Medicine in the armed services

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For the average doctor, joining the services is a major, unpredictable step. Here, in the 1990s, eyebrows are raised, colleagues grin, and former NHS consultants warn how impossible it will be to return to the secure fold of the NHS. But are the services so very different from civilian practice? Certainly, as a former military doctor I see the NHS becoming more like the army every day. Indeed I am often heard to say that my time in the services was the best training for civilian life available.

Until qualification the training of civilian and service doctors is the same. But the service medical student, or "cadet," in exchange for six years of his professional life, gets paid more as a student and is secure in the knowledge that the rat race for limited civilian jobs does not apply to him. In my day the cadets were the students with the fast cars and beautiful women, mixing in social circles that I knew nothing about.

Not all service doctors join as cadets. An appreciable number are now direct entrants, joining the service payroll after qualification for a multitude of reasons. Most confess to a degree of disillusionment with the NHS and are looking for something different, though are concerned about leaving government employment altogether. Others seek adventure and the outdoor life. The majority, particularly those destined to become general practitioners, join because of the generous training programmes on offer—MRCGP, MRCP, or FRCS, all within six years, and a good time to boot. It is a difficult offer to refuse.

General duties phase

For whatever reason and at whatever stage a doctor joins the services before he is let loose on soldiers, sailors, or RAF personnel he must first endure basic training. This is because the services have long recognised that civilian training does not cover many aspects relevant to service practice. How right they are. I shall always remember my first week in the army, when the problems I had to deal with included a shotgun wound to the buttock, cerebral malaria, leishmaniasis, and an outbreak of food poisoning in 47 soldiers. My earlier days as a houseman to a royal surgeon in no way

prepared me for that. Basic training is designed to plug the gaps and, more importantly, teaches a doctor to speak the language of his patients.

The trained service doctor is then ready for his first posting, usually as a general duties medical officer somewhere in the world. The world for the services is getting smaller, and it is unlikely that a new service doctor will be posted anywhere other than the United Kingdom, Germany, Cyprus, Gibraltar, or the Far East. Short attachments to more exotic locations are sometimes possible, but it is only the minority who receive them. For many service doctors this general duties medical post provides the greatest responsibility of their professional career. Few doctors who have been a regimental medical officer, for example, would deny that the job was the most demanding and yet most enjoyable post they had ever held. Disillusionment, if it does arrive, comes later, when the general duties phase is ended and the specialist phase of training begins.

Active service

Though modern service medical practice is essentially a peacetime practice, the occasional war still exists to put service doctors through their paces. This is when medicine becomes very real. Some would say that I have been fortunate to have seen active service in many different parts of the world. Having been through it, I am not so sure. As a service doctor, particularly if you are near the front line, any casualties you treat are likely to be your friends. I lost more than 20 good friends as an army doctor, all through active service somewhere. In one case the dead man was a friend I had known since school; he was shot on a pavement in Belfast.

The doctor on active service is there to provide both medical and moral support. To feel fear is natural, and any man who says that he does not is a liar. A serviceman cannot express his fears openly to his colleagues. I remember many men during the Falklands confrontation telling me how terrified they were. And yet when I saw the same men later in the company of other soldiers not a trace of fear did I see. The professional soldier has to adopt the "it'll never happen to me" policy as a means of protecting himself from the incredible strains that waiting for battle can impose.

Not all service doctors see active service. Many may complete the initial six years having never seen a gunshot wound. Even in Northern Ireland most soldiers with injuries caused by missiles are now sent to civilian hospitals rather than to the military wing of the Musgrave Park Hospital in Belfast. For the committed and intelligent service doctor this is frustrating. He has been trained for war, yet has never been to war. Experiences such as the Falklands conflict are few. Just being a service doctor is not enough at this stage, and many seek to specialise as a result.

Becoming a specialist

Specialisation, be it in general practice, occupational medicine, orthopaedic surgery, or other subjects is becoming increasingly common in the services. For those who choose to stay on beyond their six years there are opportunities to train in some of the best units in the land. Training, leading to accreditation in the

Doctors train for war. A simulated casualty is marked with the letter "M" to indicate that he has received morphine for pain relief

EASTERN DISTRICT ARCHIVES

UNIT 2. SHORT STATEMENT TO BE COMPLETED BY INJURED PERSON (when possible), EXPLAINING CIRCUMSTANCES IN WHICH INJURY WAS INCURRED

Should statements of witnesses be attached but see relevant Service instructions. If injury was sustained in the performance of official duty, the particular act of duty is to be specified.

I WAS OFF DUTY ON TUES. AUG 25 81.
 AT ABOUT 1845 HRS, I RAN DOWN TO ANSWER THE DOOR.
 I WAS CONFRONTED BY TWO ARMED MEN, WHO AS SOON
 AS I OPENED THE DOOR, ONE OF THEM OPENED FIRE
 HE FIRED AT LEAST 3 OR 4 ROUNDS FROM A PISTOL.
 3 OR 4 WOUNDS HIT ME.

16 SEP 81 Signature _____

TO BE COMPLETED BY A MEDICAL OFFICER

Diagnosis of Injury: Gushot wound
Left Arm

Terrorism—the modern face of war. A statement by a UDR soldier shot at point blank range in his home

chosen subject, takes place both within service institutions and the NHS. Often the trainee can choose where he wishes to go and the services arrange the programme accordingly. Once training has started, however, the trainee has then to agree to remain with the services for a certain set period after accreditation is achieved. This has obvious implications should a trained specialist wish to apply for posts within the NHS. The time bar, as it is called, may prevent him from competing on an equal footing with his civilian colleagues.

Once accredited, a service specialist then returns to the fold, his training over. He has worked for the NHS for several years at no expense to the NHS but now must be posted to a service hospital or base. If fortunate he will receive a posting to one of the flagship hospitals around the United Kingdom. He will have junior staff, his own ward, perhaps even the right of private practice. But mobilisation plans insist that smaller hospitals in outlying areas are kept going. Attempts to centralise patient care may seem sensible from a medical viewpoint, but the wide distribution of the service population often dictates otherwise. The junior consultant may thus be posted to a small peripheral hospital with no junior staff, little back up, and a low clinical workload. It is not surprising to

Service doctors must be able to adapt to the unexpected (the author about to perform a laparotomy on a goat in the Middle East)

find several service clinicians feeling frustrated and depressed as a result.

Looking after their own

As defence cuts bite deeper it is frequently suggested that a single services medical system would be a cost effective solution. This is unlikely—firstly, because it is difficult to prove that such an arrangement would be any cheaper than current expenditure, and, secondly, because many service doctors are vehemently against the idea of a unified system. Army doctors treat soldiers, navy doctors treat sailors, and air force doctors treat their own. Realistically, life is not that simple, and several service hospitals do have all three services working within them. At regimental level, however, it is difficult to imagine a soldier accepting a sailor as his doctor or a sailor accepting a soldier as his. The background and training that each has experienced are so vastly different. None the less, despite discussions on a unified medical service, service personnel can take heart from the current political support they enjoy—that the three services' medical systems should remain separate entities, albeit with a triservice medical director.

An alternative would be to create service wings in civilian hospitals. This is already in operation in Belfast. Such an arrangement would allow immediate access to civilian facilities, while at the same time providing more unpaid staff for NHS use. There are difficulties: in Belfast security is the obvious problem; the military wing is not freely connected with its civilian counterpart and, in functional terms, might as well be a separate institution. Should such a free connection exist, be it in Belfast or elsewhere, there is danger that the service component of such wings might be diluted by an influx of civilian practices. Again, the identity of the service doctor would be lost and staffing might well suffer as a consequence.

Back in "Civvy Street"

For most service doctors there will come a time when it seems reasonable to leave and attempt to make a living out in "Civvy Street." More than 75% leave at

"Gassed" by John Singer Sargent

the end of the initial six years. This is a very lonely time, which I remember only too well. For many years the services had fed me, paid me, posted me, and cared for me. Suddenly it was over and I found myself having to justify to potential civilian bosses why I had dared to veer from the normal course of civilian surgical training. Few of the people I met at this stage had any realisation of what skills a service doctor had that might be useful in civilian life. Trying to explain that the services excel in such subjects as diving and aviation medicine, rehabilitation, and mass casualty organisation was often greeted with tolerant disbelief. Perhaps this is why so many of my service doctor friends are now established in careers in, for example, oil rig rescue, the pharmaceutical industry, or bodyguard medical training. In this white paper era, however, I suspect that the service doctor will be in great civilian demand. The administrative training a service doctor receives is almost second to none, and administrative expertise is undoubtedly the way forward in our "modern" NHS.

Future of armed medical services

Surrounded by a health service with colossal waiting list problems the services are in an enviable position. Waiting lists for service personnel simply do not exist, at least in most specialties. But a serviceman might have to travel some distance to seek an opinion. Though many garrison towns have their own service hospital, this is not always the case, and it may mean a serviceman spending two nights away from home for one specialist outpatient consultation. None the less, service hospitals are popular among service personnel, are often in excellent decorative state, and have a bed occupancy appreciably lower than their NHS counterparts, which allows many service hospitals to admit civilian patients whenever possible (which is also important for training recognition). Indeed for many health districts the existence of a local service hospital

staves off the need to produce extra beds from meagre NHS resources.

Faced with increasing staffing concerns women now feature highly in the services, both as doctors and as nurses. The army now admits that 10% of their doctors are women, and though many regiments would publicly shudder at the prospect of a female regimental medical officer working in the front line, behind the scenes these macho men are softies and look after their "quack" as carefully as they can.

The armed medical services have had to change to keep pace with changing times. The 1990s will produce further changes still. As the threat of war within NATO recedes, so other areas of operation appear. Indeed, as I write these lines, the Gulf crisis looms large. Modern day political attitudes ensure that the armed medical services have to work harder to survive. Already four fifths of the wartime military medical establishment would come from civilians and the Territorial and Army Volunteer Reserve. It would not take much to persuade a government to increase this still further and to rely less on the regular full timer. Aware of this, the medical services are continually seeking new openings beyond those that entail armed conflict—disaster relief, NHS waiting list initiatives, and trauma life support training to mention but a few. Time will tell how successful these efforts are. Perhaps the Gulf crisis, as did the Falklands crisis, will highlight how vital their role is; perhaps not. What is without doubt is the importance of having a cadre of capable men and women who are able to move at a moment's notice to give medical care to sick or injured servicemen. Long may they continue—I wish them well.

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