Welcome the wounded: Australian service nurses in recent theatres of conflict

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Abstract

An exhibition titled *Nurses: from Zululand to Afghanistan* opened at the Memorial in late 2011. The exhibition examines an important but often neglected aspect of Australian involvement in war. This paper is a collation of research undertaken to support the exhibition, and covers the period from the end of the Vietnam War to the current involvement in Afghanistan, to chart the development of modern-day service nursing. The personal stories of service nurses across five very different episodes of Australian wartime and peacekeeping commitments – the Persian Gulf War, Rwanda, East Timor, Iraq, and Afghanistan – illuminate the challenges faced by nurses on a deployment, and the skills, courage and dedication that they have historically brought to their missions.

Introduction

A Tuesday in September:

There is little more confronting than treating one who wears your uniform. I ask myself how I return home, how I return my team home, if we leave one of our own behind. As we worked with our Australian casualties I made a concerted effort to remember the Christian names of each of the boys as we treated them so that when I spoke to their mates and Commanders throughout the night I hoped that I could convey that they were as important to us as they were to them, and that there was absolutely no chance we would leave them behind.[1]

[1] Cooper, Squadron Leader Sharon, "Military Nursing in Afghanistan, 2008", in Ekins, Ashley and Stewart, Elizabeth (eds.), *War wounds: the medicine and trauma of conflict*, Wollombi, NSW, Exisle Publishing, 2011, p. 199.

This passage from a nurse's diary could have been written in any of the conflicts to which Australian nurses have deployed. Traditionally, the nurses' foremost duty has been to provide medical care to Australian soldiers wounded in battle, and nurses continue to regard this responsibility as the definitive act of their service. This diary entry was, in fact, written by Squadron Leader Sharon Cooper during her three-month deployment to Afghanistan in 2008. In most ways, the requirements of contemporary service nursing of Cooper's generation differs vastly in nature from its earlier incarnations, but the values and philosophies that have permeated service nursing since its historical beginnings remain at its core.

Image 1: Wendy Sharpe, *Three female nurses attending patient, Dili hospital, East Timor*, watercolour, pastel on paper, 23 December 1999 AWM ART91188.005

Such themes of change and continuity are explored in a travelling exhibition titled *Nurses: from Zululand to Afghanistan*, that opened at the Australian War Memorial in December 2011 before moving to other centres. This report is a compilation of research for the exhibition, which was conducted over six weeks as a summer scholar at the Memorial in early 2011. Though the exhibition will cover a much longer period of time, this report specifically covers service nursing since the

Vietnam War, with a focus on the different roles that Australian nurses have played in conflicts since 1990. The evolving identity and experience of service nursing is explored through stories from five different conflicts: the deployment of Australian nurses to the US Navy Hospital Ship *Comfort* during the First Gulf War of 1990–91, the peacekeeping operations in Rwanda in 1995, in East Timor/Timor-Leste since 1999, and the recent experiences of nurses in Iraq and Afghanistan. This report covers the background to these conflicts, the structure and timing of the deployments of Australian nurses, and their experiences on deployment. Stories from nurses have been collected from interviews, service newsletters and written memoirs, and it is through their personal accounts that the physical, emotional and moral undertakings of the role have been articulated.

All nurses referred to in this report are nursing officers, which is a specific position within the services for qualified nurses. Throughout the 1970s and 1980s, the present structure of qualification and rank progression was formalised for nurses, and in 1988 the Royal Australian Army Nursing Corps (RAANC) became a specialised officer corps when all non-commissioned nursing assistants were transferred out of the nursing corps to the medical corps. In the Royal Australian Navy (RAN) and the Royal Australian Air Force (RAAF), nursing officers were integrated into their respective services once the women's services were disbanded in the mid-1980s, and nurses hold the equivalent nursing and officer qualifications to those held by members of the RAANC.

Research on these recent conflicts remains a work in progress as official documents are still closed, official histories are not yet complete, and the Memorial's collections from these wars are still in the embryonic phase. The inclusion of these most recent conflicts in this exhibition has been a catalyst to developing a more extensive collection of objects and stories relating to service nursing, and establishing links with the community of service nurses. Memorial staff have undertaken oral history interviews with a number of nurses, many of whom have donated photographs, medals, uniforms and other relics from their deployments.

Post–Vietnam: a period of rapid change

After the Vietnam War, service nursing underwent a period of modernisation that transformed it into the structure that exists today. Some of these developments reflected the changing position of women in the civilian workforce, while others were a consequence of the continuing integration of the ADF health services.[2] While this process has stripped service nursing of some of its iconic features, such as the traditional capes and veils, the nurses are forging an identity in new ways through the work that they have undertaken since the 1990s.

In 1970, the Royal Australian Army Nursing Corps (RAANC) became the first of the three nursing services to allow women to retain their positions after marriage, and from 1975, the policy of automatic discharge on pregnancy was rescinded.[3] On 15 June 1972, Lieutenant Gregory Law was appointed as the first male nursing officer in the RAANC. At the time, there was considerable resistance to males entering the corps, with Law's appointment having been deferred as long as possible after his conscription as a National Serviceman.[4] The other services maintained female-only nursing corps until their respective women's services and nursing services were disbanded and integrated into the wider RAAF in 1977 and the RAN in 1985. Males remain a minority in the ranks of service nursing, but nevertheless have had an important impact on the service, as they have been able to fill combat support positions, including participating in active operations, that have been traditionally unavailable to women. Figures from 2005 show that of a combined force of almost 500 ADF nurses (both permanent and reserve), 36 per cent were male.[5]

The acceptance of male nurses and the integration of the women's corps into the mainstream services had significant consequences for female nurses. By 1979,

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[2] "About Joint Health Command", Joint Health Command, accessed 31 March 2011, <http://www.defence.gov.au/health/about/i-about_jhc.htm>
[3] Bassett, Jan, *Guns and brooches: Australian army nursing from the Boer War to the Gulf War,* Melbourne, Oxford University Press, 1992, p. 203.
[4] Bassett, *Guns and brooches*, p. 204. Also note: conscription into the National Service operated from 1964 to 1972.
[5] Stackpool, Andrew, "Fast Facts", *Air Force news*, 2005, accessed 31 march 2011 at <http://www.defence.gov.au/news/raafnews/editions/4723/images/14-fast-facts.gif>

females across the three services had been granted equal pay with their male rank equivalents. New uniforms were also implemented in stages, with the RAANC switching from their traditional grey uniforms to green ones in 1978, and RAN nurses losing the final components of their traditional uniform, including the veils, in 1984.

The 1970s and 1980s also saw the formalisation of the nurses' career path. Nursing officer applicants today are expected to have completed their university degree, be registered with a state regulatory body, and have demonstrated two years of experience in an acute care setting.[6] Qualified nurses are accepted as nursing officers on probation, to undergo basic military training in their selected service and attend officer training. The formalisation of the dual role of nurse and military officer is a defining feature of the modern ADF nursing services, and the increased operational tempo since the 1990s has given many nurses the opportunity to distinguish themselves in leadership roles. The responsibility of command is explored in several sections of this report.

Despite deployments to many dangerous and volatile situations as part of both war and peacekeeping operations, at the time of writing no nurses have been killed in combat situations during or since the Vietnam War. However, the nurses' stories that follow demonstrate the difficult and dangerous circumstances in which they perform their work, and also highlight the ability of the nursing services to adapt to the changing nature of contemporary warfare, in which new demands have been placed on the nurses to negotiate complex conflict environments. A dramatic development post-Vietnam was the introduction of weapons for nurses on deployments, and this has had significant consequences for the nursing role. From 1988, members of the RAANC were expected to carry side arms when on duty in theatres of combat. Prior to this directive, there had been resistance to the idea of

[6] Australian Defence Force, "Navy: Nursing Officer", Defence Jobs, PDF downloaded 31 January 2011, <http://www.defencejobs.gov.au/navy/jobs/NursingOfficer/>; Australian Defence Force, "Army: Nursing Officer", Defence Jobs, PDF downloaded 31 January 2011, <http://www.defencejobs.gov.au/army/jobs/NursingOfficer/>; Australian Defence Force, "Air Force: Nursing Officer", Defence Jobs, PDF downloaded 31 January 2011, <http://www.defencejobs.gov.au/airforce/jobs/NursingOfficer/>

nurses carrying arms. Director of Nursing Services (DNS), Colonel S.J. Southwell wrote, "My policy is that they don't carry arms ... It's a tradition as far as I'm concerned, the nursing corps have never carried them ... I go back to the Geneva conventions ... we're protected."[7] However, the following DNS, Colonel Jan McCarthy, issued the new directive in June 1988 for "RAANC members to participate fully in drill practice and parades by carrying Arms", and in theatres of combat "for last resort protection of their patients and themselves".[8] Pistols were soon replaced with rifles, and in East Timor, nurses were even involved in patrolling the perimeter of the hospital compound. Most recently, several male nurses with special forces training deployed to Afghanistan and participated in combat operations and patrols, as well as providing immediate medical attention to injured Australian and allied personnel.

The other defining theme of the post-Vietnam era has been the humanitarian and peacekeeping activities of the ADF, which have become a key element of the modern identity of service nursing and have been an important factor in many nurses' decision to join the services. With the advent of international peacekeeping operations after the Second World War, there was a major shift in the identity of the patient, as nurses faced floods of "wild-eyed refugee children and the shell-shocked and dispossessed people who daily faced a battle for survival."[9] These activities have also brought about opportunities for the ADF health services to work in multi-national teams, through which the Australians have forged an international reputation as a professional and highly trained force.

Persian Gulf War

On 2 August 1990, Iraq launched its invasion of Kuwait, and within 12 hours had seized control of its neighbour. The international community voiced its condemnation of the invasion by invoking the United Nations Charter and imposing

[7] Bassett, *Guns and Brooches*, p. 205.
[8] Bassett, *Guns and brooches*, p. 205.
[9] McCullagh, Catherine (ed.), *Willingly into the fray: one hundred years of Australian Army Nursing*, Newport, NSW, Big Sky Publishing, 2010, pp. x–xi.

economic sanctions on Iraq. On 8 August, the United States announced the deployment of a substantial force to the Gulf, and with Britain and the support of most Arab nations, began to establish a multinational taskforce. Australia was also concerned about the balance of power in the Middle East, and eager to see the international system succeed in the face of Iraq's aggression.[10] On 10 August, Prime Minister Bob Hawke announced Australia's involvement in the coalition, under the auspices of the United Nations. This was the first Australian deployment to an active war zone since Vietnam.

A RAN Gulf Task Force took part in the naval blockade to impose trade embargoes on Iraq, and Australia also contributed two ten-person surgical teams (the Australian Task Group Medical Support Element [TGMSE]) to serve on the US Navy Hospital Ship *Comfort*. On 18 September 1990, TGMSE 1, consisting of 17 RAN permanent, two RAN reserve personnel, and one army surgeon embarked on the *Comfort*. This group, which included 6 women, comprised two anaesthetists, two surgeons, four nurses and twelve general nursing aides and operating theatre technicians. The presence of this team allowed US medical teams to deploy out to other ships as required.

The *Comfort,* a huge white ship with the iconic Red Cross painted prominently, was a converted oil tanker carrying a US Navy medical team of over 1,200 personnel. It held twelve major operating theatres (comparable with a major city hospital), a thousand hospital beds (including 80 intensive care beds), a large dental section, pathology and blood banking facilities, X-ray and CT scan equipment, and burns therapy.[11] The Australian nurses were briefed to expect mass casualties and the possibility of NBC (nuclear, biological and chemical) warfare. From the outset, this created a sense of tension on board, which was compounded by the risks inherent in operating in oil-polluted and mined waters, and often engulfed in the thick black smoke from burning oil wells.

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[10] Londey, Peter, *Other people's wars: a history of Australian peacekeeping*, Crows Nest, NSW, Allen and Unwin, 2004, p. 154.
[11] McCullagh, *Willingly into the fray*, p. 238.

Image 2: USNS *Comfort*, carrying 1,000 hospital beds and a crew of 1,200, is refuelled in the Gulf. (Source: Sea Power Centre)

The *Comfort* received its first serious casualties in November when four sailors from USS *Iwo Jima* were evacuated to *Comfort* with life-threatening burns caused by a high pressure jet of superheated steam.[12] Six others in the same incident had died instantly. The four were treated for 48 hours by a team that included Australian doctors and nurses; however, with 100 per cent burns, none survived. Senior Australian nurses helped to counsel those from the medical team who had not previously experienced such horrific injuries.[13]

In January 1991 the nature of the war escalated from a trade blockade to an intensive air and bombing campaign known as Operation Desert Storm, and on the cusp of this operation, TGMSE 1 was replaced by TGMSE 2 and 3. These two teams,

[12] Flynn, Commodore Michael, "Commodore Michael J Flynn, RANR", in Mortimer, John and Stevens, David (eds.), *Papers in Australian maritime affairs No. 28: the RAN in the Gulf 1990–2009*, Sea Power Centre – Australia, p. 279.
[13] Flynn, "Commodore Michael J Flynn, RANR", p. 279.

comprising 40 personnel in total, were tri-service in their composition, with nine army and eight RAAF personnel and the remaining 23 from the RAN. Among them were four RAANC nursing officers, including Captains Diana Kumnick and Nick Masotti, both Intensive Care Unit (ICU) nurses, who had to quickly overcome the unfamiliarity of life on a naval ship. The daily routine focused on intensive training programs and drilling for the potential handling of mass casualties and chemical contamination. As Kumnick recalled:

> There were quite a few patients on board with various ailments, a few accidents, minor ops, but none in ICU. Our days were spent doing drills, drills and more drills. Casualty receiving drills, fire drills, evacuation drills, gas drills, lifeboat drills. Then we had lectures, in-service training, everything possible to try and improve our readiness and to stave off boredom and frustration. [14]

Masotti also highlighted the novel nature of the types of drills that the Australian medical teams were exposed to on board the *Comfort*, including "drills for NBC warfare, egress [escape simulations], decontamination and mass casualty drills, all of which were eye-openers for us."[15]

The Australian nurses recalled the need to adapt quickly to the American accent, and the different terminology used for familiar equipment.[16] They found their American counterparts to be highly professional and very welcoming. Kumnick thought that sharing operating theatres with American nurses was an exercise in professional development: "There were so many specialist nurses and doctors who dealt with trauma on a daily basis back in the States that there was a great opportunity to learn and share experiences."[17] The Australian nurses in turn contributed to on-board entertainment, with Kumnick involved in a typically Australian celebration:

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[14] McCullagh, *Willingly into the fray*, p. 239.
[15] McCullagh, *Willingly into the fray*, p. 244.
[16] McCullagh, *Willingly into the fray*, p. 237, 239.
[17] McCullagh, *Willingly into the fray*, p. 239.

> On Australia Day we Aussies made it our business to advertise our country by putting up posters of kangaroos and koalas … In the afternoon we staged a demonstration game of cricket – not easy with the ball tied with fishing line to stop it falling into the sea.[18]

The onset of the ground invasion on 24 February 1991, announced to the crew via the public address system, changed the atmosphere on the *Comfort* from one of restless waiting to one of tension. Masotti was confronted by the dimensions of the task ahead:

> We were warned that they expected upwards of 20,000 casualties on the first day, a number that boggles the mind. I just sat there a little overwhelmed; I could not even imagine that number. But as true dedicated professionals, everyone just went about their business with increased fervour and zeal. [19]

Fortunately, these figures were never realised. The general 60-bed hospital ward saw an average of 20 medical and surgical patients a day, most of whom stayed three or four days, and all of whom were non-battle casualties from surrounding ships – much below the capacity of the *Comfort*'s facilities.[20] Despite a sense of anti-climax, the nurses were thankful that there were no battle casualties. Kumnick summarised this feeling:

> I think the fact that the ship was positioned in the thick of the action with all the manpower and training and technology to provide the soldiers every care if needed, gave us all a great feeling of achievement. It certainly gave the soldiers on the ground a sense of "comfort" knowing we were there.[21]

Rwanda

In the early 1990s, many Australians had little awareness of the land-locked central-African country of Rwanda. Rwanda had a long history of civil unrest, due to conflict between its two main ethnic groups – the minority Tutsi and the majority

[18] McCullagh, *Willingly into the fray*, p. 241.
[19] McCullagh, *Willingly into the fray*, p. 244.
[20] Bassett, *Guns and brooches*, p. 210.
[21] McCullagh, *Willingly into the fray*, p. 245.

Hutu – and a history of colonial rule that had aggravated this relationship. Following renewed fighting from 1990, a peace agreement was signed in August 1993, and the small United Nations Assistance Mission in Rwanda (known as UNAMIR) was deployed to monitor the situation. After the assassination of President Habyarimana, who had favoured peace, a militia group of Hutu extremists called the *Interahamwe*, began a wholesale slaughter of Tutsi and moderate Hutus. As many as one million people were killed in this act of genocide from early April until mid-July 1994, and an estimated 2 million refugees fled to neighbouring countries.[22]

On 21 July 1994 Prime Minister Paul Keating announced the commitment of a medical contingent to Rwanda as part of UNAMIR II, and around 300 Australian personnel deployed as Australian Services Contingent (ASC) 1, known as AUSMED (comprising a medical team of doctors, nurses and medical/nursing assistants, and an infantry force for protection and logistics). This mission, named Operation Tamar, was to last one year from August 1994, with a second rotation of a further 300 personnel to deploy in February 1995. The first and second contingents comprised 16 and 22 nursing officers respectively.

ASC 1 arrived on 22 August 1994, in the wake of a genocide committed with extraordinary speed, to a country still ravaged by civil war. By this time, the Tutsi-dominated Rwandan Patriotic Army (RPA) was fighting its way back into Rwanda and had claimed back the capital, Kigali, taking revenge for the initial genocide in the process.[23] The public health system had completely collapsed, water and power supplies were not operational, and schools and businesses were in ruins.

Major Beverley Wright of the RAANC was appointed the senior nursing officer during this first rotation. She recalled that prior to the arrival of ASC 1, an advance party of 74 Australians had entered Rwanda to begin to establish a working medical facility in the Central Hospital Kigali. She wrote: "Evidence of significant carnage was everywhere: patients had bolted leaving intravenous lines dangling,

[22] Fry, Gavin, *Rwanda: the Australian contingent 1994–1995*, Canberra, Defence Centre Publishing, 1996, p. 5; O'Halloran, Kevin, *Pure massacre: Aussie soldiers reflect on the Rwandan genocide*, Newport, NSW, Big Sky Publishing, 2010, pp. 17–18; Londey, *Other people's wars*, p. 197.
[23] Fry, *Rwanda: the Australian contingent*, p. 30.

and the walls were splattered with the blood of those fleeing for their lives."[24] As nurses had done in many previous deployments, Major Wright's team continued the intensive scrub-down of the hospital wing, in order to establish a functional intensive care unit, operating theatre, x-ray department and a general ward. From the outset, the AUSMED team had the capacity to act beyond its role of providing medical support to the 5,500 UN personnel, and opened its doors to a flood of local civilians.

The Australians were faced with trauma injuries of a type and scale not usually seen in Australia, and some nurses experienced a steep learning curve in treating grenade injuries and gunshot and machete wounds. Many nurses also had rotations out of the Kigali hospital to refugee camps, such as in Butare and Kibeho, as many refugees required attention for old wounds that had never been treated. The contingent also provided preventive and environmental health programs, including mass immunisations and water quality testing, and training programs for Rwandan hospital staff. In November 1994, Australian nurses sought an arrangement with two wards at the Kigali hospital run by non-governmental organisations (NGOs), to implement training programs for the Rwandan nurses. Major Wright believed that one of the most significant legacies her team could leave would be higher levels of health care and hygiene practices. She recalled:

> The specific areas of need that were identified were many and varied. They were addressed by strategies such as initiating a daily ward routine which saw the Rwandan nurses included in the ward rounds with [our] surgeons. This was vital in preventing patients we had cared for from being neglected when they returned to the NGO section of the hospital.[25]

Her team were mindful of the cultural differences, as well practical inhibitions such as lack of running water, that challenged their efforts to change ingrained habits:

[24] McCullagh, *Willingly into the fray*, p. 292.
[25] McCullagh, *Willingly into the fray*, p. 294.

> We do not impose 1st world standards, value judgments or our own culture on these folks but come from a perspective of respecting their cultural beliefs and customs and see ourselves very much as visitors to their country.[26]

By the end of the first six months, the contingent had made a significant contribution to the stabilisation of Rwanda by assisting with the re-establishment of permanent health care. However, the situation deteriorated again, and the new year saw increasing instances of violence around refugee camps as the RPA tried to shift the masses of displaced persons out of the longer-term camps.[27] It was into this renewed tension that the second contingent deployed.

Image 3: AUSMED personnel treating refugees at Kibeho in the wake of the massacre. (AWM P02211.021)

RAANC Nursing Officer Captain Lewis MacLeod deployed with ASC 2 in February 1995. For the second rotation of AUSMED staff, the crisis point occurred from 22 April 1995, when a month of suppressed violence erupted at the Kibeho Internally Displaced Persons camp and RPA soldiers massacred up to 4,000 refugees.

[26] Newsletter, Wright, Lt-Col Beverley, November 1994, p. 2., AWM PR00581.
[27] Fry, *Rwanda: The Australian Contingent*, p. 53.

The Australian medical personnel and their infantry escort were faced with the terrible situation of watching while RPA soldiers attempted to goad them into breaking with the UN mandate by shooting women and children in front of them. The Australians held to their mission and provided what relief they could to the wounded and dying at Casualty Clearing Posts. On the following day when they returned, their first task was to count the dead.

The Kibeho massacre put the contingent's capabilities to the test in a number of ways. MacLeod recalled that their wing at the Kigali Hospital was filled to capacity: "After Kibeho we operated non-stop for 48 hours and they just kept coming through the door." Captain MacLeod had struggled to find an operating theatre for a boy who had been evacuated from Kibeho with shrapnel in his chest:

> I remember [Nursing Office in charge] Mary Brandy stuck her head through the door [and said,] "You've got another one coming in 15 minutes"… So I went next door and quickly made up [an] operating theatre ... and he came in ... he had a nick the size of a match head in his aorta, and so all we did was put one suture in this kid. But the story behind him was that his Mum said ... if you get hit, run to the "masunga", the white people, so he did that ... He survived, and for weeks afterwards he would come and kiss us and [say] "Thank you for saving me." And the RPA were after him, because he was a Hutu ... so we tried to protect him. I don't know what happened with him.[28]

In the wake of the Kibeho incident, the Australians were faced with coming to terms with what they saw and the role they played. As MacLeod reflected:

> I think we were all fatigued; the ones that had been there were certainly traumatised. I was talking to the medical officer, and she was just sitting on the step looking out ... I just sat down beside her and said, "How yer goin?"… they call it the thousand-yard stare.[29]

For his performance during the Kibeho incident, MacLeod was awarded a Nursing Service Cross. There are plans to conduct a further oral history interview

[28] Interview, Capt Lewis MacLeod, 11 July 2005, AWM S03383.
[29] Interview, Capt Lewis MacLeod, 11 July 2005, AWM S03383.

with him to learn more about the circumstances under which he worked in Rwanda: he had a multifaceted role as a theatre nurse and at the Casualty Clearing Posts in Kibeho, as well as having a pivotal role in supporting contingent personnel throughout the ordeal. MacLeod's medal will be loaned to the Memorial for the duration of the nurses exhibition.

East Timor

Australia's next major peacekeeping commitment was much closer to home. In May 1999, Indonesia, Portugal and the United Nations signed an agreement for the conduct of a referendum in East Timor, so that the people could vote on the matter of their independence from Indonesia. The election was overseen by a United Nations contingent of mainly civilian volunteers and civilian police, including members of the Australian Federal Police. Despite this, instances of Indonesian military personnel and sympathetic militias intimidating East Timorese were rife.[30] When, on 30 August 1999, the East Timorese voted resoundingly for independence, the Indonesian military and East Timorese pro-Indonesia militia groups unleashed a campaign of wholesale destruction, burning business and government premises, and displacing hundreds of thousands of East Timorese from their homes. At least hundreds were killed during this period.[31]

Subsequently Australia led an international peacekeeping mission into East Timor to quell the situation. Indonesia was unwilling to accept the peacekeepers in East Timor, but international pressure soon caused them to accept the force, which deployed on 20 September 1999. They were known as the International Force East Timor (INTERFET) and operated under a United Nations Security Council mandate. This was Australia's first opportunity to lead a multinational military mission. The deployment was intended as a short-term emergency intervention, and on 27

[30] Horner, David, Londey, Peter and Bou, Jean, *Australian peacekeeping: sixty years in the field*, Port Melbourne, Vic., Cambridge University Press, 2009, p. 103; Londey, *Other people's wars*, p. 237.
[31] McCullagh, *Willingly into the fray*, p. 355.

October 1999 was replaced with the United Nations Transitional Administration in East Timor (UNTAET), which remained until East Timorese independence in 2002.[32]

At the time when the pending deployment of INTERFET was gaining momentum, RAANC nursing officer Lieutenant Kristy Sturtevant was on long-term study placement at Liverpool Hospital in Sydney. Here, she received some practical advice from a mentor, "who gave me a contaminated-waste bag, [and] took me around the whole department to get paediatric equipment ... So I had a big rubbish bag full of cannulas and fluids and stuff for kids … knowing from past experience that's probably the first thing we would see."[33]

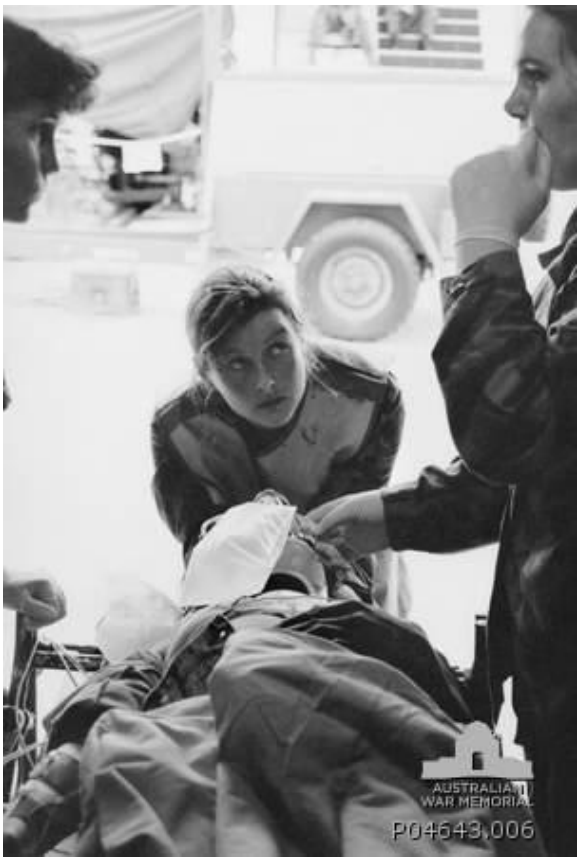

Image 4: Captain Kristy Sturtevant and her team resuscitate an East Timorese woman who fell from a truck. (AWM P04643.006)

[32] Horner, et al., *Australian peacekeeping*, p. 104.
[33] Interview, Capt Kristy Davies (formerly Sturtevant), 14 October 2005, AWM F08185.

Sturtevant arrived in East Timor on 1 October 1999, and was struck by how quiet the streets of Dili were, with the majority of the population having fled to surrounding hills. The hospital was based in an old museum, and backed onto an airstrip. The commanding officer decided that the hospital staff would perform their own security patrols, and nurses found themselves in an uncommon situation. The INTERFET personnel worked under a UN mandate that imposed strict limitations on the peacekeeping force. They were not to fire upon any parties except in defence of themselves or other people.[34] Furthermore, the nurses' Red Cross armbands identified them as non-combatants, and taking up arms on patrol seemed like a potential conflict with the Geneva Conventions that protected the nurses. As Sturtevant recalled in an interview with the Memorial in 2005:

> It was a little disconcerting to be on a gun picket with your weapon over the wall when you had a red cross on. It was a little bit confusing at times as to where did you draw the line. And we also had to do protection for the environmental health people … which felt a bit odd as it wasn't really a role that we were there [for].[35]

Sturtevant was deployed to lead the 1st Field Hospital resuscitation team, but initially found herself in a primary health care role, treating troops with dengue fever, and administering immunisations to INTERFET personnel. The hospital facility soon started to see lines of East Timorese seeking medical assistance, and the less urgent medical cases had to be sent away to the nearby French Red Cross hospital, while surgical cases were treated at the 1st Field Hospital. Sturtevant's bag of paediatric supplies was handy for dealing with younger patients.

When she assumed her role in the resuscitation team, it kept her tied to the "resus" bay, as they had to remain in a state of readiness for incoming patients. The fluctuations of traffic through the hospital facility were demoralising at times when the wards were busy and the resus team could not leave their post, but Sturtevant said:

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[34] Londey, *Other people's wars*, p. 244.
[35] Interview, Davies, 14 October 2005.

> It was a big thing for morale over there for the soldiers to know that if anything happened there was an Australian resus team, or a Singaporean resus team just waiting, ready to take them …We used to play celebrity heads with post-it notes on our heads [while we waited].[36]

Since arriving, the medical personnel, much to their frustration, had been restricted to the hospital compound for their safety. This was somewhat relaxed after INTERFET was relieved by UNTAET. Subsequently, Captain Sturtevant (recently promoted from lieutenant) and her resus team were sent out to a truck accident to perform triage, resuscitation and evacuation of more than 20 casualties. She recalled:

> We didn't really have [any lighting], so we got all the vehicles around in a semi-circle and we had the high-beams on and we had to be careful we didn't run the batteries out, but we had the [helicopter] coming in as well so it had its bright light on, and we had the head torches on as well.[37]

She added: ""We must have spent about 12 hours out in the field doing the actual clearance and control and getting them all back."[38]

Flight Lieutenant Sharon Cooper of the RAAF, deployed to East Timor in a subsequent rotation with the 3rd Combat Support Hospital, similarly recalled the frustration of being restricted to the hospital compound for the first few weeks.

> The only way for us to get out and explore Dili was if we went out and did the mosquito fogging run with the Environmental Health Team … Everyone was desperate to get their seat … because that actually gave us [a view of] the city of Dili, the absolute devastation that had occurred in Dili, but also, I desperately wanted some insight into the population that we had been deployed to help.[39]

Cooper followed the tradition of many of her nursing predecessors and became involved with a local orphanage in Dili. "That was probably the highlight of my deployments. It took me away from the hospital ... and it gave me a way of

[36] Interview, Davies, 14 October 2005.
[37] Interview, Davies, 14 October 2005.
[38] Interview, Davies, 14 October 2005.
[39] Interview, Sqn Ldr Sharon Cooper, AWM S04790.

delivering aid to East Timor in my own way, and worked with the children of East Timor."[40]

Iraq War

The 11 September 2001 terrorist attacks against the United States had a dramatic effect on Australian defence policy, and were the catalyst for Australia's involvement in two wars early in the 21st century. Australian operations in Iraq began in March 2003 when a US-led coalition invaded the country in the wake of the attacks. US President George W. Bush had argued that a threat was posed by hostile nations such as Iraq, who potentially held chemical, biological and radiological (CBR) weaponry.[41] As in the previous Gulf War, the threat of this type of warfare created an atmosphere of tension, and required specially trained CBR response units to remain on standby.[42]

Iraqi forces were defeated in a just over a month, and the capital, Baghdad, and the city of Basra were simultaneously taken by coalition ground forces. However, a guerrilla war ensued with Iraqi forces that opposed the occupation, and this costly campaign continued until combat troops withdrew in 2009. A significant component of Australia's mission, Operation Catalyst, was to contribute to the stabilisation of the country by training Iraqi personnel to take responsibility for their own security.[43] Over 20,000 ADF personnel deployed over this period.

This war, like the one that has been waged in Afghanistan since late 2001, was in marked contrast to the experiences of peacekeeping and humanitarian work that the nurses had seen since the First Gulf War. The nature of warfare in these two conflicts was such that nurses were under direct threat from insurgent activity, and also saw a much higher number of Australian and coalition troops in need of life- and limb-saving treatment. Medical support for Australian personnel was provided

[40] Interview, Cooper.
[41] McCullagh, *Willingly into the fray*, p. 399.
[42] Almond, Lt Kate, "Selfless service", *Army: the soldiers' newspaper*, accessed 31 March 2011, <http://www.defence.gov.au/news/armynews/editions/1077/features/feature02.htm>
[43] Department of Defence, "Operation CATALYST Iraq", Department of Defence, accessed 31 March 2011, <http://www.defence.gov.au/opEx/global/opcatalyst/>

in a number of ways. The RAN deployed HMA Ships *Kanimbla* and *Manoora* as Primary Care Reception Facilities with surgical and Intensive Care Unit (ICU) capabilities, and Aero Medical Evacuation teams were used to transport casualties to the ships. Several rotations of tri-service medical teams also deployed to US field hospitals in a reciprocal arrangement whereby Australian medical teams could be housed in a fully operational hospital, and in turn fill niche clinical roles in the American teams.[44]

Lieutenant Darren Stendt, a Nursing Officer in the RAANC, was deployed to Iraq as an ICU nurse in April 2005. Stendt had a background in the infantry and extensive experience as a critical care nurse, but nevertheless found the volume of patients and extreme trauma injuries to be a confronting experience.[45] He and a tri-service team of 20 Australian medical personnel were posted to the US 32nd Expeditionary Medical Group Air Force Theatre Hospital in Balad. This major field hospital provided full-spectrum treatment to coalition forces, civilians and contractors, Iraqi forces and civilians, and also to enemy prisoners of war (EPWs).[46]

Stendt treated a range of patients during his six-month deployment, and remembers in particular the case of 10-year-old Basima, who had presented with a gunshot wound to the head. Basima recovered from surgery in the ICU, and Stendt performed the critical care nursing duties. He trained the little girl's father to perform the tasks of washing her and changing the bed sheets, as staff resources in the busy hospital were stretched, and the hospital facility experienced large numbers of high-dependency patients. Basima's father returned daily to follow her progress, communicating only in broken English and sign language with the medical team. Basima required oxygen via a tracheostomy and regular antibiotics over an extended stay in hospital, but eventually was ready for discharge.

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[44] Rosenfeld, Jeffrey, Rosengarten, Andrew, Paterson, Michael, "Health support in the Iraq War", *ADF health*, vol. 7, April 2006, p. 2.
[45] Stendt, Darren, "A nurse's experience in Iraq", *ADF health*, vol. 7, October 2006, p. 87.
[46] US Air Force, "Fact Sheet", 332nd Expeditionary Medical Group, accessed 31 March 2011, <http://www.balad.afcent.af.mil/library/factsheets/factsheet.asp?id=4033>

> One day when her father stepped out, she was dressed and sat out of bed. When he returned, he was reduced to tears of joy. For the first time, he had seen her dressed, like a girl, sitting in a chair holding a doll. As the tears fell, he waved his arm in a blessing towards me and the ICU doctor, and he picked up an Australian flag which was hanging on a nearby wall, draped it around himself and kissed the Southern Cross.[47]

Many other cases did not bring any joy, as Stendt also nursed patients with debilitating injuries, often sustained from blasts from improvised explosive devices (IEDs). These did not discriminate, and Stendt provided intensive care to innumerable coalition and Iraqi troops and civilians who had sustained horrific wounds. He wrote in an article for *ADF health* magazine that the volume and repetitiveness of these traumatic injuries, and his inability to communicate with his patients (as they were either intubated for breathing assistance or spoke little English) were at times demoralising on long shifts in the ICU ward.[48] Some patients could not be identified, while others were known to have lost their families and homes to the war. These kinds of experiences took a significant toll on the nurses, who strove to treat their patients with humanity and dignity. As Stendt wrote:

> The dying often came to the ICU, where they were usually left in the care of the chaplain or a nurse … these patients had unrecoverable injuries and were palliated in the ICU, sometimes for hours until they died. Iraqi or American, they were not to die alone.[49]

Flight Lieutenant Amanda Banks has told the story of caring for a critically injured Iraqi woman during her posting to the same medical facility in Balad. The woman, whose husband had been identified as an insurgent, had sustained severe wounds and 80 per cent burns when a bomb that she had been making had

[47] Stendt, "A nurse's experience in Iraq", p. 89.
[48] Stendt, "A nurse's experience in Iraq", p. 88.
[49] Stendt, "A nurse's experience in Iraq", p. 90.

exploded.[50] Banks recalled the Geneva Convention, and her role to provide medical care to all. She volunteered to care for this woman.

> I found myself comparing our lives, my uniform with my boots covered with human body fluids and her dress. Her hair was long, matted and full of straw, blood and cow dung. Mine was pulled back in military style with hairnet and two pins. I cut hers into a modern style and hoped it was culturally appropriate. Her acceptance of her missing husband killed in Fallujah, while my loving boyfriend had just proposed to me in Venice and was safe back in Australia for Christmas. Her face, arms and legs were disfigured from burns – my face, legs and arms were thinner from cafeteria food and long working hours.[51]

Banks's and Stendt's stories illuminate the depth of empathy that the nurses displayed during the shared hours and the intimacy of providing physical care, in spite of cultural and ideological differences. Banks received the Nursing Service Cross for her performance on deployment to Iraq.

Afghanistan

Contemporary with most of the commitment in Iraq was Australia's deployment to Afghanistan, where a coalition of international forces sought to combat the terrorist organisation Al Qaeda that had been supported by that country's Taliban regime. On 7 October 2001, Operation Enduring Freedom was launched against Al Qaeda and Taliban strongholds, which involved small numbers of coalition troops (including Australian special operations forces) supplementing US-led air-strikes.[52] The Taliban surrendered on 9 December 2001, but the coalition of international forces was to continue in the longer term as the International Security Assistance Force (ISAF), under a UN mandate and the leadership of the

[50] Stackpool, Andrew, "'I love you. You saved my life'", *Air Force news*, accessed 31 March 2011, <http://www.defence.gov.au/news/raafnews/editions/4723/features/feature03.htm>
[51] Stackpool, "'I love you. You saved my life.'"
[52] Department of Defence, "Progress in Afghanistan since 2001 fact sheet", Department of Defence, accessed 31 March 2011, <http://www.defence.gov.au/op/afghanistan/info/factsheet.htm>

North Atlantic Treaty Organisation (NATO), conducted counter-insurgency operations and sought to stabilise Afghanistan.[53] The Australian commitment was named Operation Slipper, which was withdrawn from December 2002, but renewed in September 2005 following a surge in Taliban activity. The focus of Operation Slipper was to disrupt insurgent activity using special operations forces, and to contribute to the stabilisation of Afghanistan with an element known as the Reconstruction Task Force. The role of the ADF health services has been to support the reconstruction phase by contributing to the re-establishment of a healthcare system, as well as supporting the Australian and coalition troops with immediate medical and surgical support.

Image 5: A recent donation to the Memorial, this nurse's uniform with the Red Cross brassard was worn by Flight Lieutenant Heather Dodd as part of the Australian Medical Task Force 2. (Author's own image)

In 2008, Squadron Leader Sharon Cooper (RAAF) was deployed to lead the ADF critical care team at the Dutch medical facility at Tarin Kowt in Afghanistan.

[53] Department of Defence, "The International Security Assistance Force fact sheet", Department of Defence, accessed 31 March 2011, http://www.defence.gov.au/op/afghanistan/info/factsheet.htm>

Cooper's eloquent diary entries from her three-month deployment demonstrate her remarkable attitude towards leadership, and compassion towards her charges, but also highlight a theme of Australian nurses rising to the dual challenges of leadership and nursing roles in war. On her second deployment to East Timor in 2004, Cooper (then a flight lieutenant) had sustained severe injuries in a helicopter crash while flying to the aid of an East Timorese woman undergoing an obstructed labour. After 12 months of rehabilitation, including learning to walk again after a serious spinal fracture, she resumed unrestricted service. Her experience of previous deployments and her own recovery from injury were critical in shaping her service in Afghanistan as commander of a RAAF combat surgical team. An extract from Cooper's diary reads:

> A Thursday in July
>
> I already feel incredibly attached to my team, and I think I catch glimpses of their attachment to me ... I struggle with the knowledge that I cannot protect them from their personal experiences of this journey ... I can't deliver them home to their families in the condition I received them.[54]

Cooper's team consisted of 13 medical personnel, of whom the majority were reservists. They were working in a Dutch facility that was essentially a series of shipping containers arranged down a corridor. The Australians established a strong working relationship with their Dutch counterparts, as Cooper discussed in an interview with the Memorial:

> The majority of the Dutch spoke English. We didn't speak any Dutch at all ... In high stress situations like a trauma or resus, the Dutch would revert to their language. Which I'm sure that if we spoke a second language, we would revert to English as well ... that's the most effective way to communicate in a high-stress situation. But if we asked them to speak English they would revert back.[55]

[54] Cooper, "Military Nursing in Afghanistan, 2008", p. 192.
[55] Interview, Cooper.

As in many previous deployments, the surgical team treated the worst kinds of physical injuries of warfare. Patients were brought in with traumatic amputations, stabbing and gunshot wounds, and blast injuries, including the devastation caused by IEDs, which maimed both civilian and soldier indiscriminately. Cooper's diary gives insight into the diverse presentations to the critical care ward at the Tarin Kowt hospital:

> A Monday in August
>
> Big trauma day. Biggest so far. Up from 0600 until 0300 with only two very short sit-down meals for rest.
>
> First patient – Local National Policeman. Execution type gunshot wounds x 3 … My doctors, having done all they can, have shown such sensitivity to this man and his family, explaining that there is nothing more that can be done. I watch the pain and remorse on their faces. The patient was so annoyed with them. Not because of the news that they were delivering, but because the time they were taking to do so was interfering with his enjoyment of fresh fruit being fed to him by the nurse.
>
> … Second patient – Local national. Gunshot wound x 2, chest and L thigh. Flesh wounds only. Very lucky, good prognosis. Not keen to talk or even give us a name. Whose side is he on?
>
> …Third and final patient – NATO soldier with traumatic amputations of both hands. Apparently he was adjusting a grenade on his belt, behind his back, when it exploded.[56]

The members of the surgical team were also brutally reminded of their primary purpose when they received word of incoming injured Australian soldiers:

> A Tuesday in September
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> We received the largest number of Australian combat casualties in one attack since the Vietnam War ... There is little more confronting than treating one who wears your uniform.[57]

[56] Cooper, "Military nursing in Afghanistan, 2008", p. 197.
[57] Cooper, "Military nursing in Afghanistan, 2008", p. 199.

In Afghanistan new previously unknown circumstances for Australian service nursing have also emerged. In 2008, Captain Roneel Chandra deployed with Special Operations Task Group Rotation 7 as a specialist nursing officer to work in a multinational team attached to the US Air Force 305th Rescue Squadron. After completing his nursing qualification as a trauma and ICU nurse, Chandra joined the Army Reserve as an infantryman and later joined the regular army. In 2005, he decided to leave the infantry and join the nursing corps, and after being accepted into the special forces, joined the 2nd Commando Regiment. This background and specialist training gave Chandra a different perspective on the nursing role – a perspective that had historically been denied to the all-female nursing services in past conflicts. Likewise, Lieutenant Darren Stendt undertook another deployment to Afghanistan, this time as a member of the 1st Commando Regiment as the unit's first nursing officer.[58] He has unique experience as a nurse deployed in the field, who has "participated in offensive operations" and was present at some of the major incidents the Australian troops have experienced in Afghanistan.[59] These kinds of postings foreshadow a new era in the use of nursing officers in theatres of conflict, and there is little doubt that the nature of the nursing officer role will continue to adapt to modern warfare, and as debate continues about women filling frontline combat roles in the ADF.

Conclusion

The citation for the Nursing Service Cross reads: "For outstanding devotion and competency in the performance of Nursing duties".[60] Devotion is a weighty word, but it is certainly a theme that runs throughout the history of service nursing. The willingness of Australian nursing officers to put their own lives at risk to deliver life-saving care, and their dedication to all patients, regardless of origin, are

[58] Email correspondence with author, Stendt, Darren, 14 February 2011.
[59] Email correspondence with author, Stendt, Darren, 14 February 2011.

[60] Australian Government, "Search Australian Honours", It's an Honour, accessed 31 March 2011, <http://www.itsanhonour.gov.au/honours/honour_roll/search.cfm?aus_award_id=1132122&search_type=quick&showInd=true>

representative of the values and philosophies that have permeated service nursing since its historical beginnings, and often their duties take a significant toll on them personally. Yet, tellingly, it is frequently the nurses who say they are "grateful" to have been sent into the fray.