AMMA JOURNAL VOL 10 ISSUE 3

DECEMBER 2001

The John Thomson Oration 2000: Private Bosisto – The Debt and the Challenge [1]

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ABSTRACT
A FEW YEARS AGO, a French farmer discovered the body of an Australian soldier - namely Private Bosisto - near a feature called 'the windmill' close to a village of Pozieres. This soldier had been missing in action since 1916 and was part of the 27th Battalion, Australian Imperial Force, and was killed in an attack that began at 2100 on the 4th of August 1916.

As he was missing in action, he remained on the regimental books, which were inherited by 10/27 RSAR, the Army Reserve Battalion in South Australia. The Commanding Officer, LTCOL Doug Strain, energetic and with initiative, noted the administrative requirements for the soldier to be buried appropriately. Thus, a detachment from the Battalion went to France and, with full ceremonial honours, interred Private Russell George Bosisto with his mates.

FORENSIC FINDINGS
What were the forensic findings? There was no formal forensic examination. However, he was found with his water bottle almost cut in half and had two fractured femurs. The possible wounds were such that he may well have been saved today had he been retrieved.

He had full kit, minus his helmet. He had a fixed bayonet, with the weapon loaded on action and 200 rounds of ammunition. He carried his grenades; thus he was going into battle when he died. His webbing was made of kangaroo skin, which had not rotted and had been thus personalised. Private Bosisto also carried two officer's pips in his pocket. There were two theories to explain this, neither of which are mutually exclusive.

The first was that if he were captured by the Germans, who did not know the difference between Australian officers and men, he would put on the pips and be treated better as an officer.

The second theory is based on the Australians being paid a lot more than other armies and a party going on behind the lines. The British had Officers Clubs, which were very good, and the British did not know the difference between Australian officers and soldiers. Thus two pips would gain him access to this. Private Bosisto had been let out of detention in order to take part in this battle.

Private Bosisto was making the best of life, understanding full well that he had a high chance of dying - which he subsequently did. All ten members of his section died, and he was found 200 metres ahead of the others. Therein lie the debt and the challenge of how to deliver, in modern times, the health care our soldiers deserve.

MILITARY MEDICINE
The nature of Military Medicine demonstrates a paradox. On one hand, there is ostensibly a fit and healthy force, probably the fittest members of the community the military is designed to defend. On the other hand, the potential for major damage to this force exists from disease, accident and combat.

In peacetime, Military Medicine is preventative and sports medicine orientated, documenting the medical status of the force to maximise its deployability. Essentially, peacetime is a quiet time, enabling the development of doctrine and plans using the best available knowledge and technology for the next operation. The amount of

medical knowledge has doubled since 1992 and the management of this amount of information, technology and skill, and its integration with the Australian Defence Force, is essentially best practice in peace and war.

The knowledge edge rests in the teaching hospitals and private practices in peacetime and balancing civilian medical skills and operational requirements is the key to training for war and training to win. The knowledge edge needs to be brought to the cutting edge of operational health.

In War, or Military Operations Other Than War, there is an increased demand for medical services and how the balance between civilian medicine and operational medicine is managed will reflect our ability to deliver.

WAR AND MILITARY OPERATIONS OTHER THAN WAR

Casualty surges reflect operational activity. There are peaks and troughs. In the battles of World War I and in World War II this was demonstrated obviously. In the Western desert, there were sporting knee injuries during the quiet times.

Sport is encouraged for fitness, morale, team play and elimination of boredom. This was similar to the pattern of injuries in the Gulf War. The force was getting ready. It was training, they were playing sport, and they had injuries. The overall aim is to conserve manpower and maintain effective troops in the field.

Does lifesaving surgery do this? Not really, but given the values of our democracy, we have the higher obligation to the soldier who places himself in harm's way for his community, to save his life and limbs. It is a confidence and morale booster and indirectly contributes to the calibre of the force and its effectiveness. First aid, evacuation, triage, resuscitation, stabilisation and definitive medical care all consume assets. If winning the battle saves lives, does this elaborate activity contribute to the effectiveness of the Force? If motivation and leadership are the keys to the mind-game of winning, the answer is emphatically, yes.

Our enemies in South Vietnam used weapons to maim in order to undermine morale, to consume assets and destroy the political will to win. The casualty evacuation techniques in battle and surgery gave confidence to the troops although the effectiveness of the television campaign on the political world was obvious.

What about recent wars - for example, the Gulf War? The two United States hospital ships of 1000 beds did not take combat casualties. What message did the deployment of such assets to the front line deliver[7] First, to the enemy it was a clear message of caring for the troops, in sharp contrast to the care given to the Iraqi troops. The Allies were prepared to risk significant assets, which were vulnerable to mine or missile attack, and demonstrated commitment and a will to win. The Marine pilots said that if the aircraft were hit they would nurse their aircraft back to the ocean and ditch by the ship.

We were not busy, however, but each day brought the possibility of large numbers of casualties from combat or chemical and biological warfare. The real cases were from accident and sport, and the commonest operation in the Gulf War was arthroscopy of the knee, with a 70% return to duty. There were 1400 medical and nursing staff. What could be done whilst we were waiting? We ran lectures and courses. There were fitness programs and we drilled: abandon-ship drill, chemical and biological warfare drill, mass casualty drills, finally ending with the ‘mother of all drills': we could take 50 major casualties at once.

Research and other protocols were developed and tri-service doctrine for the ADF came of age amongst those of us from the three services who served there. We looked after each other. Ships hit mines near us (USS TRIPOLI and an AEGIS cruiser) and one Silkworm missile was taken out 20km away by HMS Gloucester. One hundred-plus Scud missiles landed somewhere in the sea. The neurosurgeon on board had not operated for six months. The cardiothoracic surgeon, a friend, leaked a berry aneurysm and the neurosurgeon would not operate. The patient was treated conservatively, evacuated, and recovered.

If you are waiting for cases, how long do you go before skills and confidence drop to an unacceptable level? Do you rotate the staff every three months or so? And what about continuing education courses with CD-ROM, video etc. to maintain skills? Rotating from a busy civilian environment brings those skills, so short rotations have an advantage.

What about modern endoscopy, particularly arthroscopic surgery? It is equipment-intensive but patient friendly, being non-invasive. There was a 70% return to duty in the Gulf War and that is a massive conservation of manpower and a force-multiplier. If those troops had been sent home and someone else had to return to take their place and to be trained as a member of the team, there would be a considerable loss.

I identified six patients in my five weeks in East Timor who could have had arthroscopic surgery, and this included the RSM who had a loose body locking his elbow. He could unfortunately have been locked into the saluting position.

If we are rotating medical specialists from busy civilian practices and the teaching hospitals, why not use them in the quiet times as they wait for potential disasters? This could save money and keep all the staff busy, maintaining skills better than drills. The standards of arthroscopic surgery should be higher than in civilian practice, which depends entirely on the standard of the equipment - which should be the best.

In 1992, 3 Forward General Hospital deployed to RAAF Edinburgh. $250,000 worth of endoscopic and other equipment was loaned from industry and utilised under canvas, treating a number of serving members. Industry was compliant as they saw this was an opportunity to demonstrate their equipment to medical specialists who were potential purchasers, or certainly a significant influence within their civilian practices and teaching hospitals.

In 1997, $80,000 worth of equipment was loaned to the 2 Division exercise on Bathurst Island for arthroscopic surgery. The Tiwi Islanders are naturally good Australian Rules footballers and, with the advent of football boots, demonstrated a large number of knee injuries, which could be treated under canvas, taking them from the Darwin Hospital waiting list, which was extensive. Ear and eye surgery, in large numbers, was also performed in a short time.

We are like 'firemen' waiting for the big blaze: the mass trauma load, the vehicle that hits a mine or the battle casualties. The major road crash or the air dis aster, plus the ever-present possibility of combat casualties, are more likely in war than in Military Operations Other than War.

In Grenada, 70% of wounds were peripheral and probably the best figures for modern combat troops wearing body armour - not too dissimilar to combat in South Vietnam. The pieces that protrude get hit anyway, and a head or thoracic central wound may well be fatal.

Anaesthetics and emergency medicine remain within the 'core activities', but the other specialties on deployment move into major high-velocity trauma, which is not common in civilian Australian practice. We train for this, an example being. the Definitive Surgical Trauma Course run by the Royal Australasian College of Surgeons with the recent military module.

Our surgical teams for ten years have been aimed at a General surgeon and an Orthopaedic surgeon together, to get as broad a base as possible and provide mutual support.

During quiet times, there is surplus medical staff that can be used for humanitarian work. This can be in-house, where a patient is brought to the facility, as well as aid to the civilian hospitals nearby and out reach to villages, etc. Rwanda, Bougainville and East Timor have all demonstrated this. Forensic support and postgraduate training and meetings have occurred and built bridges between countries on UN missions and shared medical knowledge. Malaria is not a major issue for Ghanaian doctors. The first UN medical conference in Geneva in 1997 developed to some degree from the postgraduate activity in Rwanda.

Orthopaedics can be divided into limb-saving surgery, stabilisation and evacuation. Arthroscopic surgery has an internal operating environment - namely the joint itself- and, given the technology, can be easily applied, with a high return to duty. The balance between the two capitalises on the civilian skills of the deployed specialists. It maintains a back ground of activity and a steady preparation for the surge. The application of modern medical technology in the field is the foundation for future developments.

LEADERSHIP

What is the thread that ties all this together? It is leadership. We do not know who the father of modern American business managerial practice is; however, we do know who the mother is. This is Mary Parker Follet t. In the 1920s she advocated a flat management structure, as opposed to the hierarchical structure, and this has been adopted generally. She said that leadership comes from ability and not a position in the hierarchy, and that this is empowering of all individuals who can demonstrate initiative and move for ward in their own environment. This is the thread that binds all our activities together in a common purpose.

The Defence Secretary at the beginning of 2000 said we have spent $12 billion per annum on the ADF but could not put 5000 troops into East Timor without an extra levy on the citizens. He asked, why was this so? - which is a reasonable question. The Minister of Defence, the Chief of the Defence Force and the Defence Secretary considered all aspects of Defence and presented the view that the bureaucracy had 'learned helplessness'.

They came up with a number of meetings, work shops and presentations to generate an attitudinal change and a revitalising of the bureaucracy. [1] have distilled five of their leadership points, namely:

- accountability
- responsibility
- transparency
- good communications and
- the avoidance of stove piping

If these words are used in practice, as opposed to being seen as bureaucratic jargon to be acknowledged only until the wind changes, then we can achieve what is best for the defence of this nation.

The leadership issue is not new, and Aristotle, one of the students of Socrates, has written in regard to ethos, pathos and logos, the central features of leader ship as he saw it. Ethos is your ethical behaviour and the higher you get in any structure the more scrutiny comes upon you and personality defects become more obvious; and without good ethical behaviour, our credibility- and thus leadership- will fail. Pathos is the passion, and how much one cares for the task in hand. Logos is the knowledge and skill required to achieve the task

CONCLUSION

In conclusion, the focus of all our efforts is on the soldier, sailor and airman who places himself in harm's way for the citizens of this nation.

What is the building block of the ADF? Well, Private Bosisto, with his initiative and courage, his joie de vivre and his attitude to authority, is that building block. In 1916, the Anzac tradition was just beginning but it has gone on from there and is the very ethos of how we do business in the ADF The Private Bosisto's of the ADF are alive and well, just read the paper, and if we are to train for war, and train to win, it is our work to nurture the Private Bosisto's. That is the debt and therein lies the challenge of bringing the knowledge to the cutting edge of operational health.

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