

FOCUS ON . . . HOSPEX

INTRODUCTION

M Nadin¹, PF Mahoney²

¹Deputy Commander, 2 Medical Brigade, ²Defence Professor Anaesthesia and Critical Care

This short series of articles focuses on the development of HOSPEX, which is now a firmly engrained part of pre-deployment training (PDT) for both current Theatres of Operations in Iraq and Afghanistan. HOSPEX is part of a continuum of training from the individual skills taught on BATLS, basic trauma team management introduced on BATLS, surgical concepts delivered on War Surgery courses through to the whole system rehearsal offered by HOSPEX.

As well as giving clinical teams the opportunity to work together, HOSPEX provides an environment to exercise Command elements along with personnel holding key appointments such as the Deployed Medical Director. It provides high quality, responsive training- and lessons from the Joint Theatre Trauma Conferences and the Joint Theatre Trauma Registry are used to inform the clinical scenarios on HOSPEX in a similar way that

they are used to refine BATLS. Historically, Field Hospital exercises were not always thus, and the need for change is described as well as a detailed description of HOSPEX in its current format. Two invited external views discuss HOSPEX in the context of simulation and current UK simulation practice.

The deployed clinical environment is complex. Damage Control Resuscitation concepts for managing severe ballistic injury developed within the DMS go beyond current civilian protocols. Clinical personnel deploying to the current operational theatres need the opportunity to become comfortable with these in advance of using them. HOSPEX continues to develop – a recent addition is a CH47 MERT simulator to provide the link between operational prehospital care and the deployed hospital. This development is vital to ensure that Clinical PDT continues to meet the needs of our deploying personnel and their patients.

HOSPEX: A HISTORICAL VIEW AND THE NEED FOR CHANGE

CWFM Cox, P Roberts

Clinical Faculty, Army Medical Services Training Centre (AMSTC), Towthorpe Lines, Strensall

Abstract

This article briefly describes the historical background of the Cold War Hospital Exercises from which the necessity for change was identified. The genesis of the current Role 3 Collective Clinical Training is outlined.

Introduction

Hospital Exercises (HOSPEX) in the 1980's were a largely notional concern; specialist surgeons occupied a tented operating theatre for 2 or 3 nights and estimated the length of time to complete an operation on an exercise 'patient'. Oversight was provided by regular Army Umpires, who were often less experienced than the players themselves and usually treated as an adversary. Casualties were normally played by cadets and 'make up' limited; there was little or no attempt at simulation. These exercises were geared towards the Cold War with mass casualties and a hospital capacity of up to 800 beds, when exercise play focussed on moving large numbers of casualties rearwards and clinical proficiency assumed. It is against this background that the transformation of Hospex into a responsive, useful and credible predeployment activity was planned and implemented.

Identifying the contemporary requirement

Medical Role 2 Enhanced, defined as "basic secondary care facility built around Primary Surgery, ICU and beds with nursing

support" and Role 3, which is "provision of Theatre secondary healthcare within the restrictions of the Theatre Holding Policy" [1] exercise-based, collective training within the AMS, evolved from the Cold War high-intensity warfighting scenarios described above that were envisaged, should World War 3 start. Regular field hospitals held an annual MAXI MASH exercise, which was deemed sufficient preparation for such scenarios. This exercise contained very little realism, virtually no simulation and much that was notional. Its lack of value in preparing teams and individuals for their war role was apparent at the beginning of the 1991 Gulf Conflict.

Little changed until the end of Operation TELIC 1 in 2003, which was the Coalition invasion of Iraq and overthrow of Saddam Hussein. Colonel Robbie Patterson had deployed as a consultant orthopaedic surgeon to a Role 3 unit during TELIC 1 and realised there was a need to radically transform pre-deployment training to make field hospitals significantly more fit for role. This was based on the appreciation of three factors:

- The changing nature of military operations and their impact on the provision of medical care.
- The changing 'political' environment of peacetime clinical practice and the impact of Clinical Governance - a process

Corresponding Author: Col P Roberts AMSTC, Towthorpe Lines, Strensall, York, YO32 9SS

of validation that maintains clinical improvement in the ascendancy.

- A demand, driven by these two factors, to increase the level of sophistication of medical care in the field.

In his role as Chief Umpire at the Army Medical Services Training Centre (AMSTC) and assisted by a small team of Reservists he set transforming the hospital exercises held at AMSTC.

His vision was to establish Role 3 Collective Clinical Training (R3CCT) as a vital activity within the AMSTC, with a fully resourced staff infrastructure, funding and a progressive annual programme of planned activity, designed to develop best collective clinical practice and team cohesion, in accordance with the imperatives of Clinical Governance. This training was to incorporate realism and credibility, and was to be achieved by innovative training methods and modalities, such as high and low fidelity simulators, as well as traditional human (casualty) simulation. This training would be lead by a clinical faculty with previous and contemporary operational experience.

As a result of this initiative, R3CCT has been transformed. A Faculty has been established to facilitate and continue this transformation. In particular, realism and credibility in R3CCT is now the norm, which is important because more and more exercise players possess increasingly sophisticated operational experience. It is thus paramount that clinical training builds on this experience. That said, R3CCT needs to compensate for the disparate clinical background of exercise players, whilst, at the same time promoting teamwork within a group of people, often meeting for the first time at AMSTC. There is also a requirement to meet the needs of operational medical commanders.

In transforming the Hospital exercise described at the start of this article into the current 'fit for purpose' activity required consideration of and action on the factors listed in Table 1.

Problem	Action
The initial R3CCT effort was heavily dependent on a small group of Reservist personnel providing the Faculty.	The Faculty needed to grow and have an appropriate proportion of Regular clinical personnel.
Not all Defence Consultant Advisers (DCA) were engaged in the strategic planning of training.	A closer relationship between the Faculty and DCAs needed to be forged.
Individuals' professional skills were already established and accredited but the acquisition of military clinical currency needed to be improved.	To allow individuals within clinical teams to enter the operational environment with confidence and competence.
Optimal use of simulators and simulated training at AMSTC had yet to be realised.	This would require additional simulator procurement and recruitment of dedicated training personnel.
A requirement to develop modular continuation training in order to minimise military medical skill fade.	

Table 1. The problems to be confronted in modernising HOSPEX

These factors have, to a greater or lesser degree, all been addressed and are described in more detail by Davies et al [2], but suffice it to say that HOSPEX continues to evolve as it seeks to accurately reflect changes to the contemporary operational environment and clinical practice.

References

1. JDP 4-03
2. TJ Davies, MN Nadin, DJ McArthur, CWFM Cox, P Roberts. HOSPEX 2008. *J R Army Med Corps* 2008; 154(3): 195-7