AMMA JOURNAL VOL 9 ISSUE 2

AUGUST 2000

Restructuring the Naval Reserve Health Branch: A Proposal[1]

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Introduction

The function of the Naval Health Services is to provide the health support necessary to ensure maximum effectiveness of naval operations in peace and war. [1] The role of the Reserve Health Branch is to support the Permanent Service in the completion of this function. An initial review of the current structure of the Reserve Health Branch of the Navy, with the existing structures for both Army and the Air Force, was instrumental in the development of this proposal. [2] This proposal was submitted to the Chief of Navy for consideration in March 2000.

The Proposal

The aim of this proposal is to provide a detailed outline of the proposed structure for the Reserve Health Branch of the Navy. Whilst this paper will refer only to the Navy Reserve Health Branch, it is vital to acknowledge that the Defence Health Service is a tri-service organisation and therefore the structures for Navy, Army and Air Force reserve health branches will all need to be very similar. The present situation, where it is advantageous to be with one particular service rather than another, is causing considerable instability, particularly for Navy and is not sustainable in the long term.

Administrative Structure

It is proposed to establish a national triumvirate consisting of the Director of the Reserve Health Branch Navy (DRHB-N) and his counterparts from Army and Air Force. The triumvirate would be billeted in Canberra within the office of the Director General of Defence Health Services (DGDHS) and would be responsible to him for the delivery of tri- service Reserve Health Support. They would be provided with administrative support by DGDHS. Whilst this is a national position, it does not mean that the DRHB-N needs to reside or work in Canberra.

The principle user of Reserve Health Services for the Navy is the Fleet Medical Officer whose offices are at the Maritime Headquarters in Sydney. It is the Fleet Medical Officer who is also the recipient of the funds for the Reserve Health Branch for the Navy and the

DRHB-N would continue to be responsible to the FMO for delivery of single service Reserve health support.

DRHB-N should have the day to day executive control of the Reserve Health Branch of the Navy and be the addressee for all correspondence. The FMO would continue to report via DGRES-N to the Deputy Chief of Navy for single service instruction. As is the current situation, the DRHB-N would continue to have the rank of CAPT (06).

At present there is a triumvirate in each state. The roles and functions of this triumvirate will be strengthened under the proposed new structure, encompassing all aspects of Reserve Health function in that state, including responsibility for recruiting, training and administration. The administrative structures need to be tightened to ensure career management of all officers is improved. Each member of this triumvirate would have rank at the COL [E] or LtCol [E] level depending on experience, the size of the branch in that state, and the rank of tri- service equivalents. The Navy representative for that state would be called the Principal Reserve Medical

Officer-Navy. Administrative support would need to be provided to this triumvirate and this could be provided in a tri-service manner utilising elements of the existing single service administrative support structures.

Specialist Reserve

The recent peacekeeping and humanitarian missions to Rwanda, New Guinea, Bougainville and Timor have highlighted the need for the Australian defence forces to have the services of a number of specialist medical officers, particularly general and orthopaedic surgeons, anaesthetists and intensivists. The concurrent support of Operation Belisi in Bougainville and the Internet forces in East Timor has placed considerable strain on the available numbers of specialists within these categories.

The Navy, in comparison with the other two services, has relatively few of these specialists. Both the Anny and the Airforce have specialist streams within their health reserves and this has been fundamental to their ability to recruit appropriately trained officers. It is therefore proposed to split the Navy Reserve Health Branch into two streams, a specialist stream and a general stream.

While the specialist stream is designed to support primarily the roles and functions of the Primary Care Reception Facility [PCRFI. They would also be used in support of tri- service operations. HMAS MANOORA is currently progressing through her work-up trials and HMAS KANIMBLA is still being refitted in Newcastle. To meet the operational requirements of this ship, a specialist anaesthetist, surgeon and an intensive care and/or emergency specialist will be required. It is these specialists who would be targeted in the recruiting drive for the specialist stream.

In addition, this specialist stream would encompass all the other medical consultants who currently support the roles and functions of the Health Branch within the Australian Navy and the Australian Defence Force. This stream would also contain the specialist dentists, nursing officers and general practitioners who have the FRACGP. The recruiting numbers of specialists in all these areas would be targeted to meet the requirements of the ADF for that individual specialty.

All officers entering this specialist stream would of necessity have civilian qualifications which satisfy the specifications of the National Specialist Qualification Advisory Committee (NSQAC). They would enter at least at the rank of LCDR [04). Some seniority may be granted dependent upon their civilian experience. Promotion to CMDR would be semi-automatic after 5 years of service, dependent upon continuing appropriate and effective civilian and naval service. For those specialists defined under the public service guidelines as senior specialists (usually meaning at least 5 years of specialist experience). These officers would be entered at the CMDR (05) level. Promotion to CAPf (06) would be by selection, dependent upon a number of factors including billet vacancy, civilian status and naval experience. This rank would normally be reserved for those officers in a pre-eminent position such as the consultants to the Surgeon General Australian Defence Forces. These officers would all have acting rank with a substantive base as a LCDR.

Members of the specialist stream may transfer across to the general stream, provided they meet all the guidelines relating to administrative experience required of those officers within the general stream.

It is proposed that these officers be used only in their areas of specialised skill with a minimum training requirement of 5 days per year. Whilst it may not be initially achievable, it is desirable that the long-term recruiting goal for these officers ought to be their entry as junior specialists, perhaps even within the training schemes so that their specialist experience matches their naval experience. The triumvirate in each state would be an integral part of the recruiting drive for these specialists with the emphasis being on recruiting specialists for the ADF as a whole and allowing the individual specialist to join the service of his choice.

General Reserve

The other stream of the Reserve Health Branch for the Navy would be the general stream. This would include non - specialist medical officers, dental officers, nursing officers, medical administration officers, pathology technical

officers, radiography officers and medical sailors. The primary aim of this stream of the Reserve Health Branch would be support of HMAS ships and establishments. Some of these people would be targeted for the support of the PCRF and joint operations.

Entry to this stream would be as per the existing entry structure dependent upon qualification, skills and experience, and promotion would be in accordance with existing guidelines. For the medical officers within the general stream, it is anticipated that, as they would often be operating as a solo medical officer, they would require more administrative skills than those within the specialist stream who usually operate in a team situation would. Whilst it is anticipated that the majority of these people would be general practitioners, members of the specialist stream could also be within the general stream provide they meet all the administration requirements of this stream.

Members of the general stream of the Reserve Health Branch would be required to serve a minimum of 14 days per year. Promotion to the positions of DRHB-N and PRMO-N for each state would only be available to officers within the general stream. Promotion to the position of ASGADF-N would be available to officers of both streams, but it is noted that an officer from the specialist stream would need to have considerable administrative background to carry out the current roles and functions of this position. Officers within the general stream of the Reserve Health Branch would have substantive rank.

Recruiting

There is an urgent need to recruit appropriately skilled officers, particularly to the specialist stream. The current recruiting processes are proving cumbersome, slow and a distinct impediment to the recruitment of suitably qualified officers into the Reserve Health Branch of the Navy. An urgent review is needed of the recruitment process to make sure that suitably qualified enthusiastic officers are not frustrated and ultimately lost to the Navy because of administrative inefficiencies within the recruiting process. The administrative staff, both for the national triumvirate and the relevant state triumvirate, should be tasked to actively liaise with the appropriate local recruiting authority to make sure the process is as speedy as possible. Recruitment to the specialist branch should be undertaken via both a national advertising campaign within the medical press and also by direct liaison between the triumvirates and the teaching hospitals and professional colleges.

Training

In late 1999, a review of the reserve officer direct entry course was undertaken at HMAS CRESWELL. At the time of writing, the formal decisions taken at that meeting have not been published. The current course is a distinct impediment to effective recruiting for the Navy as it is much longer than the courses required by both the Army and the Air Force. Surveys of Health Branch officers upon completion of the current course have found that the most common criticism is that the course is too long, that boredom is a problem, and that many of the subjects covered are irrelevant, particularly in view of the person's professional background. It is proposed that a direct entry officer course for the Health Branch be established, that this be of only two weeks duration and should cover all the current course material. At the end of this course, the officer should be fit to proceed to sea or to join a specialist surgical team.

As the requirements of the two streams of the Reserve Health Branch would be different because of the nature of their operations, it is proposed the training after this initial entry course is targeted to the specific needs of that group. For those in the specialist stream, who would always be acting in their particular specialist area within a team situation where administrative help would be available as part of that team, little or no further administrative training would be needed. Their specialist training should be focused on familiarisation with the operative environment in which they would perform. For those officers attached to the PCRF, this would include, at least annually, a familiarisation course with the instruments and operating environment of the PCRF with special emphasis upon team building.

Continuing medical education for these officers should be mandatory to make sure that the knowledge of the officer is appropriate for a military setting as opposed to conventional civilian practice.

For those medical officers within the general stream, the training should be aimed at making sure that they are adequately skilled to perform either as a solo medical officer at sea or within a naval hospital environment. Given the increasingly tri-service operational nature of the Defence Health Branch, the value of naval medical officers participating within Army and Air Force exercises and operations should also be stressed. Suitable training courses for medical officers within the general stream would include the EMST course, the Underwater Medicine course, the medical officer's NBC course and appropriate courses in occupational health and safety and tropical medicine. Given the increasing participation of the ADF in humanitarian and disaster relief exercises, a course in medical planning for such scenarios is strongly advised.

Prior to promotion to the rank of CMDR, general stream officers should be required to successfully complete the Reserve Staff Acquaint Course. The requirement to complete continuing medical education, via participation in lectures and meetings specific to the appropriate needs of the medical officer, is strongly supported. This should help in the delivery of a highly and appropriately trained health force and ensure medical best practice' is achieved.

The current NBCD courses, both initial and requalification, extend over five weekdays. Attendance is difficult for many medical officers because of busy professional workloads and is an expense for the Navy in manhours. As a result, vital personnel are sometimes not qualified when required and a waiver is granted. Consideration needs to be given to making the theory portion of the course a correspondence module and conducting the practical portions of the course on weekends. Recently, at HMAS Creswell, a weekend course covering firefighting, the smoke chamber and damage control was conducted and proved very successful.

It is very likely that specialist medical officers from Army and Air Force would serve upon the PCRF to supplement the existing Navy specialists. A course would need to be designed to equip these officers with the necessary skills to function effectively and safely onboard a ship.

Retiring Age

The current requirement is that all Health Branch officers are transferred to the inactive list at age 55 and retired at age 60. Officers on the inactive list cannot be promoted except by special appointment by Chief of Navy. As officers have to serve at least 12 months in rank to be considered for promotion, this means that officers over the age of 53 years and 6 months are effectively barred from promotion.

The nature of medical education is that most officers do not complete their undergraduate training until their mid-twenties. They then, have to complete several years of compulsory residency training. For those entering a specialty course, there is usually another 5 or 6 years of postgraduate training to be undertaken.

The result of this prolonged training course is that most medical officers, particularly the specialists. Are only entering and establishing their practices during their mid and late thirties and hence their ability to devote spare time to the service of the ADF is limited during this period. Usually by the late forties and early fifties. medical officers have established their practices. their families are now growing up and they now have the time available to devote to service in the ADF.

They have also reached the peak of their clinical skills and experience and under the current guidelines, it is at this very time that the restrictions upon promotion start to occur. It is therefore proposed that officers are allowed to serve in the active Reserve through to the age of 60 and the promotions be allowed to continue all the way through that period setting a promotional cut-off date of 58.5 years rather than the current 53.5 years.

Conclusion

The Reserve Health Branch of the Navy is currently suffering from a desperate lack of general and specialist medical, dental and nursing officers. This is primarily due to its present structure, which has inhibited recruiting, training and retention of appropriately qualified personnel and placed the Navy at a significant disadvantage in

relation to the other two services. The branch is currently unable to fulfill its obligations outlined in JP2060 and the Defence of Australia 97.[3]

Recommendations

To correct these problems so the Navy Reserve Health Branch can be reinvigorated and perform its stated functions in providing the necessary health support to ensure maximum effectiveness of ADF operations in both peace and war, it is recommended that:

- a tri-service orientation be adopted;
- administrative responsibility be clearly defined;
- administrative support needs to be provided;
- a specialist reserve needs to be formed;
- revision of training courses needs to occur;
- revised rank and promotions scheme to be implemented;
- there is modification to the recruiting procedures; and
- altered retirement provisions, to more truly reflect current medical practice, be made.

References:

1. Royal Australian Navy. *ABR 1991 (Vol. 1).* Canberra: DPBUS; 1996.
2. AF minute 70/3/45-2 (FHSU 328/99) dated Aug 99.
3. Department of Defence. *Defence of Australia*. Canberra: DPUBS; 1997