The Mother of All Excuses to Take Study Leave

by David Rew, MChir FRCS Senior Registrar in General Surgery, Southampton

This yearbook has previously carried articles on military surgery and the Territorial Army medical services, but most ASIT members will have little contact with military medicine. The Defence Medical Services (DMS) are party to the British post-graduate training system, and the traffic between civilian and military life is two way. Serving military surgeons are trained in NHS accredited posts, and a number of NHS surgeons have pledged their support to the Armed Services as reservists. Surgical trainees who have been active with the TAVR usually have limited time for military training because of their NHS career demands. DMS surgeons are a valuable repository of knowledge in the management of war trauma, and have been active in promoting the Advanced Trauma Life Support concept (ATLS) in the UK in recent years.

The TAVR medical services have been structured for 40 years around a plan to defend Western Europe from the late Soviet hordes in full-scale war. The legal and political framework of the TAVR had not envisaged piecemeal use of medical specialists in the 'National Interest' short of such an event. The Iraqi invasion of Kuwait caused considerable political and planning difficulties when the scale of the British military deployment was defined. The Regular Forces were unable to match the medical plan from their full-time resources. The mobilisation of reserves consisted of a compulsory call up of ex-regular specialists and a substantially voluntary turn out of TAVR personnel, once the terms and conditions of service had been clarified.

Based as it was on the defensive doctrine of Northern Europe, implying relatively short distances for casualty evacuation on familiar territory, the medical plan had to be completely rewritten to account for a rapid advance on changing desert lines of communication which could not be pre-prepared. The British Army had the textbooks of the North African Campaigns of World War II for guidance. Only the Israelis have had comparable experience of mobile desert warfare in recent years, and they have taught the need for the forward deployment of experienced surgical and anaesthetic teams. This optimises treatment within the 'golden hour' of opportunity following wounding. This doctrine is demanding of suitably trained medical personnel who possess both military aptitude and the professional skills.

The chain of trauma care in the Gulf began at the point of injury with 'buddy-buddy' treatment. (This included the distribution to soldiers of auto-injectable antibiotics). It worked back through the Regimental Medical Officer, often an SHO equivalent, and his paramedics at the Aid Post to the Armoured Field Ambulance (AFA) dressing station. The AFA was a general purpose medical unit of some 400 men and women responsible for collection, resuscitation, triage and rearward evacuation of casualties to the field hospitals. Large numbers of wheeled and tracked ambulances were available, but in practice the helicopter was heavily used to cover the large expanses of rutted desert.

Each Field Advanced Resuscitation Team (FST) was attached to the dressing station of one of the two AFAs. It consisted of two surgeons (registrar and senior registrar grade), two anaesthetists (registrar to consultant grade) and eight support personnel (operating theatre specialists and combat medical technicians). Teams were composed almost evenly of Regular Parachute Field Ambulance personnel and neo-

David Rew (front) and Stuart Scott (behind) on a Scud at a US Patriot Battery Site in Rhiyadh. We travelled further and were arguably more dangerous.

civilian staff taken up from trade (STUFT). Each team was tasked to undertake essential resuscitative measures only, and was equipped with tentage and chemical warfare protection shelters, two portable operating tables, a multi-outlet ventilator for nerve gas casualties and medical stores for up to 50 casualties pending resupply. The presence of surgical teams close behind the forward units was reported to have made a valued contribution to general morale of the troops.

Stuart Scott and myself at Southampton were fortunate to have support from both families and senior colleagues, a situation which did not always obtain. We

followed the political developments in the Autumn of 1990 in the media and through an informal military network. Our voluntary enlistment led ultimately to postings to the two Field Surgical Teams which were integral to the 4th and 7th (UK) armoured brigades. The formal mobilisation on 27 December 1990 was followed by intensive refresher training in chemical and biological warfare survival drills. The threat was real, and rarely can instructors have had such an attentive audience. We were pincushioned with vaccinations before a poignant weekend of leave with our families, and then flew direct to Riyadh in mid-January. We were still setting up 205 Evacuation Hospital TAVR in an empty airport terminal when the air and missile war began. After a week in Riyadh's Scud Alley, we were sent through Al Jubail on the Gulf to the relative peace of the wastes of the Northern Arabian desert. There followed a month of acclimatisation to cold nights, rain and sandstorms. There were training exercises, major manoeuvres, deception plans, false starts and regular self-medication with pyridostigmine. We mixed and trained with our American reserve colleagues in VII Corps and compared notes, practices and equipment.

Finally, as the 1991 Association of Surgeons spring meeting in Oxford was drawing closer, Schwarzkopf was obliged to act. We said unit prayers in sombre mood, wrote final letters to our young widows and orphans, and launched into the maelstrom of Desert Storm. We witnessed the awesome firepower of the modern artillery barrage and of the Armoured Division in the assault. We drove with reckless disregard to

4th Armoured brigade field surgical team at work in a makeshift outdoor roadside operating theatre, Iraq/Kuwait border, evening of G + 3.

Health and Safety at Work Regulations with our Union flags flying around mines, unexploded ordnance and abandoned bunkers. We waited for the suffering to unfold. We took and fed prisoners. We stabilised the few Iraqi casualties that we received before sending them on their way to the field hospitals by helicopter. We raced into Kuwait and marked time in the ignorant sunshine while Basra and the oilfields burned on the horizon, the Kuwaiti Palestinians were hounded and the Kurds packed their bags. The fruits of war were bitter.

Two weeks later we were decommissioned without ceremony on a wet March Oxfordshire airfield in our smart M&S demob tracksuits. What was achieved in professional terms? Huge logistic and planning problems were overcome, and military surgeons played an important role in this. The Advanced Trauma Life Support doctrine was widely disseminated and was put to use where possible in the field, but the resuscitation and evacuation chain was never stressed with casualties of any nationality. The drills which we had devised to treat surgical casualties on the chemical front line remained on ice. The devastation of the Basra highway and the continuing tragedy of the Kurds ensured that the Gulf war is one of those which, like Vietnam and Afghanistan before, the public would rather forget. We had to be content with blunting the ambitions of the Bagdad dictator as we wallowed in the mire of world power politics. We Hailed Mary in Storming Norman's mother of all American Football matches, called off in dispute over the final touchdown.

War is a tragic failure of the political process, but British surgeons in training can help to alleviate the suffering which ensues. An old taboo was broken during the Gulf conflict and later in Kurdistan in Operation Safe Haven over the use of civilian specialists in support of the Regular Armed Forces. Reservists have regained public respectability. The experience and political confidence gained should make it much easier in future to combine civilian medical and paramedical teams with the specialist equipment and airlift capacity of the Military in disaster relief and other crisis operations. The reserve medical services have survived the Defence cuts restructured and enhanced. They will have a continuing need for younger NHS surgeons with the broad mix of skills and aptitude, but there are no guarantees either of adventure or of safe passage for surgical volunteers.

For two incandescent months our years of weekend soldiering had earned us a grandstand seat, extraordinary memories and a small footnote to an astounding military campaign. We shared Remembrance Day in 1991 with fading generations of warriors and families who long ago learned the hard realities of war.