

**DEVELOPING VIBRANT STATE DEFENSE FORCES:
A SUCCESSFUL MEDICAL AND HEALTH SERVICE MODEL**

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The Katrina disaster spiked concern among Federal planners that “the United States is incapable of delivering mass care ... the emergency medical response system is woefully inadequate” (Rood, 2005, p. 38). Katrina starkly revealed numerous holes in our ability to deal with mass casualties, including the lack of any “coordinated system for recruiting, deploying, and managing volunteers” who invariably show up at crises, often only to add to the chaos (Franco, et al., 2006, p. 135). In this article we present a significant counter example to these uncoordinated, impaired, spontaneously converging volunteers by documenting how well trained and highly disciplined State Defense Force medical units can provide basic to mid level acuity medical capacity to augment overwhelmed first responders during mass casualty events.

One such unit, the Maryland Defense Force (MDDF) medical command [now the 10th Medical Regiment (10MEDRGT)], served with distinction during the Hurricane Katrina crises when called up by Maryland’s Adjutant General, Major General Bruce F. Tuxill, as approved by Governor, Robert L. Ehrlich, Jr. During the two-and-one-half weeks they were deployed in the field, the 10MEDRGT provided a variety of medical services for more than 6,000 injured and suffering patients at six MDDF field treatment stations.

The success of the Maryland Defense Force demonstrates that these virtually unknown state military organizations [which are lawful reserves to their state National Guard (NG)] can, under proper direction, provide much needed surge medical capacity to first responders who are quickly overwhelmed in large scale crises like Katrina (Rood, 2005). The need for a sufficient and reliable source of cohesively organized emergency medical volunteers is too great to have to rely on the spontaneous unaffiliated volunteers who converge on disaster scenes only to become part of the problem. Instead, why not expand SDF medical commands which are well situated to ramp up in order to provide this organized surge capacity manpower. This can happen if SDFs conduct two major activities. First they must exploit the sense of national jeopardy that, research shows, stirs volunteerism in the wake of critical events like Katrina and 9/11. And second, they must recruit and organize medical professionals into cohesive, SDF medical units.

Predictably, emergency service volunteerism has increased dramatically since 9/11 and Katrina (Penner, 2004). This spike of pro-social enthusiasm was evident in many emergency service organizations, including the uniformed, paramilitary auxiliaries of the Armed Forces of the United States: the U.S. Air Force’s Civil Air Patrol (CAP) and the U.S. Coast Guard Auxiliary (CGAUX). The CAP fields more than 58,000 volunteers and flies 95 percent of the nation’s air search and rescue missions, while the CGAUX utilizes another 32,000 volunteers in, among other duties, critical waterborne civil preparedness roles. These auxiliaries are more-or-less subject to the direct control of the Armed Forces that parent them, and have no official ties to the states in which their members serve. Volunteers also flocked to the State Defense Forces (SDFs), which are a grossly “overlooked asset” that

Report Documentation Page

Form Approved
OMB No. 0704-0188

Public reporting burden for the collection of information is estimated to average 1 hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to Washington Headquarters Services, Directorate for Information Operations and Reports, 1215 Jefferson Davis Highway, Suite 1204, Arlington VA 22202-4302. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to a penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

1. REPORT DATE 2006		2. REPORT TYPE		3. DATES COVERED 00-00-2006 to 00-00-2006	
4. TITLE AND SUBTITLE Developing Vibrant State Defense Forces: A Successful Medical and Health Service Model				5a. CONTRACT NUMBER	
				5b. GRANT NUMBER	
				5c. PROGRAM ELEMENT NUMBER	
6. AUTHOR(S)				5d. PROJECT NUMBER	
				5e. TASK NUMBER	
				5f. WORK UNIT NUMBER	
7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES) State Defense Force Publication Center,19819 Maycrest Way,Germantown,MD,20876-6339				8. PERFORMING ORGANIZATION REPORT NUMBER	
9. SPONSORING/MONITORING AGENCY NAME(S) AND ADDRESS(ES)				10. SPONSOR/MONITOR'S ACRONYM(S)	
				11. SPONSOR/MONITOR'S REPORT NUMBER(S)	
12. DISTRIBUTION/AVAILABILITY STATEMENT Approved for public release; distribution unlimited					
13. SUPPLEMENTARY NOTES See also ADA494466. Pub in: State Defense Force Monograph Series, Winter 2006, Medical Support Teams. © 2008 State Defense Forces Publications Center. Creative Commons Attribution License.					
14. ABSTRACT					
15. SUBJECT TERMS					
16. SECURITY CLASSIFICATION OF:			17. LIMITATION OF ABSTRACT Same as Report (SAR)	18. NUMBER OF PAGES 21	19a. NAME OF RESPONSIBLE PERSON
a. REPORT unclassified	b. ABSTRACT unclassified	c. THIS PAGE unclassified			

provides an opportunity for citizens to serve in a less demanding military environment than the Federal Active or Reserve Forces (Bankus, 2006). SDFs are lawful militias, not to be confused with the unofficial groups of political malcontents who usurped the title “militia” in the mid-90s. Instead, SDFs are explicitly sanctioned by Congress, pursuant to the provisions of the U.S. Constitution prohibiting the States from maintaining troops other than the NG (as the state militia) without Congress’s approval. As such, SDFs are housed in state military departments and legally subject to military discipline and state codes of military justice.

SDF Purpose and Roles

Adjutants General and their SDF commanders who desire to provide their states with enhanced emergency medical resources can take advantage of the emotional impact caused by events like Katrina, and 9/11 that research shows spurs the public to seek opportunities for meaningful participation when communities face the need for mass casualty Disaster Relief Operations (DRO). If SDFs can adapt to this new reality, then the desirable goal of finding and keeping sufficient volunteers to make these state forces a truly effective means to help relieve states facing domestic emergencies.

To a large extent, SDFs suffer from a peculiar sort of chicken-and-egg conundrum that afflicts volunteer service organizations in general. That is, the organization will not get meaningful, real-world missions unless it has a credible force that can execute them, but it cannot attract and hold such members unless and until it has the missions to keep their interest. Later in this paper, we shall show how critical mass can be achieved if an extraordinary external event catalyzes the volunteer reaction and organizational planners exploit this event for the public good.

Thus far, many State Adjutants General seem to not recognize the opportunities for SDFs presented by the post 9/11 environment. Instead, many have either minimized or closed out their state’s SDF, or relegated them to the traditional SDF role of replacing NG units when federalized, which happened on a giant scale during World Wars I and II when SDFs also safeguarded public property. However, since Lieutenant General H. Steven Blum, Director of the National Guard Bureau, pledges that no more than one-half of any state’s NG resources would be mobilized in the post-Cold War era, these traditional SDF “force replacement” roles, for now, are effectively meaningless (although, if the DoD succeeds in doing away with extant limitations to domestic Federal NG call up for natural or manmade disasters, then, these traditional SDF “force replacement” roles may once again breathe life). But new exigencies and emergent threats show the need for large numbers of trained medical or health personnel is great, and are thus far unmet. SDF medical units can help plug these gaps, but too often have not, for a variety of reasons that we shall now explore.

With a few notable exceptions, TAGs’ support for SDF’s are ambivalent for understandable reasons. Some TAGs and/or their Operations and Planning Directors, for example, see their SDFs as potential sponges for already constrained state funds, while others just do not see the need for largely “on-paper” units, already overloaded with high ranking cadre. Others simply do not see how such forces might be reconfigured. The professional literature that might trigger such new thinking is limited to only two sources: *The State Guard Association of the United States of America Journal*; and the *State Defense Force Publication Center* (<http://www.sdfpc.org>); however, only the latter expressly explores new missions and functions in its *Journal* and *Monograph Series*. This scant, but developing, literature already suggests that professional directorates, particularly those comprised of medical, legal [Judge Advocate General (JAG)], communications, Chaplaincy, and military emergency management units, can provide a meaningful substitute for the obsolete and unrealistic (and often hollow) light infantry, military

police, or constabulary roles (although the latter do prove useful in rare cases, like Alaska, with its sparse population and gigantic land mass) that traditionally framed so many SDF missions and, for the most part, still do.

The material presented in this article examines how two states have restructured their SDFs around core units of professional directorates by recruiting highly skilled volunteer experts who already have the necessary preparation and credentials to deploy with very little additional training, to become essential medical components that can augment emergency first responders in Disaster Relief Operations. Furthermore, SDF medical units are in a particularly enviable position to be able to provide needed clinical support to the NG by “providing back-fill for physicians, dentists and mid-level providers who are deployed or on training missions” and by serving as “medical readiness assets for mobile support teams, labs, immunizations, latent TB screening, and post-deployment assessments.” (COL Eric Allely, Maryland State Surgeon, 2006).

This article provides insights into how such units may be formed and how they can function to effectively augment overwhelmed first responders and other exhausted health infrastructure in the mitigation of anticipated health and terrorism threats. These roles provide opportunities that can reverse historic SDF recruitment and retention problems, by offering meaningful roles that attract and keep professionals who wish to contribute to the well-being of their communities. If this challenge is not accepted by the state military hierarchy, then the recent gains realized by some SDF’s post 9/11 may disappear in “been there, bought the cap and shirt” disappointment.

Background: SDF Legal Status and Role

As a volunteer citizen “army” every community, from Colonial days forward, sponsored some form of a lawfully sanctioned, organized standing militia; however, these uniformed select units were localized (as opposed to the general) militias that only trained annually, and were composed of all males of arms-bearing age who were not specifically exempt (Nelson, 1995). SDFs are Congressionally authorized in 32 U.S. Code, Sect. 109, as “other troops” rather than as militia. Since 1903, the term “militia” has generally signified a state’s National Guard. Notwithstanding this unique “other troop” definition, state legislatures have invariably classified their SDF as a third component of the state’s organized militia, the other two elements being the Army and Air National Guards in their state status. This makes SDFs unique creatures of the state. Its members have no Federal Reserve status as their NG colleagues do, nor can they be federalized except *in extremis*, should a desperate President exercise his Constitutional and statutory emergency powers to federalize all state militias. Otherwise, SDF units may assist in a major multi-jurisdictional DRO under the command of the state Adjutant General even if unified command is exercised by Federal military authorities.

While NG troops are paid for their activities in uniform, SDF soldiers serve as unpaid volunteers for training, normal drills, and duty (Nelson, 1995), and they typically purchase their own uniforms, which Army Regulations specifically authorize them to wear with distinguishing state insignia. SDF troops are occasionally paid if ordered up by the Governor, but SDF soldiers overwhelmingly serve under voluntary state active duty orders without pay.

SDF personnel are authorized to wear any earned federal military and civilian awards and decorations, and may earn and wear state authorized NG and SDF awards and decorations as well as those awarded to them by other nations and states.

During the Cold War, when there was a potential for the United States to be exposed to land, sea and air attack, the SDFs, with “traditional” deep reserve and NG replacement missions, maintained a reasonable size and growth pattern. Since 9/11 there have been widespread calls for citizen participation, and many “think-tank” appeals for the expansion of the SDFs, leading to (as yet un-enacted) legislation to strengthen them (Homeland Security IntelWatch, 2004; Brinkerhoff, 2001; Tomisek, 2002; Bankus, 2005; Bankus, 2006; Carafano, & Brinkerhoff, 2005; Freedberg, 2002; Kennedy, 2003; Phillips, n.d., Tulak, Kraft, & Silbaugh, 2005). Oddly enough, however, even in this era of heightened homeland defense awareness and regular NG deployment, SDFs, remain small, with only about 14,000 mostly middle aged or older personnel nationwide still typically plying their obsolete Cold War era missions. In contrast, the CAP has, nationwide, 60,000 members, half of whom are Senior Members (over age 21), the other half Cadets (ages 11-21). Many argue that SDFs could do as well.

Proponents of the proposed State Defense Force Improvement Act of 2005, for example, believe that even relatively token federal support could boost SDF ranks to 250,000 (Kennedy, 2003), which is far, fewer than the 400,000 that the Military Order of World Wars (MOWW) believes could be raised if SDFs were “properly supported” (MOWW, n.d.). The Department of Defense (DoD) also believes that SDFs “could be expanded” (DoD, 2005). Even without additional resources, a succession of national traumas (9/11, the Gulf War, to say nothing of a string of natural disasters) has pushed SDF numbers up, appreciably in some organizations, though growth is far from even across states, due to a variety of factors that bear examination.

Theories of Emergency Volunteerism and SDF Strength Levels

It is axiomatic that “historic events” and profound crises inspire volunteerism, driven by the impulse to protect one’s nation, home, and hearth against a perceived threat (Penner, 2004). To some extent, this is a function of the socially and evolutionarily useful trait of altruism. Research clearly shows, for example, that the humanitarian instinct to help in a crisis, as pushed by “rescue hope or need to support a sentinel effect,” is much more common than the selfish malevolence of looting (Tierney, 2003). Unfortunately, research also shows that this pro-social surge is often “short lived” (Penner, 2004, p.653). Consider, for example, Penner’s finding of how the more than 300 percent nationwide increase in volunteerism inspired by 9/11 eventually dropped back to pre-disaster rates, despite serious efforts to sustain these high levels of participation. Sadly, the American populace often has a short attention span.

Wholly apart from altruism, Terror Management Theory (TMT) predicts that defensive emergency service volunteering affords the threatened, or “mortality sentient,” volunteer an enhanced sense of anxiety-reducing control over a perceived threat. This vicarious agency brings the threat into the realm of indirect personal control (Greenberg, Solomon & Pyszczynski, 1997). Of course, altruism, which is a well-researched volunteer motive (Nelson, Hooker, DeHart, Edwards & Lanning 2004), complements TMT insofar as, in the context of emergencies, altruism may represent an adaptive response that promotes within-group survival (Raphael, 1986). In this view, altruism also is stoked by threat salience and perceived vulnerability.

The protective volunteer response attenuates over time for two main reasons. First, the threat “decays” over time. Just as yesterday’s news doesn’t sell newspapers, yesterday’s threats often soon fade away in the face of new concerns. Second, for non-spontaneous organizational volunteers, the volunteer organization might not be perceived as making a meaningful contribution to disaster mitigation. In

either case, the altruistic impulse to make a meaningful protective contribution is diffused or re-directed to other pro-social endeavors (Mileti, 1999).

It is clear that volunteer levels historically rise and fall in proportion to the citizenry's perceived susceptibility to an external threat. The unparalleled menace of World War II, for example, made mortality sentence a rational mode for males of arms-bearing age, and the altruistic drive toward self-sacrifice soared. By the time of the Pearl Harbor attack, roiling war clouds pushed State Guards' membership rolls to more than 89,000 volunteers. By 1943, 170,000 men were so serving (Nelson, 1995). Many of these, like the Home Guard in the United Kingdom, or even the *Volkssturm* in Germany, were veterans of World War I, too old or not physically fit for military service overseas.

Although the end of the war terminated these all-volunteer units, the Korean War sparked a revival of sorts. Even though a federal law got the state Adjutants General back into a State Guard (now renamed SDF) planning mode, implementation was strangled, *inter alia*, by lack of funding (Historical Evaluation and Research Organization, 1981). By 1955, the escalating Cold War saw the formal revival of the classic all-volunteer state militia. But growth was sluggish until "the collapse of U.S.-Soviet détente in the late 1970s" (Stentiford, cited in Bankus, 2005, p. 30). This heightened threat level sparked SDF volunteerism. SDFs were identified, for example, by the Reagan Administration as a "vital element of plans to protect the population against a massive Soviet nuclear attack and to reconstitute society under civil rule in the aftermath of an attack" (Brinkerhoff, 2001, no page). Threat salience and a real mission spiked SDF numbers. In 1985, The State Defense Force Association [now the State Guard Association of the United States (SGAUS)] was formed.

Unfortunately, the actual number of SDF troops enrolled during this period is not precisely recorded.

Inferences, though, about total SDF troop strength can be gleaned from occasional hints in the literature. Nelson (1995) reported an earlier phone survey of SDF personnel officers, suggesting that the national SDF volunteer force hovered around some 20,000 soldiers during the late Cold War. Indeed, this number may already have mirrored a decline in strength from the peak. The evidence for this speculation is indirect. Anecdotally, Nelson's own organization at the time, the Oregon State Defense Force, (ORSDF) fielded more than 400 soldiers at the unit's Semi-Annual Training throughout the mid-to-late 1980s. By 1994, however, with no more Cold War, and no viable mission other than to replace a federalized NG, which had not been federalized on any appreciable scale since World War II (despite Viet Nam and the Cold War), ORSDF exercises drew fewer than 200 soldiers. In 1995, Oregon's Adjutant General ordered a major downsizing and reorganization of the ORSDF, which consequently became limited to an active cadre of 150 personnel, mostly officers (Norris, 2001).

Indeed, forced downsizing was common beginning in the very late 1980s and continuing throughout the 1990s. During this period, several SDFs were "stood down" or disbanded (the Utah SDF, the Michigan Emergency Volunteers and Georgia SDF, for example), or were maintained "on the books," but, in reality, were "ghost" units (Louisiana, New Mexico). Published information shows that the total number of SDFs declined during the 1990s from an apparent high of 26 (Nelson, 1995) to an apparent low of 19 (Hall, 2003). Indeed, a *USA Today* analysis of SDF membership bluntly concluded that "the forces had become nearly non-existent" by the turn of the Millennium (Hall, 2003). This report of the death of SDFs was, fortunately, like Mark Twain's famous obituary, premature. Freedberg's claim "that most of these state-controlled forces have faded away since the 1980s..." is erroneous. We estimate that total SDF strength probably never dipped below 8,000 troops nationwide.

Nevertheless, those that remained struggled, largely in vain, for meaningful roles. Many SDFs persisted in training for combat support and other traditional military roles that required a supply of “from-scratch-trained” enlisted troops, such as military police, constabulary, light infantry, and so forth. However, without a good deal of funding, part-time volunteer soldiers without prior military experience could not possibly be trained to capability levels even remotely approaching comparable active component Military Occupational Skill standards. The modern force utilization environment demands, for example, a high level of sophistication on fine points of military and constitutional law on the part of military police troops. World War II-vintage notions of making a soldier a military policeman simply by giving him a weapon and a brassard obviously could not survive Kent State. Nor could ill-trained personnel be expected to mesh seamlessly with their NG counterparts. Still, even if it is a bit dated, SDF personnel often have great stores of military experience “In many cases it is not uncommon in a group of four or five SDF officers to find 100 plus years of military experience and dozens ... of military training schools ...” (Patterson, 2006, page 5).

As a result of this lack of funding on the one hand and experienced troops on the other, many TAGs elected to eliminate, drastically reduce, or simply ignore their SDF. Other missions – such as search and rescue – proved somewhat more viable, but there are many overlapping resources trained specially and even primarily for this mission, such as CAP cadets and even Explorer Scouts. SDFs, though, lacked such groups’ equipment, money, infrastructure, or even name recognition. Put simply, SDFs had no market niche.

Following the end of the Cold War SDFs were commanded and staffed primarily by veterans, a significant number of whom had earned combat decorations, yet they were often detailed as parking guides, staffing county fair first aid stations, marching in parades, and other functions normally performed by local veterans groups. Nevertheless, community service roles became the mainstay of most surviving SDFs during the 1990s. As should be obvious, such missions relegated SDFs to the backwaters of public service, utterly failing to attract or retain sufficient numbers of high quality volunteers. Such organizations could only hope to attract and keep die-hards whose desire to serve outweighed the lack of a meaningful role in which to serve.

At the same time, many TAGs were uncomfortable with the image projected by grey-templed field grade officers directing parking lot traffic. The effect of all this, lamented Freedberg (2002), was that most SDFs became “little more than social clubs,” consisting largely of aging veterans yearning for military camaraderie and shared reminiscences. As Brinkerhoff put it in 2001: “State Defense Forces today are moribund.” (2001, no page).

However, after 9/11, COL Byers W. Coleman, Executive Director of SGAUS and a member of the Georgia State Guard, quickly concluded that homeland security missions held promise for increased SDF volunteerism, reporting that “many groups have had enormous growth since the September 2001 terrorist attacks” (Kelderman, nd.). *USA Today* reported that “after Sept. 11, the membership of state defense forces had grown by thousands to nearly 12,000 in 19 states and Puerto Rico” (Hall, 2003 www.usatoday.com/news/sept11/2003-09-07-state-defense_x.htm).

However, this growth was uneven. For instance, although Virginia and Georgia grew by more than 100 percent, growth in Alaska, Tennessee, New Mexico, and Washington (State) was more modest (Hall, 2003). A few SDFs actually declined in membership during this period. New Mexico, for example has nearly halted volunteer recruitment. Captain Ken Hacker, director of personnel for New Mexico’s 2nd SDF Brigade (personal communication, February 4, 2006) explains that his SDF is

officially re-organizing, but is actually downsizing and can currently muster only about 200 of the 500 people needed for current, basic missions.

Of course, not all loss of SDF strength can be attributed to lack of missions or of TAG support. During the 1990s, membership in volunteer fire companies, for example, also plummeted precipitously, due to factors that could also influence SDFs and other emergency service organizations. This is reflected by the experience in Pennsylvania, where the 1970s pool of more than 300,000 volunteer firefighters has slipped to 72,000 today (Hampson, 2005). Hampson offers some reasons for this drastic decline:

“... blame it on changes in society: longer commutes, two-income households, year-round youth sports, chain stores that won’t release workers midday to jump a fire truck ... Blame it on stricter training requirements, fewer big fires and the lure of paying jobs in the cities.” (2005, no page).

Other social factors are also making it harder for organizations to find and keep volunteers who will stay for the long term. Consider, for example, how short-term, episodic volunteering is up, while long-term organizational joining (the type required by SDFs) is down. This is exacerbated by increased competition for organizational volunteers, in government agencies and private, not-for-profit organizations. Other social factors that discourage volunteerism include the phenomenon known as “bunkering,” in which people seem to be less civically involved generally, preferring to stay at home engaging their cable TVs and DVDs or pursuing vicarious socializing via cyber-space.

Finally, we suggest that another factor contributing to the decline in volunteers is the increasing level of professionalism, acquired only through intensive training, which is required of today’s volunteers. For example, a young person joining a volunteer fire company cannot simply learn the necessary firefighting skills to be certified as a firefighter by riding along on the back step of a fire truck - even if they still had back steps, now banned as safety hazards. Instead, the erstwhile volunteer must complete hours of classroom and practical instruction to achieve the level of firefighting professionalism demanded in today’s environment. The same, of course, is true in spades for volunteer Emergency Medical Technicians, Paramedics, CRTs, and so forth (Hampson, 2005).

Interestingly, even following the 9/11 attacks, where firemen loomed as iconic heroes, fire company volunteerism continues to fall. Thus, threat salience and altruism, the hallmarks of emergency volunteer motivation, must be assessed in the broader social context, and more narrowly within the context of national trends in volunteerism.

Still, despite these negative trends, SDF volunteer membership is on a clear upward swing. Two years after the aforementioned *USA Today* article on SDF troop strength (2003), Carafano and Brinkerhoff (2005) reported that SDF volunteers had risen to 14,000 troops in 23 states, a number that has been confirmed by the DoD (2005). Experts expect this growth trend to continue, albeit at an attenuated rate, stimulated by persistent worries about pandemic influenza and other infectious diseases, the seemingly increasing frequency and intensity of natural disasters, and continued anxiety about biological, radiological, chemical and nuclear terrorism. These factors clearly should encourage volunteers to flock to their SDFs in order to be able to provide their communities with the necessary emergency support; however, this can only happen in those states where TAGs direct SDF leaders to develop highly visible commands with missions that are relevant to today’s threats and vulnerabilities. Nothing less will attract and keep volunteers who wish to serve their community.

Moreover, these reconfigured SDFs should consider building their forces around professional units who can draw already experienced and credentialed professionals who are proficient in skills that are highly useful to the NG (e.g., medical, chaplaincy, JAG). Doing this will eliminate the problem of job incompetence that can trouble SDF units who try to transform raw civilians without military training into competent and reliable military service support or security personnel as these health professionals are already trained, licensed, experienced, and often recognized practitioners and even leaders in their fields.

Another necessary feature is to tailor different levels of time commitment and participation patterns in order to draw in the widest possible pool of volunteers. Many physicians and other health professionals, for example, are very busy, and do not have time to drill two evenings, or a weekend every month, but who could, however, serve during a catastrophic event. These professionals might form a standby reserve pool of volunteers who could be called up under state voluntary orders to serve in a crisis. These reserve “minutemen” should be invited, but not required, to attend all training opportunities, group exercises, and regular drills. Minimal mandatory training for these standby professionals might be limited to half-day quarterly seminars, and perhaps one day annual muster to assess the correctness of uniform and refresh their skills in basic military customs and courtesies. They should also be kept abreast of all unit activities and developments via proven long-distance management techniques, including monthly electronic newsletters, and regular email announcements. They should also be encouraged to take any of a staggering range of home study courses that are available online that relate to disaster relief, the National Disaster Medical System, incident command and a host of other subjects important to homeland security work.

Moreover, building Medical Commands also opens new opportunities for other volunteers with limited skills and training. Much experience shows that the SDF Medical commands serving in the field have a need for significant numbers of non-medical support personnel. People without health backgrounds can provide valuable administrative support, victim tracking, logistical assistance, and crowd flow control, among other duties that require little training but that are essential in a deployment. For example, a recent state-wide mass casualty, HAZMAT training event, 35 Maryland SDF medical personnel were tasked to provide simulated surge capacity health support to county hospitals by staffing two field treatment centers. These medical troops were accompanied by only six support personnel, who were too few to quickly assemble the 70 cots and perform other necessary support roles that needed to be accomplished in this real-time simulation. The nurses and physicians pitched in, to no ill effect, but in actual emergencies this could harm unit efficiency perhaps imperilling patient health and safety.

Emerging SDF Medical and Public Health Roles

“Emergency services” has long been discussed as a possible prime SDF post-Cold War mission, and some analysts have argued that “all (SDFs) share a responsibility to provide the states capabilities to respond to disasters, both natural and man-made, including terrorist attacks and subversive acts” (Tulak, et al., 2003, no page; Hershkowitz & Wardell, 2005, no page). Moreover, the SGAUS has long urged SDFs to embrace an emergency services role, and it has recently revised and enhanced its Military Emergency Management Specialist Academy, a “distance learning” program for training SDF troops in emergency management. But, SDF involvement in this area, with the exception of Maryland, Georgia, South Carolina and Texas, is still limited and uneven.

Many TAGs are concerned about liability issues should such forces be deployed, but other TAGs have found solutions to these concerns and now even the DoD (November, 2005) sees a viable niche for

SDFs as value-added force multipliers in a range of missions, including homeland security and during natural emergencies.

Such catastrophic events as the 9/11 terrorist attacks and Hurricanes Katrina and Rita have provided opportunities to demonstrate the potential success of this new approach to SDF community support. For instance, the New Jersey Naval Militia provided disaster medical assistance immediately following 9/11; the Texas State Guard, including their Medical Rangers, provided in-state support for both citizens and police during Hurricanes Katrina and Rita; and most uniquely, the Maryland Defense Force (MDDF) deployed some 200 medical professionals under state military orders to the Katrina disaster site in Louisiana.

Maryland Defense Force's 10th Medical Regiment (10MEDRGT)

Following Katrina, the Maryland Defence Force's Medical Command (now designated the 10th Medical Regiment, linking it to its historic WWII Maryland State Guard roots), has grown from fewer than 20 medical and allied professional volunteers just prior to Katrina to more than 130 such personnel today, with high calibre applications still coming in, albeit at a predictably diminished rate a year after the catastrophe.

As a consequence of its growth and demonstrated ability, Maryland's civil emergency service authorities have integrated the MDDF into the state's public health emergency plans. In a display of confidence for ability to represent the state, Maryland sent MDDF physicians and a dentist to Bosnia as part of a Maryland Air National Guard humanitarian and training mission – a first for any SDF. The 10MEDRGT's demonstrated successes (along with those of the MDDF JAG, Finance and Chaplain Corps) encouraged the Maryland NG State Surgeon to begin to integrate the 10MEDRGT into the Maryland Joint Medical Team.

Emergence of the MDDF Medical Role

During the 1990s the MDDF was constituted as a Military Police unit; however, its missions mainly involved providing parking assistance, crowd courtesy and light first aid work at various public holiday celebrations. In the mid-to-late 1990s, SDF commanders Brigadier Generals (MD) Frank Barranco, M.D., and M. Hall Worthington, both promoted emergency service and ground search and rescue mission, and actively supported staff actions to design disaster mitigation missions and creative recruitment programs (Hershkowitz, 1998, no page; Hershkowitz, 2000, no page); however, these were rejected by TAG at the time resulting in a sharp decline in officer appointments, enlistments and morale. In 2002 the MDDF was down-sized in order to permit a change in personnel profile and mission structure.

The new MDDF Commanding General, Brigadier General (MD) Benjamin F. Lucas, II, a retired U.S. Air Force Colonel, with prior service in the U.S. Marine Corps and in the MDARNG, and an experienced lawyer, recommended a realignment of the MDDF and its personnel in order to permit a viable mission structure by providing legal, chaplain, and medical services that would both support the NG and also provide medical emergency resources to state civil authorities when faced with a major medical crises. A new TAG, Major General Bruce F. Tuxill, Maryland Air NG (MDANG), not only embraced the new SDF plan, but provided unprecedented resource and moral support that allowed the SDF to enrich jobs and build new roles and competencies that would bring superior value to the National

Guard and the state of Maryland (and later to the citizens of Jefferson Parish, Louisiana, and to Bosnian mountain villagers).

With this support, the MDDF command reorganized its medical directorate and proceeded with development of a mission oriented structure. Using the Texas State Guard's "Medical Rangers" as a guide, MDDF registered its new medical directorate as a Medical Reserve Corps (MRC).

The MRC program, established under the Surgeon General nationwide in 2002, was based on the U.S.A. Freedom Corps, which was created after 9/11 to strengthen America's health and emergency service infrastructure to promote homeland security. The MRC's specific role is to augment civil health agencies' capabilities with rapid response, trained and organized local medical and health volunteers when faced with a major health crisis. MRCs also provide health education, disease prevention and other non-emergency public health services consistent with local needs and priorities.

The Texas State Guard (TXSG) had been the first SDF to register its medical unit as a statewide MRC, in March of 2003, when the Texas Medical Rangers (the MRC's working name) was headquartered at the University of Texas Health Science Center in San Antonio. The Rangers also received one of the 167 U.S. Department of Health and Human Services MRC start-up grants for \$50,000. The MDDF decided to follow the TXSG model in order to gain technical assistance from the Office of the Surgeon General (OSG), and also to garner the added recognition and credibility that the MRC title might confer. The MDDF also hoped coming under the MRC tent would lead to some funding opportunities and would serve as an entrée to public health and emergency planners who were as yet unaware of SDF capabilities.

But the new MDDF MRC would differ in certain key respects from the TXSG's model. First, the MDDF learned that the funding for new units was no longer available from the OSG. Second, the MDDF was discouraged by the OSG from registering as a statewide unit, as the OSG was aggressively pushing local, community-based models, specifically identified with geopolitical locations (usually counties). Besides, Maryland already had one highly unusual statewide-chartered MRC sponsored by the State's Department of Health and Mental Hygiene (DHMH), which would later prove to have an important connection to the MDDF. MDDF planners prepared to solicit local, county level resources and partners as an initial step to broader statewide recognition and involvement.

Another major developmental difference between the Texas State Guard TXSG MRC and the MDDF MRC would be Maryland's bottom-up approach to program development, as opposed to the top down approach that had been adopted in Texas. The key to Texas' success was its adherence to OSG's guidance that MRC's must cultivate "champions" whose "connections and enthusiasm can make a big difference for an MRC that is otherwise struggling to make itself known and to be taken seriously" (OSG, 2004, p. 11).

Texas had a powerful champion indeed! Major General (USA, ret.) Harold L. Timboe, M.D., former commander of the famed Walter Reed Army Medical Center and Assistant Vice President for Research Administration at the University of Texas Health Science Center, was the TXSG MRC's first commander. He was a classic internal champion, with huge state and national clout. General Timboe's prestige in the military and health care communities nationally undoubtedly influenced Texas Governor Rick Perry's order for the Texas TAG to establish the TXSG MRC at the University of Texas Health Science Center at San Antonio.

Unfortunately, the nascent MDDF Medical Directorate did not (at its formative stage) have an “inside champion” of this high level of influence, nor did it have a connection with a medical school. It would thus have to be built from the bottom up. Fortunately, a respected local physician, who was a retired Regular Naval Captain, commanded it. Its Deputy Commander and MRC project action officer was (one of the authors, Nelson), a professor in the Health Science Department in Towson University (TU), which, although lacking a medical school, has a nursing school and other allied health departments. Nelson also had a store of prior experience in responsible posts with SDF and SDF-type organizations, including the Oregon and Washington SDFs and the Civil Air Patrol.

Consequently, TU was targeted as the initial MDDF external MRC Partner, a prerequisite established by the OSG for MRC registration.

Meetings with TU administrators led to the University President’s approval for officially hosting the MDDF MRC. University officials determined that there would be no liability issues barring it from assisting in the development of various future MDDF MRC projects, or in providing in-kind support, primarily in the service time of the MDDF MRC action officer.

It was at this point that the MDDF MRC project action officer petitioned the OSG for the formal audit that was required for official MRC registration. In approving the petition, the MRC National Program Officer concluded that the MDDF model would be a strong model, “as Military based MRCs tended to be the strongest” (personal communication, Nelson w/ LCDR April D. Kidd, USPHS, January 11, 2004).

The TU connection led directly to the next partnering contact, which would be crucial. The Baltimore County Health Department’s Coordinator of Public Health Emergency Preparedness (PHEP) was serving on TU’s Homeland Security Master’s Degree Program Advisory Committee – as was Nelson, the MDDF MRC project officer. As the County PHEP coordinator had just written a plan for the development of a Baltimore County MRC, she quickly realized that the TU / MDDF MRC (in Baltimore County) would readily fill the bill.

With this new county-level external champion, the MDDF Medical Directorate and its MRC began to grow rapidly. In June of 2005, the Baltimore County Health Department hired a part-time temporary recruiter for the MDDF MRC and provided the organization with a local office, phone, computer, administrative and other in-kind support for six-months in order to kick-start the MRC’s development. The recruiter, a recent TU graduate, was also commissioned into the MDDF, which lent the credibility of her military status to her recruiting efforts. The County Health Department also designed and printed several thousand color-brochures, which included the TU, Baltimore County Health Department, and MDDF logos and insignia (in a conscious effort to “Brand” the MDDF Medical Directorate). The Health Department also disseminated numerous public service announcements, and gave the MRC a full page in the County Emergency Services.

More recently OSG, working with the The National Association of County and City Health Officials (NACCHO), has implemented plans to boost MRC capacity by giving \$10,000 to any duly registered MRC regardless of its sectoral auspice as long as it meets the following criteria:

- The MRC must be duly registered with the Office of the Surgeon General.
- Has the ability to accepting funding through a NACCHO contract.
- Have an up-to-date unit profile on the Medical Reserve Corps web site.

- Is working towards NIMS implementation.

The MDDF MRC meets and exceeds these criteria. And although the MDDF MRC is jointly sponsored by the Baltimore County Health Department and TU, the MDDF retained full operational control through its military command structure. This also was to pay dividends in the future. While the unit soon availed itself of new training opportunities with various county agencies (which invariably led to broader state contacts, as the Public Health Officers in Maryland counties are actually state-appointed officers), all partners were well aware that the MDDF MRC could only be activated by the Governor, through TAG, as a state military unit.

Interestingly enough, the MDDF's military nature was greatly appreciated by the County health authorities, and clearly elevated the MRC's status among local public health and emergency preparedness leaders. Illustrative of this was an occasion when a Baltimore County hospital emergency training task force planned a press conference for an impending mass casualty HAZMAT event. Health department officials specifically requested that MDDF medical officers should show up in uniform to be photographed with other (Health Department, University, and hospital) participants.

Traditional civilian first responders were initially more cautious. Police and fire department rank structures are quite different from military rank structures, though they often share the same titles and badges of rank, and non-supervisory MDDF officers often held higher grades than high-level, supervisory fire and police personnel. This caused some initial tension in planning meetings, in the form of territorial posturing by the local uniformed first responders who bluntly reminded MRC staff of their emergency arena primacy. However, MDDF planners quickly overcame such concerns by stressing the supplementary, secondary-responder nature of the MDDF MRC's role and by making it clear that MDDF resources were always subordinate to the civilian, first-responder incident commander. This approach paid off. Soon, MDDF MRC staff officers were fully accepted by all involved uniformed civilian agencies, and there followed invitations to a range of joint training programs from multiple government agencies, including, most significantly, the Baltimore City Fire Department, which sponsored its own MRC!

Although they help sponsor the MDDF medical unit in its County level MRC status, County health authorities cannot directly "order" the MDDF MRC into the field as this is the Governor's exclusive prerogative as the state's military Commander-in-Chief. Instead, civil authorities must request MDDF MRC support through Maryland's Joint [civil (MEMA) and military (MDNG)] Operations Center, or MJOC, which then routes the request to TAG through channels for consideration by the Governor. In the event of a local or Baltimore county level emergency, the full force of the MDDF would be, theoretically, free to respond as a county resource. In a larger statewide crisis, however, the MDDF in its State role, would go wherever incident command determined the need to be the greatest. Regardless, in subsequent county training activities, Baltimore County planners articulated, time and again how the MDDF medical unit was an exceptional bargain, whose involvement added real muscle to the local surge capacity infrastructure.

Also, the fact that people cannot join the Baltimore County MRC without joining the military MDDF put off some otherwise interested health professionals, who balked at being identified in any capacity with a military organization. The idea of forming an MDDF civil auxiliary was abandoned, although a civilian style uniform was later approved for those who were unable or unwilling to meet military grooming standards, but only a very few members fall into this category.

Just prior to the Hurricane Katrina disaster, recruiting into the MDDF MRC increased; however, attracting volunteers was still not easy. At this stage, there were always many more inquirers than actual joiners. Nevertheless, by mid-August, the Medical Directorate (MDDF MRC) had grown from no more than six active members to more than twenty, largely thanks to first-rate recruiting material and the talents of the recruiting officer. People were ready enough to become involved in homeland defense and public health emergency preparedness, even though many were initially leery of the military nature of the organization.

TXSG MRC commander Major General Timboe had warned MDDF medical commanders that a military-based MRC would never grow fast, as many health professionals without prior military service would balk at its military aspect. Still, MDDF medical planners remained optimistic. They realized, though, that it would take at least another year before they could count anywhere near one hundred allied health personnel in the ranks.

Potential members' concerns ranged from worrying about the threat of a mandatory call-up to the extremely remote fear of being court-martialed for going AWOL ("absent without official leave") which is mentioned in the application). Other fears, such as being federalized and sent overseas, were baseless and quickly dispelled whenever raised. More realistic, though, were concerns that members might need "to be available at their local hospitals during times of emergency" (Abouafia, et al., 2006, p.19) or that there would be a conflict between their private practice and their MDDF MRC service. Finally, more than a few applicants were excited about joining, but ultimately did not because of a spouse's concerns about the potential downside of military involvement.

Unit recruiters redesigned the application to be less intimidating. They became proficient in countering the number one fear: mandatory call up. They did this by stressing how they would probably never be called to involuntary state active duty, as this would essentially destroy the organization (by harming the careers of the MDDF MRC members). Recruiters explained how members would only be requested to accept a mission voluntarily, which, if agreed to, would result in them being put under voluntary orders for state active duty without pay. True, this would obligate them to a military chain of command. However, such negative concerns were countered when recruiters stressed how state active duty conferred both unparalleled liability protection against malpractice suits and workers' compensation coverage should they be injured in the line of duty. These incentives sealed the deal in many cases, and although most nibblers still didn't bite, more did than ever before, and some of these new members would later emerge as key players during the Katrina relief effort. For example, there was LTC (MD) Jim Doyle, a VA hospital physician who, although new to the MDDF, acted as the second Katrina deployment Medical director, after the first Commander, LTC Patrick Shanahan (a three year MDDF veteran) returned to his private practice following a stage-setting initial week in the field.

The Katrina Activation

Official and media reports on the extent of the Katrina crisis prompted the Maryland Military Department to prepare to mobilize human and material resources to aid in the impending recovery effort. Calls for urgent assistance from Louisiana were first answered by the Maryland Emergency Management Agency, which dispatched emergency managers south almost as soon as the massive scale of the hurricane's effects became apparent. This was followed by further pressing requests from Louisiana for medical-resources support to assist with anticipated mass casualties and to provide health care for those trapped in New Orleans. These requests were channeled through a Federally mandated, interstate mutual aid agreement, the Emergency Management Assistance Compact (EMAC), which allows for the pooling

and centrally-coordinated allocation of state disaster response resources to help when local, state, or regional emergency service infrastructures are overwhelmed.

MG Tuxill (MD TAG) contacted MDDF Commanding General, BG Frederic N. Smalkin, with a request to see what medical resources the MDDF could bring to bear at the scene, not only in its role as an MRC, but also as a command-and-control cadre through which the state Department of Health and Mental Hygiene's MRC volunteers could best be utilized. Consequently, by order of Maryland Governor Robert Ehrlich, Jr., and direction of TAG, MDDF Commanding General BG Smalkin issued Special Order No. 05-01 on 30 August 2005, directing MDDF Acting Medical Director COL Wayne Nelson, to select "medically-qualified soldiers" who would accept assignment to "participate in humanitarian missions in response and recovery from Hurricane/Tropical Storm Katrina."

Working day and night, COL Nelson and others assembled a team – the first of three – for deployment. Twenty-two MDDF medical and support personnel reported five days later to the Warfield ANG Base, Middle River, Maryland, where they met with 68 civilian volunteers of the Department of Health and Mental Hygiene's statewide Medical Reserve Corps. Governor Ehrlich, Adjutant General Tuxill, Assistant Adjutants General for Army and Air, BG Edward Leacock and Brig. Gen. General Charles Morgan, as well as MDDF CG BG Smalkin also were present, with a bevy of press, to cement final arrangements and to bid farewell to the assembled task force, now preparing to fly to New Orleans Naval Air Station on two Maryland Air National Guard MDANG C-130J aircraft.

In anticipation of the deployment several significant issues had to be resolved, for instance: (1) the need to provide legal protection for medical personnel practicing outside their area of insurance coverage; (2) protection in case of injury while on deployment; (3) air and ground transportation, billeting and other logistical concerns; and (4) on-site communications. An additional complexity was how to resolve these issues for the civilian volunteers who had not yet been requested through EMAC. Normally, sorting all this out would take several committees virtually months to hammer out with multiple MOUs, to say nothing of hours of legal review.

In conversations between MDDF CG Smalkin and COL Jim Grove, Maryland Joint Forces HQ J-3, a solution to this difficulty suggested itself. It was a solution that would literally make history. They came to the realization that all the foregoing problems and concerns might be eliminated if the civilian DHMH MRC's personnel could be sworn in as MDDF soldiers, at least "for the duration." They agreed that the following requirements were key:

- Give the volunteers absolute immunity from suit for any act done within the scope of their MDDF duties.
- Provide the volunteers with protection under the Maryland Tort Claims Act should the immunity be questioned.
- Provide the volunteers with protection against occupational disease, injury or disability under the Maryland Workers' Compensation law while on active service.
- Ensure that, as state troops, the volunteers could utilize military air and ground transportation, billeting, communications and supplies.

- Provide the volunteers with a military command and control environment, allowing them to fully concentrate on the medical and humanitarian aspects of the mission.

Looking into the statutes and regulations governing the MDDF, BG Smalkin and staff concluded that there was no impediment to, and full statutory authority for, the Governor to authorize induction of the volunteers as MDDF officers and enlisted personnel, as appropriate, and to order MDDF troops whether previously members or specially inducted, to deploy to assist the Governors of other States.

The status question having been thus settled, all volunteers reported to Warfield, were given appropriate immunizations, by personnel of the Baltimore County Health Department, and were processed for entry into the MDDF by MDDF G-1 volunteers and other members of the MDDF General Staff. Uniforms, of course, could not be supplied to everyone, but at least those who were previously members of the MDDF (no matter how little time they had been members) were able to be properly uniformed before deployment.

Appropriate military grades were assigned to the DHMH volunteers on their induction as an expedient for the Katrina Hurricane deployments, roughly on the following basis:

- Major. Medical and health related personnel with a Doctorate Degree
- Captain Medical and health related personnel with a Master's Degree
- First Lieutenant. . . . Medical and health related personnel with a Bachelor's Degree
- Second Lieutenant. . . Other Registered Nurses
- Sergeant First Class. . Non-degree holding specialists (Paramedics, EMTs, etc.)
- Sergeant. Other non-degree holders.

All DHMH MRC volunteers agreed to their "Tarmac induction," with virtually no dissent, after it was explained to them that this would provide them with essentially "bulletproof" liability coverage plus Workers' Compensation, and allow for their transportation in military conveyances and their being watched over by military personnel for logistical and security support. They were told their service would be without salary, but, of course, they expected none from the beginning. MDDF command hoped that the returning volunteers would decide to remain within the MDDF, forming a growing medical contingent; however, the civilian temporary military volunteers were assured that they could resign upon their return if they so wished. After these things were explained, each new MDDF soldier signed the oath of appointment or enlistment, and the group was sworn in by BG Smalkin *en masse*. They then boarded the aircraft, and virtually no one present that day had any realistic idea of what would await them upon their arrival "in theater."

The new volunteer soldiers were fortunate that the MDDF route was chosen as the vehicle for utilizing their strong desire to serve. All the civilian volunteers were eager to help the Gulf Coast victims of Hurricane Katrina, but they were leaderless, had no organized structure, had no provisions, no security to say nothing of the aforementioned malpractice coverage that would prove essential in the unstable Katrina disaster zone. It is highly likely, had things gone differently, that many of these civilian volunteers would end up like others who converged on the 9/11 and Katrina disaster scenes, as Orloff notes:

"Many community volunteers responding to 9/11 reported the frustration feeling underutilized and unsure ... [and] Four years later ... volunteers on the Gulf Coast

...[were left] to fend for themselves; instead of being part relief effort, they became the victims” (September 9, 2006).

But this fate did not befall Maryland’s militarily-led medical “troops” because the NG and its sister organization the MDDF were the solution; they assured military transport and security as well as state-provided liability and workers’ compensation coverage. As an unexpected bonus, the unique military camaraderie shared by “combat” troops soon captured even the newcomers with no prior military service. A strong, but at the same time responsive, touch by the field commander sealed the success of the mission.

MDDF and Bosnia

Shortly after the Katrina mission, COL Barish, one of the authors, took Command of the Medical Directorate. As the Vice Dean of Clinical Affairs at the University of Maryland School of Medicine, as well as Professor of Emergency Medicine and Professor of Medicine, he had the high profile needed to recruit and keep health care workers, especially physicians, in the Medical Directorate, later the 10MEDRGT.

The 10MEDRGT had attracted a large number of members from the health care community who appeared inclined to volunteer their services in a military mission environment; however, many were disinclined to commit themselves to the NG due to their concern over involuntary mobilization. COL Barish, recognizing this concern, sought out creative missions that incorporated the basic medical concept that physicians are particularly attracted to humanitarian service.

This logic led COL Barish to promote an existing State Partnership program between Maryland and Bosnia. He believed that the 10MEDRGT could participate in the NG’s annual humanitarian mission there.

His initial proposal received an enthusiastic response from the MDDF command and TAG. Despite apparent legal barriers, the joint military leadership put their heads together and a plan emerged. In the Spring of 2006, the commander of the 175th Medical Group of the Maryland Air National Guard, Lt. Col. Randy Brown, requested MDDF physicians and dentists to augment the unit’s Annual Training, a humanitarian assistance mission in medically under-served rural Bosnia. There was initial resistance from the DoD to having non-federalized State Defense Force personnel on an overseas NG mission. However, this was resolved by issuing Invitational Travel Orders to the MDDF medical personnel who volunteered for the event. Another issue was the wearing of military uniforms for those personnel. However, force protection required that the MDDF soldiers not stand out visually from the rest of the NG team, so the MDDF class C uniforms were authorized for the mission.

In the Fall issue of the Maryland Military Department Digest (November, 5, 2006), MG Tuxill (TAG) noted, with pride, that this was the first time that the MDDF has been deployed outside the U.S. In fact, it is almost certainly the first time any SDF has been deployed overseas. This mission gave five MDDF physicians and one dentist a chance to serve with over 70 NG medical and support personnel in a four week initiative that treated over 2,000 Bosnian citizens, some of whom had not received medical care in many years. In a letter to SDF Commander BG Smalkin, the U.S Ambassador to Bosnia, Douglas L. McElhaney, praised the “volunteer doctors of the Maryland Defense Force and the 175th Medical Group” who worked hand in hand with doctors from the Armed Forces of Bosnia and Herzegovina, thus raising the prestige of both militaries” (McElhaney, 2006) (the same NG journal

detailing the Bosnia mission also highlighted how one of the MDDF's veteran nurses was selected by the Maryland Nurse's association, in her military capacity, as one of the twelve "Face of Nursing" calendar profile subjects who reflect an outstanding example of nursing).

The Bosnia mission, despite not reaching the high profile of the Katrina mission, proved to be an exciting concept and attracted still more volunteers for the 10MEDRGT. COL Barish's creative thinking about meaningful missions has opened a new vista for SDF participation in NG activities, one that, if emulated, should enhance the growth and mission portfolio of the SDF nationwide.

The MDDF into the Future

Following Katrina and Bosnia, the growing 10MEDREG has been involved in a number of initiatives in support of the NG and civil authorities. It staffed two surge capacity field treatment centers during a statewide emergency mass casualty field exercise, provided mental health professionals in Post-Deployment Health Reassessments (PDHRA) for the MDARNG, and participated in a joint state military medical conference among many other program development activities.

Most recently, the MDARNG PDHRA program manager, LTC Michael Gafney, sought additional MDDF personnel (MDs, PAs, RNs) to assess both physical and mental problems of soldiers from the 243rd Engineering company, which had returned from Iraq in July 2006. PDHRAs are a mandatory three- to six-month post-demobilization reassessment for new or persistent physical or mental health problems. Prior to this, the screenings were done by a DoD contractor, with the MDDF providing a Mental Health team to care for soldiers identified by the DoD contract providers. The MDDF is, as always, providing this medical care at no charge, which MDDF LTC Jim Doyle says is "our proud duty." And since the 243rd is a 'high profile' unit which suffered heavy casualties in Iraq, and the DoD contractor was unavailable, the MDDF's help was necessary to accomplish the PDHRA in the mandated time frame, and reflects another way the MDDF can boost NG capacity.

10th MDDF Medical Regiment Mental Health Team

The 10th's mental health team (MHT) was especially busy after Katrina. Its commander, who was recruited just prior to Katrina, MAJ Mark Ritter, then a psychiatrist with the National Institutes of Health, is now serving as the chair of the Maryland Army National Guard Mental Health Commission, which is a joint civil and military entity that brokers or directly provides resources to enhance a comprehensive mental health plan for NG soldiers and their families.

The MDDF Mental Health Team also actively supports the above-mentioned DoD PDHRA initiative, wherein MDDF Mental Health personnel have helped organize the demobilization site process, by screening the *Battle Mind* video and making presentations designed to de-stigmatize the PDHRA mental health self-reporting process. MAJ Ritter and his team also help educate soldiers to change their attitudes about asking for mental health support. The core mental health goal of PDHRA is to determine whether a soldier's mental health complaint is related to injuries suffered in the line of duty' (LOD). If so, as a follow up, the Mental Health Commission, which includes the Department of Health and Mental Hygiene MRC volunteers, assures effective referral, to make sure that soldiers needing mental health will be treated with the same respect and compassion as those who are physically wounded.

Training opportunities for mental health personnel, and all medical specialties have exploded. 10MEDRGT personnel can choose from a range of classroom and online experiences on an almost continual basis. This is an integral part of the unit's solid record of retention in the year following Katrina. Although many of the Katrina "Temps" chose to stick with the 10th in the standby reserve status, others have assumed active and even command positions. The leadership of those without prior military service aptly demonstrate that integrating SDF volunteers in support of key NG missions can help bridge the much talked about estrangement between civil and military cultures and promotes the image that true citizen soldiers in Battle Dress are also neighborly doctors, nurses and other healers and helpers, and above that, dedicated community servants (Feaver and Kohn as cited in Hooker, 2003-2004, p.6).

The vibrant record of the 10MEDRGT represents the fruits of not only effective pre-Katrina strategic planning anticipating new roles and missions, but also reflects the creative pro-social exploitation of emergent threats and opportunities that allowed newly attracted volunteers to meaningfully contribute their skills in highly difficult and chaotic real life crises as well as ongoing, multi agency, public preparedness field training simulations, while also performing hearts-and-minds-winning humanitarian missions, and providing support to the heavily taxed state NG.

The newly structured MDDF ensures that top-notch health professionals in all fields, who have the will and time to serve when needed, can be used by SDFs to help the nation, resolving the previously mentioned chicken-and-egg conundrum, by succeeding at meaningful, real-world missions that both support the NG, TAG, and state military department to build the mutual trust, reliability and respect that will assure 21st century relevance and success to a long overlooked SDFs.

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