such as trailers, or in a "borrowed" building.

**Organization:** The physician assigned to the medical company will be deployed with several physician assistants (PAs)and several other physicians (usually other PROFIS officers.) The brigade surgeon is usually the only permanently assigned staff officer. This is usually a young captain fresh out of residency (ER, family practice, pediatrics or internal medicine), a general medical officer (rotating internship graduate), or a residency trained senior captain or junior major. A frequent area of conflict occurs when the PROFIS physicians outrank the brigade surgeon, especially if the PROFIS docs are of a nature to remind people of their rank on a regular basis. (Generally this is an unnecessary exercise. If you find yourself having to point out your rank to people frequently, something is probably wrong.) The medical company has the same basic equipment as the Level I BAS. It also has a number of holding beds ("patient hold") with a capacity for patients to stay for up to 72 hours. There is also a patient evacuation section with ambulances (M997 filed litter ambulance [FLA]). In the current deployed environment, it is not unusual for a Level II medical company to deploy with and support a hospital surgical slice or a forward surgical team. This arrangement takes extraordinary leadership and communication skills on the part of all the professionals involved.

**Functions:** Practitioners deploying with a medical company will generally be assigned or involved with one of three functions, and often all three at one time or another. According to doctrine, the dentist acts as triage officer in a mass casualty (MASCAL). In truth, having the most experienced clinician in that role is better. Treatment teams will operate in the medical facility under the leadership of a clinician. Patient evacuation is also a provider's responsibility, especially in a MASCAL situation where one clinician will be responsible to monitor patients already treated until they leave by ground or air. In many cases, the provider assigned to help cover the patients in patient-hold will also supervise the clinical aspects of patient evacuation. Each unit operates differently. These battle drills should be discussed and rehearsed ahead of time.

Once the medical company is set and the unit transitions to "sustainment operations," the bulk of the company's work will be sick call. Historically, disease, non-battle injury (DNBI) has resulted in far higher numbers of casualties than battle injury. Such is the case at most Level II facilities in Southwest Asia today. Service members in the field suffer from musculoskeletal injuries, skin infections and rashes, respiratory infections, and gastrointestinal infections with

vomiting, diarrhea, and dehydration. Minor and major medical problems including anaphylaxis, insect stings, arthropod and snake bites, and cold and heat injuries constitute a significant portion of the physician's efforts. In the combat theater, sick-call is often 24 hours a day, and the medic screening and self-treatment protocols can often be helpful in making sure that the clinicians get enough sleep.

**Operational Tempo (OPTEMPO):** One recurring problem which plagues the medical company is the "changing class picture" where professionals and support staff are continually rotating in and out of the company area either due to reassignment, rest and relaxation (R&R), or curtailed PROFIS rotations. Poorly coordinated work/rest cycles may place professionals with support staff whom they do not know well. Having teams cross train obviates this somewhat. Battle-drills, even dry-run at the beginning of shifts to determine roles in an emergency, is time well spent.

It is in vogue for commanders to push providers out with the Soldiers either to support them medically or to participate with them in medical readiness outreach exercises. This puts a drain on the personnel and on the CLVIII (medical) supplies that must be accounted and compensated for. Generally, there is enough redundancy in the system to allow for these other missions or situations, but the commander should be advised regarding the potential impact and degradation of services at the company.

Casualties die in combat because they do not receive appropriate care at the point of wounding, or they do not reach definitive care quickly enough. Trauma victims generally need an operating room and a surgeon. This truth is the basis of deploying surgical "slice" elements from the combat support hospital or forward surgical teams. In general, neither of these is organic to the medical company. Thus every effort is made to get trauma victims to surgical therapy as quickly as possible. Even where there is surgical capacity positioned with the medical company, if expeditious evacuation to the Level II facility is available, the medical company may be bypassed and the patient flown directly to the hospital.

**Key Personnel:** The key people for you to meet in the medical company are the same as those in the BAS. The list includes the battalion commander, the medical company commander and 1SG, and the battalion S4. Approach the battalion commander early on and ask him what the overall mission of the unit is. This will help enormously in understanding your role in it and also help you to understand why your priorities may not be the same priorities of the command. For example, it may not make sense for you to push to build a fixed troop medical clinic (TMC) if the unit is going to move in the next few days or weeks.

The medical company is usually a captain who has already served as a medical platoon leader as a lieutenant, and has done one or two staff positions in the company or battalion. The company command is a huge deal for him, and is often a major determining factor for promotion to major and selection for intermediate-level education (ILE) military training in residence (Command and General Staff College). So, the commander will be under a great deal of pressure. If your company commander really has as his first priority the medical care of Soldiers, he will be a great asset. Most commanders are great officers who aggressively look after their people, including you if you let yourself be a part of the company. Whether or not you want to be a part

of the company is a decision you will have to make early on. Do physical training with the unit. Go on road marches. Become a part of the unit.

Even though the company commander has command authority over the docs, as a captain he or she will probably be out-ranked by the doctors. Thus there may be a bit of an inferiority complex about the rank difference at the beginning of the deployment. Make it clear to the commander that you work for him, even if you are a major or lieutenant colonel. If your company commander seems only to care about his officer evaluation report (OER), he will only be helpful in so far as the battalion commander's priorities coincide with your own. Regardless, if he sees that you are not interested in competing with him, he will tend to be more helpful in reaching your goals in providing Soldier care.

On the other hand some people are just stubborn. If this is true of your commander, he may need to be reminded that the providers have to have what they need to do their job. Assess his leadership ability early. You may have a commander with great intentions. If he does not know how to communicate to the Soldiers, he will be a detriment. Even with aggressive efforts toward mentorship, you will probably be unable to change some commanders. But you can modify how you approach issues with him based on what you observe. Let your company commander know early on that you are his ally, that you are committed to the unit's success in caring for patients and to his success as a commander.

The unit NCOs are also key allies. In particular, the first sergeant will take care of you – if he sees you as a part of the company. (By the way, his name is "First Sergeant," not "Top" unless he invites you to call him that, and never "Sarge.") The treatment platoon NCO also is a key person to know. If you have dysfunction in your TMC or treatment area, this is the first person to help fix it. Unfortunately a weak, poorly trained treatment platoon NCO can make your entire TMC run poorly.

**Civilian Medical Operations (CMO):** If the unit will be doing CMO, you can expect to see children. You will need to determine whether the unit is equipped for this mission (with liquid antibiotics and children's multivitamins, for example). Will the unit be responsible for the care of detainees? If so, diabetes is very common in Iraq. Insulin and hypoglycemic agents need to be added to the list of drugs. All of these items are available through the supply, but you need to be specific. One logistics officer pointed out to me that he could not just order "pediatric stuff." You need to know what you want. One additional word of caution when you are going through the medication lists: Before excluding anything on the list, make sure you review it with the dentist. Some of the items that you may not recognize belong to the dentist.

**Supply:** The S4 is the person from the battalion staff who can help you get anything you want. Supply and equipment will be a challenge for you, first because what is available in the medical company is not what you have at the hospital. Get familiar with the unit equipment and medication stock before deployment. Know everything in the medical and surgical chests. Know what medications you will have for sick call. Be reasonable about demanding your favorite drugs. If you really need to have it to practice good medicine, then order it. But in most cases the medications you have in the chests will be enough to care for 95% of what you will be

seeing. (For example, you may not have azithromycin packs, but doxycycline works well for afebrile pneumonia in adults.)

Depending on the preferences of the division or brigade surgeon, the basic medication stock may be modified, sometimes by the addition of trendy medical items of questionable use. A popular current example is quick clot. This is a powder that promotes clot development in a rapidly bleeding individual by inducing chemical "cautery" action. Surgeons in general tend to hate it because this material makes it very difficult to perform surgical repairs. It can also cause second degree burns. But since it is "new," it is attractive to staff officers who really are trying to do the right thing for patients. Before jumping on this sort of bandwagon, check with other experienced providers or the appropriate agency within the Army Medical Department (AMEDD) prior to potentially wasting away Soldier lives or needed funds.

You would think that the standard list of drugs and equipment is rigid. In fact, there really is some variability and flexibility. A Level II has x-ray, dental, lab, and patient hold capabilities by definition. But there is really no protocol for the specific laboratory capability, and the equipment is variable. Learn the capability ahead of time. This is a simple fix. Many of the small, portable chemistry machines are in the ordering system, are easy to use and are very durable (Piccolo, I-Stat.) Knowing the unit location and mission will be helpful. If the unit deploys to one isolated location you should push to have a robust laboratory capability. Usually, if you explain it to the commander he or she will be supportive, and the laboratory technician (you will have one in most companies) will jump at the opportunity to have more to do.

**Electric Power:** Electric power is something that you take for granted in a clinic in the states. It is not a given in the field, and the doctor should be at least familiar with the challenges of a reliable supply of electricity. For example, the dental mission is a huge drain on power. The dentist will need to be able to do exams, dental x-rays, cleanings, fillings and minor operative procedures. This work requires a generator by itself. The additional x-ray machine will probably require its own generator. The treatment and patient hold tents also need power for lights and equipment. All of this equipment is damaged easily by desert dust and heat. Although deploying operating generators is not the doctor's primary job, it is important to be able to ask the questions ahead of time. When you do, the command will realize that you are considering broad aspects of the mission, and will be more likely to see you as a part of the team.

**Required Skills:** It is worth brushing up on some specific skills before you deploy with the medical company. In addition to advanced trauma life support (ATLS), a physician should be familiar with Tactical Combat Casualty Care (TC3). There are several things about ATLS that are just not practical regarding the care of wounded Soldiers. For example, the vast majority of preventable casualty deaths are from exsanguinating limb injuries (66%) and pneumothorax (30%). These problems can be addressed by simple procedures: a tourniquet or needle decompression, respectively. Tourniquets are discouraged in some settings and by some instructors. But their use should be encouraged. Do not hesitate to use them even at the Level II before evacuating a patient to higher care. Remember that a bulky dressing is not a tourniquet. It just hides the bleeding long enough to get a Soldier out of your treatment tent, but it may also cost him his life if he bleeds out on the helicopter ride.

In addition to the trauma skills, more mundane routines include the removal of ingrown toenails and suturing. Also, being comfortable reading bone x-rays, especially of the ankle and wrist, is essential. Learning specific physical therapy exercises is also helpful. In fact physical therapists and chiropractors would be well utilized in the medical company, especially when the brigade units are co-located. Our patients are truly professional athletes, and we are often ill-prepared to keep them in peak "performance" condition. Pediatricians tend to get called for the placement of difficult intravenous lines. A half-day in the operating room placing peripheral and central IV lines is time well spent.

**Medical Records:** Routine Soldier health care is the bread and butter of the medical company. Make sure that your Soldiers' deployable medical records (DD 2766) are completed. This is especially true with respect to their immunization status and G6PD status. The Soldier's immunization record never seems to be complete and is often scattered through the records. You will be surprised how important this immunization mission is. Because of this, making sure that several of the staff have accounts in the centralized medical protection system (MEDPROS) immunization data base will really assist your command in keeping track of something that they get "beat-up" on regularly.

**Vaccines:** All of the posts have local wild critters that Soldiers feel compelled to play with. Make sure that you have rabies vaccine and immunoglobulin available. There are also a host of very poisonous snakes in Iraq. Usually, the local Level III will have snake anti-venom along with the strict guidelines of how to use it. Know who has the anti-venom. You will very likely need it.

**Fitting In:** Some of the best advice for the doc deploying with a medical company includes the same basic things you would consider and do if you deployed at any level. When you have a problem, suggest a solution. Use common sense. Be willing to socialize and be yourself. But avoid getting too personally friendly with the medics. Do not let any of the enlisted have any reason to think you have favorites. Do not allow them to call you by your first name. Do your job well and with enthusiasm. That way when you do complain about problems, people will listen. Always make yourself available when called upon, even when you are tired or depressed (something everyone experiences now and again.) Working gets you out of your depression and the unit learns that you really care. Be protective of your rest time, but flexible enough to respond to Soldier's needs.

Be willing to jump in and do the manual labor. Be physically fit so that you can out-score most of the enlisted on the PT test. Go to bat for the line Soldiers (for example, pushing to get one of the Soldiers sent home on emergency leave whose wife was maxed out on tocolytics and is going to be delivering a very premature infant.) Be aggressive about awards for your medics. Start working on write-ups with the platoon leaders early on in the deployment.

**The Level II Physician**

- TMC medicine
- Know advanced trauma life support.
- Get to know, trust, and be trusted by the battalion and company commanders.
- Get to know your logistician (supply officer).

- Know the Level II missions and capabilities.
- Keep Soldier's immunizations up to date.
- Know your Soldiers, but not too well.
- Know the company lines of communication.
- Learn how to communicate with folks at the higher Level of care III.
- Learn medical logistics.
- Listen when you come to the unit.
- Never say, "That's not my job."

# Chapter IX: The Physician in the Forward Surgical Team / Combat Support Hospital (Level III)

## Introduction

More than at any other level, the provider who deploys with the Level III facility will likely feel right at home. In a stable environment, this facility more resembles the table of distribution and allowances (TDA) facility in the states than any other place you might be deployed. Staff wear scrubs, work with state-of-the-art equipment, and care for a wide range of medical and surgical diseases, in addition to battle wounded. There will be obvious differences, of course, as in many of the facilities in Iraq or Afghanistan the staff will wear weapons and in some the wear of individual body armor (IBA) and Kevlars all the time is recommended. And of course, in any of the Level III facilities in theater, you stand a good chance of caring for adult and pediatric host-nation patients.

**Key Personnel:** Meet the deputy commander for clinical services and the chief nurse early on. These are the folks who set and enforce the policies that are designed to optimize patient care in the austere environment. Do not hit the ground and try to change things. Look, listen, and learn for your first weeks on the ground or with the unit. Chances are that the procedures they have developed exist for a reason. Avoid unilateral decisions regarding patient care procedures. If you think something needs to be changed, find allies and build consensus without focusing overly on the existing standard or status quo.

**Specialist Availability:** There are pediatric patients cared for every day in all of the Level III facilities. Make sure that you bring or order pediatric equipment. It is in the system. A call back to an Army Medical Centers (MEDCEN) Pediatrics Department supply NCO will help identify stock numbers you might need. Find out if there are pediatricians with special skill sets in the area where you are operating your hospital. At this point, doctrine recognizes pediatricians as general medical officers. However, across Iraq and Afghanistan there have been pediatric intensivists, pulmonologists, cardiologists, endocrinologists, gastroenterologists, infectious disease specialist, adolescent medicine physicians, developmentalists, geneticists, and oncologists deployed. This is true for internal medicine and surgical specialists, especially in the Navy and Air Force. Find out the capability in your area and use the specialists. It improves hospital care, provides education for staff, and allows the provider to practice in their sub-specialty and keep skills current.

**Operations:** The same rules for treatment drills and command and control apply as did at the other levels of care. Unfortunately, it is likely that you will get so much experience with trauma and emergencies that you will not need too many dry-run rehearsals. The same range of potential conflicts in command and control as you would see in a TDA facility exist in the theater Level III. It may be exacerbated if there is a poor working relationship between your hospital command and the next higher command, the medical brigade or task force surgeon. You should determine the lines of command and control early on, as these will help you understand the reasons for some directives.

**Employment:** Our current conflict (OIF) is the first conflict in which forward surgical teams are utilized extensively in the combat phase. Use of these teams in combination with other therapeutic breakthroughs has dropped the "died of wounds" rate to the lowest ever, down from 25% in Desert Shield/Desert Storm to 10 % for OIF. However there is relatively brisk debate and controversy regarding the continued use of these units in some of their deployment strategies. No one would deny the lives these professionals saved during the maneuver phase. It is in current sustainment operations where some argue that they are being underutilized. In this phase, most casualties are able to be evacuated to the Combat Support Hospital (CSH), where they can be thoroughly cared for and supported, directly bypassing Level II facilities. As a general rule, surgeons and wounded patients belong in the CSH. However, this places the surgeons who are deployed in a forward surgical team (FST) at a great disadvantage after the actual combat advance is over. There are long periods of inactivity, made even worse in some of the forward operating bases (FOBs) because many lack amenities, especially early on. Still, physicians should know that deployments may take them to places that are arid, isolated, and spartan, so plan accordingly. Some sites have plans for rotating surgeons to the CSH, but these plans may not be implemented for a variety of practical reasons.

**Split Based Operations:** It is common for an FST or CSH to be divided into sections which are then deployed to any number of different sites. The difficulty is that the doctrine does not really support extended split based operations. Doctrine will need to be developed and modified, while providers find themselves in challenging circumstances trying to accommodate for the fact that these units do not divide in half cleanly. For example, the issue of "command" has been a sticky one. Whoever is in charge of the "split" part, should be recognized as a "commander" with the attendant authority necessary to accomplish the mission. The "split" commander may be subordinate to the "main body" commander. However, since it is a separate hospital operation and in many cases is separated by great distances from the "mother ship," the "split" section should also have some independent communication with higher headquarters. Every officer could be selected to lead one of these split units, thus every officer should be well-versed in the theory and practice of leadership.

Another rarely discussed point about split operations is the impact that dividing a unit can have on morale and esprit. It is an interesting cultural observation that Navy and Air Force medical units are loathe to do what Army units do regularly: shave capability slices (an operating room and staff) or personnel from units and move them around the battlefield. Stories of this experience and the impact that it had abound in reports from deployed providers. Too often, higher headquarters views the hospital as a manpower pool to provide extra medics or docs for whatever mission comes along. One Navy colleague pointed out to me that neither the Navy nor the Air Force wear unit patches. The Army is the only one who needs patches, to remind them who they originally belonged to before they were tasked and cross-leveled to other commands.

Split operations, or even normal FST operations require the Level III personnel to co-locate with a Level I or II facility. The relationship between the personnel in the supporting BAS or medical company, and the personnel in the FST of the hospital can either be highly functional or highly dysfunctional. It tends to be operator dependent. Some companies will have great esprit and a "one-team" approach. They will work well with the surgical staff. But it is variable. It is important for you to be professional at all times. Manifest the "three As" of a successful

physician: be affable, available, and able. There may be a difference of outlook and "wavelength" between medical troop/company commanders, who are often medical service corps captains. Ideally there should be a strong working relationship between everyone. It is especially critical between the executive officer of the FST and the medical troop/company commander.

**Miscellaneous:** As with Level I and Level II medical leaders, it is essential for the physicians to get to know the commander of their forward operating base (FOB). Try to get yourself invited to attend the daily battle update briefs, and be almost on a first name basis with the line commanders of equivalent rank. When you are a part of the FOB team, everyone stays informed, and the medical unit is much better taken care of, and not just placed in a corner and neglected unless needed. One's relationship to subordinates is also key. Give them someone to look up to and emulate, but do not be afraid to ask them questions, particularly basic military matters – they will appreciate your interest. Finally, aggressively teach. Providers can give teaching sessions and demonstration on practical matters, both medical and non-medical in nature. The medics usually appreciated the training, and the providers enjoy teaching.

**Soldier Skills:** Basic Soldier skills are still important, even at the Level III. Know how to clear and use your weapon. Keep it clean and in good repair. Wear your uniform like a professional. Maintain a personal battle rhythm that keeps you eating well, exercising regularly, and getting enough rest. Make sure you catch up on rest after long sessions in the operating room or emergency room. Set goals (correspondence courses, books to read, journaling, learn an instrument) to fill the down time. Do not hesitate to help out with "grunt" labor. Do not think or act as if you are too good to help clean, move, set-up, or tear-down. Nothing undermines the teamwork of a unit faster. Remember that we are Soldiers who are physicians, and not docs wrest from the polished corridors of our hospitals and medical centers. Our uniformed colleagues are watching.

**Physicians at Level III**

- The mission is the same/similar as home station.
- Know the deputy commander for clinical services.
- Prepare to care for hospitalized children and elderly patients.
- Investigate and use local military medical resources.
- Use down-time constructively.
- Prepare for split-operations: know how to lead.
- Understand the mission and capability of unit you are split to join.
- Master basic Soldier skills.
- Pitch in with the work.

# Chapter X: Caring for Battlefield Casualties

## Introduction

Unfortunately, there is a whole new generation of physicians who have become experts in the care of victims of horrific trauma. They have gained this experience, resuscitating trauma victims, and operating on them, in the streets and deserts of Southwest Asia. The number of providers with this expertise grows with every rotation of forces. In this chapter more than any other, they speak from their experience.

You cannot prepare for the shock of seeing and treating combat casualties. The wounds can be horrific and extensive. But you will be the one that all the medics look to for leadership in the trauma care setting. Only by frequently reviewing these skills and training with the unit and with the unit's equipment will you have the confidence in your own skills. This will increase the confidence of the medics.

If you have the type of personality that screams and yells and curses when you are in a stressful trauma setting, figure out how to change. Take a deep breath and stay calm and remember to check your pulse first. Many of these Soldiers on the trauma table are still alert and may or may not know how close they are to dying. You must do everything in your power to remain calm- for their sake. Your medics will most likely be young and have little experience. If you lose your cool, then they will lose their focus. Stay calm.

**Treatment Techniques:** The principles of Tactical Combat Casualty Care (TC3) apply when considering how and where to treat casualties. Asherman Chest Seal, needle decompression with 2.5" 12-14G Angiocath and, when tactically appropriate, chest tube insertion can make a difference in severe chest injuries. Cricothyroidotomies are done frequently due to large number of facial injuries from IED and mortar shrapnel. Multiple techniques work. Pick one you are comfortable with, and train. Some providers prefer not to use the tracheostomy kits, and instead prefer to use a 7.0 cuffed endotracheal tube.

Use tourniquets early. Issue tourniquets to every Soldier; the new personnel aide kit for Soldiers will include a tourniquet. The ones most commonly recommended are the combat application tourniquet (CAT) and other one-handed, winless tourniquets. Ratchet tourniquets work very well on large limbs. The "school house" solution to uncontrolled bleeding is a stepwise progression from direct pressure, to pressure dressing, to tourniquet. However, TC3 advocates tourniquet use before any other type of intervention in any severe bleeding as well as its early conversion to a pressure dressing using kerlex gauze and/or hemostatic agents and an emergency trauma dressing (Israeli dressing). Certainly, do not forget to apply direct pressure, but go early with the tourniquet.

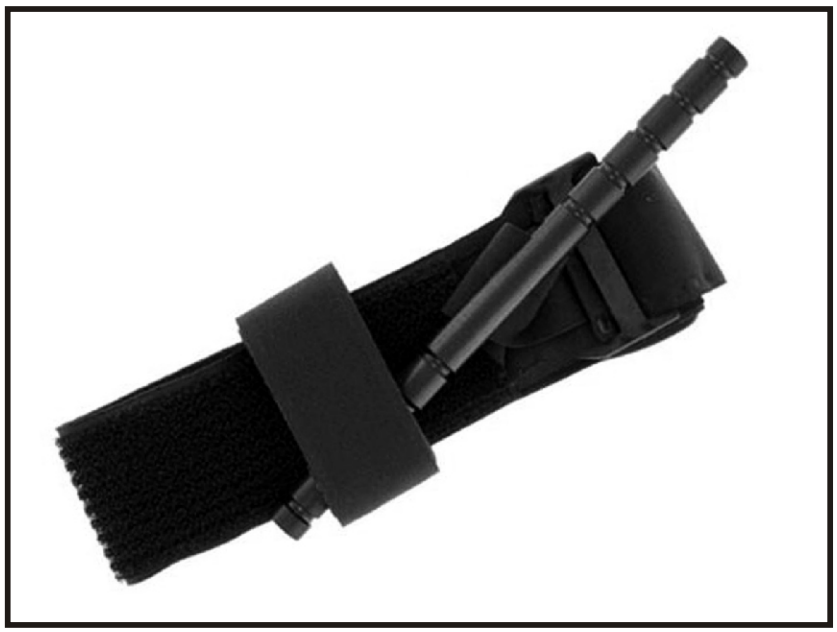


**Figure 7. CAT (combat application tourniquet)**

Early establishment of intravenous (IV) access is critical. The IV fluids do not necessarily need to be started right away, but early access is key. Once the patient progresses to peripheral vascular collapse with continued blood loss, vascular access can mean the difference between life and death.

Central lines are critical if you have access to the equipment, training in the use, and the tactical timing permits. They are available through the Class VIII supply system, but you will need to make a point of ordering them. They are not usually contained in a unit's on-hand stock of supplies. In cases where a Soldier loses both legs, one arm, and has a fracture to the other arm, there are NO peripheral sites. Again, current unit kits do not contain central lines. It is a good idea to obtain them before deploying.

Some new devices are currently on the market for adult intraosseous (IO) lines (both sternal and tibial). They are expensive and not available by order through the current military supply system. They can, however, make a difference in saving lives. Bringing some of these along with you (as well as a catalog to reorder supplies once in theater) is helpful. If you have never used one of these devices, I would recommend getting one to practice with and bring the product literature with you. They work very differently than standard intravenous lines. In particular, the infusion rates will not be as rapid as you expect. This may cause some confusion during resuscitation. The package literature will tell you what to reasonably expect in the way of infusion rate if you have a question. The most widely carried is the F.A.S.T. 1 Adult Intraosseous Infusion System. This system has a spring loaded IO needle that is placed into the casualty's sternum.


**Figure 8. F.A.S.T. 1 Adult Intraosseous Infusion System**

Do not be afraid to use morphine or other narcotics. Train your medics (the trustworthy ones) on how to use it. Get your unit to order the morphine 10mg auto-injectors (NSN 6505-01-302-5530.) They are durable, easy to use, and can be administered in the field by the trained medics prior to arrival at the aid station, or in the triage area for patients waiting for treatment. The Fentanyl oral transmucosal system (Fentanyl "lollipops") is another excellent pain control method. One technique advocated involves taping a 400-1600mcg stick to the finger of the casualty and to have him place it in his mouth as needed. The worry about overdosing is lessened as the gravity of his arm will cause the lollipop to fall out of his mouth if he becomes sedated. Obviously, make sure that your treatment area has formal procedures to maintain positive control on narcotics and has ready access to naloxone. The responsibility will often fall on the doc.

Treat even minor battle wounds as if they are infected from the first day. This seems obvious, but initially some minor wounds can seem insignificant, and docs can make the mistake of being cavalier about antibiotic treatment. The truth is that the doc should really work to be convinced that a patient does not need antibiotics. Several special operations units have started issuing "combat pill packs" to every Soldier with instructions to take the contents (Gatifloxcin 400mg and Tylenol 1000mg) after becoming wounded as soon as possible after hemorrhage control has been established and if the Soldier is still able to drink.

Watch for unsuspected shock; patients are usually more in shock than you initially expect. These Soldiers are often in peak condition and their bodies have an amazing capacity to compensate. When they do begin to decompensate, they do it rapidly. Medical personnel should have ready access to Hextend crystalloids, as this is the preferred resuscitation fluid for severe hemorrhages initially. Combat lifesavers and uninjured Soldiers should have enough IV fluids that the medic should not need to carry much into battle. The practice of hypovolemic resuscitation is the standard of care on the battlefield. Its understanding and practice should be second nature to the medic and other providers on the battlefield.

**Training:** When addressing the training available to care for war wounded, it is important to point out that there really is not anything that completely captures the skills a provider needs. Nothing can really prepare a doc for the experiences of a large MASCAL situation. While Basic Life Support (BLS) and Advanced Cardiac Life Support (ACLS) courses are important for credentialing in the TDA hospital setting, they are not very useful in the field setting. Prehospital treatment life support (PHTLS) and Advanced Trauma Life Support (ATLS) are helpful, and a refresher course in both or either prior to deployment is extremely useful. These courses review skills you will need and use (chest tube placement, use of traction splints, cricothyroidotomies, and other advanced airway skills.)

It is essential to combine this type of training with training that focuses on Combat Casualty Care. This should include familiarization with early application of tourniquets, use of hemostatic dressings, and use of newer field dressings such as the Israeli dressings, all while under fire. Unless you are an emergency medicine physician at a major medical center, you likely do not encounter trauma patients on a regular basis, and even they do not usually see the types of injuries created on the battlefield. There is a push now to develop or send docs to advanced courses on trauma management, including trauma center on-the-job training, Operational Emergency Medical Sills (OEMS) Course, TC3 Course, and various distance learning courses, all with different refresher requirements. ATLS simply is not enough. One of the best opportunities for training is what is referred to in theater as the "right-seat, left-seat ride." Incoming providers need to run through several trauma/MASCAL situations with the outgoing providers to learn some of the tricks of the trade. This it true at any Level I through III, where incoming personnel have the opportunity to learn alongside outgoing staff – before they head for home. The Air Force seems to have this down better than any other service.

**MASCAL:** There are two ways to learn MASCAL: drills and "live fire." Drill for MASCAL situations but recognize that the best training will come with the actual event. Put someone in charge of MASCAL. Clearly establish the command and control. This is a role for the senior NCO during an emergency, particularly the first sergeant. The NCO is most helpful outside the aid station by controlling the labor pools and ensuring accountability and tagging of gear, weapons, and other ordnance. (Remember to clear the weapons.) Remember also that damaged Kevlars or body armor need to be collected centrally. There are protocols in each theater for this as part of the trauma registry, to study and improve protection for the Soldier. Consult with the brigade or division surgeon. The first sergeant also plays a key role in control of information flow to the Soldiers who accompany patients. Ask for a single liaison from the unit chain of command to the unit.

Develop algorithm-based MASCAL plans to cover all possibilities. Conduct frequent MASCAL rehearsals and a good integration with the S3 Plans shop for tasking of other units on the base to provide litter bearers, nonstandard evacuation vehicles, and other duties. Remember that there are different types of MASCALs. For example, there are MASCALs that occur outside the FOB (i.e. multiple civilian casualties) and ones that occur inside the FOB (i.e. vehicle borne IED [VBIED] or mortar or rocket attack). The plans and execution are markedly different for each.

Develop plans and rehearse each of the different types of MASCALs. There is no one, standard MASCAL plan for all settings or circumstances. Especially be wary of someone trying to sell you a "one size fits all approach" to the MASCAL plan. Each operating base will also have a slightly different plan based on force protection issues, physical layout, and proximity to higher-level facilities. All plans will address communication plans, chain of command, and evacuation routes. Bullhorns, handheld radios, triage lanes with marked placards are helpful in communication and planning. Good lighting is essential but is dictated by the tactical situation- if mortars are falling while you are receiving casualties, turn off all unnecessary lights. Establish your inflow and outflow routes for evacuation as soon as you arrive at your FOB. Also ask your local engineers to build the clinic or hospital a bunker that can be used to treat and protect wounded while rounds are still incoming.

"Live fire" MASCALs happen, so it is best to be prepared. But if they happen before you have time to prepare, remain calm and do the best you can to triage, treat, and evacuate the casualties. Above all, in every case conduct a thorough after-action review (AAR) and learn from every event. MASCALs are by nature chaotic, and the docs are engrossed in casualty care. These are the medical situations when the medical service folks and the support folks earn their pay. Make sure that you have all of the non-medical personnel participate in all rehearsals. Make sure that you train and incorporate all of the combat lifesavers on the base in MASCAL preparation. The rehearsals are sometimes boring and annoying and everyone would rather be doing something else, but when the casualties are real, everyone has a real job to do and needs to do it correctly.

In fact, a report from an actual MASCAL puts all this in context: "I think all the prior training I had in MASCALs went out the window when we had 63 patients through our aid station in 3 hours! What we found is that no one was in the "expectant" category even with that many wounded. One provider can survey the work of a dozen medics when all they have to do is place bandages and start IVs. Instead, docs and PAs focused on the worst patients, even if their chances for survival were slim. Perhaps that was wrong doctrinally, but it worked."

Initial trauma care boils down to a few essentials: stop bleeding, decompress a pneumothorax, stabilize an airway, establish vascular access, and initiate fluid resuscitation. Do not be afraid to do what you think is right for the patients, with consideration to all the capabilities and limitations that you know better than anyone else. The "guy on the ground" is right (despite the way you sometimes get treated or talked to by "higher ups") in regard to knowing what you need (supply and personnel) to get the job done. Do not be afraid to give your absolute best effort in preparation and in practice, for all your patients. Remember, as one doc reminded me, "there is no malpractice insurance in Iraq."

**Treating Battlefield Casualties**

- Remember the principles of TC3.
- It is impossible to be completely prepared for the experience combat trauma.
- Learn how to stay calm.
- Know how to obtain a surgical airway.
- Control bleeding with tourniquets and hemostatic agents.
- Get central/peripheral venous access or insert an IO infusion system.
- Control pain.
- Drill for every MASCAL contingency – involve everyone.
- Conduct after-action reports.

## Military Triage

When the call comes that a MASCAL has occurred, the medical treatment facility (MTF) must be prepared to evaluate, treat, and arrange transport for the wounded. For those who have experienced this firsthand, it is an extremely stressful event that can be made worse by disorganization and inexperience. MASCALs are declared when the medical resources available are overwhelmed by the number, type, or rate of incoming casualties. Military triage is an attempt to impose order during chaos and make an initially overwhelming situation manageable.

Triage is the process of sorting casualties to identify the priority of treatment and evacuation of the wounded, given the limitations of the currently available resources (time, equipment, supplies, personnel, and evacuation capabilities) and the mission. The ultimate goals of triage are the preservation of life, limb, and eyesight in those who must be evacuated and the return to duty of the greatest possible number of Soldiers. Triage is a fluid process at all levels, from the point of injury (POI) to the treatment table at the CSH, allowing for a change in category at any time and in any setting. In the extreme example, a casualty may be triaged from emergent to expectant during surgery, abruptly terminating the procedure ("on-the-table triage"). The following chart represents the triage categories and gives examples of each.

| Triage Category | Category Description | Examples |
|---|---|---|
| **Immediate** | This group includes those Soldiers requiring lifesaving surgery. The surgical procedures in this category should not be time consuming and should concern only those patients with high chances of survival. | • Upper airway obstruction<br>• Severe respiratory distress<br>• Life threatening bleeding<br>• Tension pneumothorax<br>• Hemothorax<br>• Flail chest<br>• Extensive 2nd or 3rd degree burns<br>• Untreated poisoning (chemical agent) and severe symptoms<br>• Heat stroke<br>• Decompensated shock<br>• Rapidly deteriorating level of consciousness<br>• Any other life threatening condition that is rapidly progressing |

| Triage Category | Category Description | Examples |
|---|---|---|
| **Delayed** | This group includes those wounded who are badly in need of time-consuming surgery, but whose general condition permits delay in surgical treatment without unduly endangering life. Sustaining treatment will be required (e.g., stabilizing IV fluids, splinting, administration of antibiotics, catheterization, gastric decompression, and relief of pain). | • Compensated shock<br>• Fracture, dislocation, or injury causing circulatory compromise<br>• Severe bleeding, controlled by a tourniquet or other means<br>• Suspected compartment syndrome<br>• Penetrating head, neck, chest, back, or abdominal injuries without airway or breathing compromise or decompensated shock<br>• Uncomplicated immobilized cervical spine injuries<br>• Large, dirty, or crushed soft tissue injuries<br>• Severe combat stress symptoms or psychosis |
| **Minimal** | These casualties have relatively minor injuries and can effectively care for themselves or can be helped by non-medical personnel. | • Uncomplicated closed fractures and dislocations<br>• Uncomplicated or minor lacerations (including those involving tendons, muscles, and nerves)<br>• Frostbite<br>• Strains and sprains<br>• Minor head injury (loss of consciousness of less than 5 minutes with normal mental status and equal pupils) |
| **Expectant** | Casualties in this category have wounds that are so extensive that even if they were the sole casualty and had the benefit of optimal medical resource application, their survival would be unlikely. The expectant casualty should not be abandoned, but should be separated from the view of other casualties. Using a minimal but competent staff, provide comfort measures for these casualties. | • Traumatic cardiac arrest<br>• Massive brain injury<br>• 2nd or 3rd degree burns over 70% of the body surface area<br>• Gun shot wound to the head with a Glasgow Coma Scale of 3 |

# Chapter XI: Evacuating Battlefield Casualties

## Introduction

The movement of battlefield casualties is one of the things that the military in general and the Army Medical Department in particular do that no one else can do. There is a large body of experience and doctrine written on the subject. Unfortunately, as with most things, the experience of medical personnel in Southwest Asia is rewriting that doctrine. For example, at the Joint Readiness Training and National Training Centers, we practiced the notion of a step-wise approach to evacuating casualties first from the line, then to the Level I, then to the Level II, then to the Level III. That is almost never the practice in theater. Patients are rarely evacuated to the Level II facility unless it is a routine casualty who needs patient hold, an x-ray, or minimal lab work. Combat casualties are evacuated for definitive care or resuscitative surgery, to the forward surgical team or combat support hospital (CSH).

**Doctrine vs. Reality:** Evacuation of patients in the urban environment involves many of the same challenges faced by American forces in Mogadishu more than a decade ago. American forces are heavily engaged in the urban centers of Iraq and, to a lesser degree, Afghanistan. For example, Sadr City, Iraq has a population of 2.2 million people in twenty-three square kilometers, or nearly one hundred thousand people per square kilometer. It is a dense population center by any definition. The threat and challenge of urban warfare make it difficult, if not impossible, to follow the doctrine of using ambulance exchange points (AXP) and casualty collection points (CCP).

These same challenges make the establishment of forward aide stations nearly impossible. These sites are very difficult to secure because they take so much combat power that they become impractical. In addition, any standing group of troops becomes a target for indirect fire. Docs report instances of mortar attacks on medical vehicles and troops that were stationary for only twenty minutes. Sadly, the enemy does not follow the Laws of Land Warfare as described in the Geneva Convention. They do attack medical vehicles and personnel. There are many examples of indirect fire attacks on MEDCAPs in certain sectors in Iraq that resulted in coalition forces killed or wounded.

**Evacuation:** When a Soldier is wounded, they are usually rushed to a forward aide station positioned with a battalion tactical center or all the way to the nearest Level I facility. MEDEVAC helicopters will not land inside the city, so the goal is to get the casualty out of the urban jungle. This can take time due to continued enemy contact (as much as forty-five minutes on one occasion to travel a mere three blocks). The majority of military vehicles operating as evacuation assets in Sadr City have to be armored. Casualties are evacuated to aid stations in M113s or Bradleys, driving at top speed all the way from the fight.

Forward aide station operated by the infantry medics are helpful in certain situations, but because MEDEVAC birds (helicopters) cannot land inside the city, only immediate stabilization (bleeding or airway) is done at these locations, and then the casualty is moved quickly to the Level I fixed aid station for further care. Thorough, proper training of the line medics is essential. They must also be provided with the essential tools. If the security situation is

somewhat stable, the aide station can also serve as a modified AXP, where the casualties can be transferred from a fighting vehicle to a medical transport vehicle.

In Iraq, docs rely heavily on air evacuation assets for urgent and priority casualties because of the dangers on the road. Doctrine does not call for such heavy reliance on air, but it has become a necessity in this environment. This puts a huge burden on air evacuation assets, and makes them occasionally unavailable. Ground evacuation is utilized when air is not available. The key for successful ground evacuation is knowing the quickest routes. The quickest routes are not always the shortest routes. Traffic patterns and pedestrian traffic will dictate evacuation strategies. The S2 and S3 shops are good resources for information on predictive analysis of traffic and pedestrian congestion of roads.

One area of debate is whether or not to call the air MEDEVAC prior to the casualty reaching the Level I facility. It has been done both ways, and there are reports of good and bad outcomes for both strategies. If the bird is called prior to the arrival of the casualty, the casualty might arrive after the bird has landed, thus eliminating the ability to further stabilize if the patient is immediately loaded onto the aircraft. If the choice is made to bring the patient into the aid station to stabilize, then the MEDEVAC helicopter is left waiting on the landing zone (LZ) and other casualties are possibly left waiting as well. (More than one provider has been on the receiving end of a "bird is waiting at another location" message.)

Waiting to call the bird until after the casualty has arrived allows for the providers to make an assessment and further stabilize while the bird is en route. However, in cases such as surgical urgent gunshot wound to the chest for example, any delay can possibly mean the loss of a Soldier. There is no easy answer or formula. The best option is to give the medics on the ground the power to make a judgment call on whether they feel a casualty is urgent surgical, urgent, or priority and determine if they want the bird called while they are transporting the casualty to the treatment facility. It is best to leave the decision to the provider or the medic on the ground knowing that the MEDEVAC flight crew and the provider at the next level of care can all upgrade the evacuation status if they are informed of or witness deterioration in the patient's status.

"Nonstandard" air evacuation assets are the rules in all services except the Army, and are referred to as casualty evacuation (CASEVAC). Increasingly, the full range of Army helicopters are being used for CASEVAC. A tactical aircraft can be utilized as a MEDEVAC with modification, through the addition of a medic (and sometimes a PA or physician depending on the size of the mission and the casualty estimate) and some basic trauma gear, such as a trauma kit capable of suspension from the cabin ceiling of a UH-60 or bulkhead of a CH-47 containing ATLS equipment, a burn blanket, a splint kit, a fluid warmer, a patient warming blanket, a collapsible litter, and medical oxygen. In contrast, the typical tactical aircraft does not have any medical capabilities and is only capable of transporting patients from the point of injury to the nearest medical facility, which may be more than 45 minutes of flight time away.

Additionally, the addition of on-board medical personnel may be able to advise which field medical facility is best equipped to handle the patient(s) based on the injury, rather than going to the nearest one. Most units relied on the MEDEVAC to provide en route patient care; whereas

with the addition of one or two trained medical personnel and a minimum of equipment every combat aviation mission could be capable of providing first line medical care from the point of injury to the evacuation facility.

**Evacuation of Non-Battle Casualties:** Actually, one of the biggest difficulties facing providers is the evacuation of non-battle casualties. Trauma victims are typically treated and pushed up the system. The more challenging air or ground evacuations are those for medical conditions that develop during the deployment (or preexisting conditions for that matter.) Ground evacuation is extremely dangerous in Iraq, and essentially impossible in Afghanistan where there is no reliable road system and the distances and terrain make ground movement impossible. Medical command and control is challenged by prioritizing air assets to move routine patients. This is a challenge for the provider who must face the Soldier with back pain who needs to see the orthopedist or the one with headache who needs a CT scan at the CSH. It is an ongoing challenge, and will be as long as the threat level remains as high as it is.

Many larger sites are fortunate to have an aeromedical evacuation liaison team (AELT) to assist in the coordination and use of Air Force assets to move patients. While there seems to be some variability in the personnel assigned to these positions, uniformly AMEDD staff praise their contributions and assistance with patient movement.

American military patients evacuated to the Level III are generally only kept there if there is reasonable hope for their return to duty. If it is unlikely within a one-week or so time frame, the patients are moved to the Level IV facility in Germany. Again, the goal of keeping patients at the Level IV is to return them to duty. If it is unlikely that they will return, the patient will be moved to a medical center or community hospital stateside. The return to duty rate of patients who are evacuated to the Level IV is very low, less than one in five. And unfortunately these service members are often lost to the visibility of their commands. Recently, the staff at Landstuhl has introduced the "Deployed Warrior Medical Management Center" (DWMMC) patient tracking system, a web-based system that pulls data from other personnel systems and allows for a single place for the providers and commanders to go to check on the status of evacuated patients.

**Evacuation of Battlefield Casualties**

- "Doctrinal" patient evacuation is not practiced
- Urban warfare and extreme distance complicate evacuation
- Ground evacuation is not a good option in Iraq or Afghanistan for different reasons (danger and distance respectively)
- Timing of the call for air evacuation is variable and situation dependent
- Nonstandard CASEVAC can be easily adjsuted to have medical capability
- Routine evacuation of non-battle illness presents additional challenges
- AELTs provide essential expertise
- New web-based systems (DWMMC) improve patient tracking

## Evacuation Time Periods

| Evacuation Category | Army | Navy | Marines | Air Force |
|---|---|---|---|---|
| **Urgent** (To save life limb or eyesight) | within 2 hours | within 2 hours | within 2 hours | ASAP |
| **Priority** (Medical condition could deteriorate) | within 4 hours | within 4 hours | within 4 hours | within 24 hours |
| **Routine** (Condition is not expected to deteriorate significantly while awaiting flight) | within 24 hours | within 24 hours | within 24 hours | within 72 hours |

**NOTE:** The categories of evacuation precedence are urgent, priority, and routine. The evacuation time periods are flexible, mission dependent, and vary greatly among the services based upon the different types of evacuation assets that each uses. The Army uses the "Urgent Surgical" subcategory to identify casualties that may need immediate surgical intervention. The Army also uses a "convenience" category for personnel requiring medical evacuation for conditions that are not expected to significantly change for an extended period of time (greater than 72 hours).

## 9-Line MEDEVAC Request Format

Line 1. Location of the pick-up site

Line 2. Radio frequency, call sign, and suffix

Line 3. Number of patients by precedence:
- A - Urgent
- B - Urgent Surgical
- C - Priority
- D - Routine
- E - Convenience

Line 4. Special equipment required:
- A - None
- B - Hoist
- C - Extraction equipment
- D - Ventilator

Line 5. Number of patients:
- A - Litter
- B - Ambulatory

Line 6. Security at pick-up site:
- N - No enemy troops in area
- P - Possible enemy troops in area (approach with caution)
- E - Enemy troops in area (approach with caution)
- X - Enemy troops in area (armed escort required)
- * *In peacetime* - number and types of wounds, injuries, and illnesses **(but also desired in wartime for planning purposes)**

Line 7. Method of marking pick-up site:
- A - Panels
- B - Pyrotechnic signal
- C - Smoke signal
- D - None
- E - Other

Line 8. Patient nationality and status:
- A - US Military
- B - US Civilian
- C - Non-US Military
- D - Non-US Civilian
- E - Enemy prisoner-of-war (EPW)

Line 9. NBC contamination:
- N - Nuclear
- B - Biological
- C - Chemical
- * *In peacetime* - terrain description of pick-up site **(but also desired in wartime as NBC contamination is rarely an issue)**

# Chapter XII: The Physician in the Command / Administrative Role

## Introduction

One of the assumptions in the military is that rank reflects leadership experience and ability. In the medical corps, increasing rank has traditionally been awarded because of clinical ability. It is less so now, but there are many lieutenant colonels and colonel providers who have limited or no administrative or leadership experience. Yet there is and will continue to be a steady demand for medical corps officers with these talents in theater.

Senior doctors tend to fall into one of a few groups almost regardless of the position they hold. Some are senior physicians who are very savvy clinically with a great depth of technical and professional medical experience. These docs are not only great providers (in most cases) but they also know how the system works and how to work the system. What they sometimes lack is the understanding of the significance of their position. The mantle of leadership hangs about them like an ill-fitting, uncomfortable garment.

**Clinical Power:** Medicine is, in very simple terms, an effort to wrest control of an undesirable situation (disease) to restore a preferred condition (health). The passion for "control" that permeates the process of medical education and practice is the only natural thing that inexperienced clinicians bring to leadership, whether they serve as department chief in a TDA facility or commander of a unit in combat. Too often, it is the single most obvious characteristic of medical leadership, obvious to all who are watching, but unfortunately not to the doctor/leader. He may be the last to see his fist wrapped tightly around his rice bowl. He may never see it.

**Position Power:** There is another group of senior leaders who seem too conscious of the significance of their position. It may be a bit unfair, but for these officers, the command or leadership position seems to be more a matter of a thoroughfare on the way to somewhere else. When I was promoted to colonel, one of my friends gave me a BDU cap with a metal rod sticking out from the bill, and a single star dangling on the end of it. It was a joke (I hope) but reflects something that permeates senior leadership: a reach for the star(s). The jump from O6 to O7 is a topic of conversation I have heard in many settings by senior folks. It is a mystery to most, even some who have achieved the rank, but it is an obsession to some.

**Leader Power:** A third group of leaders recognize the significance of a leadership position but not as a path or opportunity to promote their own agenda or a chance to fill a personal rice bowl. Leadership and senior administration roles are opportunities for personal growth, but also opportunities to promote the growth of those in the command. Most importantly, these are the chances we get to influence and improve the systems that care for service members and their families.

**Preparation for Leader Roles:** Preparation for these roles means first that we must be excellent physicians and serious about soldiering. It is a recurrent theme. Captains and majors are well advised to become students of leadership early in their careers. Observe good leaders and bad. Learn all you can about communication and resolution of conflict, as that seems to be

the biggest job of a commander in almost any setting. While the situation is improving in reserve, guard, and active units, too often command and senior leadership has gone to those who ask for it regardless of qualifications. The Air Force has a system where no officer commands in the field that has not had a previous command position. The other services could learn from this.

**Mentorship:** One of the cornerstones of successful leadership is a history of mentorship. Mentorship is not a passive process. The folks who have been most successful in mentorship relationships have been those junior officers who have actively sought a mentor, and those senior officers who have proactively identified officers with the potential to replace themselves. Mentorship takes many different forms, but in simplest forms is just a relationship between the senior and junior officer where both meet regularly, talk, and listen carefully to one another. It is a lifelong process and one of the keys to success as you approach senior leadership opportunities. Uniformed physicians have always been excellent clinicians. Our doctors both in garrison and in the field today have reinforced this truth. There is a wholly different arena for medical officers: field command and staff surgeon positions. This generation of captains and majors has the challenge to excel in these positions. Our efforts to identify and mentor promising officers will ensure that the generation following us will do even better than prior generations.

**Identify Strengths and Weaknesses:** Any good leader knows his or her weaknesses. A strong staff can fill in whatever gaps there are and compensate for deficiencies. Choose from your very best and get them in positions where they can use their talents to the best of their ability. This may take some moving of people and positions. Do not be afraid to do it. A staff position mismatch shortchanges both the organization and the individual. An excellent staff will reflect better on the leader than any single accomplishment the leader might achieve individually. As one department chief told me, “Surround yourself with good people and get the hell out of their way.”

**Maintain Healthy Relationships:** Things get done in the military as they do in any organization, on the basis of healthy relationships. Successful leaders generally establish and maintain relationships easily. Your strongest relationships will be with your previous hospital or staff colleagues. There will be a temptation for you to use these established lines of communication to get what you need or want for your field unit to be successful. Resist the temptation. Recognize and utilize your unit’s chain of command. Do not bypass a level of the chain because someone above (or in another chain) is “an old friend.” Your reliance on an old friend for help may cost you a new one.

**The Physician in Command or Administration**

- Doctors are not always well prepared for medical leadership positions.
- Mentoring is a cornerstone to leadership success that starts early.
- Good leaders know their weaknesses.
- Use your staff to compensate for your deficiencies.
- Use your chain of command, not previously established connections, to get things done.

# Chapter XIII : Humanitarian Contingencies

## Introduction

Nation building and rebuilding is a big part of our mission in Southwest Asia. Medical work in the community is a huge part of that mission, and providers from all specialties are playing a role. In Iraq, providers are helping a relatively developed medical system with well-trained clinicians get back on its feet. In Afghanistan, military medical missions are engagement operations that build trust between the local populace, the Afghan national government and the American military. Military humanitarianism is an ongoing part of our mission, especially as we have moved into stability and sustainment operations. The U.S. has long been in the business of military humanitarianism and the past decades have witnessed scores of events in which uniformed providers cared for local nationals in U.S. facilities. In the combat zone today, this practice continues and it is a key part of the strategic agenda for the region. Providers, in particular primary care providers, are playing a big role.

**Outreach:** Women and children are major recipients of care on these medical outreach missions. This is especially true in Afghanistan where one in four children dies before age five and one in twelve women die in childbirth. In the Muslim cultures of Iraq and Afghanistan, only female providers can care for women. Female doctors, medics, and physician assistants (PAs) are very much in demand. In some places in Afghanistan, female clerks and truck drivers take the history from female patients, walk outside the building and talk to the doctors about what they saw on the patient and what they were told. A story is told of one female PA who went up under a patient's burka with her to examine an area of concern. Providers are rising to the challenge, and have learned a number of tricks in providing humanitarian assistance. We must be prepared administratively, clinically, and logistically to care for this population.

**Civil Action Missions:** On medical civil action missions in Afghanistan, bring some sort of toy/trinkets (super balls, beads, toy cars, pens, crayons) to give out to the kids in a village. Have the interpreters and the Afghan Soldiers tell the children to sit down along a wall. Tell them that anyone who does not sit down will not get anything. This lets them feel like they do not have to come through the medical line to be able to "get something" and allows the medical team to focus on the people who really are ill or need help. Most importantly, this draws children away from the vehicles while they are being loaded and lined up, keeping them from danger and decreasing the security risk of someone tossing something into a vehicle. Churches and civic action groups can usually be counted on to send items for distribution (do not carry them in your luggage regardless.) And the effect of goods and service makes the people in the village (apparently) less inclined to support the enemy. In some cases, the shoes and other humanitarian gifts made the local villages much more pro-American. In some cases, caches of weapons were recovered as a way, village elders said, of re-paying American generosity. Coordinate these aspects of the mission with the civil affairs officers who are organizing the mission.

**Mission Planning:** Providers will be frustrated when they are left out of the planning process for these missions. And this will almost always be the case if you are not aggressive and proactive. A provider needs to be involved in planning to make sure that the whole team understands the expectations and rules of engagement. The inability to address glaring medical

needs in many patients you will encounter will be another source of frustration and potential conflict in the staff. If at all possible, integrate and coordinate your efforts with the other non-governmental organizations (NGOs) in the region. If the planner tells you that he or she does not know anything about NGOs in the area, stress the importance of this level of coordination at the level of the civil/military operations center in order to avoid a duplication of effort.

**Humanitarian Training:** Increasingly, training in humanitarian/refugee medicine is a part of military medical training programs. The Military Medicine Humanitarian Assistance Course is run out of the Department of Pediatrics at the Uniformed Services University of the Health Sciences <http://www.usuhs.mil/>. A number of other courses are available through the Center of Excellence for Disaster Management and Humanitarian Assistance in Hawaii and the International Committee of the Red Cross. Excellent resources to help prepare for these humanitarian missions are available from the World Health Organization <http://www.who.int/en/> and the International Committee of the Red Cross <http://www.icrc.org/eng>. Providers who like working with children and want to gain the experience of practicing relatively sophisticated medicine in relatively austere conditions should consider volunteering for a mission with Operation Smile <www.operationsmile.org>. The group sends teams to developing world countries to repair craniofacial defects in children who would otherwise never have the opportunity.

**Humanitarian Contingencies**

- Nation building and rebuilding are important pieces of the military agenda.
- Women and children are major targets of humanitarian outreach.
- Pediatrics and gynecology skills are a premium.
- Female providers are preferentially used for humanitarian missions.
- Get involved with planning of medical civil/military missions.
- Coordinate with local NGOs.
- Seek training in humanitarian assistance and disaster management.

# Chapter XIV: Service Specific Considerations

## Introduction

A large Navy hospital unit recently moved into our predominately Army barracks in Kuwait. To say they were appalled with the level of cleanliness and the standards we had grown accustomed to is an understatement. Weeks after the move I was still apt to be berated for the conditions of the latrines and hallways, which by the way I had mopped only a week before they moved in. Culturally, they are used to the standards of a ship. We are used to living in the dirt. To us, the barracks were a huge step up. To our Navy colleagues, it was moving into the slums. The episode was a simple example of cultural differences that exist between services that we are only beginning to appreciate in this joint environment.

**Component Medical Services:** The bulk of the medical mission in Southwest Asia belongs to the Army. It makes sense, since we have most of the medical resources. Navy medicine supports the Marines. There are no "marine" docs. They live and work with the Marines, but are usually deployed from Navy health care facilities. The Navy also has deployed large "expeditionary" hospitals to theater, providing "sustainment" care in some areas of the theater. The Air Force currently shoulders the evacuation mission and a large slice of the Level III care. Joint medical forces exist under the command of Army medical brigades. The closer the units work together, the more differences become apparent.

Army units still deploy for a year. Navy personnel deploy for six month tours. Navy medical staff with Marine units generally deploy for seven months and Air Force personnel deploy frequently, but for four month intervals. Each service has its own "battle rhythm" and the differences have the potential to create conflict and division.

Navy medical staff with Marine units belong to the Marine units and are commanded by Marines, much like Army personnel below the division level. The Navy has a completely different concept of medical command, with the hospital assuming command and control for all clinics in a region. The Army will put the clinics under a provisional battalion for command, control, and support. The battalion supports the clinics with supply, maintenance, and equipment needs. In the Navy, the hospital provides only medical oversight of the clinics. Additional requirements are met by other support units (such as Seabees). There are different expectations for command and support.

Hospital tents are different as is the equipment in the tents. The Army can learn much from the modular hospital concept fielded by the Air Force and Navy. While the Army attitude of "do more with less," or "suck it up and drive on," might apply to infantry battalions in the field, it might not be as applicable in a Level III hospital where we are grappling to control infection rates and surgical complications. Air Force surgeons, for example, have data-driven protocols for minimizing infection and surgical complications. There should not be service specific differences in the critical areas of medical or surgical practice, unless the operational tempo dictates them. The best practice should be the template for practice across the services, regardless of which service is the champion.

Different units and different medical personnel in different services do different things. The Air Force Combat Stress Teams that have been so successful in the Kuwait theater are primarily focused on prevention of combat stress while it seems that the Army has a much bigger focus on the diagnosis and treatment post facto. With the different focus, mental health professionals in different services will have different training and background. Different regulations dictate things as specific as the management of pseudofolliculitis barbae and as general as the standards for determining fitness for duty. A unit in one service with the same name as a unit in another may not have the same capability or mission focus.

There are big differences between us. These cultural differences have developed over decades, if not centuries. No amount of discussion about "purple suits" will change these differences over night. The ideal first step for providers and commanders from different services to develop a better understanding is to invite healthy dialogue between them. This includes talking and listening to differences. It takes time and has to be an intentional effort. When deployed, visit sister-service units and facilities, frequently if you are working with them. Ask questions and listen to answers. Work toward compromise in problem solving. Have zero tolerance for "service-bashing" and different service slander. People do not know or believe you are "just joking."

Identify someone you trust in each of the sister services that you can "vent" to and bounce ideas off of. It should be a relatively senior or experienced person with a perspective on their own service and experience in dealing with others. This person will serve as a "subject matter expert" for guidelines, regulations, practice differences, and issues that deal with standards of operation within a specific service. If you have a question about something, or an apparent difference of opinion, start by bouncing it off your subject matter expert. Armed (hopefully) with better perspective, sit down with your counterpart and, in the words of Steven Covey, listen to understand. Often the resolution or solution will present itself in the course of the conversation.

Cooperation in a joint environment is not as efficient as working within a single service. It requires additional time and effort. You will encounter repeated difficulties to be worked through. Cooperation is, however, not optional. Our joint mission is caring for service members. With the magnitude of this conflict no one service can do it alone. We all wear the desert camouflage uniform. And as a wise Navy officer reminded me, "Everybody's uniform says 'U.S.'"

## Chapter XV: Conclusions: Pitfalls and Pearls

In the months before a deployment, in the down times of a deployment, or pretty much any time between, it is worth taking stock of one's military career. We are all leaders, and will all at one time or another at a quiet moment in the treatment tent or while waiting for a convoy to get under way be in the position of counseling junior officers and enlisted. What will you tell them about the pitfalls you have seen? What pearls will you offer to them? Here are some thoughts from the perspective of two decades in the Army, so they are obviously biased by the green I have worn. But I think the principles can be generalized. Feel free to plagiarize. It is very likely that none of these thoughts are original.

It is usually one of three things that trips up officers, young or old. The first is the pursuit of self. To quote James Kitfield in his excellent book about the military between Vietnam and the Gulf War (Prodigal Soldiers) too often the motto, "duty, honor, country" becomes "me, my [back], and my career." Early on in any military career, an officer needs to ask himself, "What am I working for?" And be honest about the answer. Sometimes the things we are working for are really not worth it.

Who remembers Claudia Kennedy? Did you recall that Lieutenant Genera Kennedy was the Army Deputy Chief of Staff for Intelligence from 1997-2000? Probably not. She was only the highest-ranking woman in the history of the Army. How about Dennis Reimer or Eric Shinseki? Would you recognize them if you met them? They were two of the most recent Army Chiefs of Staff. How soon we forget. One of the senior physicians at Tripler tells a story of when he was acting hospital commander, and a white-haired gentleman was wandering the halls of the hospital looking unsuccessfully for a clinic. It was General William Westmorland, Army Chief of Staff from 1968 to 1972. No one knew who he was.

We would all probably recognize Lieutenant General James Peake. We might even know Dr. Ron Blanck, if we saw him. But what about Drs. Alcide LaNoue or Frank Ledford? Drs. Quinn Becker or Bernie Mittemeyer? Could you pick them out of a line-up? It is discouraging that they should be forgotten so quickly. They wore twelve stars between them. They were the Surgeons General of the Army before Lieutenant General Blanck. They contributed more than a century of service to the Army. These men reached the pinnacle of power and prestige in the Army Medical Department, and we cannott remember a thing about them. Those of us serving now do not know them by name or by face. I do not know these men at all, and I know nothing of their motivations while they were in the Army. But I would venture to say that if they spent three decades pouring themselves into their "careers" at the expense of their personal lives, their families, and their friends, then they left the Army with very little.

Every officer must ask him or herself a simple question, "What am I working for?" Anyone can sew two stripes on their trousers. Are you interested in the job the general does? Do you know anything of the headaches and the aggravation? Do you know that you will not get to see patients anymore? Do you know you lose your specialty bonus? I know that some who read this will one-day wear stars. My hope is that they pursue the position of leadership for the opportunity to use their gifts and talents to serve the Army and the country. I hope that it is not just a matter of ambition. As a wise medical corps colonel once told me, "Just because the

ladder has another rung, it doesn't mean you have to step up on it." Mostly, I hope that those who become generals do not do it at the expense of their personal lives, their spouse, their children, colleagues, or comrades. It is almost assured, that within a few years of taking off green polyester, the Army and the country will forget them. If family, friends, and outside interests are gone, it will be very lonely life.

After self, the next area that shipwrecks many officers is inappropriate sexual relationships. My first PROFIS battalion commander was relieved for having an affair with an enlisted Soldier in his command. When I was stationed at my first duty assignment, a brigade commander whose children I cared for was relieved for an affair with a lieutenant in his unit. I would wager that neither officer set out to destroy his career. Probably everyone on active duty knows someone who ruined his or her life through sexual indiscretion or fraternization.

Each officer, male and female, will have to set his or her own standards for keeping out of this kind of trouble, particularly on long deployments. Consider these basic rules, especially if you are married and especially in regard to enlisted Soldiers. Do not be alone with a member of the opposite sex who is not your spouse. Do not be in a car alone (if it can be avoided), do not work late together alone, do not allow a member of the opposite sex to come to your barracks or tent alone. To some, these may seem foolish and unnecessary. But officers have shipwrecked their marriages and careers on deployment. Every officer should decide for him or herself, just how big a "fence" to construct to keep out of trouble in this area. Sexual harassment is another potential career-ender. Do not comment about the appearance of members of the opposite sex at work, either favorably or not. Do not touch them and do not joke about them.

Sexual indiscretion often results from the third of the three pitfalls: alcohol. The officer corps has moved away from the obligatory Friday afternoon "happy hours" with the commanders. Consumption of alcohol in theater is a violation of "general order number one." Somehow, people still find it. Back stateside, where being ticketed for driving under the influence (DUI) will end a career faster than almost any other cause, drinking alcohol at all in theater will get you in deep trouble. I have known several former officers for whom this is the case. Drink in moderation, when stateside or on R&R in Qatar (where there is a three-beer limit.) Drink when off-duty and only when you know you will not be driving. Decide before hand what and how much you will drink, and stick to that limit. Look out for other officers. And make arrangements for another driver or taxi if things get out of hand.

General John Wickham said that "the Army is not an institution, it is an occupation." What we do in the Army is our occupation. We may be doctors or nurses, corpsmen or technicians, tankers or infantrymen. These are all the things that we do. Being an officer is who we are. The character and leadership that goes with the commission does not come off with the DCUs or BDUs at the end of the day. That person is who we are when we go to the kids' school play, to church, to the beach, or to the kitchen table with our spouses and children. George Washington said that "An army of asses led by a lion is infinitely better than an army of lions led by an ass." If we are asses as officers at work we will be asses at home and in our neighborhoods. We are always officers.

As officers, the military will offer you countless opportunities to assume responsibility in management and administration, both on deployment and stateside. Embrace them. When you finish your time on active duty, it is your management experience that will set you off from the rest of the crowd of applicants. Your clinical skills will be assumed. Doctors and nurses in the military all train in excellent programs, are licensed or board certified, and have unparalleled experience. But when you apply for another position in five, ten, or twenty years, your administrative, teaching, and research experience will also set your application apart from the pack. So look for and embrace additional duties.

Despite the fact that we are always officers, leadership will always be an option. One is not a leader merely because of rank, position, seniority or title. We have all chosen to be officers. So we must also choose, on a daily basis, to be leaders. Leadership is not necessarily something learned in college or graduate school. Learn leadership. Watch great leaders. Watch not-so-great leaders. Become a student of leadership. Read about it. (There is no shortage of excellent books, and new ones appear all the time. There is a suggested list at the end of this newsletter, complied from recommendations of other lifelong students.) Talk about leadership in groups and in one-on-one "mentor" relationships.

Decide what your own philosophy of leadership will be so you can model it continuously, conspicuously, and consistently. Refine your philosophy over time. Test it in new situations. Become mentors yourself, and teach leadership to junior officers. I was criticized once for writing in the senior rater section of a captain's OER that I thought the officer would be a general one day. "Only a General should say that someone will be a general one day," I was told. I think that is nonsense. I am not a general and very likely will never be one. But I know by now what a good one looks like. I know what a not-so-good one looks like. And I believe that I know what one looks like when he or she is still a captain. I am a student of leadership. We all should be.

We are all intentional officers. Our commissions were not by conscript. Our deployments are a direct extension of decisions and choices we have consciously made. We are officers on purpose. We must be officers with a purpose. I believe that we have the greatest honor that could be offered to medical professionals. We have the opportunity to care for the most deserving of all our countrymen: American's sons and daughters, on the battlefield and in garrison. It is our duty, it is our privilege, and it is our calling.

*So nigh to grandeur is our dust*
*So near to God is man*
*When duty whispers, lo 'thou must'*
*And youth replies, 'I can.'*
*Ralph Waldo Emerson*

# Epilogue

*Personal statement from a young pediatrician as she prepared to deploy for a second tour of Iraq:*

I was a very green and nervous new staff coming out of residency at Tripler to Darnall, the busiest MEDDAC in the Department of Defense (DoD) system. As soon as I arrived, in addition to my patent panel, I picked up the duties of Medical Record Review and officer in charge (OIC) of the Adolescent Clinic. As a member of the Medical Record Review Committee, I was charged with reviewing in-patient and out-patient medical records. I would note the deficiencies, look for trends among the providers, and make recommendations for possible ways to improve our charting in this Joint Commission on Accreditation of Health care Organizations (JCAHO) era. The Adolescent Clinic was in a flux, as they had previously had a true adolescent doc running it. I still attempted to make sure that we offered routine PAP smears, birth control, and, most importantly, counseling for the teens we have here.

I was also taking in-house calls about once a week covering our 12 bed ward and the 250-300 births per month. I was ward or nursery attending once or twice a month providing patient care and resident, medical student, and PA student education. We also had residents and PA students in our clinic whom we "precepted." I was seeing a lot, and learning even more. There are many sick and complicated kids here due to our proximity to Wilford Hall and Brooke Army Medical Center (BAMC), and the sub-specialists there.

In December 2002, I was PROFIS to the 546th Area Support Medical Company (ASMC), and joined them in January 2003. I then deployed with them in February. We arrived in Kuwait, and stayed at Camp Arifjan for about 2 weeks picking up supplies and equipment. We helped out at the aid station there, slept in a huge warehouse with hundreds of other Soldiers, and started getting to know one another. We then moved to some intermediate bases such as Camp Virginia. This was the first time I was left on my own, covering Camp Victory before there was any electricity, water, or food. We set up in a “Fez” tent and saw sick call patients while there was daylight. If you needed to be seen after that, I had Soldiers holding their min-Mag-lites over the patients to be able to see anything. We were taking care of incoming 101st Airborne Soldiers, and it was truly amazing to see whole battalions show up out of nowhere overnight.

I learned a lot those two weeks. I had unknowingly allowed myself to be dropped off with no communication abilities, no knowledge of how to use Single-Channel Ground and Airborne Radio System (SINCGARS), and four Soldiers in my care who truly looked to me as their leader. I was in charge of making sure we had enough water and MREs from the units that we were there supporting, not letting them get assigned any unnecessary “details,” and finding out where our patients went that needed additional care. Luckily, there was an Air Force base set up nearby with a CSH that was willing to take our Soldiers. I experienced my first major sand storm there; all of the tents on our pad got blown down except for ours and the one behind us which were protected by our vehicles. I knew then that my learning curve had better be steep to survive this experience.

I rejoined my unit in time to move forward and we started the ground war right behind the 3ID Military Police (MP) unit that we were supporting. It was three harrowing days driving through the desert to reach Tillel Air base. The MPs set up an enemy prisoner-of-war (EPW) camp and we provided medical care. Our first patient came within minutes of our arrival and I was the first to take a patient, a man with a gunshot wound (GSW) to the chest. We pulled the chests off the back of the trailer and took care of him between parked vehicles. The bullet had somehow missed his lungs, and so we checked him for any more injuries, started some IVs, and made sure he was stable until the FST that was working with us arrived and set up to take him to the operating room (OR). That was the busiest and most interesting three weeks of the six months that I was there. We took care of hundreds of EPWs with simple things from conjunctivitis and gastroenteritis, to horrific things like Iraqi Soldiers with 60-80% full thickness burns, amputations, gun shot wounds, and shrapnel injuries. I saw my first pediatric patients there - a five-year-old with multiple burns and GSWs, his three-year-old sister who had a few bumps and scrapes, and their dad who had a GSW. Their mother, four siblings, and seven other family members died after being caught in crossfire. I had to do things differently with him as we did not have pediatric meds, IVs, or endotracheal tubes (ETTs). We tried our best to care for him and last I heard, he was transferred to the CSH and then sent to the U.S.S. Comfort.

When the CSH arrived, we transitioned into running the TMC and sick call, and letting the CSH take the traumas. We also held and helped arrange MEDEVAC for injured American Soldiers to the rear, and provided medical care to the British Soldiers. The two other docs and I would go to the CSH daily to help the single family practice (FP) doc assigned to the field hospital slice assigned to the CSH round on his 60-80 patients daily. I did lots of wound care at this time, packing and unpacking wounds, helping determine when extremities needed to be amputated. I also had a small pediatrics ward there of six to eight kids with primarily burns, shrapnel injuries, and amputations. I learned how to turn a latex glove, water, and salt and sugar packets from MREs into oral resuscitation fluid for an infant. There were two adolescents in the intesive care unit (ICU) who had GSWs who were seen in local Iraqi hospitals and discharged within days of surgery, and came to us septic and with open abdominal wounds. They had probably been sent home to die, but came to us when they heard that we were providing medical care. Iraqi citizens who heard that we were providing medical care just showed up at the front gates of the base as they had minimal medical care in the community.

After about another three weeks of this, we jumped farther north to Balad Airbase/Logistics Support Area (LSA) Anaconda. We arrived when there were a few hundred Soldiers there, and set up the TMC, lucky for us, across the street from the future PX. There we provided routine care to the growing number of Soldiers. I learned how to do things like shave corns and remove toenails, but never truly got comfortable treating potential myocardial infarction (MIs) and other serious adult medical conditions.

I arrived back to Fort Hood in July 2003 and though it took me a few weeks to adjust to the very different way we treat kids and adults, but I fell back in happy to not be in the desert anymore. I participated in the 03/04 National Training Center (NTC) rotation, helping to train up reservists on their way to Iraq in February 2004. In June, I became the OIC of the pediatrics clinic where we average more than 5,000 outpatient visits monthly. Darnall has 20% of the CONUS pediatric population, and one of the highest birth rates as well. We recently had a problem with our AC

units, and so I was charged with moving the clinic within days to another clinic where we had 1/3rd of the rooms, all this with minimal disruption to patient care. I rate five providers, and senior rate one NCOIC. In addition, we are preparing for JCAHO this fall. I continue to be member of the Medical Record Review Committee.

Unfortunately I will not have time to do the many things that I wanted to do in our clinic and department as I will be deploying again this winter. Luckily I will be going with the same unit I have been in the trenches with, and we have a bond that I appreciate more now than ever. I know that these Soldiers will be the ones looking after me and potentially saving my life, and I am already grateful to them. I hope that there is more time for formal teaching of these young Soldiers, and I feel I am better able to lead them with more experience beneath my belt. Also, I hope to remain receptive to what they have to teach me. I hope that I am able to care for injured and ill Soldiers to the best of my ability, and not become jaded or cynical. Most of all I hope to come home safe and sound to my husband and family, and bring my Soldiers home safe and sound to their families as well.

## Suggested Packing List

Note that the items you will need will very much depend on to where you are being deployed, and for how long you will be deployed. The packing list for deployment with a hospital in Bosnia is very different than the packing needed for an assignment with a battalion aide station (BAS) in Iraq. As soon as you know that you are going to deploy, call your unit to find out what the plan for eating, sleeping, and traveling is. These are items all suggested by your colleagues.

**Carry on Bag:** Should be as big as you can get away with, subdued in color, but not readily identifiable as military.

- Laptop and disks (essential)
- Pelican Brand Laptop Case (bump, dust, water resistant)
- USB thumb drive or two
- 6 month to one year supply of personal meds
- 60 day supply of sleeping tablets
- Sunscreen and lip balm
- Polished steel hand mirror
- Wet wipes in reclosable dispenser
- Foot powder and blister kit (mole skin)
- Diarrhea kit (Imodium, Cipro)
- Creams: Steroid, Bactoban, Hemorrhoid cream
- Emergency toilet paper (always keep the paper supplied in the MREs)
- Sunglasses, 2 pair
- Toothbrush and soap in case, shampoo, shaving gear
- Rechargeable electric shaver
- Standard razor
- Feminine hygiene supplies
- Paperback books, as many as you can pack
- Put some books in boxes for someone to send later
- Digital camera
- Change of socks and underwear
- Shot records
- Passport (probably will not need)
- Orders (many copies)
- Note pad
- Stamps/paper/envelope
- Pens and pencils
- Poncho and poncho liner
- ID Card and Geneva Convention card
- Credit card (take at least one)
- Address book
- Down pillow
- Supply of food such as Power Bars for the plane, you will do a lot of "hurry up and waiting"
- Drinking water for the trip in your canteen or bottle of water

- Money and change for any candy machines and telephones

**Military Duffel Bag:** Mark prominently with paint your name and unit, lock with combination lock, place copy of orders in side pocket.

- 2 Mag-Lites , with red and blue filters and head band holder for hands free reading
- Headlamp (or two)
- Rechargeable batteries and charger
- Lighter
- Indelible marker
- Extra shiny and subdued rank (pin and sew on)
- Watch with alarm and nightlight features
- Sewing kit
- 100 mile an hour tape
- Rope, 550 green parachute cord (order spool <http://www.vtarmynavy.com/>)
- Plastic Ziploc bags (pack everything in them)
- 2 mesh bags for laundry
- 4-8 green bungee cords
- OD green space blanket
- Insect repellent (Bullfrog or Deep Woods Off)
- Civilian compass
- Thermarest chair with OD green Thermarest sleeping pad
- Australian shower
- Packets of laundry soap and scrub brush
- Plastic bucket put in the bottom of duffel bag
- Small Vornado electric fan (if it does not fit send it through the mail)
- Neck or leg wallet
- Voltage converters and plugs
- All electric items should be dual voltage
- Sheet sown into a sleeping sack
- Sleeping bag
- Mosquito netting with four wooden poles
- Camouflage civilian tent
- TA-50: Make sure it is all put together; when you are issued it make sure you do not receive all the old stuff. They will want it new when you turn it in. Only write your name on parts that can be painted, otherwise you will end up buying the piece of equipment.
- Take three complete sets of BDUs. If you are going to use desert BDUs, order light-weight sets from Ranger Joes (or wait to see what you are issued, usually 4 pair)
- Gloves with liners (generally issued)
- Mosquito head net
- 2 sets of very well broken in boots (issued)
- 2 sets of running shoes
- 7-8 sets of cotton underwear
- “Under-armor” brown t-shirts
- 7-8 pairs of white sport socks and OD socks
- Merino wool socks are expensive, but worth every penny (Smartwool)

- If you are going to a very cold climate take running tights and long johns
- 1 set of wrinkle-free civilian clothes
- 3 sets of Army PT uniform
- 2-3 pairs of civilian t-shirts and nylon running shorts to sleep in
- Teva shoes or shower shoes
- 4-5 towels (OD) and a camping towel
- Hammer, folding saw, and nails (For long deployments to 3rd world countries)
- Cold weather gear
- Extra can of Permethrin
- Rain gear; Gore Tex
- Leatherman
- Chess set/cards/cribbidge board
- Hammock
- Small backpacking tent
- Self-inflating mattress (issued with some TA-50)
- Small, magnetic lamp
- Walkman with rechargeable batteries
- Crystal Light makes reverse osmosis water purification units (ROWPU) water at least palatable
- Leather shoulder holster
- "Drop holster" (wear on thigh, for carrying pistol while wearing body armor)
- "Belly band" holster with elastic for running with the 9mm and several magazines
- Face-Saver (by Remmington)
- Anti-fog treatment for lenses (Wiley-X goggles)
- Journal - get a nice one and use it
- Magazines of whatever hobby you have at home, sports, outdoor stuff, anything
- Laminate pictures of your kids, spouse, dogs, whatever. Keep them in the top of your Kevlar so it reminds you what you have to live for back at home. You will catch yourself smiling at those pictures every once in a while.
- Two copies of your important medical records
- Two copies of your "Inter-facility Credentials Transfer Brief" (ICTB) (Credentials documents)
- Extra copies of eyeglass prescription
- Palm Pilot / PDA

**Professional Equipment**

- Stethoscope
- Ophthalmoscope and otoscope
- Trauma shears/scissors
- Get an aid bag issued to you and fill it with IV equipment, chest tubes, basic surgical kit, pocket mask, bandages, airways. Blackhawk Industries, London Bridge, and Tactical Tailor all make excellent aid bags- check with your unit, they may be able to purchase one for you.
- Professional reading and correspondence courses such as CGSC
- A small, lockable tool box for narcotics

- Central line kits (at least four per aid station)
- IO line kits (several on the market for either sternal or tibial IO lines).
- Pediatric sized NG tubes, ET tubes, masks, etc.
- Tuning fork (evaluation of hearing loss is very common)
- Personal preference medical equipment, suture, or surgical instrument
- Extra suture as well as vascular shunts
- Personal operative eye protection
- Loupes
- Operating shoes (it is difficult to get bloodstains off of the DCU boot)

## References and Suggested Readings

- Beneson's Control of Communicable Diseases in Man
- A tropical medicine book
- A dermatology picture book
- The Harriet Lane Handbook
- Sanford Guide to Antimicrobial Therapy
- Cecil's Medicine
- A basic sport medicine book
- Tintinelli Emergency Medicine
- *Micromedex* for the PDA
- Special Operation Forces Medical Handbook
- Essentials of Musculoskeletal Care, edited by Walter B. Greene, MD
- Tarascon's Pocket Pharmacopoeia
- Griffith's 5-Minute Clinical Consult
- Merck Manual
- 5-Minute Sports Medicine Consult
- Current Medical Diagnosis & Treatment
- Washington Manual
- Pediatric "Red Book" of Diagnosis and Management of Infectious Diseases
- CDC Guidelines for the Treatment of Sexually Transmitted Diseases
- Emergency War Surgery

Note that military references can usually be found on line through <www.google.com> by searching on "**AR ##-###.**"

**AR 40-501,** ***Flight Surgeon References***
**AR 40-501,** ***Standards of Medical Fitness***
**AR 600-8-22,** ***Military Awards***
**AR 600-8-4,** ***Line of Duty Policy, Procedures, and Investigations***
**AR 600-9,** ***The Army Weight Control Program***
**AR 601-142,** ***Army Medical Department Professional Filler System***
**AR 670-1,** ***Wear and Appearance of the Army Uniform and Insignia***
**DA Form 1156,** ***Casualty Feeder Report***
**DD Form 1380,** ***Field Medical Card***
**FM 4-02.21,** ***Division and Brigade Surgeon's Handbook (Digitized): TTP***
**FM 4-02.4,** ***Medical Platoon Leader's Handbook***
**FM 4-02.6,** ***The Medical Company: TTP***
**FM 5-0,** ***Army Planning and Orders Production***
**FM 6-0,** ***Mission Command: Command and Control of Army Forces***
**FM 21-10,** ***Field Hygiene and Sanitation***
**FM 27-10,** ***Law of Land Warfare***
**Joint Publication (JP) 4-02,** ***Doctrine for Health Service Support in a Joint Operations***

**Additional Help Links:**

*Predeployment Ongoing Readiness: Operation R.E.A.D.Y.*
<http://trol.redstone.army.mil/acslink/opready/ongoing.pdf>
*Postdeployment Homecoming and Reunion: Operations R.E.A.D.Y.*
<http://trol.redstone.army.mil/acslink/opready/homecoming.pdf>
*Family Assistance Center: Operation R.E.A.D.Y.*
<http://trol.redstone.army.mil/acslink/opready/fam_asst.pdf>
*My Goodbye Book: A Booklet about Military Separation for Young Children from Three through Five*
<http://trol.redstone.army.mil/acslink/opready/mybook.pdf>
*Separations Happen: A Booklet for 13, 14, & 15 Year Olds Whose Families Are in the Military*
<http://trol.redstone.army.mil/acslink/opready/separate.pdf>
*"I Can Do That!": A Booklet about Military Separation for Young People Ages nine through Twleve*
<http://trol.redstone.army.mil/acslink/opready/icando.pdf>
*Goodbyes Are Hard: A Booklet about Military Separation for Six through Eight Year Old Children*
<http://trol.redstone.army.mil/acslink/opready/goodbyes.pdf>
TRICARE Online
<https://www.tricareonline.com/>

**Suggested Reading List**

In your study of leadership, consider these books suggested by your colleagues for when you have extra time, a credit card, and access to <www.amazon.com>.

Ambrose, Stephen E. Citizen Soldiers: The US Army from the Normandy Beaches to the Bulge to the Surrender of Germany. Simon and Schuster, 1998.
*Ambrose's best analysis of American Soldiers in WWII*

Ambrose, Stephen E. Eisenhower: Soldier and President. Touchstone Book, 1990.
*One of the best biographies of this great leader…very readable*

Ambrose, Stephen E. Undaunted Courage: Meriwether Lewis, Thomas Jefferson, and the Opening of American West. Simon and Schuster, 1996.
*How about leadership in the Lewis and Clark expedition?*

Axelrod, Alan. Patton on Leadership. Prentice Hall, 1999.
*Standard Army reading, even folks in the corporate world read this one*

Bible
*A lot of it takes place in Iraq*

Bennis, Warren. On Becoming a Leader. Addison-Wesley Publishing Co., 1989.
*A business world classic*

Bowden, Mark. Blackhawk Down: A Story of Modern War. NY: Penguin Books, 2000.
*Best analysis of urban warfare in a developing country…look at the medical challenges*

Butler, F. K. Jr., J. Hagmann, and E. G.. Butler. "Tactical Combat Casualty Care in Special Operations." Military Medicine 161 (August 1996): Supplement 1-16.

Coffee, Gerald. Beyond Survival. Putnam, 1990.
*Spent seven years in a North Vietnam prison*

Cohen, William A. The Stuff of Heroes: The Eight Universal Laws of Leadership. Longstreet Press, 1998.
*A general officer survey of generals and what they think leadership means*

The Complete Idiot's Guide to Understanding Islam. Penguin Putnam, 2001.
*Self-explanatory*

Covey, Stephen R. Principle-Centered Leadership. Simon and Schuster, 1992.
*Excellent analysis of principle-based leadership*

Covey, Stephen R. Seven Habits of Highly Effective People. Simon and Schuster, 1989.
*A must read for everyone at some point in their adult life*

Durant, Michael. In the Company of Heroes. Putnam Publishing Group, 2003.
*Story of the helicopter pilot shot down in Mogadishu*

Fox, Jeffrey J. How to Become a CEO. NY: Hyperion, 1998.
*This is a favorite of BG Granger*

Frankl, Viktor. Man's Search for Meaning. Pocket, 1997.
*Dr. Frankl is a psychiatrist who s pent years in a concentration camp during WWII*

Goleman, Daniel, Richard Boyatzis, and Annie McKee. Primal Leadership: Realizing the Power of Emotional Intelligence. Harvard Business School Publishing, 2002.
*Recent work examining the role of emotional intelligence and leadership*

Greenleaf, Robert K. Servant Leadership: A Journey into the Nature of Legitimate Power and Greatness. Mahwah, New Jersey: Paulist Press, 2002.
*A classic study on the servant style of leadership*

Hackworth, David H. About Face: The Odyssey of an American Warrior. NY: Simon and Schuster, 1989.
*Biographical work about the decay of the American military WWII through Vietnam*

Heinlein, Robert A. Starship Troopers. NY: Berkley Publishing Group, 1959.
*Classic science fiction work about duty and leadership (much better than the movie!)*

Howarth, David. We Die Alone. The Lyon's Press, 1999.
*Jan Baalsrud's true story of a desperate attempt to attack a German base in Russia 1943*

Keegan, John. The Face of Battle. NY: Penguin Books, 1976.
*Summary of warfare through the ages from the eyes of Soldiers*

Keegan, John. The Mask of Command. NY: Penguin Books, 1987.
*Excellent analysis of historical styles of leadership*

Kitfield, James. Prodigal Soldiers. Dulles, VA: Brassey Publishing, 1997.
*Excellent analysis of the US Military between Vietnam and Gulf War I*

Lansing, Alfred. Endurance: Shackleton's Incredible Voyage. Carroll & Graf Publishers, 1999.
*Ernest Shackleton's story of survival in the South Atlantic; a story every leader should know*

MacKey, Sandra. The Reckoning: Iraq and the Lagacy of Saddam Hussein. NY: W.W. Norton & Company, Inc., 2002.
*A history of Iraq, especially under Saddam*

Manchester, William. The Last Lion: Winston Spencer Churchill: Visions of Glory, 1874 - 1932. Delta Publishing, 1983.
*Two part volume on the most influential man of the 20th Century*

Masters, John. The Road Past Mandalay: A Personal Narrative. Bantam Books, 1979.
*One of the very best stories of medicine in war, set in WWII Burma*

Maxwell, John C. The 21 Indispensable Qualities of a Leader: Becoming the Person Others Will Want to Follow. Nashville, Tennessee: Thomas Nelson, Inc., 1999.
*Short summaries of leadership qualities*

Maxwell, John C. The 21 Irrefutable Laws of Leadership. Nashville, Tennessee: Thomas Nelson, Inc., 1996.
*Short summaries of leadership laws*

Moore, Harold G and Joseph L Galloway. We Were Soldiers Once and Young. Random House,1992.
*Great overview of Ia Drang Battle and the naive American Army entrance to Vietnam*

Myrer, Anton. Once an Eagle. Harper Torch, 2001.
*Classic fiction work about two conflicting styles and motives for leadership*

Perret, Goeffrey. A Country Made by War. Random House, 1989.
*Excellent overview of American military history through Vietnam, very readable*

Perret, Geoffrey. Old Soldiers Never Die: The Life of Douglas MacArthur. Adams Media, 1997.
*Another excellent, readable biography of a great American leader*

Peters, Ralph. Fighting for the Future. Mechanicsburg, PA: Stackpole Books, 1999.
*Thought-provoking look at the future battles of the US Military*

Phillips, Donald T. Lincoln on Leadership. NY: Warner Books, 1992.
*The first of the "...on leadership" biographies, and the best*

Qur'an. Translated by Abdullah Yasuf Ali. 5th edition. Elmhurst, NY: Tahrike Tarsile Qur'an, Inc., 2000.
*Interesting to see what it really says- don't believe what people tell you*

Shackleton, Ernest. South. (Reprint) Carroll & Graf Publishers, 1998.
*Unequaled leadership example from turn of the century*

Slim, Field Marshal Viscount William. Defeat into Victory. Cooper Square Publishing, 2000.
*How to admit to and learn from mistakes, do much with little, never give up, and the power of a commander who believes in preventive medicine in the worst environments imaginable.*

Smilth. Perry M., Ph.D. Rules and Tools for Leaders. NY: Penguin Putnam, 2002.
*Was required reading for all V Corps staff principle officers*

Stewart James B. Heart of a Soldier. NY: Simon & Schuster, 2002.
*Story of Rick Rescorla, a corporate security chief and his actions on 9/11*

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**http://call.army.mil**

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**Handbooks**: Handbooks are "how to" manuals on specific subjects such as rehearsals, inactivation, and convoy operations.

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