

# PAULATIM

## 2010



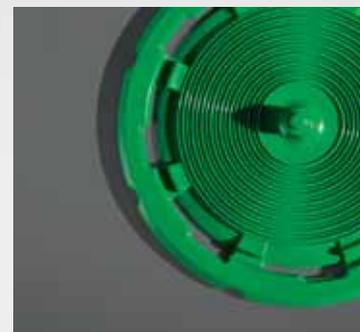
MAGAZINE OF THE  
ROYAL AUSTRALIAN  
ARMY MEDICAL CORPS



## New Generation Sterile Container

**New!**

Green Check®  
and Lateral  
Flow paths



### MicroStop®

*Your first line of defence*

The operation is about to take place. The patient is being prepared. In the OR, the sterile containers are being checked for sterility prior to opening. The indicators are green, the Greencheck® pins are visible from the outside: green for go. The containers are opened, the OR nurse finds everything the surgeon needs and what's more it's all in place.

The new generation of MicroStop® Sterile Containers have been optimised once again. Based on Pasteur's swan-neck flask, the MicroStop®'s flow barrier system achieves a filtration rate of 99.99997% and is significantly more effective than any disposable filter. They are available in a variety of sizes for every operation to ensure **Safe Transportation, Reliable Storage and Guaranteed Sterility.**

For more information please contact Medical + Optical

**Medical + Optical**

Caring about bringing quality to you

[www.medopt.com.au](http://www.medopt.com.au) ☎ 1800 225 065

**KLS martin**  
GROUP



**HEAD OF CORPS**  
MAJGEN P. Alexander

**CORPS RSM**  
WO1 A. de Santa-ana

**DEPUTY HEAD OF CORPS**  
COL G. Whelan (FT)  
BRIG D. Duncan (PT)

**REPRESENTATIVE HONORARY COLONEL**  
COL J. Taske

*Paulatim is published annually as the official magazine of the Royal Australian Army Medical Corps. The views expressed in Paulatim are entirely those of the contributors and are not necessarily the views or policy of the Royal Australian Army Medical Corps*

PAULATIM ISSN 1448-5893

**EDITORS**

CAPT A. Dent and MAJ M. Treloar  
S02 Corps (Health Services)  
HOC CELL  
ALTC  
Bonegilla VIC 3693

Royal Australian Army Medical Corps Journal  
"Paulatim" Edition 3



Head Office:  
P.O. Box 507  
North Melbourne, VIC 3051  
Ph: (03) 9329 7571  
Fax: (03) 9326 5107  
Email: :summit@summitpublishing.com.au

The views expressed in Paulatim are those of the contributors and are not necessarily those of the publisher and/or advertiser/s. Summit Publishing Pty Ltd accepts no responsibility for the accuracy of any information contained in any advertising and/or editorial content.

**ADVERTISERS ALERT**

Summit Publishing Pty Ltd is appointed by the *Royal Australian Army Medical Corps* as the authorised publisher of Paulatim. There are individuals operating who claim to be representatives of official publications who are sending bogus advertising invoices or bogus advertising proofs to advertisers in *Paulatim*. Should you be approached to place advertising, or should you receive an invoice for payment of advertising, ensure you verify the company's bona fides. In particular, any invoice or communication on whose behalf the publication is published. Also, the company should be easily contactable and able to provide proof of publication.

# CONTENTS



Message from the Head of Corps Major General Paul Alexander .....	3
Message from the Corps RSM RAAMC WO1 Angel de Santa-ana .....	5
Message from the Corps Representative Honorary Colonel – COL John Taske .....	7
Health Branch HQ Forces Command – A Year in Review .....	9
1HSB responding to an adaptive army and 110 year Army history .....	13
1 HSB – Paulatim 2010 .....	15
Physiotherapists in the Military .....	18
2 CAV REGT RAP 2010.....	19
Olgeta Warrior 2010 – 2 HSB Surgical PL .....	20
Close Health Support Company, 3 CSSB .....	21
3 CSSB Health Company Submissions.....	22
Health Company Training Cell .....	23
3 BDE Precincts Regimental Aid Posts.....	24
Life as an RAP medic .....	24
PTIs .....	25
Mission Essential Health Training – 3 HSB.....	26
ASEAN Regional Forum .....	27
AUSMTF-4 – (3 HSB) .....	28
Ex Predators Gallop .....	29
Operation Resolute (TSE 53) .....	30
South Australia Cadet AFX.....	30
Ex ANZAC Exchange 09.....	31
Exercise LEMNOS .....	33
Primary Health Care Team 5th Aviation Regiment .....	34
Regimental Aid Post (RAP) 5RAR .....	35
RAP at 8/9 RAR .....	37
The Deployed (Other) Half of 8/9 RAR RAP .....	38
3rd Health Coy 9th Combat Service Support Battalion .....	39
10 Health Company – 2nd Force Support Battalion .....	40
0001 Advanced Medical Technician Course .....	41
The Nine Core Values of the RAAF as Applied to Medics.....	41
Army School of Health – Advanced Medical Training Team .....	43
Training Developments .....	44
Health Cell – ASLO – ALTC .....	45
“The Knowledge – Skills we have so others may live” .....	46
Breaking the chain: Townsville Field Training Area 2010.....	48
HQ 1 DIV G07 Branch 2010 .....	50
National Boer War Memorial.....	52
EX RIMPAC 10 – Living the Dream .....	54
Diploma of Paramedical Science .....	56
6RAR RAP / MTF-1 RAP .....	58
The Next Step for Australian Army Medics.....	60
A Combat Medic in Action .....	63
SASR Gymnasium .....	66
The Medical Retrieval Team – Future of Casualty Evacuation in the AO .....	67
Directorate of Army Health .....	69
Oakey Medical Centre .....	71
1 Brigade PTI Platoon Update 2010.....	72
Royal Military College Duntroon – Field Medical Support Section (FMSS) .....	73
Considering the Deployable Role for Army Physical Training Instructors.....	74
Afghan and Australian medical progress .....	75
JeHDI .....	77
1 RTB P&RT Section.....	78
Lavarack Barracks Medical Centre .....	79
LBMC – Our First Posting .....	80
MTF 1 Physiotherapy .....	81
Operation Azure / United Nations Mission in Sudan .....	82
Watch your language .....	84
What is military health and what's in it for me? .....	85
Operational Mentor and Liaison Team (OMLT) – D Medics in Afghanistan .....	87
The role of physiotherapy in war .....	88
IF.....	90
Environmental Health Report .....	91
Demystifying Soldier Career Management .....	93
Health at the frontline .....	94
Voodoo Medicine .....	96
School of Infantry and Singleton Military Area Gymnasium .....	99
Veterinarians in the Australian Military .....	100
RAAMC Key Ring Register .....	101
RAAMC Officer Promotions – 2010 .....	102
RAAMC Other Ranks Promotions – 2010 .....	103
Award Winners .....	104
Combined Health Corps Conference – 2011 .....	104

Fast becoming the #1 tax agent  
for ADF members



**Defence Force tax specialists** - We have extensive experience across all ranks and specialities, including:

- Members who have served overseas, and/or have investment properties
- Members who have fallen behind on lodging their tax returns

**Maximum returns** - We know all the specific deductions, so you get a great tax return every year!

**Phone consultations** - All tax returns are completed over the phone, so you don't have to leave your base, ship or assignment.

**One tax agent** - We are not limited by locality so you and your family don't ever have to look for another tax agent again.

## SPECIAL OFFER

Introduce your partner to us and they will receive a 20% discount on our fee

Call 1300 763 575 24/7  
or visit us online at [www.phatreturns.com.au](http://www.phatreturns.com.au)

# Message from the Head of Corps

## Major General Paul Alexander



I assumed my appointment as Head of Corps early in the New Year, on the retirement of Brigadier Tony Gill. I am privileged to serve as your Head of Corps, particularly in a time when the Corps is involved in significant operations as well as being subject to a major reform program. In addition to the changes within Army Health, there has been complementary reform within the Joint Health space.

Over the past 12 months I have had the opportunity to visit many of you in the barracks setting as well as in the field. I am continuously impressed with the enthusiasm, dedication and commitment shown by members of the Corps whenever I visit. The core values of the Army Courage, Initiative and Teamwork are very evident within the RAAMC.

Army is well underway with significant force modernisation reviews including the Health Force Structure. I would like to thank Colonel Georgeina Whelan and her staff for the great work she has done in developing the proposed health structures. I endorse this work and I am positive that the proposals will result in greater health capability. The strong relationships between medics and the soldiers they support will be maintained as this element is essential to providing the highest quality of medical support. Other initiatives are being developed to ensure our doctrine and health concepts remain up to date. We are taking the lessons we learn on operations and from our Coalition partners to ensure we deliver best quality care. Pre-hospital care and training, damage control, resuscitation, surgery, mild traumatic brain injury and mental health are all areas where we are continuously reviewing our policies and service delivery.

There has been emphasis placed on the further development of the Medical Assistant courses and I wish formally acknowledge and thank the Army School of Health for their fine efforts in enhancing the training continuum.

I do want to bring to your attention some initiatives that will enhance our health delivery. I am pleased we have progressed the Joint eHealth Data and Information system, colloquially known as JeHDI. JeHDI will replace HealthKeys and MIMI to deliver a state of the art ehealth solution in the garrison and on operations. We are leading the nation with this initiative, and partnering outside Defence with DVA and the Department of Health. In the past 12 months we have also secured substantial pay rises and adjustments to pay scales for our doctors – other trades and professions are under review. We are also about to embark on a project that creates full-time Defence-funded registrar positions around the country. I see this later initiative as crucial to retaining our doctor workforce.

In April the Governor-General Ms Quentin Bryce, AC accepted our invitation to hold the position of Colonel in Chief of the RAAMC. This reinforces the high level of respect and support that the Corps has achieved, and I look forward to meeting her in October to discuss RAAMC matters.

RSM WO1 Angel de Santa-ana and I attended the Royal New Zealand Army Medical Corps Banner Parade in May. We were honoured to represent the RAAMC at this important occasion, showing that the ANZAC camaraderie is alive and well in 2010.

This year I have also had the pleasure of attending the RMC graduation parade and prize ceremony in June, and I would like to welcome our two new graduates, LT Lyn Adamson and LT Abbie Willmore. I would also like to congratulate LT Willmore on winning Major Susan Felsche Memorial Award this year. Congratulations Abbie!

I will close by thanking you all for your continued service and by wishing you and your families a Merry Christmas and Happy New Year for 2011. Paulatim.



I CAN STILL KEEP UP WITH HIM

**CELEBREX**<sup>®</sup>  
(celecoxib)

GET ACTIVE. STAY ACTIVE.!

**PBS Information: Restricted Benefit. Symptomatic treatment of osteoarthritis and rheumatoid arthritis. Refer to PBS schedule for full PBS restricted benefit information.**

**BEFORE PRESCRIBING, PLEASE REVIEW FULL PRODUCT INFORMATION AVAILABLE FROM PFIZER AUSTRALIA PTY LTD.**

**Minimum Product Information. CELEBREX<sup>®</sup> (celecoxib) 100 mg and 200 mg Capsules. Indications:** Symptomatic treatment of osteoarthritis (OA), rheumatoid arthritis (RA) & ankylosing spondylitis (AS). Treatment of primary dysmenorrhoea in adults. **Contraindications:** Hypersensitivity to ingredients; allergic-type reactions to sulphonamides; concomitant use with other NSAIDs; aspirin/NSAID sensitive asthma; urticarial/allergic reactions to aspirin or NSAIDs; peri-operatively in CABG surgery; unstable/significant established IHD, PAD or cerebrovascular disease; active peptic ulceration; GI bleeding; estimated creatinine clearance <30 mL/min, CHF; severe hepatic impairment. **Precautions:** known CV disease or risk factors; history of atherosclerotic CV disease; history of GI ulcer disease or bleeding; renal disease; asthma; IBD; fluid retention & oedema; hypertension; heart failure; pregnancy & lactation; children <18 years; concomitant use with ACE inhibitors or angiotensin receptor antagonists & thiazide diuretics. Discontinue at first appearance of skin rash, mucosal lesions or any sign of hypersensitivity. See full PI for details. **Adverse Effects:** More common: dyspepsia, diarrhoea, abdominal pain, nausea, headache, sinusitis, URTI, dizziness, vomiting, hypertension. See full PI for details. **Dosage and Administration:** Use lowest effective dose for shortest duration possible. Review long-term patients regularly. **OA & AS:** 200 mg daily or in divided doses. **RA:** 200 mg daily in two divided doses; up to 400 mg daily short term only. **Primary dysmenorrhoea** (maximum 5 days): Day 1: 400 mg daily or 200 mg bid. Day 2 onwards: 200 mg daily. Additional 200 mg dose may be taken on any day if required. See full PI for details. Based on TGA approved PI of 18 March 2008 and last amended on 09 September 2009. **PBS Dispensed Price:** \$32.31 (100 mg x 60, 200 mg x 30). **Reference:** 1. CELEBREX Approved Product Information. Pfizer Australia Pty Ltd, ABN 50 008 422 348. 38-42 Wharf Road, West Ryde, NSW 2114. [www.pfizer.com.au](http://www.pfizer.com.au). Pfizer Medical Information: 1800 675 229. CELEBREX<sup>®</sup> is a registered trademark of Pharmacia. Pharmacia is a wholly-owned subsidiary of Pfizer Inc. 04/10 H&T PPU0393/DJ.



PAUL3

# Message from the Corps RSM RAAMC

## WO1 Angel de Santa-ana



It is with pride that I officially acknowledge the contributions of the following members from the RAAMC:

WO1	G. Alterarotor	37 years
WO2	P. Bacon	30 years
LT	W. Kessell	28 years
WO1	S. Keogh.	27 years
WO2	A. Nicholuson	24 years
CAPT	T. Hayden	23 years

All of the above men have discharged from the ARA since our last publication. These men have had a distinguished career with in the RAAMC and their professionalism and dedication are a prime example of *esprit de corps*. I wish them and their families well in future.

The RAAMC Key Ring membership is going from strength to strength last years membership of 88 has now grown to 151. A list of contributing members can be found at the rear of the magazine with their designated Key Ring number. The winners for this years Key Ring draw were:

1st prize	WO2	R. Atwell	3 CSSB	\$250.00
2nd prize	LT	A. O'Shea	1 CSSB	\$150.00
3rd prize	PTE	J. Gummow	RBMC	\$100.00

I would encourage all members of the RAAMC to contribute to Corps Funds. Information can be found on the Corps Website, which contains a user guide on how to make an allotment to the Corps funds.

The development of the new training continuum for medics continues with positive results. The first Advanced Medical Technician (AMT) course is now approaching the half way mark through their new training continuum which on completion students will be awarded a Certificate IV(Nursing) and registration as a Divisional Two Nurse with Medication Endorsement. What this means to Army is that as soon as the AMT successfully completes their course, 22 April 2011, they become a deployable asset for the Australian Army.

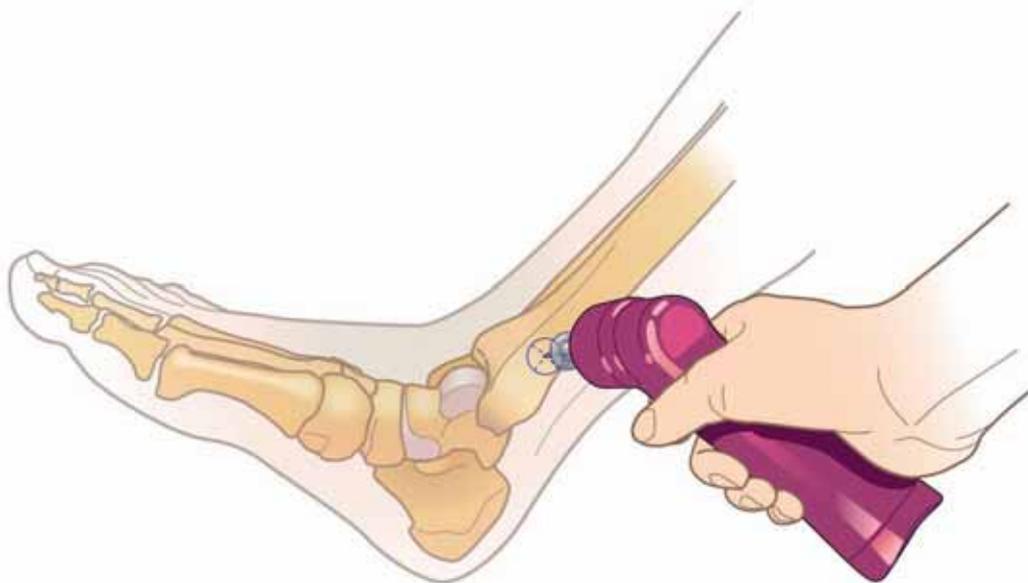
The Corps continues to serve with distinction in order to achieve its primary role of conservation of manpower. It is through their dedication and professionalism that they continue to render health care of the highest standard both on Operations and in Australia. As the Corps RSM I commend you for your professionalism and good soldiering for the future.

PAULATIM

# Some patients **don't have time** to wait for a central line!



When you're fighting for life minutes are too long!  
Get intraosseous access in ten seconds!



vidacare®

For further information, please contact your local  
**Mayo Healthcare Sales Representative**  
or call our **National Customer Service** on 1300 360 226  
or visit our website at [www.mayohealthcare.com.au](http://www.mayohealthcare.com.au)

# Message from the Corps Representative Honorary Colonel — COL John Taske



Allow me to introduce myself. My name is John Taske and I am your Representative Honorary Colonel. To me, it is both an honour and a privilege to have been asked to fill this position. My army career started in 1959 when I was called up for National Service with the Infantry. I stayed in the Reserve Forces (Inf) for six years, working my way up through the non-commissioned ranks to Lieutenant and then, in 1966, transferred to Medical Corps in order to go to Vietnam as a Regimental Medical Officer. In Vietnam, I served with the 5th Battalion and 6th Battalion RAR and the 1st Field Regiment RAA. My regular army career spanned 16 years, including three years in the SAS Regiment. I attended Joint Services Staff College in 1977 and then took up my final posting as Commander Field Force Medical Services from 1978 to 1981. I resigned to take up a career in the specialty of Anaesthesia and Intensive Care.

The title and role of Representative Honorary Colonel / Colonel Commandant of a Corps, is not widely understood. It is an honorary or ceremonial title and the appointment is made by the Chief of Army on the recommendation of the Head of Corps. It is usually conferred upon a retired senior officer of that Corps. An Honorary Colonel's rank can range from Lt Colonel to General. In my case, I wear the rank of Colonel, my rank on retirement from the Army. The position does not carry any executive military powers. The main function of this traditional military position is to act as an advocate for the members of the Corps (In my case all members, past and presently serving in the RAAMC) and to advise the Head of Corps on relevant policy matters.

'Elder Statesman' is the term used by the Engineer Corps to describe their Colonel Commandant and they also emphasize the position to be a "valuable source of advice and counsel for all ranks" and providing a link between serving and former members of the Corps".

I too wish to emphasize this part of my role as Representative Honorary Colonel. I am your Advocate and I hope to meet as many of you as possible whilst I fill this position and to hear about what you are doing, what your aspirations are for the future and any thoughts or ideas you may have on how things that you do every day may be improved. If you see me around, I would like you to come up and talk to me. I too was a 'baggy arse' once and really enjoy hearing what young soldiers are up to these days.

PAULATIM



# Advancing Medication Management Everywhere.

- Reliable
- Versatile
- Flight Approved



Hospira Pty Ltd, ABN 13 107 058 328  
Level 3/390 St Kilda Road Melbourne Vic 3004 Australia  
Tel: +61 3 9868 0170 [www.hospira.com.au](http://www.hospira.com.au)

100903GEM



# Health Branch HQ Forces Command A Year in Review

It has been a privilege working with a very busy and dedicated team of health professionals posted to Health Branch HQ Forces Command over the past 12 months. The support Army Health has received from the Command and staff of Forces Command has enabled us to truly realise three key initiatives: The Army Combat Health Restructure, the roll-out of Exercise Primary Survey series of Health - Mission Specific Training and the initial planning for the role out of the Comprehensive Soldier Fitness program which we hope to profile next year.

The Forces Command Health Team comprises of: Col Charles New (Reserve), LTCOL Paul Rogers, LTCOL David Collins, LTCOL Brian Johnston, LTCOL Julie Finucane (Reserve) LTCOL Rod Pedersen (Reserve) MAJ Mick Kent, MAJ Paul Morgan, MAJ Sean Kennaway, MAJ GreG Brown (Reserve), CAPT Carol Waldeck, The mighty WO1 Team of Liz Matthews, Tania Harmer, Clay Baker and Lyn Daly and our administrative support Officer – Hanna Al-Dainy.

## ARMY HEALTH SUPPORT FORCE MODERNISATION

*From the on-set the notion of challenging the traditional paradigm of Army health structures was going to be a tough call. However, three years of analysis, review, discussion, argument and finally logic identified that challenging the organisation to accept that a change to those traditional structures was the only way forward was finally agreed upon.*

The challenge of recruiting and retaining qualified health personnel, the demanding training regime, cost of medical equipment and clinical governance requirements of a deployable health capability now confronts the Army. The recognition of the Land Based Trauma System (LBTS) within the ADF Combat Health Operating System (CHOS) enables Army to rebalance its combat health to optimise its deployable effect and redress employment structures issues. The size and mix of the capabilities to be delivered to support the LBTS under the auspices of the Combat Health Support (CHS) structure has been at the forefront of considerations for Army health over the last three years. The integration of the Full Time and Part Time health workforce was part of the analysis and is articulated in the detail of the CHS structures.

**Land Based Trauma System.** Army health units now and into the future will be required to conduct a multitude of tasks within a joint taskforce setting, at short-notice, across the full spectrum of conflict. The progress in design and subsequent introduction of various weapon

systems has changed the nature and mechanism of injury; therefore, health effect (personnel, medical equipment and training) will need to be adaptive and responsive. The LBTS seeks to deliver this requirement by providing a modular and scaled force, trained and equipped for this need. The system focuses on providing quality, timely care from the most forward deployed elements of the force through to the rapid response, evacuation and stabilisation of casualties across the entire battle space.

This system has been developed based upon the 10 minute – 60 minute – 2 hour metric.<sup>1</sup> This system is based on the guiding principles of proximity and responsiveness and applied to land based operations.

The LBTS will introduce the following capability to Army CHS for Land based operations as follows:

- a. a structure capable of delivering a robust CHS effect further forward on the battlefield;
- b. establishment of new Shock Trauma and Aero-Medical Evacuation capabilities;
- c. a structure that addresses current clinical capability gaps in CHS, such as the void of asset in 7 Bde;
- d. a centralised CHS structure that facilitates better coordination of support to meet Army RTS, MST and CHS requirements;
- e. an enhanced structure to maximise the 'high end' ARES health professional integration into Army health structures;
- f. improved operational mental health training;
- g. the establishment of the Combat Health Training Team (CHTT) that bridges the gap between extant individual training establishments and those required to support foundation warfighting and MST;
- h. establishment of structures to support significant CA initiatives related to Welfare Boards and management and rehabilitation of ill and injured personnel; and
- i. establishment of Aviation Medicine airworthiness health advice to COMD FORCOMD.
- j. **Force Health Protection System.** The Land Based Health Protection System (LBHPS) has two sub-systems:
  - i. **The Primary Health Care System (PHCS)** provides primary care to NSA standards where possible. PHCS facilities including

physiotherapy conditioning and reconditioning but have limited 'low dependency holding capacity for minor injury, sick and mental health cases. This sub-system is also the primary provider of Operational Mental Health Support.

- ii. **The Occupational and Environmental Health System (OEHS)** identifies, assesses and mitigates environmental and occupational health threats. Hazard Assessment Teams (HAT) can conduct an extended range of surveys. HAT deploy with all larger JTF or where the health estimate has identified significant (or unknown) environmental risks. The HAT will form part of the JTFs ISTAR and CBRN defence capabilities, and will be trained for this role.

## CHS G2 CONCEPT and CHS STRUCTURE

The CHS restructure is designed to address the lack of capacity which exists within Army health by brigading the limited health assets available to permit the maximum degree of flexibility. Therefore all of Army's deployable combat Health capability will be transferred to under full command of 17 CSS Bde based on the following unit constructs:

**1 CHSB.** 1 CHSB (formerly 1 Health Support Battalion) consists of integral and close health support personnel centralised under Close Health Support Companies (CHSC) in Robertson, Lavarack and Gallipoli Barracks. HQ 1 CHSB is to initially remain in Holsworthy with the intention of relocating it to Gallipoli Barracks by 2020. The key capabilities provided by 1 CHSB are as follows:

- a. Medical Technicians (MT) down to platoon level for each RAINF line unit IAW Inf 2012 structures as well as additional MT for non-manoeuvre units,
- b. deployable close health platoons capable of providing integral health support for up to three BG capable of augmentation by other deployable health capabilities such as Shock Trauma, EH, Psych, diagnostics, AME, rehabilitation and surgical;
- c. a new Aero-Medical Evacuation (AME) capability comprising four AME teams;
- d. rebalanced surface evacuation capability to allow Role 1 to Role 2 health unit patient transfer;
- e. centralised management of combat health support within RTS and augmentation of GHS as endorsed under RLA Transition Plans with JHC; and
- f. centralised management of PTI in Darwin, Adelaide, Townsville and Brisbane to provide regional physical conditioning and rehabilitation, and support to soldier rehabilitation units.

**2 GHSB.** General health support currently residing in 1 and 2 Health Support Battalion (HSB) will be amalgamated into 2 GHSB and located

at Gallipoli Barracks. 2 GHSB will be a fully integrated (ARA and ARES) hospital that will centralise the niche capabilities currently resident in the HSB and CSSB Health Coy such as Dental, Environmental Health (EH), Imaging, Pathology and Physiotherapy. Its role, tasks and structure is included at annex B. The key capabilities provided by 2 GHSB are as follows:

- a. Two surgical coy will provide the principle deployable clinical capability. These will be independently deployable entities capable of forming a discreet small 'hospital'.
- b. Surgical Coy will be based upon complete departments which mirror clinical services in a hospital able to manage complex trauma cases as well as routine sick and non-surgical medical cases.
- c. Surgical Coy will be capable of two site operations able to provide simultaneously a Role 2 Enhanced (R2E) and a Role 2 Light Manoeuvre (R2LM) surgical capability for short durations.
- d. A Shock Trauma (ST) PI will be capable of deploying forward in direct support of CHS PI to provide advanced non-surgical resuscitation capability.
- e. The Army centre of excellence for dental, pathology, and imaging will be retained within 2 GHSB in Enoggera.
- f. Army's EH assets will be centralised into three PI and a Hazard Assessment Team under the EH Coy.
- g. The Dental PI will retain Army's deployable dental capability able to provide up to five teams.

**3 HTRB.** 3 HTRB (formerly 3 HSB) will retain its HQ in Adelaide to provide command, control and management of ARES health specialists that are vital to Army's deployable Health capability. It will be predominantly ARES and has been ring-fenced under the ARES AFF. 3 HTRB will retain a company HQ in Adelaide and Melbourne, and establish a new company HQ in Sydney. Its role, tasks and structure is included at annex B. The key capabilities provided by 3 HTRB are as follows:

- a. recruitment, development and nurturing of 'high end' ARES health professionals capable of augmenting other deployable health capabilities (ST / EH / Psych / Diagnostics / AME / Rehab / and surgical capabilities for the CHSB and GHSB) to provide an enhanced combat health effect;
- b. expanded regional presence in order to attract and retain ARES health professionals; and
- c. lead 'high end' clinical health MST for Army.

**1 Psych Unit.** All deployable Army psychology teams will revert to a centralised construct under 1 Psych Unit within 17 CSS Bde. 1 Psych Unit will be a fully integrated (ARA and ARES) unit with its teams remaining geographically decentralised in their current locations. The key capabilities provided by 1 Psych Unit are as follows:

- a. rebalanced deployable AAPsych capability to allow the optimal task-specific Psychology Support Teams (PsST) through augmentation of CHSB and GHSB;
- b. centralised management of all operational mental health capability within RTS and augmentation of the GHS Mental Health and Psychology Sections as endorsed under RLA with JHC;
- c. dedicated specialist capability development and operational analysis; and
- d. standardisation of MST for all deployable PsST.

**Garrison Health Support.** The CHS restructure will facilitate the GHS transition and enable JHC to deliver comprehensive GHS. This will incorporate augmentation through the RTS cycles, maintenance of habitual relationships between close health elements and bde elements they predominately support, enable the establishment of Army clinical governance regimes of GHS models of care, enable the establishment of bde level welfare boards/injured personnel management cells and support soldier rehabilitation and transition.

**ARES Combat Health Capability.** The ARES is a key Combat Health enabler and integrated into a number of the CHS structures to provide a whole of force package. The 3 HTRB will manage the personnel that generate the 'high end' clinical ARES capability for the Army. The development of the ARES health capability (outside 3 HTRB) will be informed by the ARA CHS implementation, outcome of the Health ECR (particularly the Combat Medical Attendant) and the ARES AFF. This will shape the future structure of ARES capability currently resident within 2 Div.

*I need to acknowledge the work of a small team of key staff if it were not for their vision, commitment and stamina over the past four years the Combat Health Restructure would still be a pipe dream: MAJ Caitlin Langford, LTCOL Ian Marsh, LTCOL Fred Parker, LTCOL Andy Williams, LTCOL Richard Mallet, LTCOL Stan Papastamatis, MAJ Liz Barnette, MAJ Blue Reidy, MAJ Phil Butt, MAJ Nathan Fraser, MAJ Lee Melberzs, WO1 Tony McKindlay, WO1 Michael Clarke and LAST but not LEAST two officers who should be made honorary members of the Army Health Service : LTCOL Paul Rogers (RACT) and LTCOL Michelle Miller (RACT).*

## HEALTH TRAINING — MISSION SPECIFIC TRAINING

Health Training Continuum. The effective generation of the LBTS requires adherence to detailed and prescriptive clinical training regimes within the foundation warfighting and mission specific training programs. Given the complexity and sophistication of this training a significant portion of this will be undertaken via strategic alliance programs with state and federal health facilities. However, the key to readiness of the Health Force is Health Mission Specific Training as demonstrated via the Primary Survey series of training and the

programs run at 3 HSB in Adelaide. Currently, this training is run by HQ Forces Command staff supported by KEEN AND DEDICATED GROUP OF Army Reserve instructors, Army Reserve specialist medical advisors and partnering with industry — Cubic Australia and Care Flight. The MST Team comprising of: COL Charles New, MAJ Greg Brown, MAJ Sean Kennaway, MAJ Tania Rogerson, WO1 Liz Matthews and a trusted team of support staff have delivered first rate quality training to the deploying Bdes for the past two years. Most recently we have been very excited about the integration of Battle Smart into the program. By 2012 the mantel for this training will be passed to ALTC.

**Army School of Health (ASH).** ASH will be central in meeting Adaptive Army's intent by ensuring the delivery of timely and operationally relevant training. The establishment of a Combat Health Training Team within ASH reflects its expanded role in delivering and coordinating foundation warfighting and close health MST.

The on-going development of health specific foundation warfighting skills is fundamental to success on operations and will be embedded in the health training continuum that covers All Corps Soldier training and relevant employment category continuum. This training will be delivered under the Army Training Continuum (ATC) construct that will see the "school" extended through the establishment of the 3 HTRB. The training continuum will demonstrate effective use of Technical Control from within FORCOMD that extends from AHQ through Functional Commands, through the Training Authority (TA) at the school and culminate with delivery by the unit, in this instance 3 HTRB.

### Combat Health Training Team Concept of Operations

**Mission:** The CHTT is to conduct Combat Health Foundation Warfighting and coordinate selected Medical Mission Specific Training as directed by CO ASH and under the technical control of the Command Health Officer FORCOMD IOT prepare individual and collective Army Force Elements for 'A War' and mission rehearsal conducted by LCRC on behalf of 1 Div for 'The War'.

**Execution:** The role of the CHTT is to deliver up to Army Training Level 2 individual combat health foundation warfighting training at ALTC and selected BDE locations, and coordinate collective medical mission specific training up to Army Training level 3 at Army Training Standard A utilising blended ARA, ARES and contracted support .

Special Acknowledgement must be made of MAJ Blue Reidy, WO1 Liz Matthews, WO1 Stu Robertson, LTCOL Barney Flint, SHO 17 CSS Bde designate and LTCOL Stan Papastanatis CO 3 HSB for their outstanding contributions to the early development of this training.

A snap shot of MST in profile is detailed on the following pages.

*By: COL Georgeina Whelan AM CSC*

## References

1. Bellamy R.F. "The Cause of Death in Conventional Land Warfare: Implications for Casualty Care Research" *Mil Med.* 1084; 149:55-62

# **One reason why you should talk to your doctor before you travel**

**Because a trip overseas could expose you to any number of diseases. Like Hep B.**

**There are many ways you can catch Hep B. Tattoos, injecting drug use, unprotected sex... or a simple accident.**

**You could just B travelling to a destination with a higher prevalence of Hep B than others.<sup>1</sup> You could B travelling to a country where a seemingly simple cut or accident requiring medical treatment might be all it takes to put you at risk of exposure to Hep B.<sup>2</sup>**

**So B sure before you travel. Ask your doctor about Hep B vaccination and other travel related diseases – ideally 6–8 weeks before you go.**

**Talk to your doctor today and for more information visit**

**B** [SureBeforeYouTravel.com.au](http://SureBeforeYouTravel.com.au)

# 1 HSB responding to an adaptive army and 110 year Army history

1 HSB was formed on 01 Apr 1968 during the Vietnam War. 1 HSB has a distinguished history of supporting the ADF at a tactical level and supporting the Government at a strategic level through humanitarian assistance. The unit has and will continue to provide small, rapidly deployable health teams to support the community locally, nationally and internationally.



*1 HSB at amongst the sand dunes of Vung Tau, South Vietnam 1967.*

The health restructure is ensuring a more efficient and effective use of health capability. The health restructure will change the focus of 1 HSB from large scale hospital operations to tasked focused groups able to support the future land operating concept (FLOC) combat teams.

1 HSB's involvement in the Operation Sumarta Assist, Padang Assist, Vic Fire Assist and ACAP highlights the ability of task oriented health teams to provide population support and indigenous capacity building to support a whole of government approach.



*LT Watson during Operation Padang.*

*1 HSB in Rwanda.*



*CPL Kumar during ACAP 2009.*

1 HSB's focus will remain on supporting the joint land combat capability. Regional Coys will continue to support the fighting elements within each geographical locality. By implementing internal workplace reform and through better civilian and military relationships 1 HSB will offer a high standard of care. Strategic alliances with local medical facilities and the effective use of the ARES capability are ensuring clinical skills are continuing to develop. The centralisation of medical assets in each BDE location will ensure all medical personnel will, through these alliances, become masters of their professions.

1 HSB will remain at the forefront of providing small medical elements at short notice to support all military and government and will have the ability to sustain support to longer term operations. 1 HSB a 99% survival rate during the Vietnam War and will endeavour to carry this legacy well into the 21st century.

*By: CAPT Karla Strong*

# Medical Developments – the leaders in oxygen delivery systems



[www.medicaldev.com](http://www.medicaldev.com)

Medical  
Developments  
International

Manufacturers of:

**Penthrox®**  
methoxyflurane  
PAIN ■■■■■→ RELIEF

PAUL-3

## Point-of-care CR

Complete solutions for your digital imaging needs in the field

Versatility      Productivity      Performance

With over 400 military installations worldwide our Point-of-Care range suits extreme working conditions, requiring no air ventilation.

These robust CR systems are lightweight and compact for efficient deployment, easy transportation and set up.

Visit [www.carestreamhealth.com/cr-solutions](http://www.carestreamhealth.com/cr-solutions) for more information or call 1300 651 786



*Some of the accessories shown are not part of the standard equipment supplied.*

**Carestream** HEALTH

The innovation powering **Kodak** health products

PAUL-3

# 1 HSB – Paulatim 2010



## CO's Intro

Since the last issue of Paulatim, 1 HSB has continued to maintain a high tempo of activity. This has ranged from deployment on OP PADANG ASSIST, practically the day after we came online, through to a broad range of support tasks and participation in exercises. The following few stories from unit members give a glimpse of these activities.

I've been honoured to have had the privilege of commanding 1 HSB in 2009 and 2010, and also for the opportunity to work with such a fantastic team of people. I wish you all well for the future.

I hand over command to LTCOL Ian Marsh. I wish him, and those remaining at 1 HSB, all the best as they lean forward into the challenges of the future Combat Health Force.

*By: LTCOL Lachlan Sinclair  
Commanding Officer*

## Operation Padang Assist 2009:

On the 3 October, 2009, The 1st Health Support Battalion (1HSB) was tasked as part of a Whole of Government effort, to provide health support to the people of Sungai Gerringing, a small village approximately 80km north of Padang, Indonesia. This was in response to damage caused by a catastrophic earthquake on the island of West Sumatra. As much of the local infrastructure remained 1 HSB provided a Primary Health Care Team, Resuscitation capability, 2 bed Medium dependency unit and environmental health support. Together, these capabilities were named the '1st Health Support Element' (1HSE).

In the village of Sungai Gerringing the health clinic, known as 'Puskesmas' had been severely damaged by the earthquake. 1HSE provided healthcare to the villagers whilst an engineer team from 1 Combat Engineer Regiment constructed a temporary clinic building. To avoid creating dependency, 1HSE provided a healthcare clinic which mirrored the original service offered by the Puskesmas, in so far as the opening hours were the same and the level of treatment offered was similar. The location of 1HSE was a football pitch in the centre of the village, which created its own challenges during the monsoon weather, especially in terms of water drainage and the hot and humid climate.

The presentations cared for by 1HSE ranged from acute injuries secondary to the earthquake to complex pre-existing chronic health



conditions. The earthquake injuries were largely musculoskeletal in nature including wounds, fractures and infections. As the deployment progressed, less and less earthquake related cases were seen and patients presented with longstanding conditions. 1328 patients were treated over the four week deployment, with 146 of these patients seen by an outreach team that was deployed into the more isolated areas. The operation gave all members exposure to deployed health care and was an incredible opportunity to expand clinical assessment skills and clinical knowledge, which all members relished.

*By: CAPT Brad Hulls and CAPT Jane Currie*

## 2 PI Clinical Coy

Headed up by LT Caroline Brett and SGT Jean-Noel Chung, 2010 has been a productive year for 2 PI. We have sent 9 members on their AMAC as part of career progression as well as PTE Danny Davey on JLC. The remaining platoon members have been involved in supporting various field activities and courses such as Combat First Aid and Care of the Battle Casualty, making for a busy year thus far.

Attachments: CPL Chenks (Longlook)  
 Detachments: CPL Peta Siggers (Longlook)  
 CPL Chris Tyrrell (Running Black-Ops over west)  
 CPL Angela Dare (Swanning it throughout Europe)

Additionally, the Clinical Company training team magicians (consisting of LT Victoria Edwards and SGT Leona Doherty), have established a robust Strategic Alliance program to greatly enhance the clinical exposure and focus for the company. From clinical training, provided by SME's and external presenters, to placements within a vast range of locations encompassing Concord Burns Unit, Liverpool Hospital ED and ICU, Holsworthy RAP's (2 CDO Regt, 3 RAR, 6 AAVN Regt and 1 HSB) as well as the recent addition of NSW Ambulance placements have been organised by the training team to enhance the skills and knowledge of the Platoon and Company as a whole.

Vampire Flight 4 has been the major activity that has been conducted for the year to date. It consisted of rolling out a Level 3 facility to Marangaroo Training Area (Lithgow) into a location expertly sited to maximise our exposure to copious amounts of mud, rain and cold weather as well as test the resolve and morale within the unit. Surprisingly the 16 weather haven tents maintained an acceptable level of water resistance throughout the activity. Highlights for the activity included walking around in mud, interesting scenarios in the mud, standing upright in mud, doing piquets in mud and mopping up mud that had been tracked into the facility. We also went up in Blackhawks for a day to escape the mud.

Special mention goes out to the Sallyman who worked tirelessly to supply the much needed caffeine, biscuits and pikelets required by the troops to survive the ordeal – even emerging from the mud at 3am to bring a little piece of liquid joy to all on a daily basis.

## Initial Resus Team – Kapyong Warrior

Exercise KAPYONG WARRIOR is an annual exercise to mount and insert, via parachute, an Airborne Combat Team. The Airborne Combat Team consists of a normal light Infantry Company from 3 RAR, with its artillery, signals and logistic attachments. The exercise begins with a parachute insertion into a training area, traditionally Singleton, followed by progressive training from blank fire and culminating in a company live fire attack, supported by artillery and Close Air Support (CAS).

The Initial Resus Team deployed to the Singleton Military Area on the 10 August 2010 using the large weather-haven tent system. The team consisted of CAPT Dave Heslop (MO), CAPT Roneel Chandra, CPL Regan Bryce (AMAC), LCPL Corey Hill (AMAC) and PTE John Milnes (BMAC). The IRT arrived 12 hours prior P Hour, the capability was setup and operational within 2 hours. The Combat Team and IRT received 7 casualties (6 x Priority 3 and 1 x Priority 1) the majority of the injuries consisted of lower limb injuries. The Priority 1 patient (who had sustained spinal injuries) was retrieved from the drop zone and stabilized at the IRT. Civilian emergency services were notified and subsequently a NSW Ambulance helicopter was launched from



Bankstown airport. The helicopter met with the Evacuation crew at Singleton range control for patient transfer to John Hunter trauma centre.

Once all the sorties were complete and all patients transferred to appropriate medical facilities, the IRT was packed loaded for the return trip home. In true IRT fashion the entire task was complete within 24 hours.

*By: CAPT Roneel Chandra*

## From scrubs to DPCU: the transition of entry nursing officers to the military

We marched into 1st Health Support Battalion in Jan 2010. Having trained as registered nurses and completed two years postgraduate, entering into our first posting was a steep and exciting learning curve, both as clinicians and as soldiers. It was the search of something more challenging and rewarding that brought the three of us to choose a nursing career in the Army. Although we all had very different backgrounds with varying levels of past military experience, the freedom to travel, be involved in specialised courses and nurse in the great outdoors were a few of the attractions that made military practice more appealing than our civilian nursing prospects.

The year began with an introduction to the 1st Health Support Battalion (1HSB) where we were placed in a Nursing Platoon and began functioning as Nursing Officers. Initially our day to day routine involved clinical training, equipment familiarisation, military training, and involvement with the clinical capabilities, in particular the clinical governance committee.

In April we completed our SSO course in Duntroon, Canberra. The course provided a fantastic opportunity to meet and network with fellow officers, especially the other health professionals on the course. After completing five weeks at the Royal Military College and returning to 1HSB we were straight into the swing of preparations for exercise Vampire Flight IV (VFIV). Sixteen weather havens were erected to contain the capabilities and deployed personnel. Headquarters, Resus, IRT, PHCT, OT, ICU, MDU and LDU, as well as pathology, x-ray and environmental health made these watertight tents their home for a week. The exercise involved caring for simulated casualties, who presented with injuries consistent with those often received from an earthquake. At close of exercise, the total number of "patients" treated was 84 but more importantly was the first opportunity to work in and with our clinical capabilities and the weather haven tent system.

All in all, the exercise was a success and was thoroughly enjoyed by all. The three of us would like to take this opportunity to thank all who were involved in the VFIV exercise and everyone at 1HSB for making

our transition to the unit a welcome one. We can only hope that all future exercises and operations in our nursing careers run as well as this one. LT Cooper Brady, LT Matthew Hillan and LT Emma Philpott.

## Pathology Section 1 HSB

2010 saw the posting of two new laboratory technicians who have recently graduated from the Associate Degree program in Medical Laboratory Science at RMIT. Both experienced Medical Technicians integrated well into the laboratory environment.

The section continues to operate its Base Hospital laboratory to its dependencies in the Liverpool Military Area. The operation of the base lab not only provides an efficient service, it is also an excellent training facility for laboratory personnel and for medics who have expressed an interest to transfer into Pathology.

With the section's deployable laboratories, extensive work during Exercise Vampire Flight helped to configure the operational component using the Weatherhaven to transition from Level 3 Combat Health Support to the new Role 2 construct.

## Army's X Ray Vision

In 2010, LT Busch, LT Levesque, and LT Vipond have been given the opportunity to not only keep up to date with the public hospital system at Blacktown Hospital, but to increase their clinical skills by working in the various medical imaging departments. Twice per week at Blacktown Hospital our staff have supported emergency, theatre, fracture clinics, fluoroscopy, ICU and mobile rounds.

The Radiographers are very fortunate to work closely with CAPT Nol, a Reserve Radiographer and Chief Radiographer at Blacktown hospital. Training has included CT Course and the ability to have the first qualified ARA Sonographer (mid 2010). This civilian working liaison is visioned to continue with the new health restructure.

*By: LT Georgia Vipond  
Radiographic Officer, Medical Imaging Team*

## Welcome to the Next Generation of Point of Care Testing

**epoc**  
BLOOD ANALYSIS

- Fast lab quality bedside results
- Wireless communication to LIS/HIS
- A panel of critical care tests, on a single test card
- The cost effective point of care solution
- Room temperature storage



epoc<sup>®</sup> BGEM test card panel  
Measured analytes: pH, PCO<sub>2</sub>, PO<sub>2</sub>, Na, K, iCa, Glu, Hct, Lactate  
Calculated values: HCO<sub>3</sub>, TCO<sub>2</sub>, Base Excess, sO<sub>2</sub>, Hb



Learn more at [www.epocal.com](http://www.epocal.com)



Alere Australia Pty Ltd, 532 Seventeen Mile Rocks Rd,  
Sinnamon Park, QLD 4073, Australia  
Office: +61 7 3363 7100  
Fax: +61 7 3363 7199  
Email: [au.enquiries@alere.com](mailto:au.enquiries@alere.com)

© 2010 Alere. All rights reserved.  
epoc is a registered trademark of Epocal, Inc.

PR0587

PAUL3

# Physiotherapists in the Military

There is a myth that's been circulating since the rise of the health care industry that cannot be sugar coated: *'Physiotherapists are devils in disguise'*.

Every person has overheard a vicious rumour or seen these fit elite athletes (likened to PTIs) without the red and white attire, and avoid them like a deadly plague. It's only when an injury occurs that the MO dictates the need for a physio session... that is when the 'psychological' trauma sets in.

The designated appointment rapidly approaches, your palms begin to sweat and little thoughts begin racing around and mingling with your everyday actions. After what seems like eternity, the physiotherapist approaches you to begin the session. Rapid and precise Q & A relating to the nature and history of the injury leave a misguided sense of security, but the myth quickly returns. Next, you are observed and recorded, muscle length and strength testing, joint range of movement and restriction analysis.

Instantly the physiotherapist identifies the origin of pain, applying precise pressure to the area, waiting for you to yelp with validation. Moving quickly to strike, the devil in disguise commences a variety of treatment techniques ranging between joint mobilisation, bio-mechanical education, stretching and, ignoring comfort for remedy, massage. As the session ends, you are then provided with a home exercise program and another appointment with this so called 'devil'.

## *'Physiotherapists are devils in disguise'*

Contrary to favoured belief, physiotherapists are more than pain inflictors. The most important component of physiotherapy is self management. While we can dig into those sore, tight muscles and give them a work over, or mobilise stiff joints, it is really up to the individual to comply with the home exercise program which may include stretches, strengthening exercise and sometimes all the body needs is some rest!

At 1HSB there are presently four Military and five Civilian physios, offering varied degrees of experience, from University graduate to 20 years, including several with masters degrees. Hydrotherapy and core exercise classes have regular attendance on alternate mornings and with constant referrals between physio and PTIs, rehabilitation programs are well tailored to individuals. We have two physios on deployment and we Exercised during Talisman Sabre in 2009.

Remember, next time you get a referral from the MO and your palms start sweating, physiotherapy is not all about the massages... and we are not always the devil, as physiotherapy does come to an end.

*By: LT Caitlin Scott, Physiotherapist at 1HSB*

**ambIT®**  
AMBULATORY INFUSION THERAPY

Use the best in pain control to care for your nation's bravest.

Tested and proven on the battlefield and in air evacuation, the ambIT® Infusion Pump provides the best solution for versatility, safety and accuracy in pain control.

Distributed in Australia by Allied Medical.  
Email: [info@alliedmedical.com.au](mailto:info@alliedmedical.com.au) Tel: +61 8 9266 0190  
Contact us today to learn more about the ambIT®

PAUL-3

**WATERJEL**  
TECHNOLOGIES

For relief of painful burns, WATERJEL's got you covered.

Burn dressings that immediately cool the skin and relieve the pain.

Also in blankets, kits and burns stations.

Cool the BURN

Not the PATIENT

**BOSCO** Distributed by: Bosco Medical Australia Pty Ltd  
MEDICAL AUSTRALIA Toll Free Phone: 1800 026 726 [www.boscomed.com.au](http://www.boscomed.com.au)

PAUL-3

# 2 CAV REGT RAP 2010

2 CAV RAP has not had much time to write into Paulatim over the last couple of years due to the busy tempo of the Unit. I think the last submission was in 2007. Since then, the Unit and its medics have been on constant deployment to all theatres of war in the MEAO and exercises across Australia.

2010 started with a rush. Three new med techs were posted to the Regiment; CPL Michelle Wallace, the first ever female posted to the RAP, CPL Matthew Gale from Oakey and LCPL Daniel Maxfield from the bowels of 2 HSB. Continuing their tour from last year were CPL Brent Farrell and his umbilical brother CPL Kevin Sturman, CAPT Oscar Aldridge the RMO, Mrs Sue Jamieson the CHP and old Weiry as the SGT. CPL Troy Harvey transferred to the land of choccos to join CPL John Halpin in the land of tax free dollars.

The Regiment was down a couple of ambulances due to MRTF increasing their 2/14 handed over another LAV around April (THANKS FOR EVERYTHING MEDICAL BEING IN DATE GUYS). RCB90 kicked off with Michelle deploying as the medic. A SQN enjoyed her cross-trade skills of preventative medicine in latrine construction and reminding the boys that ladies of the night in Malaysia are not always 'ladies'.

Galey completed his SUBJ 1 SGT and moved into the B SQN medic position, spending most of his time either out in the field or fishing in the harbour.

Maxy completed his JLC and was promoted to full Corporal. Although his Troop Sergeant has recommended that he go CAV, he believes his way of life is that of the Infanteer and is looking to Corps transfer.

Brenno and Kev attended Primary Survey 1 and trained with their respective battle groups, making sure their 'juice' intake was kept up at all times. Both have done exceptionally well over the past two years and have earned their deployments.

The Doc was here, there, everywhere...even managing a trip to New York somehow. A very good doctor with exceptional trauma skills and very well trained in making his Sergeant and Corporals a brew without being asked.



The RAP as a whole (and in fact the entire Support Squadron) did not deploy once this year due to the training program being more focused on the deploying forces. Sue kept up her high standard of clinical care and surrogate mother skills. Her knowledge of all the boys & girls in the Regiment is one of the RAP's most valuable assets and with her help all PM4's were 100% correct.

Lieutenant Bill Greer and Privates Danial Heslop & Blake Healy from Health Coy, 1 CSSB, were detached to the RAP to help facilitate the 5th Bn's left out of battle troops; a job very well done and appreciated.

By the time of Paulatim publication, 2 CAV RAP will most likely be 'HUBBED' to Robertson Barracks Medical Centre or in the process of doing so.

End of the year sees Weiry on the road to civilian life, Galey promoted and posted to 1 ARMD REGT, Brenno deployed to SECDET XVII, Big Kev deployed on MRTF2, Michelle & Maxy holding the fort at 2 CAV. The RMO is off to Afghanistan soon for a senior medical officer position. Good luck to all those deployed and keep safe!

Weiry would also like to take this opportunity to say thanks and goodbye to all the Corps members with whom he has worked over the last fifteen years. He will be starting the 10th Field Ambulance association in Tasmania.

By: Sergeant J.M.A. Weir

# Olgeta Warrior 2010 – 2 HSB Surgical PL

EX Olgeta Warrior (Ex OW 10) was the umbrella name for combined Australian and Papua New Guinea Defence Forces (ADF/PNGDF) exercises conducted in Australia and Papua New Guinea during the period June to September 2010. The exercises involved in Ex OW 10 were Ex WANTOK WARRIOR (Ex WW 10), a reciprocal infantry company exchange, Ex HELIGON LUK, a high density altitude rotary wing exercise, Ex PUK PUK, an engineer SQN deployment to assist in the development of PNGDF infrastructure and Ex LOGI TURA, which saw elements of the PNGDF deploy to Australia. The exercise linked ADF commitments to the PNGDF and sought to develop relations and operational capability between the two forces.

The base that accommodated us for the duration of our stay was Moem Barracks at Wewak in the East Sepik Province. The A and B Company soldiers from 2RPIR were kind enough to move out of their lines so that their barracks could become our homes for our short stay in Wewak. The people of PNG were very enthusiastic about our arrival and greeted us warmly.

After the initial acclimatisation to the heat and humidity, our next challenge was to get our containers (Tricons) in location. Once delivered at little late, the Weatherhaven® Controlled Environment Soft Shelters (CESS) took 4 hours to construct. The facility, consisting of 3 large and 4 small shelters with vestibules, contained Operating Theatre (OT), Central Sterilising and Supply Department (CSSD), Resuscitation (RESUS), Intensive Care Unit (ICU), Medium Dependency Unit (MDU), X-RAY and Pathology (PATH).

Whilst in PNG we were able to utilise all elements of the Surgical

Platoon (SP). We even had the first surgery to be conducted in this facility. Most days went by without any major injuries, but the hospital was constantly kept busy with minor injuries, lessons and scenarios. During Ex WW 10 some personnel participated in survival training and during Ex PUK PUK, we were able to assist the Engineers by repainting the front entrance and the gym of Moem Barracks. This was a wonderful opportunity to contribute to the exercise in a non-clinical role.

Our community work extended past construction duties to the assistance we were able to provide to the local hospital. The intent of our involvement was our ability to contribute man hours to the local hospital. Our surgeons assisted and participated in operating lists every Tuesday and Thursday which allowed our theatre team to support local registrars, as well as gain valuable experience themselves. Our Advanced Medical Technicians were able to work in the Accident & Emergency section of the local hospital on Monday, Wednesday, Friday and Saturday. This opportunity was invaluable and allowed our medical personnel to interact with local health professionals and share clinical and cultural experiences.

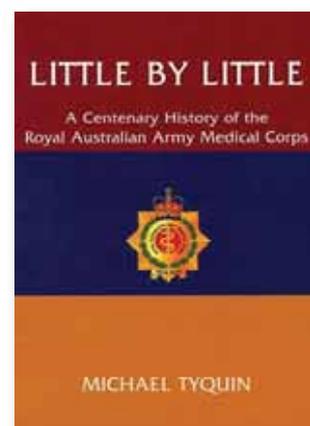
The exercise was extremely successful and allowed 2 HSB to do a complete shake out of the SP in a foreign country in a low threat environment. Ex Olgeta Warrior was worthwhile, not only for the experience gained by using the new facility, but also the wide expanse of knowledge the medical personnel absorbed relating to injuries and illnesses associated with a tropical third world country.

By: LT A. Smith

## History of the RAAMC

A detailed history of the RAAMC can be found in the book "Little by Little" the RAAMC Centenary.

This book can be purchased from the SO2 Corps for \$49.95 (cheque only).



# Close Health Support Company, 3 CSSB



## Introduction

Health Company has experienced a very high tempo and busy year within 3 Bde during 2010. Although this is no different to previous years, 2010 is and continues to be different due to the rollout of the Close Health Support Company (CHSC) Pilot. The Pilot was allocated to 3 Bde in late December 2009 and was subsequently sponsored by Health Company, 3 CSSB from 15 February 2010.

The CHSC Pilot seeks to establish the CHSC structure within 3 CSSB in order to establish the practices, procedures and conditions for the duplication of capability across FORCOMD. The Pilot also seeks to establish the preconditions necessary for the raising of the CHSC and the transition of the CHSC garrison capability to JHC (at a date TBA).

The main objectives of the 3 Bde Pilot are:

- a. Maintain deployable Role 1 (enhanced) capability for the RBG and maintain readiness for RCT/RBG commitments whilst attempting to raise a qualified Airborne Combat Team Resus capability in 2010;
- b. Centralisation and cross level of military health staff within 3 Bde less PTI and PSST elms (incl 10 FSB);
- c. Develop MOU which complies with Regional Level Agreements (Health) between Joint Health Comd and Army;
- d. Develop a training regime for all staff and for primary health and combat casualty care (CCC);
- e. Maintain deployable Regimental Aid Post (RAP) first line deployable health capabilities, commensurate with the respective units CACD NTM or 3 Bde directed NTM; and
- f. Commence quantified data capture and task analysis of this data IOT inform the duplication of CHSC capability across FORCOMD.

## Structure

Throughout the course of 2010, the Health Company structure has morphed into the new elements within the CHSC arena. These capabilities have, and are being raised as a result of cross levelling within the Bde (from each of the RAPs across Lavarack Barracks and 10 FSB), hard work and sorting of superseded or expired equipment.

Due to 3 Bde requirements, the CHSC structures have seen the transition of the traditional "Treatment teams" to Close Health Platoons (CHP) and specialist elements. It is anticipated that the military Dental, Imaging and Pathology personnel may relocate to Brisbane and Darwin in the next two-three years. The future of Environmental Health capabilities is still being reviewed and debate exists as to its place in the Close and/or General Health spaces.

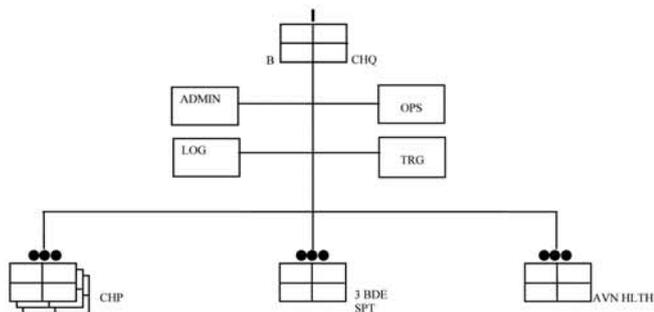
Currently, CHSC Townsville (to be known as BRAVO Company within the Close Health Support Battalion) is made up of the following (see diagram 1.):

1. **Company Headquarters**
  - a. Administration (Ord Room)
  - b. Operations Cell (current, future, courses, plans)
  - c. Health Training Cell (CFA and AMT/clinical competencies)
  - d. Q Store
2. **Close Health Platoons (CHP). Comprising of:**
  - a. PLHQ
  - b. Primary Health Care Team (PHCT)
  - c. Resus Team (Resus)
  - d. Staging Element
  - e. Each teams x 2 or 3 (pending vehicle serviceability)
  - f. Note: no holding capacity
3. **Close Health Platoon (RTS). Support to garrison / RTS:**
  - a. PHCT x 2 (developing)
  - b. RESUS x 2 (developing)
  - c. EVAC Teams (developing)
  - d. Holding Element (similar to traditional LDU capability)
  - e. PTI teams (rehabilitation/physical fitness)
4. **Specialist Platoon (until transition of other elms to DWN / BNE)**
  - a. Dental Platoon
  - b. Imaging and Pathology
  - c. Environmental Health Platoon/Section

Congratulations and commendations to all personnel within the Company during 2010. A lot of hard work, effort, commitment and

dedication. Best wishes to all Corps personnel for a safe Christmas, New Year and deployment period in 2011.

**Diagram 1: CHSC structure 2010 – Townsville**



A GREAT effort from the soldiers and officers within the CHSC this year. A high paced, challenging and busy year. It is hoped that the efforts of the team in Townsville set the tone for the informing of new and exciting developments in Army Health. We look forward to a busy lead up period to next year's deployments with MTF, FSU, CTU and TLBG on the horizon.

*Major Elisabeth Barnett*



## 3 CSSB Health Company Submissions

### Close Health Platoons (CHP)

2010 is introducing some major changes in the Medical Corps.

This year the 3rd Combat Service Support Battalion (3CSSB) has implemented the new Close Health Support Company (CHSC) pilot. With the new structure of the Corps in Townsville underway there has been a lot of reshuffling of the medics around the barracks. Apart from the LBMC medics, the majority of medics are now pooled in one of three locations, the hubbed Eastern and Western RAP's and the 3CSSB cages, with also a smaller group working out of the old 2RAR RAP where they have formed the Training Cell.

So far this year everyone has been hard at work trying to iron out the wrinkles of the new pilot. With the new structure some of the aims are to decrease the workload of the MO's and other medical staff by having two hubbed RAP's (and another when 3RAR move into location) rather than having the medical staff scattered around the barracks. With the new Training Cell we now will have dedicated staff to provide training for the medics to get competencies signed off and organise placements for medics to go on, also while running CFA/Recert courses.

Having more medics at Health Coy 3CSSB also sees more manpower to spread around for the different exercises running throughout the year and allowing other people to go on courses.

With the Hubbed RAP's it is now making it easier with the shortage of MO's to see the patients, as now there are 3-4 units utilising each RAP. With 3RAR moving up some time in the near future there will also be a Central RAP which will house the three infantry units. With the new way the RAP's now work has made them busier than ever. With a few medics on either AMAC or other courses this has also made things a bit more difficult. As you can imagine a single RAP looking after 3-4 units things can get a bit hectic, but the good staff at the RAP's seem to be handling the workload.

Up at Health Coy 3CSSB and in the cages the staff is working hard to get the new structure under way. With the new manning of the Two CHP, both which will be equipped with a Primary Health Care Section and Resus bay, the medics and Nursing Officers are busy sorting out equipment for the upcoming exercises where we will get to test out the new structure. The Integral medics remain in the platoons who will venture out with their respective unit to provide any support needed to the soldiers.

At Health Coy Training Cell, located at the previous 2 RAR RAP, the staff are working hard to get the new training facility under way, where they will be running the CFA, while also organising training for the medics to get the yearly competencies done for the year.

So with the new CHSB pilot well underway the staff of Health Coy 3CSSB is working hard to smooth out all the bumps to ensure a smoother transition for other Units who will mirror the same structure in 2011.

By: LT Hollie Cahill

## Health Company Training Cell

CHSC Training Cell, 3 CSSB has moved from the confines of the Company HQ at 3 CSSB into the former 2 RAR RAP to establish a training environment suitable to facilitate the Combat First Aid Course (CFAC), Combat First Aid Recertification Course (CFARC) and competency training of medics, nurses and doctors.

The Training Cell has been very busy this year with the pilot in full swing. The start of the year found CAPT Matthew FitzGerald and SGT Nicola Turner with a lot to organise, plan and carry out. The addition of WO2 Anthony Tyrrell to the cell ensured that the initial CFACs for 3 Bde were made a little easier to conduct, prior to him transitioning to the Competency Cell to manage all of the medics across 3 Bde. We then had the addition of CPL Mark Deacon and CPL Gregory Pride with their fresh ideas and recent overseas deployment bring a glimmering shed of light into the cell. Last but by no means least, the addition of SGT Wayne McMurtrie to provide an extra hand in the Competency Cell.

The CFA Cell comprising of SGT Turner, CPL Deacon and CPL Pride have managed to qualify 69 CFA and requalify 35 CFA to date. Courses are still inevitable within the defence force, with CPL Deacon away on Sub1 for SGT, and most of the cell participating in the SIM MAN course at the beginning of the year.

As with any cell starting from scratch there are always a couple of hurdles to overcome. The introduction of the Care of the Battle Casualty (CBC) package has been made a little easier with WO2 Tyrrell and CPL Pride being heavily involved in the Primary Survey.

August will see CAPT FitzGerald and SGT Turner off to Tully to assist with a course, WO2 Tyrrell gallivanting all over the countryside with Primary Survey, CPL Pride taking some well deserved leave, SGT McMurtrie recovering from surgery and CPL Deacon working hard on course. The staff are also looking forward to some QAS and ED placements at The Townsville Hospital as part of the Professional Development Program prior to another CFAC and CFARC in November.

### Environmental Health

The Environmental Health (EH) role within the CSSBs are always known for being demanding. There is no exception to this in 3 CSSB where the team has been kept busy with the constant manning and shakeout of the CSST, as well as support to various exercises such as EX VAMPIRE, 3RAR EX WARFIGHTER, EX BLAZING SUN, EX WONTOK WARRIOR, EX PUK PUK, EX CATA and EX HAMEL. Added to this workload, are the ongoing Brigade related support taskings including health briefs, water



sanitising, dipping of uniforms, mess inspections and vector control tasks that provide a constant flow of work. Overall, EH Platoon in 3 CSSB is a very high-tempo role.

Locality wise, Townsville is an ideal location to base an EH capability/asset such as that currently within 3 CSSB. The area of North Queensland provides a number of unique health issues and threats; for example: significant communicable disease potential in training areas (eg – leptospirosis outbreak in Tully) and the ongoing potential threats of vector borne diseases (over 1,000 reported cases of Dengue Fever last year within the Townsville area). With the forces stationed in Townsville growing over the next couple of years (with the move/addition of 3 RAR to Lavarack Barracks), these issues become greatly applicable for EH concern not only as a result of increased exercises and shakeouts that will be conducted, but also in relation everyday Garrison duties.

Despite all of this, under the planned health structure EH assets are to be centralised within the General Health Support Battalion (GHSB) located in Brisbane. They would then form, in effect, an EH Company that would be administered by the EH trade. However, debate is being had whether this is the most efficient way of utilising the EH resource, given the high workloads and work rates associated with the CSSBs. Although the GHSB format will always exist, there may be potential to have detachments in CHSCs located in Townsville and Darwin, which would fulfil the current role of the CSSBs.

### Dental

16 FD, or Lavarack Barracks Dental Centre as it is more commonly known, has had a demanding and eventful year. The entire team has been instrumental in ensuring that the high dental readiness is maintained regardless of the high tempo sustained by 3 Bde. Our dental teams have up to now supported two Health Coy exercises this year, including Ex VAMPIRE – a Coy Shakeout and Ex BLAZING SUN

— a CSST deployment. Our presence in the field was useful for all parties involved as the dental teams gained valuable experience treating numerous patients for a range of different dental procedures in a field environment, which resulted in a significant proportion of members being upgraded.

16 FD have also been involved in a variety of first aid and medical scenarios, the biggest of which was a mass casualty where dental played a vital role in managing the triage element. The CHSC Pilot had little implications on us but soon 3CSSB Dental will make the transition over to LBMC to more accurately represent our role as an integral component of garrison support.

*By: SGT Nicola Turner*



## 3 BDE Precincts Regimental Aid Posts

### JJ Davis, MM Health Facility (Western RAP)

This year has seen the culmination of 5 Unit RAP's into one health facility under the new Glose Clinical Health Support Company restructure. The Davis facility now looks after 1MP, 3 CER, 2 RAR, B 3/4 and 4 Field Regt. The Davis Facility is now maned by CAPT Jones, LT Hasse, SGT Gallagher, CPL Clark, CPL Degelder, CPL Godfrey, CPL Johnson, CPL Stewart, CPL Westlake, PTE Entwistle, PTE King, PTE Moyle and PTE Pizzoni and our ever hard working civilian staff.

During this year the staff of the Davis facility have had to over come some major obstacles, the least of which having to look after so many large units, which on some days, leaves our waiting room looking like

the unemployment line at the local centre link. On most days sick parade finishes just in time for the Dr's to turn around and pick up their first appointment of the day and the medics dealing with the pile of paperwork and health assessments that we all love.

Throughout this year we have also managed to send CPL Clark and CPL Westlake on Sub One for SGT, CPL Stewart on Sub Two for SGT, PTE King and PTE Pizzoni on AMAC and next month CPL Degelder will be attending Sub One SGT. While we have been left with enough staff to deal with the day to day running of the health centre, we have also had to process a large amount of post deployment medicals and three units deploying on various exercises throughout the world.

*By: CPL Clark*

## Life as an RAP medic

As fairly new Basic Medical Operators, posted to 3CSSB we have been lucky enough to experience some of our time in the 'cages' and are now working in the RAP where we can keep up our clinical skills and signing of competencies.

In the RAP there are a variety of people with different levels of qualifications working together to help treat and prevent injuries and illnesses. These include 3 military doctors, 2 civilian doctors, 1 nursing officer, 3 civilian nursing officers, 1 SGT medic, 7 medics combined of basic and advanced medical operators and 2 receptionists. This may seem a lot, but in reality we rarely, have the full manning. This is due to various reasons such as courses, clinical placements, leave, civilian obligations and other reasons. The medics also have a rotation of Duty

Medic and Administrative Medic; positions that last a week long each, and are used to ease the burden of certain workloads in various aspects of the RAP.

At the RAP we look after 3 units, 10 FSB, 3 CSSB and 1RAR with approximately 1700 members in total. An average day consists of a sick parade, MO consultations, medical board assessments, vaccination parades, pre and post deployments, maintaining medical equipment checks, ordering of medical stores, medical training, filing, auditing of medical documents, entering medical data on MIMI, recalling of patients as required, specialist referrals and many more tasks. In the month of June, we collectively saw 2842 patients and we completed 338 vaccinations, 609 pathology tests and 265 medical board assessments.

An average day starts with sick parade from 0730 until approximately 0930h. Between 0930h and 1000h as much filing and medical data entering we can manage is done. This is in between any late sick parade members or long stay patients that we receive. 1000h kicks off the start of booked annual health assessments, post deployments, comprehensive health examinations and other routine health examinations. These are booked half hourly with five medics and finish each day at about 1430h. After that, everyone works together to finish filing, data entry and other such tasks that need to be completed for the facility to run effectively.

There are always plenty of opportunities to learn something new and to refine older skills. Most Wednesday afternoons we try to do a couple of

hours training, (if the work load allows.) This can involve anything from running through scenarios, plaster cast training, wound care management, eye examination, sports medicine, abdomen examinations, and many more. The medical officers here are very keen on furthering our education by encouraging us to assist them in minor procedures such as incisions, mole removals, and toe nail removals and other such procedures.

Working in the RAP has been extremely beneficial and rewarding in maintaining skills and gaining new experience, and also for giving us confidence in ourselves as medics.

By: PTEs Bottari and Lowien

## PTIs



When first posted to 3 CSSB, my former RSM stated, during induction, that 'Physical Training is the corner stone of good soldiering'. During the same period, The Commander, 3rd Brigade, expressed his focus to support the soldiers and their families with the future development of the Lavarack Barracks Health and Lifestyle Precinct. With the Chain of Command emphasising a physical training, health and lifestyle focus, and with the numbers in the 3rd Brigade increasing to over 5000 soldiers, improvements to our physical and recreational services could not come at a better time.

Having been handed the keys to the Old Lavarack Barracks Cinema, I mean Lavarack Barracks Area Gym (LBAG), and finding out from my predecessors that there where plans for a new paint job over the asbestos walls, a possible carpet clean, and approved plans for two undercover PT areas, 'Balance' was my first PT lesson. Considering the expansion of the 3rd Brigade, the Brigade Commander's focus on soldiers and their families, and the CA focus on MSD, the reconstruction of a new LBAG was the only solution.

With the backing from above, the Stage 4 Lavarack Barracks Redevelopment working group stopped asking question about cleaning and refocused on what services could be provided with the reconstruction of a new LBAG. The plans soon took on new shapes with the floor space to house an independent weights and cardio room, separate boxercise room, rock climbing, abseiling and repelling area, squash courts, class room, and twice the floor space to support MSD, CFL cses, PT and sports across the 3rd Brigade. With a new Western and Eastern PT facility complete on Oct 09, the new Lavarack Barracks Obstacle Course expected to be complete Jun 10, and the LBAG

expected to be completed by Sep 10, there is exciting times ahead.

Some say that it is difficult as a PTI to be selected for deployment. I believe if you asked all the PTIs posted within the 3rd Brigade, over the past three years, they would tell you differently. Currently there are two PTIs deployed and two have recently returned from deployment; Deployments consisting of four separate deployment locations, this year alone. Besides recent PTIs who have marched into unit within the 3rd Brigade, all PTIs have been deployed, or have been offered a deployment, at one time or another over the past three years. If it is a deployment you are after, I will use the analogy *Location, Location, Location* as when you are choosing a home.

As part of the CA focus 'I am an Australian soldier' campaign, the PTIs have taken on the role of instructing, training and supporting the delivery of MSD to all ARA and A-Res personnel. Again the 3rd Brigade PTIs have been supporting MSD with a 3 CSSB, 3 CSR and 3 CER hosted MSD Recertification, Exponent and Instructor courses so far this year. Currently the 3rd Brigade has a further 18 MSD Courses planned for units for the remainder of 2010.

'Positions vacant' — Who's now keen to be posted to the 3rd Brigade? Unfortunately all the PTIs who where posted out at the end of 2008 where not replaced, and although this year has seen PTI numbers increase, PTI numbers are still down in several units who have PTIs on their entitlement. I am hoping for a positive outcome, when the PTIs become part of the Close Health Support Battalions, with a boosting of PTI numbers here in the 3rd Brigade for 2011.

By: WOPI 3 CSSB and 3rd Brigade PT Manager; WO2 Gibbs

# Mission Essential Health Training — 3 HSB

## “EX Bullwinkle 09”

May and June was a very busy time for 3 HSB with the MEHT 2009 formerly known as EX BULLWINKLE. During the course period we trained medical specialists from all over the country. The courses conducted were Early Management of Severe Burns (EMSB); Major Incident Medical Management and Support (MIMMS); Focused Assessment with Sonography for Trauma (FAST); Wound Management; and Early Management of Severe Trauma (EMST). The AUSMTF 4 team spearheaded the participation of the courses with this being their Mission Rehearsal Exercise (MRE) specific training for their time in Afghanistan in the coming months.

The courses period kicked off with EMSB with the team from Royal Adelaide Hospital Burns Unit and their happy band of specialists bringing some very realistic and quality training to the defence members who participated, the moulage was spectacular. One member from AUSMTF 4 commented that some of the wounds from an RPG looked similar to what was seen on the EMSB course. The course was very well received and is anticipated to be conducted biannually within our professional development training continuum.

All participants enjoyed the MIMMS training as not only health specialists were able to do this course, some participants found this course easier with no medical background as the parameters are set for casualty sorting are cut and dry. The example of this was on the final day laypersons did not ‘Prioritise’, casualties as medical personal do but went purely of the sorting cards.

The MIMMS course had 24 participants all of which found the course invaluable. The FAST course has been conducted within the unit for the

**Overall MEHT 2009 was a resounding success and has set 3 HSB as the centre for learning excellence.**

past two years and continues to be very beneficial. Some of our new Medical Officers were impressed with the technology. The Royal Adelaide Hospital provided three patients with ongoing problems that provided some real time experience for the course participants.

The Royal Australasian College of Surgeons let 3 HSB host an EMST course which the TRGWO found very easy to organise Ha Ha. The course was a resounding success 14 Surgeons, Anaesthetists and Medical Officers gained their qualification from the College, and importantly it has contributed to their CL2 qualification. In addition the course provided experience for eight observers, normally only four observers.

It should be noted that the assistance provided by COL Neuhaus and WGCDR Pearce was paramount in dealing with some of the external organisations. The team from AUSMTF 4 found the training beneficial and were better prepared than any team before. The training was the first of its kind and has set new standards for defence medical training. The unit has received good reports from COL Health and BDE COMD 17 CSS BDE, MEHT 2010 looks to be bigger and better. Overall MEHT 2009 was a resounding success and has set 3 HSB as the centre for learning excellence.

*By: WO2 G. Cox, NSC (3 HSB)*

*‘Make things as simple as possible but no simpler’ — Albert Einstein*

# ASEAN Regional Forum

## Voluntary Demonstration of Response (ARF-VDR) 04-08 May 2009

The ASEAN Regional Forum – Voluntary Demonstration of Response (ARF-VDR) was held from 04-08 May 2009. The activity was jointly hosted by the Philippines and the United States and was based on the scenario of a super-typhoon hitting the Central Luzon province in the Philippines. The exercise was the first of its kind for the ARF and was a considerable advancement in regional disaster relief mutual aid.

The ARF-VDR was a joint military and civil operation comprising the cooperation of 27 countries, including the Philippines, Australia, Papua New Guinea, the USA, Indonesia and Japan, to name a few. The Australian contingent for the exercise consisted of Australian Defence Force (ADF) members as well as representatives from AusAID and the Department of Foreign Affairs and Trade.

Whilst the ARF-VDR demonstrated air, land and sea response capabilities, the main focus for the Australian delegation was to participate in the Engineering Civic Action Program (ENCAP) and Medical Civic Action Program (MEDCAP). ENCAP's role was to conduct school repairs, participate in a water purification project and the construction of a suspension footbridge. 21 Construction Regiment, along with a multi-national engineering party, worked solidly on the latter two projects – an amazing effort given the hot tropical conditions they were subjected to.

The Australian component of the international MEDCAP team comprised of a Primary Health Care Team (PHCT), Environmental Health capability and Dental Services. This contingent was broken into two teams working in two separate locations – Sapang Bato and Olongapo. The Sapang Bato team included: MAJ Tim Humphrey (MO, 3 HSB), LCPL Alecia Brown (Theatre Technician, 3 HSB), PTE Sonya Brookes (CMA, 3 HSB) and PTE Caitlin Forrester (CMA, 3 HSB). The Olongapo team consisted of: MAJ Wayne Chow (Dentist, 2 HSB), CAPT Dan Schmidt (NO, 3 HSB), SGT Mark Allen (Dental Technician, 2 HSB), SGT Dermot Oakley (AMT, 3 HSB), CPL Stephen Shelverton (EH Technician, 2 HSB), LCPL Fiona McCallum (CMA, 3 HSB), PTE Evan Watson-Keast (Dental Assistant, 2 HSB) and PTE Andrew Chappell (EH Technician, 2 HSB).

The Sapang Bato and Olongapo locations were chosen as sites for the ARF-VDR exercise due to the significant number of local residents who were rendered homeless following the eruption of Mount Pinatubo in 1991. Due to both their distance to major cities and the location in which they live, regular and quality health care is not easy for the local population to access.

We arrived at Sapang Bato ready for work on the 4th of May 2009. The site comprised of a Pharmacy tent and a PHCT. The Indonesian

contingent operated the Pharmacy with the aid of a Filipino interpreter, whilst the PHCT accommodated four Medical Officers (MO), one Combat Medical Attendant (CMA), four interpreters, and four patients. The space was very limited with only one examination bed. In addition, the noise from both the rain and generators made chest auscultation and conversing with patients very difficult.

From very early on day one we realised just how busy we were going to be throughout the week ahead. A significant proportion of the local population had already begun queuing – most having more than a two hour wait to see an MO. We treated an assortment of cases, such as infected wounds, diabetes with subsequent ulcerations, fractures and impetigo. Management and wound dressing was very difficult given the conditions and lack of medical supplies. As a result we had to improvise as best we could.

As well as minor cases, we witnessed some more serious conditions over the five-day period. These included fractures, suspected cancers and ovarian cysts. These cases had to be referred out to other facilities – namely the local hospital for further investigation, as we had no access to x-ray, ultrasound or the capacity to provide exploratory surgery.

Another facility set up at Sapang Bato was the immunisation clinic. This was located across the road from the PHCT in the local church. We had two CMA's assisting the Filipino nurses with administering Tet-tox and Polio vaccines. Although patient flow was a bit disorganised in the beginning, once we got a routine established we were kept very busy. Soon, word that free vaccines were available reached further up the mountain. Thus, the local population took full advantage of the service which was amazing to see. An added advantage to the clinic was that we found quite a few medical conditions in children that their parents were not aware of. Some examples included oral thrush, chicken pox, burns and impetigo. Consequently we were able to refer these cases across the road to the PHCT for treatment.

The ARF-VDR was a successful exercise on many levels. Primarily, it achieved its aim of demonstrating the capacity for a multi-national party to provide humanitarian assistance in a disaster situation, such as a super-typhoon as depicted in this instance. In a 'real-life' disaster relief situation, a lack of appropriate resources and health-care requirements can have fatal results. Thus, exercises such as the ARF-VDR are of the utmost importance, as they provide real patients and resources in a real-time scenario, but without many of the consequences that could otherwise occur. They provide an invaluable opportunity to make sure resourcing issues are addressed and continual improvements are made so when a disaster really does occur, a more efficient multi-



national response transpires. Further to this on a more personal level, activities such as the ARF-VDR provide fantastic training opportunities for RAAMC members. This is especially true for more junior members such as CMA's, for whom training in such a multi-faceted real-life training environment is difficult to come by. Overall, this exercise was

fantastic to be a part of for all involved. The memories of the hundreds of smiles we created and the words of sincere gratitude we heard all too often will stay with us for a long time to come.

---

*By: LCPL S. Brookes & PTE C. Forrester (3 HSB)*

## AUSMTF-4 – (3 HSB)

The 3rd Health Support Battalion was the lead unit for the recent deployment of Australian Medical Treatment Facility rotation 4 (AUSMTF-4) to OP SLIPPER. AUSMTF-4's task was to augment the Netherlands led Role 2E in Afghanistan in the capacity of Operating Theatre and Intensive Care.

AUSMTF 4 was identified to deploy on OP SLIPPER since the middle of last year. Since that time, work slowly and progressively developed the team who had undergone extensive training to ensure they were ready for the work they will experience in this environment.

AUSMTF 4 personnel were predominantly from 3rd Health Support Battalion (Keswick and Victoria Detachment) with additional support from the 1st Health Support Battalion and the Royal Australian Navy Reserve. SGT Darren Baile was the only ARA member of the team. Many members had previously deployed a number of times prior to this deployment with several members having deployed to the Middle East Area of Operations (MEAO) previously. For MAJ Andy Higgs (RAAMC), LT's Danielle McKenna and Emma Palmer (RAANC) this was their first deployment since being commissioned into the military.

AUSMTF 4 was led by MAJ Connie Jongeneel (RAANC) with CAPT Paul Wirth (RAANC) as the 2IC. MAJ Michael Reade and COL 'Toby' Thomas were the Clinical Directors in their respective rotations.

During April 2009 eight members of AUSMTF 4 travelled to Holland to train with the deploying Role 2E team who were to be part of the Netherlands Logistic Support Detachment (LSD 10) and to which AUSMTF-4 was to be embedded with. This had proven to be the ideal foundations in which to build the framework of working with each other whilst in Afghanistan. This opportunity allowed the team to meet SGT Raoul Cromwell – Theatre Technician and CPL Odette Versloot –

ICU Technician, both of whom would be part of the team in the ICU and OT.

AUSMTF-4 celebrated many events whilst on deployment, the first being three birthdays. CMDR Paul Luckin, LTs Andrew Dansie and Emma Palmer all had birthdays never to forget with LT Dansie meeting MAJGEN Kelly on his birthday.

Many members of AUSMTF-4 enjoyed the sporting life Tarin Kowt had to offer, mainly the five mile and ten mile runs. This event occurred alternate Sundays with a one off T-shirt awaiting those who completed the distance regardless how many times they participated. There was even a rumour some members used an alias in the run to get another T-shirt.

For the shopping enthusiasts there were opportunities to pick up a few bargains from the local market as well as the two local shops who sold anything from clothing to souvenirs to Lindt chocolates. I understand there were several carpets that made their way back to Australia.

For those who deployed on AUSMTF 4, I am sure everyone left part of their heart at the Role 2E. Invariably there will be mixed emotions from the deployment however the experience, friendships and environment will live on inside each person for some time to come.

AUSMTF 4 deployed from 21 July to 1 October 2009. For the deployed time the AUSMTF 4 team had undertaken no less than 110 operations with the ICU occupancy bed rate at 61%. AUSMTF 4 is to be commended for their hard work and dedication in providing best practice in their clinical role.

Thank you team

---

*MAJ C. Jongeneel (3 HSB)*

# Ex Predators Gallop

3 HSB provided medical support to 1 CSSB in their preparation for Ex PREDATORS RUN at the Mt Bundy Training Area, which is east of Darwin near the Kakadu National Park. We were helped by a Team from Care Flight which included a Doc, a Medic and two Pilots. 1 CSSB also provided us a LT Nursing Officer and an Evac driver.

Its hard to condense our three weeks into a few words as so much happened over the short period. We arrived at Scale A of the Mt Bundy Training Area, also known as Camp Krusty (with all the local wild life of snakes and jumping spiders that co-ordinate into section attacks), which is east of Darwin and never stopped running until we left. We watched the Abram Tanks roll in and did not quite understand what came with them. Swine Flu! Yep they brought a few cases with them from Ex TALISMAN SABRE 09. The cases filled the Hospital at Robertson Barracks and we were looking to the Royal Darwin Hospital next. Our Evac driver and ambulance's were getting such a work out, that they broke down and we swapped vehicles about four times. I even had to drive a guy with a broken finger into the Royal Darwin Hospital (RDH) in a land

rover and I may have got a little lost on the way back which added an extra hour to the trip.

Somewhere during the first week a Recon Course turned up, and that gave us a steady supply of patients. Our driver, Lamby got tagged out, and a new driver, Hunter, got tagged in. The nice LT NO had her appendix out. The Care flight doc got traded from a female to a Male, and we even sent SGT Brian "Harry" Callahan back to Robbo for a rest up with swine flu. We received an extra Medic from 1 CSSB for a few days as we needed to set up an LDU isolation ward. Through it all the 3 HSB medics stuck it out, PTE Lauren Cocker, PTE Angela Stanfield, LCPL Sonya Brookes, and myself, with CAPT Dan Schmidt.

The exercise was another learning curve for everyone. In return we got to have a good look over all the hardware, including rides in the Abrams, the Care flight chopper, and eat great food from the cooks at the on site mess.

I can definitely recommend any one, of any rank, to attend the next one.

*By: LCPL C. Frank (3 HSB)*



Supports for Foot, Ankle,  
Knee, Back, etc and  
Physiotherapy Equipment

**Australia's Widest  
Sportsmed Range**

6 Park Road, Oakleigh  
Victoria 3166

**Ph: 1300 785 786**  
**Fax: 1300 785 788**  
**Website: [www.sportstek.net](http://www.sportstek.net)**

PAUL-3

# BARD

ABN 50 001 468 935

**Bard Australia Pty. Ltd.**  
69-71 Waterloo Road North Ryde NSW 2113

**TEL: +61 2 8875 4000**  
**FAX: +61 2 8875 4050**

**CUSTOMER SERVICE:**  
**Freecall 1800 257 232**  
**WEB: [www.crbard.com](http://www.crbard.com)**

#### **PRODUCTS:**

- Medical Devices • Urology Catheters • Vascular Access • Vascular Grafts • Peripheral Stents
- Customised Kits • Hernia Repair

PAUL-3

# Operation Resolute (TSE 53)

A Mixture of regular and reserve soldiers have completed an eventful three months of "sea duty" with two Armidale class patrol boats.

The deployment from March 2009 was a part of the Transit Security Element (TSE) 53. TSE 53 was assigned to Op RESOLUTE operating out of HMAS Coonawarra and supporting the Navy by securing and apprehending illegal foreign fishing and people-smuggling vessels.

TSE 53 provided escort parties for more than 250 asylum seekers and participated in more than six boarding's.

17 CSS Bde provided personnel from many units, including 9 and 10 FSB, 3 HSB and 1 MP Bn. A wide variety of trades were represented, with Air Dispatchers, Combat Engineers, Clerks, Combat Medical Assistants and Drivers gaining their sea legs. A wide range of skills were brought together and more were learnt as TSE personnel were involved in boarding, steaming parties and keeping watch at sea.

Far from her job as a fourth year apprentice plumber in Adelaide, PTE

Kye Hall (Photo – top right), 3 HSB, enjoyed the unusual challenge of undertaking Army Reserve service with the Navy. "Transporting potential illegal immigrants from their vessels to HMAS Tobruk at night was a little scary, but a great thrill" PTE Hall said.

Members of TSE 53 spoke highly of the Navy crews and said the Navy lingo was a little hard to learn, but they were soon speaking like sailors and would recommend the experience to others.

The 3 HSB members that deployed on OP REOLUTE (TSE 53) were as follows:

WO2 C. Graham (RAAMC) – 3 HSB

PTE J. Di Santo (RACT) – 3 HSB

PTE S. Haeussermann (RAAMC) – 3 HSB

PTE K. Hall (RAAMC) – 3 HSB

PTE S. Thomas (RAADC) – 3 HSB

## South Australia Cadet AFX

**28 Sep to 3 Oct 09**

It was that time of the year again, when the kids are on holidays, and the Cadets get together for their annual camp.

This year the camp was held at Murray Bridge Training Area, and like many other years the Army lent a hand to help it work. This year the health support was provided by the medical team out of Hampstead Barracks along with a team from 3 HSB. The HSB put in a large support team this year including a 12 Bed holding facility, Resus bay and Primary Health care team. All this support was provided by an excellent crew of LCPL Frank, PTE Sims, PTE Crocker and PTE Lee-Justine. The team was backed up by myself as the Health ops and team leader.

Was this camp worth supporting? That was the question asked of me when I returned, and my answer is "yes" it most defiantly was. This activity was a chance for the medics to experience things that even an ARA medic would be hard pressed seeing. Although we all like to see our children as the future of the world, not all children are that way inclined, unfortunately, some of the cases we saw stemmed to depression, psych illness and dysfunctional families. However the

biggest achievements of the week were not what clinical cases we saw but what other elements of support we performed. All the team got to provide some level of support outside of the RAP, whether it was guiding the cadets under the turning disc of a Blackhawk helicopter (needless to say being the Marker panel as it approached, thanks LCPL Christine Frank) to giving First Aid lessons to performing FFI's at the Range. Not only did this give the team a chance to hone their skills in trade and instruction, it also gave them a huge boost in moral, taking charge of a Coy and a time to teach. This not only excited all the CMA's, they loved it.

The best thing I saw as the team leader was the soldiers initiative in monitoring the health of the whole camp and making sure water was where it was supposed to be, something we had to really push because of one reason or another. By the end of the week I was very impressed with how the team performed and happy to see how professional all the CMA's are.

Well done Team!

By: SGT B. Callahan (3 HSB)

# Ex ANZAC Exchange 09

From August until November, I was fortunate enough to partake in Ex ANZAC Exchange 2009, an International exchange exercise with the New Zealand Defence Force where 30 selected Australians Defence members exchange roles with NZ members IOT experience the different cultures and traditions of each others services.

Our journey began in Sydney where we were inducted into the ANZAC Series, and briefed on what we may expect. We then flew to New Zealand where upon arrival; we were dispersed to our new units respectively. I was separated from all the other Australians, and sent to Waiouru, in the North Island.

Waiouru is a military camp, nearly 800m above sea level, and the place in which all recruits and army cadets are sent to do their basic training. I worked as a medic in the Health and Emergency Services Centre (HESC), which provided primary care facilities, but also with a resus capability. My anxiety and nerves were completely put to rest immediately, as the HESC unit, and in fact everyone in Waiouru, made me feel so at home and part of the community.

My work day consisted of sick parades, med boards and due to the fact our patients were almost solely recruits, plenty of immunisations!

About a month into my trip, I was involved in an exercise to "Sione Latu", designed to simulate a natural disaster. It involved a fair portion of the NZDF, and was definitely a highlight of my trip experience wise. As the medics, we were sent out on recon within the community of Sione Latu, to treat the "locals" for such things as cholera and dehydration; and help deliver aid such as shelter and water. We would then return and report back to command on the numbers and degree of devastation within the villages. It seems ironic that only a few weeks later, the disaster at Samoa occurred, so what a fantastic opportunity it was for everyone to have had such good training on this simulated exercise almost identical in nature.

On my return back to Waiouru, we worked closely with the firies on

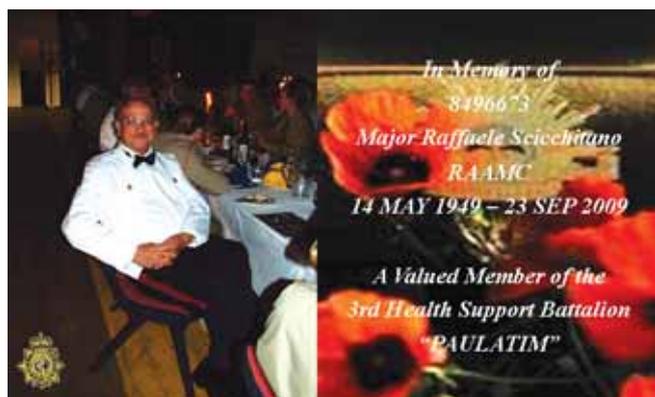
base, conducting scenarios on a frequent basis. In this, old cars were obtained, and "volunteers" agreed to be placed in them, moulaged up. The firies and ambo medics would then arrive at the scene, followed by extrication and treatment of our patients. On one of these occasions, I myself agreed to be a patient; a terrifying experience I hope never to have again. Even though it was only a scenario, it gave me a new perspective on MVA's and what it would be like for my patients, as I sat trembling on the other side of the "Jaws of life".

Our time in New Zealand also involved a lot of road trips and sightseeing. Every weekend I was taken and shown another town – be it the Zorbs in Rotorua, or the hot pools of Taupo, or skiing down the slopes of Mt Ruapehu, I fell in love with the country and all it has to offer. Towards the end of the trip we were lucky enough to have a week off to travel the south island, where we partook in the terrorizing feats of bungee jumping and white water rafting.

I feel truly blessed to have had this opportunity, and never in my wildest imagination would I ever have expected it to have been as incredible an experience as it was- I don't believe it possible to talk my time in NZ up enough! To look back and remember how nervous and terrified I was to be so far from home, not knowing a single soul, I simply can not praise enough how beautiful and welcoming the people at the HESC were. They became my family away from home. They never looked down on me if I had a question to ask about something I did not know, and from this my clinical knowledge and experience grew. From suturing legs to packing pilonidal cysts, I learnt so much in my time at the HESC, and made some amazing friends for life.

The ANZAC series provides an excellent chance for New Zealand and Australia to work together and further strengthen our bonds. I for one can not wait to work with the NZDF again, and hope some day in the near future, to return and work there once more.

By: PTE K. Mason – (3 HSB)



# aspenmedical

wherever we're needed.

From reducing surgery waiting lists to supplying complete medical facilities in remote locations, Aspen Medical has the people, equipment and innovation to provide world class health solutions.



So whatever the healthcare issue, wherever the location,  
Aspen Medical can deliver.

[aspenmedical.com.au](http://aspenmedical.com.au)

PAUL-3



**Australian Government**

**VVCS – Veterans and Veterans Families  
Counselling Service**

## Supporting Australia's veterans, peacekeepers and their families

VVCS provides counselling and support services to Australian veterans, peacekeepers, eligible members of the Defence Force community and their families, and F-111 Fuel Tank Maintenance workers and their partners and immediate family members. VVCS is a specialised, free and confidential Australia-wide service.

**VVCS can provide you with:**

- Individual, couple and family counselling including case management services
- After-hours crisis telephone counselling via Veterans Line
- Group programs including Anger Management, Depression, Anxiety, Lifestyle Management and Heart Health
- Support on transition from military to civilian life, including The Stepping Out Program
- Information, self-help resources and referrals to other services.

We can help you work through issues such as stress, relationship, family problems and other lifestyle issues as well as emotional or psychological issues associated with your military service.

If you need support or would like more information about us please give us a call or visit our website.

**1800 011 046\***

[www.dva.gov.au/health/vvcs](http://www.dva.gov.au/health/vvcs)

\* Free local call. Calls from mobile and pay phones may incur charges.



**Veterans and Veterans Families Counselling Service**  
A service founded by Vietnam veterans

PAUL-3

adcorp32755

# Exercise LEMNOS

This year EX LEMNOS was held over the weekend 24-25 Oct at the Murray Bridge Training Area (MUTA). The primary aim was to deploy a surgical platoon (Role 2 (+) (enhanced) that exposed Clinical Coy personnel to the current pattern of injuries that are encountered by health personnel in Afghanistan. The secondary aim was to expose, refresh and develop Clinical Coy personnel to the packing, loading, unloading and setting up of a surgical platoon in the field environment.

Of the 18 personnel from Clinical Coy who attended, two were MO's from the Specialist Advisory Group, and 3 were medical assistants from Health Coy 9 CSSB. The Role 2 (+) was well supported by five personnel from Admin Coy.

In addition to a two bay resuscitation team, one bed theatre team, two bed intensive care team, and four bed medium dependency unit team Clinical Coy deployed an operations team and evacuation team.

EX LEMNOS involved a two tiered approach along the continuum of care, which facilitated the medics at gaining experience at pre-hospital care and transportation of casualties and handover procedures to a Role 2 (+) and subsequent on going interventions by Medical & NO's and GMA's.

The concept of operations for the Role 2 (+) was to receive patients for a 24 hour period commencing at 1200 hrs on 24 October. Over this period staff were exposed to a total of 12 casualty scenarios. Patients were collected from the nearby casualty clearing station by the evacuation team and brought into the Role 2 (+) either into the resuscitation bay or directly to the patient ward environment.

In line with the current pattern of injuries experienced by health professionals in the Middle Eastern Area of Operations (MEAO), many casualties presented to the Role 2 (+) as multiple presentations. The casualties were experiencing a variety of conditions including gunshot wounds, IED blasts, RPG blasts and snake bites. The multiple

presentations developed the medical officers ability to make sound decisions on clinical management and how to effectively manage demand particularly in times of surge.

The final casualty presentation to the resuscitation bay was based on a local national family. This scenario exposed and developed the staff members ability to care for the casualties within a cultural sensitive environment. This was made more realistic with the casualties wearing clothes similar to those worn by the local nationals in Afghanistan.

This was the first time all scenarios had individual packages with clinical information, photos and x rays. Each of the Directing Staff (DS) were placed along the continuum of care and in affect "were reading off the same page" The DS were able to feed clinical information into each scenario and comment on how it really happened in their experience.

In conclusion all members involved in the exercising of the Role 2 (+) enhanced felt this was a valuable opportunity to expose, refresh and develop their knowledge of providing health care in a field setting. The success of this exercise can be contributed to several members of AUSMTF-4 who have recently returned from Afghanistan.

What made EX LEMNOS such a resounding success was the current experiences of COL Thomas, MAJ Jongeneel & CAPT Wirth and the additional work by MAJ Jongeneel of having each scenario in folders for each of the DS and x rays on a laptop computer for the medical officer and other members of the resuscitation team to view as needed.

The work done by WO2 Cox, SGT Bailes and SGT Callahan in preparing the casualties and supervising the medics with pre-hospital care and transportation allowed the medics to have several competencies signed off through their exposure to a variety of experiences during the exercise.

By: LTCOL K. Haas – (3 HSB)

# Primary Health Care Team 5th Aviation Regiment



The Primary Health Care Team of the 5th Aviation Regiment have been through the usual trial and tribulations of supporting a very busy and constantly deployed unit. Not only do we face the usual ups and downs of manning losses, courses and leave, but provide medical support to OP Astute (Blackhawks) and OP Slipper (Chinooks). These deployments require the absence of a medic for six and eight months each.

The PHCT supports approximately 780 personnel from almost every Corps in the Army, whom all play an integral role in keeping the Blackhawks, Chinooks and (occasionally) the MRH90 in the air and properly manned. The PHCT is part of Logistic Support Squadron, one of five squadrons within the Regiment. A, B and C squadrons are our flying squadrons, and Technical Support Squadron (around 350 people) completes the epic manning required to maintain 5th Aviation Regiment's airborne capability.

Our Command elements consist of: the RMO, CAPT Robert Kennedy, with us after a posting to 1st Aviation Regiment, RNO CAPT Jason Nardini, Aviation Nurse and our troop commander; SGT Craig Crossan, posted in from RMC-D. On the floor we have CPL Marie Congdon, with aviation experience on OP Slipper; LCPL Wendy Cottee, RWAME and FWAME qualified; CPL Malcolm Roberts, recently returned from OP Slipper; CPL David Ross, on OP Astute, supporting the Timor Leste Aviation Group, and; CPL Dallas Tonks, completing his 4th year with the Regiment. We are assisted by our civilian staff: AVMO Deep Joseph; NO Alan Johnson (an ex RAAFie life support fitter) and the effervescent Mandy Moyle, our receptionist. We also have COL Jeff Brock (SO1 AVMED, HQ 16 AVN

BDE) and COL Jon Turner (SMO 3BDE) who provide the aircrew medical confirmation.

EX Pegasus Strafer, an annual occurrence and held early in the year, is a live fire exercise focusing on the weapons qualifications of aircrew. This was manned by CAPT Nardini and SGT Crossan boldly going where no 6x6 ambulance should go: High Range Training Area.

In July, Logistic Support Squadron headed off on EX Titan Challenge, the sub-units' annual adventurous training activity. This year the exercise consisted of three activities: Climbing Mount Bartle Frere (highest point in Queensland 5325ft), White Water Rafting and; Sea Kayaking. SGT Crossan and CPL Tonks attended both as participants and medical support.

EX Helicon Luk, is a small operation requiring two Chinooks and two Blackhawks to make their way to Papua New Guinea. Upon arrival at Madang, the aircrew embark on the functional aspects of the trip: being high altitude training. This involves regularly taking the aircraft above 10,000 feet, engine failure drills and DACC tasking. Supported by CAPT Kennedy, CAPT Nardini and CPL Tonks, the medical team covered AME support and Primary Health Care rolls.

During EX HAMEL Battle Group PEGASUS was raised. This involved 40 aircraft and 1000 personnel from across 16 AVN BDE concentrating at 5th Aviation Regiment, conducting 24/7 operations. This increased the tempo of the PHCT significantly as well as the staffing levels.

The PHCT lavish the perks of working in an aviation environment and grimace as we plough through the workload it sometimes entails. The challenges of ensuring the PHCT runs smoothly requires us all to work in close and direct teams, both with each other and the flying squadron commanders.

5th Aviation Regiment Primary Health Care Team: Providing timely and highly sustainable health care support to the members of the Regiment, maintaining a deployable focus in order to win the land battle.

---

*By: CPL Dallas Tonks*

# Regimental Aid Post (RAP) 5RAR

RAP 5RAR started the year with the usual change of personnel following the posting cycle shuffle. The RAP welcomed LT Erica Van Ash, SGT Kerrie Lees, CPL Dave Cantwell, CPL Heath Schofield, PTE Nathan Dovey, PTE Damien Gardiner, PTE Mitchell Gulliver and PTE Darcy McInnes. The new crew joined the ranks of CAPT Gary Heathcote, WO2 Adrian Brooks, LCPL Don Rivadillo and the ever charismatic civilian nurse Carol Perry.

To kick the year off, CPL Schofield and LCPL Rivadillo deployed to Rifle Company Butterworth (RCB) in support of B-COY 5RAR. The two boys hand their hands full supporting the rotation conducting jungle and urban training with the usual injuries, illness and epic prickly heat.

While the boys were living it up at RCB the rest of the team had to quickly find our feet and switch our focus to the upcoming deployment to Afghanistan, Mentoring Task Force (MTF) -2, in the second half of the year. As anyone who has been involved in preparing a battle group for a deployment can testify, this can be a very demanding a task. You'd think that since we've being constantly deploying for over a decade now, that someone, somewhere would have found an easy and painless

way to prepare for a deployment. Well I'm afraid to say that we still haven't found the answer.

As part of our lead up training the RAP staff has been very fortunate to have been involved in a never ending list of specialised medical and trade courses. We have had some of the most experienced and knowledgeable medical clinicians from around the country, military and civilian, pumping us full of information making us to date arguably the Army's most prepared medical team to ever go on deployment. This training has varied widely from mental health, paediatrics, burns courses, mass cas training, and mission specific advance trauma treatment to name a few. One of our courses, Primary Survey One, attracted a bit of media attention and unfortunately cost the RAP staff several cartons of beer.

To make up the numbers required for medical support of MTF-2, we have had to poach medics, nurses and doctors from through out 1st BDE and around the country. For those joining us and everyone in the Battle Group on behalf of RAP 5RAR we hope for everyone a rewarding but safe trip home.

By: CPL Dave Cantwell



## PAULATIM

*DON'T JUST BE PART OF  
HISTORY, MAKE HISTORY –  
BECOME A SUBSCRIBED  
MEMBER TODAY*

## RAAMC CORPS SUBSCRIPTIONS

**\$26.00 per year for soldiers and \$52.00 for officers.**

Payable in full amount or make an allotment of \$1.00/\$2.00 per pay.

Reserve personnel are able to make a payment into Corps funds via bank deposit. For ARA personnel the preferred option is to create an allotment through PMKeys SS via the following path:

*PMKeys SS – My Pay – Allotment – New – Organisation Code (WE005 RAAMC Corps Fund) – Enter amount (\$1 Soldier / \$2 Officer) – Submit*

or

For full details of all the benefits that a subscribed member and your unit are entitled to and how to subscribe, go to RAAMC Standing Orders Chapter 19 at:  
<http://intranet.defence.gov.au/armyweb/sites/RAAMC>

Be a subscribed member of the Corps and the benefits that are associated with being a financial member.

- Individually numbered RAAMC key ring
- RAAMC Corps rules
- Discharge gift
- Eligible for the mid year key ring draw with great prizes
- And more!

*It is the esprit de corps and pride of the members in belonging to such a diverse organisation which should be reflected in Corps subscriptions, and ultimately used to enhance and promote their membership and loyalty.*



# Innovative solutions you can trust, whatever the situation

3M Medical is proud to assist The Royal Australian Army Medical Corps with a broad range of products and solutions.

- **Asepsis** – from clippers, respirators and drapes, such as our loban™ antimicrobial incise drapes
- **Hand Hygiene** – the Avagard™ range of healthcare-specific hand and body washes, that meet International and National standards
- **Patient Assessment** – market leading products such as Red Dot™ Electrodes, and Littmann® Stethoscopes
- **Wound Care** – a wide range of solutions for IV insertion to wound care to compression bandaging, with well-known brands such as Tegaderm™, Micropore™, and Coban™
- **Immobilisation** – including casting products, splints and padding
- **Sterilisation** – a comprehensive range of biological indicators, autoclave tapes, cleaners and disinfectants

For more information, phone our 3M customer service team on 1300 363 878

3M, loban, Avagard, Red Dot, Littmann, Tegaderm, Micropore, and Coban are trademarks of 3M Company. Please recycle. Printed in Australia. © 2009. All rights reserved.



PAUL-3

Queensland X-Ray offers a 24/7 imaging service at a number of its hospital sites which means there is always someone available to provide...  
a clearer picture of your health

Administration  
Ph: 07 3422 8800

**QUEENSLAND X-RAY** [www.qldxray.com.au](http://www.qldxray.com.au)

Brisbane • Cairns • Gold Coast • Mackay • Toowoomba • Townsville

PAUL-3

**MDR**  
MEDICAL DEVICE RESEARCH

*Providing insight and practical solutions through advanced engineering analysis*

Medical Device Research (MDR) is a solutions-based consulting company able to provide advanced engineering solutions. MDR excels where client requirements are unique and has an established track record in niche engineering areas including:

- Gait analysis
- Sports injury repair modelling
- Biomechanical testing capabilities (NATA accredited facility)
- Expert and forensic engineering advice
- Fracture modelling
- Modelling of fire, blast and ballistic scenarios

Medical Device Research Australia Pty Ltd  
Phone: +61 2 9011 5211, Email: [info@mdresearch.com.au](mailto:info@mdresearch.com.au)

PAUL-3

# RAP at 8/9 RAR

The RAP at 8/9 RAR was re-established in early 2008. Initial staffing was provided by CPL Mark Brown, CPL Fiona Binyon and PTE James Parkes who all did a great job of restarting the Battalion Medical Platoon.

In August 2008 the WOMED, WO2 Wayne Jellatt was TDY from DFSS to enhance the RAP staffing and to organise the RAP's equipment holdings and processes. In early 2009 the RAP staffing was grown to include a RMO CAPT Luke Jeremijenko, NURSO CAPT Joanne Sawyer, RAPSGT Troy Roberts, RAPCPL's Wayne Doolan, Lenard Bigler, and RAPTE, Matthew Cox. By mid 2009 the RMO was posted to 2HSB and CAPT Carl Bryant came onto CFTS from deployment and took the helm.

2009 was an extremely busy period with the battalion running back to back RAINF IET cses to gain fully manned rifle Coys by the end of the year, supporting the various Bn live fire activities and also to support the 7 Brig activities being held in Townsville at High Range Training Area. In addition the Bn was tasked to provide operational spt to SFTG, MRTF, MTF1, and a Rifle Coy and BHQ/Logistics deployment to OP ASTUTE in early 2010.

With the start of 2010 the RAP had lost CAPT Joanne Sawyer to 2HSB and the RAP gained LT Sue Cascone from 2 HSB, CPL Frank Klesnik from 1 CSSB, CPL Adam Glazner from Singleton and PTE Monty Beaumont from 1 CSSB.

In Feb 2010 the Bn deployed to East Timor for 8 months and the RAP was left with a rear guard consisting of the a new civilian MO, Dr John Vince from 2 CER and formerly 1 FD REGT, WOMED, NURSO, CPL Klesnik, CPL Glazner, PTE Beaumont and the ever faithful PTE Cam O'Neil who is a reservist attached from 7 CSSB.

The rest of 2010 has been challenging with PTE Parkes successfully completing his JLC, and the combination of the 6RAR, and 2 CER RAP to attending the 8/9 RAR RAP for Doctor consults and other procedures.

With the end of 2010 approaching the Bn will be returning from OP ASTUTE and personnel deployed with 6RAR on OP SLIPPER, a much earned break over the Christmas period to come.

2011 will see the departure of the WOMED WO2 Jellatt who after 22 yrs service will be discharging from the ADF in July and transferring to the reserves. WO2 Jellatt will be staying in the Brisbane area and working in the Civil Medical Practice Management service. In addition the RMO CAPT Carl Bryant is ceasing CFTS and moving to Darwin, LT Sue Cascone is moving to 1 AVVN Darwin on promotion to CAPT, CPL Wayne Doolan is moving onto RMC on promotion to SGT, PTE Matthew Cox is moving on to 5 RAR in Darwin and PTE James Parkes is being posted to IRR in Sydney.

The future of 8/9 RAR RAP will be in good hands with CAPT Sayce from 2HSB, LT Clinton Grose from 2 HSB, WO2 Chris Oakley from 1 HSB posting into 8/9 RAR in 2011.

## brenniston

FIRST AID & WORKPLACE SAFETY 

- First Aid and Emergency Products
- Cabinet and Bag Supplier
- Specialised Kits
- Chemical Burn Kits
- Defibrillators
- Trauma Kits
- Resuscitation
- Rescue Equipment
- Long-Life Ration Bars

1300 730 079  
[www.brenniston.com.au](http://www.brenniston.com.au)



*The carers' choice in slide sheets*

Contact: John Cleary      Phone/Fax: 03 5345 7559  
 Mobile: 0429 433 594      Email: [jc4em@ncable.net.au](mailto:jc4em@ncable.net.au)

[www.easymoveslidesheets.com.au](http://www.easymoveslidesheets.com.au)

# The Deployed (Other) Half of 8/9 RAR RAP

The RAP staff of 8/9 RAR have split in half this year for an 8 month deployment to East Timor. The deployed members are CAPT Carl Bryant, SGT Troy Roberts, CPL Len Bigler, CPL Wayne Doolan and PTE Matthew Cox.

We have been kept busy over here, we hit the ground running arriving in country in February and straight into running our first Combat First Aid course for A COY 8/9 RAR, putting it together in a week's notice. Despite the limited time and resources the course went ahead and without any problems. We have been busy running courses throughout the deployment.

The 4 month mark hit and we had a change over in the Rifle COY's exit Alpha and enter Bravo. We have also been busy with MEDCAPS which have occurred once every 1-2 months. This is a combined effort between FFDL, ISF and Ministry of Health. The MEDCAPS are usually conducted over 2 – 3 days in some of the outer villages. The clinics are a full on day from start to finish. Our last MEDCAP we saw over 850 people in 3 days.

The COY medics have been kept busy with ranges and patrols as well as helping out with the courses period. We have also had the chance to check out the USN Mercy that was over here as part of Pacific Partnership 2010.

As our rotation has almost come to end, we will be kept busy with stocktakes, handover to the new rotation 9RQR and finally our final pack up and departure. It has been a long 8 months and all of us are looking forward to getting home to spend some time with our families.



*L-R – CAPT Carl Bryant, SGT Troy Roberts, CPL Len Bigler and SGT Joao Carrascalao from DCP with the New Zealand Medics on Anzac day 2010.*



*L – R CPL Wayne Doolan, CPL Len Bigler, CAPT Carl Bryant, SGT Joao Carrascalao and SGT Troy Roberts.*

# 3rd Health Coy 9th Combat Service Support Battalion



The 3rd Health Company is a ARes Role 2 medical unit of the 9th Combat Service Support Battalion (9CSSB) was raised on 01 July 1995 at Warradale Barracks a. The unit's emblem is a platypus. It was chosen because it is a unique Australian animal that displays great resourcefulness and endeavor. The unit motto is 'Deeds Not Words', which reflects the unit attitude of action over rhetoric. 3rd Field Ambulance, our original unit was raised in 1914 saw service in both World Wars and proudly holds Simpson and his donkey as founding members.

3rd Health Company has 2x ARA medics, WO2 Jason Craig and myself. My role is OPS/ TRG /RAP /PAY/ EQUIP MAINTENANCE SGT (amongst other positions) which has been interesting and a big learning curve as it is my first posting to a reserve unit.. Our current OC is MAJ Grant Schuster, 2IC being CAPT Steven White and our CSM is WO2 Sandra Petrie. The reserves staff consist of 2x Medical Officers, 3 x Nursing Officers, We currently have 22 medics parading and has a Psych Support Team. Unfortunately WO2 Craig has been reposted to Combat Training Team in Townsville. We were very sad to see him go and miss his nicknames and his laugh

The company parades 3 Tuesdays and a weekend monthly maintaining all vaccinations and delivering health support to all Reserve members of 9 CSSB as well as the Australian Army Band – Adelaide and 1 MP – Adelaide. PTE Lavender and PTE Gabrielle do a great job of loading all members onto Health keys. It is hard to believe that in the couple of hours that we have on a parade Tuesday night we perform AHA, CPHE, MEGR, vaccinations and take any pathology that is required.

This year has been a very busy with never ending med support tasks. The company has provided support to the Clipsal 500, Junior Leaders courses at Murray Bridge Range (MUTA), Smithfield Careers Day, AUR support for both Mod 1 and Mod 2 RAINF courses at Cultana (CUTA), HRR and RRF training and members participating on Anzac Day. Our staff supported pre-deployment training of all Rotation 23 Op Anode staff as well.

Many of our Medics and Nursing Officers have been on a course this year from MARC Mod 1 and MARC Mod 2, CMA Mod 1, Mod 2A, Mod 2B, Junior Leaders Course, Sub 4 Mod 1, Sub 4 Mod 2.

Two of our medics, CPL Keating and PTE Lavender attended the first CMA Mod 3 course which was conducted in Perth and the CSM attended the Prohibited Substance Testing and Alcohol Testing course at Keswick. The company ran an annual skills maintenance weekend to enable medics to have their competency log books signed off after completing scenarios. Our highlight for the year was the 9CSSB Ball.



*PTE's Megan Sayers, Kara Hali, Veronica Hardy & LCPL Amy Eastham.*



*PTE Angella Gabrielle and her fiancé Steve.*

We have had many new additions this year including CPL Nicole Browne who gave birth to twin boys and are all doing well. We have welcomed new trainees into the company during the year, PTE Faccenda, PTE Flynn, PTE Dunne, PTE Kilford and PTE Christensen of which two of them have successfully completed their Mod 1 already.

*By: SGT Melissa Chandler*

# 10 Health Company

## 2nd Force Support Battalion

In the year 2000, 10 Field Ambulance changed its name to 10 Health Coy, which has a headquarters based in Hobart and a detachment in Launceston. 10 Health Coy is a reserve organisation tasked to provide level two health support to support the Battalion.

At 10 Health Coy there are many part-time positions available including: Doctors, Nursing Officers, Physical Training Instructors, Medical Assistants, Environmental Health Specialists, Drivers, a Store Person and Administration Clerks. 10 Health Coy is responsible for all medical training and support in Tasmania. This encompasses all units visiting the state, for whatever purpose including adventure training and unit exercises. We are also responsible for supporting DACC tasks and inter-unit support for resident units. All of these tasks give the soldiers the chance to demonstrate their skills and identify any inadequacies. Fortunately all the reports are favourable.

After the mandatory training at the beginning of the year it was time to begin the normal routine of external courses and ongoing currency training. This was conducted by members with a high amount of enthusiasm and professionalism considering their trade was in somewhat limbo.

In June the unit conducted a Combat Medical Attendant course, followed in July with a First Aid Recertification course, and they topped it off with a Combat First Aid course. A special thanks to WO2 Dave Leak who travelled down from Randwick to assist and instruct in all the courses.

The ARes staff at 10 Health Coy demonstrated their commitment and ability to conduct well organised and structured training courses, not only for local Tasmanian units, but the broader Army.

Capt Alisa Wickham, who predominantly organised all requirements for the above medical courses, has been aptly rewarded with a deployment to East Timor. Below is a photo of CAPT Alisa Wickham from the International Stabilisation Force (ISF) meeting with the local children in the village of Nitibe in the Oecussi enclave, East Timor during a Medical Civic Action Program (MEDCAP).

SGT Kieron Skinner has recently returned from Op Slipper, in between bouts of shivering he has stated it was a challenging experience and

has learnt a lot. CAPT John Kippax has recently returned after 2 weeks in P.N.G. In addition, many of our NO and medics have provided much needed instructor support throughout Australia.



10 Health Coy is fortunate to have two PTI's. CPL Sandy Eaton joined us earlier in the year from Darwin, which was good timing as WO2 Gavin Wickham is currently the acting RSM of 2 FSB. The PTI's role is to provide support to all ADO organisations in Tasmania. They currently provide support and / or guidance on physical conditioning, Military Self Defence, rehabilitation (musculoskeletal) and weight loss to Regular and Reserve ADF members in Tasmania.

Brigading of the health assets in Tasmania has resulted in 12/40 RTR and 16 Fd Bty RAP's being amalgamated with 10 Health Coy. This has been quite an effort in relation to the need for coordination of personnel and training needs all with different chains of command. What's very positive is the fact that the all staff have access to valuable training needs and the competencies of our staff maintained. Also, we have saved on the equipment needs and maintenance requirements in the Hobart region.



# 0001 Advanced Medical Technician Course

After an enduring three months in Elands River Platoon and just missing out on the BMAC 0057, we learnt that we would be a part of the newest training continuum which combines BMA and AMA components with a five month civilian placement working as Enrolled nurses.

At first we were not sure about what to expect on the course with very limited medical knowledge. Learning that our course was the first course to get the Enrolled Nursing certificate was a good goal to aim for. Then the anatomy and physiology lessons started and the work load became heavier, having to remember each individual system and what it all details seemed like a daunting task but we got through it and before we knew it we were on our first clinical placement of aged care. Once we got into our first clinical placement it became apparent that everything we were taught was relevant to our clinical care.

Clinical placement 2 came around and before we knew it we were starting Clinical placement 3 which put us into a military environment, we worked with such units as ARTC, RAAF WAGGA, 1HSB, 6AVN and 2CMDOREGT.

Clinical Placement four came and went very quickly working in mental health and rehabilitation facilities.

We finished our pharmacology and our drug calculation exams and sadly lost a few members of our course. Yet again before we knew it we had learnt our emergency drug protocols and started to prepare for our

field phase. The field phase was a great experience except for the – 1degree temperatures and the day's of rain we loved. It was a high tempo for nine days which involved assessment's on: Casualty Treatment Regimes, being evacuation medics, working in resuscitation bays and our favourite care under fire.

The next few weeks after field were finalising assessments, completing a BFA and preparing to go for our five month clinical placement. The majority of the students will head up to Sydney to work in such hospitals as Liverpool Hospital, Concord Hospital, Campbelltown Hospital and Camden Hospital. The rest of the students will be working in Albury Wodonga Health.

So after 9 long months training in HSW on the new continuum and receiving our Certificate IV in Nursing with drug endorsement and Cert IV Pathology we are ready to progress on and put all of our newly learnt skills into practice in civilian hospitals.

We both are looking forward to the next five months of civilian placement and the AMA component of course. There will be challenges ahead but hopefully we will be able to adapt and overcome as a team and become the first medics ever to complete the new Advanced Medical Technicians Course.

*By: Pte James Overall and Pte Aidan Matthews*

## The Nine Core Values of the RAAF as Applied to Medics

**The RAAF has nine core values. These values are to include:**

- Display honest commitment to the RAAF values,
- Strive for excellence,
- Be fair to and respect the rights of others,
- Balance work and family commitments,
- Work together as a team,
- Communicate in an open and honest manner,
- Be professional and innovative,
- Be recognised for their loyalty, Integrity and determination,
- Serve with pride and Dedication

The "RAAF Rules Of Fair Go" can be applied as a medic directly. A medic is relied upon in a time of need, wether for life saving intervention or just someone to confide in. It is for this reason these values are important. A medics adherence to the rules of a fair go are a strong base to ensure the conduct of a medic is of a high standard and keeps alive the proud history of medics in the ADF.

*By: CPL P. Sullivan*

**MASTER OF PUBLIC HEALTH  
(Defence)**



**The Centre for Military and Veteran's Health (CMVH) offers the Master of Public Health (Defence) through the University of Queensland**



Courses Start February and July  
Graduate Certificate and  
Graduate Diploma options

*Topics covered include:*

**Epidemiology**  
Occupational and Environmental Health  
Infectious and Tropical Diseases  
Health Aspects of Disaster  
Introduction to Military Medicine

For details on the MPH (Defence) and CMVH short courses, please call the Professional Development Officer on (07) 3346 4940, email [cmvh.enquiries@uq.edu.au](mailto:cmvh.enquiries@uq.edu.au) or visit [www.cmvh.org.au](http://www.cmvh.org.au)

*Advancing knowledge about the health issues of  
Australia's defence personnel and veterans*



Australian Government  
Department of Defence  
Department of Veterans' Affairs



THE UNIVERSITY  
OF QUEENSLAND  
AUSTRALIA



Charles Darwin  
UNIVERSITY



THE UNIVERSITY  
OF ADELAIDE  
AUSTRALIA

PAUL-3

**anspec**  
*Integrating Defence  
with the Pharmaceutical Industry*

[www.anspec.com.au](http://www.anspec.com.au)

PAUL-3



**DELTA MEDICAL**

**DISPOSABLE MEDICAL PRODUCTS**

**OPERATING/THEATRE HEADWEAR**

Berets Lightweight, Circular Hats, Tieback Hats, Surgeons  
Hoods, Head Scarves, Face Shields

**SUNDRY DISPOSABLEWEAR**

Overshoes, Fluid Barrier Boots, Sleeve Covers, Aprons,  
Gowns, Briefs, Pelvic Vees, Arm Slings

**INCONTINENCE PRODUCTS**

Bed Pads

**ABSORPTION PRODUCTS**

Underpads, Procedure Mats, Draw Sheets

**MISCELLANEOUS PRODUCTS**

Mattress Protectors, Body Bags, Arm Boards

DELTA MEDICAL Ph: 1800 033 191  
PO BOX 4394, LOGANHOLME DC QLD 4129  
90 CHETWYND STREET, LOGANHOLM QLD 4129  
Phone: (07) 3209 9733 Fax: (07) 3209 9744  
Email: [info@paradisepvc.com.au](mailto:info@paradisepvc.com.au)

**ISO 9001:2000**

For the sale of medical & surgical products

PAUL-3

**Synthes.** Dedicated to health

Suppliers of premium  
orthopaedic instruments,  
implants and training  
to the defence force  
since 1973



**SYNTHES**®

1800 synthes  
[www.synthes.com](http://www.synthes.com)  
[assist.au@synthes.com](mailto:assist.au@synthes.com)

PAUL-3

# Army School of Health

## Advanced Medical Training Team

The Advanced Medical Training Team (AMTT) headed by CAPT Sean Parker with WO2 Nathan Holdforth, SGT Jason Brown, SGT Richard Kelson, SGT Christopher Owen, SGT Matthew Shoemark, SGT Adam Tyne and SGT Luke Woodland has had another successful year with close to 80 Basic Medical Operators trained and qualified as Advanced Medical Technicians (AMT).

AMTT is supported by Monash University with Mr John Knight and Mr Mal Peters providing excellent tuition to AMAC students. With our third back to back and over lapping course running for the year the last of the AMAC courses as we know it is due to end come 15 Oct 10. The first of the medics trained under the new continuum will arrive at AMTT on 22 Nov 10, a busy end to the year.

AMTT has developed and incorporated a number of changes to the way we train and assess the future AMT. Of significance is the team approach to the ACLS assessment, with a four person team the AMT is expected to lead, supervise and treat a cardiac patient. Another major element of the course is ATLS; the ATLS assessment has become more robust and incorporates Care of the Battle Casualty (CBC) and places increased physical and mental challenges on the AMT prior to treating their casualty. EX GASCON is the primary activity for the training of AMTs in ATLS and includes a bullring to refresh BLS and introduce advanced interventions and culminates in a two day field activity practicing CBC and ATLS. To those staff moving on in 2011, good luck with your future endeavours and for those staying keep up the excellent training.

## EX JOHORE MERSING

### The Return of the Celeriter

A major activity conducted during the AMAC course is EX JOHORE MERSING. The name Johore Mersing refers to an area of the Malaya peninsula which the Australian 8th Division was tasked with defending in August 1941. A number of medical units were located in this area of Malaya, of note was the 2/9 Field Ambulance. With Japanese forces bearing down on them, not only did they achieve patient treatment they made record time of deploying and redeploying, moving hundreds of tons of personnel and equipment. In addition to receiving and treating casualties the 2/9 Field Ambulance constructed almost 1 km of road and a large bomb proof underground dressing station. Casualty rates reached were 3.5 per 100 troops by September 1941, approximately 400-500 per day.

EX JOHORE MERSING is a team activity designed to test the courage, initiative and teamwork of course students, it builds on mateship and Espirit de Corps. The half day activity is conducted over a gruelling 10 km course and includes the obstacle course, stretcher carry, patient treatment + stretcher carry, quick decision exercise, PT stand, equipment carry and closes with another stretcher carry. This activity has been run twice, the winning team from the 0042 AMAC completed the course in 1 hr 34 min. After a significant adjustment to the course the winning team from the 0043 AMAC completed the course in 2 hr 22 min. A mighty achievement by both teams and each time lead across the line by SGT Luke Woodland, the challenge exists for the 0048 AMAC to better the time of 2 hr 22 min and for SGT Woodland to achieve a third victory.



0042 AMAC                      25 Jan – 14 May                      Syndicate 1  
SGT Woodland, CPL Dobson, PTE Allen, PTE Boyce, PTE Braithwaite-Smith,  
PTE Cook, PTE Dovey, PTE DeBoer, PTE Fiebig, PTE Green.



0043 AMAC                      19 Apr – 30 Jul                      Syndicate 3  
SGT Woodland, PTE Budworth, PTE Elliott, PTE Gardiner, PTE Gummow,  
PTE Kirby, PTE McInnes and PTE Vivier.

# Army School of Health Training Developments

Within the Army School of Health, Health Services Wing conducts trade training for health professionals and providers within the Army. Health training needs to remain relevant, current and to the highest standard of instruction given the importance of health assets to military operations. As a consequence, training programs are subject to continual evaluation, review and improvement. Some of the most recent developments in the development and implementation of health training within the Army School of Health includes:

## Medic Training

The recent development of medic training now allows an independently operating medical capability in a much shorter time frame. This new training continuum has commenced and is going well. The Basic Medical Training Team conducts the initial medical trade training which covers pre-hospital care and operational environment medic skills. The Royal Melbourne Institute of Technology (RMIT) play a large role in the delivery of this component of training. The Advanced Medical Training Team conduct the advanced component of the medic course and covers emergency care of the battlefield casualty, primary health care and the medical administration required to practice in the operational and barracks environment. The training is conducted with Monash University and at completion of training the graduates are eligible for applying for recognition towards the Diploma of Paramedic Studies offered by Monash. The Reserve courses train the Combat Medical Attendant to achieve Army qualifications that enable them to support Reserve activities on operations and in the barracks and field environment.



## Specialist Nursing / Medical Officer Training

The Nursing Officer course is undergoing review to improve the sequencing of the course to allow for greater flexibility in attendance, particularly for Reserve nurses. The issue of recertification is being addressed including the use of professional logbooks to ensure robust training and continuing professional development. The Medical Officer training course focuses on the management of mass casualty situations,

trauma casualties, deployed health and the provision of Army healthcare. Development of this course is underway to identify relevant competencies for inclusion in the course.



## Environmental Health

The Preventative Medicine Technician Trade is about to undergo major changes to its training continuum to incorporate a new industrial hygiene monitoring capability. The changes will involve the inclusion of an intermediate course and a revamp of the advanced course. The intermediate course will include training on the use of industrial hygiene monitoring equipment such as noise dosimeter kits, sound level meters, light meters, environmental stress index monitors, air samplers, anemometers, vibration meters and air particulate kits.

The advanced course will include planning and strategies for monitoring industrial hygiene in the workplace. This will give Army a new capability to conduct regular planned industrial hygiene monitoring of workplaces whilst on operations. Industrial hygiene equipment will be procured and issued to all units that contain Preventive Medicine assets so the newly trained technicians can commence industrial hygiene monitoring in their workplace.

The Preventative Medicine Basic Course is also undergoing some changes. Primarily the course is undergoing processes to enable the recognition of more civilian accreditation for members completing the course. This involves replacing 12 Defence Industry Units of Competency and replacing them with 36 Nationally recognised Units of Competency including a CERT III in Public Safety (Preventive Medicine).

## Psychology

The Examiner Psychological Trade has just commenced a large scale review of capability and training to ensure that the most updated and appropriate mental health support is being provided to ADF personnel. The provision of mental health support in the military is a high priority at this stage and will see the roll out of new and improved training as per capability requirements in early 2012. Current civilian training programs will be utilised to provide best practice training as well as awarding civilian qualifications as the foundation of the mental health work that Examiner Psychological's undertake.

# Health Cell – ASLO – ALTC

The Army School of Logistic Operations (ASLO) is situated at South Bandiana in the North East of Victoria. The school is the key enabling training institution for Army's Combat Service Support (CSS) officers and soldiers. Its structure is centred on an Integrated Logistics cell, which delivers common and underpinning CSS training to the Suite of Logistic Officer Courses (SOLOC) and; Special to Corps (STC) cells that deliver the specific corps centric training to the STC components of the SOLOC and respective STC subject courses for sergeant and corporal. The important message for 'Paulatim' readers is that all RAAMC personnel will, at some stage, undertake one or more courses at ASLO as part of their career continuum.

The instructional ideology at ASLO, and specifically, within the Health Cell, focuses on preparing officers, warrant officers and senior non-commissioned officers to undertake employment roles within the CSS environment and specifically, in the Health space. In this, the Health Cell aims to present relevant and contemporary instruction built around Health Support doctrine in the first instance, but also focuses on Corps Ethos and Traditions, Health Trades Management, Health Administration and varying levels of exposure to Health Planning. It is often noted that Specialist Service Officers are generally on a relative steep learning

curve in coming to terms with fundamental military skills such as formats for the delivery of orders and understanding the machinations of the Military Appreciation Process.

The course load at ASLO, following on from previous years, remains consistently heavy. As such, 2010 will see the completion of two LOACs, three LOICs, two LOBCs, three WOCSS courses and numerous STC subject courses. Despite the course load, instructors posted to ASLO enjoy the opportunity to meet new Health Services personnel and catch up with others as they cycle through their career courses.

RAAMC personnel are well represented at ASLO, forming 15 percent of the school staff. To that end, the Health Cell welcomed two new instructors in 2010: joining CAPT Trav Radford and WO2 Adrian Spencer is CAPT Damon Higginbotham and WO2 George Phillips. RAAMC personnel posted to other roles at ASLO include MAJ Bruce Murfin (2IC ASLO), CAPT Carl Knaggs (Lead Instructor WOCSS course) and WO2 Rod Folvig (LOIC course manager). Posted out of ASLO and commencing new roles in 2010 are MAJ Danny McCuaig, CAPT Damien Batty, CAPT Donald Harding, WO2 Jason Craig and WO2 Josh McDade.



**RAAMC staff at the Army School of Logistic Operations**

*L-R: MAJ Bruce Murfin, WO2 Adrian Spencer, CAPT Trav Radford, CAPT Damon Higginbotham, CAPT Carl Knaggs, WO2 George Phillips and WO2 Rod Folvig.*

# “The Knowledge — Skills we have so others may live”

This article is not just about places where people are deployed, or what's happening in some Hospital or RAP. This is about where “The Knowledge” to improve the skills for medics is going, and asks why limited knowledge is being passed onto medics who are about to deploy, and why the knowledge from the SF community is not being made available to others.

**“The knowledge** is information, or lessons learnt, from medics to medics.”

As background, I joined the Royal Australian Army Medical Corps in September 2000, commencing my training as part of MA1 and MA2. This course was based on basic medical teachings — this is where “The Knowledge” began. After the course, I was posted to Kapooka Health Centre, and here I practiced my skill and improved on “The Knowledge” that I had been given. After 18 months, I went onto the Advanced Army Medical Course (AAMC). This is where “The Knowledge” increased and I began to learn new procedures and practices. Danger, Respond, Airway, Breathing, Circulation (DRABC) became the focus of “The Knowledge”. As a SNCO, I was now able to shape some training as part of unit CFA courses. Still DRABC was the basis of “The Knowledge”.

When Australia's involvement in Afghanistan starts we find “The Knowledge” that we had was not up to speed. DRABC was all good and well on exercise but out with the FOB's a new facet to “The Knowledge” was needed and fast. In the last two deployments to Afghanistan (being MRTF1 and MRTF2), all the medics who deployed have agreed that they were not prepared for the deployment. They spent their time preparing the battalions for the trip — med boards and inoculation parades. But at no time had there been any feedback to assist with training the medics, or to improve on “The Knowledge” that they would need.

The 6th Battalion, Royal Australian Regiment is warned out for deployment in 2008, MTF-1 is raised, all company groups are reshuffled into mentor and combat teams and the medics are placed into each company. In April 2009, for the first time, the RAP and 40 CFAs in the battalion get training from specialist groups. The RAP staff and the CFAs go to the Army School of Health, and with assistance from CareFlight.

This training was by far the best training that we have received. September finally arrives and the team from the School with the same members from CareFlight come up for a second week of training. After that week we then move over to 7 CSSB and conduct two weeks of further training, which is run by a civilian company called Fulcrum.

They run us through more scenarios and quick decision activities. And this pays off with more Knowledge for later use.

November arrives and we finally conduct the BG MRE we were supporting the BG, rather than improving our Knowledge, we received some information from the medics in country. It was only once we get into country that we get some quality information from the medics in our FOB's. All of us have reservations with what to expect and how to deal with it.

Nothing happens for a month and suddenly I receive 3 casualties as a result of an IED explosion east of the patrol base. We treat the casualties and evac them to TK and they survive, and my confidence increases — all the training we had pays off.



*Myself on left and CFA on right, Cat A and B awaiting AME.*

Our Knowledge increases tenfold, as does our experience. Finally ROGL comes around and I head back to TK for a break then onto home. I catch up with SOTG medic and we exchange “the knowledge”. I tell him I carry far less equipment than him, and I make the point that his task is different to mine. But his response is simple and to the point:

**“What makes you think that my guys don't bleed the same as your guys?”**

I feel embarrassed at this point and I immediately change my opinion. I ask him why he thought this knowledge wasn't being passed on, and why other medics didn't know this stuff. And he said, “All you need to do is ask”. And there it is...ask.

I arrived in AMAB and found the medics there wanting “The Knowledge” to pass onto the incoming elements on RSO&I, as they were unaware of

what was happening in-country. They were asking for info but nothing was being sent to them. I pass on some stuff and they all listened intently. Even the MO was interested.



AME complete.

## Conclusion

In the quest for "The Knowledge", I knew I had asked questions of the medics from MRTF-2, and they provided the answers to those questions – stuff like how much medical equipment to carry, situation with treating the locals and the Afghan soldiers, anything that would help us prepare. The MRE did not help us, as it was primarily focussed on the Infantry skills. However, the training at the School with CareFlight, and in Brisbane with Fulcrum was invaluable.

I find that most medics are happy to pass knowledge on to those who ask – even the SOTG medics are more than happy to tell us what they

have learnt, what they did to treat their casualties, what works for them, and what didn't work. OPSEC should not be a reason for withholding these lessons.

This also starts with the right teaching at a basic level. Tactical Care of the Combat Casualty (TCCC) is the fundamental teaching that should be taught from the basic level. SOTG have been using the TCCC for almost a decade, but the rest of the Army is now coming to terms that we are well behind in military first aid. TCCC works, and has been proven by many medics and CFAs.

Some people may get offended by what I have said, but if we can't say it, who will and when will things change?. All we are talking about is the best way to save lives and that means teaching the right stuff...opinion...Stay safe.

By: SGT T Binyon



SGT BINYON resting during a short halt.

**MT. BARKER & DISTRICT  
HEALTH SERVICES INC.**

INCORPORATING  
MT. BARKER DISTRICT SOLDIERS  
MEMORIAL HOSPITAL & ADELAIDE  
HILLS COMMUNITY HEALTH SERVICES

Mt Barker District Soldiers Memorial Hospital Inc (incorporating Adelaide Hills Community Health Service) celebrated 80 years of service to the Community in 1999. Providing: Acute Medical, Surgical and Obstetric Care, Community Nursing, Health Promotion and Domiciliary Care. Established in 1919 by the Mount Barker Community and named in honour of soldiers from the district who served and died in the Great War of 1914-1919. Supporting the Local Community.

**Wellington Road, Mt Barket SA  
P.O. Box 42, Mt Barker 5251  
Ph: (08) 8393 1777 • Fax (08) 8393 1700**

Government of South Australia  
Country Health SA Inc

PAUL-3

**TDAdesign.com.au**

## Desktop Publishing

*Prepress specialist in:*

- Magazines
- Newsletters
- Diaries
- Stationery
- Books
- Journals
- Advertisements
- Calendars

**0409 944 844**

Email: [prepress@tdadesign.com.au](mailto:prepress@tdadesign.com.au)  
Web: [www.tdadesign.com.au](http://www.tdadesign.com.au)

PAUL-3

# Breaking the chain: Townsville Field Training Area 2010

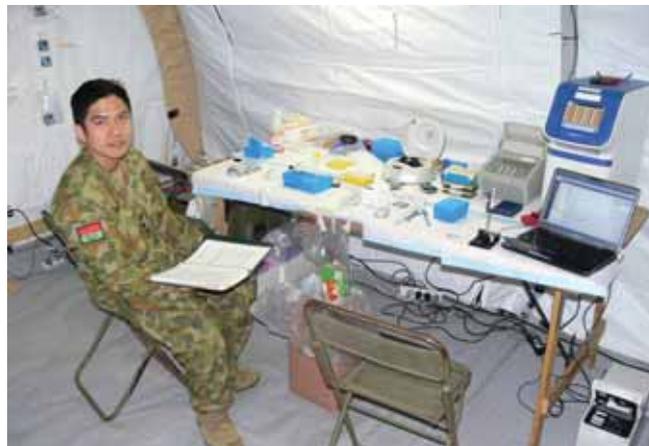
Years in the making, a front line “crack” team of environmental health professionals and specialists descended upon Townsville Field Training Area (TFTA) in May 2010. The TFTA, never before completely assessed by environmental health personnel, was to be dissected by entomologist to virologists, Western Australians to Tasmanians. No stone was to be left unturned, no insect was to escape investigation, and no water point was to miss examination. From arboviruses to zoonotic diseases all was to be exposed to the masses. This began the most comprehensive Health Assessment ever to be completed on the TFTA.

For years myths circulated of an elite team of environmental health brethren with roles idyllically tailored to break the chain of infection and disease proactively in the field. Unknown to most, concealed in doctrine, and laying dormant after several previous attempts to orchestrate, was a Health Assessment Team (HAT).



*HAT at Camp Engstrom (left to right), MAJ Steven Frances, CPL Shannon Beckman, LT Ben Brumpton, PTE Kenneth Breen, CAPT Brady McPherson, LCPL Ben Scalzo, CAPT Andrew Tout, CAPT Weng Chow, LT Richard Bradbury, Dr Russell McInnes, MAJ Tim Inglis.*

On the 12th May 2010, this myth became reality with a combined team of 1st Health Support Battalion, 2nd Health Support Battalion, Army Malaria Institute, full time and reservist members joining forces to create the HAT. Exercise TOP HAT, as the field component was known, was conducted during the period 12 – 21 May 2010 in the TFTA. The HAT consisted of 11 personnel which included a Public Health Physician, an Entomologist, Environmental Health Officers and technicians as well as Scientific Officers. All these personnel had one key goal, to collect and analyse environmental health information and advise on environmental health countermeasures. In addition to key personnel the HAT was bombed-up with a range of arsenal including;



*Scientific Officer CAPT Weng Chow recording PCR results.*

epidemiology surveillance data, geographical information systems, water analysis equipment, environmental samplers, vector traps and a sophisticated polymerase chain reaction (PCR) laboratory. Each piece of equipment guided by skilled personnel provided a comprehensive picture and analysis of the health risks associated with the TFTA.

The TFTA, which is located 50 km west of Townsville, North Queensland, poses a number of important disease and safety threats to the health of military personnel. Discussed below are some of the more interesting or hazardous findings, beginning with climate. PCR results confirmed the presence of the Ross River, Barmah Forest and Murray Valley Encephalitis viruses within trapped mosquito vectors from the TFTA. This finding enforces the need for strict compliance to mosquito control measures by all personnel deploying into the TFTA.

Health surveillance data also revealed motor vehicle accidents as a substantial risk to military personnel. The road system within the TFTA is variable depending on the time of year and recent use. There have been numerous motor vehicle accidents on the range in recent years with several accidents occurring whilst the survey team was present in the training area. This finding reinforces the need to exercise caution at all times when driving a motor vehicle.

The close environment of military training also provides opportunities for outbreaks of communicable diseases, particularly food and water borne diseases and those relating to personal hygiene. It is imperative that commanders enforce safe food and water practices and deploy with adequate hygiene supplies such as soap and handtowel. Water sources in the TFTA must be monitored by Environmental Health personnel to ensure it is fit for consumption.



*Entomologist MAJ Steven Frances and PTE Ben Scalzo indentifying adult mosquitoes.*

The TFTA also harbours a variety of flora and fauna which can cause serious illness or even death to troops in the field. Military personnel, in particular medical staff, should be familiar with the main features of these hazardous flora and fauna and all personnel must be aware of the first aid principles required to treat personnel who come into contact with them.

TFTA's climate and unique history of mining, military and agricultural activities also came under examination and was found to present a number of other safety hazards. These included Unexploded Ordinances (UXOs), disused mining shafts, cattle dips, fire and other severe weather events. Personnel need to be vigilant of their own safety and report any safety hazards to Range Control.



*TFTA hazardous site, Argentine smelter.*



*CPL Shannon Beckman water testing at Line Creek Junction.*

The information gathered during EX TOP HAT was used to compile a number of products. These products include a comprehensive report and risk assessment of the threats/hazards, an action-report directed at DSG, an Environmental Health pre-deployment presentation and brief as well as an information brochure that targets personnel deploying into the TFTA. Both hard and electronic copies of all these products will be available soon.

With a core belief in prevention, you can be assured that Environmental Health is doing its best to train and utilise our experience to prevent disease and non-battle injuries both nationally and internationally. As technology improves, faster, more comprehensive and more accurate assessments can be conducted to provide targeted environmental and occupational health support to deployed forces. It is hoped that with the success of EX TOP HAT in 2010, other training areas can be assessed on a yearly basis ensuring up-to-date information is available to commanders and health planners at all times.

*By: LT Ben Brumpton*

# HQ 1 DIV G07 Branch 2010

January 2010 witnessed the change in roles for Headquarters 1st Division, with a move away from the raise, train, sustain function as the Headquarters to the deployable brigades; to the role of administering, mounting, force preparing, assessing and certifying, as well as demounting of force elements and individuals deploying on Operations. In addition to this, the Headquarters has also retained its more traditional role of deploying a scalable Joint Task Force Headquarters for short notice contingency Operations (except for Pak Assist though...). This change in focus has presented the health branch staff with some excellent opportunities to develop their professionalism in health planning, as well as improve our sense of humour. A run down of the year's events include, EX Pozieres Prospect, Care of the Battle Casualty (CBC) Training, Ex Primary Survey 1, 2 and 3, Psych, AACAP veterinary duties and the Kokoda Challenge.

Ex POZIERES LAUNCH is the writing exercise which sets the architecture for the series, providing a framework for the Brigades to work within utilising JTFHQ as the deployed higher Headquarters. Major David Bullock and Captains Dan Briffa and Amanda Parry set about the production of a suitable Health Support Plan, health briefings, health CONOPS and start states for each of the three Brigade Exercises. Ex PP1 – PP3 are the Brigade exercises, culminating with Ex PP4 (HAMEL) during which the forthcoming on-line Brigade and associated CSS elements within 17 CSS Bde conducts a Mission Rehearsal Exercise (MRE).

With the threat of a tropical cyclone off the north coast of Queensland, PP1 began with a tactical JTFHQ deployed aboard HMAS Manoora. CAPT Parry joined the merry party as the Health watchkeeper. Within a day of leaving the serenity of Cairns, seas started to get progressively rougher. Inside the JOR (room on top of ship with maximum movement and no windows), the war continued with communications successfully established with 1 Bde on land. With sea states reaching 5 (swell of 4-6 m) and an impending threat of 6, the CCTV screen provided little reassurance showing waves breaking over the bow of the ship, nor did a water bottle as it sailed unassisted across the room. As the colour drained from many a face, a few of us less sea-worthy individuals escaped to the comfort of our bunks. For those of you who haven't had the fortune of living on a ship, picture a coffin with one open side stacked 3 high, and that is more or less a bunk. Armed with the obligatory sick-bag this bunk was a haven. Needless to say, there was little indulgence of the Navy food onboard.

Simulating the arrival of the tac JTFHQ in the destination country, we moved back onto dry land (although still feeling the movement), and re-established comms. Long hours drained the energy of the skeleton JOR but in a closing address the COMD said that he was "unable to

break" the JOR. All scenarios were dealt with successfully and many lessons learnt (including a resolution to never apply for the RAN).

Ex PP2 bore witness to the deployment of JTFHQ, 3 Bde and 17 CSS Bde who synchronised Ex WARHORSE to the PP series facilitating the CPX of the logistic and healthcare continuums in a field environment. The health cells of JTFHQ and HQ 17 CSS bde and personnel from 1, 2 & 3 HSB were tested in the art of providing health support in an adaptive army concept. Despite communications and electronic connectivity difficulties resulting from elements being deployed in Brisbane, Townsville and Canungra, all objectives were achieved and lessons identified for more effective integration.

As the JTFHQ deployments are scalable, the Ex PP series will culminate in 2010 with the deployment of the Major JTFHQ to Townsville to provide the deployed JTF 661 in support of 3 Brigade during Ex HAMEL, 2 HSB during MRE and the 3 CSSB field trial of the CS Health Coy concept.

Along with many other South-East Queensland based organisations, the health branch decided to enter a team for the 2010 Kokoda Challenge, a 96km trek through the Gold Coast hinterland raising money for the Kokoda Youth Program. The "1 Div Warriors" team was captained by CAPT Dan Briffa, and included MAJ Dave Bullock as well as two other non-medical members of the Headquarters, MAJ Anita Gannon and CPL Nicole Morse.

With the number of teams limited this year to 300, positions filled up fast and team leader CAPT Briffa took a risk entering a team despite having only one other team member (MAJ Bullock), no support crew and no idea how to raise the minimum \$2000 fundraising support. Despite the unassuming beginning, strict adherence to the Corps motto ensured that little by little, the 1 Div Warriors raised a team of four, support crew of three, obtained uniforms, raised \$2850 and completed the course with all members crossing the finish line together with flair, panache and sore legs.



Kokoda challenge night.

Hiccups and set backs along the way included team training nonchalance and a courier company mix up resulting in MAJ Gannon driving 100km less than 24hr prior to the event to pick up the team uniforms herself. In the end however, the entire team made it to the start line appropriately attired and carbo-loaded from a Hog's Breath meal the night before. The set backs certainly didn't end at the start line however; just three hours into the event the team captain suffered leg cramps. Despite being initially dejected about slowing the team down, CAPT Briffa's spirits markedly improved after a leg rub from MAJ Bullock and by getting into MAJ Anita Gannon's pants. Looking decidedly debonair in his newly acquired purple skins, CAPT Briffa was able to continue on, albeit at a reduced pace. The successful result of all team members crossing the line together in 25hrs was testament to the team and crew's mateship and tenacity.



*Kokoda challenge finish.*

In addition to all the other activities mentioned, the health branch also managed to participate actively in many aspects of force preparation such as the CBC training conducted at 39 PSB, and the Ex Primary Survey series. In order to achieve this, the health branch relied heavily on two of its reservists, MAJ Dan Belanszky and WO2 Nina Valencia. Thanks largely to their efforts HQ 1 Div was not only able to maintain a presence at all of these activities from a certification standpoint, but



*Health branch rock.*

also in many instances provided an Observer Trainer in the form of WO2 Nina Valencia. Despite the busy schedule and large amounts of time spent away, the force preparation team also found the time to run an Army First Aid Refresher course, (now a pre-requisite for CBC, CFA and other related courses) re-certifying over 60 of the Headquarters staff.

Despite HQ 1 Div having changed role to that of Force Preparation, mounting and demounting, the ability of the HQ to deploy a penny packeted, effects orientated JTFHQ remains at the forefront of the 1 Div mission and one of the many challenges this year has been getting the message out about the new, dual roles of the Div. Needless to say the Health Branch has been kept busy this year with three full time and four part time staff managing to support four Pozieres CPX activities, three Primary Survey Exercises, numerous CBC courses, run several AFA Refresher courses and still allow time for staff to attend career development courses such as Grade 2, Grade 3 and Joint Health Planning Course.

*By: Capt Briffa RAAMC*

# "National Boer War Memorial"



## YOU ARE INVITED TO HELP COMMEMORATE THE VETERANS OF THE BOER WAR

The Prime Minister, as Chairman of the National Capital Memorials Committee, has allocated a site in ANZAC Parade, Canberra for the funding, design and construction of a National Boer War Memorial (NBWM) to commemorate the soldiers and nurses who served in South Africa between 1899 and 1902.

The Government has stated that Australia-wide community support must be demonstrated before it will give any financial assistance. It is estimated that about \$3 million will be needed to complete the memorial by the designated deadline.



## They were the first ANZACs



## AUSTRALIANS & NEW ZEALANDERS FOUGHT TOGETHER DURING THE BOER WAR

It's estimated that some 23,000 Australians & 6,057 New Zealanders served in the Boer War with nearly 1,000 & 232 respectively dying in South Africa.

Australian and New Zealand contingent troops played a prominent part in most of the major actions of the Boer War, while others serving with local or Imperial units represented our two countries in every action that was fought.

The ANZACs quickly established an enviable reputation as superb fighters using their bushcraft, riding and shooting skills to produce formidable fighting units and future commanders.

## Six Victoria Crosses Awarded



*During the Boer War, six Australians and one New Zealander were awarded the Victoria Cross, the highest award for exceptional valour.*

## RECOGNISING THE HEROIC DEEDS OF BOER WAR VC WINNERS

Recognising the major aspects of the Campaign will be a requirement for the design of the National Boer War Memorial in Canberra. The courageous deeds of these Australian VC winners will also be a feature:

- CAPT Neville Howse, NSW Army Medical Corps. Vredefort, Orange Free State, 24/7/1900.
- LT Guy Wylly, 1st Tasmanian Imperial Bushmen. Warm Bad, Transvall, 1/9/1900.
- TPR John Bisdee, 1st Tasmanian Imperial Bushmen. Warm Bad, Transvall, 1/9/1900.
- LT Frederick Bell, 6th West Australian Mtd Infantry. Brakpan, Transvaal, 16/5/1901.
- SGT James Rogers, South African Constabulary. Thaba 'Nchu, Orange Free State, 15/6/1901.
- LT Leslie Maygar, 5th Victorian Mounted Rifles. Geelhoutboom, Natal, 23/11/1901



*Adelaide's Boer War Memorial.*

# A National Boer War Memorial to be Built

## A NATIONAL DESIGN COMPETITION

A National Competition will be conducted to attract a wide selection of design submissions for the design of a new NBWM on Canberra's Anzac Parade. The Prime Minister, as the Chairman of the National Capital Memorials Committee, will then decide on the winning design.



## PUBLIC RECOGNITION OF DONORS

### PLATINUM • GOLD • SILVER • BRONZE

Donations of any amount are valuable to us. To better recognise larger donations we will award these three levels of certificates which will entitle the donors to use that level donor logo on their organisation's stationery.

<b>BRONZE</b>	\$1,000 to \$9,999
<b>SILVER</b>	\$10,000 to \$49,999
<b>GOLD</b>	\$50,000 to \$99,000
<b>PLATINUM</b>	\$100,000 and above

Gold and Platinum donors will also have their logos placed on future NBWM materials and our website.

## Why a National Boer War Memorial?



### OTHER MAJOR WARS ARE COMMEMORATED IN CANBERRA BUT NOT THE BOER WAR

The Boer War is significant because apart from World War I and World War II the nation lost more soldiers there than the total of all conflicts

since WWII including the Malaysian Emergency, Korea, the Indonesian Confrontation, Vietnam, East Timor Iraq and Afghanistan.

It should not have taken all this time for Australia to formally recognise their sacrifice. Australians now have the opportunity to address this by joining the NBWM volunteers and/or donating to the NBWM Fund.

For further information, Tel: (02) 8335 5309

Fax: (02) 8335 5357

Email: [bwmthree@bigpond.com](mailto:bwmthree@bigpond.com)

Web: [www.bwm.org.au](http://www.bwm.org.au)

## Donations needed to fund the Memorial



### FOR THE BOER WAR MEMORIAL PROJECT TO SUCCEED IT WILL NEED YOUR SUPPORT

#### PLEASE DONATE

- by electronic transfer to the Defence Credit Union Account ~ BSB: 803-205, Account No. 20739876;
- by credit card or secure PayPal account using [www.bwm.org.au](http://www.bwm.org.au); or
- by mail to NBWM, Building 96 Victoria Barracks, Paddington NSW 2021

*Official NBWM receipts will be issued to satisfy Tax Office deductibility requirements.*

# EX RIMPAC 10 – Living the Dream

It is not often that a GSO RAAMC Officer gets the opportunity to gain experience as a Battle Captain but Exercise Rim-of-the-Pacific (RIMPAC) 2010 gave me such an opportunity.

EX RIMPAC 10 was the 22nd exercise in the series and included over 14 nations with the United States, Australia, Canada, Chile, Japan, Peru and the Republic of Korea as standing participants. A multinational maritime exercise, it is designed to enhance key war fighting skill sets and coalition interoperability enabling coalition partner participation in realistic littoral operations. Thirty-five ships, 200 aircraft and 20,000 personnel took part. It is held every two years and is the largest exercise in the world.

I was selected as one of four Battle Captains who worked in the Combined Forces Land Component Command (CFLCC) which consisted of staff drawn from the United States Marine Corps (USMC), Canadian Army, Republic of Korea Army and Australian Army. The primary role of the CFLCC was to represent the combined ground forces and facilitate command and control between the Command Combined Task Force (CCTF) and Special Purpose Marine Air Ground Task Force (SPMAGTF).

Although we all spoke English, I did encounter some language problems with the USMC personnel. The main asset of the CFLCC was the

SPMAGTF. It was a combined force that, as the name indicates, contained air, ground, logistic and maritime elements. The SPMAGTF was dispersed across three ships: USS Bonhomme Richard (BHR), USS Cleveland (CLV) and HMAS Kanimbla (KAN). The majority of the SPMAGTF were located on the BHR with a Coy (+) on KAN and Coy (+) on CLV.

While many of the Australian participants were afloat during the exercise, I was based at the Pacific Warfighting Centre at Ford Island. This provided me a unique opportunity to learn about the history of Pearl Harbour. I was also impressed with the Pearl Harbour Naval Base. Among the many wonders was the accommodation which was, by Australian Army standards, excellent as I did not require my sleeping



*A photo of all the ships participating in RIMPAC 10 with the aircraft carrier, USS Ronald Regan, leading.*



*A USMC AAV crew conducting ship to shore rehearsals.*



*SPMAGTF personnel conducting amphibious assault rehearsals at MCBH.*



*A USMC AAV driver carefully negotiating their way back onto the HMAS Kanimbla.*



*A LCAC returning to ship after cross loading equipment.*



*USMC personnel from the SPMAGTF unloading from a CH-53 at PTA for the FSCEX.*



*Various personnel being evacuated by the SPMAGTF during the NEO scenario.*



*A LCAC unloading equipment for the SPMAGTF during the NEO scenario at MCTAB .*

bag, stretcher or hootchie. I was, in fact, presented with a room that contained a bed, bathroom, TV, lounge, fridge and microwave.

Some of the highlights for me from a military perspective were observing the 2 RAR soldiers ‘splash’ and ‘swim’ ashore in the US Amphibious Assault Vehicles(AAVs) that apparently accommodate up to 21 soldiers. I was told they are not designed for comfort and that not everybody enjoyed the experience. I was also fortunate enough to see a number of other ship to shore insertion methods. In addition I was able to participate as a role player during the NEO.

A number of medical exercises were conducted during the exercise including a mass casualty exercise that involved several ships and over 50 casualties. Any personnel injured were treated on board their ships and if required backloaded to the Tripler Army Medical Centre or the Queens Medical Centre in Honolulu.

EX RIMPAC 10 was one of the best experiences of my military career. I greatly enjoyed working with service personnel from my own and other countries as well as other cultures, learning how they do things and broadening my skills base. It was a unique opportunity for this GSO RAAMC to participate in such and exercise and in such a different role and for that I am very grateful. I look forward to participating in the next one!

*By: Capt Driver, RAAMC*



*SPMAGTF personnel participating in the FSCEX at PTA.*

# Diploma of Paramedical Science

The flourishing relationship between the ADF and Monash University has delivered Defence members with a unique career advancing opportunity via a pathway to attaining a Diploma of Paramedical Science (Ambulance).

Qualified Monash University staff will now be able to assess ADF Advanced Medical Technicians (AMTs) for certain skills, and award suitably qualified AMTs with the Diploma through a process known as Recognition of Prior Learning (RPL). The additional qualification will provide eligible ADF members with another career path opportunity.

Albury-based WO2 Matt Franks has recently taken advantage of the RPL process, and after an assessment and demonstration of his skills and knowledge using 'competency mapping', was awarded the Diploma.

WO2 Franks said he was pleased with the ease of the RPL process, which recognises the unique roles and responsibilities of ADF AMTs.

"I was confident that twenty years of ADF training and work had provided me with the necessary knowledge and expertise to attain the Diploma, and the Monash University assessors avoided the confusing

terminology and complicated paperwork often used in the sector," WO2 Franks said.

"As Monash University respects the ADF as a credible organisation that delivers high quality training to AMTs, assessment was simple and also very affordable.

"I could demonstrate my competencies easily and provide the necessary evidence to support my Diploma application.

"The paperwork I had to complete – from application through to the final presentation of evidence and assessment – was straightforward. The entire process from application to qualification took only four weeks, and I would strongly recommend to any ADF member in a similar situation to take advantage of the partnership between Defence and Monash Uni to equip themselves with the Diploma."

Monash University assessors have highlighted to interested applicants that the formal qualification - HLT50407 Diploma of Paramedical Science (Ambulance) – requires the completion of the pre-requisite Driving Training Unit (HLTAMBT301A). However, a person who does not hold a Military Drivers Licence or ROA showing authority to drive a



WO2 Matt Franks is awarded his Diploma of Paramedical Science (Ambulance) by PROF Frank Archer, (Head of Department of Community Emergency Health and Paramedic Practice), and John Knight, (Academic Coordinator, Department of Community Emergency Health and Paramedic Practice).

dedicated ADF Emergency Vehicle, such as a DEV course, can still apply for RPL.

"There is no requirement for a full ambulance license to be eligible for RPL," WO2 Franks said.

"You can still qualify for the Diploma, but it would simply mean that a small amount of additional training or assessment will be required. This can be easily achieved by using the additional driving unit assessment checklist, and having it signed off by a person holding the qualification in the unit."

Application packages may only be obtained from Monash University at Health Service Wing ALTC from email [adfprpl.dcehpp@monash.edu](mailto:adfprpl.dcehpp@monash.edu) or contacting [john.knight5@defence.gov.au](mailto:john.knight5@defence.gov.au), (02 6055 4743).

Applicants will be emailed a comprehensive package including a step by step process which clearly articulates the requirements for successful RPL.

## The AMA to DPS Pathway

Monash University developed the AMA to DPS Program with the aim of making the process *quick, simple and cost effective*. At the same time, it was also important to develop a process that was valid, reliable, and consistent. The following four simple steps illustrate the process to being awarded the Diploma by RPL:

### Step 1: Information Stage

The ADF member (Applicant):

- Requests Application Kit
- Reads Information in Detail
- Seeks Clarification if Required

### Step 2: Application Stage

The ADF member (Applicant):

- Submits Application Form (Part A)
- Pays the RPL Processing Fee
- Submits Evidence (Part B)

### Step 3: Assessment Stage

Monash University assessors:

- Makes RPL Determination
- Contacts Applicant by Phone
- Confirms Determination in Writing

### Step 4: Qualification Stage

When Full RPL Awarded:

- Applicant Pays Qualification Fee
- Monash University issues Diploma and the Statement of Attainment

## DISCHARGING

### *after 20 YEARS service*

Leaving the Corps after 20 years service? Well we would like to know about it so your service can be acknowledged in an appropriate manner. Often information about a members departure from the Army and the RAAMC gets to us too late.

Please contact the Corps RSM and let him know the following:

Your Current Unit,

Your Date of Discharge,

The Unit you will be discharged from if different from the one above.

# 6RAR RAP / MTF-1 RAP

We began 2009 as 6RAR RAP and by October our numbers had swelled from an original Doctor, Nurse and 7 Medics to an amazing 16 Medics, a physio and a PTI. We were joined by medics from throughout 7 BDE and beyond to prepare to deploy to Afghanistan as part of Mentoring Task Force One. What had already been a busy year we were set to get much busier.

Prior to attending MRE in November / December we attended courses such as Live Tissue Training, Primary Survey II and III, Military Specific Advanced life support and Field Trauma Course. This new suite of courses put us in great stead for the trip, taught us all many new and exciting skills and allowed us to anticipate and prepare for exactly what we all joined the army for. For many of us it was our first deployment and there was a great deal of anxiety and a great deal of keenness to get over there and get into the job.

First we attended MRE in High Range, this was both laborious and fun as we got to see and do some amazing things, however compared to the training that we'd already received the medical component of the MRE was missing. It did give the patrol medics a chance to work and know their mentoring teams, and us a chance to consolidate what they had learnt.

Finally after several hundred pre-deployment medicals, AHA's and countless inoculations with a bit of leave sprinkled in there, it was time to fly into Afghanistan. We quickly took over from MRTF-2 and by the middle of February we had all well and truly settled into our roles. The first shock was the weather, it was freezing as we were coming out of winter, and gave us Brisbanites a real taste of the cold with ice most mornings and snow at times.

The second shock was a big dose of reality, because as soon as we hit the ground, medics at the patrol bases had trauma that they had to deal with, only a phone was their means of contacting outsiders. The Medics found themselves treating Australian soldiers and were kept busy with the treatment of ANA soldiers and local civilians. This allowed for the use of not only emergency skills as well as primary care skills and they saw everything from malingerers to weird and wonderful medical conditions isolated only in the third world. Often times I would receive a late night call from a tired and sleepy medic describing a fascinating condition for which I'd never seen or only read about myself.

Amongst the resus team at Tarin Kowt, trauma was a constant part of the day. We quickly integrated with the Dutch at the Role 2 Facility and found them to be friendly, slightly crazy and always professional. The Australian team of a RMO, RNO and 4 Medics were kept constantly busy with a primary care role in looking after Australians, Local contractors



*CPL Leigh Willis, CPL Joshua Bozanquet, PTE Matthew Krause, CPL Hollie McBride, CAPT Glen Mulhall and WO2 Phil Macleod in the RAP, Role 2, Tarin Kowt, Afghanistan. Drinking near beers of course.*



*LT Emma Cameron and CPL Hollie McBride attend to an Afghani Local boy during a MEDCAP in the Miribad Valley.*

and interpreters, contractors, ANA, local civilians including kids and whoever else would come through the door or off the chopper. We had the experience of receiving the casualties straight off the chopper into the resus facility and to the ward. The experience that we received seeing penetrating trauma, being involved in massive resus and assisting in treatment of unusual diseases was second to none.

All the more interesting were opportunities for some of the Fobbits as we get called to make our way outside the wire (OTW), whether replacing a medic for leave or attending a Medical community assistance program. These opportunities broke up the monotony sometimes and allowed us to experience living and working OTW.

Equally our physio was kept plenty busy with constant cliental through battle and non-battle injuries, rehabilitation and trips to patrol bases

which she relished. The PTI has developed the gym over here and has enhanced the facilities and PT sessions to ensure the continued health and wellbeing of all members.

All of the MTF-1 medical team whether in TK and working out of the Role 2, patrolling the Miribad or Baluchi Vallies, accompanying convoys to KAF or heading out to Deh Rae Wood, they have worked tirelessly and as I write this continue to work tirelessly to enhance and benefit the health of the members of the teams out there and also in saving lives and ensuring the safety of our men and women of the army.

The loss of life, especially of our own generates the reality and risk of what we do. The ADF and medics have witnessed trauma and will be carried by each member long after we return. For all of those guys and girls still over there, our hope is you all come home soon and safely. The members of MTF-1 are as follows:

#### Resus and Primary Care

CAPT Glen "Doc" Mulhall (Jan - Jun)

CAPT Andrew "Doc" Whitworth (Jun - Current)

LT Steve "Nurseo" McIntyre

WO2 Phil "Mac" Macleod

CPL Leigh "What you talkin' about" Willis

CPL Hollie "Hol" McBride

CPL Joshua "Boz" Bozanquet

PTE Matthew "Krausey" Krause

#### Mentoring Team Alpha

SGT Joel "Trav" Travica

CPL James "Milo" Dwyer

CPL Eullyses "Shim" Sestoso

LCPL Mark "HB" Hughes-Brown

#### Mentoring Team Charlie

SGT Timothy "The Binyonski" Binyon

CPL Gary "Franco" Francis

CPL Robert "Nev" Nevello

CPL Timothy "Stan" Stansmore

#### Combat Team Delta

CPL Mitchell "Chatty" Chatt

CPL Christopher "Bonesy" Bones

CPL "Butch" Cassidy

By: Capt G. Mulhall, RAAMC



SGT Joel Travica, Mentoring Team Alpha, PB Wali RAP, Miribad Valley, Afghanistan.



CPL Hollie McBride, CAPT Glen Mulhall, LT Steve McIntyre, CPL Leigh Willis, CPL Joshua Bozanquet, PTE Matthew Krause, WO2 Phil Macleod in the Resus Room, Role 2, Tarin Kowt, Afghanistan.



SGT Timothy "The Binyonski" Binyon, Mentoring Team Charlie, TK, Afghanistan.

# The Next Step for Australian Army Medics

A Physician Assistant (PA) is defined as a “midlevel health care practitioner working under the delegated authority of a medical practitioner”.<sup>1</sup> The PA profession has developed over several decades in the US and proven to be successful in augmenting the medical workforce and addressing geographical inequities in the provision of health services. Such outcomes have been mirrored more recently in Canada and the UK.<sup>2,3</sup> No framework currently exists for Medics however to upskill.

The wheels are starting to turn in regards to the acceptance and integration of PA into the Australian health system. Australian health policy makers have looked to emulate the success of PA overseas by developing our own PA profession. The South Australian and Queensland health departments have conducted recent trials on the use of overseas trained PA in their public hospitals.<sup>4,5</sup> A review of these trials is underway with the prospect of PA professional recognition and employment in these states a genuine possibility.

PA could play a valuable role in the Army’s health system, providing accreditation for medics in their own right, upskill medics for key functions in the fighting echelons, replace MO and providing the ability for medics to clinically up-skill. A review of the current training continuum for Australian Army medics and opportunities for ongoing professional development is in order. In early 2009, a new structure for training medics to the level of Advanced Medical Technician (AMT) was instituted. A medics formal training is complete after the Advanced Medical Assistant Course. AMTs are then posted to units to begin their career as medics.<sup>6</sup>

Once a medic has completed AMAC and become an AMT, further medical training options for medics are very limited. Few positions are available for medics to up-skill. Opportunities include ADF courses such as Rotary Wing Aeromedical Evacuation (RWAME) training, Fixed Wing Aeromedical Evacuation Training, Underwater Medicine and Aviation Medicine, placements in public hospitals through ‘strategic alliance’ agreements. Once a medic moves into senior positions as a SGT or WO, they take on a management and training role, with little need to either utilise or develop their clinical skills. It is at this point that many senior medics, some of the Corps’ most experienced and capable members, feel they need to make a decision regarding their future prospects – stay in the Army to mentor and manage junior medics as a WO or ASWOC, or leave the army to pursue professional development in the civilian healthcare sector.

This latter option generally involves further formal studies and with their associated sacrifices. Popular study choices for medics leaving the army include nursing, paramedical science or medicine. Others who choose not to go on to other studies may find work as medics on a

contract basis with mining companies or on oil rigs. Employment in public health organisations, medical administration, medical training providers and consultancy are other options, but generally do not involve practising clinical medicine.

Medics, particularly senior medics, must be offered a pathway within the Army for the ongoing development of their clinical skills. This will give those medics that do not wish to pursue a career in training and management an incentive to remain in the ARA. The Corps’ investment in these members’ years of training will continue to pay dividends and not be lost as it is when medics discharge. The Corps will also retain its most seasoned NCOs, maximising the effectiveness of our presence both on operations and at home.

In July 2009, the University of Queensland (UQ) welcomed the first intake of students into its new Master of Physician Assistant Studies (MPhysAsstSt). The first program of its kind in Australia, it is open to students who possess a bachelor’s degree in a health related discipline, a Grade Point Average (GPA) of 4.0 and one year of experience in direct patient contact. Students study four Part A courses dealing with PA theory and clinical skills on a part-time basis over one year, followed by eight Part B courses on a full-time basis over another year that involve rotations in general practice, internal medicine, aged care, surgery and emergency medicine, as well as two elective rotations. The Part A courses are taught externally, with a two residential teaching periods each semester (two weeks at the start of the semester and one week towards the end). The Part B courses can be undertaken in clinics, aged care facilities and hospitals as discussed with, and approved by, the Program Director. Students can choose to exit the program after completing the Part A courses with a Graduate Certificate in Physician Assistant Studies (GCPhysAsstSt).<sup>1,3</sup>

Many RAAMC medics do not have a bachelor’s degree, making them ineligible for direct entry into the MPhysAsstSt. However, an alternative pathway to the MPhysAsstSt is through the GCPhysAsstSt. The prerequisites for the GCPhysAsstSt are a post-secondary health qualification and a minimum of five years full-time recent experience in direct patient care. GCPhysAsstSt students complete the four Part A courses, with those achieving a GPA of 5.0 being guaranteed entry to the MPhysAsstSt. Students then only need to complete the remaining eight Part B courses.<sup>1</sup> Karen Mulitalo, Program Director at UQ for both the Masters and Grad Cert programs, has confirmed that the Army’s medic training continuum (BMAC, Cert IV Nursing, OJT, AMAC) as outlined above is considered to be a ‘post-secondary health qualification’ for the purposes of entry to the GCPhysAsstSt (oral communication, May 2010). Once in the MPhysAsstSt, there is even the option for a medic’s work in primary health care in the Army to be accredited as part of their general practice and elective terms.<sup>6</sup>

## Proposed Pathway — Medic to PA

RAAMC medics should be able to view progression to PA as a realistic pathway in their long-term career development. Senior medics should be expected to either go into training, mentoring and management as a WO or ASWOC, or strive to undertake PA training to further develop their clinical skills. Stagnation of these skills at the senior NCO level will not be an option. The most likely decision point for medics will be once they reach the rank of SGT. By this stage, medics will have completed 18 months of training through ALTC, followed by at least two years as a PTE(P) and three years as a CPL. They will therefore have at least five years of clinical experience once promoted to SGT and possess the requisite training and experience to apply for entry to the GCPhysAsstSt.

Medics aspiring to train as PA can then apply for selection into an 'Army Physician Assistant Scheme' (APA), which would operate in a similar fashion to the current ADF Graduate Medical Scheme. Selection into APA would be competitive and possibly involve aptitude testing and a panel interview. Medics who have demonstrated sound clinical abilities and a commitment to a career in RAAMC will receive sponsorship to undertake the GCPhysAsstSt (or MPhysAsstSt if they meet the previous degree requirement) through UQ. Ideally, there will be 'quarantined' places in the UQ courses for RAAMC medics sponsored through APA, meaning medics will not need to apply separately to the University.

During their first year in either the GCPhysAsstSt or MPhysAsstSt, students will only be studying part-time (two courses each semester). This would allow APA students to continue to work in their current unit. Alternatively, they could be posted to a medical facility (e.g. HSB or CSSB) in a supernumerary position. Students would have a reasonable amount of study time during work hours, as determined by their chain-of-command. Students would have their university tuition and associated fees paid for through APA and an appropriate textbook and professional development allowance.

Students in the GCPhysAsstSt stream will be eligible to proceed to the Master's program if they achieve a GPA of 5.0 or above. Those that do not achieve this score, or do not wish to go on to the MPhysAsstSt, will exit APA with a GCPhysAsstSt and resume their duties in their unit. The support they received through the scheme would be considered military-related training and would not attract a Return of Service Obligation (ROSO).

Students that continue studying towards the MPhysAsstSt will receive ongoing support through APA. They would undertake long-term schooling and complete the Part B courses on a full-time basis. They will continue to receive their current salary, accrue annual and long-service leave, be eligible for housing support in accordance with their classification and be covered by ADF medical and dental services. They will also be required to abide by army directives regarding health and fitness, use of prohibited substances and travel restrictions. In most

cases, APA students will be able remain in their original posting locality, with the possibility available for students to post to another region if clinical rotations required for the Part B courses are not available locally.

Once graduated from the degree, APA students will be commissioned as a Specialist Service Officer (SSO) at the rank of LT and be posted to a large army medical facility as a first year PA with a two-year ROSO. Non-military PA graduates who did not receive military sponsorship for their training would also be eligible to apply for direct entry to the Army as SSOs. During this first year, PA will complete a suite of courses similar to those undertaken by other RAAMC SSOs, including the SSO course at RMC Duntroon, Logistic Officer's Basic Course (Health Phase) and Military Advanced Resuscitation Course (MARC) at ALTC, and possibly the Early Management of Severe Trauma (EMST) course as observers.

## The RAAMC PA

First year PA in the Army would work in large medical facilities, such as in an HSB, CSSB, or Garrison Health Facility (once implemented). They would be supervised by a Medical Level 3 or 4 (formally Competency Levels 3-5) Medical Officer in the unit, who would monitor their management of patients, write their Performance Appraisal Reports (PARs) and provide them with informal and formal clinical training and mentoring. The PA would see patients for sick parade, take appointments outside of sick parade timings, perform minor procedures as per their training and skill set, and assist medical officers in clinical tasks as required. They would also be expected to provide clinical guidance and training to medics in the unit, and provide medical planning and support to exercises and activities as tasked by the unit. There would be opportunities for PA to attend professional development events, such as conferences and courses, with the approval of their chain-of-command, and even deploy if operationally required.

Following completion of their first-year 'orientation', PA would either remain at their HSB/CSSB/Garrison Health Facility, or be posted to a unit, preferably one without a uniformed MO. In this case, they would be the senior medical provider for the unit. They would continue to work under the supervision of an MO located in the same region, albeit remotely. Alternatively, they could be supervised by civilian doctors providing medical services to their unit, if available. PA would be expected to meet the healthcare needs of their unit, both in Australia and on deployment, and be guaranteed access to an MO within a reasonable timeframe for referral and advice purposes. Supervising MOs would meet with their PA regularly to directly observe and provide feedback on their consultations with patients. In the long-term, PA would progress through the ranks in a similar way to other SSO health professionals, taking on a managerial, training and/or senior clinician role. Postings options could include larger medical facilities, the Army School of Health at ALTC and headquarters positions involving health planning and policy development.

The experience and high-end skills of RAAMC PA would make them suitable to perform many of the tasks currently reserved for MOs. Prescribing medications and performing minor procedures within the boundaries of their registration are examples. Managing resuscitations in the field as team leaders and engaging in operations in a deployed environment where the use of an MO is not considered viable are others. Such skills would make PA ideal for employment in units with a high operational tempo and the need for seasoned healthcare personnel with field experience, such as the units that make up Special Operations Command.

An MPhysAsstSt would provide RAAMC medical personnel a qualification that has paramount utility in the ADF as well as a recognised professional body to ensure ongoing maintenance of a civilian qualification. Like doctors and nurses in the Army, PA will not need to undertake further studies to be able to work in their field of expertise in the community. This security may actually promote the retention of PA and the senior medics. For Medics this presents lesser risk in that staying in the Army will not be a greater risk than the potential of 'a job waiting on the outside'. This is the converse of the situation many medics currently face, where remaining in the Army for too long carries the risk of allowing the opportunity to train for a 'real job' to 'slip away'. Medics are, quite rightly, concerned about what their future employment prospects are once they commence their post-Army career.

During a period of structural change, and operational manoeuvre the RAAMC should provide options to further clinical skills and professional

qualifications of Military Health professionals. There is a program; there are plans for professional recognition, and a need for highly skilled healthcare personnel in the Army. Drawing on the talent from within the Corps and encouraging our most capable medics to rise to the challenge of PA is an efficient, realistic and logical way of improving retention and morale within the Corps.

By: *CAPT Nevin Colgrave*

## References

1. University of Queensland, Master of physician studies [Internet]. 2010 [cited 2010 May 22]. Available from: [http://www.uq.edu.au/study/program.html?acad\\_prog=5474](http://www.uq.edu.au/study/program.html?acad_prog=5474)
2. Frossard LA, Liebich G, Hooker RS, Brooks PM, Robinson L. Introducing physician assistants into new roles: international experiences. *MJA* 2008; 188(4):199-201.
3. Forde A, PAhen D. Physician assistants in the military: Australian implications. *JMVH* 2010; 17(4):22-24.
4. Government of South Australia. SA trials physician assistants – archived news [Internet]. 2008 [cited 2010 May 22]. Available from: [http://www.adamant.com.au/our\\_clients/browse/www.premier.sa.gov.au/news.php?id=3601](http://www.adamant.com.au/our_clients/browse/www.premier.sa.gov.au/news.php?id=3601)
5. Queensland Government. Physician's assistant pilot program in Queensland [Internet]. 2008 [updated 2008 Oct 30; cited 2010 May 22]. Available from: <http://www.health.qld.gov.au/pa/>
6. Australian Army, Army School of Health. The new RAAMC training continuum and gap training [Internet]. 2009 [updated 2010 Feb 22; cited 2010 May 22] <http://intranet.defence.gov.au/armyweb/Sites/ASH/comweb.asp?page=194852&Title=Gap%20Training%20Info>



## HARKNESS MEMORIAL MEDAL

The award is designed as a tribute to the service given to the Corps by the late Geoffrey Harkness, OBE, ED, who served continuously in the Corps from December 1941 to May 1971. Colonel Geoffrey Harkness served as an RMO in New Guinea, as a Field Ambulance Officer and as ADAH Southern Command. In addition he served for 14 years as DDGMS (CMF) AHQ. During this period he was Deputy to three DGMS' and played a significant role in the development of the Corps. He was responsible for much of the strong support the Corps has received from the civilian medical profession. His loyalty to the Corps and the DGMS', and his unselfish dedication to them was a hallmark of his service. The award is funded from a special fund raised by subscriptions from Senior Officers of the RAAMC and members of the civilian medical profession.

The conditions of the selection for this award are: The emphasis is to be on contribution to the RAAMC. It is considered that this must be in every way of an outstanding nature and by which the Corps has obtained some benefit; it may be in command, administrative, clinical or technical fields. Continuous long service without any major or outstanding effort is insufficient for the purpose as the medal is not a long service award. Nominations for the award should be forwarded on an AB777 through the chain of command to reach SO2 CORPS, HLTH SVCS, Milpo BANDIANA, VIC, 3693 no later than 31 July each year.

# A Combat Medic in Action

In November 2007 I was invited to deliver a presentation to the attendees of the 2007 NSW Military Health Symposium and again in 2008 on my experiences as a Combat Medic in the British Army.

Due to the response from attendees at these two events I have decided to put my presentation into print to allow other members of the Corps to experience what it is like to be a Combat Medic in Action.

My military career in the British Army began in 1977 and over the next 25 years I was to undertake several tours of Germany, Cyprus, Hong Kong, the Persian Gulf, the Former Republic of Yugoslavia, and various African countries. I saw Active Service in the Falklands War 1982, the first Gulf War 1991, and Croatia part of the Former Republic of Yugoslavia 1992 – 93 as part of the United Nations Protection Force (UNPROFOR). I was also involved in a number of unspecified operational tasks both in an operational capacity and in a medical support capacity.



*Combat Medical Technicians undergoing casualty management training.*

On completion of my training at Keogh Barracks I was posted to my first unit in February 1979, 6 Field Force Field Ambulance. This unit was later renamed 16 Field Ambulance. It was during my service with 16 Field Ambulance that I had my first encounter with Active Service and experienced combat in April 1982 as a result of the Argentine invasion of the Falkland Islands.

The Falklands War was a remarkable episode in the history of the three countries involved in the war, Great Britain, Argentina and the Falkland Islands.



*The Falkland Islands.*



PAULATIM  
Little by Little



IN ARDIUS FIDELIS  
Faithful in Adversity

As we undertook pre-deployment training at Sennybridge in the Brecon Beacons, Wales, little did we know then that the weather conditions and the terrain we were training on would be identical to what was to face us in the South Atlantic. Two weeks (27 Apr) later I deployed with A and B Sections, 16 Fd Amb on two Townsend Thoresen North Sea Car Ferries to the South Atlantic as part of the 5 Inf Bde advance party. The remainder of 5 Inf Bde, including remaining Fd Amb Sects and Dressing Station, followed 2 weeks later (12 May) on the QE2.

During our journey south we continued training concentrating on weapon handling live fire and advanced first aid. Replacement medical sections had to be drawn from the DS element to support Infantry battalions. This would have dire consequences for two of my mates LCPL Ian 'Scouse' Farrell and PTE Kenneth 'Kenny' Preston were destined never to return to England.

On the 28th May 1982 I landed on the Falkland Islands at a place called San Carlos, where only a week earlier 21st May British forces had secured a beachhead with the landings of 40 Commando RM at San Carlos, 45 Commando RM at Ajax Bay, 2 Para and Sussex Mountains and 3 Para at Port San Carlos. By the 23rd May the bridgehead was consolidated with over 5,000 troops dug in around San Carlos. Whilst at San Carlos the primary role of the medics on the ground was to provide medical support to several fighting patrols involved in fire fights.



*Medics assisting casualties during a lull in the fighting.*

By 27th May 35 more members of the task force were killed. The 27th May saw the death of eight more RM Commandos and 18 members of 2 Para were killed at the Battle for Goose Green, including the Commanding Officer LTCOL H Jones who later was to receive a posthumous Victoria Cross.

Over the next couple of days 5 Inf Bde consolidated it's forces at San

Carlos in preparation for a march on Port Stanley, the Falkland Islands capital. During this period San Carlos came under constant air attack from Argentine aircraft. However, due to the danger of Argentine air attack the ships were diverted into a small cove at Fitzroy. This move was made in broad daylight and was to have tragic results. Due to severe leadership errors disembarkation of troops from Sir Galahad was delayed resulting in both ships coming under a devastating air attack.



*Sir Galahad before the air attack.*

The Sir Tristram was seriously damaged in the attack and the Sir Galahad was destroyed resulting in the death of 49 soldiers, most of who were from the Mortar Pl located in the hold along with the Fd Amb equipment. 179 men were wounded, with 135 of these suffering severe burns. This was the worst loss sustained by the British Task Force during the war.

The Galahad was hit by at least six rockets and bombs with devastating effect. At the time of the attack I had just finished writing a letter home to my family below deck in the accommodation. The post box was located in the ships canteen two decks up so I decided to post it after visiting the toilet. As I got to the door of the toilet I decided for some unknown reason that I would post the letter first and then go to the toilet and as I turned away from the toilet the first rocket hit the toilets killing everyone inside. The force of the explosion threw me up one flight of stairs resulting in me sustaining minor injuries from burns to the front of my head and shrapnel in my rear end.

Everything turned black; the air was filled with thick black smoke and the sounds of men screaming which was closely followed by the smell of



*Evacuation of the Sir Galahad, which can be seen in the back ground.*

burnt flesh. I struggled through the darkness and found my way on deck. The deck was littered with burnt and shattered bodies. For some reason I thought we had been torpedoed due to the fact that I could see rings in the water, I later found out that these rings on the water were caused by the helicopters that had rushed to aid the evacuation from the ship.

With the aid of some of the other medics who found their way on to the deck we began to treat wounded and helped get them off the ship. I can remember the attack on the Galahad, treating casualties on deck and on land but even to this day I can not remember how I got off the ship.

Once ashore I assisted with the treatment of the wounded, which seemed to be never ending. A makeshift treatment facility was set up in an old school house and this is where the most serious casualties were taken for treatment until they could be evacuated to the hospital ship SS Uganda. Most of the casualties that we dealt with were suffering from horrendous burns where their skin had literally melted. We had to beg, steal or borrow what medical equipment we could as most of the Field Ambulance equipment had been lost on the Galahad. In the space of a couple of hours we had treated nearly 200 casualties.

Along with the burns many casualties from the Galahad had also lost limbs. I remember unloading a casualty from one of the helicopters and grabbed his legs to transfer him to a stretcher. As I looked down at him I saw I was only holding the lower part of his body his torso was still on the helicopter. I remember thinking I hope he was dead before I grabbed him. At one stage my mind became all numb and I felt like I was just moving lumps of burnt meat. The smell of burnt flesh is not one you can easily forget and even today after 28 years if I smell burnt meat I see images of these burnt soldiers.

It was while treating the injured from the Galahad that I learnt that members of the Fd Amb had also been killed in the air attack. These turned out to be Scouse, Kenny and our 2IC Major Roger Nutbeam.

It was several hours before all the casualties had been treated and evacuated and we had time to reflect on what had just taken place. When I heard that my best mate Scouse was one of the missing believed killed I felt a rush of remorse come over me. He was my best mate and he should not have been with the Welsh Guards, he normally worked in the DS but was put in the Section at Ascension to replace me. The remorse became overwhelming and placing a full magazine on to my SMG, I went round the back of the sheep pens; put the barrel in my mouth cocked the weapon and pulled the trigger. I had not realised that during the evacuation from the Galahad my SMG had been immersed in sea water resulting in a stoppage. I recocked the weapon a second time but the same thing happened. In frustration I threw the weapon at the wall and began to cry.

Later that night all those who had received injuries on the Galahad were evacuated from Fitzroy to one of the ships anchored in San Carlos

Water for some R & R. As I had sustained burns to my head and shrapnel injuries to my rear I to was evacuated. Arrangements would be made for those who had suffered injuries in the attack on the Galahad to be treated and evacuated out of theatre of operations. It was at this point that I realised that I had sustained some injuries and a flood of relief came over me with the knowledge that I was going home. After a hot meal and shower on board the ship an announcement came over the tannoy informing the following personnel to report to the deck for transfer to a helicopter. My name was on the list. This was it I was going home!

30 minutes later I found my self back on dry land. With my SMG in my hand and weighted down with ammo and medical equipment. The final push to free the Falklands was on and I wasn't going home just yet.



*The final tab (march) to Stanley.*

For the next five days I found my self either working in the make shift dressing station at Fitzroy, collecting wounded from the various battlefields or providing close medical support to the Gurkhas and Scots Guards as the mountains around Port Stanley were assaulted. During the assaults as we passed many of the wounded both our own and the Argentineans we would throw them a couple of dressings and tell them we would be back later until then they had to rely on self aid.

The problems of casualty evacuation to the Regimental Aid Posts and beyond were immense. Due to the soft terrain vehicles could not be used so evacuation was reliant on stretcher bearers. In some cases the wounded soldiers had to walk considerable distances before receiving any treatment. Most engagements took place at night on remote hill sides in adverse weather conditions. Many soldiers, including ones who had lost limbs lay for many hours relying on self aid. We did not know it then but these conditions proved crucial to the survival rate of the wounded due to the extreme cold experienced. Where possible helicopters were used to evacuate casualties from the battlefield.

All the wooden crosses in the cemetery had the beret of the soldier who had died placed on them to help identify who they were and the units they served in. We could not do this for MAJ Nutbeam as his beret had been lost on the Galahad so I removed the RAMC Cap badge from my



*Evacuation of battlefield casualties.*

own beret and using a rusty nail secured it to the cross. We then lowered him in to the grave and the padre said a few words before we each saluted the 2IC for one last time.



*The Sir Galahad before being towed away and sunk as a War Grave.*

Almost two weeks after the cease fire the a Service of Remembrance was held on the deck of the Sir Tristram while the Sir Galahad, which was still burning, was towed out to sea and sunk as a war grave. Scouse and Kenny were never going home.

Two months later I returned to the UK from the Falklands. The journey down to the Falkland Islands which seemed like an eternity ago took three weeks, the journey back took two days It would be another two months before I was allowed any leave as on my return my section was still the Spearhead section and we were put on standby for another operational deployment. In October 1982 I was posted out of 16 Field Ambulance to the Junior Regiment Royal Signals Medical Reception Station.

This was not the end of my Falklands experience however. In February 1983, I became yet another casualty of the Falklands War after suffering a severe bout of Battle Shock now known as Post Traumatic Stress disorder PTSD. 250 British Servicemen were killed in the Falklands War and since then almost the same number have died as a result of PTSD related circumstances. Nor was this the last of my operational tours, but that is another story.

*By: Captain Andy Brayshaw RAAMC*

# SASR Gymnasium

As PTI's I believe it is our job to ensure that our fellow soldiers are physically prepared for battle. At SASR we are constantly trying to improve the longevity of our beret and non-beret staff through the physical training continuum. The range and scope of missions that they may be required to conduct, forces us to adapt their training to meet their immediate needs. It is also important for us to ensure that the overall mission requirements of future conflicts are also trained for, without jeopardising the current requirements. Given the scope of insertion techniques and Operational environments, this presents significant challenges to the PTI staff.

New training techniques such as Bikram Yoga and Pilate's have been trialled amongst a wide range of members and we have seen the positive effects, both from the members themselves and from the medical staff. Injury is often the catalyst that forces a person to change their training habits, however we are having some success attempting to change members training habits and pre-empt injuries and hope to offer Pilate's classes from within the Gymnasium.

At times we are given the opportunity to offer training courses to unit members. Recently the PTI's have been able to offer Level 1 and 2 CrossFit courses. This has given members the opportunity to educate themselves in their chosen method of training. Offering these courses educates members in correct training techniques and allows them to test and evaluate the training for themselves in a controlled environment, thus preventing injuries.

SASR incur a wide variety of injuries, both battlefield and training related. Amongst the injuries, shoulder surgery is one of the highest for

training related injuries and gun shot wounds for battlefield injuries. PTI's at SASR play a large part in the rehabilitation of members, we tend to spend more time trying to slow members down rather than pushing them along as they are so keen to return to work. We use a variety of equipment for rehabilitation purposes from reformers to an altitude trainer and constantly liaise with the physiotherapy team. This united approach to rehabilitation, that includes doctors, physiotherapists, PTI's and psychologists has also enabled more effective feedback through the medical chain with monthly meetings conducted that discuss a total case management strategy.

A recent success story that fully utilised this strategy was CPL G. In 2008 CPL G was shot through the chest whilst in Afghanistan. The 7.62 round punctured a lung and barely missed his heart. With the assistance of PTI's and the medical staff, CPL G has spent all of his time and effort rehabilitating himself, with the ultimate goal of returning to his job without limitations. He has regularly used the altitude trainer to increase his fitness and improve his lung capacity. He is well on track to his goal of deploying with his squadron in 2011.

Aside from our daily routine as a Physical Training Instructor, the complex injuries and our involvement in their rehabilitation process makes this a very rewarding job. Working with a group of highly motivated soldiers makes life as a Physical Training Instructor very interesting and you find yourself constantly trying to come up with new ways to keep them challenged.

*By: Tina Muddle, CPL PTI, SASR*

sanofi pasteur  
The vaccines business of sanofi-aventis Group

Creating vaccines,  
protecting life

OUR VACCINES PROTECT AGAINST • WHOOPING COUGH • DIPHTHERIA • HAEMOPHILUS INFLUENZA B INFECTIONS • MENINGOCOCCUS MENINGITIS • PNEUMOCOCCAL INFECTIONS • TETANUS • TUBERCULOSIS • CHOLERA • TYPHOID FEVER • YELLOW FEVER • MUMPS • POLIOMYELITIS • MEASLES • RUBELLA • INFLUENZA • HEPATITIS A • RABIES • JAPANESE ENCEPHALITIS • CHICKENPOX

## WE PROTECT MORE THAN YOU'D EXPECT.



DOCTORS FOR DOCTORS

Freecall 1800 061 113 [www.mips.com.au](http://www.mips.com.au)

Medical Indemnity Protection Society Ltd.

# The Medical Retrieval Team – Future of Casualty Evacuation in the AO

The Australian Army is a small force that relies on the ability to manoeuvre quickly and rapidly adapt to the situation to maximise lethality. Sadly, despite the superior training of Army medical personnel, it has taken far too many years for medical support to our soldiers to parallel how we fight. The streamlining of medical services into a Close Health Support Battalion and a General Health Support Battalion has allowed for a review of how casualties are moved from point of injury to definitive care and the skill levels of those clinicians involved. This article will examine the current model used by the Army and propose changes to improve casualty survivability.

The previous model is primarily based on road evacuation, with the use of Tactical Aero-medical Evacuation (AME) limited to casualties requiring urgent surgical intervention. This approach focuses on removing the burden of injured soldiers from the fighting force. While this increases the morale of the troops, it often presents a significant delay in getting those wounded to the best medical care for their injury, i.e. a patient with a broken leg may ride in an ambulance for up to 2 hours before reaching a facility that could confirm the break with an x-ray then apply an appropriate intervention.

There is also a limitation on the care provided by the team conducting the retrieval. Medical Officers and Nursing Officers generally do not conduct road evacuations nor do they go on every AME mission flown. Their skills are required at the point of definitive care and are consequentially reserved for the most urgent cases. The reliance then is on Medics to perform these roles as a secondary task to providing integrated medical support to patrolling groups. This may lead to an increase in fatigue amongst the Medics causing an unintentional decrease in care as a result and a lack of rapport with the aircrew. A changing infantry model with embedded Medics is only going to increase the pressure on them and highlights the need for a change.

The future is to provide a rapid, adaptable and dedicated evacuation capability with a focus on delivering patients to the best available care as well as providing quality en-route care by appropriately skilled clinicians (Hartenstein, 2008). The American Military use an evacuation team that focuses on the use of AME with road ambulances to move patients to and from landing zones. The American Military have dedicated specially trained AME aircrews coupled with United States Air Force Pararescuemen or Paramedic Qualified Corpsmen or Medics. This approach aims to retrieve the patient from the immediate rear of the fight and deliver them to a surgical element within the Golden Hour (Corcoran, 2010).

The British model is also based on a reliance on AME; however it differs with the use of road ambulances as part of standard military operations. The British Medical Emergency Response Team (MERT) is a key component of their evacuation capabilities. The MERT has no standard definition but allows for flexibility on a case by case basis. A study by Doctors Davis, Rickards & Ollerton (2007) focused on what clinicians were best utilised in the retrieval of casualties. Their paper based study concluded 3 things: The inclusion of a doctor with critical care skills is associated with improved survival in victims of major trauma, Emergency anaesthesia and controlled ventilation pre-hospital is associated with improved survival in victims of severe traumatic brain injury (TBI) and Emergency anaesthesia, controlled ventilation and intercostals drainage pre-hospital is associated with improved survival in victims of severe thoracic injury. This study indicates that the MERT doctrine currently in use by the British Military provides the best care for their soldiers.

In his article, GOL Hartenstein (2008) examines the current NATO directives on AME. He discusses that the Golden Hour could be extended up to two hours if that patient was delivered to a surgeons operating table. This concept provides more freedom when collocating AME assets with surgical assets. The research indicates that the average flight time of 40 minutes gives a flight radius of 120 kilometres. This means that a centrally located surgical facility in the Uruzgan Province of Afghanistan would allow for a Rotary Wing AME aircraft to access all regions in this area and they would return patients to a surgeon inside the proposed two hour window.

The Australian Army does not have the aircrews or airframes to support the formation of dedicated AME Rotary Wing Assets attached to the General Health Support Battalion on a full time basis, nor the capabilities to place a Doctor or Nurse on every AME mission flown. Considering this and the conclusions drawn by Davis, Rickards and Ollerton (2007), the future of casualty evacuation for the Australian Army could be the establishment of dedicated Medical Retrieval Teams with dedicated Aircrew and Rotary Wing Assets attached to a Forward Surgical Team for the purpose of that Operation and to reduce the reliance on road evacuation.

The Medical Retrieval Team (MRT) would be a two man team consisting of a Physicians Assistant (PA) and a Medical Technician (MT). Given the trouble recruiting Medical Officers, this composition is ideal as the PA can perform emergency surgical procedures at the point of retrieval allowing for a patient to be stabilised prior to flight or in flight

anaesthetics and advanced airway management. This enables the MT to deliver a high standard of care to the less severely injured patients and liaise with the aircrew and ground forces. An alternate version of this Team is using a Critical Care or Intensive Care trained nurse and a MT. Their experience in nursing critically ill patients would allow nurses to make decisions based on a patient's potential to survive the flight and thoroughly brief the receiving doctors to allow the surgeons to prepare for the patients arrival.

In terms of an allocation for the Order of Battle, the Battle Group would see an Aviation Troop consisting of four Blackhawk helicopters, their aircrew and appropriate ground crew and the Evacuation capability consisting of four MRTs overseen by the Regimental Medical Officer attached to the Battle Group Surgical capability. The use of four Blackhawk helicopters and four MRTs allows for adequate crew rest which would decreasing the number of fatigue based errors, allow for helicopter maintenance and factor in the possibility of a aircraft being grounded. The helicopters would be setup to act as air ambulances prepared ready to go on the receipt of a nine line CASEVAC request.

In conclusion, the method of employing casualty evacuation in the AO used by the Australian Army requires a review to fall into line with the changes to the Infantry Platoon model and the restructure of medical services. This will ensure that the burden of the injured soldier is removed from their Platoon and they are delivered to the appropriate level of medical care. The model proposed above limits the impact on Australia's small resource pool and ensures the delivery of high quality care to soldiers from point of injury to definitive care.

By: CPL Jonathan Stevens, Advanced Medical Technician

## References

- Corcoran, M. (Presenter). (2010, February 16). The golden hour. In *Foreign Correspondent* [Television Program] [Transcript]. Canberra, Australia: ABC TV. Retrieved from <http://www.abc.net.au/foreign/content/2010/s2820327.htm>
- Davis, P., Rickards, A., & Ollerton, J. (2007). Determining the composition and benefit of the pre-hospital medical response team in the conflict setting. *Journal of the Royal Army Medical Corps*, 153(4), 296-273. Retrieved from <http://www.ramcjournal.com/2007/dec07/davis.pdf>
- Hartenstein, I. (2008). *Medical evacuation in Afghanistan: Lessons identified! Lessons learned?*. Retrieved from the North Atlantic Treaty Organisation Research and Technology Organisation website: <http://ftp.rta.nato.int/public//PubFullText/RTO/MP/RTO-MP-HFM-157//MP-HFM-157-05.doc>



## C.F. MARKS MEDAL

This award is designed as a memorial to the late COL C.F. Marks, OBE, ED, who had a long and distinguished career in the RAAMC. Charles Ferdinand Marks was appointed into the AAMC on 12 June 1937. After serving in the Middle East and New Guinea during the Second World War he was transferred to the Reserve of Officers on 21 December 1944. Subsequently in the CMF he was appointed CO of 7 Fd Amb and 11 Fd Amb between 1948 and 1954. On 29 March 1954 he was appointed Deputy Director of Medical Services, HQ, Northern Command and promoted Colonel on 14 May 1955. He was awarded the ED in 1956 and OBE in 1962. The award is funded from a donation given generously by his widow Mrs J. Marks. The conditions of the selection for this award are: The award is to be given for an outstanding individual effort where the RAAMC has benefited in some way. The emphasis is to be on contribution to the Corps and this may be in the medical, administrative, technical or logistic areas and may be in either non medical or medical units. Continuous long service without any major outstanding effort is insufficient for the purpose as the medallion is not a long service award. The recipient's service should be generally of a high standard. Enthusiasm, selflessness and dedication to the Corps are necessary contributory factors – The recipient must be a serving non-commissioned member of the RAAMC (ARA or GRes).

The award consists of a medallion and a certificate and includes a cash prize of \$500.00. Nominations for the award should be forwarded on an AB777 through the chain of command to reach SO2 CORPS, HLTH SVCS, Milpo BANDIANA, VIC, 3693 no later than 31 July each year.

# Directorate of Army Health

The Directorate of Army Health (DAH) was established in late 2008 and is responsible ensuring that Army personnel receive the highest standard of health care in prevailing circumstances. The DAH is responsible for providing all Army input into the Occupational Health (including prevention), Treatment, Rehabilitation, and compensation elements of the Army Occupational Health and Safety Management System.

The Directorate of Army Health has continued to mature as it finds its home within Army HQ. Having spent a bit of time in the wilderness of Fern Hill Park we have relocated to Russell Offices, in R1, level 3 the floor below the Office of the Chief of Army and much better positioned to influence health issues within Army.

The breadth of issues is vast and the staff have been doing a great job of progressing them over a wide front. Conscious that an organization can only sustain so much change at one time, the priority of effort for 2010 has been implementing the Army Casualty Administration and Support framework, the transition to Joint Health Command led garrison health care through Regional Level Agreements (RLA) and the restructure of Combat Health Services (CHS) to optimise health capability. 2011 will see the focus move towards implementing the revised MEC system, the introduction of an electronic ADF health record in addition to the implementation of the RLA and CHS restructure.

## Manning

Colonel Leonard Brennan	Director
BRIG Darrel Duncan (ARES)	Director General Health Reserves-Army Specialist Adviser Group
COL Sue Winter (ARES)	SO1 Health Operations and Governance
LTCOL Fred Parker	SO1 Policy and Plans
LTCOL George Georgiadis	SO1 Health Personnel and Capability
LTCOL Roger Holmes (ARES)	Army Casualty Adviser
Mr. Ron Tattersall (APS)	SO2 Casualty Management
MAJ William (Jamie) Harper	SO2 Mental Health
MAJ Garry Dodd	SO2 Rehabilitation
MAJ Rich Christie	SO2 Physical Employment Standard
MAJ Ryan Holmes (Projects)	Specialist Adviser Group
MAJ Mike Tyquin (ARES)	SO3 Health Personnel Management
CAPT Kristy Davies (ARES)	WO1 SMT / Business Manager
WO1 Alison Stewart	AS06 Health Information Manager
Vacant	

In addition, the Casualty Management capability has grown with the addition of four ARA Casualty Advisors and 14 Regional Casualty Administration Support Officers.

Does Army have the lead in Casualty Administration and Support? **Yes!**

CA invited the Canadian Forces to visit Australia in 2007 for the purpose of outlining the Canadian method of casualty management. Following this visit, DAH, cobbled together a small dedicated group of staff officers drawn from the APS, RAAMC, and AAPsych to develop a casualty administration and support framework similar to that adopted by the Canadian Forces. The approach establishes a clear framework for Unit and Health support to rehabilitation of injured soldiers.

CA invited a number of Army's seriously injured personnel and their families to Canberra in March 2010 so that he could gauge the effectiveness of his casualty management framework. The open forum provided an opportunity to engage with the Minister for Defence, and the Minister for Veterans' Affairs and Defence Personnel, CDF, CJHLTH and other key personnel in the casualty management and welfare space. The forum was a valuable activity in identifying what we as an organization are doing well and areas where we can improve casualty management. It is anticipated that the forum will become an annual event.

Significant progress has been occurred within DAH working with the Personnel Branch Communications Adviser to prepare a viable website on the Defence Intranet. This website has been developed to be compatible with a number of text readers (e.g. JAWS and DRAGON) that supports communication needs of our sight impaired casualties. Access to this sight is through the following link: HYPERLINK "<http://intranet.defence.gov.au/armyweb/sites/woundeddigger/ComWeb.asp?page=201116>"

In September 2010, the Wounded Digger Website will be available on the World Wide Web

CA has responded to the concerns of many casualties who identified the need to have support coordinated from one source rather than being directed to the many key stake holders that are present in the provision of care to Army casualties. With this in mind, Army has established four full-time Army Casualty Assisting Officers (ACAO) to assist unit commanders in accessing guidance and advice to effectively manage casualties and provide support to immediate family who are essential for the well-being and recovery.

A key task allocated to the directorate this year has been its role in development of the Close Health Support Battalion concept as part of the FORCOMD lead Combat Health Support restructure.

The years work will be realized with presentation of the Health Force Modernisation Plan to the CASAC. The restructure will see a more coordinated approach to health care in the operational, garrison and raise train sustain space. It's a shift in the way of doing business that



will reduce hollowness in deployable capabilities and well as getting health staff employed in health roles.

It's been a long time coming but the hard work of our mental health people well supported with technical expertise across the Mental Health organisation has resulted in the generation of DVD addressing Post Traumatic Stress Disorder. It is a resource that will have great versatility within the Army and will go a long way to further demystifying and de-stigmatising psychological stress reactions and other aspects of Mental Ill Health. The DVD is likely to be launched in September 10.

The Australian Defence Force Paralympic Sports Program (ADFPSP) (incorporating the ADFPSA Australian Defence Force Paralympic Sports Association (ADFPSA) in conjunction with the Australian Paralympic Committee (APC) was established in 2009 to provide wounded and severely injured ADF members with acquired disabilities, equitable access to sport through to the elite international level. The ADFPSP conducts two high performance camps annually and subject to funding plans to conduct range of future activities such as the Kokoda Track and the Sydney to Hobart Yacht Race.

The Policy and Plans cell has been light on this year however key tasks undertaken this year include, input and monitoring of the review of DI(G) 16-15 Medical Employment Classification System, the parallel review of DI(A)159-1 PULHEEMS, the generation of the Army SunSmart policy (lees the Beret policy change in ASODS) and Army oversight of the development of Occupational Medicine Occupational Hygiene capability in Defence.

CAPT Kristy Davies has done an outstanding job in gripping up procedures required to manage the MO CPD and SOGS payment schemes. She has been a key contributor to the review and development of the treatment protocols using her considerable Nursing background to support the Directorate in the generation of this very important document.

## Staff Leaving in 2011

### **LTCOL Parker**

Leaves the directorate after three years to take up post at HQ 1st Division as the Senior Health Officer. Out of the pot and into the Frying pan. Goodbye and good luck.

### **MAJ Dodd**

Despite superhuman performances in the BFA, has reached that point in his life where Army says he can't be in the ARA anymore. Gary will retire from the ARA in January and move to a Reserve position. We all wish him the best of luck with his future endeavors and Reserve service.

### **MAJ Swinney**

Kev Swinney has managed to secure himself a deployment with the UN on OP PALADIN for 2011. We wish him a safe and successful deployment.

### **WO1 Stewart**

Despite our best efforts to hold onto Ali, the Career Management Agency has spoken. . . Ali is off to ALTC, Development Group to take up the position of ECA for Health Corps. We thank her for her dedication and commitment in carrying out her varied tasks at DAH, and look forward to working with her in developing the health capability.

In summary short term bureaucracy can be challenging such as media inquiries and ministerial representations needing to be juggled with longer term projects. The Directorate though is responding to the future challenges from a higher tempo and new methods of war at our point of injury.

---

*By: LTCOL Parker*

# Oakey Medical Centre

The Oakey Medical Centre (OMC) is located within the Army Aviation Training Centre (AAVNTC). OMC is a part of Darling Downs Medical Services (DDMS) which in turn also looks after the Cabarlah Medical Centre (CMC), Dental Section and a small Psychology Section at AAVNTC.

OMC is a quirky little medical centre that is commanded by MAJ Susan Steel who is also a great training resource for the medics and nurses as well as being a very experienced senior Aviation Medical Officer (SAVMO). Earlier in the year MAJ Steel deployed on USS Mercy to Vietnam where she provided humanitarian aid to the local population.

Our other staff include:

- CAPT John (Kangaroo) Skipp an experienced nursing officer.
- LT Craig Smith, who in another life was a medic.
- WO2 Greg Ralph as our CSM who is the back bone of OMC.
- SGT Warren Douglas is the medical SGT and heading off to ALTC.
- CPL Alison Rolles as the dental supervisor and Ops Cpl position. CPL Rolles is off to 1 CSSB at the end of the year.
- CPL Luke Myers, Section commander of the Equipment and Resources Section (ERS) includes; PTE Richard Gurdler, PTE Nicola Emsley and PTE Sean McKay.
- CPL Kerrin Lyon, Med boards CPL and helped by PTE Richard Bateman.
- CPL Daniel Simpson, Out Patients Department (OPD) CPL and he looks after PTE Sean Linley, PTE Luke Ardill, PTE Caleb Shields and PTE Toniel Hartley.
- CMC is the other half of DDMS which provides health care to Borneo Barracks. Unfortunately their fearless leader CAPT Natalie Evans is being posted to a Long Term Schooling (LTS) position
  - CPL Maree Leonard is the senior medical technician and heads off to 3 CSSB.
  - LCPL Kat Cole has been the glue that holds all the little pieces of CMC together. As she calls it, "Kats house of fun."

DDMS is a good posting with lots to offer people in the medical stream. CAPT Kate Munro is our ARA Psychologist and our GRES Psych Examiner is WO2 Sue McManus. CPL Penny Looker is the ARA Psych Examiner who is currently on maternity leave. As a Medical Technician you are a priority for Rotary Wing Air Medical Evacuation Course. You gain a good education and experience around helicopters and work closely with the Incidence Response Regiment (IRR) and the Military Police. Close exposure to a lot senior medical officers allows pertinent training.

The Oakey Dental Section also caters for Cabarlah as well as Oakey. Our Army Reservist dentist, MAJ Tate works here as a civilian and an Army Reservist. CPL Rolles (as well as working in the Operations Cell,) also wears the hat of our Senior Dental Assistant. Under her are PTE Yasmin Hampton and PTE Cherise Kite.

We have also covered a wide range of random activities such as Ground Crewmen Aircraft Support Initial Employment Training at Wide Bay Training Area (WBTA), Bicycle ride from Cabarlah in Queensland to Canberra, adventure training at Jindabyne and a variety of ROCL relief positions for the MEAO.

As the end of the year fast approaches we lose some of our assets to other units such as PTE Wayne Allen who is off to 7 RAR, PTE Nicola Emsley who is heading up to Townsville to work at 5 Aviation Regt RAP and PTE Sean McKay who is heading to a new contingency of 1 CSSB in South Australia.

*By: CPL Simpson*



*CSM shows LT Smith how to iron.*



*OMC Group shot (only part of the crew).*



*Treatment in Med One.*

# 1 Brigade PTI Platoon Update 2010



1 BDE is an active, on the go, eventful, on occasion hot, location which certainly keeps the PTI PI on the edge engaged in diverse tasks ranging anywhere from the typical daily routine to deployment training. 2010 has been just another action packed and responsive year for the 1 BDE PTIs. This year the PTI PI consisted of the following PTIs:

- WO2 Steve Davis – Gym Manager;
- SGT Ken Carter – Gym Supervisor Nth Gym (UK Lateral Aug 09);
- SGT Justen Taylor – Gym Supervisor Sth Gym (MTF 2);
- SGT Ang Durant – Detached 1CSSB/Hlth Coy Ops;
- CPL Annie Colby – 1 BDE Rehab PTI;
- CPL Jason Colquhoun – 1 BDE Rehab PTI 2IC;
- CPL Anthony Novak – 1 BDE CFLC SME;
- CPL Brendan Southwick – 1 BDE MSD SME;
- CPL Corey Tomlins – PTI PI OH&S; and
- CPL Darren Wilcock – PTI PI budget & procurement (UK Lateral Jun 10).

Ablly assisted by some dedicated CFLs kindly on full time loan:

- LCPL Joe Aberdeen – UATL Indoor climbing wall SME;
- LCPL Steve Cotton – universal right hand man; and
- CPL Samuel Mosley – recent CFL graduate.

2010 has been an extremely eventful, unsystematic year for the PTI PI due to the higher tempo of activities. The routine has been responsive to short notice tasks. It has been an opportunity for the CPL to take on higher levels of responsibility due to a SGT PTI deficit and to fill in the gaps when others are away.

This year we've seen the constant evolution of rehab, firstly with SGT Ken Carter then CPL Annie Colby maintaining a well-defined regime for the 1 BDE soldiers. This is a continual improvement process where CPL Jason Colquhoun is currently working on the next return to work progression table which will benefit the injured soldiers and also the units in the long run.

SGT Justen (Squizzy) Taylor is currently preparing for deployment with 5 RAR MTF2. He has been very busy putting together some exceptionally challenging PT sessions for all soldiers involved and making sure that they are physically prepared. Acclimatisation has proved to be a major concern for military personnel in the Northern Territory and many soldiers who have not acclimatised and performed activities in the heat have been subject to heat stress and heat related illness.

With short notice to move, Squizzy was able to leave the comforts of barracks life in February and support the CSST on EX Southern Reach 10. During the EX he was kept busy with PT, programs, remedial, sports and rehab sessions and employed the available CFLs for assistance. As Squizzy does not like to sit still, he also participated in first aid, EHAT and IMT training just to name a few. CPL Corey Tomlins was Squizzy's replacement in Mar and continued the valued PTI support as well as completing LF2 & 6 on the range and was actively involved as the enemy coordinator.

As I sit here with blisters healing from the CFA we participated in at East Point last Fri, I reflect on the fact that there is just enough time left in the year to wrap up with a few more activities such as:

**Sep** – 1 BDE cross country competitions and 2 x PTI on promotion cses.

**Oct** – 1 x PTI Attending state level coaching mentoring at Brisbane; 1 x PTI going to Melb ½ Marathon and CFLC prep.

**Nov** – CFLC; 1 x PTI promotion cse; 1 x PTI deployed and 1 BDE swim comp.

Then it is time to soak up the wet season and complete cyclone prep prior to the stand down period. From the PTI PI here in Darwin we wish everyone the best for the future.

---

*By: WO2 S. Davis, WOPTI*

# Royal Military College Duntroon Field Medical Support Section (FMSS)

The FMSS Team for 2010 consists of –

SGT Lydia Martin

CPL Brendan Kelly

CPL James Rathbone

CPL Kaye Buchanan

CPL Vanessa Palmer

Field Medical Support Section (FMSS) is located at the Royal Military College at Duntroon minutes from the centre of Canberra. After being posted to RMC we have all experienced the Army in a different light as well as seeing much of Australia. SGT Martin has been dealing with what at times are numerous requests for medic support. Her biggest bug bear are range practices – so please read MLW 2-9-2 Range Regulations Table 1-2 if being posted to RMC. “Warm and fuzzy” is not an acceptable reason for having a medic at a Cat A range.

Apart from dealing with our constant manning shortages, SGT Martin is often organising many Army First Aid Recertification courses and Combat First Aid courses. We have provided medical support (PHCT / RAP and Field Evacuation Care) to Specialist Service Officer (SSO) Courses, ADFA, 1st, 2nd and 3rd Class activities and other activities. The field activities conducted through this year have included activities held at Majura, Puckapunyal, Wide Bay, Holsworthy and Darwin (which is just slightly hotter than the usual weather we get down south).

Over the course of the year FMSS has utilised external support from medical staff (Medics, Nursing Officers and Medical Officers) for some taskings at RMC. FMSS would like to thank the following units for detaching their medical personnel: 1 HSB, 2 HSB, AFG, LBMC & 7 CSSB (especially those who leave sunny Queensland to travel down here to sub zero temperatures). This extra assistance and help has been very much appreciated by RMC and FMSS and has allowed us to cover all taskings and provide an excellent level of health care to the cadets here at the Royal Military College.

Overall, being posted to RMC as a medic is a very challenging yet rewarding place to be. There are plenty of field opportunities allowing you to practice your clinical abilities, as well as consolidating your instructional skills.

As the end of the year draws to a close we would like to take this opportunity to congratulate CPL Vanessa Palmer and husband on the arrival of their daughter in August. 2010 also sees the departure from FMSS of CPL James Rathbone and SGT Lydia Martin.

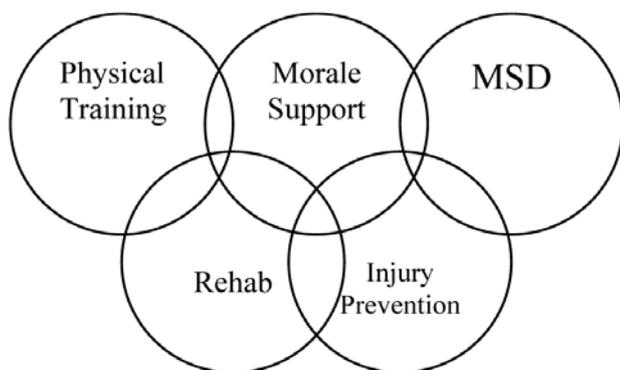
I would also like to Farewell SGT Rob Buttery who was here upon us marching into FMSS this year. He has moved onto greener pastures within the civilian world and we wish him all the best in his new chosen profession.

*By: CPL Buchanan and FMSS Staff*

# Considering the Deployable Role for Army Physical Training Instructors

This year 15 PTIs have been deployed, have just returned or are preparing for operations. These PTIs have been deployed on all manner of operations from Afghanistan to PNG and yet not one was deployed with a medical unit or in the primary role of rehabilitation. These PTIs provided support by delivering the five mandated services. They are adaptive and are able to concentrate their efforts at any time on the main focus and requirements of the unit.

PTIs have long concentrated on developing skills, enhancing physical and emotional resilience, maintaining soldier wellbeing and inculcating a sense of teamwork and Army ethos amongst the participants in physical activities. The diagram, shown below, highlights the services that are provided by Army PTIs. However, it would appear that whilst other Corps and units have embraced all that a PTI can deliver, RAAMC focus and attitude towards PTIs remains exclusively in the rehabilitation environment. The capabilities of PTIs are interconnected and at different times the focus may change so that the primary services can be delivered to meet the commander's intent.



These defined and mandated roles enhance combat power by:

- **physical training** to compliment foundation warfighting and skills associated with performing the role of an Australian Soldier,
- **morale support** activities to sustain cognitive capabilities, positive attitudes and encourage sound lifestyle behaviours;
- supervise, provide instruction and governance over the complex **military self defence** environment;
- physical conditioning, skill development and leadership in the physical **rehabilitation** and mental health environment; and

- leadership in **injury prevention** through:
  - scientifically based and progressive training regimes,
  - training and assurance strategies to monitor the conduct of sport and physical training activities.
  - developing physical and mental resilience in soldiers, and
  - analysis of injury data and trends.

LWD 1-2 Combat Health Support 2009 states that physical activity is important for health and well being and LWP 1-2-3 Health Support Battalion 2005 identifies that preventative health can be achieved through health education and promotion, injury prevention and Physical Training. The later also states that PTIs provide **limited** rehab services and that PTIs **contribute** to the rehab team. This reinforces that PTIs provide physical conditioning within the rehabilitation environment. PTIs are taught in the rehabilitation module at the ADFPTS that they do not treat the injury. PTIs are trained to provide physical conditioning to maintain non injured sights and deliver progressive training to allow personnel to return to the work environment.

LWP 1-2-3 states that PTIs assists in developing capability to endure physical and emotional stress and it is reasonable to expect that personnel working in the health fraternity on operations would benefit equally from a physical training program that has been adopted for the operational environment to ensure maintenance in the deployable force.

RAAMC policy documents clearly articulate the role of PTIs and physical training. PTIs can contribute significantly not only to the well being of personnel receiving care from the health units, but also to the members of the unit. PTIs are able to provide services that will promote health, enhance capability and contribute to the health status of any deployable force.

PTIs provide physical conditioning in the rehabilitation environment and I hope that personnel within the Corps will start to think in this vein. I encourage those who are considering manning for RAAMC operational commitments in the future to consider all that PTIs can deliver and not just to think of them strictly as a rehabilitation option.

By: WO1 Clayton Baker

# Afghan and Australian medical progress



**KANDAHAR, Afghanistan** – In the hotly contested Kandahar Province, Colonel Mahommad Hakim and Major Ijtemaye Akmal, medical officers in the Afghan National Army 205th Hero Corps, plan medical operational support for Afghan government-led efforts to improve security and economic opportunity for the Kandahari people. I sit next to them and wait to provide advice when they ask for it.

While much of Australia's Media focus has been in Uruzgan province and the Mentoring Task Force (MTF), Colonel John Simeoni, Commander 205th Corps Coalition Advisory Team, has been quietly building a team of advisors to work at the Afghan corps-level encouraging change from the top. I am a member of this team; a group of NATO military specialists helping the Afghans stand on their own feet militarily.

Twenty-three Australian, British, American, Canadian and Dutch soldiers support the 205th Corps headquarters, as it provides security and stability within Kandahar Province, currently the most dangerous region in Afghanistan. A specialty which recently came into focus is medical support and planning.

Hakim and Akmal are responsible for the medical support of 15,000 soldiers throughout the province. It's a large job and, considering the vast array of current operations, providing medical support is no mean feat. 205th Corps medical manning stands near 46 percent. Not good for a military fighting machine involved in route clearance, aggressive patrolling and provincial security and affected by targeting.

Since May 2010, I have advised Hakim and Akmal in developing plans at corps-level to build and establish systems and capabilities. From daily discussions to major briefings received by senior government officials, military leadership and media, the job has been challenging and rewarding – in equal allotments.

The day-to-day running of medical support to the Corps is a most topical issue. The Corps medical figures are impressive, with over 1000 cases of gastro-related illness during in June alone. In addition, the medical supply system is new, and little issues are still being ironed out. Hakim is constantly working on ways to make these systems work for him and support the vast machine that he, in turn, supports.

This often involves trips to the main supply warehouses in Kabul to gain visibility on the movement and purchase of correct medical supplies. On the other hand, it also often involves movement out to patrol bases and forward operating bases to ensure basic medical continuation training and distribution of stores to the correct areas.

In the back of Hakim's mind, however, is the fact that everyday, basic operations must be balanced with contingency, crisis and military operations. It is a challenge the Afghans have over 30 years of experience in, and a new one to an Australian. We enjoy peace on our home turf.

205th Corps medical's biggest challenge has been manning. The ANA leave process is very different than the Australian system. It is considered acceptable for soldiers at every level of command take leave without notice. Often, they are gone for three or more weeks. This can have severe consequences when trying to plan an operation and half of your staff is not available.

Constant conflicts within Kandahar province provide another obstacle to the ANA. Medical specialists are often far too intelligent to want to move to Kandahar, which is largely considered the most dangerous area in Afghanistan. They would much rather work up north in Kabul – earning more money, living close to their families and staying out of the way of insurgents.





It's a hard task to try and convince them otherwise. My in-brief with Hakim informed me a new brigade was being raised, but medical manning would not be increased to support the new Brigade. However, the Afghan way is to persevere and they just did some creative re-arranging in order to get the job done.

As the first Australian to attempt medical services support at the corps-level, I have discovered many positives and challenges with the job. In a culture where females do not rate positions of responsibility or power, it was a pleasant surprise to be readily accepted by Hakim and Akmal. They have taken it upon themselves to become cultural advisors in return for my medical advice.

At first they were wary, not because I was female, but because they thought I was a doctor. Upon finding out I am a General Service Officer (GSO) Medical Corps- specializing in training, administration and planning, they lost their wariness and became excited. Hakim and Akmal don't need doctors teaching them what they already know. Where they have been lacking is in the areas of planning, administration and training. Our partnership is a perfect fit.

Over many cups of chai tea, I've found that Hakim and his trusty Akmal can conquer most problems thrown at them: audits of brigades revealing unexpected surprises, lack of ability to correctly track and



identify patients moved around the country by ANA and coalition assets, and Hakim's very sensible routine of sleeping after lunch.

Hakim, Akmal and I work in partnership with a coalition team at Regional Command – South (RC(S)), in aligning the interests of the ANA with the abilities of RC(S) to support. Under this system, the focus on medical services has increased. We have not only now confirmed the need for an advisor at Corps level, but the push is on to ensure partnering and mentoring down at Kandak level (Coy level). It's a fantastic win overall for the medical services – who have plenty of work coming their way.

Although I have been the advisor, I think I've learned the most so far. I'm a proud Australian through and through, but the Afghan culture's principles of hospitality, loyalty and family are awe-inspiring. Hakim and his team endeavor to keep wounded soldiers within the corps. In this way, soldiers support their permanently wounded brothers despite debilitating mental and physical injuries from which there is no recovery. Hakim's staff runs weekly clinics for female family members; and the motto held by all is no matter whom the person is, they will be treated. This philosophy extends even to the enemy, as the recent case of caring for three insurgents who had attacked the ANA.

*By: Capt. Emma-Jayne Grigson*

# JeHDI

## Why is JHC involved in processing with an electronic health initiative?

Joint Health Command (JHC) provides health care and ensures the operational preparedness of ADF, and provides health force-preparation and advice in conjunction with Headquarters Joint Operations Command (HQ JOC). JHC develops strategic health policy, provides strategic level health advice and exercises technical and financial control of ADF health units.

Garrison Health Operations (GHO) coordinates the provision of high quality non-operational health support to ADF members and entitled personnel both within Australia and overseas.

Health staff within HQ JOC and the single-service environmental commands are responsible for health aspects of deployable capability.

JHC is seeking to implement an eHealth system that will rationalise and consolidate the information currently gathered through existing systems to enable better health service provision effectiveness and efficiency.

## Expectations of JeHDI

The purpose of the Joint e-Health Data and Information System (JeHDI) Project is to develop and implement an ADF electronic health information system that will link health data from recruitment to

discharge and subsequent management in other agencies and will:

- Provide an electronic health record (EHR) for ADF personnel
- Improve the productivity of health care personnel/contractors
- Provide the ability to map health related trends and patterns from ADF health data
- Provide the ability to derive financial reports related to the provision of health care to ADF personnel
- Maintain the security of health data

## We need your assistance!

We are making the opportunity available for you to provide direct input to the Project team as the JeHDI system is developed. The team seeks your comments based upon your professional, local and personal experience. A series of user workshops were held to develop the set of scenarios illustrated on this site. There is a core set of 27 scenarios that are being used to develop the prototype.

Further details can be found at  
<http://intranet.defence.gov.au/vcdf/sites/JHCPMO>



## REPRESENTATIVE HONORARY COLONEL'S CERTIFICATE OF RECOGNITION

This award is designed to recognise commitment and dedication to the Royal Australian Army Medical Corps by a member of the Army Reserve or Regular Army. The Certificate of Recognition will be awarded to a member for services considered by the Reviewing Committee to be above the 'Call of Duty'.

The conditions of the selection for this award are:

- an outstanding individual effort for continued service, commitment and for dedication to the Corps; and
- an Other Rank member of the RAAMC Army, Reserve or Regular Army.

The number of awards to be issued per year will be at the discretion of the Committee

Reviewing Committee. Payment of the production of the certificate and framing, including postage, is by Corps Funds.

Nominations for the award should be forwarded through the chain of command to reach the Corps RSM NLT 30 August each year. Nominations are to be submitted in Minute format. The Minute should include a detailed justification for the nomination. If more than one member is nominated from a single unit, priority order is to be specified.

The Reviewing Committee will consist of:

- Representative Honorary Colonel;
- Regional Honorary Colonels (as available);
- Head of Corps RAAMC;
- Deputy Head of Corps (ARA and ARes); and the
- Corps RSM.

# 1 RTB P&RT Section



The 1RTB Gymnasium saw 2010 kick off with a few new faces. Unlike many units however, four of these smiling faces belonged to two married couples. This was sure to make for an interesting year. Before too long the "Domestic Bliss Board" was implemented and "discussions" ranging from who ate the last sandwich to whose form was better in a CrossFit workout were soon chalked up.

Our PTI section is currently still the largest in the ADF with 21 PTI's in total. There are two PTI's partaking in each lesson given to recruits and at our busiest times, there are in excess of 1200 recruits. Staff PT is also catered for every Monday, Wednesday and Friday. In an effort to ensure PTI's are remaining proficient and to maintain professional development, members have been producing 15-20 minute presentations on a PT related topic of their choice along with weekly placements with the Physiotherapists on base. We have also been running MSD Courses both here at Kapooka and at other military bases. This year PTI's and recruits have also participated in a PT display at RAAF Base Wagga.

In late May the Gymnasium including the PTI offices were completely gutted as construction of the new facility began. Construction on the Gymnasium is scheduled to be complete by October 2010 and until then; the 21 PTI's are working out of the Weary Dunlop accommodation blocks. Cosy, but for a Wagga winter it could be a blessing in disguise! The final product will see the existing Gymnasium revamped a new 30 meter indoor pool, another indoor basketball court, and an extra hard standing area with a new RDJ facility.

On May 2 members of the PTI section defended their title for the third year in a row in the annual Lions Club Chariot Race. The chariot team consisted of five members; one to ride in the chariot and four to pull. Those pulling ran 100m in pairs with the second pair running the chariot back to the starting position. For the event, CPL Nigel Bell graciously offered the exclusive use of his son to ride in the chariot.



After confirming with officials that this was within the rules it was game on. CPL Debono put a lot of effort into organising the event including the fundraising which were collected from recruits and staff with an impressive \$ 8,000 raised. This year proceeds went to The Haven which is a not-for-profit facility that provides an excellent standard of care, accommodation and other services for the aged. The chariot team consisted of WO2 Mick Chattin, CPL James Debono, CPL Jimmy Wright, CPL Michael Price and SGT Bev Hargraves who graciously joined our team courtesy of 1HSB.

Three members from P&RT Section also attended the 2010 FILEX Fitness Industry Convention in Sydney from 30 April – 2 May. The event was very professional, informative and a great excuse to catch up with new and old friends alike! Over the three days there were many lectures and demonstrations ranging from nutrition to developing strength programs. Registration also granted free entry into the expo showcasing a huge range of companies, products and services. It's always interesting to see what is being offered in the civilian sector.

So what's to follow in 2010? Main events for KAPOOKA include; fundraising for the Cancer Council from August 9 – 13, the Wagga Wagga Trail Marathon August 15, the Cross Country which will be run on September 1. October 13 will see the ADCU Shield Soccer Competition and November 13 will host the Kapooka 9's Rugby League. The ADCU Basketball Shield will be held on November 17. Good times!

*By: CPL Tamara Davies*

# Lavarack Barracks Medical Centre

The dawn of 2010 brought many new faces to LBMC as we finished farewelling the old. LTCOL K. Clifford arrived as the new Commanding Officer, whilst WO2 C. Eustace became our new CSM and quickly instilled what can best be described as 'the fear of god' to the junior medics – and might I add – some of the civilian staff. We welcomed CAPT T. Damrow to the Unit Nursing Managers Position where he swiftly placed the PCU under his tender wing and moulded it into the busy beehive it is today. Many new medics joined our ranks, and sadly said goodbye to some old, including Mr. Greg Payne who after 17 years. We are saying goodbye to our X-RAY and Pathology department and also our radiographer Mr Keith Barry who's quick wit and friendly face will be missed.

This year has been one of change for LBMC with major building developments already underway. LBMC is responding to the change in the provision of Garrison health care and the increased dependency created when 3 RAR relocate to Lavarack Barracks. The new additions to the current building include a significantly larger RAP facility with room for 10 doctors, an extra four beds in the Patient Care Unit and a hydrotherapy pool and extra treatment areas for the Physiotherapy department.

This year we competed in Brigade Commander's Trophy events for the first time in well, long enough for anyone to remember who exactly we were. The swimming carnival in March was the first of the 3rd Brigade sporting events for 2010 and we unleashed two of our junior medics, PTE A. Hutton and PTE J. "Smiley" Kuskopf to join the "Combined Minor Units (CMU)" team that consisted LBMC, 5 Avn Regt, 1MP and HQ 3BDE members. Unknown to the rest of the LBMC staff – and the rest

of the brigade for that matter – we didn't unleash medics but actual dolphins that devoured the other swimmers as if they were tuna fish. The winnings were endless with CMU taking out overall 1st place in the Men's Division and 2nd in the Women's Division, as well as 2nd in the Male 4 x 50m Medley Relay and 1st in the Female 4 x 50m Medley Relay and 2nd in the 4 x 50m Relay. However the winnings did not end there; individually our swimmers continued to devour. PTE J. Kuskopf took an overall 3rd for Champion Swimmer, 1st in 400m Freestyle and 3rd in 200m Freestyle.

May brought the Brigade Shooting competition, which is an important event for assessing the standard of war fighting skills within 3 Brigade. Medics CPL J. Murphy, PTE J. Barndon and ex 3RAR super keen infantryman PTE B. Davoren joined forces with members from 1MP to create another CMU team. Team CMU finished overall in 7th position.

All in all, this year has been a good year so far. We happily work through the noise of construction as LBMC is receiving the revamp of all facilities as the PCU and Physio department are extended as well as a complete revamp on the inside. We also witnessed the breaking of a hundred single men's hearts when LT M. Taylor and PTE B. Wearing tied their respective knots and became a Mrs. We also 'goed' and 'gaaed' over LT S. Bowen's new born baby Finn, who is appropriately named to carry the dolphin analogy. So, the year has seen all new changes so far, not only new faces and skills, but an overall new presence of LBMC in the wider Lavarack community.

*By: CPL Tracey Martin*

# LBMC – Our First Posting

As Basic Medical Operators newly passed out from ALTC, LBMC is a great first posting. LBMC has so far provided an excellent opportunity for us as BMOs to consolidate our medical and interpersonal skills, and further prepare us for our Advanced Medical Technician Course and future postings.

Working within the hospital setting of LBMC, even as BMOs, we have the great opportunity to be involved with the care of a broad spectrum of injuries and illnesses, ranging from coughs, colds to more severe MVAs and injuries sustained by members in the course of training and deployment. Being a medic at LBMC does not limit us to treating casualties in a ward environment, we also have the opportunity to work in various RAP's both attached and detached to LBMC, and support other units training activities and ceremonial occasions when medical staff are required.

As part of the LBMC training curriculum, all medics posted here are

required to attend compulsory training activities that are generally on a Wednesday afternoon. The training revises such skills as CTRs, plastering, military law, drill, weapons etc so that we do not lose touch with the skills that are not regularly part of our everyday work.

Work aside, as members of LBMC we are actively competing in the Brigade Commander's trophy as part of the Combined Minor Units team, and relish the chance to get out of the hospital and compete against other soldiers from different units.

With 2010 half over and 2011 in the near future there are many more exciting times ahead for the men and women of LBMC, as many of us posted here bounce from rostered duties to courses and exercises all over the country to further our individual skills and proudly carry the LBMC banner.

*By: PTE Corbett and PTE Davoren*

## FROM THE SUDAN TO AFGHANISTAN

Painting by Martin Campbell



Detailed Framing

### COST

\$250 plain print (unframed) + postage & handling, \$350.00 framed print (basic)+ postage & handling & \$450.00 framed print (detailed) + postage & handling.

### PAYMENT

Direct / Electronic Funds Transfer with transfer confirmation faxed /emailed to SO2 Corps. Payment to include P&H unless alternate means to collect print has been prearranged with SO2 Corps.

### TRANSFER DETAILS

Defence Force Credit Union Limited  
Account Name. RAAMC Corps Fund  
BSB 803205  
Account Number 20532756

\* Please ensure that your name recorded on the transfer.

### DELIVERY DETAILS

Ensure full address details are emailed through to SO2 Corps.

### POSTAGE & HANDLING COSTS

(Including GST)

#### Australia Post

- Print only:

Anywhere in Australia \$9.90

#### Fastways Couriers (Albury)

- Framed print:

Perth / Darwin / Townsville \$70.50

Adelaide / Brisbane / Tasmania \$37.50

Sydney \$32.00

Melbourne / Canberra \$23.20

### POC

SO2 Corps Health Services,  
CAPT Angela Dent:  
Ph (02) 6055 4090 Fax (02) 6055 2436  
Email [angela.dent@defence.gov.au](mailto:angela.dent@defence.gov.au)



Basic Framing



# MTF 1 Physiotherapy

I am deployed to Tarin Kowt, Southern Afghanistan on Op Slipper with MTF 1, the 6 RAR Battle Group on an 8 month rotation. Being the first Physiotherapist to deploy with this group, I had the task of setting up a 'department' which now consists of a 2 metre by 8 metre armoured container, situated in the Dutch Role 2 Hospital.

My role here involves treating mainly Australian soldiers for musculoskeletal injuries sustained on deployment. I have also been involved in treating ward patients, mainly locals, and the occasional coalition member. I have treated all within the base, from locals to all nations personnel within the AO.

Having worked at 2 HSB for 2 years before deploying to TK, I spent a lot of my clinical time treating postural overuse injuries from computer overuse! But now, transferred 11,000 kms away to Southern Afghanistan, the majority of my workload is low back and neck injuries as a result of heavy weight on the skeleton and muscles.

The Logistics Support resupply runs, nicknamed 'shojos' – Afghan for resupply – head out to the patrol bases on a monthly basis. I jump on board these to visit the soldiers out at the bases where they're patrolling up to 6 days a week. Many guys are carrying ongoing chronic injuries, managed by exercise programs and their medics. Reviewing patients at the patrol bases, and assessing new injuries, has been the most rewarding part of the deployment. Helping to keep the guys out there doing their jobs, when they'd otherwise need to come back to TK for treatment, has been a useful addition to the Battle Group.



I've also had the chance to be involved in a MED CAP in the Mirabad Valley with CAPT Glen Mulhall, CMDR Simon Winder and CPL Holly McBride. I attended in the capacity of a female medical professional rather than a physio but here we erected a 14 x 28 tent and set up medical supplies on a couple of tables next to an aqueduct and group of Qalas. It was an experience in itself, being able to interact with the locals, particularly the children who, once they realised we had toys and lollies, weren't going to leave us alone.

There's two months to go and, while I can't wait to get home to see family and friends and get away from the dust, I have certainly enjoyed my time here and wish the next battle group an injury-free tour.

*By: LT Emma Cameron, 6 RAR BG – Tarin Kowt Afghanistan*



# Operation Azure / United Nations Mission in Sudan May – November 2009

Events in Sudan are rarely brought to the attention of the Australian public. When this does occur, it's usually for all the wrong reasons. This is the irony of Sudan's recent history; despite the long term suffering it has undergone, the wider world remains blissfully unaware of Sudan's history. Since independence in 1956, Sudan has suffered through forty years of sporadic civil war, ongoing tribal conflicts, famine and epidemics. Approximately 2.5 million people were killed as a result of civil wars and approximately 4 million people were displaced as a result of the civil wars and tribal conflicts.

After the years of fighting, an uneasy peace was brokered in 2005 between the Islamist Government of the North, led by President Omar al Bashir and the Sudanese People's Liberation Movement/Army (SPLM/A) led by Dr John Garang. The Comprehensive Peace Agreement (CPA) paved the way for UN Security Council Resolution 1590 of 24 March 2005 and the establishment of the United Nations Mission in Sudan (UNMIS). ADF personnel have been involved in UNMIS since its inception. The ADF commitment consists of a small group of predominantly logistic staff officers in UNMIS HQ in Khartoum and a small group of detached Military Observers, scattered across Southern Sudan. Our mission was simple; monitor the situation to ensure the CPA is adhered to and set the conditions for the April 2010 elections and independence referendum of early 2011.

In May 2009, Australian Contingent 9 (ASC9) UN Military Observers (UNMOs) left Australia for their six month tour in the largest country in Africa. Much of the information we gathered before departure was from our peers who had gone before us on previous rotations or from what books we could find about the place. From the information we gathered, one thing we quickly realised was that you could probably not deploy to a more austere and vast conflict zone in the world.

After settling into Australia House in Khartoum, we commenced our two week UN induction, which taught us the basics of being an UNMO. Our task was simple; monitor the actions of the Sudanese Armed Forces (SAF) and the SPLA to ensure that neither side was breaching the CPA. One thing we quickly gathered was that Australian soldiers are highly regarded on the mission because of their work ethic and their ability to interact with people from varied backgrounds. The north of Sudan is typically arid, desert and hot. The people appear to be more Arab than African and are predominantly Islamic. They consider themselves to be part of the Arab world and are quite proud of their Islamic heritage.

After two weeks in the sandy furnace that is Northern Sudan, the UNMOs were allocated to their team sites and dispatched to Southern



*ASC 9 UNMOs (L to R): Major Brian Ardley, CAPT Paul Manuel, CAPT Sharon Cord, LTCOL Glenn Taylor (COMASC Rotation 10), CAPT Luke Hodda, CAPT Peter Amaricai and LEUT Katrina Gosper, RAN.*

Sudan. The south is a complete contrast to the north. The desert gives way to savannah and jungle. People are from Neolithic tribes, very tall, very dark skinned and predominantly from Animist and Christian beliefs. They prefer English to Arabic for business and speak a variety of indigenous languages as their primary language. The climate in the south was more akin to life in Northern Australia. Treatable diseases and illness such as diarrhoea and malaria were commonplace and fatal. Health care in the region was scant and dependant on NGO support, particularly in remote areas. Added to this HIV/AIDS was rife and notoriously under-reported. Many people remain illiterate. Southern Sudanese under the age of 40 have grown up their entire lives in the spectre of conflict, with peace being sporadic at best.

I was assigned to Sector III of VI to the town of Malakal, the capital of Upper Nile State along with CAPT Sharon Cord (AACC). We were fortunate enough to be allocated to a team site that was located on the banks of the White Nile, which enabled us to conduct patrols by river in addition to four-wheeled drive patrols and rotary wing patrols to more remote areas.

Patrolling in Sector III was by no means an easy feat. The sector is roughly the approximate size of the UK and has only 100km of paved road. There were 100 UNMOs across 5 team sites covering the sector. Our allocated AO was one of five in Sector III. AO Malakal was roughly the size of Tasmania and split across the middle by the White Nile. Patrolling on the far bank by four wheel drive was impossible – the nearest bridge was over 500km away. To cover this area we had 25

UNMOs of which up to 10 could be assigned on other tasks or duties at any one time. Many UNMOs had no four wheel drive experience and this became evident when the wet season arrived in earnest and a 5km drive into Malakal town became a boggy half day adventure!

Typically a patrol would consist of several UNMOs, a national monitor from the SAF and SPLA, a UN Police Representative (UNPOL), a language assistant, a force protection detachment from the 13th Mahir Regiment, Indian Army. We'd normally start with PT and then have breakfast before attending the morning briefing. After briefing, the day's patrols would depart to conduct their tasks. When not involved in patrols, some of the staff had additional duties such as Operations Officer, Intel Officer or Pers Officer. Outside of the larger towns like Malakal, most people lived as they had for thousands of years, building thatched *Tukul* (huts) with mud brick walls and living off cattle grazing and subsistence farming. Children would stare at you and whisper *khawaja* (white person) as you passed by. Kids would break into smiles and laughter hearing a *khawaja* attempt Arabic or Dinka, impersonate a kangaroo or try their hand at soccer.

UNMOs gathered facts and evidence for further investigation or referred the allegations to the appropriate UN Agency. Monitoring of the CPA in Southern Sudan is problematic. The human terrain in Southern Sudan is complex and makes meaningful dialogue between parties difficult, particularly when there was ambivalence or even outright hostility to our presence.

Rivalry between tribes took a turn for the worse during ASC9's deployment. On 2 Aug 09 simmering tensions between Nuer, Dinka, Murle and Shilluk tribes boiled over. On that day, 187 Murle people killed by Lou Nuer tribesmen close to the border of Ethiopia. On 20-21 Sep 09, 167 Dinka were killed at Duk Padiet, by Lou Nuer tribesmen despite the presence of local security forces. The tribal violence in Southern Sudan in 2009 resulted in more fatalities than in the conflict in Darfur for the same time. It is ongoing.

From amongst our own, there were also losses. On 22 September 2009, PTE More Vijay, aged 24 of the 13th Mahir Regiment died accidentally from electrocution in the UN compound in Malakal. His untimely death was a reminder to all of the dangers of service in the UN and the military. He is survived by his wife and son.

My deployment to Sudan was both rewarding and challenging. Operating away from the umbrella of the Australian Army above all else, a deployment to Sudan is an eye opener. Speaking to people who had no concept of a democratically elected government or had grown up their entire lives not knowing lasting peace makes you really appreciate how lucky we are to live in Australia and how important it is for members of the Australian Army to be an active participant in missions such as these.

*By: Major Paul Manuel, RAAMC and UN Observer*



*TS Malakal and Sector III UNMO HQ Staff (L to R): MAJ Atef Al-Shurman (Jordan), CAPT Osvaldo Noguti (Brazil), CAPT Farouk Maliwun (Thailand), MAJ Henrik Neilsen (Denmark), CAPT Paul Manuel, CAPT Henry Miranda (Ecuador), MAJ Kim Song-Soo (South Korea), CAPT Malick Dicko (Mali) and CAPT Fares Al-Shamiri (Yemen).*

# Watch your language

One of the challenges within any ADF operation is communication. Also consider that in Australia there are approximately 22 million people speaking almost 400 languages.<sup>1</sup> Irrelevant of the area of where the operation is being conducted, soldiers need to communicate with others around them. Languages Other Than English (LOTE) can lead to participation with the people in the surrounding environment and an increase in information access whilst on deployment.

The ADF is communicating with the "Net Generation". Numerous articles have been written on this topic and this generation's interaction with the ADF including mentoring of junior leaders.<sup>2</sup> Junior leaders (ranks of LCPL/CPL and LT/CAPT) normally interact with many subordinates on a daily basis. These leaders are in the position to potentially recognize and actively encourage their subordinates to attempt LOTE training or testing. These junior leaders will also be able to use LOTE trained members to enhance their communication on deployments and in the battlefield.

Junior commanders can use a skilled LOTE member to provide basic introductory phrases to the rest of the sub unit. The basic salutations (hello/goodbye/Mr/Mrs/Miss) and expressions/phrases (thank you/please/ouch/stop) can start communication with a stranger who may be a patient, enemy, POW or potential informant. Consider if one unit LOTE trained member was to teach a phrase per week to your unit/subunit. I suggest that by the end of the year your personnel could potentially be able to appropriately use all the common basic salutation phrases of the target language. Empowering and then demanding the junior leader to develop LOTE at the lowest team level within the sub unit will ensure future capability for the future potential roles.<sup>3</sup>

Language capability is an all corps responsibility and therefore commanders at all levels should be actively forward planning and participating in long term strategies to grow these capabilities.<sup>4</sup> It appears individual units staff must struggle against competing training and unit needs in order to participate in LOTE training. There is little awareness of the need to develop LOTE capability within the ADF, a necessity born from our geographic position.

ADF health professionals have a reputation confirmed by the number of awards over the past few decades in many theatres, operations and within different roles. The requirements of ADF health professionals

over the past few decades have been complex and future requirements require further planning, discussion and doctrine.<sup>5</sup> As our strategic reach, reputation and countries we work in vary all staff should plan and encourage LOTE growth and training for future potential operations. LOTE training within the ADF is well organised and available in many forms. The training has many benefits for the unit and has financial benefits for the individual. This training is publicised and available to all ranks.

Soldiers will have a continuing requirement in future operations for LOTE skills. The unit or sub-unit that has these internal skills will more effectively communicate with the deployed social environment. This will lead to more effective participation within that environment and gathering of information from it which can lead to better efficiency and patient health during operations.

WO2 Josh McDade is currently a career manager at SCMA. His operational and overseas experiences include Rifle Coy Butterworth, 1st Guards (Singapore), OP BEL ISI II, OP WARDEN/STABALISE, OP GOLD, OP Tanager, High Density and Altitude Training (PNG) and OP CITADEL. His Force preparation experience includes for all of the above as well as UNAMIR, OP SCRUMMAGE, OP MAZURKA, OP FALCONER, OP BASTILLE, OP SLIPPER and many more. He has communicated (in their mother tongue) with natives of Malaysia, Indonesia, PNG and Bougainville whilst deployed overseas. WO2 McDade's awards include AASM, ASM, ADM, DLSM, UN medal, MUC and Commander Training Command – Army Commendation.

By: WO2 Josh McDade

## References

<sup>1</sup>Year Book 2009-2010, Australian Bureau of Statistics

<sup>2</sup>Lt Col Dan Fortune, Commanding the Net Generation, *Australian Army Journal*, Volume 1, Number 2

<sup>4</sup>D Ashley, Adaptive campaigning and the need to empower our junior leaders to deliver the 'I'm an Australian soldier' initiative, *Australian Army Journal*, Volume 6, Number 3

<sup>5</sup>Harry Baxter, Challenging times, *Defence Magazine*, May 2006

<sup>6</sup>SJ Neuhaus, Ni Klinge, RM Mallet and DHM Saul, Adaptive Campaigning – Implications for Operational Health Support, *Australian Army Journal*, Volume 5, Number 3

# What is military health and what's in it for me?

**“Medical Operational Capability must be delivered by personnel who are sufficiently integrated into the moral, physical and conceptual components of fighting power in order to be able to conduct their mission successfully”.**

You may of heard our non-health brethren say “what is this black magic, military health is just like RAEME equipment chain, isn't it?” The reality is military health is unique and many articles within this magazine highlight the key differentiators, some emotively. fundamental difference is that we cannot remove the human from health delivery. I would like to discuss what is different about military health, what challenges face the ADF and what you must do to make a difference.

Military Health development for each of us is a work in progress, and yet is a basic skill area; I believe that any military health professional has key components to improve unit outcomes and satisfaction. I classify these as Military (all corps requirements), Military Health (key components) and Specialist (principal specialist skill-set). These skills may appear in conflict but through diligence enable a balanced approach to employing skills on the work place. One example of this conflict is the provision of clinical support to civilian casualties whilst in uniform. These skills over time contribute to the required competency for any military health professional to deploy at various levels. What makes us unique, and truly different should be what we take to our workplaces, they include but are not limited to:

- **Legal Status.** The Geneva Conventions, and Defence acts confer a number of rights and duties on Australia. These duties and rights apply to each of us by virtue of acts of parliament and are therefore enshrined in Australian law. Any lack of compliance can therefore be punishable by law. These are designed to provide freedom of health delivery on a battlefield. There is a requirement to provide care to all casualties, irrespective of origin.
- **Clinical Prioritisation.** Another principal of the Geneva Conventions is that priority is based solely on clinical need rather than the operational importance of individuals or their origin. Casualties are sorted into their priority groups using a system known as triage.
- **Casualty Deterioration.** Unlike damaged equipment, casualties cannot be left for periods of time without deteriorating.
- **Standards of Care.** The standard of medical care provided has a permanent effect on the medical outcome of casualties. Delayed or poor quality care cannot be reversed after the event; many effects are irreversible. These effects are far more critical than in many other logistic functions.
- **Ethical Issues.** A moral dilemma can occur whilst a military health professional is deployed. This dilemma occurs where application of oaths, clinical obligations of registration are conflict with military service creating friction e.g. care of civilians.
- **Continuity.** Continuity includes both clinical and information continuity:
  - **Clinical Continuity.** Once health has been compromised medical care must be delivered continuously and progressively to ensure optimum results. Some casualties will need rapid evacuation to other health facilities. Continuous links should be maintained to allow casualties to be transferred. This is unlike the other logistic functions where continuous links may be unachievable for all or part of an operation or campaign.
  - **Information Continuity.** Clinical continuity is underpinned by information continuity. This has two aspects, access to individual clinical data via patient records and direct communications between attending clinicians. Agreed protocols reduce the requirement of the latter.
- **Time.**
  - **Medical planning is based on time rather than distance per se.** Time taken to reach expert treatment will influence survival rate, complication rate, rate of recovery and in the longer term the ultimate quality of life of the casualty.
  - **Within the logistic chain, prioritisation of additional transport can speed up the delivery of supplies by increasing the lift available.** Faster evacuation means or intermediate medical staging facilities are required if the clinical timelines are to be met and continuity of care delivered.
  - **The clinical timelines for land-based operations dictate that the medical operational timeline is that of the current battle requiring constant regulation of casualties.** This differs from logistic support/supply planning which aims to resource battles in advance, or recovering equipment from previous battle and is focused on the next battle.
- **Space.** Although the terms ‘forwards’ and ‘rearwards’ are less clearly defined in a non-linear battle-space, they retain some utility when discussing the relationship of units and facilities to operational activity. In terms of space, the medical effort is ‘forward’ because that is where most casualties are generated. By contrast the main logistic support/supply effort is ‘rearwards’ because that is from where stock is held, controlled and dispatched.

Some of these differences change over time presenting challenges to each of us. Greater troop dispersion and improved lethality of weapons in the modern battlefield implies we will need to apply greater tactical understanding and more technical expertise to accurately support and coordinate the health effort. Yet we focus on improving clinical improve skills of our military health staff. To ensure health planning, military health staff will need to have better contact with the whole Battle Group. That is better communication, and manoeuvre and application of military health skills.

Another constant challenge is the expectation that care for casualties will be based on optimal, comparable civilian levels of medical care creates a tension. The civilian sector faces fundamental change and uncertainty greater than our own. Health accounts for a significant proportion of government expenditure. History dictates expenditure on health continually rises due to dependency and demand. In this environment, earlier intervention and prevention has lead to shorter periods of hospitalisation, better health, and longer life. This can only work if health care assets are structured to achieve a common outcome, even if they are in competition with each other.

Comparable levels of civilian care can be based on a military health chain of care. This can be replicated within the ADF through adaptation of the existing framework. A joint approach to health starts with Prevention (physical conditioning, diet, environmental health and health intelligence), where prevention fails emergency procedures (casualty evacuation and medical regulation) stabilise life and deliver the casualty to the most appropriate treatment facility. Treatment can be provided to save life and promote functioning and assist healing (role 1 – 3 medical support), prior to rehabilitation (physical conditioning and ongoing support) and return to duty or discharge. Every military health professional should be able to explain each to our colleagues and prospective patients.

One way to minimise the tension and challenges is to reduce unnecessary duplication of services. At present considerable expertise is "tied up" in a few senior people, a lack of knowledge then emerges at the tactical and operational health planning making determination of strategic and future capability difficult. A step towards jointery has



occurred with ADF health refocussed under a central command with regional delivery. This spoke and hub model of health care has provided small well-coordinated health units responsible for the Land, Air and Maritime Health delivery. We have generated an independent chain of care for our patients providing a seamless transition of patient management from point of injury overseas and returning to comparable levels of treatment in Australia. Yet we cannot remove that fact that health is an emotive issue resulting in a perception of military health support being sub-optimal against civilian levels of care.

One way to reduce further tension is through the delivery of numerous joint health projects. These are highlighted and summarised below:

- JP 2048 the amphibious ship brings larger joint health capability. The Primary Casualty Reception Facility provides a that can grow from a complement of 25 staff to a 75 staff facility with:
  - 6 resuscitation bays, (TRIAGE area in the aircraft hangar);
  - 2 operating facilities (each capable of housing up to 2 operating tables);
  - 2 Intensive Care beds (ICU)
  - 6 (8) HDU beds; and
  - 36 LDU beds.
- JP 2060 has delivered Phase 1 and Phase 2 Deployable Health Capability (DHC) for example replacing canvas with weather-haven systems to remove duplication of single service solutions to deliver a joint operational capability. Phase 3 will provide a three tiered enhancement to our operational support including:
  - Health systems
  - Health Training systems
  - Health C4I

These two projects will present enhancements and combined health optimisation however there are several projects including mobility platforms such as the new Army Vehicle project (overlander), Land 400 (Armour replacement), enhanced tactical communications and Strategic Reform that will provide overall optimisation of ADF Health.

I challenge each of you to think of military health as restrained, conservative and inflexible. Please challenge yourself, as I believe often that you are the only limiting factor and by improving your utility in Military Health you improve the health of others.

In sum, the changing face of ADF Health services has several constants, deployed health capability must provide comparable levels of civilian care to our soldiers, and every health professional has the obligation of understanding the differences of Defence health and be able to utilise them. We live in exciting times, the difference will be the way we apply it, as enhanced capability can be delivered and single service barriers dropped by enhanced jointness.

By: MAJ Mike Treloar

# Operational Mentor and Liaison Team (OMLT) – D Medics in Afghanistan

In May 2009, the men of MRTF 2 had been training together for some time, and were in some cases already deploying to Afghanistan.

We medics left in Townsville watched enviously as they conducted training around barracks in their DPDU's. So, it was with great surprise when noms were called for 4 medics to become part of a new group of soldiers, who would deploy in support of MRTF 2, to be called OMLT-D. A serious case of being in the right place at the right time meant that WO2 Pete Vigar, WO2 Glenn Jackson, CPL Mitch Conway and PTE Matt Friswell were soon training with a highly motivated group of Infanteers, Artillerymen and Engineers. Fris was replaced during pre-deployment by CPL Evan Brook, who had been loitering with intent at the 1 RAR RAP.

Our role upon arrival at Tarin Kowt was to primarily mentor the medics of the 4th Kandak, as well as assist with the corps specific training of the Infantry, Artillery and Recon soldiers of 4th Kandak.

What follows is a snapshot of the role of each of the medics of OMLT-D.

**WO2 Pete Vigar** – Pete was the senior medic and began the tour as the HQ medic, responsible for the training of our Afghan National Army (ANA) medics of the 4th Kandak. He was re-deployed to a Patrol Base where he would spend the next couple of months. Pete's fitness regime, which he commenced at TK continued, and some say that it was due to his new slim silhouette that saved him when he was 'fragged' in an IED incident. Upon his return to TK just prior to RTA, Pete had the body and endurance of a Kenyan long distance runner, but not the tan.

**CPL Evan Brook** – Brooksy started off as the Engineer team however he spent his days at the Australian RAP, occasionally seeing patients and obtaining life membership of the US DEFAC (Dining Hall) where the primary ingredients were fat, sugar and salt. He completed some time with a Patrol Base for a period.

**CPL Mitch Conway** – the 'Ranga' of our group. Mitch worked in a couple of Patrol Bases where he gained invaluable experience plying his trade, on occasion under fire. Mitch also got to travel to Kandahar as part of the infamous Kandahar Convoy, a mind sapping 18 hour journey in an ASLAV ambo variant averaging less than 10km/h.

**CPL Adrian Bell** – Belly arrived mid tour and took over as the Engineer Team medic after Brooksy discovered the DFAC. Belly initially conducted a mini CFA course within 4th Kandak however soon took off to a Patrol base with the Recon Team. Mentoring would often prove difficult but Belly kept at it and is now responsible for the likely 'future RSM of the

ANA Medical Corps', Naqibullah. Belly also experienced participated in Contiki Kandahar.

**CPL Rick Dowling** – Rick arrived mid tour to replace WO2 Vigar. His patience and instructional skill ensured that the students that 'graduated' from our little course had real skills. Rick also travelled to Kandahar on the 2nd convoy, and some time OTW where he experienced the coldest conditions of the tour, snow and chilling wind. Rick was able to "acquire" a RAP facility for 4th Kandak. Luckily the Dutch were so generous.

**WO2 Glenn Jackson** – Spent the vast majority of the tour inside the walls of TK, looking out and watching the other medics of OMLT-D go off on exciting adventures at far off patrol bases.

In our experience, the medics of the 4th Kandak (and indeed the 4th Bde) were generally the brightest and most literate of the ORs. We found them doing every other job except their own, due to their higher than normal literacy rates. All three of the medics of 4th Kandak were studying English each evening in the hope of discharging late in 2010 and plan to attempt to find employment as translators for coalition forces. This is due to the greater pay rate and better conditions. But the increased capability of the medics of 4th Kandak is something that the medics of OMLT-D can be incredibly proud of. The hospitality shown to us and the acceptance we encountered was unimaginable. Having said that, there is still much to do but it is an incredibly rewarding job.

For the medics the skills and experiences obtained at the various patrol bases must be passed on to those not fortunate enough to deploy yet. The experiences with the taking part in the Kandahar convoys and with our ANA brethren was amazing. Some stunning scenery, the worlds biggest map model and a convoy that stretched further than the eye can see. A logistical feat almost equal to the construction of the Great Wall of China. And then there was the Boardwalk....

In conclusion, deploying to the MEAO as part of OMLT-D was an excellent opportunity for the medics chosen. The experiences and memories gained from both a clinical and soldiering viewpoint will no doubt last a lifetime for each of us and we thoroughly recommend it should the opportunity arise.

*By: WO2 Glenn Jackson*

# The role of physiotherapy in war

Physiotherapists have been serving with the Australian Defence Force (ADF) since 1915 when the first contingent of masseurs and masseuses left Australian shores to serve with the Australian Imperial Force (AIF) in Egypt. (Physiotherapy in war; H. C. Wilson; Gillingham Printers Pty Ltd 1995: pg 1).

Masseuses had the rank of private, with the privileges of an officer rank but were not allowed to treat officers. Masseurs held commissioned rank. In 1915 masseuses & masseurs became part of the medical establishment and authority was given to establish an Army Massage Service, having an establishment of 6 honorary Lieutenant Masseurs who worked in the Command Posts and 48 Masseuses with the rank of Staff Nurse, who worked in the Auxiliary Hospitals in England. Interestingly, it was not until 1919 that the UK Army got a similar service.

In 1915 the Director General of Medical Services (DGMS) recognised the valuable service that Masseur/ses could provide as he advised that joint injuries can be set at once, provided they are transported on ships with facilities for massage. Staff Sergeant Beck, a masseuse, wrote in 1916 from Mena House in Egypt there were plentiful supplies of injuries to knees, ankles, and lumbago. The range of treatment included massage and hot air baths to open wounds treated with zinc or copper ionization. (Physiotherapy in war; H. C. Wilson; Gillingham Printers Pty Ltd 1995).

Much like the advancement of medicine through war, a wider concept of physical therapy emerged towards the end of WW1. This being the recognition and incorporation of remedial exercises aimed at the attainment of a functional result. From this concept, physiotherapy and its philosophy in the restoration of movement and function through manual and exercise therapy were born.

During WW2, there were several different treatment approaches that were developed. For burns saline baths were provided, whereby the physiotherapist's role was to prevent joint stiffness by graduated movements in the heated solutions. Numerous pinch grafts were applied, once taken the physiotherapist applied. Open wounds were initially treated using the closed procedure, which involved primary excision and enclosing in plaster until healing occurred. This caused very stiff joints which needed passive & active movement and remedial physiotherapist exercises. For orthopaedic injuries patients were moved to Cairo. From the initial onset, the physiotherapist's role has been two fold. To rehabilitate ADF members and return them to active duty, thus maintaining the fighting force in the Area of Operation (AO), and to rehabilitate ADF members who are required to leave the service through injury to facilitate their transition to civilian life.

The Vietnam War demonstrated the need for a physiotherapist to be well forward in the battle space. Physiotherapist LT H. Skewes was the only physiotherapist deployed with the 1st Australian Field Hospital in Vung Tau and undertook chest care to soldiers in ICU following mine explosions; minor gun shot wounds or fragment wounds requiring short term rehabilitation. LT H. Skewes worked close to the fighting, so different to physiotherapists of WW1 and WW2 who were in the rear echelons.

The work of physiotherapists has been no more aptly demonstrated than from my deployment with Special Operations Task Group (SOTG), Afghanistan. This presented a unique challenge where not only is the physiotherapist required to adapt to the environment to effectively apply techniques.

SOTG members are highly specialised and physically fit. Muscular-skeletal injuries whilst out side the wire (OTW) present as lower neck, mid back, rib, lower back, or shoulder strains, with the occasional ankle



*The before and after result of a localised Grade V manipulation to L4/5 to restore Lumbar extension.*

inversion and knee strains. A quick recovery is needed to enable the member to resume his role in the best possible physical condition. Adapted treatment regimes are often applied, extending the normal treatment into the field for the situation they are going into.

An example of this is a Costovertebral joint strain, where the member continues the correction OTW by using a rolled up towel, cat stretches or a tennis ball under the joint. Lumbar facet joint dysfunction is another example that was often seen because of the weight carried OTW. This dysfunction was usually successfully treated quickly with a localised Lumbar manipulation, with a follow up program.

The mind set of SOTG members is also of consideration in their rehabilitation. They are highly motivated and focused individuals which can be used to a physiotherapist's advantage in their rehabilitation by facilitating and accelerating their recovery. Due to their high fitness level, recovery can be fast tracked but this can be off set by the physical demands placed on the body when performing their assigned tasks OTW. Having such a close invested hands on application to their injury; the physiotherapist is in the best position to offer careful guidance to the patient (and to their superior) in what they can and can't do OTW in terms of their injury, as not to aggravate or to put at risk their recovery rate.

The weight from body armour, ammunition, weapon, helmet and back pack whilst on extended patrols or riding inside a Bush Master (BM) vehicle, was found to contribute to spinal joint dysfunctions. Manipulation to these joints, muscular dry needling, specific mobilising stretches and strengthening programs facilitate a quick and effective recovery. Occasionally taping was also used to maintain correction and to de-load the injury site. One example of a potentially serious condition experienced by a SOTG member was constant bilateral pins and needles extending down the arms from C7 and 8 nerve roots. This problem had the potential to return the member to Australia for long term treatment, thereby depleting the unit of a valuable operator and effectively reducing the effectiveness of his section as there was no replacement and also adding a monetary cost for the ADF. This member was able to remain in country with his section whilst undergoing mobilisation treatment (grade III unilateral PAIs) to his lower neck region, together with neural glides, and was able to operate normally OTW with some careful guidance in regards to specific exercises and postural advice. He made a full recovery prior to the end of his rotation.

Lower leg muscular-skeletal injuries pose a serious challenge for the physiotherapist because of the need for the member to be able to jump, run, squat and land from various heights (e.g. inserting from a helicopter, jumping down from a B M vehicle or running over rough ground whilst under fire). The physiotherapist carefully balances the restoration of movement, with strength and stability and the reduction of pain. One particular example was an ankle inversion sprain in which the SOTG member was rehabilitated from an inability to weight bear due to pain, weakness and swelling through, not only to full function



*Grade III unilateral mobilisation to C7/T1 to restore segmental mobility for the nerve root to exit.*

but to a function that demanded the ankle to perform beyond normal expected requirements. Again, he was able to stay with his unit and be a valuable participant in their operations while undergoing his rehabilitation.

Another aspect of this deployment was the concept of Hearts and Minds. I provided a physiotherapy service once a week to US FST Camp Ripley, treating local Afghan civilians who had been injured either through accident or conflict. This contributed to their overall perception that we were the preferred help rather than the Taliban. There were many orthopaedic conditions, the majority being fractures as a result of gun shot wounds. One example was an elderly Afghan man who had been shot in the thigh, fracturing his Femur. Not only was there a need to keep his upper and lower limbs functional but also a requirement for a walking frame, which I fashioned out of two unserviceable metal chairs for him to mobilise with. This allowed him to return home using the walking frame and freed up a valuable bed space which was much needed in the FST. Treating many of these hypo-mobile ankles and knees following removal of the external fixation and rehabilitating them back to functional walking again, harked back to those earlier days of physiotherapists in WW1.

The experience of front line physiotherapy taught me the need to draw upon all my years as a physiotherapist to deal with complex clinical issues that were posed in a unique but demanding environment, and to often think laterally to overcome clinical problems or deficiencies.



*The walking frame fabricated from two chairs (the type of chair used is depicted).*

*Elderly Afghan man mobilising NWB with the frame.*

Providing Australian military physiotherapists to Australian troops is paramount, as our high level of training and the type of training is quite different to that of our counterparts in other armies. With the development of our profession over recent years in regards to knowledge, skills and manual techniques, we are well placed to offer an essential service to maintain the fighting capacity of ADF units within an AO. I believe that providing an Australian military physiotherapy service well forward in the health chain optimally maintains Force

Preservation essential for continued combat operations. The importance of implementing this concept should be extended to all future overseas operations.

*By: Capt Rolf Sellentin, 2 Cdo Rgt, B. App. Sc. (Physiotherapy), M. App. Sc. (Manipulative Physiotherapy).*

## **IF** – *By Corporal J. Stevens*

If you can race up mountains at the double  
Med kit strapped to your back  
Oxygen with you in case of trouble  
Stretcher prepared for quick evac

If you can work under artillery fire  
Calming-talking-triaging as you go  
And although the situation is dire  
Treat them all, friend or foe

If you can run to a mate falling  
Bullets passing you, almost getting hit  
And despite their injuries keep them smiling  
As you pull gear from your kit

If you can go on treating for hours  
Not even stopping for a feed  
And lecture your Company powers  
To maintain your medical needs

If you can work in darkness without error  
And keep your procedure nice and clean  
If you can calm you patients terror  
And from them a vital history glean

If you keep your Company running  
And follow every change it makes  
And get them moving – What's more keep them moving  
Only stop to nurse bruises, pains and aches

And fight to keep them drinking water  
Through jungle and desert – keeping up a gruelling pace  
And hold your curse when someone falters  
Dehydration evident put cannula and fluid in place

To keep your temper when your nerves are fraying  
Neath blazing sun and swift torrential rain  
And stoically ignore insects playing  
In cramped environs treat pain

Stock a capability to the letter  
And help achieve the hospital's goal  
Although you're not always team leader  
Be content to know the role

If all these things you're confident of doing  
And have the will to help come what may  
You're a MEDIC now – start preparing  
Paulatim that's the way

# Environmental Health Report

## Exercise Southern Reach 2010

This report outlines and describes the main issues and concerns that were raised and dealt with by the 1st Combat Service Support Battalion (1CSSB) Environmental Health (Env Hlth) Team deployed on Exercise Southern Reach 2010 (SR10). Areas regarding Health and Hygiene, Heat Issues, Water testing, Pesticide usage, and local Flora and Fauna threats are raised and discussed.

Various assessments were conducted while on SR10. These assessments included but were not limited to, living accommodation standards; showers, ablutions, latrines (SAL's) and food preparation areas. The importance of these assessments were to reduce the incidence of the spread of communal living illnesses through early detection and prevention. By using this method of attending to the matter at hand, the issues were quickly resolved and no health related problems were attributed to lack of hygiene.

The level of hygiene expected for communal Showers, Ablutions and Latrines (SAL) must be higher than most other places because of the high risk of transmitting tinea and oral-faecal diseases such as Hepatitis A, and gastroenteritis. Hygiene concerns had a detrimental effect upon the general health and wellbeing of the troops as soldiers presented to the Medical Team with health issues such as sore eyes and occasionally gastrointestinal disorders.

It was noticed on several occasions that the SAL's were considered unhygienic because of a direct result of the poor hygiene standards. The implementation of careful planning averted the possibility of any major health incident occurring.

Upon first arrival at the Cultana Training Area (CUTA) while on EX SR10, the food preparation and serving areas were immediately assessed to ensure the facilities were adequate and capable of preparing and serving the quantity and quality of food required for up to 1000 members.

Once one primary entrance and exit was established, it became possible for the Env Hlth Team to control hand hygiene upon entrance to the dining facility. This was achieved through the implementation of an antiseptic hand wash station at the entrance to the facility and the constant presence of a health team member to ensure hand hygiene rulings were carried out and maintained.

The presence of flies in the dining facility presented a very real health threat because of their potential as a vector of disease such as gastroenteritis. This health threat did not appear until several weeks into the exercise. Once noted immediate action was taken to eliminate this potential hazard. This elimination consisted of the spraying of the



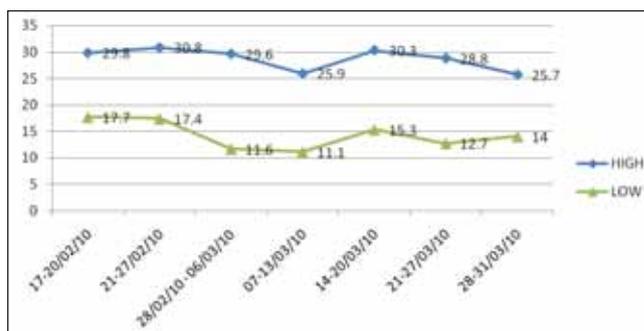
*Environmental Health Vehicle during a simulated IED while on EXSR10.*

dining facility with an insecticide that provided a "knock down" ability and also a repellent affect. However, realising this measure alone was not effective enough additional signs were sited in order to ensure that personnel were constantly reminded to close all doors used upon entering and exiting the dining facility.

These barrier sprays were implemented once every week and as a result, it was noticed that the intensity of flies dropped remarkably. Through the use of such preventative methods as described any serious health threats to personnel within the CUTA were dramatically reduced and an acceptable level of health and hygiene was maintained.

Over the duration of Exercise SR10 concerns were raised over the potential incidence for heat injuries. Specifically concerns were linked to the causes of heat stroke or indirectly related to human exhaustion from arduous working conditions.

In order to effectively combat this potential problem, Wet Bulb Globe Temperature (WBGT) readings were taken four times a day and distributed to all commanders. Also, a work/rest table used widely throughout the Australian Defence Force (ADF) was followed as per guidelines. Attached is Table 1.1 which shows the high and low temperature readings for each week of the exercise. This data was



*Table 1.1 High/Low Weekly Readings.*

obtained through the use of an automated data table in which daily readings were inputted.

Due to the careful management of military work/rest tables used in direct correlation with accurate WBGT readings, any serious heat or heat related injuries were able to be avoided and the health of all personnel was maintained to the highest possible level. This information can be used in future exercises to the GUTA.

Various water tests were conducted by Env Hlth over the space of the exercise and it was discovered that all water sources used water piped directly from the local town of Port Augusta. The use of water jerries was also a potential source of disease and even if using town water that chlorine with its inherent disinfective qualities would decrease through prolonged storage and transportation of water. Therefore, a higher rate of chlorine was necessary than the town water provided. All water tankers brought in were promptly inspected and dosed accordingly.

It was also noticed that when personnel did not see a pesticide having an immediate effect, they often asked for the area to be sprayed again. This was due to a misconception that the pesticides used would disintegrate quickly, when in reality they were residual pesticides and were able to work effectively for several weeks. This problem was resolved quickly and effectively through the dissemination of information to all willing recipients.

Over the duration of Exercise SR10 no personnel had their health or wellbeing threatened due to any dangerous contact with flora or fauna within the GUTA. However, there were several incidents in which the Env Hlth Team was called upon to handle potentially hazardous reptiles being snakes. During the exercise three different snakes were caught being two brown snakes and one carpet python. Thankfully, one member of the Env Hlth team was an accredited snake handler.

The Env Hlth team who deployed on EXSR10 conducted assessments to reduce incidence of illness and disease amongst ADF members. Measures to reduce illness outbreaks included visual inspections, quantitative assays and physical interventions. The outcome being a relatively low incidence of Prev Hlth was achieved.

---

*By: Pte D. Jak on the 31/03/2010 while deployed on Ex SR10*



*Carpet Python Found at Scale A while on EXSR10.*

Photograph by Pte. Jak.



*Game face! Env Hlth technician Pte. Jak on EX SR10.*

# Demystifying Soldier Career Management

The Health Services career managers have provided answers to some of the more common questions asked about soldier career management.

The SCMA Health Services Cell manages the careers of approximately 820 RAAMC soldiers to fill 747 positions; 80 RAADC soldiers to fill 84 positions; and 51 AAPSYCH soldiers to fill 50 positions. The cell consists of:

**Senior Career Manager – CAPT Paul Mitchell, RAAMC GSO.**  
Manages WO2 (all trades) and SGT (all trades less ECN 031).

**WO1 Career Manager – WO1 Anna Mercieca, RAAMC ECN 350 RSM.**

Manages CPL-SGT (ECN 031 only)

**WO2 Career Manager – WO2 Josh McDade, RAAMC ECN 031 MED OP.**

Manages PTE-LCPL (all trades) and CPL (all trades less ECN 031).

The majority of postings arise due to Service requirements and are based on the following functional priorities:

1. Service need
  - Staffing the Army IAW CA's priorities (APEP)
  - Provision of capability to meet operational requirements
2. Career development needs of the soldier
  - Employment Specifications for trade
  - Profile
  - Ability/performance and potential of the soldier
3. Personal preferences of the soldier

Soldiers are expected to contribute to their own career management by keeping their career manager informed of changes to their circumstances and or posting preferences. The best means of achieving this is via the Employee Preferences and Restrictions (EPAR) completed through PMKeys Self-Service.

Soldiers are posted to meet the needs of the Service and gain the necessary experience required by their trade's Employment Specifications to prepare them for promotion to WO1 and not just their next posting/appointment. Remaining in the same unit / command (including SOCOMD) does not allow the soldier to gain the necessary experience and denies opportunities for their peers to be posted to that unit to gain experience. Soldiers with a limited posting profile may be less competitive for promotion relative to their peers who may have a broader profile.

Sometimes Service couples cannot be posted to the same geographic,

basically Service couples will not be given higher priority for postings over other soldiers. Service couples should note that co-location is not always achievable in their preferred posting locality. Where co-location is not achievable, soldiers have the option of proceeding on posting unaccompanied or applying for LSL or LWOP.

Soldiers are often panelled for specific career courses at particular times to enhance their career development and prepare them for specialist positions. As a guide, soldiers should complete all promotion courses (less Subject 1), prior to them being eligible for PAC. As such, soldiers should anticipate completing one career course per annum pending course vacancies and soldier availability. Refusal to attend promotion courses without valid reason is considered to be Restricted Service and may have career implications.

Your promotion and other positing factors are discussed at the Personnel Advisory Committee (PAC). It makes recommendations to the appropriate delegate on suitability for promotion of soldiers to SGT and above. The role of the PAC is to consider all soldiers who are eligible for promotion and place them into an order of merit against their peers within their respective trade. The number of soldiers promoted each year is dependent upon the number of vacancies within their trade. As such, eligible soldiers compete against their peers for promotion into any vacancies that may arise within their trade each year.

A part of the PAC is identifying career streams for staff. The regimental stream exists for soldiers that have the goal of becoming a RSM (ECN 350). Soldiers in this stream should undertake various regimental postings throughout their career to make them competitive for selection as a RSM as detailed in Employment Specifications. Soldiers in the regimental stream are still required to undertake and be promoted into trade positions up to and including WO2.

Soldiers that do not have the goal of becoming a RSM are allocated to the trade stream. Soldiers in the trade stream will generally not undertake any regimental postings but may do so to meet a Service need.

Employment Specifications are the responsibility of ALTC and not SCMA. Any inquiries relating to ES should be addressed to the RAAMC Employment Category Manager at ALTC.

All soldiers and officers with soldiers under their command are highly encouraged to be familiar with the following:

- SCMA website
- The SCMA Handbook (available on the SCMA website)
- DI(A) Pers 47-11 Career Management of Soldiers in the Australian Regular Army and Army Reserve
- RAAMC Employment Specifications

# Health at the frontline

Dear RAAMC members,

Greetings from your medical corps colleagues at SOHQ. There is a small collection of articles that highlight what we do, have done and some lessons learnt. From a HQ perspective there has been a significant evolution in the way in which business is now conducted and we have been fortunate in being able to attain significant and valuable face to face time with our health personnel located at Sydney, Perth and Melbourne. It has established relationships that allow us to enhance the profile of 'Health Services' within the command and increases our ability to add value to unconventional operational effects.

## Introduction by Corps Representatives in the Health Branch:

Major Paul Platon-Jones and Warrant Officer Class One Stewart Robertson (and of course not forgetting our newest member, LTCOL Alison Berlioz-Nott).

## DEPLOYING VOODOO STYLE



*'An inside look into a medic's deployment within SOCOMD'.*



**This article is written to provide an insight into what is experienced by Medical Technicians (MT) employed on operations with SOCOMD**



Each Special Operations Task Group (SOTG) deploys with approximately six RAAMC personnel. Three of these members are embedded within the Force Elements; they are the Team MTs. The remaining members generate the resuscitation capability, pre-hospital life support, primary health care team and the evacuation capability. As can be envisaged, working in the unconventional battle space places greater stress on the medical support elements systems and personnel.

The medical training for a SOTG deployment commences six months prior to the deployment date. This training allows for the certification of military proficiencies, assessment of currency/competency/confidence related to clinical skills and enhancement of teamwork and group dynamics.

The military assessments may include; however, are not limited to such aspects as fast roping, languages, heavy weapons and SOCOMD specific tactical training. Naturally, we also undertake the standard vaccination parades and ensure outstanding medical requirements are addressed prior to the deployment of the Force Element. Furthermore, the Med Team deploying with each SOTG rotation conduct combat first aid recertification which allows for the strengthening of an already close rapport with the operators. Some of the health specific training included:

- A week long medical training activity is conducted utilising the Environmental Simulation Training Facility (ESTF) located at the Army School of Health – Latchford Barracks. This training activity focuses on the stages of Care of the Battle Casualty (CBC) / Tactical Combat Casualty Care (TC3). Of note, this activity is not actually training per se rather it is an incorporation of all lessons learned from previous SOTG deployments.
- RAAMC members deploying as part of an SOTG conduct a three week (continual) clinical placement at a civilian institution. This placement involves a minimum of one week in Operating Theatres (OT) practising advanced airway management and one week in an Emergency Department (ED) where medics spend the majority of time in the resuscitation bays and/or triage area. The other week is usually an amalgamation of OT or ED.
- A new addition to pre-deployment training has been Acute Mental Health on Operations providing a theoretical background in the recognition, assessment, immediate treatment and management of individuals who present with acute mental health symptoms in a deployment context.

Unlike conventional Mission Rehearsal Exercises (MRE), SOCOMD medical personnel have considerable involvement in the overall strategic outcomes of SOTG MREs. This can be attributed to SOTG commanders at all levels embracing the force enhancement capabilities of the medical element not only on the battlefield but also in the force preservation space. Apart from the provision of general health care that keeps the operator in the fight, during the exercise, medical elements form an integral embedded component of the assault teams in the conduct of operational full mission profiles.

During the deployment, SOCOMD medical personnel are exposed to a unique operating tempo and culture. Some of the key lessons we have learned on a posting to SOCOMD have been:

Garrison patient work includes shoulder dislocations, ATV rollovers, suturing, suspected viral meningitis and facial fragmentation injuries to name a few. Due to the large amount of musculoskeletal injuries, SOTG has its own physiotherapist. These presentations result from the nature of employment of the Field Elements we support.

Whilst the primary role of the medic is to provide emergency and primary health support to the fighting force, they are also commonly called upon to conduct 'med caps'. A med cap is a 'sick parade' for local nationals and allows ADF personnel to build rapport with local villagers. The common methods of insertion are vehicle and helicopter operations, followed by foot mounted patrolling.

Medics often deploy on vehicle or helicopter mounted operations. We use the Bushmaster vehicle. Whilst on vehicle operations, medics man guns and are employed as vehicle commanders. The use of airframes for patrols usually involves landing at a secure landing zone (LZ), followed by a few kilometre patrol to the target area. After the air insertion, the walk over some of the harshest country, carrying your life and medical life support tools on your back for a period of hours to weeks is no easy feat.

One of the most professionally rewarding tasks allocated to SOTG medics is Operation VODOO. These missions are arranged by the SOTG to allow medics the opportunity to work on the American Aero Medical Evacuation (AME) birds. Some of the missions we deploy on include responding to point of injury (POI) casualties, mass casualties, coalition FOB's and patient transfers to and from Kandahar.

For those who are not aware of the term forward surgical team, it is a US term for a level 2 health facility that offers resuscitation (4 tables), imagery (x-ray & fast scans), surgery (2 tables), intensive care (2 beds) and a small holding capability (8 beds). The facility which we worked in at TK was run by both US Air Force and Navy. The clinical work we undertook included but was not limited to anaesthetics in surgery, working in the resuscitation bays and treating local nationals during local clinics. Honestly, one of the most clinical hands-on areas the majority of us have worked.



Deploying on operations as part of an SOTG is the highlight for all RAAMC personnel employed within SOCOMD. For us it culminates years of military and medical training in an operational environment, pushing them to the end of their physical, mental and medical limits. RAAMC personnel are currently on their 13th rotation with the SOTG of which no two have been the same. The lessons are passed on to each member, resulting in RAAMC personnel have been awarded Nursing Service Crosses (NSC), the Medal of Gallantry (MG), Commanders Citations and a range of other Australian Defence Force Commendations for their service.

## Little by Little

### Outdated but still followed

The Royal Australian Army Medical Corps comes from a long and proud history with linkages dating as far back as the First Fleet in 1788 to the New South Wales Medical Staff Corp in 1854 and to the birth, as we know it, of the RAAMC in 1901. Along with the formation of the RAAMC came the RAAMC Badge with a well-known Latin phrase Paulatim 'Little by Little'. This appropriate Latin phrase was a modest expression of the RAAMC's slowly developing skills and capabilities. I propose that Military Medicine especially, has progressed a long way, yet the RAAMC is still only progressing 'Little by Little'.

The RAAMC does not have a centralised collation of all medical lessons learnt on operations and back home. Many of us 're-invent the wheel' developing new medical equipment, medical SOP's (Standard Operating Procedures) or training and development ideas when the equipment has already been built and trailed. I believe there are many lessons that are interchangeable from unit to unit, man to man and even from the ADF Tri-services. I propose a controlled and organised medical database managed by the Army Logistical Training Centre (ALTC) Health Service Wing (HSW) and accessed via DRN would provide the repository of knowledge required providing easy access for all RAAMC and RAANC personnel to up-to-date medical advice and support from Subject Matter Experts. The data base would also assist Training and Development Cells in obtaining insight, feedback and advice on medical equipment, medical SOP's and lessons learnt on operations and back home. A web page orientated medical database would stop 're-inventing the wheel'.

As it stands there is no governance on medic training conducted within the RAAMC external from the HSW. In a civilian practice this would be unacceptable. Whilst ALTC HSW provide the intensive initial training for each level of competency, something just as important as initial clinical training is continuation and continuity of clinical training. It has been suggested numerous times that a training team originating from, or raised in conjunction with, ALTC HSW be established. Other methods could include sending senior medics intermittently to ALTC to conduct clinical training. Releasing monthly medical training packages from HSW to all health establishments would also have merit. Regardless, no overarching policy of continuing professional development for medics exists. AMAC Competency Log Books are not the sole solution.

Retention has been a big issue within the RAAMC for a long time now, both for doctors and medics alike. Solutions have been discussed at great length ranging from monetary advances, posting promises and internal medical course's just to name a few, However, there is one category, that is seldom appreciated within the RAAMC and that is the clinical professional. As it stands, after AMAC and excluding the rare Underwater Medical Clinicians Course, there is no higher clinical education, for medics within the RAAMC. An RAAMC supported external education for proficient senior medics, perhaps a Military version of the Physician's Assistant Course offered at the University of Queensland. This has been trialled and proven effective within the ranks of United States military. A PA or equivalent tertiary sponsored course will give the medic the graduate degree, a Grade Point Average (GPA) which in turn can be used to sit the Graduate Australian Medical Schools Admission Test (GAMSAT).

Appropriate post description for clinical and RAAMC posting allocation to individuals may prevent professionally deficient medics and doctors being posted into an inappropriate unit, promoted too early and deployed purely on promises. Over the last 15 years, more Australian lives have been lost during military training than in combat. To assist in appropriate post descriptions, Posting Risk Categories could be created. For instance, a posting in support of Special Forces would be a Risk Category 5 due to its dangerous training and deployment risk, however, a sedentary posting to 51 Water Bottle Repair Unit (not an actual unit) would be a Risk Category 1. This could be extended to deployments. Combined with the RAAMC reporting honestly and mindful of the fact that reporting favourably when not due can lead to widening negative consequences in the long run will enable fit for purpose medics being posted.

The Australian Army, internationally, leads the way in many aspects and there is no reason that the Royal Australian Army Medical Corps cannot be one of those. I believe there are some fundamental changes that we can make as a Corps to turn us into a leading organisation. I am very proud to be serving as a medic within the RAAMC and hope it motivates consideration, discussion and change.

*By: SGT J. WALTER, NSC and Bar, Training Sergeant  
Regimental Aid Post, Special Air Service Regiment*

# Voodoo Medicine

## "DOMINATING THE DARK ARTS"



**The aim of this article is to provide those interested, an insight into the employment of Medical Technicians of the Royal Australian Army Medical Corp (RAAMC) personnel in Special Operations Command (SOCOMD) as part of the Special Operations Task Group's 'Voodoo' line of operation.**

"Voodoo Medicine" is the brand name of SOCOMD Medical.

A brotherhood of RAAMC personnel posted to the units of Australia's SOCOMD. The voodoo design itself was created by a member within SOCOMD.

Voodoo medics are highly competent and professional in both soldiering and medical skills. This generates extreme confidence in our abilities. The majority of RAAMC personnel employed within 'Voodoo Medicine' do not hold any higher grading of medical competency within Defence. The distinction is that 'Voodoo' medics are continually exposed to both Primary Health Care Patients and trauma casualties on training scenarios, exercises, clinical placements and operational tours due to the nature of the personnel and capabilities we support. We place an extremely high emphasis on clinical training and skill maintenance.

For those who have not had the opportunity to operate in these conditions; or those who are preparing to deploy on operations with only limited exposure within a 'single operator' level environment; or if you're just interested and motivated to improve your skills and knowledge, the door at Voodoo medicine is always open to teach, train and mentor motivated individuals. Voodoo medicine has a large holding of extremely motivated, passionate and skilled RAAMC personnel to facilitate this.

The level of training received by RAAMC personnel is extremely

extensive and without continual training, guidance, mentoring and reporting, practical skills and knowledge are lost. We commend ourselves on our operational and domestic accomplishments and regard ourselves as clinical governance experts in Role 1 health care.

Obviously employment limitations exist within any Army organisation. So, due to the nature of employment within Voodoo medicine, personnel are very hesitant to move on from the command; employment is therefore very competitive. This has and always will be a problem (we want to retain skilled, motivated operators), but it always comes to a point where family needs to take priority and a posting away from the command for a few years is required. This is when identified personnel are put up against the medic triangle and the nature of the beast is competitiveness (best person for the job), not all will meet the standards.



It is highly recommended to anyone interested in employment within Voodoo medicine to create a career profile for themselves. Support Infantry Battalions Operations, get your Military skills, go to the role 2 and 3 facilities (learn their capabilities, consolidate your skills), get courses up (parachuting, weapons, languages), maintain your motivation and fitness (training physically and studying clinically), improve your clinical skills (civilian training, AME courses, UM Cse, clinical placements). This makes you competitive. You will learn your strengths and understand your weaknesses. Believe it or not, throughout RAAMC there are individuals actively identifying personnel at all units and training establishments for future employment within Voodoo medicine.

## Units

RAAMC personnel support five SOCOMD units. They are: The Special Air Service Regiment (SASR), commonly known as "Bad Medicine"; The 2nd Commando Regiment, known as "2 CRAP"; our ARES brethren at The 1st Commando Regiment, The Incident Response Regiment (IRR); The Special Operations Logistics Squadron (SOLS) and The Special Forces Training Centre (SFTC).

The longest serving Voodoo Medicine call sign (C/S) is "Bad Medicine". These members support the SASR and are based on the west coast of Australia, in Perth. Employment within 'Bad Medicine', will see you

operate in both 'Green and Black' roles, through an array of insertion techniques. 'Bad Medicine' has the largest manning of proficient Underwater Medicine Medical Clinicians (UMMC) in the Army.

'2 CRAP' support the 2nd Commando Regiment. Some of you may recognise 'CRAP Medicine' as the motto of the RAP for the unit formally known as 4th Battalion Royal Australian Regiment (Commando). In 2009, The Commando Regiment broke ties with the Royal Australian Regiment (RAR) and formed a new unit – the 2nd Commando Regiment. The RAAMC personnel employed within '2 CRAP' operate similarly to those of 'Bad Medicine' however, they work from the east coast of Australia in Holsworthy Barracks.

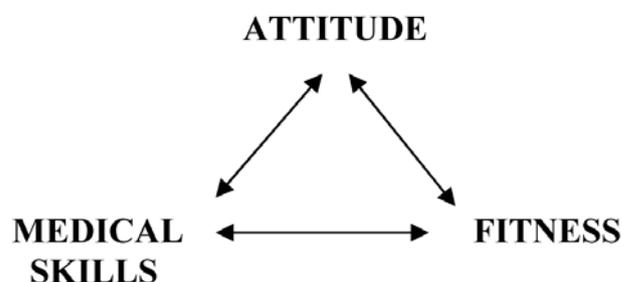
The RAAMC personnel posted to the IRR provide the Australian Defence Force's (ADF) contribution to Nuclear, Biological, Chemical and Radiological (NBCR) threats domestically. They are based on the east coast of Australia at Holsworthy and support the predominately Royal Australian Engineer (RAE) unit in addition to other tasks on demand. Employment within the IRR, involves retrieval medics and resuscitation bays.

The SOLS and the SFTC are small units that provide support to the SOCOMD training continuum and operations. They have a small allocation of RAAMC positions but remain a firm progression block for employment as a medic within the 'Voodoo Medicine' world.

## Medics's, 'the medics triangle' and courses

RAAMC personnel in the wider ADF, are collectively known as 'medics'. However, personnel employed within SOCOMD (bad medicine and 2 CRAP) are given the operational call sign (C/S) of medic This C/S can be held by any rank within RAAMC who meets the requirements. The areas that distinguish a 'medic' from a medic are substantial and consist of personnel meeting the following requirements:

- being posted into the position;
- being an Advanced Medical Technician (AMT) or UM qualified;
- holding SF weapons qualifications;
- completion of the Special Operations Force Induction Course (SOFIC) mod 1 and 2;
- qualified in specialist insertion skills (parachuting and/or fast roping)



The requirement for employment within voodoo medicine focuses on three key aspects that we refer to as the medics triangle’.

These three key areas identify the type of individual who will thrive within SOCOMD medical. However, a break in the stability of the triangle, and your employment within Voodoo Medicine will be extremely limited.

If you strive for excellence, employment satisfaction and don’t mind long hours, time away from home and loved ones, and meet the requirements of the Voodoo triangle, contact the RAP SGT at SASR or the Tobruk Lines Health Centre and ask to speak to the training SGT. Likewise, do not hesitate to approach Voodoo medical personnel supporting or attending courses at the Army School of Health (ASH).

Voodoo medicine prides itself on ensuring that its personnel are up to date, clinically proficient and competent in all skills. This is achieved through training such as: unit level training; employment with civilian organisations (emergency departments, operating theatres and ambulance services (intensive care and SCAT); Wyvern Serpent (Operational focus), and international training opportunities.



*Sergeant J and a US medic, carry an Afghan child to an ambulance after an aeromedical evacuation mission.*

The types of courses personnel seeking employment within Voodoo medicine can look forward to include: Advanced Medical Technician (AMT), Specialist Medical Technician (SMT), Underwater Medical Clinician (UM), Rotary Wing Aero Medical Evacuation (RWAME), Fixed Wing Aero Medical Evacuation (FWAME), PARA (land and water), fast roping, special forces weapons, Special Operations Forces Induction Course (SOFIC), Nuclear/ Biological/ Chemical (NBC) medical, languages and Special Casualty Access Team (SCAT) paramedic to name a few.

## Conclusion

Employment within SOCOMD medical opens a world of opportunities – in particular, you will be rewarded by working with the most elite and professional soldiers in the world. You will be constantly tested in your soldiering and medical skill. You will conduct world class training you never dreamed of, both domestically and internationally. It will be the highlight of your employment within the ADF and should be the goal of every member of the RAAMC.

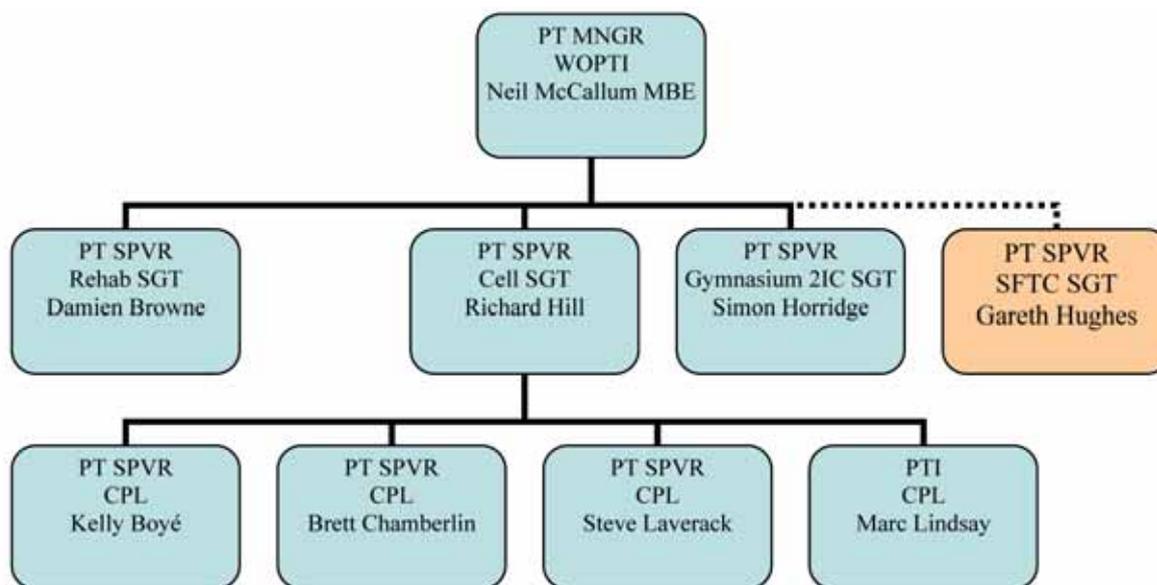
*By: RAP SGT, 2 Cdo Regt*



*A Medic from Australia's Special Operations Task Group stands by to depart with US forces on another Aero Medical Evacuation (AME) mission from the flight line at Tarin Kot.*

# School of Infantry and Singleton Military Area Gymnasium

## Lone Pine Barracks NSW, Physical Training Instructors 2010



Physical Training Instructors (PTI's) are assigned to an Initial Employment Training (IET) platoon and remain as the instructor for the duration of the course. At the completion of the basic rifleman course the PTI's are included in the march out by presenting a commentary to the family and friends of the platoon while they conduct a Military Self Defence and an Obstacle Course Display. The most rewarding aspect of the job is knowing you have contributed in the members' transformation from recruit to trained soldiers.

As warfare is becoming more complex and diverse, the PT cell has developed the training program deliver instruction that is calibrated with operational needs. Recently a new 13 week PT program has been implemented which is part of the constant evolution of training development. The new program has been designed to not only develop physical fitness but to develop initiative, encourage teamwork and aims to bring training inline with the Army Capability Requirement (ACR) for Infantry 2012. The ACR introduces changes to section sizes and the type of combat loads being carried.

Earlier this year work began on upgrading the gym facility under the Enhanced Land Force project. These improvements include an extension to the weights room, pool area and new office space. The obstacle course received a facelift at the end of last year with new urban orientated obstacles being introduced to provide the skill sets needed on the modern battlefield.

Inclosing, the Unit and PTI's have had a very demanding and successful year; this was recognised with the following awards being presented:

- **SOI – Certificate of Achievement**, Defence Occupational Health and Safety Awards 2010, for its outstanding performance in improving rehabilitation and return to work services for Trainees and personnel.
- **SGT Damien Browne – Silver Commendation**, for his excellent work within the Rehabilitation cell.
- **CPL Steve Laverack – Soldiers Medallion**, for his outstanding efforts as a PTI within a very busy training unit.

# Veterinarians in the Australian Military

Until it was disbanded at the end of WWII, there was a Veterinary corps providing care to the military horses and other animals. There are now but a handful of Veterinarians in the military, most of whom are reservists, and fall under the RAAMC banner. Apart from the novelty factor, uniformed veterinarians currently undertake a number of tasks but are largely underutilised. There are two reservist Veterinary Officer positions at the Army Malaria Institute (AMI) caring for the colony of Aotus monkeys. These monkeys do not suffer malaria like humans do as they will self-clear the parasite.



Other Veterinarians are present within the military in non-Veterinary positions but provide input into Exercises such as AACAP and Pacific Partnership, as well as assistance to Military Working Dogs (MWD) and unit mascots.

Every year a Veterinary Officer attends AACAP. In 2010 was held in Ernabella (Pukatja to the locals) and was attended by two Veterinarians: MAJ Amanda Parry and CAPT John Hunter. The primary aim of veterinary involvement was to desex as many of the local dogs as possible and euthanise some animals to aid in population control. This was done in a makeshift 'surgery' with an FS table for our surgery table. The efforts of the construction team were greatly appreciated after they made some leg extensions for the tables to raise the height and save our backs as we performed surgery. We were also ably assisted by our dog wrangling team: CPL Seton Wardrop and especially LT Stacey Lawrence, an EHO who took up the challenge of being our nurse come anaesthetist and did the job brilliantly!



In addition to surgery we conducted general examinations, house calls and parasite control. The two local donkeys who had the run of the town were spared from the scalpel.



Another activity we were involved in was the US-lead Exercise Pacific Partnership which provides health care, including veterinary assistance, to the south pacific region each year. AS involvement in PP 09 was limited due to the outbreak of Swine Flu, however LT Garnett Hall participated in PP 10. LT Hall is currently deployed on OP Astute and attended the Timor Leste phase of PP10 in August as part of a veterinary team. In addition to providing small animal veterinary services, the veterinary teams travelled to regional communities to treat livestock, and assisted in the investigation of a disease outbreak.

With the ever-present threat of IEDs in Afghanistan, our Explosive Detection Dogs (EDD) are becoming a much more important asset. Veterinary care on deployments is largely reliant on coalition veterinarians or health personnel.



I am currently working within the health cell of 1 Div and in conjunction with SME am developing veterinary policies for our MWD to improve the care of our canine soldiers. I welcome any input from members and health personnel who have had experiences caring for MWD.

For any veterinary matters contact MAJ Parry, HQ 1 Div or email [amanda.parry@defence.gov.au](mailto:amanda.parry@defence.gov.au).

By: MAJ Amanda Parry

# RAAMC Key Ring Register

Rank	Surname	Initial	Key No
HOC			0001
DHOC			0002
CORPS RSM			0003
MAJGEN	Rosenfeld	JV	0010
BRIG	Duncan	D	0116
COL	Rudzki	SJ	0006
CO	Whelan	GM	0005
HON COL	Perks	BL	0089
LTCOL	Cooke	JW	0025
LTCOL	Fletcher	SE	0011
LTCOL	Georgiadis	G	1982
LTCOL	Holmes	RJ	0088
LTCOL	Kitchner	SJ	0114
LTCOL	Marshl	D	0052
LTCOL	Parker	FJ	0120
LTCOL	Schramm	CA	0079
LTCOL	Sinclair	L	0118
MAJ	Beeson	N	0014
MAJ	Butt	PJ	0093
MAJ	Collins	PR	0022
MAJ	Dabbousy		0096
MAJ	Frances	SP	0029
MAJ	Inglis	T	0104
MAJ	King	JA	0046
MAJ	Loveridge	RS	408
MAJ	Lumsdaine	SJ	0050
MAJ	Martin	L	0103
MAJ	Murfin	BA	0008
MAJ	Palmer	SJ	0061
MAJ	Quayle	WA	0064
MAJ	Reidy	FT	1914
MAJ	Smith	JR	1970
MAJ	Straskye	J	0009
MAJ	Williams	DL	0117
MAJ	Quayle	WA	0111
CAPT	Aldridge	OB	0080
CAPT	Atkinson	GJ	0109
CAPT	Baldwinson	SJ	0078
CAPT	Batty	DM	0013
CAPT	Brayshaw	A	0112
CAPT	Bryant	CR	0017
CAPT	Clancy	SL	0122
CAPT	Dent	AM	0130
CAPT	Dixon	KJ	340
WO2	Franks	MD	0030
WO2	Gurr	DL	0037
WO2	Holdforth	N	0124
WO2	Hunt	AA	0100
WO2	Johnton	DC	0043
WO2	Leak	D	0098
WO2	Lee	PJ	0048
WO2	Mackenzie	AG	0576
WO2	McDade	J	0055
WO2	Morris	VLA	0129

Rank	Surname	Initial	Key No
CAPT	Dunne	K	0142
CAPT	Gray	NL	0036
CAPT	Haigh	R	0138
CAPT	Heslop	DJ	0082
CAPT	Higginbotham	D	0144
CAPT	Johnson	L	7348
CAPT	Kirk	TB	0047
CAPT	Lewis	P	0069
CAPT	Mitchell	PW	0092
CAPT	Piercey	JE	0132
CAPT	Reinhrt	AM	0121
CAPT	Sayce	AP	0140
CAPT	Von Saldern	PM	0085
CAPT	Waldeck	CA	0108
CAPT	Whitworth	AG	0127
LT	Brett	CE	0015
LT	Briffa	DB	0016
LT	Cameron	EE	0019
LT	Chalmers	JH	0021
LT	Humphreys	AN	0040
LT	Jones	SM	0044
LT	Kolka	JM	0083
LT	Mackay	BJ	0051
LT	O'Shea	A	0105
LT	Porto	A	0143
LT	Poyntz	EL	0063
LT	Rowe-Roberts	NL	0110
LT	Smith	A	0141
WO1	Baker	CC	185
WO1	Clarke	MS	0101
WO1	de Santa-ana	A	0007
WO1	Harmer	TL	0125
WO1	Matthews	EA	0087
WO1	McKindley	A	0056
WO1	Menser	MT	0057
WO1	Mercieca	AR	0058
WO1	Robertson	SB	0066
WO1	Solomo	PIP	350
WO1	Stewart	AM	0074
WO2	Abell	A	0119
WO2	Atwell	RP	0012
WO2	Busbridge	B	1976
WO2	Cox	G	1031
WO2	Evans	J	0028
SGT	Sinnott	GF	0071
SGT	Tanner	KA	0106
SGT	Taylor	J	0102
SGT	Taylor	JJ	0148
SGT	Vermeer	LW	0094
SGT	Walsh	TT	0091
SGT	Weeks	SJ	0077
CPL	Bellim	S	0115
CPL	Cntwell	DJ	0128
CPL	Chatt	M	0145

Correct as at 26 Aug 10

Rank	Surname	Initial	Key No
WO2	Pavlenko	MP	0062
WO2	Pratt	BJ	322
WO2	Price	BD	0084
WO2	Spencer	AG	0072
SGT	Balcombe	SR	0123
SGT	Barbour	H	0099
SGT	Carrascalao	JM	0020
SGT	Crossan	CA	0026
SGT	Cuttler	RL	0076
SGT	Durant	AJ	0027
SGT	Fitzallen	DR	042
SGT	Harris	KA	0038
SGT	Jackson	II	0041
SGT	Kelson	RJ	0045
SGT	McConnell	KE	0053
SGT	McCrae	T	0054
SGT	McMurtrie	WT	0135
SGT	Page	RJ	0060
SGT	Quirke	M	0107
SGT	Rotheram	HA	0067
SGT	Rowe	BJ	0149
SGT	Ryan	G	0146
SGT	Sheppard	RA	0070
SGT	Shoemark	MA	291

Rank	Surname	Initial	Key No
CPL	Chiesa	B	0113
CPL	Congdon	ML	0023
CPL	Godfrey	BD	034
CPL	Grace	DW	0035
CPL	Grace	TR	0137
CPL	Head	CJ	0039
CPL	Lindstrom	B	0139
CPL	Madden	J	0147
CPL	Matthews	JL	0097
CPL	Rutland	MG	0090
CPL	Schofield	HG	0068
CPL	Stevens	JGH	0131
CPL	Stott	M	0095
CPL	Tait	LT	0075
CPL	Williams	RD	0126
LCPL	Roberts	NA	0065
PTE	Cantrick	AW	0136
PTE	Gardiner	D	0032
PTE	Gilson	DE	0033
PTE	Gray	BJ	0081
PTE	Gummow	JW	0086
PTE	Linley	SP	0049
PTE	Turner	MB	0134

Correct as at 26 Aug 10

On behalf of the HOC, I would like to personally thank those contributing members for supporting the RAAMC Corps.

Corps RSM.

## The RAAMC Badge Guide

The Badge is required to be carried at all times. Any person who fails to produce their badge owes a Liquid penalty to the challenger. Any person challenged who produces their badge is owed liquid refreshment to the challenger. Only one challenge per person per day (multiple challenges at one time is not acceptable). Currency of badge must be up to date.

## RAAMC Officer Promotions – 2010

### Members Promoted from LT to CAPT:

Alcock (GSO MO)  
 Gurieff (GSO MO)  
 Haigh (GSO MO)  
 Humphreys (GSO MO)  
 Worboys (GSO MO)  
 Flemmett (ASWOC MO GSO)  
 Wilsen (Radio)  
 Patterson (Pharm)  
 Botteher (Physio)  
 Brown (Physio)  
 MacKay (Physio)  
 Bowen (Physio)

### Members Promoted from CAPT to MAJ:

Barnett (GSO MO)  
 Gordon (GSO MO)  
 Lee (GSO MO)  
 Manuel (GSO MO)  
 Reinhardt (GSO MO)  
 Swinney (GSO MO)  
 Platon-Jones (ASWOC MO GSO)  
 Steel (MO SSO)  
 Kennedy (MO SSO)

### Members that Corps Transferred:

Flemmett (ASWOC MO GSO)  
 Melberzs (GSO MO)  
 Robinson (GSO MO)

### Officers Entering the Trained Force:

Hughes (GSO MO)  
 Smith (GSO MO)  
 Willmore (GSO MO)  
 Adamson (GSO MO)  
 Hewett (GSO MO)  
 Gojkovic (EHO)  
 Buise (Pharm)  
 McDonald (Pharm)  
 Such (Pharm)  
 De Boer (Physio)  
 Wheatley (Physio)

### Members Promoted from MAJ to LTCOL:

Berlioz-Nott (MO SSO)

# RAAMC Other Ranks Promotions – 2010

The following other rank promotions were confirmed by SCMA in 2010

CPL Allen, Cameron Scott	MED OP	SOA	CPL Webb, Daniel Paul	PTI	ASH
CPL Chapman, Nakia Marie	PRVNTMED	1 HSB	CPL Wilkinson, Cherie Betty	PTI	1 RTB
CPL Fraser, Taryn Ann	PRVNTMED	2 HSB	LCPL Featherston, Bennett James	MED OP	2 CDO
CPL Barratt, Carmel Anastacia	MED OP	39 PSB	LCPL Scalzo, Benjamin John	PRVNTMED	1 HSB
CPL Bone, Christopher James	MED OP	1 CSSB	LCPL Hill, Corey Jay	MED OP	1 HSB
CPL Bouzanquet, Joshua David	MED OP	7 CSSB	LCPL Wright, Steven Nathaniel	MED OP	3 CSSB
CPL Briskey, Jamie Troy	MED OP	2 Cdo Regt	LCPL Cripps, Ryan Christopher	MED OP	1 HSB
CPL Buchanan, Kaye Leah	MED OP	RMC-D	LCPL Hanson, Ethan Alexander	MED OP	SOARMOD
CPL Conway, Mitchell Bryan	MED OP	B Sqn 3/4 Cav	LCPL Purcell, Barry Fergal	MED OP	IRR
CPL Dann, Barry Michael	MED OP	1 Armd Regt	LCPL Scott, Benjamin Thomas	MED OP	2 HSB
CPL Newkirk, Katie Maree	MED OP	1 HSB	LCPL Walton, Bryant Thomas	MED OP	7 CSSB
CPL Devine, Jason	MED OP	RBMC	LCPL Robertson, Samantha	MED OP	1 CSSB
CPL Dowling, Ricky Ian Claude Kevin	MED OP	4 Fd Regt	LCPL Hansson, Kessa Louise	MED OP	1 CSSB
CPL Greig, Ellen Caden	MED OP	8/12 Mdm Regt	SGT Duncan, Shane John	PTI	AHQ
CPL Howes, Nathan James	MED OP	1 CER	SGT Hargrave, Bevan Joel	PTI	1 HSB
CPL Janetzki, Belinda Dawn	MED OP	DFSS	SGT Hender, Emma Mary	PTI	ASH
CPL Kelly, Brendan John	MED OP	RMC-D	SGT Thickett, Cameron Michael	PTI	3 RAR
CPL Kirkpatrick, James William	MED OP	1 CSR	SGT Hammon, Andre Dean	TECH OP THR	2 HSB
CPL Klesnik, Frank Alex	MED OP	8/9 RAR	SGT Pickering, John Leslie	TECH LAB	2 HSB
CPL Lindstrom, Bjorn Emerik	MED OP	2/14 LHR	SGT Brannock, Ryan William	MED OP	2 HSB
CPL Lugton, Warwick	MED OP	1 CSSB	SGT Brown, Jason Mathew Thomas	MED OP	ASH
CPL Lynn, Emerson Roger	MED OP	NORFORCE	SGT Brown, Mark Daniel	MED OP	SOI
CPL Madden, Joshua Anthony Brian	MED OP	2/14 LHR	SGT Burton, Heath	MED OP	1 RTB
CPL Martin, Tracey Frances	MED OP	LBMC	SGT Butler, Troy Neil	MED OP	3 CSSB
CPL Maxfield, Daniel Robert	MED OP	2 Cav Regt	SGT Chandler, Melissa Jade	MED OP	9 CSSB
CPL McGlone, Brett Andrew	MED OP	1 CER	SGT Chung, Jean Noel	MED OP	1 HSB
CPL McGregor, Benjamin Luke	MED OP	PTS	SGT Douglas, Warren Scott	MED OP	HC Oakey
CPL McPhillips, Peter Francis	MED OP	16 AD Regt	SGT Fitzallen, Damian Rex	MED OP	SASR
CPL Near, Stuart John	MED OP	3 RAR	SGT Grace, David Wayne	MED OP	5 CSSB
CPL Saunders, Benjamin James	MED OP	3 CSSB	SGT Knuckey, Nicole Louise	MED OP	2 CER
CPL Seaton, Robert James	MED OP	1 CSSB	SGT Lonergan, Peter James	MED OP	3 RAR
CPL Sestoso, Ulyses	MED OP	7 CSSB	SGT Miller, Daryl Eric	MED OP	Med Cent Hobart
CPL Smith, Peter Allen	MED OP	2 RAR	SGT Morcom, Jason Patrick	MED OP	DFSS
CPL Smith, Tanya Marie	MED OP	1 Avn Regt	SGT Owen, Christopher Mark	MED OP	ASH
CPL Thompson, Michael Thomas	MED OP	3 CER	SGT Price, Matthew Craig	MED OP	ARTC
CPL Thorpe, Michelle Grace	MED OP	1 Avn Regt	SGT Rogash, Bernadette Maree	MED OP	7 CSSB
CPL Werner, Christopher Benjamin	MED OP	10 FSB	SGT Rowe, Benjamin James	MED OP	1 Sig Regt
CPL Wight, Robert James	MED OP	7 CSSB	SGT Sheppard, Racheal Anne	MED OP	ASH
CPL Hastie, Kelly Emily	MED OP	LBMC	SGT Stein, Eleanor Jane	MED OP	LBMC
CPL Castle, Aaron Malcom	PTI	1 HSB	SGT Turner, Nicola	MED OP	3 CSSB
CPL Davies, Adam Ellis	PTI	1 RTB	SGT Tyne, Adam Elliott	MED OP	ASH
CPL Hudson, Andrew Geoffrey	PTI	CATC	SGT Walter, Rhonda Sharon	MED OP	APNRE
CPL Lindsay, Marc Lawrence	PTI	SOI	SGT White, Brett Stuart	MED OP	3 CSR
CPL Scales, Cameron Vaughan	PTI	1 HSB	SGT Witt, Deirdre Georgina	MED OP	1 CSSB
CPL Toonen, Kevin Paul	PTI	ADFA	SGT Adamson, Sara Kristie	PTI	ASH



SGT Bleijie, Linden Jan	PTI	2 HSB	WO2 Picker, Adrian Charles	PTI	1 HSB
WO1 Bowie, Donald Vincent	MED OP	FR	WO2 Samson, Scott Brady	PTI	DFSS
WO1 Harmer, Tania lee	MED OP	HQ FORCOMD	WO2 Abell, Andre Mark	MED OP	3 RAR
WO1 Menser, Mark Trevor	MED OP	ASH	WO2 Ratcliffe, Kerry Lynne	MED OP	7 RAR
WO1 Wyatt, Michelle	RSM Tier B	ALTC	WO2 Sanders, Karinna Anne	MED OP	11 CSSB
WO1 Muller, Kevin Joseph	PRVNT MED	ASH	WO2 Tyrrell, Anthony James	MED OP	2 RAR
WO2 Brown, Glenn Stuart	PTI	ADFPTS	WO2 Weeks, Sven Jasyn	MED OP	2 HSB
WO2 McCallum, Neil Hugh	PTI	SOI	WO2 Writer, Aaron Troy	MED OP	1 HSB
WO2 Morley, Lesley Jayne	PTI	SME			

## Award Winners

### Winner of the Harkness Award 2010

Lieutenant Colonel Paul Byleveld

### Winner of the C.F. Marks Award 2010

Warrant Officer Class Two Graham Parker

### Winner of the Butler Award 2010

Captain Nevin Colgrave

## Combined Health Corps Conference – 2011

A Combined Health Corps Conference will be held on Wednesday the 4 May 2011 to coincide with the Asia Pacific Conference (2 - 6 May 11) in Sydney. This will allow health personnel a choice to attend both activities making the most of available unit funding, or simply attend the Combined Health Corps Conference. The intent is to have a one day activity with an evening meal planned for the conclusion of the conference. The theme for the conference will be how the restructure of Combat Health will affect careers, where we see career structures heading in the future and how people will be managed. It will also provide an opportunity for a progress report on developments to date

and what is to be expected in the near future. All Corps personnel are invited to attend and where funding is limited within units, it is a request of the HOC that a supervisor and soldier representative attend and report back to their unit. Representation from soldiers at the Combined Health Corps Conference is strongly encouraged by the HOC.

Further details will be made available via the RAAMC website once they are confirmed.

(NB: Due to Force Preparation that week, there is no accommodation at the Randwick Barracks SGT's or Officers Mess).

# DUOSCOPE

THE NEW DUAL BLADE DISPOSABLE  
EMERGENCY LARYNGOSCOPE



**NEW!!**  
**DESERT STORM**  
Colour  
Military Model

- **COMPACT**
- **EASY TO USE**
- **2 BLADES IN 1**
- **LIGHT WEIGHT**
- **ILLUMINATION TESTER**
- **BATTERIES EASILY REMOVED**
- **LONG LIFE ILLUMINATION**  
(OVER 24 HOURS CONTINUOUS ILLUMINATION)
- **NO ASSEMBLY - QUICK ACTION**



**Parker Healthcare Pty Ltd**  
16 Redland Drive, Mitcham, VIC 3132 Australia  
Ph: +61 3 9872 0222 Fax: +61 3 9873 5911  
E-mail: [icu@parkerhealth.com.au](mailto:icu@parkerhealth.com.au)  
[www.parkerhealth.com.au](http://www.parkerhealth.com.au)



PAUL 3



“  
Are you recommending  
the MedicAlert® emblem?  
”

MedicAlert® provides a proven four-part system to assist emergency services and other healthcare professionals to immediately identify important medical and personal information when it counts, in an emergency.

- 1 Bracelet or necklet with an individually engraved genuine MedicAlert® emblem attached
- 2 24/7 emergency hotline number on back of emblem
- 3 Confidential national database containing member's individual medical and personal information
- 4 Wallet-sized MedicAlert® membership card with member details



**MedicAlert®**  
FOUNDATION  
Peace of mind, always.

Phone 1800 88 22 22  
[www.medicalert.org.au](http://www.medicalert.org.au)

Inhalo®  *Integrated delivery of therapeutic gas*



## Proudly supporting the Royal Australian Army Medical Corps

BOC Ltd have more than 60 years experience supplying Australia's emergency services with essential medical gases. We have the resources and the necessary skills to respond in any emergency – when it's needed, where it's needed.

Designed in consultation with healthcare staff, the revolutionary INHALO design integrates the cylinder, valve, regulator and flowmeter into a single robust, lightweight and reliable unit.

Featuring a fibre-wrapped aluminium cylinder the INHALO solution provides a significantly larger gas capacity that means a reduction in cylinder holdings. The time saved by the integration of regulators and flowmeters, together with the 'live' contents gauge showing immediate gas availability, allows staff to concentrate on their number one priority... patient well-being.

For more information call 1300 363 109,  
visit [www.boc.com.au](http://www.boc.com.au) or send a fax on 1300 363 438.