

# The battlefield medic

John H Overton, Wayne (“Shorty”) Langford and John Straskye

John Overton interviews two experienced RAAMC officers with active service as medical assistants regarding their views of current medical assistant training



**Colonel John Overton** has provided long distinguished service to anaesthetics, paediatric health, the New South Wales Ambulance Service and Defence Health, in particular with the RAAMC. He was formerly the Deputy Executive Director of the Children’s Hospital at Westmead. He has been teacher, examiner and adviser to the NSW Ambulance Service for 40 years. He was one

of the founders of the paramedical ambulance service in 1976 and equipped the first intensive care ambulance in NSW. He continues to lecture and acts as advocate for the NSW Ambulance Service as well as examining paramedic ambulance officers. He is currently the RAAMC Honorary Colonel NSW and formerly the RAAMC Representative Honorary Colonel.



**Major Wayne (“Shorty”) Langford** enlisted in the Regular Army on 6 March 1968, and on completion of recruit training was allocated to the RAAMC. He first saw operational service in 1970, with the 4th Battalion Royal Australian Regiment as the Bravo Company Medic. Throughout more than 40 years of service, he served in a number of instructional and regimental postings until

commissioned in January 2000. Major Langford had operational service in Northern Iraq in 1991 as part of Operation Habitat, Solomon Islands in 2000 and the UN Military Hospital, East Timor, in 2001. Honours and awards include Order of Australia, Commendation for Distinguished Service (East Timor) and the Infantry Combat Badge.



**Major John Straskye** enlisted in the Regular Army in 1967. He saw active service in Vietnam with 7 RAR in 1970 as a Rifle Company Medical Assistant, and was awarded the Infantry Combat Badge for this service. In 1979, he served with 8/9 RAR as the Medical Platoon Sergeant. He has served as a Company Sergeant Major, Instructor and Training Development Warrant Officer at the

School of Army Health in both Healesville and Portsea. He transferred to the Active Reserve in 1988 and currently serves with HSAR-ER. He is the webmaster of raamc.com.au and adfhealth.com. He has also served with the ANZUK Force in Singapore, UNFORCYP, UNAMET/UNTAET and Operation Uphold Democracy — Haiti.

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## Over your extensive service, what changes have you noted in health training? What is your opinion regarding today’s practice?

**WL:** By way of background, I have had experience as an Instructor at the School of Army Health Healesville from 1972 to 1974, 1977 to 1980, and 1985 to 1986. During that time, I lectured to the Basic Medical Assistant Course (BMAC), Advanced Medical Assistant Course, Special Air Service Regimental Medic’s Course, Nuclear Chemical Biological Warfare Course and other courses run at the Corps School.

For a number of years, I have firmly believed that our medical assistant training has been too orientated towards the Royal Australian Army Nursing Corps (RAANC). Last time I looked, the BMAC content was well over 33 weeks, which makes it almost impossible for a General Reservist to complete in less than 5 years.

My own training consisted of a BMAC of 6 weeks at the School of Army Health, a further 8 weeks at the 1st Military Hospital, and the most important training I received was by the regimental medical officer in the infantry battalion. This included intravenous therapy, traumatic amputations, drug administration in emergency situations, and treatment of high-velocity weapon injuries. All this training helped not only me, but others like me in my job as a medic in an infantry battalion during my time in Vietnam. The aim of all my training was basic yet simple. It was based on the principle to stabilise and evacuate.

My last deployment as a medical assistant was in 1991 on Operation Habitat. However, I am confident that my training would still enable me to provide an effective level of medical support should I be required to do so even today.

**JS:** I believe that, in the past, the Royal Australian Army Medical Corps (RAAMC) abrogated its responsibility for medical assistant and other rank training to the RAANC. Many nursing officers involved with other rank medical training were highly qualified as tutors, but had no experience on the battlefield. Those who did have active service experience only came in contact with the battle casualty in the field hospital, either in triage, the operating theatre or in the ward post op. There was a reluctance to give medical assistants advanced training, possibly because of a feeling that the role of the nursing officers would be reduced or that their professional status was threatened by changes occurring in the civilian ambulance services and other paramedical professions, where greater responsibilities were placed on them. Although RAANC input is important, other rank training by RAAMC members can focus particularly on battalion medical duties, both battle casualties and for specific injuries commonly seen on operations.

## What problems do you see resulting from the new training requirements in practice today?

**WL:** I believe we have gone away from what the role of the medical assistant is. There is now far too much emphasis on civil accreditation. The role of the medical assistant has not changed — it is still to assess the situation, remove the casualty from the cause, ABC, maintain an adequate airway, control haemorrhage, treat fractures, put in an intravenous line if required, pain relief if required, treat shock and evacuate. In simple terms: stabilise and evacuate.

The current BMAC for Reservists makes it difficult to complete it in less than 5 years. Again, we shouldn't live in the past; however, the General Reserve Medical Assistant Course was only 16 days. I'm not advocating the 16-day course; what I'm saying is look at what we really need our medical assistants to do. We need to get back to the basics and conduct a course that we can then build on with further training in units.

**JS:** The obvious problem for Reservists is time. In the perfect environment, a Reservist could be qualified as a medical assistant in 5 years. A Reservist who works for, say, a Commonwealth department receives leave for two camps a year — one to attend a field exercise and the other to attend a course. Would it be fraudulent for a Reservist to request leave to attend a field exercise and in reality attend a course? If so, it could take 10 years to complete the qualification. If it is not fraudulent, when does the Reservist find time to attend his or her military skills requirements and apply the skills learnt on a field exercise with his or her unit? An achievable course for Reservists needs to be explored.

## What pertinent aspects of traditional military health practice do you believe should be retained and emphasised in today's teaching and practice?

**WL:** The enemy's tactics are somewhat different, with the use of high explosive weapons. Injuries today are far more traumatic, and require more specialist training in initial wound management and treatment. Weapon velocity has also increased, and this needs to be addressed in wound management. We need to be on the lookout for up-to-date equipment and wound management techniques and practices so that our soldiers can be confident in the ability of the medic treating them.

I remember that in Vietnam our soldiers took great comfort in knowing that if they were wounded, they were only a 25-minute chopper ride from the 1st Field Hospital. Soldiers take greater comfort in knowing that their medic is highly trained.

**JS:** I believe the benchmark for the army would be the medic at infantry battalion company level. It is paramount that medics' skills complement the "golden hour rule". These skills would include controlling bleeding and replacing fluids, maintaining an airway, providing appropriate analgesia, and

skilfully providing bandaging and splinting for evacuation. The fundamentals for this in the past were taught at the School of Army Health, and then deficiencies were quickly identified by the battalion regimental medical officer, who provided on-the-job training. This was not recognised by the Australian Defense Force; however, it saved lives. The company medic also needed to know how to recognise and treat common non-life-threatening illnesses and injuries without supervision from a medical or nursing officer. I'm sure that the Royal Australian Navy and Royal Australian Air Force have equivalent benchmarks for medics in an isolated environment.

## New applicants are presenting to the health services with different professional qualifications and experience than in previous years. How do you see their qualifications and expertise used?

**WL:** We need to be constantly looking for prospective applicants. There is what I perceive to be an untapped wealth of potential medical assistants, particularly for the GRES in the ambulance services (ie, paramedics, enrolled nurses or those who are in the process of completing their registered nurse [RN] training). These applicants need to be given prior recognition of training or have subjects allocated toward completion of their BMAC. This should be used as a recruiting tool when looking for potential applicants.

There may also be the situation where some RNs may not wish to be officers, and they should be encouraged or offered the opportunity to become medical assistants. 3HSB deployed to East Timor in 2001 with two RNs who were other ranks as medical assistants, and it worked just fine.

**JS:** Not all RNs wish to be or are suitable to be commissioned officers. Paramedics and enrolled nurses have skills that are universally recognised in Australia and overseas. Somehow, the ADF has difficulty in recognising these skills. There may be good reasons for doing so. However, we have to get on top of it and be flexible enough to adapt. It is both frustrating to the applicant and a waste of government money to retrain or lose an applicant, as is often the case today. We need to look at conversion courses for these skilled applicants and remunerate them appropriately. I see no need for advanced promotion over traditionally trained medical assistants, as this would be detrimental to morale. There would also be a need for these members to attend traditional recruit training, as is the case with all enlistees, so that they embrace the military ethos.

## How do you see the information you have given constructively used in future practice?

**WL:** I can hear them saying to themselves that these are the ramblings of some old fart. However, I have the distinct advantage with Major Straskye of being one of a very few still

serving who has actually been a medic and been involved in an operational conflict. Before you throw your hands in the air, let me clarify my remarks. Vietnam was Australia's last true conflict. I'm not taking away anything from others who are currently serving or have previously served operationally. What I am saying is that Vietnam was a conflict in the true sense of the word — a true battlefield training ground.

The training I received initially from my basic course was adequate for the day-to-day regimental aide post type of work. However, the training I received in the battalion was what helped me during my time on operations. In the early 1970s, I still remember Colonel John Taske trying to convince the DGAHS (Director-General Army Health Service) conference members that medics needed to be taught to put a line in when he said to the doctors at the conference, "Are you going to go out under fire and do it?"

The philosophy of the time was simple. ABC, control haemorrhage, treat shock, pain relief, get a drip up, call a DUSTOFF. Are we teaching our medics of today far too much? Or are we expecting them to do far more than what they are required to do? The primary role of the medic in a combat situation is to stabilise and evacuate the casualty.

As one of my COs once said, "Let's get rid of the poodle fake" from the course content and get back to the basics.

**JS:** We need to actively recruit RNs and paramedics, with a view to recognising their skills and remunerating them accordingly. They need to attend an appropriate conversion course and some on-the-job training. We also need to attract full-time members taking their discharge to the Reserve. We should offer some realistic bonuses; say \$10000 for a 3-year contract. This would be in addition to Reservist pay. The contract would be for a specific amount of training days, including field exercises and readiness requirements. The contracts should be legally enforceable with a detriment for not being compliant without a reasonable excuse. The same bonus should be provided to a Reservist who elects to go on full-time duty to obtain his qualification and return to the Reserve.

## Summary

Experience and wisdom from past practice should always be considered in future planning. New technologies, changing expectations and demands also need to enter the equation. These reflections from two highly experienced RAAMC officers form a worthy basis for our considerations both for our future role-planning and training for it.

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