AMMA JOURNAL VOL 12 ISSUE 2

JUNE 2003

Would That the White Coat Were Purple[1]

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A TRADITIONAL CHINESE CURSE GOES SOMETHING LIKE THIS: "May you live in interesting times" If it be so, then we are all most certainly cursed for these are indeed very interesting times. Economic reality has hit the military hard - the buzz word for the 90's is "downsizing" and the military medical empires have not been exempted. We are extolled to do more with less - our salaries compare poorly with the civilian colleagues who share our workplace yet each of us knows that the job we do is unique - the practice of military medicine encompasses so many exciting fields that no one individual can ever truly say that he is the master of them all. Yet all is clearly not well within our ranks - the vast majority of uniformed medical officers do not re-engage after the completion of their initial return of service obligation and our senior colleagues rarely remain to reach compulsory retiring age. Why is this so?

It would be facile to suggest that the answer to this question is easy - far greater minds than mine have sought solutions that have ranged from financial inducements to status through accelerated promotion. For every solution there has been a backlash - resentment of our pay scales from our non-medical brother officers through to erosion of the professional respect accorded to us as we have failed to formally develop our broader military officer qualities. The problem of medical officer retention has been ever present - no service has been spared at some stage or another and, clearly, there is no single answer. Whilst remaining both intrigued and tantalised by the oft-stated concept that there are no new sins on the face of this earth, I must accept that there are no new problems and certainty no new solutions. Is there, then, something that the ADF has not yet tried? I think that there is - an integrated ADF medical branch.

It is an immutable fact of human life that we all seek to define ourselves by identifying with a sub-group within society. As members of a uniformed service we pledge allegiance to our Queen, our country and to our service. I suggest that the allegiance to our service is often the stronger in that it is this allegiance that often directs our interaction with our professional brothers within the ADF. This very allegiance can become destructive when it leads to an erosion of our mutual professional respect and to a fragmentation of the delivery of quality health care to the servicemen and women of the ADF. This need not be so, as I witnessed vividly whilst on a recent Defence Cooperation visit to Canada.

I am sure that you are all aware of the "experiment" conducted in Canada in the late 1960's/70's when they fully integrated the three branches of the Armed Forces to form a single Canadian Defence Force (colloquially known as "purple suiters" although, in reality, the uniform was based on that of the Army, i.e. green). We all know that this was considered an abject failure and that the CDF has reverted to the original three services with their own uniforms, rank and doctrine. What you may not know is that the CDF medical branch has remained fully integrated - they wear the uniform of the mother service but can occupy any billet for which they are qualified. As an example, the Air Command Surgeon is a Naval Captain whilst the doctor in charge of the G-awareness programme for Air Force fighter pilots is a Navy Lieutenant-Commander. I must add for completeness, that they have a Surgeon General who is selected purely on merit (currently Air Force) and the next Surgeon General will be a female Air Force medical officer who was also the first Canadian female military pilot.

So - what are the advantages of such a system? Before listing the advantages of an integrated approach, we need to examine the reality of military medical practice within the ADE We all share the doctrinal priority of enhancing operational health - of maintaining the fighting elements at peak efficiency This often leads into our favourite

specialist areas - aviation medicine, underwater medicine and battlefield resuscitation and transport. The reality is often very different - an endless stream of mundane "unwelledness" that keeps us chained to our surgery desks. Even for those of us dedicated to a clinical career, this can become tiresome when your patient load comes from often very homogeneous populations. The job opportunities in military specialist areas are often limited and can ultimately lead to over-specialisation with the inevitable professional dead-end. The increasing emphasis on joint force operations has gone a long way to blur conventional roles and we must now have a far greater understanding of the needs of each component of the total force in combat. So what does this mean?

By integrating the medical branches of the ADF (whilst maintaining a single service identity) the potential employment pool is greatly expanded. This would then allow an individual medical officer to experience, by rotational postings, attachments etc., a much broader range of military medical specialties and thus remain professionally stimulated for a longer period of time. A larger medical pool would also permit specialisation across traditional single-service lines and thus increase the opportunity for postgraduate training and external accreditation. Hopefully, this would lead to a more natural matching of inherent interest and service needs thus creating a happier, more fulfilled medical officer population. The obvious flow-on from this would be greater retention of medical officers with enhanced corporate expertise and reduced training costs.

What then are the costs? The first casualty would have to be the traditional interservice antediluvian jingoism that has been the mainstay of military medical practice for generations. The second casualty would be selection by seniority rather than by ability. Are these costs too high? If the concept of a centralised Surgeon General is to be at all credible then the medical officers employed there need to have a realistic understanding of the needs of all three services. Most of the expensive postgraduate training programmes (e.g., MPH, MHA etc.) are common to all three services and are equally valuable to each. Specialist courses, such as the Diploma of Aviation Medicine, can be justified for selected members of all three services on the basis that military aviation remains fragmented within the ADE Similarly, the work conducted by ADF specialist centres (e.g., School of Underwater Medicine, Institute of Aviation Medicine) already have relevance to the three branch es of the ADF and would benefit from an injection of expertise from all branches.

In conclusion, I suggest that ADF medical practitioners need to critically assess the health of their own branches and seriously consider the merits of an integrated system staffed by open-minded, enthusiastic single-service members. I further suggest that this could open the way for a true profession of Military Medicine that would be satisfying and likely to encourage suitable people to devote the major portion of their professional lives to its advancement.