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Submission: ADF Medical Services.

The Global War on Terror has severely tested the military of western nations. One area that has seen a revolution is the medical services. Medical technology has progressed hugely in the last 20 years. The "golden hour" is the standard of pre-hospital care. Medical technology is getting lighter and smarter. Paramedical training is now the "norm" for per-hospital care. Nursing education is no longer hospital based. Health professional training is university based, many having higher degrees reflecting the specialisation of care.

Many of the concepts of military medicine were based in the Vietnam or Cold Wars. Today, US Army medics must all pass the Emergency Medical Technician-Basic exam. Every US Army and USMC Platoon has an attached medic or navy corpsman.

Training.

Current Medical Operators ECN 031-1 (MedOp) is Certificate IV in Defence Health Care. Only 74 graduate each year. Every platoon and troop in the Army requires an MedOps. They are very well trained but have little experience. The ADF medical school needs to move to a capital city and co-locate with a major tertiary teaching hospital.

The minimum level of nursing care in modern hospitals is the Enrolled nurse. With national standards, EN (medical endorsed) provides basic level nursing care under the direction of RNs, including the administration of medications. The EN course is an 18 month diploma level qualification. On leaving the services MedOps are not recognized as ENs.

Using medical Operators as nurses in the acute care setting is inappropriate. To work in this environment, they need to be up-skilled to EN (medical endorsement). This would be awarded on completing their year of hospital time. Every MedOps would be a qualified EN and basic emergency responder. MedOps can be sent to non-service hospitals to gain experience with real patients and real trauma.

Paramedics, Nurses and ODTs.

In Australia the basic training of paramedics has moved to university, like nursing did 20 years ago. Graduates finish university and normally complete a year of "Internship". The Advanced Medical Assistant Course is only 14 weeks. Every company / squadron has a MedTech. They are not accredited Paramedics.

Every subunit needs a fully qualified and experienced Paramedic. MedTechs need to be ungraded to Advance Paramedic Level. If MedOps are already ENs, they would received 40 credit points towards their degree and be taught in major Ambulance Service. At degree level the Paramedic would be upgraded to Sergeant and must have a high level of independence.

Similarly MedOps could use their EN credit to become RNs. Much of the work on the ward is conducted by RNs. Sergeant RNs would lead teams of ENs caring for intermediate care patients. RNs would be part of the RAANC and would introduce NCOs to the corps. Also the Army needs to accept the concept of direct entry Sergeants for nurses with higher qualifications.

Alternatively, MedOps as ENs be trained in the operating theater. A new degree course of "Operating Department Technologist" can be developed by the ADF. RNs normally fill this role but need post-graduate diplomas. Many hospitals are employing ENs, as the theatre role under-uses the high skills of a degree level nurse, except in recovery. ODT as ENs could find employment following military service.

Health Professionals on gaining post-graduate qualifications could apply for a

commission as 2nd Lieutenants, and have to pass the standard officer board. Some may choose to advance as enlisted members eg. medical troop have a Troop SgtMjr (Staff Sgt).

Forward Primary Health Care.

The Army will deploy as reinforced battalions (Battlegroups). US infantry battalions have two treatment teams. Battlegroups need three teams, two for the infantry and another for attachments. These need standardization, so all include a doctor, an emergency RN and two ENs.

Commando companies operate independently and need to return to older structure with a treatment team. Three para-commando treatment teams are needed.

Forward Care. War is a surgical disease.

Australia developed the Field Surgical Team. Today the USMC/USN has the FRSS, and the USAF the MFST. Every full brigade has a medical company, but no integrated surgical team. The medical company needs to be restructured to have two deployable Trauma and Surgical Troops, each based on the Parachute surgical team structure.

Troops contain emergency section, anesthetics, surgical, holding and services sections. The troop has one operating table, and a capacity is 6 intensive care and 10 short-term beds. Staff includes an emergency doctor, 2 anaesthetists/intensivists, general/vascular surgeon and an orthopedic surgeon. An ASAR accredited general Sonographer/radiographer, Dental and mental health teams complete the troop.

All health professionals would all be part-time, job sharing members. (Eg. Two surgeons would be half time military, half time civilian. They share civilian rooms and cover each other during Army service. Surgeons would retain private practices and income.)

Two FSTs are formed 1 & 3 Brigade, plus seven FST teams for Army Reserve brigades. The RAN forms two FST for the future Carriers. The RAAF also form two FST to support its deployment.

Combat Hospitals.

Australia maintains three HSB. None have deployed whole since Vietnam.

Today most injured members are evacuated out of theater as quickly as possible. Few patients are kept in theater. The proposal to put FST in every brigade, the need for major hospitals reduces. HSBs concentrate on medical, specialist surgical, dental, mental health and diagnostic services.

There is only the need for two HSB, one Melbourne and one Sydney. They are Australia's biggest cities and capable of supplying enough health professions to staff a field hospital. 3 HSB become a FST.

HSBs are reorganised into two 50 bed deployable mixed health support companies. The company would have enough assets to transport, set-up and run without outside support.

HS companies can leap frog forward during advances, or consolidate as single unit with the HSB support company to create a large stationary hospital.

HSB would become truly joint hospitals, with only a core of regular personal.

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