NON-COMBAT PATIENT DISPOSITION

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This section deals with the "how to" of patient disposition in the day-to-day non-combat environment. Most of the information presented will be useful whether working out of branch clinics or your BAS. How do you get a patient into the system? How are referrals dealt with? What must you do to make sure the patient is being cared for appropriately, and that all required steps have been taken to assure he or she doesn't get some nasty administrative surprises. The chapter on Medical Boards goes into considerable detail regarding the administrative processing and disposition of cases mentioned here.

With TRICARE now up and running, the member initiates getting into the system through a toll free call. That may be the way you first come in contact with the patient or perhaps, by an informal visit to sick call at the BAS. If you find that you must refer to a specialist, make sure you understand the local rules for referral, and have a pretty fair working knowledge of your region's TRICARE system. Once treated by you, or treated and returned, you may still have some problems with the disposition of that patient.

PATIENT DISPOSITION

If a member is seen at the BAS, treated, "cured" and returned to **full duty**, say so on the chart! If treated and **no duty** (bed rest) is the best course, again, say so, put it in the chart and re-evaluate, 24 hours at a time. If **light duty** is the proper course, advise up to a maximum of seven days before re-evaluation. Find out exactly what this person's duties are, and spell out the limitations on the chart and the light duty chit. Always remember that in the military, these are RECOMMENDATIONS to the command, which do not constitute an order with which the command must comply.

Uncomplicated chickenpox may present something of a dilemma if the individual is not living at home. This may require a short period of hospitalization and subsequent administrative placement on convalescent leave to prevent spread of cases in the barracks.

Shipboard duty is another special case that must be considered should you see someone who is assigned to a ship. That individual must be able-bodied (no cast or crutches) since his work place may have many occupational and environment hazards requiring full physical capability. Additionally, damage control and fire fighting becomes an all hands function in times of emergency, also requiring full function. Besides, it's awfully hard to swim with a cast.

Some alternatives when considering longer term illness or injury might be a medical holding company like the Marine Corps uses, which requires that a hospital admission has been done.

Convalescent leave may be a consideration but again, only after having been hospitalized. Extended periods of limited duty require a medical board.

Physical Conditions Not Considered A Disability

Obesity
Evaluate, treat, and document the case. If your efforts are unsuccessful, and the individual's motivation is not high enough, then administrative separation will be the ultimate outcome. Obesity is viewed as more of a behavioral than a medical problem.

Physical readiness testing
Each command may be a bit different, but usually if a member fails the PRT over 2 or 3 test periods then they may need medical evaluation, resulting in a medical board (if for medical condition), or administrative separation.

Pseudofolliculitis barbae
The cure for PFB is to avoid shaving, but that is usually an unacceptable course in most military units. Motivation for continued service is often a factor to be considered. If medical treatment is unsuccessful, they may be considered for administrative separation.

Heat intolerance
There are those who, in spite of acclimatization, are heat intolerant. While not considered a disease, administrative separation for the good of the individual and the service may be required.

Somnambulism
Administrative separation is the way to go with this condition, but one must be alert to claims of somnambulism by those who would wish to be relieved of their obligation. The grounds for separation therefore, require observation by 2 military members on 2 separate occasions to be considered valid.

Enuresis
Requires evaluation by urology, before administrative separation can be considered.

Personality disorder
A widespread and very common problem for the military, it requires diagnosis by a psychologist or psychiatrist for separation, and it also must be accompanied by poor performance.

Drugs and alcohol
CAAC evaluation is required, perhaps leading to formal levels of treatment including detoxification. If treatment is unsuccessful, administrative separation will be the outcome. You need to always have a high index of suspicion, and any Intoxicated patient seen at sick call should have an alcohol-related incident documented.

Suicidal patients
This problem has gotten a great deal of attention by the line at the highest levels. There seems to be a sense that ALL suicides are preventable, though that seems not to be the case even with the closest management of those at risk. You MUST evaluate these individuals, but they do not have to be seen by psychiatry emergently unless you believe the individual is a high risk. The section on psychiatry provides a great deal more information on suicide and a further discussion of patient disposition for psychiatric conditions.

Pregnancy
With integration of a larger number of women into naval service, the issue of pregnancy with its associated considerations has become a very important focus in recent years. The Secretary of Defense and Secretary of the Navy have gone on record saying that pregnancy and the raising of a family is not and should not be incompatible with service.

Clearly, there should be no preferential treatment because of pregnancy, but neither should there be activities or exposures to hazards, which may cause harm to the mother and developing child. While all women should remain active and in good condition, there should be no regular physical training of the kind that is usually expected in military service, and should be no PRT until 6 months post partum. There should be no swimming qualifications, weapons training, or exposure to chemicals and toxins. In short, sort of a common sense approach based upon the best and desired outcome. There have been political pressures applied to extend women at sea for longer periods, but we have little idea of the true impact of environmental hazards on the unborn in this highly industrial shipboard environment. Currently, women must be off the ship after 20 weeks, and must be within 3 hours of an MTF while aboard. This appears more a logistic consideration than a medical one, but has been the guideline nonetheless. If deployed, and you have a pregnant member who has symptoms which you feel might represent a danger, and do not have full OB/Gyn capability close by, then transfer of that individual might be the best recommendation. There should be no overseas assignments made after the 28th week of gestation, and then not to an area where there is not adequate medical care. As always, immunizations are not recommended during pregnancy, except for tetanus should that be required.

Work can be done by shifts if necessary, with no more than 15 minutes maximum at "parade rest". During the last 3 months of pregnancy, recommendations of 20 minutes rest every 4 hours may be made, with no more than 40-hour weeks.

Post partum, there is a six-month extension of weight standards to allow time for return to normal weight. Six weeks convalescent leave is normally granted to allow for recovery and bonding.

Suitability processing for overseas assignment (NAVMEDCOM 1300.1C)
Assignment of members or their dependents who have chronic or recurrent medical requirements can become an enormous burden to the parent command and the local MTF, particularly if there is not the local capability to deal with those conditions. If there is any question at all, a call to the MTF with description of the requirements of that case may forestall real problems later. Think

about what might be required; consider the capabilities of the MTF, and those of the host country. Often times, host country quality of care is well below US standards. If not, there is still the question of costs, which may be incurred.
Consider all the mental, medical, and behavioral attributes of the family, screen records, do a history and physical exam on members and dependents.

Refusal of medical treatment
If the condition limits the patient's military duties and the recommended treatment is widely accepted as effective and beneficial, then a medical board should be done.

PATIENT REFERRALS
You may find that you need to refer patients from a BAS, the field, a ship or overseas. In an emergency military referral is preferred, but civilian referral may be necessary if closer or more appropriate (check on quality of care available, especially overseas).

Elective referrals overseas are to the closest possible military facility when feasible. Such referral may require aeromedical evacuation (VERY EXPENSIVE) and may require per diem (also expensive). Be sure that consult is needed before referral, and discuss the case with more experienced senior MOs or with specialists by phone or message. Do NOT clear anyone to go to the field when he has a consult pending, or the appointment may be missed, necessitating a re-start at square one. The majority of consults are for orthopedic care, and often have long waits of 3-4 months or more in some locations. There just are not enough orthopedic surgeons to go around. You may be able to get a quick response to emergencies, or 72 hour consults, but avoid the temptation to abuse this privilege. You can sometimes "massage" the system by calling the specialist and explaining any extenuating circumstances.

How do you get the patient seen by a specialist and what hospitals and facilities are available where? Ships and overseas facilities can usually provide administrative assistance, but be sure when requesting consultation that there is communication with the facility to confirm current capabilities and make appointments.

Again, when operating in areas where TRICARE is in place, make sure you understand how that system works, and who the points of contact are.

MEDICAL DISPOSITION
If a medical problem is not expected to resolve within 30-60 days, the patient needs at least a limited duty board. If unlikely to be healed within 6-12 months or continued service will worsen the condition, then a full medical board is needed. If the member can't pass PRT over 2-3 cycles, then a medical board is needed. It's a bit confusing at times when discussing boards, since we sometimes consider informal meetings to discuss the best course of action as "boards". A general overview of medical boards follows, but you are encouraged to see the chapter on Medical Boards, for all the administrative processing details.

Whether limited duty or medical boards, they provide a very valuable function. Primarily, they are tools, which provide the unit commander with information about that member and the likelihood that he or she may be returned to duty, and when. Decisions need to be made with regard to the unit's effectiveness with the loss of that member.

The medical board is a formal process, which is convened by commanding officers of naval hospitals or clinics, to determine the fitness of an individual to continue in service. The board may find an individual *fit for duty*, but cannot find the member *unfit for duty*. Unfit for duty determinations can ONLY be made by the Physical Evaluation Board (PEB) upon review of the case. The reason for this is that determination of disability and subsequent disability payment levels, retirement, promotion, tax status etc. are determined by Federal Statute, which must be scrupulously adhered to by a special panel, the PEB. The report therefore, must be complete, with adequate information concerning the nature of the condition, its cause, aggravating factors encountered in the service and any other significant facts about the patient's condition(s).

Military members who are new to service frequently have medical problems, which make it difficult or impossible for them to serve, generally unveiled during boot camp training. Two of the more frequently encountered are retropatellar pain syndrome and plantar fasciitis. These are really conditions which are peculiar to their training, and which would not be a factor in their civilian life. Nonetheless, these people are unable to complete training and are discharged. There has been a lot of objection, but these conditions result in a lump sum payment along with their discharge from service.

Pre-existing conditions

With some frequency, conditions that have been concealed by the member, or previously unrecognized, are brought out by service. These individuals may be discharged either under "erroneous enlistment" or "Existing Prior To Entry (EPTA), without compensation. Once an individual has been on duty for 180 days, we have essentially accepted this individual with any medical problems, which have yet to come to light, and the medical board process applies. The exception is the little known "eight year rule", which states that in the case of genetic or familial conditions which appear, the service member must have eight years continuous, active service to be eligible for compensation for his medical condition.

It should be emphasized that the medical department has a great responsibility in keeping the line Navy informed on the medical condition of each of its members. The issue is readiness. Your best judgment is required.