

surgeons recruited to and trained for participating in international missions, the (extended) military version of the Definitive Surgical Trauma Care (DSTC) Course has been implemented. DSTC is given with the intention not to duplicate ATLS, nor to provide an in depth course in surgery, but rather to teach those techniques particularly applicable to the patient who requires surgery and intensive care for major trauma, in a setting where such care is not commonly practised or even necessarily available. The course, made up by a mix of lectures, case discussions and skill stations has been given at the Swedish Armed Forces Centre for Defence Medicine in Gothenburg since 2007. It has gradually evolved to incorporate also anaesthesiologists and nursing staff into an integrated team. The faculty during these courses has been made up by a mix of international and Swedish instructors. Course candidates have primarily been military health staff, but vacant slots have been offered clinicians working in civilian hospitals in the western part of Sweden. During the last course in September 2010 17/20 (85%) of the physicians and 13/17 (76%) of the nurses rated the course as very beneficial or indispensable. The Swedish Armed Forces Centre for Defence Medicine will continue to run the military version of the DSTC course. Due to a certain over-capacity, course participation can be offered the civilian health care system.

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#### (A40) Military and Civilians in Australian Disaster Medical Assistance Teams

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The Australian Government first started to deploy civilian medical teams internationally in the aftermath of the 2004 Tsunami to Banda Aceh, the Maldives, and Sri Lanka. Historically, Australia had relied upon the Australian Defence Force (ADF) to provide overseas medical assistance, but, in this instance, the volunteers deployed were civilian staff, predominantly from tertiary hospital environments. Civilian Australian Medical Assistance Teams (AUSMATs), particularly in Banda Aceh, interacted closely with the ADF after the tsunami and have had a close liaison with the ADF in subsequent disasters, particularly where ADF assistance was required for aeromedical evacuation of patients. This has included assistance after the 2005 Bali bombing, the 2009 Ashmore Reef explosion, the 2009 Samoa tsunami, and the 2010 Pakistan floods. In the latter, Australia deployed a joint military-civilian medical taskforce to provide care to the affected people in Kot Addu in central Pakistan. Having had extensive experience in both military and civilian disaster responses, the authors in this presentation will look at the lessons that can be shared between civilian and military teams in the Australian context. The military brings particular proficiency in command and control, information gathering, security, communications, general logistics, aeromedical evacuation and living in the field. The civilian AUSMATs bring specialized medical expertise, experience in operating in small teams in a range of disaster conditions, health logistics, surveillance, and public health measures in a disaster setting. Learning how to blend these skill sets will

be critical in ensuring effective and collaborative international deployments in the future.

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#### (A41) Perceptions of Military Medical Disaster Training

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**Background:** To be effective, disaster preparedness training should continually meet the needs of the trainees. Most military medical personnel undergo training focused on practicing in austere environments with little support. However, while located at their home station, disaster response is conducted in a different manner due to staffing and available resources. This survey attempts to identify areas of the military medical disaster response staff are most concerned with in order to better formulate future training for home station as well as contingency operations, ultimately increasing confidence and effectiveness.

**Methods:** An online survey service was utilized to anonymously poll 106 military medical personnel assigned to a joint Level 1 trauma center in Iraq using 38 forced Likert-scale questions. The training issue of most concern for both arenas is the patient surge. Military-civilian collaboration was a key point regarding the home station setting and supplies/equipment for the deployed setting.

**Results:** Eighty-nine percent of responders rated disaster training as moderate to very important. However, there was a low perception of disaster exercises conducted in the manner of a real-world event. This was attributed to unrealistic participation and training methods. Computer-based training (CBT) was identified as an ineffective method of training; hands-on instruction clearly identified as the preferred method. Participants rated considerable confidence in Level C personal protective equipment, and the majority surveyed would report for duty despite exposure risk.

**Conclusion:** Current training methods may not optimally produce disaster response effectiveness. Management of the patient surge was a repeating training concern for both home and deployed settings. Future training efforts should focus on military-civilian collaboration for the home station, and management of the patient surge for both arenas.

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#### (A42) Development of Slovene Military Medical Unit

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**Discussion:** During the past 12 years we have been developing our military medical unit through collaboration between the public health system and military system. We found that one system could not work separate without another. Experts from public health system are incorporated into the military structure which provides efficient technical support and logistics. Through such a system we can cooperate in international projects.

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