

In reply to Dr Worswick's article 'Medical Officer Training – An Infantryman's Perspective' JMVH Vol. 27, Number 3, as an Army Medical Level 2 Doctor from a similar Royal Australian Infantry Corps background with non-regimental experience in Recruit, Officer and overseas training of foreign forces, I can unequivocally say the training of the Army's uniformed health workforce, when compared to how well the Army trains its other members, is not good, not average, not adequate... it is just poor overall. The one exception being the Army School of Health ADF Medical Technician course currently producing wonderfully trained clinicians to a baseline level of competency.

By way of some simple examples, the Army Standing Instruction for Personnel (ASIP), Part 8 Chapter 9, mandates numerous civilian competencies a deployable (to field or operations) Medical Level 2 Treatment Team Medical Officer, a Nursing Officer in a treatment team and a Medical Technician in a treatment team must have. Currently, there is no discernible effort or output at Formation level (17 Brigade) that controls resources to centrally supervise, coordinate, fund and deliver these competencies to ensure the Army's health workforce meets these mandated civilian competencies. The net result is that very few, if any, clinicians posted to these roles have achieved the Army specified requirements for its deployable health workforce. This is a poor outcome for our treated soldiers.

Furthermore, the iSTAT point of care biochemical test machine (complete with cartridges) has finally made its way into Close Health Units so that our deployable treatment teams can identify reversible causes to inform treatment of cardiac arrest in accordance with the ALS/ALS2 Australian Resuscitation Council guidelines. iSTAT is a game changer; the proverbial turning 'night into day'. When a similar transformational piece of equipment arrives in an Infantry, Cavalry or Engineering unit e.g. night vision devices or weapon sights, a deliberate effort

is made from the Special Projects Office responsible for procurement of the equipment, together with CATC and the allocation of unit resources (time and personnel) to ensure bulk numbers of personnel are effectively trained in the new equipment system. Concurrently, training institutions are targeted to ensure it incorporates training for future throughput. The Q system is trained in maintenance and repair. In contrast, in Health there is no plan, coordination or measured outcomes for iSTAT implementation. The same applies to countless other pieces of medical equipment entering or have entered service – oxylog ventilators, tempus pro, ultrasound, MRX, etc.

Overall, the collective organisation, integration and delivery of training to achieve individual competencies and to ensure there is a baseline competency for 'how, when and for whom' an effect is delivered e.g. understanding a weapon system function, pulling the trigger at the right target and right time, is something the rest of Army generally does exceptionally well... except Health. Other groupings with similar technical requirements to health that straddle civilian and military governance, think aeronautical engineering, are light years ahead of Health – boards of inquiry into previous catastrophic failures have forced them to be.

Doctor Worswick's article into Army Medical Officer Training should not only prompt action for remediation of the training shortfalls for medical officers, particularly in the PGY1-4 space, given a seismic change in the civilian medical PGY 1 and 2 training environment from 20 years ago post the foundation of the fellowship of emergency medicine, but also prompt organisational reform for development of a 'training culture' within the Army health workforce more aligned to that of the wider Army.

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