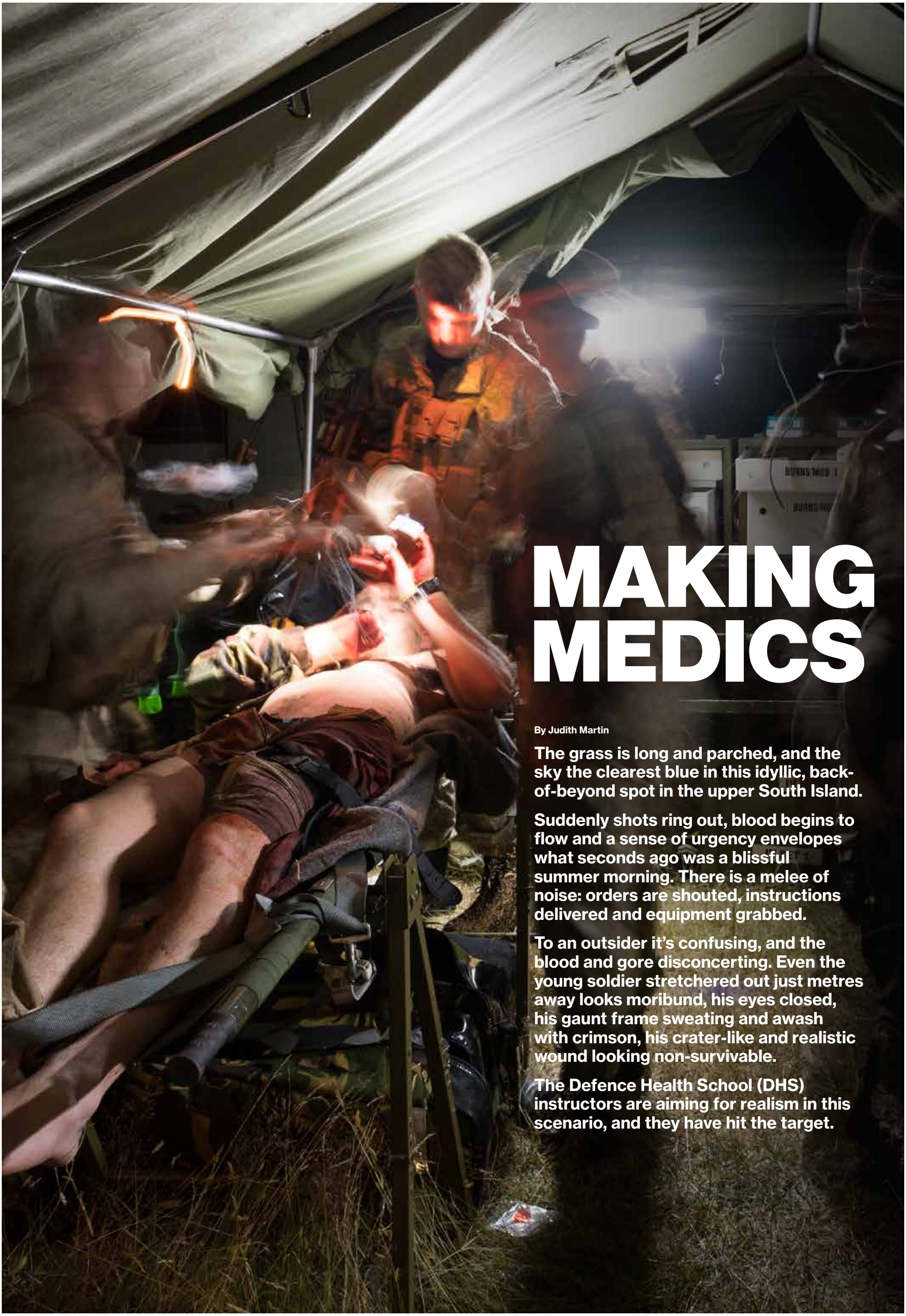


MAKING MEDICS

By Judith Martin

The grass is long and parched, and the sky the clearest blue in this idyllic, back-of-beyond spot in the upper South Island.

Suddenly shots ring out, blood begins to flow and a sense of urgency envelopes what seconds ago was a blissful summer morning. There is a melee of noise: orders are shouted, instructions delivered and equipment grabbed.

To an outsider it's confusing, and the blood and gore disconcerting. Even the young soldier stretchered out just metres away looks moribund, his eyes closed, his gaunt frame sweating and awash with crimson, his crater-like and realistic wound looking non-survivable.

The Defence Health School (DHS) instructors are aiming for realism in this scenario, and they have hit the target.

This is the final field hurdle for the senior tri-Service students (Cameron class) before they graduate as medics in May. Junior students are also attending the exercise as section members and acting as casualties.

In the RAP the casualties are being worked on by the senior students, one of whom has taken the lead and is barking instructions. Senior DHS instructor Staff Sergeant Bruce McLean has entered the fray, and he is questioning and commenting on their every move. His devil's advocate approach is a key part of his tuition (see sidebar) and as the minutes tick by he invents further aspects of the patient's deterioration, testing the linear thinking of the students as to why they are taking that particular path in their treatment regime. And he's handy with the blood beaker, splashing its contents into injured parts of the soldier's torso.

The exercise includes scenarios that challenge the students, not just medically but ethically, with other issues to consider as well such as the Geneva Convention, and the Law of Armed Conflict, to name but a few.

Cameron Class is the first group of students to complete the new two-and-a-half year training programme which has a much greater emphasis on field training, resilience, and leadership through mentoring than previous courses.

SSGT McLean says the same academic standards have been retained from the previous course, and they see students complete "pretty intensive classroom work" for 18 months of the two-and-a-half years, with 40 weeks dedicated to on-the-job training, and field work.

"To get to this position in their training, the medic must complete and be deemed competent in anatomy, physiology, and pathophysiology. The fact they are experiencing this field exercise is a huge credit to the other instructors of DHS (NZ) to get them to this point in their training. Being a medic is not an easy military trade to take on without drive and dedication to the job."

After about 40 minutes SSGT McLean calls a halt to proceedings, and announces a debrief in 10 minutes, after a brew and a clean-up. The lanky casualty peels himself from the stretcher, yawns and comments how relaxing it was just to lie there and almost die.

The debrief is... different. There are no staunch infantry standing about, but a group of young soldiers, sailors and airmen who all obviously know each other well after two and a half years together, and think nothing of delivering well-meaning hugs and other terms of endearment. It's all part of, they will explain later, communicating well and understanding people, both vital aspects of being a good medic.

SSGT McLean is brief and to the point. He's almost happy with what he saw, but there are areas that need to be smoother, slicker and better thought out.

He looks around and questions the other directing staff (DS) that he relies on for the smooth running of each scenario. Each one of the DS has a depth of knowledge through operational experience and contribute to the debrief in their own way.

"You took a long time to get the IV up. But the big plus is you didn't kill him, so well done," he smiles.

The students obviously like their instructor – he's energetic and enthusiastic, and they respect his wealth of knowledge garnered over 30-odd years in the military. They know he has served operationally and has saved lives. They fire questions at him, and his answers are concise and helpful.

The Defence Health School New Zealand will graduate a class twice a year from May 2019. This could see up to 40 qualified medics per year being sent from the school into the wider NZDF.

The new training model is taught in two parts, the first being the Military Medical Technician course, followed by the medic course. Both are split into two modules, one focusing on primary health care and the other operational care, in both operational and domestic environments.

This particular exercise was divided into two main areas to test and challenge the students, with each section overlapping giving the training an element of credibility.

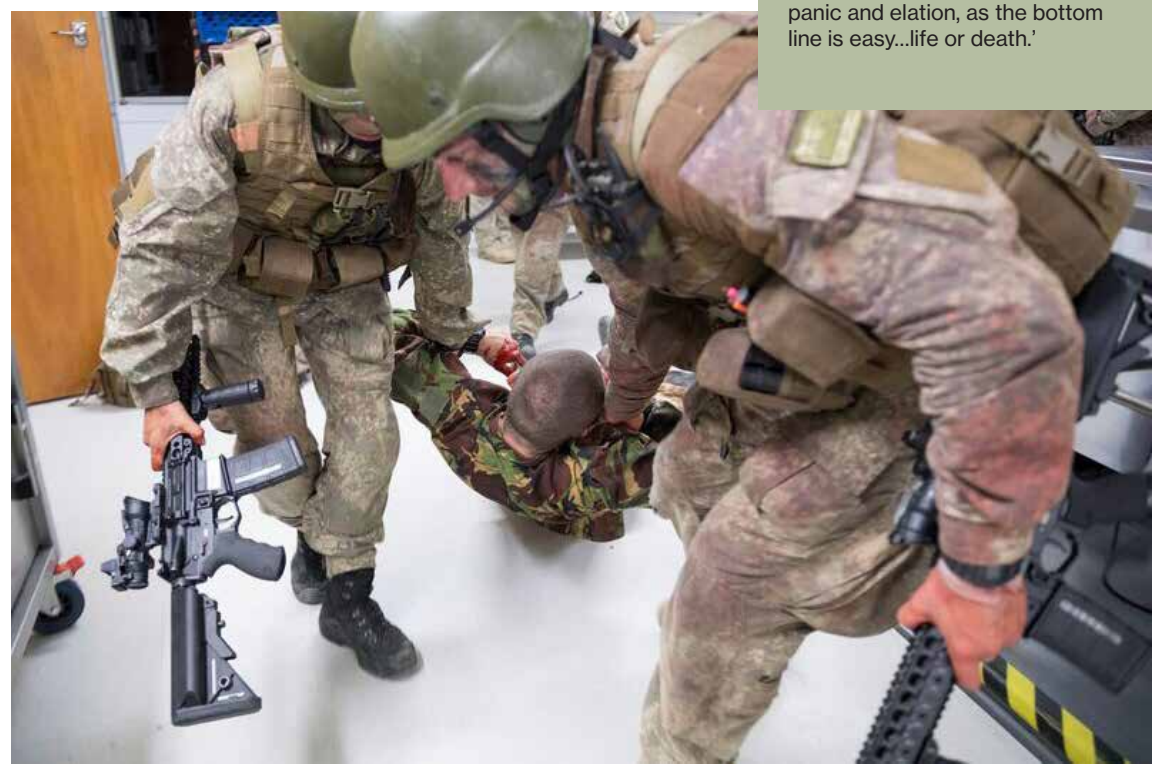
The scenarios involved situations an NZDF medic could find themselves in— dealing with injuries caused by an improvised explosive device, large flesh wounds, and severe head injuries. "The exercise must be realistic and get the students thinking critically about what they're doing. "

There's a section out patrolling which is dealing with the day to day aspects of a tactical environment ranging from man down drills, to austere medicine in a tactical combat casualty care environment. Each medic is either section leader, section medic, signaller, lead scout or gun group.

DS CPL Joel Kennedy shapes and moulds how the patrol is tested with a little help from SSGT McLean who bounces from the Role 1 medical facility“good guy”, to the curse of the patrol instigating contacts which always lead to casualties.

The pressure on the patrol is ramped up 100% during “contact” with shooting, orders being issued and lives that need saving. SSGT McLean mentions it’s at this stage the DS monitor the decision-making ability of the medic, watch the basic medicine being administered and offer advice on a possible better pathway to saving lives. “These medics are under the pump during the attack, returning fire, and balancing good medicine in-between breaths. Everything they have learnt comes into play during the attack — situational awareness, where to stand or lie or crawl, advice to command and, thrown into the mix, saving lives.

It doesn’t finish there with evacuation playing an important role to the section as it then becomes the responsibility of the evac medic to keep the patient alive long enough to reach the R1. SSGT McLean manoeuvres himself into the back of the ambulance to start testing the medic who has drawn the short straw for the intense lifesaving ride to the R1.



High levels of resilience and mental toughness, as well as knowledge and field experience make for very good medics, Staff Sergeant Bruce McLean believes.

“I talk to commanders, section leaders from all trades in the military, and common themes come through, the medic must know their job, know how to advise commanders, and be fully competent in their knowledge of medicine. These medics work solo, so whatever decision they make it must be the right one as they are dealing with people, comrades or friends so I owe my commanders and peers to produce the best product I can.

“That’s why I go hard on these guys because as a medic on operations you have to do the job right the first time because you don’t have the time to go back and do it again.” How do you develop mental toughness and resilience?

“By being part of scenarios like the one we have just done is one way. Any medic throughout our Corps, whatever rank or knowledge base would have flapped on that scenario – it was full on. On the battlefield it is often just you. You just take a big breath and start at the top and work your way down. Medics develop confidence, and from that confidence resilience is spawned. They do basic medicine, but they have to do it extremely well.”

His teaching style is deliberate. “I put the pressure on and gradually increase it, watching how they react, perhaps halting the situation in some cases where I would like to make a point, then ask them why they are doing what they are doing. To see where their thought process is, I have a bottle of blood in one hand, and I use my other hand to help with bandages, and guide them along.

“As an instructor you have to get in there and guide them, mentor them to get the best out of them. You become part of the scenario, feel the emotion, the panic and elation, as the bottom line is easy...life or death.’