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ADF health service readiness for combat 1997. A Reservist's view [2]

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Introduction

Preparation for war is an important function of the Australian Defence Force (ADF) and is especially so for our combat commander. Their basic task is to seek out, engage and defeat the enemy. Their concern will be with the how, the when, the where and the with what. They will consider both their own and their enemies strengths, weaknesses, opportunities and threats. If we do not continue to provide guidance there is a risk that the first health service contact will be the requirement for health intelligence, and this will probably be considered with the threats to the fighting force.

In the past combat commanders needed to think mainly of their core business at this time, that is fighting to win and they did not want to be distracted from this important function. However when battle and non-battle casualties started to deplete their fighting force and logistics become complicated by the movement of medical materiel forward and casualties backwards from the battle front, then the role of the health services certainly entered the commanders conscious thought patterns.

The need to consider these health issues well in advance of the above scenario is well recognised by our present day commanders. The combat commanders and members of the health services need to be constantly aware of what the health services can realistically provide under specific conditions.[1] We must continue to present to our combat commanders an easily understood and accurate report of our current capability for inclusion in their overall battle plan.

Now this is where one of our real challenges begins. I ask you how many appropriately balanced surgical teams could the ADF muster and deploy overseas within the next seven days? What information do we need to compile such a report?

For current capability reporting we need to have up-to-date information about individuals, teams of individuals, team equipment status and knowledge about how we will move units from one place to where they are needed. *Are* we sure that we know where each team member is at present? *Are* they still fit for service and are they in-date medically? Are their billet prerequisites still current and especially for reservists are they available for the present task (see Table 1)?

Table 1. Current capability reporting

1. Personnel
    - where are they at present?
    - are they medically in date?
    - are their vaccinations in date?
    - is their screening for infectious diseases in date?
    - are their billet prerequisites in date?
    - are members available?

2. Teams

- are teams fully staffed?
- has the whole team completed the training requirements?
- has the team's performance level been tested recently?

3. Equipment
    - does the team have all of its equipment?
    - does all of the equipment work?
    - when was the equipment last tested?

4. Transportability
    - can the unit be moved from point A to point B in the required time?

If the individual is in date and available what is the status of the team and its equipment and when was the last time that the team exercised together and did they reach the required performance level? What other medical equipment will be available for them to use and under what physical conditions will they be able to use this equipment - assuming that this equipment can in fact be supplied to them? Remember Cyclone Justin and its effect on Exercise Tandem Thrust 97.

What is expected of us?
We as health service professionals need to have some idea of the ADF military strategies for various perceived contingencies. Has anyone here today received any recent specific advice about the way our strategists are thinking? Such information could have an important bearing on our provision of advice and services.

Do our combat commanders have any instructions for us when we develop policies? Such instructions need to be more than just generalisations and wish lists.

Do they have any standards for what they expect us as health service professionals to attain and maintain? If they do have requirements of us how do they want us to present regular SITREP's to them? We are not unique, the USN seems to have similar problems.[2]

In the past the way of doing business resulted in the health services considering each scenario on an as-needs-be basis. Fortunately this system has changed. Joint Project 2060 is a tri-Service project aimed at planning for the provision of health service support for low intensity conflict.

Up until now unless a scenario had been experienced in the recent past there was a frantic rush to provide a service, always at short notice, often over a leave period, and somehow we manage to scrape through - a tribute to that small band of dedicated people who seem to be able to do the impossible.

This old way is not the way it should have been and would definitely not be successful now or in the future. I suspect that the initiators of JP2060 obviously recognise this as well.

The recent and continuing downsizing of the ADF in response to the Defence Efficiency Review (DER) and the subsequent Defence Reform Program (DRP) has meant that we cannot use the old ways to get out of trouble because we cannot guarantee that we will have the people with the previous experience to do the job.[3,4] This loss of a significant amount of corporate knowledge means that we need to develop a system which seriously and regularly reviews our readiness for combat and also other aspects of our core business. Our senior combat and health service commanders have this heavy responsibility and they are actively addressing these issues in ADF centres like the Headquarters Australian Theatre (HQAST).

What might we be asked to do?
Let us consider the role of the ADF and its responsibilities in more depth.

The role of the ADF is to promote the security of Australia and to protect its people and its interests (Glenn Report).[5] Other roles include assistance to the civilian community during natural disasters, our role in the SW Pacific and roles associated with our membership of the United Nations.

Predicting future scenarios

For planning purposes we and our advisers have to second guess the needs of future conflict or civil disasters. Such a guessing game runs the risk of us getting lost in the ifs-and-buts with the result that we will claim that it is all too hard and not do anything. An option is to develop two or three basic scenarios and a system for regularly assessing health service requirements and readiness for each of these scenarios. I suspect that this should be Service specific initially and then tri-Service with the results combined into a tri-Service database.

This combined approach will maximise our resources. Obviously the database would contain information on both full-time and part time members. I suggest that the database be held centrally, say with the Surgeon General's organisation, but the total document should be readily available for each of the services and their unit commanders. In this situation all in formation must flow upwards, downwards and across the various commands if it is to be of value to all those who need it.

Health Service Staffing

The level of staffing within health services teams depends on the services which these teams are expected to provide.

The requirements of combat and base support teams are obviously very different. During peacetime the tendency is to forget combat health service teams and convert base support to model civilian hospitals - even to the level of further reducing members required in uniform to minimal numbers. The longer the duration of peace the greater the civilisation program. The application of civilian staffing methods to the staffing of combat health facilities is fraught with danger.

Obtaining the right balance between staff numbers for each facility, under differing operational situations, is difficult. The concept of providing supplementary staff, e.g. Mobile Surgical Teams, as add-ons to core surgical teams is a good one and allows for considerable flexibility. However the provision of the extra medical materiel to achieve the planned upgrade is a logistical nightmare/challenge depending on your proximity to the action.

Health Service facilities

I believe it is also our duty to regularly review our health service facilities to see if they meet our present needs and the predicted needs of the next 10 to 15 years.

The ADF has performed very well in this area. The civilianisation program for base facilities will probably continue and as a result the management of these facilities may well be taken out of our hands. If this is the case it will allow us to concentrate further on the sharp end of our business.

Many of the systems we apply in the field today have their origins in wars past. Will these systems be adequate for the 21st century? What scientific and medical breakthroughs are about to radically change our ways of doing business? We must have a way of being able to assess these new technologies and seeing if they can be made robust and simple to fix if they break down when their users are on duty a long way from base support.

Navy

An area of concern that I have for the Navy is the possibility that we and our American colleagues outsmarted ourselves when we "tack on" a PCRF onto amphibious assault ships which are so valuable to their commanders that they will not be allowed to linger in dangerous areas to pick-up casualties because of the risks of being attacked and lost.

If such ships need to be held say five or even 50 miles off the beachhead how do we get the wounded out to them? Can helicopters be spared by the combat commander to undertake this role and will the weather allow flying? Are there any other methods of transport in the area to move casualties seaward, e.g. hovercraft, or should we be thinking of land based facilities as my Army colleagues do?

The problem for all health services is the functioning of the evacuation chain and its use to free up health facilities nearer the fighting front. In my opinion a combined tri-Service approach is the answer here, but I wonder when this system was last tested with a large number of patients?

Health Service Readiness Training

I suggest that this topic needs to be considered firstly at an individual level, then at the Unit level and later we can address how we fit the various units together to get a cohesive whole - which is what JP 2060 will be doing.

The individual needs to be medically fit and in -date with general vaccinations and disease screening requirements for overseas postings as I have previously stated. Then there are the Service specific requirements, e.g. NBCD and fitness for sea duties, if I again may be allowed to use Navy requirements to illustrate my point. The other two Services will have their specific requirements as well and in combined operations these requirements will be summative.

Then we need a measure of what their task requirements are and a way of knowing if they can perform the tasks expected of them. For the individual, the EMST and the nursing and medic equivalent is a good starting point, but I suspect that we need to have regular and realistic training exercises to keep our members up to standard, i.e. perform a task in a set time and achieve set goals.

Some training can be undertaken at the Unit level but some will need to be at a grander level and involve joint operations between the three services. This will cost money and take up the time of a large number of people. Is the ADF serious about getting a standard of performance in its health service and maintaining it? The existence of JP 2060 suggests that they are.

Also think about health service standards of care in the civilian community, performance indicators and the linking of performance with funding. This system of performance could be a requirement of the ADF in the not too distant future.

The development of inhouse training and reporting protocols is a way of becoming more accountable. It will be a useful management tool to justify what we do and don't do, together with what we are and are not capable of (see Table 2). Such a system will then be readily adaptable as a health service readiness reporting system for our combat commanders (see Table 3).

Table 2. Health services reporting system.
Surgical Team 1, District 1

Billet & Personnel Details	Med. Status	Courses	Availability for Scenario 1	2	3
ore	-/	-/	-/	-/	-/
MAO Support Services	-/	-/	-/	-/	-/
MO Rescue	-/	-/	-/	-/	-/
NO Rescue	-/	-/	-/	-/	-/
Surgeon	-/	-/	j(	j(	-/
Anaesthetist	-/	-/	-/	j(	j(
etc					

Scenario:
1. Defending N. Australia for 3 months
2. Contributing to UN Force
3. Responding to a civilian emergency

Other benefits of this system include the alerting of health service unit commanders and individuals of when their currencies are about to lapse. The system will also be available to assist in the planning of update courses for our members by training command.

Table 3. Health services reporting system.
Surgical teams

	Scenarios		
	1	2	3
"District" 1			
Team 1	,/	,/	I<
Team2	,/	I<	,/
Team 3 (arne)	,/	,/	I<
Team 4 (amphib)	I<	I<	,/
"District" 2			
Team 1	,/	,/	,/
Team2	I<	I<	I<
Team 3(ame)	I<	I<	I<

Further comments on training
The EMST course is an excellent one but the throughput for the ADF, including Reservists, is not quick enough for our needs. I know that the Surgeon General is well aware of this. I suspect that we will need to develop our own course and to ensure that it has suitable civilian recognition. I recommend a similar but professionally appropriate system be developed for our nursing and medical assistant colleagues. Our dental colleagues would probably undertake the military medical EMST unless they thought they would be better served in another way.

While I am considering the whole team I must point out that everyone in a health service team is a resource. When combat starts the numbers of patients may be great, for example during the Falkland's War the bombing of the Sir Galahad presented 179 casualties in a short time and during the Second World War two armour piercing bombs hit the USS Franklin and caused 1,000 casualties out of a total compliment of 3,300. Tasks that we may consider in peace time as out of the range of our junior team members may under these extreme circumstances need to be performed by them if we are to do the most good for the greatest number. EMST training for all health service personnel is vital just as basic first aid is vital for all ADF personnel for this very reason.

Conclusions
I regret to say that at this moment some aspects of our readiness for combat service remain in doubt. At this time of great change in how the ADF does business, we have a golden opportunity to correct this deficiency. I do not believe that our commanders can help us much at the moment because they have other priorities to address, but if we seize this moment and provide the right answers we will finally establish ourselves as a vital part of the ADF and our very existence will not be threatened again.

References

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