AMMA JOURNAL VOL 10 ISSUE 3

DECEMBER 2001

Honour, Chivalry and the Role of Medicine in the Military[1]

by

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The emergence of military medicine was very late during mankind's long history of war-like activities. In the valley of the River Neander, near Dusseldorf in Germany, a species of man was discovered characterised by a retreating forehead and massive brow-ridges. He was a very uncouth and primitive man; nevertheless, he found time to wage a form of warfare on his fellow Neanderthals.

In Homer's Iliad, the most influential narrative of war in Western literature, the story is almost exclusively about honour by the Greeks as well as the Trojans. This honour spurred the fight as much as victory itself. The Homeric ideal permeated Western history and even the mighty forces of the Macedonian, Alexander the Great, invading Persia in the year 334 BC, made much of the taking from a temple, armour allegedly worn at Troy, by Greeks whom he claimed as ancestors. However, the victor in the Homeric duel showed no respect for the vanquished foe. Witness the exultant Achilles dragging the body of the fallen Hector behind his chariot. Honour could be very savage.

A peculiar early 20th-century adaptation to honour arose during the Great War. The nation was France, the place Verdun in northeastern France 50 miles from the German border and the time, early 1916. Verdun was not the bloodiest battle of that war - that grisly distinction belonged to the Somme. However, probably more soldiers were killed per square yard in the defence of Verdun, the symbol of French honour, than in any other conflict before or since. A staggering 300,000 Frenchman and Germans died and approximately a further 450,000 were wounded. From a small start grew the grimmest battle in all that grim Great War, and perhaps in History itself. Certainly, it was the longest battle of all time, lasting some 10 months. The pressure on the French and German Medical Corps to meet the demands of the daily injured arriving at an average rate of 1,500 a day every day for 10 months from the Verdun sector alone, staggers the imagination. Yet the German commander at Verdun, General von Falkenhayn, almost succeeded in bleeding France white. In their defence of honour, France was saved by the arrival of the 9th French commander at Verdun, General Philippe Petain. This superannuated Colonel at war's outbreak rose to become a Marshal of France as the Commander in Chief of French Forces at its end. His successful defence of Verdun was considered universally as a model of tactical brilliance; however, the battle of Verdun clearly underscored the inherent dangers to a nation who chooses above all to maintain National Honour on the battlefield.

If we ever need further reminding of the human cost of a non-nuclear global conflict then this vignette provides reinforcement. In the Pavilion of Peace at the fabulous International Exposition held in Paris during the nervous times of 1937, a talking clock announced to visitors that figures taken from all the belligerents indicated 4 soldiers had been killed and 9 mutilated for every 1 minute of the duration of the Great War. For those who can't do instantaneous mental arithmetic, this equates to approximately 8 million, four hundred and nine thousand, six hundred soldiers killed in action. The economic effects of this carnage upon France alone were still evident through and into the mid-1930s.

Chivalry developed late in the history of Christian Europe and only then as a code for the rich. Nonetheless, chivalry became a governing ethic. By the late 19th century a further development to the conduct of warfare emerged influenced by a series of humanitarian Geneva Conventions. This enforced upon European armies an elaborate code of correct behaviour.

In 1859, the Swiss philanthropist, Jean Henri Dunant, attended the aftermath of the Battle of Solferino, just outside the delightful city of Verona in northern Italy. The casualties so horrified him that he wrote a seminal pamphlet which ended with the plea "would it not be possible to found and organise in all civilized countries permanent societies of volunteers who in time of war would give help to the wounded without regard to their nationality?" Dunant's idea was canvassed internationally and culminated in 1863 with the formation of the Red Cross. Throughout the age of chivalry and into the humanitarian 19th and 20th centuries, the role and importance of medicine under the military mantle became firmly embedded.

There have been very significant events and changes in Military Medicine here in Australia since the foundation of this now well established and growing association 10 years ago. This year is the centenary of the Australian Army, the 90th anniversary of the Royal Australian Navy and the 80th anniversary of the Royal Australian Air Force. Events around the world have seen the frequent deployment of the health services in support of Australian forces overseas.

It was in 1994 during the July weekend at our 4th AMMA conference in Melbourne that the announcement was made that an ADF contingent was to deploy with the UN to the genocide in Rwanda. This was the second major operational deployment by the Defence Health Service (DHS) since Operation Desert Shield and Desert Storm back in 1990-1991. I remember this also quite poignantly since, in the company of several officers here today, I attended the NBC course held then at the Army School of Health at Portsea during the December of 1990 whilst Operation Desert Shield was played out. I don't believe I have ever witnessed during an ADF instructional course a greater degree of attention and participation than that shown by all the students of that memorable course. During another December, this time in 1992, DHS health support deployed with the US lead and UN-sponsored Operation Restore Hope to Somalia. You may recall that Somalia at the time was perhaps the most poverty-ridden country on the African continent and had been exposed to the disastrous effects of two decades of severe drought coupled with the anarchy of a civil war.

Many operational deployments have followed since then with our current commitments centred in Timor, the Solomons and Bougaineville. On the 4th September 2001, the latter was reclassified as a Level 1 facility. The DHS also recently responded to the needs of the refugee passengers aboard HMAS MANOORA during its passage to Nauru.

Probably the most significant change affecting the military health structure in the ADF that occurred in this last decade was the implementation of the findings of the Defence Efficiency Review (DER) set up in October 1996. In the DER report published in March 1997, a key recommendation was that the medical services need to be pulled together and rationalised, taking account of community expectations and civil arrangements. The Australian National Audit Office performed an audit on the Australian Defence Force Health Services. In that report of May 1997, the primary objective of the ADF Health Services was defined as the maintenance of military personnel at required standards of health and fitness and the provision of deployable medical services in support of military operations.

A more recent follow-up audit on the health services was released in July this year and has recognised the many improvements and re-organisations that Health has implemented during the last 4 years. Necessarily, several issues have yet to be completed. In particular, the Australian National Audit Office noted that whilst the Defence Health Service Branch (DHSB) and the Joint Health Support Agency have been established, full command and control of all health resources have not been transferred to the DHS as Defence considered such an arrangement to be inconsistent with the overall command and control paradigm in the ADF.

Since the 1997 disarticulation of the ADF, the provision of deployable health services to support the several overseas operations has been achieved by the dedicated commitment of both full time and part-time health personnel. The present size of our health services is clearly the rate-limiting factor in our ability to sustain any protracted or concurrent overseas operations. Nonetheless, enthusiasm, professionalism, dedication and work excellence are all qualities in abundance throughout the Australian military health services.

Last year, a White Paper on Defence was launched in part to answer the mismatch that had arisen between the strategic objectives of Defence, the Defence capabilities and our levels of Defence funding. In that paper, a clear enunciation was made that people are capability. Defence needs to be a 'knowledge organisation' and therefore Defence must retain skilled and experienced people. Defence must ensure that people do not leave the ADF when they are of most value and this is a priority concern for Government. Defence 2000 recognised that the Reserves comprise about 42% of the total ADF and given the likelihood of frequent and concurrent operations, Reserves will be the most efficient way of providing sustainment and surge capacity. Furthermore, reserves can provide skills not available within the permanent forces, or which are held in small numbers.

Another important document was released last year, the ADF Health Status report. This inaugural report, launched by the Surgeon General, highlighted the steps taken to identify the health safety and wellbeing of ADF People, who were a key subject in the Defence White Paper. Few Defence forces in the world have produced comparable detailed health information about their members as a basis for improving their health status. The ADF Health Status Report was inspired by Australia's Health 1998, produced by the Australian Institute of Health and Welfare. In the document Australia's Health 1998, leading causes of injury and illness were identified across the Australian nation. The second edition of ADF Health Status Report is scheduled for publication towards the end of next year.

During the past 10 years individuals in Australian military medicine have come and gone but none so memorable than Sir Edward Dunlop who passed away in 1993 and only last year the passing of Matron Vivian Bulwinkle. Their infused thoughts and actions remain indelibly imprinted in the high code of conduct, which the present and future military health personnel must maintain.

Last year saw the celebration of the centenary of the awarding of the Victoria Cross to Lieutenant Howse of the NSW Army Medical Corps on the 24th July 1900. On August the 4th last her Majesty Queen Elizabeth, the Queen Mother, celebrated her 101st birthday. Her Majesty has been the Colonel-in-Chief of the RAAMC since 1948. In concert with the panoply of health facilities, ADF Health Services supported the Olympic effort and thereby playing its small part in ensuring the great success of that marvellous 27th Modem Olympiad in September 2000. Last year also saw the establishment of the chapter of Military Medicine within the Royal Australasian College of General Practitioners; thereby recognising the significance of the discipline of military medicine and the specific skills required by military medical practitioners.

The year 2000 saw the completion of the extensive refit to Her MaJesty Australian Ships Manoora and Kanimbla with the installation of the Primary Casualty Reception Facilities on the port side of the aft section of the main superstructure.

The Australian Aerospace Force has in recent years acquired new airframes. In 1999 Air Force accepted the Boeing Aircraft Corporation version of the Airborne Early Warning and Control Aircraft. This system is based on the Boeing 737-700 commercial jetliner and will enter service with 2 Squadron in 2004. In the same year, the C-130 J-30 Hercules replaced the time expired E model. In May last year the first Australian-built Hawk 127 Lead-in Fighter flew from Williamtown and heralded the decommissioning of the aging Macchi Jet Trainer. Earlier this year, the CO of 76 Squadron kindly permitted me a full familiarisation flight in the new Hawk and I was impressed that it represents a good buy as a lead-in jet trainer.

The ADF continues to grow and the Department of Defence's 10-year Defence Capability Plan, released mid-year, records the spending of 47 billion Australian dollars during the next decade. The Plan encompasses 29 aerospace projects costing 24 billion; 22 shipbuilding and naval projects totalling 10 billion; 67 command and control projects for 8 billion and 23 ground forces projects costing another 5 billion dollars.

I would like to finish with a brief report to you on some of the less known functions of the Surgeon General. What do I do in Canberra? I succeeded Major General John Pearn on the 1st January this year and took over a job in which John had excelled thereby enhancing the stature of the office. The Surgeon General along with the Judge Advocate General and the three single Service chiefs are all appointed by the Chief of the Defence Force, Admiral Chris Barrie.

On the administrative side, the Surgeon General chairs three committees that meet regularly in Canberra. The first is the DHS Advisory Council consisting of Brigadier Wayne Ramsey and the three Assistant Surgeons' General: Commodore Peter Habersberger, a cardiologist from Melbourne; Brigadier Brian Pezzutti, an anaesthetist from Sydney; and Air Commodore Roger Capps, another anaesthetist from Adelaide. The council meets 6 times a year. If I might quote from the latest follow-up ANAO audit as to the function of the council, which is curiously given as a footnote to page 45 as follows: 'The main function of the Board is to oversee the long-term goals and plans of the DHS and provide an independent view by which management performance can be monitored against the DHS strategic plan". The council further advises the DHS about issues that the branch cannot easily access other than by protracted means from learned colleges and tertiary educational bodies. It does not deal with so-called nuts and bolts issues, which are more correctly the purview of the DHS Steeling Committee. In that body, Reserve representation has been established from one of the three members of the National Council, who are Captain Graeme Shirley, Colonel VIas Eistathis and Group Captain Chris Griffiths.

The second chair for which the Surgeon General is responsible is the important Australian Defence Human Research Ethics Committee (ADHREC). The name of this committee has recently changed from the previous title of ADMEC (Australian Defence Medical Ethics Committee). This is in keeping with the national nomenclature and reinforces the scope of the committee's charter with regard to human research within the ADF. The Chief of the Defence Force with the Secretary of Defence first established ADMEC in 1988 and appoints the seven members each for a 5- year term. Professor John Pearn was formally appointed a new member to ADHREC in February this year. The committee meets 5 times a year and analyses a large and growing number of research protocols.

A related but separate and new committee was formed last year known as the Defence Health and Human Performance Research Committee which, in response to the recommendations made by the Australian National Audit Office and other reports, is to give direction and coordination to health and human performance research within the Australian Defence Organisation. This committee is chaired by the DGDHS and consists of 15 other members of whom only two are from health, the Fleet Medical Officer and the Director of Health Services HQ Air Command.

The Surgeon General also chairs the newly established group known as the DHS- Department of Veteran Affairs Advisory Panel. The Surgeon General and the Director General are the two service representatives to this senior advisory committee, which meets twice a year. The objectives of the panel's work are to facilitate the seamless transition of health care from the uniformed service to civilian life and thereby maximising the health of veterans. It considers operational-specific diseases and disorders and is presently involved with the F- Ill Deseal-Reseal Project, the effects of Depleted Uranium and the Gulf War Study.

My address today would not be complete without a brief mention of recent international events. On September 11th, gangs of men armed with box cutters and a resolute death wish murdered most foul almost 7,000 people in New York City, at the Pentagon and in Shanksville, Pennsylvania. This deed not only destroyed lives but also families. In particular, it had a devastating effect on the lives of very young children. Just one of the World Trade Centre firms that was demolished in the aerial attack employed the parents of 1.500 children. Many of the dead parents had scarcely begun their families, and the children they leave are very young. If I could further quote from the leading editorial of the 11th October edition of the New England Journal of Medicine; "we as Doctors, Dentists and Nurses cannot permit any interference with our commitment to caring for the sick and promoting health. We must seize this moment to look beyond our responses to terrorist attacks – we live in a world where far too many suffer from diseases that we know how to cure or prevent".

On Wednesday 17th October 2001, Prime Minister John Howard announced that Australia is to deploy 1,550 troops with the coalition forces. The US led aerial assault on the al-Qaeda terrorists led by Osama bin Laden. code-named 'Operation Enduring Freedom', commenced only 13 days ago on the 8th of October. With this additional international commitment of ADF personnel. The DHS has to now render health support to no less than four concurrent operations.

At no other time since Vietnam has the demand on the DHS been so intense. In part this new demand translates to the very real need for an increase in the numbers of deployable specialist health Reservists within nearly all the health disciplines. The administrative issues that this will incur must now be urgently and completely resolved once and for all by the ADF.

The international fight against terrorism coupled with the instability in the Indonesian political scene and the increase in the world 's refugees on the high seas altogether make these troubled, turbulent yet exciting times, particularly for us in the military. They provoke challenges that I am sure the Australian military medical services will successfully meet full on.