David A Rew TD MA MChir FRCS, *consultant general surgeon*
Southampton University Hospitals

Surgical support for the defence medical services

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Changes in the size, structure and operational profile of the armed forces, the legislative environment, the training of surgeons in the NHS, the demands of clinical governance and of specialisation, have caused considerable difficulties in the delivery of immediate surgical care to British service personnel at risk when on overseas service. There is an urgent need to find a durable long-term solution to the problem which requires closer co-operation between military and civilian agencies.

The Defence Medical Services (DMS) provides military and clinically trained personnel in peacetime and war to support deployments of units of the army, the navy and the air force. With the continued contraction of the population base of the forces, the DMS has become increasingly reliant upon volunteer reservists drawn from the NHS to meet shortfalls in staffing on operational deployments. Since summer 2002 there has been a rolling call-out of reservist surgeons and anaesthetists from the NHS for periods of up to six months to cover the range of military deployments overseas, most recently in the Middle East.

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The recruitment, retention and employment of reservists needs improvement, and the recent call-up has highlighted the ad hoc nature of the solutions to the progressive problems faced by the DMS. An administrative issue for the DMS now has significant implications for the individual reservists, and for the NHS as a whole. There is an urgent requirement for a new and systematic approach to the development of the infrastructure of civilian surgical support to the services, to make available professional skills to the forces in a planned and sustainable way; to create a career structure for volunteer reservists which optimises the experience of military service; and to minimise the impact upon reservists and employers through forward planning and appropriate compensation to Trusts.

The success and professionalism of the armed forces in peacekeeping and peacemaking operations has led to a worldwide spread of responsibilities in many different countries and different environments. The armed forces comprise some 200,000 men and women, along with partners and dependants, spread across the world. This population provides insufficient clinical workload to meet the peacetime training and professional needs of surgeons in any one place. The small numbers of operational casualties from the UK armed forces in recent years has further reduced the pool of experience of military trauma surgery.

British military doctrine mandates that service personnel will be supported by uniformed military medical services on operational deployments overseas. Base hospital and specialist care will ultimately be provided from fixed facilities in the NHS or host nation. However, there is a geography and timescale of risk between the point of injury and the safety of 'out of theatre' civilian hospitals where casualty resuscitation, retrieval, protection, stabilisation and evacuation is the work of military surgical teams prepared and trained to work in hazardous and adverse environments.

The regular forces are seriously under recruited of surgical personnel. A full-time surgical career in the armed forces has become progressively more difficult to sustain in recent years on clinical training, employment, deployment and remunerative grounds. The current shortfall of trained military medical personnel is extended by the demands of the modern medicolegal environment. It is no longer possible for generalist surgeons to acquire the skills to provide service across a range of disciplines, as in the past. Planning for the highest and fastest attainable and demonstrable standards of care and clinical governance throughout the medical evacuation chain mandates more specialists in the system. There is thus a recurring need for skilled individuals trained, willing and available to serve on military operations on an on-call basis, drawn primarily from the NHS.

The volunteer reserve forces are also seriously under recruited of surgical personnel. The Reserve Forces Act of 1996 changed the relationship between the individual volunteer reservist and the government, by granting the government compulsory powers of call-up and selective mobilisation in circumstances short of a national emergency or general war for periods of up to six months. There are provisions for employer and employment protection, but the disincentives for the individual reservist and would-be volunteer remain considerable, not least in matters of pension, life insurance, uncertainties about time away from work and discretionary awards.

The proposals outlined in this paper should also be more generally applicable to other specialties such as anaesthesia and to health professionals such as theatre technicians where shortages are also critical. Some of the issues are in the immediate gift of the military authorities. Others require engagement and shared ownership with the NHS and civilian bodies, including the royal colleges.

A modern military surgical service

There is a good reason to believe that an intelligent, systematic and engaging approach to the civilian sector would substantially increase the human resources available to the DMS. Civilian reservists can more easily maintain their clinical skills on a daily basis than can full-time military surgeons. The services offer considerable opportunities and career variety for the suitably motivated individual. The short-term overseas deployments which prove so disruptive to regular officers can provide a welcome distraction and opportunity to NHS surgeons.

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The challenge to the DMS, to the civilian health authorities and to the professional representative bodies are:

- to develop an administrative structure that is robust, durable and acceptable to both civilian and military agencies;
- to develop a pattern of deployment and commitment which would not prove too disruptive to the reservist and his or her employer, colleagues and family;
- to recruit and retain sufficient individuals with the breadth of skills from which to develop a workable and flexible deployment plan;
- to develop a package of terms and conditions of service which would prove attractive to sufficient numbers of trainees and established consultants to staff the model;
- to use the time and resources available for weekend and local training with maximum efficiency and effectiveness; and
- to give shared ownership of the problem to NHS Trusts and agencies and postgraduate deans, with adequate incentives to permit the planned release of specialists on time limited engagements.

The proposed model foresees a central agency within the DMS charged with the recruitment, retention, relocation, training and employment of clinical specialists, including a small cadre of full-time officers and a much larger and more flexible cadre of reservists. Each specialist reservist will be contracted to be available for up to a month per year, for a fixed number of years, in a roster of on-call availability is planned well in advance on an annual, biennial or triennial basis, and with the agreement and contractual

provision from the NHS employer.

There would be adequate compensation and incentives for civilian employers, usually NHS Trusts, and encouragement to pride of ownership of the problem for those Trusts. Individual reservists would be adequately compensated with life insurance and pension benefits and for the loss of independent practice earnings. The recruitment of sufficient part-time specialists of the appropriate calibre on a voluntary basis would cover most military deployments and eventualities short of general mobilisation and national emergencies.

The model would make largely redundant the need for compulsory mobilisation of specialists. The current provision of six months of compulsory mobilisation for reservists, regardless of employment protection and financial compensation, is viewed as too great a professional risk for most. A successful and realistic model would be based upon shorter and planned periods of deployment of up to one month, or for longer periods on a voluntary, negotiated basis, or in unique circumstances. There also remains a need for a small cadre of full-time employed surgical specialists to provide supervision, planning, education and a rapid response for operational purposes.

The reservist would be renumerated by superceding the current daily stipend with a salary package for a fixed term which might include a terminal bonus, pension contributions and a realistically calculated insurace package against death or injury leading to a loss or degradation of employment.

Administration

Currently, specialist medical reservists are recruited into regionally based reserve medical units and headquarters. They come under the immediate command of a variety of professional and reserve officers. There is a need for a unitary military organisation to replace the current heterogeneous pattern of employment of reservists. This would recruit, co-ordinate, train, develop, deploy and reward the skills of volunteer reserve specialists. This organisation might be a public body or independently contracted within the remit of the DMS.

Military training

Volunteers have a statutory commitment of two weeks and two weekends' training per year. Reserve training is largely invisible to NHS employers because it is usually done in the annual leave cycle. Training is currently largely under the direction of the parent reserve medical unit commander, whose training priorities may well differ from those of the individual specialist or the needs of the DMS. Weekend training time is a precious commodity which can be better focused upon specialist needs.

The core military training of a volunteer clinical reservist encompasses an officer induction course, followed by continuation training with units and through specialist general and clinical courses. In order to function effectively with other military personnel, reservists of all ranks and backgrounds need to understand the ethos and operational doctrine of the services. They must be reasonably fit and self sufficient in order to endure the spartan conditions of field medical units in a range of climates and be prepared to work with basic equipment. Civilian medical reservists recruited earlier in their careers have the opportunity for broader training, such as with elite combat units, which creates a valuable store of experience for a more active and integrated reserve force with a rapid deployment capability, such as in the support of special operations.

The military on-call rota

Political circumstances requiring military engagement are unpredictable. In this model, volunteer reservists would have the opportunity to be more regularly committed to operational deployments after appropriate training on a planned basis which would be integrated into civilian work schedules. Thus, an operational deployment, or an agreed period of on-call status to a co-ordinating agency would be a scheduled part of the working year, rather than a unusual event as at present.

An on-call rota of reservists, amounting to a month a year, would meet the military requirements for rapid access to specialist skills, while maximising availability of those skills to the NHS when not specifically required. This model mandates the recruitment of sufficient specialists to staff the rota, but compares favourably to the present situation, whereby an insufficient number are in demand in an unpredictable fashion. The larger the reserve pool, the more flexibly it could be used and

the less onerous the demands on the individual. The numbers needed to match this rota will vary according to training needs and the deployments of the armed forces. A pool of some 48 reserve surgeons and a similar number of anaesthetists might well suffice. If managed effectively, it would also provide a valuable fund of experience in national emergencies.

Sufficient volunteer surgeons could commit to availability for reserve service on the basis of a variety of options. These might include two-week annual credits (four weeks on alternate years or six weeks every three years, for example), using a combination of annual leave and time funded by the DMS to compensate for the additional workload. The reservist would be renumerated by superceding the current daily stipend with a salary package for a fixed term which might include a terminal bonus, pension contributions and a realistically calculated insurance package against death or injury leading to a loss or degradation of employment.

Employer attitudes

The NHS also faces a shortage of consultants relative to clinical demands. Chief executives of NHS hospitals are under considerable pressure to ensure that surgeons meet contractual, waiting list and productivity targets. It is unrealistic to expect that they will be happy to release specialists to reserve service for significant periods of time without careful forward planning and adequate alternative arrangements in place. Attitudes to reserve service will vary from Trust to Trust; government agencies and the BMA can help develop the reserve service model. In the longer term, the NHS Trusts and regional agencies might develop specific partnerships with military medical units for recruitment and employment of medical reservists. A number of European countries already organise their military medical reserves on such as a basis.

Implementation of change

The onus and authority for the modernisation of staffing of the DMS remains with that organisation in tandem with the Treasury and the government. Pay and conditions could be set at an attractive level to volunteers. Excessive financial incentives are unlikely because of the levels set in other parts of the armed services.

Conclusions

The lack of adequate provision of surgical cover for British military operations has serious consequences for the DMS and the NHS. The current ad hoc solutions and sense of crisis which result are no basis for a satisfactory long-term arrangement, and are likely to further hamper the recruitment and retention of volunteer reserve surgeons.

The introduction of a systematic on-call model for specialist reservists, based upon one month of service per year would provide a solid backbone to the skills of the DMS. The administration of this service should be placed in the hands of a specialist agency in the DMS, staffed in part by a balanced panel of experienced civilian officers with an understanding of the circumstances affecting reservists and their employers.

The durable solutions are not in the hands of the civilian or the military agencies alone. They will arise from close partnership, careful analysis and clear thinking. The royal colleges could have an influential role to play in these developments.

The commitment of time and professional skills to the forces by a reservist has held little appeal to most NHS doctors in recent years. A new approach, a sensible package of benefits and effective planning should allow the creation of a well motivated and efficient clinical reserve, which would bring the best of NHS care and personnel to overseas deployments. The numbers needed are only a small fraction of those surgeons already working in the NHS and the benefits to all parties would be significant.

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Acknowledgements

The views expressed in this paper are personal to the author on the basis of continuous reserve and short-term regular service with the armed forces since 1975. They do not represent official policy.

Reference

1 Rew DA. For debate: civilian surgeons and the support of the armed forces. *Ann R Coll Surg Engl (Suppl)* 1995; **77:**251-256.

Correspondence

Contact the editor by email at bulletin@rcseng.ac.uk

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David A Rew TD MA MChir FRCS,
consultant general surgeon
Southampton University Hospitals
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Sir,

Having recently returned from the Middle East, I read with interest the article by David Rew. It clearly highlights the deficiencies in the current support arrangements and the difficulties facing volunteer reservists and their employing NHS Trusts. The bottom line is that the current pool of both full-time and reserve DMS surgeons is too small to meet ongoing military operational commitments. Radical solutions need to be considered if we are to provide appropriate medical support to our deploying service personnel.

With the recent reduction in the size of the DMS, any future solution will inevitably require close cooperation between military and civilian agencies. The highest priority is to make military service more attractive in order to either retain full-time or recruit reserve personnel. I would recommend the establishment of a 'full-time' reserve secondary care medical service. This would be staffed by either ex-regular or appropriately trained reserve military doctors. These personnel would work full-time within NHS Trusts and be appointed to their posts through the normal NHS appointments process. However, their salary would be paid by the Ministry of Defence and the host NHS Trust charged, at rates favourable to the Trust, for their services. Their salary would be significantly higher than a civilian colleague of a similar seniority. Personnel would also receive the pension and other benefits afforded to service personnel. The financial rewards would compensate for the liability for deployment and the resulting reduction in independent income. In return, these personnel would provide support to operational deployments for a limited period each year. When not required they would work in their host NHS Trusts, just as any other consultant. Appropriate career management would ensure an appropriate balance of clinical activity, professional development and deployment.

This system would have several advantages for the NHS. Firstly, a significant proportion of the cost of employing such a consultant would be borne by the Ministry of Defence, even when not deployed. Secondly, personnel would be working throughout the NHS. Therefore, the burden of loosing staff for operational deployments would be more evenly spread and the impact on any individual Trust should be limited.

As has been highlighted by the recent war in Iraq, we now rely on the NHS to provide secondary healthcare to injured service personnel repatriated to this country. Shared ownership between military and civilian agencies should now be extended to providing personnel for medical support to the frontline. I am a consultant general surgeon, employed by the Ministry of Defence, but working full-time in an NHS Trust.

S J Parker BSc FRCS FRCS(Gen)
Surgeon commander, Royal Navy
Consultant general surgeon,
University Hospitals of Coventry and Warwickshire NHS Trust

Electronic tag – a cause of concern

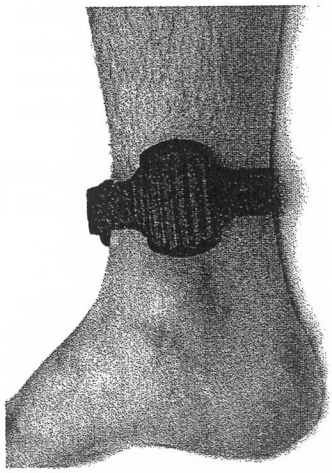
Sir,

Electronic tags are now increasingly applied to prisoners on parole. Questions arise regarding this device when these prisoners present as patients. In the following we outline information about the electronic tag and its application.

The Home Detention Curfew Scheme came into force on 28 January 1999 and currently about 1,700 prisoners in the UK now benefit from it. The tag uses electronic monitoring equipment consisting of a personal identification device (PID) – also called an electronic tag – and a site monitoring unit (SMU). The PID is slightly larger than a wristwatch and is worn on the prisoner's ankle. The SMU, which is about the size of a telephone answering machine, is placed at home and connected to the telephone line. The PID emits signals which are received by the SMU and conveyed to the monitoring centre continuously confirming the person's presence at home during the prescribed curfew hours.

The tag is applied to eligible prisoners on the approval of a prison governor and, by law, it should not be removed without their permission. Therefore, permission from the governor should be sought in advance where any elective surgery requires its removal.

In emergencies warranting its



Electronic tag in situ.

removal, the prison should be contacted on the numbers available in the instruction booklet given to the patient at the time of application of the tag. Failing this, the tag can be removed and should be handed over to the patient to inform the prison as soon as possible. According to the PID