"The Angels from Downunder"

Kim J Sullivan

Abstract

- In 2005, I went to Iraq as Officer Commanding of the Australian Medical Detachment, which deployed as part of the United States Air Force Theater Hospital.
- The hospital was a tented facility with 20 intensive care beds and 40 intermediate care (medium dependency) beds.
- The Australians rapidly integrated with the US teams, and their skills were quickly recognised.
- Challenges included adjusting to the procedural differences, different team structures, administrative processes and language (eg, different drug names). The value of exchange postings was shown, as personnel who had previously worked in US facilities had less difficulty integrating.
- There were ethical issues involving withdrawal of care for critically ill patients because of resource limits, and questions of treating civilian casualties when appropriate follow-up care is unlikely to be available.

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IN THE SECOND HALF OF 2005, I had the privilege of deploying as Officer Commanding of the Australian Medical Detachment in Iraq. A team of 20 Australian Defence Force health personnel deployed as part of the United States Air Force Theater Hospital. Bennis and Thomas have described a crucible event as a "defining moment that unleashes abilities, forces crucial choices, and sharpens focus. It teaches a person who he or she is."[1] This was a crucible event for those of us who deployed.

The team

We were the third and last rotation of ADF personnel to deploy to the hospital. Our team's structure reflected the diverse nature of the Defence Health Service. Initially, the team comprised Royal Australian Navy and Royal Australian Air Force nursing officers, and Army nursing officers and medical assistants. Both Permanent and Reserve personnel were included. There was a range of clinical specialties: intensive care, perioperative and emergency nurses, and generalists. Several members of the team deployed for shorter periods, so the mix changed slightly over time. Toward the middle of the rotation, an Army Reserve Specialist Medical Officer, an anaesthetist, joined the team.

The patients

Our deployment was for 3.5 months. During this time, there was a constant stream of casualties: coalition force members, Iraqi civilians, detainees, and contractors; men, women, and children. People from more than 20 countries were treated in the hospital during our tenure. On average, 20 to 30 patients were assessed in the emergency department each day. Most were admitted, and nearly all required surgery.

"The Angels from Downunder" is the title of a video produced by Master Sergeant S Wareye, USAF, and presented to the ADF team to commemorate their service in Iraq.

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The hospital's main remit was to preserve "life, limb and eyesight". The hospital did not care for low-dependency patients and did not deliver primary health care, nor see the "general practice" patients who often present to civilian emergency departments.

The hospital

A favourite saying of the hospital commander was, "It's not about the tents, it's about the people" — this hospital was predominantly in tents, albeit with concrete floors and air-conditioning. The Air Force Theater Hospital is a very sophisticated organisation doing magnificent work in relatively simple surroundings.

The hospital maintained about 20 intensive care beds and 40 intermediate care (which the ADF would term medium dependency) beds. There were three operating rooms, with capacity for six operating tables. Surgical specialties included neurosurgery, vascular, orthopaedics, thoracic, and ophthalmology. There was sophisticated imaging, including computed tomography with radiologist support 24 hours a day, as well as pathology and pharmacy departments. The pharmacy provided a clinical pharmacy service, supplying medications to the wards, preparing intravenous solutions and additives, and drawing up drugs during trauma calls.

Trauma calls were initiated as required, and were attended by the surgeon of the day, a trauma/emergency specialist, a

"One Team, One Mission": An Australian nurse and medical assistant working with US colleagues to provide care to an Iraqi patient.

radiographer, a pathologist, a pharmacist, and the emergency department team. A resuscitation team (as in the ADF) was not used, and the roles were significantly different. For example, the nursing officer was responsible for giving all medications and for "scribing" the resuscitation — this allowed the nursing officer to manage more than one patient, as required.

The focus of the hospital was throughput, with the aim being to evacuate coalition casualties out of the area of operations as soon as possible. "One Team, One Mission" was the motto and method adopted by the hospital. Although the Australians were easily identified by their desert uniforms and different accents, there was very much a team approach. The most appropriate person took charge, and opinions, experience and knowledge were shared to achieve the best patient outcome.

We were justifiably proud of the fact that patients who arrived at the hospital had a 96% chance of survival.

Reflections

In 2006, the theme of the ADF Nurses Conference was "go there with resolve, competence, confidence and ethics" — we did.

Resolve

As a group, we were resolved to achieve a number of things, both personal and professional. There are high expectations whenever you deploy. The DHS enjoys an excellent reputation, and rightly so, having provided health support in many settings. In recent times, the DHS has been most well known for humanitarian work in the aftermath of the 2004 tsunami and, more recently, following the earthquake in Pakistan in 2005.

The significant difference in this deployment was that most casualties would have battle injuries. There were very few non-battle casualties. The injury profile was different to that experienced in other conflicts. Changes to personal protective equipment, helmets and body armour, coupled with different tactics, techniques and procedures used by the insurgents, led to this difference.

Competence

The competence of the team members was never in doubt. All had been selected for their specific skills and all were the product of excellent training, both clinical and military. Qualifications were checked before deployment, and a credentialling process was completed for each member of the team. Formal credentialling was required for all health personnel within the hospital. This was a clinical governance measure, which ensured that personnel were employed within their area of competency.

The members of the detachment quickly settled into their new teams and integrated well with their US colleagues. Coupled with an amazing work ethic, the Australian team members consistently performed to a high standard and were sought after to be part of first-response teams.

Confidence

Confidence is necessary on a number of levels; it allows you to get on with your job. Before deploying, I was confident that we, as individuals, had the support of our colleagues in the DHS. I was confident that our families would support us, and that we, as a team, would support each other. I was confident that we had the skills and equipment to do our jobs and that we had support mechanisms in place, should we need them. I was also confident that the selection process was rigorous enough to ensure that only suitably qualified personnel would deploy. It did not take long to realise that this confidence was not misplaced.

Ethics

In some ways, this deployment challenged our resolve to act in an ethical manner. All of us had been trained in the Law of Armed Conflict; now we were required to apply that training. It is one thing to hypothesise about how you will treat a wounded enemy combatant — it is another to do so. It was heartening to witness the genuine concern for health and welfare displayed by all members of the team. All patients who presented to the hospital were treated according to their injuries, and not according to their age, race, politics, or religion.

Other ethical challenges involved the initiation of intensive care for critically ill patients when their prospects for recovery

or the quality of life that would result was doubtful. The issue of withdrawal of care from critically ill patients when the prognosis was poor and resources were limited was another area that challenged, sometimes because it seemed to take so long to reach that decision point. These decisions are particularly difficult when the identity of the patient is not known and family members cannot be consulted.

An "ethics committee", comprising medical and nursing staff, civilian interpreters to provide a cultural perspective, the chaplain and a legal officer, attempted to provide sound advice to the treating physicians.

Challenges

Cultural

A significant challenge for the team was adjusting to the procedural differences, different team structures, administrative processes, and even language. It has been said that Australia and the US are similar cultures separated by the same language. This did create barriers, but each group soon learned to allow for the other. For example, drugs were identified by generic names and our US colleagues soon learned to refer to the operating theatre rather than the operating room.

The delivery of health care by the US is different from what the ADF experiences. There appears to be a higher level of specialisation, particularly by the medical technicians, and a greater delineation of roles. Nursing officers appeared to have less of a command role for the technicians and more of a technical oversight. Australian nursing officers and medical assistants are much more flexible and generalist in their approach. A significant difference was evident in the operating theatres. The ADF perioperative nurses were able to work in all areas: anaesthetics, scrub, circulating, post-anaesthetic care. Their US peers had more limited experience and did not scrub, and were less comfortable in anaesthetic and post-anaesthetic nursing.

Acknowledging the cultural differences of Iraqi patients was less of a challenge than I had expected. Australians have a broad awareness of different cultures, and readily provided care that was culturally sensitive.

Tents

A significant challenge was the requirement to change all of the tentage during our tenure. This had to be achieved before the rainy season, and with no loss of capability. Achieving this task is a testament to the planning of the medical operations staff, the dedication of the engineers, and the goodwill and cooperation of the hospital staff. The use of engineers allowed hospital staff to concentrate on their core business. With 24-hour operations, the tentage was changed in just 11 days, with no loss of capability. The opportunity was also taken to make important changes in the distribution of patients within the hospital to produce better patient flows.

Lessons

Evacuation

Not all facets of health care can be delivered within the area of operations. Routine and emergency strategic aeromedical evacuation is an essential part of the health support plan. The hospital relied on patient throughput to ensure that it had the capacity to manage battle casualties as they occurred. A Contingency Aeromedical Staging Facility deployed as part of the Expeditionary Medical Group. This allowed routine and ambulatory casualties awaiting evacuation to be cared for away from the hospital. The ability to generate strategic aeromedical evacuation missions meant that the response time for urgent cases could be reduced significantly. The use of Critical Care Aeromedical Transport Teams enabled critically ill patients to be evacuated safely and expediently. These teams consisted of a specialist medical officer (often an intensivist, anaesthetist or respiratory physician), an intensive care nursing officer and a respiratory technician.

Host nation casualties

It is not possible in this type of situation to ignore the possibility of civilians presenting to the facility. These casualties are not necessarily humanitarian cases; however, they may have battle injuries and it will be necessary to treat them. Consequently, it is essential to have personnel who are clinically competent to handle patients who are very young or very old. A complicating factor of caring for local people in this case was the inability to transfer them out of the hospital. This produced a strain on resources, occupied beds, and had potential to change the focus of the hospital. The use of scarce resources is an issue, and a resource that is often taken for granted is the physical and emotional energy of the carers. It too has to be monitored and managed. The risk of mission creep is high.

Dealing with civilian casualties raises a number of issues. Is the treatment going to be sustainable? For example, will a patient who is given a colostomy be able to access appliances in the future? Will an amputee have access to adequate physiotherapy, and where will the prosthesis come from? It is one thing to save someone's life by surgery, but this has to be balanced with the ability of a sometimes struggling health system to provide long-term care for a potentially highly dependent survivor.

Specialist consultation

The ability to obtain specialist advice from centres of excellence ensured that patients received the best possible care. The management of casualties was evidence-based, and the constant effort to improve care and patient outcomes was a hallmark of the hospital.

One example was in the management of burns casualties. On one occasion, multiple casualties arrived with significant burns and associated injuries. They were managed according to the existing protocols of the hospital, but their outcome

was not good. A teleconference was initiated with the burns unit at Brooke Army Medical Center in Texas and Landstuhl Regional Medical Center in Germany to discuss the management of these patients. As a result, within 7 days, new procedures had been developed and implemented, resulting in significantly improved outcomes for critically ill burn patients.

Research

As part of the goal to improve the survivability of casualties and to improve care, effort was made to gather data on the types of injuries being seen and their incidence, and to collect combat body armour from wounded personnel for later examination. This reinforced the requirement to question our own procedures, processes and training, both to validate what we are currently doing and to plan for future operations.

Credentialling

The process for credentialling personnel before deployment was at times difficult. This deployment reinforced the need to maintain accurate, current information that is easily accessible and recoverable by the component headquarters.

Exchange postings

The value of exchange postings was highlighted by the experience of several team members who had prior training and operational experience with US forces. Consequently, they assimilated much more quickly and were able to assist other members of the team to adjust to the differences in procedures, processes and equipment.

Conclusion

The chance to deploy on operations is seen as the pinnacle for any member of the ADF; to deploy as the Officer Commanding of a team of professional health care providers within a coalition facility is something that I will never be able to match. It truly was a crucible event, for me at least. The ADF can be justifiably proud of the professionalism, dedication and training of its medical assistants, nurses and doctors. They were fine ambassadors for the ADF and in particular the DHS. They truly were "The Angels from Downunder."

Competing interests

None identified.

References

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