

# Defence Anaesthesia – Look Back, Look Forward

This supplement to the Journal of the Royal Army Medical Corps examining the Challenges in Defence Anaesthesia is the latest collection of articles that examine developments in the specialty of military anaesthesia in all its facets; previously the journal has Focused On... Pain Management (March 2009) and Intensive Care (June 2009). It is coincidentally being published close to the 20-year anniversary of the 1990-1991 Gulf War. Looking back to this conflict allows us to examine how much has changed in UK Military Anaesthesia in the intervening two decades.

32 Field Hospital was one of four UK military hospitals deployed to the Arabian Gulf in 1991. It was located in the desert in Northern Saudi Arabia and housed 200 beds, eight operating tables, eight resuscitation bays and a treatment department. The resuscitation teams comprised three people (a doctor, nurse and medic) with responsibility for two resuscitation bays each. Anaesthesia duties were to be shared with Dental officers and the McVicar operating tables were arranged in zig-zag fashion in the open tented area with the two head ends close together. This meant that, if required, one anaesthetist could look after two patients at once. Anaesthesia was given with the triservice kit using halothane and trilene. The 'Cold War' template of the hospital meant that critical care as such did not exist. The long tented corridors of the hospital were dark and in January 1991 the complex was very cold at night. Fortunately the anticipated casualty load did not arrive – and those patients who came through the hospital were given the best care the staff could offer with the materials and equipment to hand. I am grateful to the mentors who gave a good grounding in the resuscitation and anaesthesia of the ballistic casualty.

The Camp Bastion hospital in Afghanistan, 20 years later, is a very different place. The workload is intense. The equipment within the hospital is first class. CT scanners and digital X Ray have revolutionised our ability to image the severely injured and plan their care. Joint training on the MOST course and HOSPEX

mean that the deployed teams have a shared understanding of military damage control resuscitation concepts- and the role of anaesthesia within this. Our strong links with the Combat Casualty Care programme at DSTL Porton Down has meant that quality research is used to underpin our protocols- or where this is impractical give us a sound theoretical basis for what we want to achieve. The current state of development of the deployed hospital including intensive care and regional analgesia systems would not have been imagined by our teams in 1991.

Getting to this point has not been straightforward. As a cadre we owe a great debt to a series of Defence Consultant Advisors and single service consultant advisers, supported by key members of the clinical cadres, who have pushed at the boundaries of deployed anaesthesia and worked with the Surgeon General's Department and PJHQ to get new equipment and materials into service.

The collection of articles in this supplement gives a flavour of the level of care that these efforts have facilitated.

Not all deployed operations are, or will be, like Bastion. Everyone who has been on short notice entry operations will know the compromises that have to be made when working within a strict air cargo constraint. Defence Anaesthesia can be very proud of all the contributions made to the care of our combat casualties- but it is important as a cadre that we continually learn from our experiences, research emerging questions and contribute to ongoing operational training so the best of our practice can be adapted to whatever environments and situations we need to face in the future.

This collection of articles is a very welcome contribution to this process and I am very grateful to the editor and the journal for supporting us.

**Col Peter F Mahoney**

Defence Professor of Anaesthesia

## The Future for Military Anaesthesia After Operations in Afghanistan

### Introduction

The provision of military anaesthesia has evolved dramatically during the last few years and more specifically during Op HERRICK. The input from Defence Anaesthesia into casualty care is greater now than at any previous time. Anaesthesia as a whole provides medical capability throughout the casualty pathway almost from point of wounding through all echelons of care including Aero Medical evacuation both tactically and strategically to Role 4 and beyond with input at the Defence Medical Rehabilitation Centre at Headley Court and the Regional Rehabilitation Units.

The foundation of deployed medical capability is rooted in three factors. Having the appropriately *trained* individual, *equipped* in the correct manner and *commanded* effectively to deliver the right care at the right time in the right place. The

pace of change that has occurred during HERRICK has been frenetic. This has been in response to the demands placed upon us by the casualty load and complexity of injury. The fact that Defence Anaesthesia has been up to the challenge is in no small part due to the professionalism and leadership of every single deployed anaesthetist as well as the guidance and tenacity of various members of the cadre. As is inevitable at this time with the ramifications of the Strategic Defence and Security Review (SDSR) still to be fully absorbed, we must look to the future. What threats and challenges are likely to confront us in the future and how are we best to meet these challenges?

There are many lessons to learn from HERRICK, however we should not just try and duplicate the model that is so successful in Afghanistan in the next conflict. The pace of change that has occurred in Afghanistan was required to meet the challenges that