thoracocentesis, assisting with crycothyroidotomy and assisting with intravenous cutdown.

In other sections of this module trainees are introduced to the drugs that they may encounter as medical assistants, dental first aid, the psychological needs of the dying patient as well as nutrition and the use of special diets.

Recognise and Manage Conimon Diseases and Conditions

This is one of two modules that involves the Health Officers. As well as describing the presentation and management of a number of diseases and conditions the aetiology and preventive measlires are also discussed. Some of the areas discussed include air, insect, and water borne diseases as well as sexually transmitted diseases. Trainees are presented with typical cases for analysis. Psychological conditions are also discussed with presentations about anxiety and stress related illness and combat stress.

Manage An RAP/ Medical Centre

This module addresses the needs of the Medical Assistant who is posted to an area that requires not only clinical skills but management and administration skills as well. Previously it has been assumed that during a variety of postings the Medical Assistant will gain a working knowledge of how these things occur. included in this module are an introduction to the administrative aspects of compensation and an explanation of the AUTOQ system. In addition, guidance is also provided on how sick parades, innoculation parades and medical boards can be better administered.

Management of Orffiopaedic Injuries

This module was introduced as a result of the number of orthopaedic injuries that Medical Assistants are confronted with as a result of training or sporting accidents. The module is taught by a Physiotherapist in conjunction with a Pn. In the module the concept of fitness is discussed as well as training activities pre- and post-injury. Considerable time is devoted to the recognition and initial management in strapping techniques.

i

Identify and Advise on Occupational Health & Saf;ety Hazards

Medical Assistants may be the only medically trained personnel within a unit. It is important then if they are to properly advise the people they are supporting on health matters that they have a knowledge of how to identify potential hazards. Within this module students receive instruction in the Occupational Health and Safety (OH&S) Act and the function of OH&S committees. Th"ey are introduced to the concepts associated with mechanical, ergonomic, noise and chemical hazards. Trainees are shown how to identify and report on these hazards.

IEInploym,ent of the Advanced Medical Assistant

One of the aims of the course is to produce medical assistants with the necessary skills to work in an unsupervised position if required. It is not possible in the time provided for the course for trainees to achieve expertise in these skills. It is imperative that when Medical Assistants complete the course and return to their unit, that the Medical and Nursing Officers who supervise them provide them with the opportunity to consolidate these skills.

With the introduction of the Advanced Assistant Medicine Course, the level of care that can be provided to the units and personnel that are supported by the health services, is raised to a new level. The Medical Assistant now has the opportunity to obtain the skills that are necessary to provide that support.

RAAF Welcomes Army Takeover

3 FGH deployed at RAAF Base Edinburgh between 10 and 22 May 1993 for Exercise Crows Nest.

n close co-operation with RAAF Medical Staff and utilising some of ithe base medical facilities a range of patients underwent Surgical , Procedures. A plastic environmental shelter was used to house the operating theatre and it was equipped with state-of-the-art anaesthetic and surgical equipment.

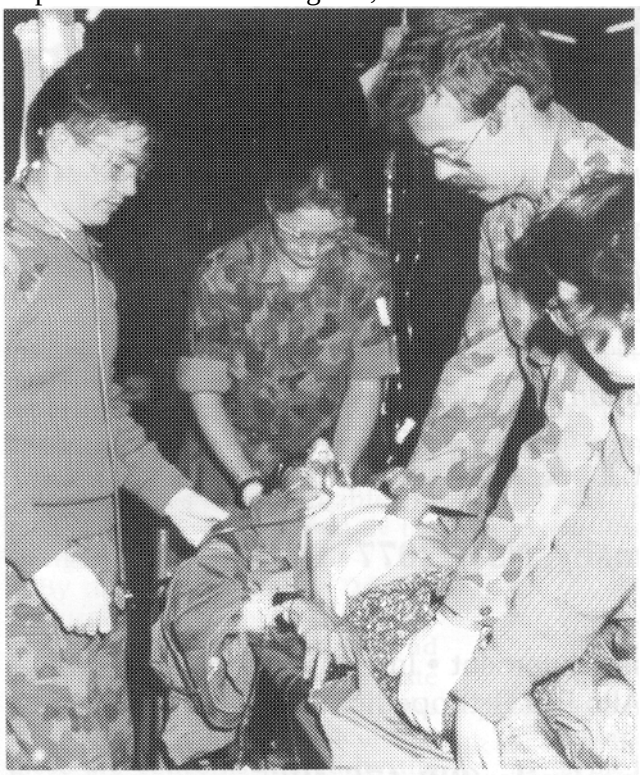
The unit demonstrated that arthroscopy was feasible under the conditions that could be expected in an operational military setting and high return to duty rate.

Thirty-seven services personnel underwent elective surgery during the exercise, saving some $60,000 that would otherwise have been expended on hospital fees in Adelaide.

The inter-service/inter-operability nattire of the exercise was demon- strated constantly with RAAF Orderlies and clerks employed at times in our tented environment and RAAF Operating Theatre Technicians and RAN Nursing Officers being utilised in the operating theatre.

Exercise Veritas Paulatim was conducted within the main exercise. Controlled by Comd Land Comd Medical Services this exercise tested evacuation SOPs from level 1 through level 3 medical facilities.

The handling of simulated battle casi.ialties in freez- ing conditions pro- vided real time training experience and offered oppor- ttinities to practice casualty collection, evacuation and resuscitation pro- cedi-ires in the field environment.



Soldiers going through rescue drills on Exercise Crows Nest

3 Field Ambulance based in Adelaide was joined by a Treatment Section from 7 Fd Amb normally based in Perth and the RAP of Adelaide University Regiment for this phase of the exercise.

Real tension was generated during resuscitation drills when the management of casualties was made to conform with "Emergency Management of Surgical Trauma" (EMST) standards. Resuscitation teams had to respond to the patients condition as described by Captain Peter Riddell, a Trauma Surgeon recently returned from a 6 month tour of duty in **Kabiii.**

These exercises offered a wide range of training opportunities to the hospital personnel in a friendly service environment that contributed greatly to the morale of the unit.

Medical

0

Assistant Training Revisited

by LTCOL Annette Summers 3FWD GEN HOSP

Is it time that we re-evaluated tbeposition of the medical assistant in the Regular and Reserve Components of the Army?'

here is increasing concern that the present training system does Tnot provide the medical assistant with the level of competence and capabilities to perform the tasks currently expected of them. Do we have unrealistic expectations of the medical assistant? Are we still equating the medical assistant of today with that of yesterday. 1 suspect that the medical assistant of yesterday deployed in a wartime situation got by on good luck, quick on-the-job- training and an attitude that anything is better than nothing, so short cuts and practices unacceptable in Australia today were excused by the emergency of the situation.

By the level of recent DGAHS instructions, revamping of medical assistant training packages and adjustment of pay levels to equate with the relevant experience of the medical assistant, it is evident that these are concerns shared by the military health services. However, these measures do not ensure quality of practice of the medical assistant. Competence of practice of other health professionals within the military service is assured by the parameters set by regulations, registration and certification. But not so the medical assistant. There are no parameters or protocols of practice which ensure that the medical assistant actually practises to the level of training given, not beyond it or below it. How do we as the officers responsible for the sick or injured soldier measure what it is the medical assistant can or cannot do in a given situation.

Too often, level of training is equated with ability to perform. This results in rewriting of training packages when the level is not reached to include or exclude tasks which we think the medical assistant may need to do in any given situation. This means that certain tasks are included when we want a medical assistant to reach a certain level of performance and other tasks are excluded when we think it is beyond their level of performance. Then when the individual medical assistant is placed in a position which requires a higher level of performance we give him or her on- the-job- training and let them do the task.

There is no question that the content of the training must reflect what the medical assistant is required to do but the level of training or pay cannot be the only measurement of the medical assistants competence or ability. There must be some protocols for practice **put** into place which leaves the medical assistant, the legal system, the commanding officer and the health professional responsible for their practice, in no doubt as to what a medical assistant can or cannot do in a given situation.

These protocols sbould reflect..

a. The limitations of the medical assistant's practice in relation to the level or extent of his/her training.

b. The limitations of the medical assistant's practice in relation to the situation of employment these may include.

1. ARA medical assistant in peacetime Australia or equivalent in;
   i. a hospital under supervision ii. in the field under supervision
   iii. in the field during individxial support
2. GRes medical assistant in peacetime AListralia or equivalent in:
   i. a hospital tinder supervision ii. in the field under supervision
   iii. in the field during individual Support
3. Deployment of the medical assistant in wartime conditions in:
   i. a hospital ii. the field

c. The level of responsibility of the supervising medical or nursing officer for the medical assistants medical practice in a given situation.

d. The legal and ethical parameters of the practice of the medical assistant.

e. The extent of safety and protection offered to the soldier and the medical assistant when the medical assistant acts within his/her parameters of practice.

f. The strategies to be implemented when the medical assistant does not act within his/her parameters of practice.

g. The strategies to be implemented to maintain the required standards of medical assistant practice.

The protocols should not simply be a list of tasks which state what a medical assistant can or cannot do, but a framework through which the limitations of practice of the medical assistant can be interpreted.

The benefits of providing protocols or guidelines for the practice of medical assistants are many. They would provide a clear definition of what a medical assistant may or may not do in certain situations. They would provide protection for the medical assistant, the patient (military or civilian) and the Defence Force, should a question of competence arise. They would establish parameters of practice in keeping with other professions and civilian occupations. They give a basis for credit transfer and recognition of qualifications from military to civilian and visa versa which is not based solely on equivalence of training, but competency criteria and creditable guidelines of practice.

They have the further benefits of giving the medical assistant the confidence and competence to practise safety in any given situation. They will allow the medical assistant the maximlirn training for tasks instead of the minimal training which is at present undertaken to limit practice. It ensures the provision of ongoing training and maintenance of the standard of practice, and most importantly it provides the medical assistant, other health professionals and military personnel with an awareness that there are limitations in the practice of medical assistants.

The Army health services must consid@r implementation of protocols of practice for the medical assistant. it is not sufficient to train a person in certain tasks which involve the health of other individuals and then hope that they put the training into practice. Both medical officers and nursing officers practice within the guidelines of their respective regulations and Acts, as do other allied health professionals in the civilian sector. The Army must be seen to be in keeping with this practice and afford the sick or injured soldier the same protection from the medical assistant as he or she receives from other health personnel.

Introduction to the 3rd Forward General Hospital

Welcome to 3rd Forward General Hospital (3FGH), the only General Hospital on the Australian Army Order ofbattle.

he main unit is based at Keswick Barracks in Adelaide. Under Teommand to 3 FGH are three Mobile Field Surgical Teams (MFST) one is established from 3 FGH and the other two are located in Perth with 7 Field Ambulance and in Melbourne with 6 Field Ambulance.

We wear the colour patch consisting of a blue rectangle superimposed on a brown diamond that was worn by members of 3 Australian General Hospital. 3 AGH was raised in 1915 as a 1,050 bed hospital. it served initially in the United Kingdom and then in Egypt, Lernnos and Mudros, taking casualties from Gallipoli.

In October 1915, 3 AGH moved back to the UK and on then to France on April 1916 as a 1,500 bed unit. This unit served on the Western Front for two years, eventually increasing its bed capacity to 2,000.

During World War Two there was a 3rd Special Hospital which served in the UK from May 1940. In **jtiiy** of that year it formed the basis for 2/3 AGH which was operational until March 1941 when its staff were used to supplement other newly raised Australian General Hospitals.

Also during World War Two 104 Military Hospital was sited at Keswick Barracks, then Daw Park. In 1959 this was re-designated as Three General Hospital and moved to Warradale Barracks. 3GH was classified as a Training Hospital in 1965 and it recruited and provided many personnel who served with 1 Australian Field Hospital and in other medical postings in Vietnam.

3GH continued as a training hospital in tandem with 3 Field Ambulance at Warradale Barracks throughout the 60s and 70s. In 1983 this hospital was re-assigned as a separate unit with its own administrative and training responsibilities. In 1989 3GH was established as 3rd Forward General Hospital and moved back to its original base in Keswick Barracks. Having gone **full** circle its role is now very similar to that of 3AGH on Lemnos in 1915.

Recent Activities

In 1985 and 1986 the unit was tasked to provide equipment (including the field operating theatre) and personnel to give medical care for the drivers and pit crew at the Australian Grand Prix.

During December 1988 and January 1989 the unit provided level 2 support and a 50 bed ward for the 15th Australian Scout jamboree held in the Adelaide Hills. 12,000 scouts and 3,000 leaders and administrative staff were supported with the unit treating over 2,000 patients in the eight days of the exercise.

During the K89 Exercise the unit deployed as a whole, performing in the role of a field hospital. 3FGH took over from 2 Fd Hosp and utilised the operating theatre, physiotherapy, X- Ray and Pathology departments of Kununurra Hospital. Some members were seended to 1 1 Fd Amb.

In September 1990 the unit provided medical support for the Annual Army Cadet Camp at Cultana. The camp was attended by 700 cadets. A 25 bed ward was established along with an RAP. Over

3rd Forward General Hospital Unit Plaque

3rd Forward General Hospital plaque consists of the following:
Seven pointed star from the Royal Australian Army Medical Corps Badge, Cross of the Knight Hospitalier of Jerusalem – the first who ran effective Military Hospitals, The Sword representing the Army, (pointing down for Medical), The Snake and Staff representing Medical, Florence Nightingale's Lamp representing Nursing, Wattle for Australia, Piping Shrike indicating the close links with South Australia and this Unit, and Dull Cherry for RAAMC – Grey for RAANC.

250 casualties were treated. The unit was involved in bushwalking and medical training during the exercise and received a commendation certificate from the South Australian Police Force for its handling of a fatal road accident 'encountered during the return trip to Adelaide.

During Exercise K92 the unit provided round out professional support to 1Fd Hosp at Tindal and 2Fd Hosp at Kununurra.

The 1993 annual field exercise was conducted at RAAF Base Edinburgh. With the deployment of the operating theatre and ward. During this exercise the most modern arthroscopic surgery was performed under Field conditions. In all 37 operations were completed with no post surgical problems.

MFST Deployment

a. In October of this year the MFST will deploy for the first time in support of a Brigade on Exercise 'Rhino Charge' at Cultana and Woomera;

b. On the 18 November 1993 the MFST will deploy by air to Sydney for a combined demonstration to be held on 19 and 20 November at Randwick.

The Role of the Unit

The role of the unit is to:

Provide major medical and surgical services for the sick, wounded and injured;

Conduct individual, sub-unit and unit training in peacetime. in accordance with instructions issued separately;

Augment 1 Fd Hosp (ARA) and 2 Fd Hosp (GRES) in the LSG, to provide definite level 4 medical and surgical support, and

To provide an MFST.

Organisation and Manning

3 FGH organised to provide a 50 bed field hospital and 3x25 bed MFST. The Adelaide MFST is manned by personnel shadow posted from 3FGH. 6 MFST is located with 6 Fd Amb in Melbourne and 7 MFST is located in Perth.

The authorised unit manning is 68 Officers and 104 Other Ranks, giving a total peacetime establishment of 172

CapabWties

The unit is capable of providing the following facilities..

two operating theatres;
an intensive care unit of four beds; a
central sterilising surgical department;
two twenty-five bed wards;
an X-ray department;
a pharmacy department;
a pathology department;
a physiotherapy department;
an RAP and RESUS department; and
the Admin and Log elements required to sustain the above.

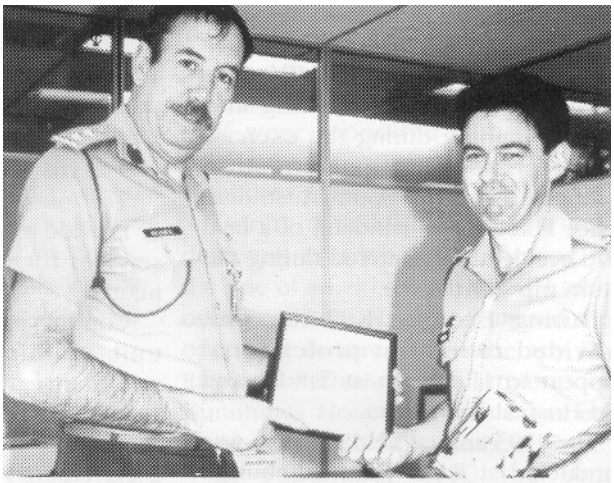
One Mobile Field Surgical Team consisting of..

resuscitation ward (2 beds) operating theatre (one table but can expand to two)
intensive care ward (4 beds), and
a 21 bed ward.

Conclusion

3rd Forward General Hospital **continues** to be a training hospital providing a rich recruiting ground for the GRES and ARA in nursing and medical specialists.

Life from the 1st Floor at HQ Log Comd (Sunny Melbourne)

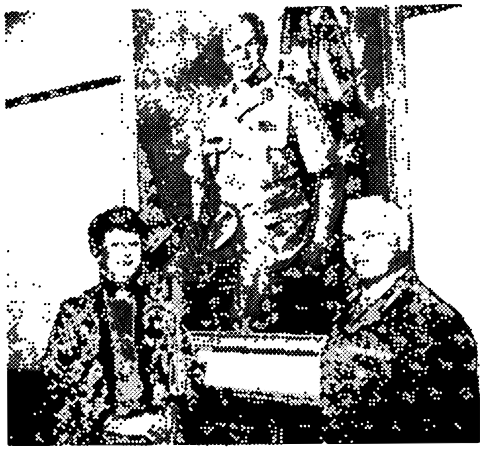


e presentation of a CGS Commendation to MAJ Bowen for his service as Senior Medical Officer for the Australian Defence Staff in Papua New Guinea (MAJ Bowen was commended for his meritorious performance, devotion to duty, humour in tryiug circumstances and professionalism)

A big bellofrom tbefirstfloor at 350 St Kilda Road, Melbourne, Vic. ne new Australian Supporl Area (ASA) Healtb Services Brancb (HSB) bas come of age and is aforce to be reckoned witb.

he Branch evolved from the relocation of elements from DMS-A and some HSSC-A's. The main responsibility of the branch is monitoring the provision of health support in the ASA. To ensure a national coverage the branch has the following incumbents/retrobates COL Andy MeNcil (a man you have no choice **but** to look up to - he also has a wicked sense of humour), LTCOL Lyndscy Baker (A true Dentist who can spot a blonde beauty at 200 metres from the ist floor windows and is heard to mumble "now she would make a good dental nurse"), LTCOL Marion Wedlock (An excellent fisherperson who oversees the rabble and keeps everyone honest), MAJ Maggic Parker (a Taswegian whose answer to all problems is "Ye Gods and little fishes" which is appropriate as she manages the medical and dental account. (It must be a call to the gods for more money), MAJ John Bowen (the French speaking Doctor whose passion for languages is only surpassed by his passion for the editorial staff of the Sun); CAPT Sharon Paimer (an avid volleyballer whose main claim to fame is that she blocked the DGAHS during the Celeriter weekend - good career move); SGT Owen Millard (secretly he runs the place as he is the only person to have access to all the keys, especially to the fax and cupboards). The branch can be found at all times (that's from 0730 hrs to 1730 hrs) at their desks (well at least three people can be found during those hours) fielding questions (Bluffing), providing advice (guessing), demanding action (bribing) and being general good guys. Well what is the branch supposed to do? It takes on the dissemination of information, which includ@s i nstructions and technical direction, allocates and monitors the Med and Den Vote, monitors the med requirements for overseas deployments, looks after med, **ni-irs** and den matters and monitors the provision of optimum health care in the ASA. It belongs in the food chain between DGAHS and the HSSC's (or equivalents - i.e. the old DMS Offices). In other words everyone will want to know HSB and even if you don't you soon will.

Unveiling of DGAHS Portrait



The history of painting the DGAHS portrait dates back to 1942 when MAJGEN S R Burston – DGMS was first painted by the renowned artist William Dargie.

Since then the portraits have been painted by such well-known artists as Ivor Hele, Inson, B V Nunan and Joshua Smith.

On 10 May 1993, a ceremony was held at Russell Office to officially unveil the portrait of the former DGAHS MAJGEN D G Rossi. MAJGEN Rossi was DGAHS from March 1990 to September 1992. The guest of honour for the evening was the artist Mrs Yve Close. The portrait of MAJGEN Rossi is the second portrait Mrs Close has painted for the RAAMC, the first being that of MAJGEN W O Rodgers DGAHS 1985-1986.

Mrs Close began drawing in her teenage years at Julian Ashtons Art School in Sydney. The Sydney based artist then became a member of the Royal Art Society where she studied painting for six years. Following this, she was tutored by Mr Joshua Smith who has been her painting partner for seventeen years. The two artists not only work together but exhibit, teach and travel extensively in connection with their work. Mr Joshua Smith also attended this unveiling.

Mrs Close has received high recognition in national portrait competitions and her work has been sought after by universities and other exhibitors both here and overseas. One of her portraits was commissioned by an institution in Rome, where it hangs today.

The portrait of BRIG (now MAJGEN) D.G. Rossi is now displayed at SOAH Officers Mess alongside the previous eight Directors General Portraits.

11th Field Ambulance

by L.M. Prado, Major, OC 11 Med Coy, 6 BA SB

11 FieldAmbulance was officially raised at Mitcbam, Soutb Australia on 1 Marcb 1916. After completing service during ~ in Europe, it was disbanded in 1919.

11 Field Ambulance was then re- raised as a Militia Unit between the two world wars. The unit served with distinction during WWII, including the siege of Tobruk and the Milne Bay campaign. Post WWII, the Unit became a CMF Unit in 1948 and was disbanded in 1962.

1 1 Field Ambulance was once again raised at Wacol in 1967 as a Regular Army Unit to provide RAAMC reinforcement to South Vietnam. The **unit** moved to Enoggera in 1971 and with the withdrawal from Vietnam in 1972 was tasked to **support** the 6th Task Force.

Since the formation of 6 Brigade the Unit has trained to develop the capability to support a Brigade in low-level and conventional operations. The unit was integrated with an Army Reserve Component in **jtine** 1986, however, the Army Reserve has since been replaced with the introduction of the Ready Reserve (RRES) Scheme in 1992.

THE HARKNESS MEDAL

Five recipients of the Harkness Medal were together at the DGAHS Exercise at Portsea in 1992. Photographed in front of the Harkness Honour Board.

Recipients of Harkness Medal: Back Row: From Left to Right: COL Eric Donaldson AO Consultant – Aviation Medicine (1973), COL Bill Kelly AO Consultant – Pharmacology (1985), COL Peter Byrne DMS 4 MD (1986). Front Row: From Left to Right: COL RAS Simpson DMS 2 Div (1989), LTCOL Tony Sweeney CO AMRU (1980).

11 Field Ambulance was once again disbanded on 20 March 1993 with the formation of 6th Brigade Administrative Support Battalion (6 BASB) and is now known as 11 Medical Coy.

1 1 Medical Company is an integrated sub-unit of 6 BASB and currently has a posted strength of 78, 46 ARA and 32 RRES. The RRES figure will increase to 50 by August with the arrival of our second intake of RRES Soldier, however the ARA component is down-sizing to 19 ARA by 1996.

By the time that Paulatim is px.iblished, 11 Med Coy, 6 BASB will have received its second intake of Ready Reserve (RRES) medical assistants from the SOAH. The Coy will then have a Ready Reserve ECN031 (MA) posted strength of fourteen CAT 3 fi- iii-time service, sixteen CAT 3 and one CAT 2 part- time service. It would seem appropriate at this stage to review the progress of RRES MA (affectionately known by the ARA membe rs as 'Ready Rockets') within 1 1 Med Coy.

For those somewhat confused by the RRES upturn, and no doubt many are, as even 6 Bde personnel have yet to fully come to terms with the complexities of the RRES - a brief explanation is appropriate.

CAT 3 RRES are recruited for one year flill-time service followed by four years part-time service (50 days per year). CAT 2 RRES are not reqliired to complete the full-time year. They serve five years part-time. Persons with professional qualifi- cations or who have military background may be able to be enlisted as a CAT 2 RRES.

During part-time training RRES must complete 50 days service usually divided into the two compulsory training periods (jan/Feb and Dec).

The first intake of RRES certainly impressed with their enthi-isiasm and willingness to learn. There was, no doubt, some difficulty with the integration of the ARA and RRES of particular note was that RRES can be panelled on a subject one course in their first year of training, whereas ARA soldiers must at least be Private 'P' for twelve months. However, by having both ARA and RRES working together within Treatment sections, teamwork quickly developed.

There are, however, a number of areas of concern. All have been or are being addressed at some level, and some are outlined below.

ARA medics need continuing exposi.ire to patients and the oppor- tunity to practice and update skills.

This proves to be difficult for many medies as can easily be appreciated, RRES medies, in a fifty day period, have limited opportunities.

Fortunately most of this will be spent in the field supporting the Brigade. In addition with the establishment of the 6 BASB RAP there is a day-to-day flow of patients for the medics to see and assess.

Naturally some part of their fifty day service needs to be spent on refresher training and the degree that this necessarily will become evident at the end of the year when last year's **"ftill** timers" return after over ten months separation. In addition it is necessary to maintain interest amongst newsletter. As well the company sends all the lecture notes and other written material covered by the ARA medics as part of their training programme. The opportunity for an Adv Med Assist Course needs to be further addressed. The RRES scheme recruits both males and females, however, only males can be allocated to combat roles. Therefore, females are posted to 6 BASB and other similar support units. In fact of this next intake thirteen of the fourteen medies are female. There is no particular problem within the BASB except for lifting and carrying Trellenborg shelters. However, it is planned that RRES medic positions at the infantry battalions are **filled** from 11 Med Coy. Obviously this will become difficult as females cannot be posted to these positions.

There is no doubt that our RRES are in general highly motivated, enthusiastic, and intelligent (two medical and two nursing students are already in the Company!). Our main challenge is to maintain their interest and further develop their skills over the year of their service.

A New

0 9 Begi.nnmg

by CAPT R Hanchel RAANC I ltb

Field Ambulance became 11 Medical Company witb the formation of 6 BASB on 20 Marcb 1993. It marks an end to afine unit witb a long and wotiby reputationfor medical excellence.

The formation of 6 BASB saw the disbandment of 11 Field Am- bulance, 106 Field Workshop, 5 Transport Squadron, 6 Field Supply and 33 Field Dental Unit. Each company now has cadre staff with ready reserve staff both full-time and part-time.

Since its formation, 11 Medical Company has been very busy with training, medical support and the transition of becoming a new identity, a company. Exercise Paulatim was a training exercise concentrating on AME in late April. Valuable training was gained by all involved. Simpson Day was a great success with surprise winners being Ist Military Hgspital. Congratulations! Thank 'you CAPT Morris and LT Kelly for organising a great day.

In late August our ready reservists arrive in the company after completing their OJT phase of the Medical Assistants course. We look forward to their arrival and incorporating them into the treatment sections. Once they arrive they have a week of IMT and continuous training in resuscitation and other clinical areas. Exercise Trial Echidna in December will be the first time that 6 BASB will exercise as a Battalion. Exercise Ready Shield in January/February will see 6 BASB supporting 6 Brigade at Shoalwater Bay.

Our ready reservists from last year have already made appearances this year to fulfil some of their part-time commitment. They have been quickly utilised to **fulfil** medical support tasks in the Bridgade area.

'The End of An Em"

At 1600 hrs on 20 March 1993, the Corps and National Flags were lowered for the last time on the unit parade ground. The final salute was taken by the CC MAJ Luis Prado and the unit was piped off the parade ground by the Pipe Major, 6 RAR, SGT R. Todkill.

The Corps flag now flies at BASB HQ with the other Coys that make up 6 BASB.

Tour of Duty

by CPL G. james RAAMC

12 May 1992 marked tbefirst day of the next eleven montbs, two weeks and one day of my Tour of Cambodia, but wbo was counting.

n arrival in Cambodia, courtesy

of the Vietnam Airlines, it no 0 longer felt like 1992 but instead

1952. All the modern conveniences that we were used to in Australia, were now a thing of the past. The next five days saw five pairs of undies thrown down the hole designated as the toilet. Night time saw mass line- ups at the thunderboxes with disappointed faces all round. Nobody had made it in time.

After a month of waiting, and sorting ox-it stores, we were finally deployed to detachments all over Cambodia. 1 was deployed to Siam Reap. Siam Reap is situated in the heart of Cambodia. It boasts one of the ancient wonders of the world, the 'ANKOR WAT". 1 soon became a good tour guide in between duties, showing people, on their days off, the great temples that the Khmer Rouge had bombed to rubble. Medical work here consisted mostly in the treatment of rashes and the occasional case of Malaria in the local community.

After four months there, 1 changed detachments to one of the most isolated detachments in the country, working with the Kiwis at Samrong. This is where most of my medical experience was gained treating those who had stood on mines. This was a weekly occurrence.

Probably the most interesting part of this medical experience was working with a medical team from Pakistan, India and Bangladesh. These countries were already well familiar with war, famine and poverty. They were very impressed by our medical equipment. It was a great surprise to me to have a Bangladesh Medical Officer ask me what an oxyviva was used for!

Cambodia medicine sometimes bordered on barbaric. Amputees would go without pain relief for up to 24 hours or more due to unavailable analgesics. Wounds were often left open for days, often leading to lethal infections.

Recreation became an important part of the evenings. Our evenings entertainment ranged from playing cards to watching videos (latest releases could be bought for US$2). The local Governor of the town gave some great parties and feasts to us, the visitors.

To all those in the Corps, who think we went to Cambodia for 12 months and had a great time, you're right, we did!

Snippets from DMS Office Defence Centre Brisbane

Notable Events

a. Survival of DRSR virtually intact, except for the change of DMS to a GRes position and the reduction in the Nursing Officer from LTCOL to ".

b. Conduct of the DMS Exercise for the first time in three years, an outstanding success! The program included Aviation Medicine and medical aspects of current UN deployments.

c. The retirement, after very long service, of Wol R.L. (Lance) Barrett. Lance is presently training as a brain surgeon at SLinnybank Private Hospital! He **colildn't** stay away from the medical scene.

d. The successfik@ combination of the final medical boards for the first year RRes intake (around 1000 over the Christmas/ New Year period).

c. DC-B Consultants Dinner held on 12 March 1993 at "Rhyndarra" (1 MIL Hosp **Officers** Mess).

f. DMS Office is on the move again (in July 1993), this tirne pennanently(?) to Bidg BI, newly refurbished accommodation. Hopefully, this will be the last rnove for some years.

L to R. Ms R L ink, Mr M Mu lca by, MAjjju iciu s, SGT T Esier, LTCOL K Farrel4 W02 C King, MAJ R Gregory and Dr H Forbes

Paulatini at 1 Mil flosp

by LT Steve Kearney

We are well into 1993, but there is no slacking off tbepace at 1 Mil Hosp.

ur theatre lists are growini longer, our regular training Ocourses are under way and confirmation of the incorporation of a **field** capability, has had unit members busily predicting requirements for the new 2 Fd Hosp at Enoggera.

Training

Once again 1 Mil Hosp has embarked on a wide variety of OJT courses for specialist Medical Corps training on behalf of the SOAH..Much of the administration, **lecturing** and examining on these courses is provided by hospital staff members. The OJT courses are time consuming, although, all the 1 Mil Hosp staff involved are still smiling.

The Pathology Technician Course is presently underway, directed by FLTITKathy Sayers. SGTjohn Staley is looking after various administrative tasks while all staff of CPL and above, are involved in lecturing. The six keen students are looking to a successful **conclusion** to the four month course on 5 November 1993.

The six month Radiographer Class One Course, **due** to be completed 27 **At-igtist** 1993, is also progressing well. MAJ Russell Dunn has indicated that the four **students** are being provided with the necessary **input** to successfully complete the course.

The SUBJ 4 PTI Course has been run for three years at 1 Mil Hosp. All seven PTIs of the 1/93 Course passed the program, which was completed on 1 June 1993, and covered some very specialised subjects. CAPT judy Wells and W02 Rod Lawerson of the Physio Department, and their staff, various members of the unit, as well as outside University lecturers were involved with the extensive program.

A marathon nine month Operating Theatre Technician Course is still in progress, and the five students, including SGT Rawic from Malaysia, for this year will complete it on 29 October 1993. CAPT Peta Durant and CPL Rick Lawton are heavily involved with the program and training.

Staff from the SOAH Detachment at 1 Mil Hosp have helped in the co-ordination and lecturing of all of the above courses. They have also conducted Part 2 training for 11 medical assistants so far this year, and have recently begun Part 2 training for a further 14 Ready Reservists.

Unit Activities

Exercise Wombat Three was conducted 1-10 May 1993 at Yellow Gully Training Area, Gatton. The Exercise Co-ordinator, SSGT Ray Mahwhinney, said the aim was to practise and revise basic military skills. The exercise involved two infantry sections, as well as HQ and enemy elements.

Adventi-ire Training will be held at the Guy Fawkes National Park in October this year. CAPT Nick Read is organising the five day activity which includes three days of intensive walking. The aim is to improve field craft and navigation skills under physically demanding conditions. CAPT Read expects it to be tough but enjoyable.

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The Hospital's Simpson Efficiency Run Team performed well this year. A passer-by commented thatthey were "a mob of geriatrics unable to compete with the Field Force boys". However the 1 Mil Hosp time of 4 min 46 see was good enoiligh to **secure** first place by 37 sec. Well Done.

1 Mil Hosp drew for second place with Kapooka Medical Centre at the RAAMC/NC Birthday Weekend celebrations in jttly. 1 Fd Hosp hosted the occasion in their **usual** style and the weekend was enjoyed by all. Our placings in the team events were as follows:

Female Celeriter Ist Place Male Tug-O-War Ist Place
Male Celeriter 2nd Place Netball
2nd Place Cross Country 3rd Place
Female Tug-O-War 3rd Place
First Aid 4th Place Touch
Football 4th Place Squash (LTCOL Millar notes that 1 Mil Hosp were beaten on a count back with the eventual second place winners).

CPL Doidge, PTE Schloss, LT Busch and WOI Lucian successfully took first place honours for their age groups, due to their individual efforts in the cross country. These age groups will remain anonymous. CPL Levesque was named best and fairest netball player.

Awards

Medals are now available to recipients of Commendations. MAJ Russell **Dtinn,** CAPT Judy Wells and CPL Richard MacDonald have previously been awarded commendations, and can therefore make the medals a proud addition to their uniforms.

Both LTCOL Athol MacKay and CAPT Wendy Newboult were awarded a citation by the American Navy for their services aboard the USNS Comfort.

" Mary Brandy was awarded the Conspicuous Service Medal on Australia Day.

In Meniorium

MW Sue Felselic

MAJ **Sue** Feische MBBS FRACGP was MOCS at I. Mil Hosp until May 1993. She was then detached with 1 Sig Regt to form part of the United Nations Peace Keeping Force in the Western Sahara. On the 21 June 1993 while at Awsard Airstrip, she was killed when the light aircraft (Pilattis Porter) she was aboard crashed during take off.

MAJ Sue Feische was a highly respected medical professional, a popular member of the unit, and she is sadly missed by all her friends and colleagues at 1 MIL Hosp.

Sun, Sand and Swiss

by MAJOR L.M. Prado OC 11
Med Coy - 6 BASB

Sometime in March 1991, while sitting comfortably in my office at the RAP at 6 RAR, during sick parade, 1 was notified by the SMO 1 Div of my likely deployment to MINURSO, (the United Nations Mission for a referendum in Western Sahara).

Like the majority of service personnel, let alone the general public 1 was completely ignorant of the conflict in the Western Sahara. After years of colonisation @he Spanish left the area then known as the Spanish Sahara in 1975. Following this a conflict has raged until the ceasefire in September 1991. The Morrocans came from the north to occupy the area left vacant by the Spanish, claiming historical rights. The local population rebelled and formed a political and military front known as the POLISARIO. For over fifteen years the parties have fought. The country is divided north and south by a sand wall known as the 'Bem', the Morrocans to the West, the Polisario to the East. Thousands of Polisario refugees live in large camps in Algeria. Families are separated by distance and war for over fifteen years with virtually no contact.

The United Nations have stepped in to supervise a ceasefire and referendum for the local population to determine between self-riile or Morrocan **rule.** However a stale mate in the process has been reached as neither side can agree on the eligibility of voters. At the time of writing this appears to be approaching settlement and hopefully a fair and safe referendum can take place.

The Australian contingent, ASC MINURSO, numbering forty-five comprised mainly signallers is responsible for providing and maintaining the United Nation Force communications, particularly for the military observers at distant teamsites in the desert.

The Western Sahara is a desolate place, a desert hot and dry or cold and dry. Depictions of the Sahara desert in films etc. are unable to give an accurate portrayal of the country. A written description is also inadequate, suffice to say that it does not differ greatly to our nation's deserts.

The RMO with the Australian contingent is responsible for level one medical care for the soldiers. The remainder of the medical support in the mission is provided by the Swiss Medical Unit, (SMU).

The SMU provides level two and limited level three facilities, based primarily in Laayuane, the capital of Western Sahara with detachments throughout the mission area. This includes out-patients and in-patients care, pharmacy, dental clinic, laboratory, X-ray, intensive care and an operating theatre.

The SMU is also responsible for acro-medical evacuation within the mission area. The close working relationship between the SMU and the Australian RMO provides excellent RAP facilities, and admission rights to the wards. Additionally the RMO is rostered for AME call-outs and routine medical rounds by air, where military observers are visited at their teamsites weekly.

The SMU lack of military and military medicine experience led to some difficulties in formulating and implementing the overall medical plan. Only the Australian contingent arrived fully immunised with a recent medical and dental cheek. Because the medical plan was initially in such disarray, other nationals arrived without even basic immunisation. Civilian United Nations staff also arrived with problems such as unstable hypertension and diabetes. However, more importantly the distribution of medical resources throughout the mission area and the casevac plan took much time in country to be finalised.

Medical problems seen in country varied depending on the 'grolip' the patient belonged to. The military, because of the poor conditions they lived in, were susceptible to communicable disease, including viral URT infections, GIT infections, and conjunctivitis.

Capt Prado treating a young local girl

The danger of mines and long patrols in the desert also meant that the military were more at risk of accidents and injury. Over twenty-five priority one or two casevacs of UN observers were conducted in the deployment period by the Australian RMO.

The civilian United Nations staff, operating mainly at Force Head-quarters in Laayoume presented often with long standing medical problems such as hypertension and angina.

The local population, because of poor medical care presented with a multitude of unusual problems such as tuberculosis. Although contact with these patients became limited by UN order it was nevertheless a most satisfying aspect of the job.

The highlights of the deployment were the seven day visit to the Polisario camps, schools and hospitals 'in the middle' of the desert in Algeria; the medical rounds to visit observers from over forty nations at their teamsites; and commanding the smaller SMU detachments forward of the main hospital. Providing on-going medical care and formulating medical plans on a long tenn ever changing operation in addition to working closely with health professionals from another nation was a unique opportunity to gain valuable operational experience.

RAP:

Force Connuffications Unit Canibodia

Story as told by SGT Wayne Lyons

Greetingsfrom the RMO and stafffrom the RAP, FCU.

The Medical Facility has been a hive of activity for most of 1993, with the unit undergoing a **huge** turnover in staff due to the rotational changes. Our thanks go out to those medical personnel we replaced, who left the place in a manageable condition.

The Force Communications Unit is soon to be disbanded due to the UN n-iission coming to a close. The RAP is responsibile for some 500 troops scattered throughout Cambodia. The RAP is situated in Pteah Austraiii, which is the HQ of the FCU, Phnom Penh. There are also numerous SAP's scattered throughout the country.

The RAP provides a 24 hour service, seven days a week and has a five bed ward. Medical backup is provided by the German Field Hospital. It also boasts a Lab facility, primarily as a malaria research lab with a capability to do clinical pathology. There is also a Health element comprising of a Health Officer, with the capability to handle all water testing for the FCU and outlaying detachments.

Corps Weekend
First International
Celeriter Meet

Like most medical units through- out Australia, the RAP staff celebrated Corps Day in the true spirit of the event. Preparations were started some three weeks prior to Corps weekend, to initiate the very first International Celeriter meet. Most of the credit for organising the event must go to SGT Norma Hinchcliffe, with special mention to the rest of the staff for putting up with her crabbiness. It was a big task to undertake in such a short time given to prepare. Special thanks go out to SGT Teny McKeown and his engineers for helping to construct the course, and the cookies for our birthday cake.

The race was run over a course of approximately 400 metres. Obstacles included a 6'6" wall, 6' deep pool, wire, a creek, cargo net and tyres. The visiting teams were given a de 'monstration run through by our veteran reserve side. Mind you they did not negotiate any of the obstacles for fear of giving away our secrets to the enemy. The five competing nations were, Australia, Canada, Germany, Ghana and Indonesia. Unfortunately the Netherlands had to pull out at the last minute due to transportation problems. Believe it or not, it is their sole purpose while in Cambodia, to control movements within the country.

The draw for positions was made by the Doc, as divine intervention pre- vented the Padre's from being on time to do the draw. The Canadians were first to negotiate the testing course, faring well, except for the water, and completed the course in 2.27.40.

The Germans were next cab off the rank. The wall posed a few problems for the heavier Germans, and precious time was lost, @%s was the case in the water. They finished the course in 2.36.25 after incurring a 1 sec penalty for an infringement.

The Ghanaian's went off third, and it would be fair to say they had problems at every obstacle. They were bigger, less fit and a lot funnier than the other teams. There was absolutely no way they were hitting the water without a little prompting. The problem with the water was that a majority of them **could** not swim as this became blatantly obvious once they were in. Every man for himself, including the patient. They eventually finished in 3.34.72 to a rousing reception. It would be a fair statement to say they were glad it was over, but wouldn't have missed it for the world.

The Indonesians were next **out,** and although much shorter in stature than the other teams, showed amazing agility to scale the wall and negotiate the course in 2.32.80.

Last, **btit** not least came the Aussies pictlired. It was up to them to knock the Canadians off their perch. All was going smoothly, and after negotiating the pool brilliantly, found themselves going the wrong way in the creek. Being as honest as the day is long, they back tracked, losing many seconds. From that mishap they stormed arol-ind the rest of the course, and **just** as it looked as though they would snatch an unlikely victory, a stumble at the end of the tyres was enough to cost them victory. They **finished** in 2.27.95, a mere 0.45 sec off the Canadian time.

Although the Canadians took home the coveted stretcher, there were no real losers. The day was a complete success, and those nations that took part wish to compete on a regular basis. it also goes to show that a multi-national force not only can work harmoniously together, **but** can also compete with each other, and have a quiet drink and a chat about it afterwards with no animosity.

Congratulations 1 Field Hospital on your win, and likewise to the girls *of* 1 Mil.

The A Team
CPT Harry Beyne
CAPT Lew Macleod
CPL joe Ring
CPL Alan Buckley
CPL Paul Stephenson
LCPL Darren Collins
" Carmel Van Der Rijt (Patient)

The B Team
CAPT SGT Norma Hinchcliffe
W02 Rod Teague
Dental W02 Tim Hazeldene
CPL Rowan McKenzie 5AVN
PTE Ned Kelly
TPT
PTE Mark Wilson
Catering
CAPT Susan Evans (Patient)

SOMALIA A Medic's View

Injanuary 1993 the 1 RAR Bn Gp, consisting of sorne 930 soldiers, deployed to Som,@lia for Operation Solace.

Included in the force were the following health services ekm~s..

a. RAP 1 RMO, 6 med assts and one hlth asst,

h. Treatment 'section from 3 BASB - MO, Nur Offr plus 13 med assts,

c. Evac section from 3 BASB - two ambulances with crew,

d. Dental section from 3 BASB - dentist plus dent asst,

c. Health section from 3 BASB - hlth offr and hlth asst and;

f. Medical staff officer located on the force HQ.

The above provided level two support to the force for 17 weeks (January to May), including nearly 3000 total RAP attendances, 113 patients admitted to the treatment section and 22 patients in the resus department.

Members of the treatment section wrote essays towards the end of the operation to ensure they reflected on their deployment and put things in perspective prior to returning home. The major facets of the operation that they wrote about was the work in the resus area, the involvement with the vaccination programs and the work in the local surgical hospital.

The essays following are a combination of the efforts of a number of people. The members whose work has been used to compile the essays are:

SGT B Dick PTE S Hall CPL K Felmingham PTE R Goldsnith CPL G Wflsen PTE M Franks CPL M Drysdale PTE S Steen PTE C Maclean M L Low PTE M Walker PTE A Woodward PTE J McCarthy

Inoculation Somali Style

Pre-deployment preparation for Operation Solace (the deployment of 1 RAR Bn Gp to Somalia) included ensuring all members of the force were immunised to DPI standard plus vaccinations against meningitis, hepatitis A and yellow fever. With around 900 members in the contingent this was a lot of needles! What a relief when we finally departed for Somalia, having completed that aspect of the preparation. Imagine our horror when our two Medical Officers (MAJ Duncan and CAPT Keating) came back from discussions with the Baidoa based non- Government Organisations (NG0s) and informed us they had volunteered us to assist in a vaccination campaign for the villages in our area of operations.

In Somalia measles causes significant death and illness, especially in the population ravaged by malnutrition. The vaccination against measles is well suited for aid organisations to commence with because it is a one injection vaccine. Keeping records of when people are given vaccines is difficult enough for RAPs - imagine how difficult it is in a nomadic population. The- equipment (vaccines, needles a@d syringes) was supplied by UNICEF, and the various NG0s in the area had allocated areas to themselves by mutual agreement. We were to assist by supplying manpower.

A team of four to six medies, plus drivers and security elements, dressed in flak jackets and helmets, with weapons on action, would follow the NG0s to the village for the day. No spacious RAPs with NCOs controlling the flow of patients. The best shade tree was identified and the equipment laid out. By this stage the children had been rounded up and were sitting waiting patiently in line. Surprisingly few cried as they got their injection, and a handful of dates or a high protein biscuit was a good substitute for jelly beans. Children under five were weighed and had their height recorded as part of nutritional surveys. In one village where 250 children under five were seen, 65 were between 65-75% of the YMO height/weight standard and 75 were less than 65% of the standard. The bleb from a 0.5ml injection doubled the diameter of some of the children's arms.

After vaccinations were finished, the children were entertained by our attempts to learn their language and we introduced some simple games. Many of the population in the distant villages had not seen any sort of ball, so much interest was shown in the oval leather bag full of gas that we produced. Disposable gloves made into balloons were also a big favourite. By the time we left the village, most children had kicked a footy and leamt to say "g-day mate".

The more seriously ill in the villages were examined by either a Nursing Officer (our own LT Dave Werda or one from the NG0s) or our MO, but only very simple treatment was available. One young boy with 10% bums to his chest and arms (the injury was four days old when we saw him) was brought to the Baidoa hospital to try and control the infection that was already established. However, other children with infected wounds, severe scabies and malaria did not qualify for admission by Somalia standards.

After the measles campaign was complete, it was,decided to expand and tackle the problem of tetanus. The reception the program has received by village elders and chiefs was encouraging and it was felt that they were able to handle the problems of record keeping and ensuring people **turned** up for the **full** program.

By the time the first doses had been given in the region, we had helped to vaccinate over 15,000 men, women and children. We were pleased to be able to help and at least the country knowing we had contributed something that would have longer term benefits for the people of the region.

Experiences of a Ready

though for real, even when they turned up at a dime a hundred in buttles of 20 at a time. We all used to moan and groan about having to do more practice of the stand and pull to see what value what we considered unrealistic patient loads would be. For those of us on Operation Solace, the moaning and groaning have stopped.

The first occasion where we received patients with gun shot wounds was in the early hours of 7 February. We were rudely wakened and told to be prepared. No idea of patient numbers or, more importantly for many of us, nationality. Tense minutes passed until we heard the chopper arriving. 10 minutes,

later, four patients, all with gun shot wounds arrived. It all fell into place pretty quickly - the drills, the practice - one patient had a bullet wound in his leg, the others had wounds to their buttocks and abdomen.

After the patients were stabilised and evacuated (just like the book says we are supposed to do), we are all too hyped to return to bed, so it is sit around with a smoke and a coffee and relive the night. The boss (MAJ Duncan) debriefs us and points out some deficiencies he noticed and outlines how we can improve our performance next time.

We only had 10 days to wait, before another early wake up call. This time three patients who arrive about 15 minutes after we are woken. Once again into the drills. One of these patients has a gun shot wound to his chest (so that is what a sucking chest wound looks like!) as well as his upper arm. He is managed with a chest drain and Heimlich valve, as well as 2 IV lines and a urethral catheter. Within 45 minutes of arriving he is ready for evacuation to the US Evac Hospital in Mogadishti. We heard later that his lung and arm were both removed but he was recovering well and would survive.

Once again, returning to sleep was impossible so it was clean up the bays and prepare for the next time then coffee and smokes. Unfor- tunately we learnt that we were not always destined to "win" and save everyone. Two Somalis and one Australian passed away in resus during the operation. Each occasion was accompanied by much soul searching and introspection to satisfy ourselves that we did everything we could have. It was a trade off we understood what the boss means when he says "Do not let your emotions get involved while you are treating someone. Switch them off until later."

After Somalia, receiving simeas on exercises will probably never be quite the same again, but at least the value and purpose behind them is fully appreciated.

The 1.ocal Hospital

Two hospitals had opened **tip** in Baidoa by the time the 1 RAR Bn Gp had arrived in jantiary 1993. One was run by an organisation called Medicens San Fronteir and looked after medical patients. They did not have a surgical capacity. The other Hospital was run by the International Medical Corps (IMC), a US based organisation founded by an American doctor to help the Mtijahrdine in Afghanistan about 10 years ago.

The IMC provided a surgical facility, using surgeons who rotated through each month. They also had a paediatrician and six registered nurses to help the 20 Somali staff they employed. The guideline for care of Somalis was that any that the coalition forces injured (either by shooting or MVA) would be treated by the military facilities, but any Somali injured by other Somalis, was not accepted by the military surgical facilities. This meant we had to transfer a number of Patients to the IMSC hospital.

Through this contact we became friends with the staff and began to visit each day and join in ward rounds and assist in the operating theatres. Some of **us** would stay out in the courtyard and be taught Somali by the local kids, while the rest of **us** would get involved in operations of all types.

The surgeons (one general surgeon and one orthopaedic) were more than happy to allow our MO to perform operations and for the medics to assist and in some cases perform procedures. The main procedures we performed were debriding wounds and incising abscesses, while we assisted at mornings and work in the treatment sections during the days. An informative part of our time here is the lectures presented to us by the MO's most afternoons. Practical and amputations, Caesarean sections, hernia repairs, internal fixation to name a few. There was also the opportunity to insert IV lines by the hundred and administer the anaesthetic agents (ketamine and valium).

The ward conditions were primitive to say the least, with no running water and stretchers for beds in most cases. The standard of dressings was initially poor, with the same instrument used for all dressings (with no cleaning in between), or ungloved hands only used ' This improved with the insistence by the surgeons on better techniques. The Somali staff were eager to learn and improve and as time went on the infection rate decreased noticeably.

Similarly, as the security situation improved the type of cases changed. Initially a number of shooting victims would present each'day, however the rate decreased and in April routine cases were appearing. Many had needed treatment years ago **but** the civil war closed the hospital and they had to wait until the situation had improved.

The Somali staff included a number of interesting characters, not the least of whom was Abdukadir Hudow Osman (Hi-idow for short). Hudow was born in, Baidoa and moved to Mogadishu to undertake training as a dentist. After one year he decided to change to medicine, and completed two years of medicine at University. The decline into civil war curtailed his studies and he moved back to Baidoa and commenced conducting first aid and health care courses for the locals. He returned to work in the hospital when it reopened and is hopeful of completing his medical studies. Without his skill and dedication the IMC staff would not he able to keep the hospital running.

The IMC hospital was a big part of the Somali experience for many of us. The IMC team (as well as the other NGO workers we met) earned our respect and admiration for the never ending and thankless work they do, while meeting locals such as Hi-idow shows as that there was hope for the people of Somalia to restore their country to a safe and productive state.

Reserve Medic Operat'i'on

by PTE T L itzo W

Being a medic for the 1 1 tb Medical Company, 6BASB certainly means a lot to me. s a new member to this unit it seems like one big happy n the 31 August 1993 a Afamily. 14 of us new Ready Reserve medics marched in and we have been virtually on the go **eyer** since. As yet we have not been "out Bush", but are looking forward to our first exercise with trepidation but anticipation.

Being 031 qualified does not mean that we do not perform other duties. By being at a small unit we have had to do tasks that would not usually be performed by medics. However 1 believe these other duties have given a wider view of the army and on a smaller scale the inner workings of 6BASB.

On the medical side, to gain wider experience all of us have been detached to the Queensland Arnbi,ilance Service and local Brisbane Hospitals. Not only have our eyes been opened to new medical treatments, **but** the experience has also given **us** skills in communication and human relations. We have been exposed to patients from all walks of life with a variety of presenting complaints. We have even had the chance to perform CPR on a real patient while on a hospital detachment - one experience I'm sure we'll never forget. And screaming through Brisbane, through red lights and stop signs in the back of an ambulance is certainly another unforgettable experience.

While at the Med Coy we have been getting settled in **our** treatment sections and sorting through stores in preparation for exercise. We have also handy suggestions on topics such as minor operations, antibiotics, ambulation and anatomy and physiology (just to name a few) have been part of our continual training.

As Ready Reserves we faced coming to our unit with some trepidation. However we have been welcomed with open arms and have become and integral part of the Ilth Medical Company.

Western Front

by L CPL T Delaney 1 1 Med Coy - 6 B4SB

contingent of 115 Australian diggers left for France as part of Operation Western Front, to commemorate former battles of the western front, fought in France and Belgium.

The trip consisted of ceremonial occasions conducted at significant battle sites across the country, all without exception hard won with the loss of thousands of Australian diggers.

The mission coincided with the 75th anniversary of Australian victories at Mont St Quentin and PerrOne.

Guests of the contingent included 14 World War 1 veterans, seven war widows and two legatees who joined the main body as they paraded at the Arc De Triomphe, Villers Bretonneus, Fromelles, Menin Gate and Perrone.

The trip for all was educational and at times emotional as each parade had it's own story of tragic loss of life and hardship. Nowhere was this more evident than at the site of Ypres, fought at Menin Road and Plygonwood, which cost Australian forces 38,000 casualties.

As members of the contingent we were proud to be part of Operation Western Front, and more than willing to offer recognition to th@se who fell for Australia.

Apart from our official duties there was ample time allocated to see the sights of Paris. The French made us feel very welcome, especially in many of the outlying towns.

On the 7th of September 1993 the contingent departed for Australia arriving home on the 9th. The trip was very worthwhile and rewarding for us all.