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LETTER TO THE EDITOR

EXPERIENCE OF A RESIDENT PHYSICIAN WITH THE DEPLOYMENT

The beginning of participation of Czech troops in a modern history of crisis management abroad dates back to 1990, when the first 200 soldiers of the Czechoslovak anti-chemical unit deployed to Kuwait. The Armed Forces of the Czech republic (CAF) formed from the Czechoslovak Armed Forces in 1992, and from the very beginning kept sending out its troops to foreign operations. An important part of any contingent is its medical support, consisting of a physician (or physicians), field nurses and stretcher-bearers/ambulance drivers. Until the recent past, no resident physician has ever been involved in foreign operation. And there was no reason for that as the CAF used to have plenty of board-certified physicians available. A change occured in 2008 by the operation of a Provincial Reconstruction Team (PRT) assisting in Afghan Logar. This operation commenced in parallel with the ongoing operation in Kosovo, another major operation putting high demands on medical support. At the same time, residency training was prolonged to a period of five years. Lack of board-certified physicians therefore led to an idea of dispatching residents to foreign operations as well. The PRT medical support involved two physicians and other medical staff. One of these physicians was a resident and worked under the supervision of a fully licensed colleague. This practice proved to be useful and therefore the dispatch of resident physicians spread also to Kosovo. The operation in Kosovo ended in 2011, PRT operation in Afghan Logar in January 2013.

Today, residents operate in foreign operations only within the Field Surgical Team (FST) of the CAF, assigned to French Field Hospital located at the Kabul International Airport (KAIA). This operation commenced in 2011 and has continued up to the present day. The FST is comprised of two surgeons, one anesthesiologist and one resident. This team cooperates with coalition medics from France, USA, Belgium and Bulgaria.

Residents may work, in accordance with Act No. 95/2004 Coll. [3], under a supervision of a board-certified colleague, because they do not meet the required specialized eligibility. The FST employ residents who work under the supervision of the French board-certified general practitioner (GP). Systemized position of the GP resident of the FST may also be occupied by internal medicine and radiology residents. However, there were some residents put on the position of a surgeon in certain FST rotations.

The article deals with an issue of residents PDT, evaluates the author's own experience from the deployment at the position of a GP resident within the second FST rotation and also higlights the positives and negatives related to deploying residents.

Resident's pre-deployment training

Each soldier, prior to his or her deployment, must go through the pre-deployment training, of which the essential purpose is to thoroughly prepare for upcomming duties in foreign operation. Deployment is usually planned well in advance to offer the unit enough time for consistent training. Indeed, each operation is somewhat specific and so may vary the details of such preparation.

Training plan [1, 2] usually includes 2 phases:

Phase 1 - National preparation and training, which covers:

- preparation of an individual, which consists of completion of special courses, e.g. driving skills, communication and signals, firearms, engineering and language course.

- preparation of commanders and staff in order to provide unit's documentation for operations and control – Commander's Order No. 1, Standard Operation Procedures (SOP), familiarize with the new environment, a medical section of contingent must replenish all the medical equipment and material required at given medical stage.

- Specialized preparation – concerns all unit members according to their occupational specialty and succesful completion of all required courses.

- Collective preparation – aimed to synchronize tactical procedures when providing combat drills and also mastering the operation of assigned weapons.

Phase 2 – NATO training (*Harmonised NATO training*) – certificate training and sync rehearsal

In terms of medical elements training, it is needed to achieve at least the following capabilities:

- To know the operational mission, mandate, rules of contingent liabilities, constraints, the basics of International Humanitarian Law
- To master the operation of unit arms (individual)
- To master the technique of throwing the hand grenades
- To know the basic combat drills
- To cope with actions within the Rapid Response Team
- To understand the system of reports and aid requests (MEDEVAC, medical and other sitreps)
- To learn and master the basic counter IED drills
- To be able to determine coordinates via GPS
- To master the operation of radio assets RF-13, PR-20, MOTOROLA, ICOM, HARRIS, including report transmissions in English
- As for the CBRN field, to know how to use the individual protective equipment, how to recognize symptoms of poisoning and how to provide first aid to affected persons, NBC warning signals and principles of decontamination
- To master helicopter marshalling signals
- To know principles of unit behaviour in relationship with local environment, culture and habits
- To manage adverse weather conditions movement and basic techniques of survival in mountains and semidesert
- To manage vehicle service and maintenance
- To complete BARTS/ BATLS courses
- To provide first aid under fire
- To accomplish 2x 14 days of practice at the departments of urgent medicine of the following facilities: Central Military Hospital – Military Faculty Hospital Prague, Military Hospitals in Olomouc and Brno, Air Rescue Service Plzeň – Líně, Emergency Medical Service
- Non-medical personnel must achieve the course of drivers/stretcher bearers (casualty collection skills)
- Personal Recovery/S.E.R.E. level A, B
- To use mobile phones, the Internet and multimedia devices in terms of protection of classified information
- Beware of potential health hazards as well as hygienic – epidemiological situation in anticipated area of operation
- To mamage planning process with and without sufficient time (under pressure)
- Knowledge of SOPs
- To master a military phraseology in English
- Use of a „PC Doctor“ application

A physician undergoes the pre-deployment prepration together with the deploying unit, focused on his or her specialty. Cooperation exercises for unit medics take mostly place at the tactical level, while the actual preparation and actions coordination of medical components are often neglected. In fact, medical service in such exercise acts more as a medical support to the departing unit, especially in cases such as live fire shooting, hand grenades throwing or training of tactical situations. Combined Arms training for the medical service of the continget is usually not scheduled separately.

Specialized preparation is quite time demanding and is initiated by adding a soldier to a contingent list. Both, soldiers and replacement, go through the full extent specialized training if they were on the list since the beginning. Those, who joined additionaly (author's case), must complete specialized training in a reduced form.

The Author herself was approached to participate in the foreign operation one week before departure. However, with regards to the activity specification and location, the safety of the author as well as her unit to be deployed, was not significantly jeopardized.

The author passed the above list of required capabilities six months after her return from the foreign operation during the preparation for another operation - Brigade Battle Group of the European Union – BG EU 2/2012.

According to Act No. 95/2004 Coll., [3] may resident physician perform his or her duties only under the supervision of a fully certified colleague of the same specialty. This law must be followed in foreign operations as well, therefore a resident physician may only contribute to operations staffed by at least two physicians [2]. As for FST concerns,

there is one resident physician working independently, without direct supervision of another Czech board-certified colleague having the same specialty. This legislative issue has been resolved so that a young resident physician works under the supervision of a board-certified colleague of the same field, yet another nationality, in this case a French.

Deployment

Deploying a soldier to a foreign operation is carried out through the personnel order of transfer under the Joint Operations Centre of the Ministry of Defence (JOC). Preceding to this, a personal interview is performed to inform a soldier what post in a foreign operation he or she would hold and what are the requirements.

In June 2010 the author graduated from the Faculty of Military Health Sciences, University of Defence (FoMHS) and the Charles University Prague - Faculty of Medicine in Hradec Králové, (FoM CU). A year later she was contacted by a superior at the Joint Forces Command (JFC) with an offer to participate in a foreign operation. She agreed with such an unexpected deployment under the condition of receiving an approval from her commander first. She was told that this deployment would be unlikely realized, nonetheless, it was required to start as soon as possible with the minimums necessary for immediate departure. The next day she completed the medical checks prior to deployment, including urine drug testing. A problem occured with a security clearance of level „confidential“ without a NATO certificate. For the given systemized position a level „secret“ was required. Joint Forces Command operatively ascertained level „confidential“ to be sufficient for this post and NATO certificate would be shipped additionally upon request, directly to the location of deployment. On the third day, she had to go to Brno for vaccination and then to Vyškov in order to replenish her field equipment and gear. The commander approved her deployment under the condition that the time spent in a foreign operation would be included within the residency preparation and military operation would not delay the date of the Medical Board Exam. Minimum requirements for deployment had been met within three days. Two days prior to the departure, a surgeon of the general staff called with the final confirmation.

On Friday morning, 22nd July 2007, the author reported for duty at the KAIA base. After arrival, she signed her personal interview and found out the details about her position. The first FST had no general practitioner (GP) in its organizational structure available. Since the second rotation, the General Staff decided to place a resident physician within the FST. As said before, the FST works as a component of the French field hospital in Kabul, author's new home and workplace for the following few moths. The following day, she was already fully embodied into the daily operations of the hospital, holding the position of a general practitioner of the primary care section under supervision of the French Army general practitioner. Barely two weeks had passed since the announcement of a possible deployment up to full performace of medical.

Daily routines and work

Activities of the military medical personnel within the area of deployment comes out of a unit task and medical needs. The medical support consists of many subtasks. When deployed with the unit, one task among others relates to training soldiers in various skills such as providing first aid, primary medical care, treating ailments and injuries, providing specialized first aid including resuscitation and stabilization, casualty search and collection, medical evacuation and triage, routine check-ups and hygienic-epidemiological surveillance. Medics deployed with the field hospital perform their duties according to their specialization, e.g. surgeons, internists, anesthesiologists, nurses, ARD nurses and paramedics. These soldiers work in a hospital, not directly in combat units, and that corresponds to their workload consisting mainly of surgical interventions and patient stabilization as well as consulting activities within their specialization for non-acute patients.

The French field hospital ROLE-3 at KAIA provided health care mainly to Afghan civilians and members of the Afghan National Army. Not less important was the care and treatment provided to coalition soldiers and NATO civilian employees. Acute care service was available 24/7. The primary care, the sphere of author's interest, was focused on GP's outpatient treatments of appointed patients in the mornings while the afternoons were devoted to appointed patients comming to receive care from specialists. Patients require more time, than usual, due to the need of translation into their mother tongue. So, the presence of an interpreter was almost always necessary. A major part of overall patients required treatment of fractures, usually with external fixators. However, these patients do not attend the following

check-ups as regularly as the treatment requires or as one would expect in peacetime conditions back home.

Each day had a routine course of action, but quite often unexpected events came up. Upon arrival of a larger number of wounded, Afghan patients receiving a planned treatment had to rebook and leave the hospital. The wounded usually needed blood substitutes, and therefore the primary care room immediately altered into a transfusion station. In case of an acute shortage of a certain blood group, an announcement via the public address system was made to call volunteer coalition troops who willingly donated their blood. They were required to fill in a regular blood donor questionnaire, followed by instructions and finally went through the basic physical examination. Yet warm, this blood was immediately carried to the operating theater where it was immediately applied. If the blood was not required, minor injuries were treated at the GP's office. The Czech FST was fully integrated into the French field hospital, comprising one of its three surgical teams.

Positives and negatives of deploying residents

A practice gained from a foreign operation is very valuable for a physician in pre-certification preparation and will reflect in future professional performance. Physicians will learn to work under conditions endangering their own lives and under time pressure. It is rarely possible to encounter gunshot wounds, comminuted fractures, intestinal parasites, tuberculosis and typhoid fever in the Czech Republic during peacetime. While working within the foreign operation, the physician gets familiar with the local culture, gaining a better view on how locals perceive women and especially children, who are often misused as a tool to receive drugs, and thus additional funds from their sales. It is not unusual to deliberately burn a child just to have access to foreign drugs and make „a business".

Compared to positives, the negatives of work in a foreign operation were almost negligible and occured mainly due to professional inexperience. For example, a senior French general practitioner could not help with the paperwork associated with the treatment of Czech soldiers, such as work-related accidents or process of repatriation. The author had to consult these issues with her supervisor in the Czech Republic via the Internet. A more significant observed issue was anot yet unified system of crediting the practice.

Education of the Czech physicians is being realized according to the Act No. 95/2004 Coll. [3], where every branch of the medicine require prescribed length of practice in order to obtain a specialist qualification. Practice recognition based on participation in foreign operation is of highly individual perception. Residents of the general practice medicine for adults must discuss with their supervisor to be sure, whether their work within the foreign operation will be recognized as a practice in a general practitioner clinic or not. If the supervisor refuses to recognize this practice, residents have no other choice than to compensate time worked in foreign operation elsewhere upon their return, resulting in extension of residency. There are residents of various medical branches participating in foreign operations, e.g. future surgeons, radiologists or internists. Their practice may not be counted within the preparation for residency, because it is required to complete such preparation at an accredited facility. Unfortunately, neither Czech field hospital, nor the FST meet that condition. Resident participating in a foreign operation never knows in advance, whether his or her foreign practice will be recognized within the residency preparation. And as said before, this appears to be the most significant drawback related to residents deployment during their residency preparation.

The author worked during the deployment in the hospital located at the KAIA base. The base was well guarded, so military-professional issues touched the author only marginally, particularly when moving outside the hospital. It was required to carry a personal firearm at all times, ballistic protection was used only a few times and as a precautionary measure only.

Comparison of theoretical and practical knowledge gained by studies at the military university and „school of life" – practice

FoM CU professionally prepares young physicians for their future role of medical professionals. FoMHS enhances professional field with the military issues. This area is mainly covered by the Department of Military Medical Service Organization, outlining the major problems young physicians may encounter while deployed in a foreign operation. During the study a variety of tactical situations are introduced and trained, however, due to a wide range of existing types of operations, reality may differ from the theory in partial ways. Department of General and Emergency

Medicine also prepares military physicians in providing first aid in combat situations (TCCC – Tactical Combat Casualty Care). Other departments of the FoMHS deal with issues of the deployment only marginally. For example, the departments of Military Hygiene and Epidemiology often repeat once acquired knowledge gained by the studying at the FoM CU, yet without further deepening and innovations. The FoMHS does not attach too much importance to the use of combat protective equipment or how a physician should behave in case of a sudden convoy or base attack. This information is given during a combined arms training prior to deployment, however contingent commanders expect that every medical professional already has got the required knowledge, for example when leaving the base or when it comes to IED issue. The author believes that the main role of the FoMHS should be preparing the future military physicians for the specifics that distinguish the military medical performance from that in the civilian sphere. In other words – the pure medical science is left to the FoM CU, while the FoMHS provides a military aimed follow-up training with the main goal set - to prepare at best any military medical professional for a situation that he or she may profesionally encouter. According to the author's opinion, the FoMHS meets this objective in questions on medical issues associated with possible military threats. On the other hand, its military aimed professional training still shows some gaps.

Conclusion

Deploying of board certified physicians only would certainly be an ideal scenario. However, due to their persistant lack within the Czech Armed Forces Medical Service the addition in form of deploying residents is justifiable. Since 2011, the SOPs of the CAF have been resolving the issue of dispatching the resident together with board certified physicians into the operations, where two physicians are needed.

Preparation and actual deployment has been adjusted according to the latest needs and experience acquired from past and present operations. There is no difference between the preparation and actual work of either resident or a fully certified physician. Indeed, the demands seem to be much higher for a resident, due to his or her lack of experience. Nonetheless, each foreign operation means a very valuable and irreplaceable experience. An inclusion of time worked within the foreign operation into the residency practice is often questionable. The FoMHS should place more emphasis on military aimed training for medical professionals. So far, the deployment of residents concerns only the Forward Surgical Team in Kabul, Afghanistan.

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