‘IN ARDUIS FIDELIS’ (‘steadfast in adversity’) is the motto of the Royal Army Medical Corps (RAMC) of the British Army. Together with the Royal Army Veterinary Corps, the Royal Army Dental Corps and the Queen Alexandra’s Royal Army Nursing Corps, the RAMC makes up the Army Medical Services. The RAMC as it is known today was formed in 1898 having operated under different guises and titles providing medical care in conflict and peace-time to the army as far back as 1660. Over the years, the officers and soldiers of the RAMC have distinguished themselves both through achievements in medicine and also through bravery in combat.

The most notable contributions of the RAMC to medicine include the discovery of the anopheles mosquito as the vector for the malaria parasite by Surgeon-Major Sir Ronald Ross (awarded the Nobel Prize in Medicine in 1902); the identification of the causative organism of brucellosis by Major-General Sir David Bruce, and the identification of the trypanosome as the infective organism of leishmaniasis by Lieutenant-General Sir William Leishman.

The Victoria Cross, the highest military decoration for valour ‘in the face of the enemy’ was instituted in 1856. It has been awarded to 27 medical personnel. Six of these were Irish doctors. Surgeon-Assistant William Bradshaw (born in Thurles, Co Tipperary, awarded during the Indian Mutiny); Surgeon-Captain Thomas Crean (born in Dublin, awarded during the Boer War); Surgeon-Major Sir Owen Edward Pennefather Lloyd (born in Co Roscommon, awarded in Burma); Surgeon-Assistant William Manley (born in Dublin, awarded in New Zealand); Colonel John Cremin (born in Bruff, Co Limerick, awarded in Burma while serving with the then Indian Medical Service); and to Lieutenant-Colonel James Reynolds (born in Dun Laoghaire, Co Dublin, awarded in the South Africa Zulu War at the battle of Rorke’s Drift which is immortalised in the Michael Caine movie ‘Zulu’).

In the history of the Victoria Cross, only three men have been awarded a second VC (known as the VC and bar). Two of these men were doctors of the RAMC. Captain Noel Chavasse was awarded both VCs during World War I. The first was awarded in 1916 for having led a group of volunteers into no-man’s-land over a 36-hour period to rescue wounded soldiers while under constant enemy fire. The second, sadly awarded posthumously, was in 1917 when despite serious wounds he remained at his post treating the wounded. He subsequently died of these wounds. As a medical student he had undertaken his clinical elective at the Rotunda Hospital, Dublin.

Under the Geneva Conventions of 1949 and its subsequent Additional Protocols of 1977, the role of medical personnel in combat is defined. While armed, usually with a rifle and side-arm, a medical officer is only permitted to fire in anger if one believes there is a direct and immediate threat to one’s life, the lives of patients or the lives of others. To do otherwise breaches international law and is considered a war crime. A medical officer must give the highest possible standard of medical care to the wounded with no regard to whether they are friend or foe, and that medical care must be given to the most severely wounded first no matter what their affiliation.

A little over 18 months ago I was commissioned as an officer in the RAMC. The initial phase of training takes place at the Royal Military Academy, Sandhurst, UK. All British Army officers undergo training at Sandhurst. The Professionally Qualified Officers Course (PQO) trains all doctors, nurses, pharmacists, physiotherapists, dentists, veterinarians, lawyers and padre in basic military skills and in leadership. In the past, the PQO course duration was a little under four weeks; however, in the high tempo climate of operations in recent years the course has been extended to three months.

The physically, mentally and emotionally exhausting course aims to train officers in military skills and physical robustness. The physical training programme aims to have all entrants achieve the basic minimum fitness requirements of the army – a timed 2.4km run/sit-ups/press-ups and a timed 13km march carrying a 20-30kg load. Long hours are spent at physical fitness, outdoor survival, radio...
communication procedures, navigation and map-reading, weapon-handling and marksmanship, military tactics, behavioural science and communication skills.

Performance is assessed mainly during mid and end of course training exercises, where skills learned are tested under conditions of sleep deprivation, fatigue and cold – trying to stay warm for six nights in a ditch in mid-February having patrolled and marched all day, often with over 40kg of equipment, is very testing. However, the team work and comraderie it inspires is tremendous and I am fortunate to have made good friends, many whom I hope will be life-long.

Leadership is encouraged throughout, with a strong emphasis on the values and standards of the army – selfless commitment, respect for others, loyalty, integrity, discipline and courage, both physical and moral. Through observation of the behaviour of the instructors; our own past experiences; and our own trial and error, I believe each of us identified and demonstrated the style of leadership we believe works for each of us individually.

It is not just about using the authority of our rank to order subordinates to carry out tasks, but a far deeper-reaching bond. I believe it to be the earning of an absolute trust of those under one’s command, to have their wellbeing as a highest priority and to inspire them to persevere through example. In simple terms, it is to rest when you have ensured that they are able to rest, to take food after they have eaten and to ensure that each person in your team knows that you are working harder than anyone to bring about the success of the task at hand.

The second phase of training was in the medical aspects of the military. It involved three months of modules from primary care, occupational medicine and tropical medicine through to Battlefield Advanced Trauma Life Support (BATLS) and Major Incident Medical Management and Support (MIMMS).

In recent years, the survival of battlefield casualties has improved dramatically. Equipment such as the combat application tourniquet (CAT) and haemostatic gauze packing (celox) has led to marked improvement in the control of compressible catastrophic haemorrhage – the leading cause of death in conflict-related trauma. The use of the Medical Emergency Response Team (MERT), essentially a helicopter emergency room manned by an emergency/anaesthetic consultant, paramedics and nurses, has dramatically shortened the transfer of the casualty from point of wounding to field hospital facility while providing trauma care in transit.

However, despite the advances in medical equipment and rapid transport to medical facilities, it can be argued that what saves the most lives is the medical training that is given to the soldiers which allows them to provide rapid first aid to keep the casualty alive until medical personnel reach the casualty.

Following completion of this course, medical officers are then attached to units across the UK and Germany. The medical officer takes command of the medical centre (regimental aid post) within the unit. In a large garrison medical centre there will be a number of medical officers, while single regiment/battalion barracks may be single-handed practices.

The medical officer will have a medical sergeant as their primary support – much like a practice manager. There will be a team of medics (combat medical technicians), similar to paramedics, that provide the medical support to the soldiers. As well as providing medical care, the medical officer is responsible for the continued training/education, appraisal and management of the medics under his or her command. The medical officer is responsible for maintaining the health of the unit and thus its combat effectiveness. The medical officer sits within the commanding officers’ circle of senior officers and advises on all health-related matters.

While quite busy and extremely challenging at times, it is a highly rewarding job and a privilege to provide care to soldiers that perform difficult tasks in hazardous settings. The coming months will see a significant number of my intake of medical officers deployed overseas on operations. One can only hope that we can provide high quality medical care in these challenging environments, remaining steadfast in adversity.

Major Dan Murphy, RAMC, who qualified in Ireland, is the regimental medical officer to an infantry battalion. He is currently on operations in Afghanistan.