

room treatment, and intensive care;

3. Early identification and prompt first aid;
4. Early airway management;
5. Early and repeated gastric lavage;
6. Muscle relaxants, possibly combined with anesthetics, are recommended for critically ill children;
7. The use of Sodium Dimercaptopropansulfonate (DMPS) as an antidote in clinical practice; and
8. Causes of death: Instead of direct toxins, the tetramine toxicity mechanism includes severe convulsions resulting in respiratory insufficiency that causes hypoxia of the brain and multiple organ failure leading to death.

Keywords: airway; children; death; first-aid; emergency department; intensive care; lavage; poisoning; sodium dimercaptopropansulfonate (DMSP); tetramine; treatment

Prehosp Disast Med 2002;17(s2):s24-25.

Task Force Session: Civilian – Military Collaboration

Co-Chairs: Air Commodore Tony Austin;¹ Dr. Edita Stok²

1. Director General, Defence Health Services, Australia
2. Co-Chair: WADEM Task Force on Civilian-Military Cooperation. Slovenia

Military Involvement in Disaster Preparedness, Organisation, and Disaster Relief – Civilian Military Co-Operation (CIMIC)

Rannveig Bremer Fjær, MD; Knut Ole Sundnes, MD
Joint Medical Services, Norwegian Defence Forces,

Introduction: In frequent humanitarian emergencies during the last decades, military forces increasingly have been engaged through provision of equipment and humanitarian assistance, and through peace-support operations. The objective of this study was to evaluate how military resources could be used in disaster preparedness as well as in disaster management and relief.

Methods: The study includes participating observations over 23 years (1979 to 2002) on the delivery of humanitarian health relief, in international peace support operations, retrospectively for UNIFIL Lebanon, SFOR, Bosnia, and prospectively for KFOR, Kosovo, and in humanitarian missions such as the Norwegian Save the Children in Yemen, ICRC in Iran, and UNICEF in Northern Iraq. Evaluation of the earthquake in Gujarat, India in January 2001 involved interviews with central relief actors and central persons within the UN and non-governmental organisations (NGOs).

Results: Overall central planning and co-ordination in disasters had not been given appropriate priority. Even in international peace-support operations, most humanitarian relief has been ad hoc, substituting lost functions mainly curative in character, e.g., 50% of the patients treated through Norwegian health installations in UNIFIL were civilians. However, in UNIFIL, a vaccination campaign was initiated in co-operation with UNICEF. In Kosovo, training of local health personnel and restoration of health institutions were prioritised before curative treatment. Still civilian organisations were reluctant to be associated with armed forces even though special military skills were recognised.

Conclusion: To facilitate adequate disaster response, continual medical intelligence, warning systems, and co-ordination and control are compulsory; each are functions available through the military systems. Further, Armed Forces non-combatant units (logistics, engineering, medical) have ample resources that could/should be used in most disaster settings, provided such use is politically compatible. A policy on CIMIC should be developed in close co-operation with host nation health authorities and WHO, especially for Primary Health Care issues.

Keywords: civilian-military cooperation; coordination; disaster; emergency; functions; intelligence; planning; policy; preparedness; response; warning systems

Prehosp Disast Med 2002;17(s2):s25.

Three Months Experience in the United Nations Military Hospital (UNMILHOSP), Dili, East Timor *Linas Dziukas*

The United Nations Military Hospital (UNMILHOSP) was established in Dili, East Timor, in late 1999. The hospital had a 3-bed Intensive Care Unit (ICU). The (medical) consultant support for the ICU was provided by the Australian Defence Forces (ADF). The author was the ICU Consultant in April–May 2001 and in March 2002.

2001 ICU Experience — Between April and May, 19 patients were treated — 12 Timorese, five Australian (3 civilian and 2 ADF soldiers), one Jordanian soldier (with a spontaneous pneumothorax), and one UN civilian (Singalese) with a severe asthma attack. The characteristics of the Timorese were: seven male, five female; average of ages = 23 years (6 were aged ≤16 years). Reasons for admission were trauma (4 motor vehicle accidents, 1 stabbing); medical (3 with sepsis, 1 with status epilepticus, one with cerebral malaria); obstetric (1 placenta accreta), and oncological (1 retinoblastoma). The major procedures provided for the Timorese were: thoracotomy / laparotomy (1); enucleation (1); and extraction of placenta (1). Ten of the Timorese were intubated and ventilated, and five of the Timorese died.

2002 ICU Experience — During March, the patients treated in the ICU were a one-month-old Timorese infant with a congenital diaphragmatic hernia (the patient was transferred to Brisbane), a 33-year-old Timorese man who had been gored in the chest and abdomen by a buffalo (the man died from septic shock), a 45-year-old Korean soldier with acute myasthenia gravis who was transferred (unintubated, but with a medical escort) to Adelaide, a 54-year-old Pakistani civilian who presented with an acute myocardial infarction complicated by ventricular fibrillation who was transferred (after thrombolysis) to Darwin, and a 19-year-old Portuguese soldier who had an epileptic seizure.

Keywords: Australian Defense Forces (ADF); diagnoses; East Timor; hospital; intensive care; mortality; treatment

Prehosp Disast Med 2002;17(s2):s25.