Draft PDF

of correspondence of the late George Stretton Gunter

in relation to

his membership of

The National Medical War Planning Committee

1967 to 1970 (approx)

ALL COMMUNICATIONS SHOULD BE
ADDRESSED TO THE
COMMONWEALTH DIRECTOR OF HEALTH

TELEPHONE NOS.: FB 4121-5

TELEGRAMS:
"QUARANTINE, MELBOURNE"

IN REPLY PLEASE QUOTE
...../.....
....

COMMONWEALTH OF AUSTRALIA

DEPARTMENT OF HEALTH
(VICTORIAN DIVISION)
COMMONWEALTH CENTRE,
CNR. SPRING AND LATROBE STREETS,

Melbourne, C.1 [illegible] *19*....

CONFIDENTIAL

Mr. George Gunter,
417 St. Kilda Road,
MELBOURNE, Vic.

Dear George,

In my discussion with you recently I outlined the present position of our Surgical Instrument lists.

Special Kits

The stage has now been reached where a new list for each specialty has been reproduced. This list has been rationalized with the Army Catalogue to a point where it now only requires your final word that the Army alternatives are acceptable or otherwise.

I am enclosing copies of the new lists, unfortunately there are not enough Army Catalogues for issue, and you will notice that the new lists show -

(a) Our Consolidated List Numbers (alphabetically);

(b) An Army Catalogue Number;

(c) Some underlined items.

The underlined items are those which need your special attention as these items were on your original specialty list but are not catalogued by the Army.

General Kit

There is included herewith also the final draft of the General Surgical Instrument Kit which has been rationalized throughout with the Army Catalogue. You will notice that we have in some cases adopted an item where the Army already listed a "near miss". In others we have felt that their specification was inadequate although their item was otherwise satisfactory. In this latter case it is apparent in discussion with Army representatives that it is perfectly feasible to add further specification to define the right instrument and this has been done.

Finally, I would ask that you not only select as between the underlined which is your item and the "near miss" Army one which is immediately above it, but that you also ensure that no items on your original list have been omitted through clerical oversight. I've been through them all but I still think that it requires further checking.

Once more, I am deeply indebted to you for your work in this matter and would be very grateful if you could finally sort this out.

If you need help with the catalogue at this stage either Mr. Rees or I can provide the information for you.

Yours sincerely,

Stanley F. Reid.

PLASTIC SURGICAL KIT

No.	Consolidated List No.	Army Catalogue No.	Item Name and Description	Unit of Issue	Quantity	Trade or Catalogue No.
1	93	6515 307/0	Forceps, mosquito, 5 in.	pairs	8	848
2	125		Forceps, Nasal, Asch	pair	1	DOWN H274
3	126		Forceps, Nasal, Walsham, R + L	pairs	2	H1894 THACK
4	174		Gag, mouth, Kilner	set	1	1107
5	150	6515 374/5	Hook, skin, Gillies	each	4	562
6	149		Needle-holder, Gillies (Stille) right handed	each	2	
7	311		Needles Suture, No. 6 "eye curved	dos.	x	
8	311		" " No. 3 "eyes curved	dos.	x	
9	311		" " No. 16 C.C.E.	dos.	x	
10	13		Raspatory, bone, Bristow, 9"	each	x	
11	~~290~~	~~6515 617/0~~	~~Razor, skin grafting, Blair~~	each	1	
12	290	" "	~~Spare blades~~	each	12	
			~~Skin graft knife - Humby type and spare blades~~ SPARE BLADES for -			
13	243		Retractor, catspaw	each	2	
14	245		Retractor, cheek, double ended open wire	each	2	2540 Dental Army.
		6515 642/0	Scissors			
15	283	" "	(d) surgical, straight, blunt and sharp, 5 in.	pairs	1	

No.	Consolidated List No.	Army Catalogue No.	Item Name and Description	Unit of Issue	Quantity	Trade or Catalogue No.
16	291		Skin Grafting Boards, 6" x 3"	each	2	
17	310		Suture Material 3/0, 4/0, 5/0 Silk (mersilk or equivalent)		x	
18	315		Syringe, dental chip	each	2	

(As Modified to 29.10.64)

BASIC GENERAL SURGICAL KIT

instruments unless specified otherwise are s.s.

Consolidated List No.	Army Catalogue No.	Item Name and Description	Unit of Issue	Quantity	Remarks
	6515 48/0	Apparatus, extension			
357	" "	(d) Kirschner Wires 25 cm. x 1.5 mm	doz.	6	Add "Kirschner"
		Aspirating Set		2	Luer syringe and needles s standardized. Tubing and adaptors not required.
		Syringe 20 cc. with Luer fitting 2 or 3 way tap with Luer needles 4" long 12G - 2 14G - 2 16G - 2 18G - 2			
		Bone Fixation Appliances			
101	6515 113/5	(c) Forceps, bone holding			
		(ii) Hey Groves, 12 in.	pair	2	
285	" "	(h) Screwdriver, plain to fit Sherman screws	each	1	
	6515 114/0	Bone-Lever, Lane			
17/85	" "	(b) 12 in.	each	x	B2462 THACK
22	6515 137/0	Brace, Hudson	each	1	
22	" "	with burrs 1 medium (conical)	each	1	
22	" "	1 small (conical)	each	1	
22	" "	perforators 1 medium	each	1	
22	" "	1 small	each	1	
66		Bradawl, Dental (Boots) with eye	each	1	Add "with eye"

Consolidated List No.	Army Catalogue No.	Item Name and Description	Unit of Issue	Quantity	Remarks
		Cat Gut			
361		atraumatic 2/0 Curved Intestinal Chromic	doz.	x	
362		2/0 Straight " "	doz.	x	Transfer to Dressings Panel
363		2 Chromic	doz.	x	
364		2 Plain	doz.	x	
365		2/0 Plain	doz.	x	
366		2/0 Chromic	doz.	x	
		Catheter, IR, Tieman's			
33	6515 184/2	(a) Size 7E	each	2	
33	" "	(b) Size 8E	each	2	
33	" "	(d) Size 10E	each	2	
32		Catheter, Neoplex (Porte) Size 24F	each	6	
	6515 185/5	Catheter retention, 5 ml balloon			"Return flow" not required. I fact, not made in this type. With this part out, Army identification acceptable, b "curved" must appear in introducer.
36	" "	(b) Size 18	each	6	
30	" "	(d) Introducer, curved (ACMI 2563)	each	1	
35		Catheter, Urethral, Foley Owens, 22F, 30 cc bag	each	6	
34		Catheter, Urethral, Whistle Tip, 22F (Neoplex)	each	6	
42		Clamp, Aortic, Beck	each	1	

Consolidated List No.	Army Catalogue No.	Item Name and Description	Unit of Issue	Quantity	Remarks
	6515 203/5	Clamp Haemostatic Blalock Cross Action, s.s.			
44	" "	(c) 1 1/16 in. jaw by $2\frac{3}{4}$ in.	each	6	
	6515 204/1	Clamp, Intestinal, Kocher			
51	" "	(a) Straight, 4" blade	each	2	add "4" blade"
46		Clamp Coarctation, Aorta, Crafoord's curved	each	2	
43		Sleeving for above	yard	1	
56		Clip Towel, Backhaus	each	6	
		Colostomy Rod Glass, 4" x $\frac{3}{8}$"	each	4	
75	6515 251/0	Dissector and Suture Carrier, McCormick, $7\frac{1}{2}$ in.	each	1	
222	6515 252/0	Director, fistula, Brodie, probe pointed, $6\frac{1}{2}$ in.	each	1	
77	6515 253/0	Director and probe, Watson Cheyne	each	1	
76		Dissector, McDonald, $7\frac{1}{2}$"	each	1	
80	6515 262/0	Drill, surgical, Chuck pattern in box - Zimmer large	each	1	"Zimmer large" must appear a this drill is used also for Kirschner wires in the war May therefore need separate Identification Number.
	6515 262/1	Drill, surgical, bits for			
80	" "	(a) 1/16 in.	each	x	
80	" "	(b) 3/32 in.	each	x	
80	" "	(c) $\frac{1}{8}$ in.	each	x	

nsolidated List No.	Army Catalogue No.	Item Name and Description	Unit of Issue	Quantity	Remarks
	6515 262/1	Drill, surgical, bits for (cont.)			
80	" "	(d) 3/16 in.	each	x	
80	" "	(e) $\frac{1}{4}$ in.	each	x	$\frac{3}{8}$" altered to $\frac{1}{4}$". N.B.: Als mistake in Army Catalogue.
	6515 296/0	Forceps, Artery			
97	" "	(d) Spencer Wells, curved, $5\frac{1}{2}$-6 in.	pairs	24	
94		Forceps, Artery, Negus short	pairs	1	
99	6515 299/0	Forceps, bone cutting, 8 in. straight, Listons	pairs	1	8" would do but must include "straight Listons".
	6515 301/0	Forceps, dissecting			
105	" "	(a) Plain 5 in.	pairs	2	
107	" "	(b) Plain $7\frac{1}{2}$ in.	pairs	2	
106	" "	(c) Plain 11 in.	pairs	1	
109	" "	(d) Toothed (1/2) 5 in.	pairs	2	
110	" "	(e) Toothed (1/2) $7\frac{1}{2}$ in.	pair	1	
113		Forceps, gall bladder, Kelly, c. on f., 7"-8"	pairs	6	
104	6515 303/2	Forceps, gall stone, Desjardirs, small stone, 90^{0} curve, 11-12 in.	pairs	1	Also known as Randall for ureteric stone. Separate identification number. Must be specified as shown.
100	6515 305/0	Forceps, lion, Ferguson, 9 in.	pairs	1	

onsolidated List No.	Army Catalogue No.	Item Name and Description	Unit of Issue	Quantity	Remarks
124	6515 307/1	Forceps, mosquito, curved	pairs	4	
		Forceps, skull-cutting, Wilms			Must be Wilms. Army Identification Number Required.
131		(b) Angled	pairs	1	
130	6515 319/0	Forceps, skull nibbling, Horsley narrow beaked	pairs	1	Or Northfield.
132	6515 320/0	Forceps, sponge holding, Rampley, 9½ in.	pairs	4	
135	6515 321/5	Forceps, tissue, Allis	pairs	4	
		Gauze, Oxycel (Haemostatic)	btle.	2	
144		Gouge, bone, St. Thomas Hospital Pattern - 7/16" Rounded End	each	1	Add words "Rounded End"
14	6515 374/3	Hook bone, Langenbeck	each	1	
	6515 407/0	Knife, Bard-Parker			
158	" "	(a) Handle No. 3 (to fit blades Nos. 10, 11 and 15)	each	4	
159	" "	(b) Handle No. 4 (to fit blades Nos. 20, 22 and 23)	each	6	
161	" "	(c) Blades No. 10	Pkts.	16	Presume (a) - (g) are separat identity numbers.
162	" "	(d) Blades No. 11	Pkts.	4	
163	" "	(e) Blades No. 15	Pkts.	8	
164	" "	(g) Blades No. 22 or No. 23 (407/0/h) or No. 24.	Pkts.	24	
160		Knife Handle, No. 7, (small blades) 5½" handle	each	2	

nsolidated List No.	Army Catalogue No.	Item Name and Description	Unit of Issue	Quantity	Remarks
171	6515 457/0	Mallet, metal, Heath, $1\frac{3}{8}$" diameter head	each	1	Add "$1\frac{3}{8}$" diameter head". Separate Army Identification Number. Army specification n considered sufficient.
	6515 491/0	Needle, aneurysm			
181	" "	(b) left cranked	each	1	
186	6515 499/0	Needle-holder, Hegar, 8 in.	each	1	
185	6515 500/0	Needle-holder, Matthieu, 7 in.	each	2	
390		Needles Suture, cutting edge (straight) 2"-$2\frac{1}{2}$"	doz.	x	
391		" " " " colt fine (curved) 3"-$3\frac{1}{2}$"	doz.	x	
392		" " " " (curved) 3"	doz.	x	
393		" " " " medium (curved) (size 10) 2"	doz.	x	
394		" " " " small (curved) (size 20) $\frac{3}{4}$"	doz.	x	
395		" " Mayo Trocar point, size large (sizes 1 or 2)	doz.	x	
396		" " " Taper point, size large (size 1)	doz.	x	
397		" " " " " " small (sizes 3 or 4)	doz.	x	
398		" " Round body curved, large (Peritoneal) (size 3)	doz.	x	
399		" " " " " medium (size 10)	doz.	x	
400		" " " " " small (size 20)	doz.	x	
401		" " " " " intestinal (sizes 3 or 4)	doz.	x	
402		" " Round straight, intestinal (sizes 5 or 6)	doz.	x	
403		" " " $\frac{1}{2}$ circle, intestinal (size 1)	doz.	x	

Consolidated List No.	Army Catalogue No.	Item Name and Description	Unit of Issue	Quantity	Remarks
209	6515 520/0	Osteotome, McEwen, in case (set of 5	set	1	
219		Pliers, [illegible] up to 2.5 cm [illegible]	pair	1	
223		Probe, Lachrymal, Horner type [illegible]	box	1	
224	6515 595/0	Probe, silver, malleable	each	4	Add "malleable"
	6515 614/0	Raspatory, rib, Doyen			
237	" "	(a) right	each	1	
237	" "	(b) left	each	1	
290		Skin graft knife - Humby type	each	1	
290		Spare blades for	each	6	
241	6515 621/0	Retractor, Army pattern, 1 in. Carry Rycll Durham type	each	2	Add "Cunny Rycll Durham type"
255		Retractor, self retaining, Jefferson type	each	2	
	6515 622/0	Retractor, copper spatula (16-20 gauge)			
246	" "	(b) 1" x 12"	each	1	
251	6515 623/6	Retractor, Langenbeck, blade $1\frac{3}{4}$ in. long x $\frac{1}{2}$ in. wide	each	2	
	6515 626/0	Retractor, single hook			
257	" "	(b) Blunt, 7"	each	2	
247		Retractor, Deaver, $\frac{1}{2}$" x 10"	each	2	

Consolidated List No.	Army Catalogue No.	Item Name and Description	Unit of Issue	Quantity	Remarks
248		Retractor, Deaver, 1" x 12-14"	each	2	
248		Retractor, Deaver, 2" x 12-14"	each	2	
263		Rugine, Nelson's	each	1	
267	6515 636/0	Saw, amputation, 9", moveable back, complete with blade	each	1	Size and moveable back necessary. Spare blades not required.
269	6515 639/0	Saw, thread, Gigli olivecrona modified, 50 cm.	each	2	These specifications must be added.
270	" "	(b) handles for	each	2	
271	" "	(c) guide for	each	1	
	6515 642/0	Scissors			
280	" "	(b) Surgical, c on f Mayo, 6"-7"	pairs	2	
279	" "	(k) Iris, straight, $3\frac{1}{2}$ in. fine point	pairs	1	
281		Scissors, tonsil, Metzenbaums, 7", C on F.	pairs	1	
282		Scissors, Metzenbaums, 10", C on F.	pairs	1	Called gall bladder or sympathectomy scissors.
416		Scoop, Volkmann, double ended, medium, $8\frac{1}{2}$"	each	1	
303		Spreader, rib, Finochietto, adult size	each	1	
289	6515 653/0	Shears, plaster, Lorenz swedish pattern, 13"	pair	1	Add "Lorenz swedish pattern 13"." These specifications must be added.

Consolidated List No.	Army Catalogue No.	Item, Name and Description	Unit of Issue	Quantities	Remarks
259		Shears, rib, Waterhouse or Pollock type, 8"-10"	pair	1	
294		Sounds, urethral, Clayton, curved, 12/16 - 24/32". Set of 7 in canvas roll.	set	1	Straight not required. Separate Identification No.
		Syringe, Toomey, 30 cc.	each	1	
325		Thread, cotton, black, No 30	reel		
		Thread, linen, 1 or 2 oz. reels			
328		(b) Size 40	oz.	x	
327		(c) Size 18-20	oz.	x	
		Thread (non-absorbable) Suture			
323		Silk (mersilk) 5/0 arterial curved [illegible] No. 12	reels	x	
324		" " 2/0 " " "	reels	x	
326		" " No. 1	reels	x	
335		Tracheotomy Set - metal tubes 26, 28, 32 and 36 size with spreader.	sets	4	See tracheostomy set attached. Modified to be complete. In ward.
339		Trocar and cannula, Nelaton's large (CU1190)	each	x	
330	6515 675/0	Wax, bone, materials - 2.5% vial		x	
	6515 675/1	Wire, suture, (Baboock type) for sternum and bone, in spools			
335	" "	(d) bone, 18 gauge (CU1194)	1 oz. reels	x	20 and 22 now required.

TRACHEOSTOMY INSTRUMENTS IN CASE - FOR A KIT IN WARD

Consists of -

Forceps - Dilating, Tousseau	1
Langenbeck $1\frac{3}{4}$" blade x $\frac{1}{2}$"	1
Retractor - Single Hook, Blunt	1
B.P. Handle for small blades	1
B.P. Blades (1 small curved)	1
(1 sharp point)	1
Tube, Tracheotomy, Metal	
26F	
Sub B 28F	1
" C 32F	1
36F	
Cat Gut 2/0	
Artery Forceps	3
R.B. Needle (small to take C.G.)	

TELEPHONE: 61 9111
TELEGRAMS: 'HEALTH, CANBERRA'
P.O. BOX NO. 93
CANBERRA, A.C.T.

IN REPLY PLEASE QUOTE 1200/1/48

DEPARTMENT OF HEALTH

CANBERRA, A.C.T.

5 JUN 1967

Mr. G. Gunter,
417 St. Kilda Road,
MELBOURNE. Vic.

Dear Sir,

The Acting Chairman of the National Medical War Planning Committee has approved of the recommendation of the Standing Committee that the Consultant group of Specialists co-opted at various times by the Sub-Committees should be established as an official Group under the jurisdiction of the National Medical War Planning Committee.

As a member of the Consultant Group who has contributed a considerable amount of work for Mr. S.F. Reid's Surgical Instruments and Hospital Equipment Sub-Committee, I would be pleased if you would advise me whether you are willing to accept appointment to this official Consultant Group.

In order that official status may be given to this Consultant Group it will be necessary for members to be security cleared. For this purpose I am forwarding herewith the form of clearance for completion.

It would be appreciated if this form could be completed by you as soon as convenient and returned to the Secretary, National Medical War Planning Committee, Box 93 P.O., Canberra A.C.T.

As it will be necessary for this completed form to be photostated, it is requested that a black biro or black ink be used.

Yours faithfully,

(T.H. Betts)
Secretary
National Medical War Planning Committee

15th June, 1967.

The Secretary,
National Medical War Planning Committee,
Department of Health,
Box 93, P.O.,
CANBERRA, A.C.T.

Dear Sir,

Your ref: 1200/1/48.

In reply to your letter of the 5th June, 1967.

I wish to advise that I am pleased to accept appointment to the Surgical Instruments and Hospital Equipment Sub-Committee, under the jurisdiction of the National Medical War Planning Committee.

I enclose herewith the completed form in connection with security clearance.

Yours faithfully,

M.S., F.R.C.S., F.R.A.C.S.

Encl:

11

7th September, 1967.

Secretary,
National Medical War Planning Committee,
Department of Health,
CANBERRA. A.C.T. 2600

Dear Sir,

Your ref: 1200/1/1

This is by way of an initial acknowledgment of your letter of the 7th September, 1967 and its enclosures, with regard to Mr. Gunter's appointment to the Consultant Group of the National Medical War Planning Committee.

Mr. Gunter is at present in Vietnam and will not be returning to Melbourne until late October. Your communication will be passed on to him when he returns.

Yours faithfully,

Secretary to Mr. Gunter.

TELEPHONE: 61 9111
TELEGRAMS: 'HEALTH, CANBERRA'
P.O. BOX NO. 93
CANBERRA, A.C.T.

IN REPLY PLEASE QUOTE 1200/1/1

DEPARTMENT OF HEALTH

CANBERRA, A.C.T. 2600

7 SEP 1967

Mr. G.S. Gunter,
404 Albert Street,
EAST MELBOURNE C2. VIC. 3002

Dear Mr. Gunter,

At the first meeting of the National Medical War Planning Committee, held in Canberra, on Friday 25th August, 1967, your appointment to the Consultant Group was confirmed.

In advising this decision, I desire to inform you that as this Consultant Group is an official body under the jurisdiction of the National Medical War Planning Committee, members will be entitled to the allowances and fees as now applies with members of the main Committee and Sub-Committee. These allowances and fees to the Consultant Group will be applicable when members are co-opted to attend meetings of Sub-Committees or Working Parties as required.

The attached format which sets out the fees and allowances for members of the main Committee, Standing Committee and the Sub-Committees, will also apply to members of the newly formed Consultant Group.

Also enclosed, for your information, is a copy of the role of the National Medical War Planning Committee.

I desire to inform you that advice has been received that you have been security cleared to "Secret Level".

Yours sincerely,

(T.H. Betts)
Secretary
National Medical War Planning Committee

NATIONAL MEDICAL WAR PLANNING COMMITTEE

Allowances and fees for members of the National Medical War Planning Committee, Standing Committee and Sub-Committees.

The rates of these allowances are determined from time to time and the current rates, effective as from 25th January 1966, are shown below:

TRAVELLING ALLOWANCES

All members of Committees and Sub-Committees are eligible for travelling allowances if they are necessarily absent from home overnight in order to attend meetings. The amounts payable to individual members, other than officers of the Commonwealth Public Service are as follows:

Chairman (or Acting Chairman) at the rate of $17 per day

Members - at the rate of $13.50 per day

NOTE: Claims will be calculated on an hourly basis.

SITTING FEES

Members of Committees and Sub-Committees who are of independent status and are not receiving continuing salaries (e.g. private medical and dental practitioners and private pharmacists) are eligible for sitting fees as follows:-

Chairman (or acting chairman)	$30.00 per day
Members	$25.00 per day

FARES

All members of Committees and Sub-Committees are entitled to free transport to and from meetings. Air Travel bookings are arranged through the offices of the Commonwealth Department of Health in the capital cities and members will be contacted by these offices to ascertain their booking requirements. These offices also usually arrange cars when required for members. However, if a member attending a meeting has to personally hire and pay a taxi or car to take him to or from the meeting the expenses incurred will be refunded if a claim is received on a Treasury Form 12A (available at meetings). Claims of cash payments exceeding $1.00 should be supported by a receipt.
Note. Any cancellation of travel should be notified immediately to the Commonwealth Department of Health.

PAYMENT OF TRAVELLING ALLOWANCES, EXPENSES AND SITTING FEES.

All claims by members for payment of travelling allowance, expenses and sitting fees, should be submitted to the Secretariat of the meeting concerned or to the Secretary, National Medical War Planning Committee P.O. Box 93 Canberra, A.C.T.

(T.H. Betts)
Secretary
National Medical War Planning Committee

1.5.67

CONFIDENTIAL.

PROPOSED REVISED STATEMENT OF THE ROLE OF THE CENTRAL MEDICAL PLANNING COMMITTEE

Peacetime - Planning at the National Level.

The functions of the Central Medical Planning Committee are exercised in relation to the defence planning situation approved by the Government from time to time. In general terms the functions are to investigate and determine the measures which need to be taken to ensure the maintenance of a proper balance in the provision of medical and ancilliary personnel, facilities, equipment and supplies for members of the Armed Services and civilians with a view to the maintenance of the highest standard of medical practice that can be provided by available national resources.

In particular the exercise of these functions involves:-

- The continuous review and assessment of the likely demands from the Armed Services and State and Commonwealth authorities for medical and ancilliary manpower, equipment and supplies.
- The determination of what is essential medical equipment and supplies.
- The continuous review of the resources of medical manpower, equipment and supplies. This would include the preparation and maintenance of a register of medical practitioners and appropriate information about ancilliary medical personnel in conjunction with the Department of Labour and National Service; the preparation and maintenance, through or in conjunction with the appropriate authorities, of statistics of hospital and emergency hospital accommodation, equipment and supplies; surveys of the stocks held, present and potential capacity of industry and trade; etc.
- The marrying of demands for medical resources to the resources likely to be available and the isolation of deficiencies, weaknesses and surpluses.
- The working out of the measures that would be necessary to overcome, eliminate or alleviate the anticipated problems and the bringing of these before the appropriate authority.

/2

CONFIDENTIAL.

- The preparation of advice to the Commonwealth Government on policy matters arising in the course of planning the use of medical manpower, equipment and supplies and the channel for submission of these matters (The C.M.P.C. itself would be expected to determine matters where Government policy aspects are not involved).

Except where circumstances otherwise demanded these matters would be covered in broad general terms.

Peacetime - Operational Planning

4. The C.M.P.C. would not be responsible for the preparation of operational plans. This planning is the responsibility of the Armed Services in relation to service personnel and of the State Government Authorities (Commonwealth for Commonwealth Territories) in relation to Civilians.

5. The State Government Authorities may be expected to look for considerable leadership, assistance and guidance from the C.M.P.C. for some time because of the vastness of the problem, and, in the case of most States in Australia, the absence of practical experience in this field and experienced trained full-time staff.

6. On the other hand the Armed Services having properly established medical organisations with considerable experience behind them will not need to look to the C.M.P.C. to the same extent.

7. The role of the C.M.P.C. in respect of operational planning by State Governments Authorities and the Armed Services would therefore be:-

- liaise with the authorities concerned to further the co-ordination, development and implementation of medical plans based upon and integrated into an overall national plan.
- assist the development of medical plans by providing national guidance on policy and problems in relation to the use of medical manpower and resources; by providing information on problems to be met, and the results of the study of problems at the national level and by other countries; and by providing specific assistance as agreed with State Authorities and the Armed Services.

.../3

CONFIDENTIAL.

War.

8. The only real changes in the role of the C.M.P.C. would be:-

- the power of direction and decision would be increased as and when necessary.
- the provisioning of manpower, equipment and supplies would be brought under direct control.

COMMONWEALTH OF AUSTRALIA

NATIONAL MEDICAL WAR PLANNING COMMITTEE

[redacted]

P.O. BOX NO. 100
CURTIN, A.C.T., 2605

28 AUG 1970

Mr. G. Gunter,
404 Albert Street,
EAST MELBOURNE, Vic. 3002.

Dear George,

You will recall that at the last meeting of the Surgical Instruments and Hospital Equipment Sub-Committee in 1967 it was decided that a trade survey should be carried out to ascertain the availability of the essential items which we considered necessary to maintain surgical services under a limited war situation. Although the survey was carried out I did not call the Sub-Committee together to consider the results because the emphasis on planning was changed from shooting to nuclear war.

About two years ago the Chairmen of the Sub-Committees were directed to give priority attention to planning services to meet the mass casualty situation which would result from a nuclear attack on one or more of the Capital cities. Quite obviously in planning for this contingency many assumptions have to be made because of the large number of unknowns. The Standing Committee has endeavoured to obtain direction on a number of factors which would have an important bearing on the functioning of a medical service under National disaster conditions. Many of the important questions still remain unanswered.

Casualties

The problem is considerable and is highlighted by the following figures which have been estimated for Melbourne which is taken as the example in the attached papers. In Melbourne it has been estimated that with a 10 megaton weapon there would be approximately 818,000 killed and 640,000 injured. The injuries will be various combinations of -

1. Radiation
2. Thermal burns
3. Traumatic injuries.

..2/

We are advised that most casualties will suffer from burns and 70% will have limb injuries. There will be also a high proportion of casualties subjected to radiation. The proportion and combination of these different types of injuries will vary with the distance from ground zero.

In the light of the problem as set out above the Standing Committee has drawn up a draft plan which incorporates the principles which have been agreed upon over a number of years. The plan has been developed on the assumption that certain essential facilities will be available but only in the outer metropolitan and country areas, i.e., it is assumed that a nuclear attack on a Capital city would destroy all the major Hospital and the key medical and nursing personnel, medical supplies, etc., in the city.

The broad medical planning envisages that there will be the following medical facilities -

(1) The first medical facility which will be close to the disaster area is known as a Forward Medical Aid Unit (F.M.A.U.).

(2) Casualties would be evacuated from these Units to large country cities or towns which have been designated. These are known as Hospital Towns.

In between (1) and (2) all the Hospitals on the evacuation route would be classified as Intermediate Hospitals.

The Forward Medical Aid Units

These would set up as near to the disaster area as possible. The prime function of these units would be to sort casualties according to an accepted classification. The only treatment given at this level would be analgesics, sedatives, bandages, haemostasis and a limited number of tracheostomies for actual or impending respiratory obstruction.

The classification of casualties would be as follows :

a. Priority I, Immediate Treatment: cases that require and should respond to immediate simple surgical procedures. Examples are :

(1) Soft tissue wounds particularly of extremities.

(2) Compound fractures of large bones.

(3) Traumatic amputations or crushing injuries of extremities.

(4) Sucking chest wounds.

(5) Burns of the head and neck requiring tracheostomy.

The number in this group is estimated to be 5% of the total casualties.

..3/

b. Priority II, Delayed Treatment: cases which require resuscitative or other supportive measures but surgical procedures can be delayed. Examples are :

(1) Moderate lacerations.

(2) Closed fractures of large bones.

(3) Second degree or mixed burns of 15% to 40% of body area.

The number in this group is estimated to be 45% of the total.

c. Priority III, Minimal Treatment: cases requiring initial medical attention and hospitalisation with minimal care. These cases may be required to return to work, assist other casualties or be evacuated to welfare centres with only out-patient type care. Examples are :

(1) Burns of the face with oedema of the eyelids and who are unable to see.

(2) Burns of the hands.

(3) Burns of less than 15% of body area.

(4) Simple fractures of small bones.

The number in this group is estimated to be 45% of the total.

d. Priority IV, Expectant Treatment: cases so severely injured that prognosis is poor and the extensive treatment, time and facilities required are not possible under mass casualty conditions. Examples are :

(1) Burns of more than 40% of body area.

(2) Multiple severe injuries.

(3) Major penetrating abdominal and thoracic wounds.

(4) Fatal whole body radiation of doses of 400 rads or more.

This group is expected to comprise 5% of the total casualties.

After sorting at the F.M.A.U., it is probable that only casualties in Priority I and II will be evacuated to Intermediate Hospitals and to Hospital towns. The difference between the number injured and the number evacuated to hospital is influenced by a number of factors. The Minimal Treatment Group will not justify hospitalisation under the disaster conditions and the Expectant Group will be too badly injured to survive with the limited treatment immediately available. These two groups account for 50% of the casualties. In addition there will be a number of casualties who will survive the explosion but will die before being rescued or be in such a poor condition

..4/

at time of rescue that they will be sorted into the Expectant Group. The total number to be evacuated to hospital is expected to be in the range of 180,000.

Those in Priority III group will be sent to a holding unit or returned to work or assist with other casualties.

Those in Priority IV will be sent to a holding unit where they will be given palliation for their symptoms.

It is apparent that the intention is to treat those with the least injuries so that they may become productive members of the community as soon as possible and those with very serious injuries will receive little more than analgesics because the intensive care necessary for their recovery will not be available.

The Intermediate Hospitals will be those distributed between the F.M.A.U.'s and the Hospital Towns. For purposes of this appreciation of the problem it is assumed that 10% of the total evacuated to Hospital Towns will be diverted to or held in Intermediate Hospitals.

At the Hospital Town level it is expected that for Victoria 120,000 casualties will require operation. This is an assumption which I have made for the purposes of this report.

Supply of surgical instruments and consumables, and hospital equipment

Only the first two of these are dealt with in this preliminary report. I have made the basic assumption that it is not practicable to think in terms of instruments in less than functioning units, for instance instruments capable of laparotomy or instruments capable of amputation.

In the first phase or stage of nuclear disaster, that is for surgery performed at an Intermediate Hospital or in the early stages at a Hospital Town I have assumed that all this surgery can be performed by the following :

1. Instruments as for a laparotomy (General).
2. Instruments to open a chest (Thoracotomy).
3. Instruments to open a skull (Craniotomy).
4. Instruments to amputate a limb (Amputation kits).

All of this is of course plus anaesthetic machines.

Because of the problem involved it was felt that an important source of instruments would be the doctor who would move with his bag to the point at which he was required. The total source of instruments, apart from any stock piling that may be necessary, would be as follows :

1. The doctor and his bag.

..5/

2. Country Hospital.

3. Interstate Hospital.

4. Interstate trade houses.

Medical Man Power

For purposes of assessing the medical man power available the Committee is in the process of compiling a medical register of all doctors throughout Australia. This will provide valuable information. In seeking this information I felt that we should attempt to estimate the instrument resources held by doctors. We accordingly asked them if they had a kit of instruments capable of performing :

1. Laparotomy;

2. Thoracotomy;

3. Amputation;

4. Craniotomy.

The purpose of this was the concept that the best functioning unit would be a doctor and his appropriate bag sent to the point at which the surgery was required. The attached papers include information on the data available up to date.

I have prepared the attached papers as a feasibility study in an attempt to present the logistics problem as far as surgery is concerned. This purports to survey the type of surgery required at various points and to estimate the total surgical instrument resources required. A separate assessment of some of the consumables required for a standard operation has been carried out and when this is elaborated it can be determined whether and to what extent stock piling of surgical consumables is necessary.

There are many wild assumptions in these documents for which I offer no apology because there is no reliable source from which any estimates may be obtained so that the figures are really in the nature of an uneducated guess.

This letter is to give you some idea of the stage and aim of the current planning. The intention is to assess requirements so that we may bring to the notice of the Commonwealth Government the necessity to establish and maintain a stockpile of instruments, equipment and consumables to ensure that casualties may be treated.

Other sub-committees have attempted to do the same in their particular fields - essential drugs and dressings. I propose to submit this preliminary document to the Standing Committee at its meeting on 17th September. This document has been sent to all members of my Sub-Committee for their examination and I would appreciate comments on many of the nebulous statements in the papers.

..6/

I have not called a meeting of the Sub-Committee to consider this matter because I felt that it would be dealt with better by individual examination rather than at a meeting which would be very time consuming and less productive.

Quite obviously there are very big gaps in the information supplied here and if you have any queries concerning the principles laid down for the emergency medical service I suggest that you contact Mr. R. V. Rees, telephone 669-2597, who would make available to you any material you may require.

Yours sincerely,

(S. F. Reid),
CHAIRMAN,
SURGICAL INSTRUMENTS AND HOSPITAL
EQUIPMENT SUB-COMMITTEE.

SURGICAL INSTRUMENTS AND HOSPITAL EQUIPMENT COMMITTEE

INDEX

SCOPE OF TREATMENT BY STAGES AND PHASES

F.M.A.U.

Haemostasis (for primary haemorrhage) - (forceps / ligature)
Tracheostomy - urgent only (not "elective" for unconscious patient)
Catheterisation - possibly
Syringes and needles for analgesics.

Intermediate Hospital

Haemostasis (for reactionary haemorrhage) (forceps / ligature)
Tracheostomy (for oedema of glottis etc. possibly few "elective" for comatose patients)
Amputation - (completion of partial amp. / gas gangrene / non viable limb)
"Craniotomy" occasional (if circumstances permit)
Close sucking chest wounds
Laparotomy (possible depending on case load)
Catheterisation for pelvic injuries etc. with retention

Base Hospital

First Phase

General Surgery

(Haemostasis (secondary haemorrhage) (forceps / ligature)
(Amputation - mangled limb
(- gas gangrene
(Close sucking chest wounds
(Laparotomy for (delayed bleeding
((low grade peritonitis
((abdominal sepsis
((obstruction (Intestinal)
(Delayed primary suture
(Incision of abscesses
(Ocular injuries
(Craniotomy
(Splintage (plaster)

Intermediate Phase

(Specialist surgery (simple repair phase) in this group

Late Phase

(Late reconstructive procedures - not budgeted for - can be supplied after the holocaust.

F. M. A. U.

3,000 casualties per day

(1)	Immediate treatment group	5%	150 per day -	6 per hour
(11)	Delayed treatment group	45%	1,350 per day -	70 per hour
(111)	Minimal treatment group	45%	1,350 per day -	70 per hour
(1V)	Expectant treatment group	5%	150 per day -	6 per hour

Plus non casualty surgery (ignored at this point)

A. Haemostasis - haemorrhage as a problem is not common in casualty surgery.

5% of group (1) + group (11) on the 1st day only	- total	80
(reactionary haemorrhage on the second day)	- total	10
	Total	90

Probably 9/10 will be secured by a pressure bandage.
Therefore 10 cases at each F.M.A.U. will require Forceps / ligature

Deduce therefore a surgeons bag will provide the forceps (24 forceps) and therefore no stock pile of instruments at F.M.A.U.

Haemostasis by catgut (already sterilised) -
2/0 x 2 standard packs - 24 off
per F.M.A.U.

B. Tracheostomy - for established and incipient respiratory obstruction (no elective tracheostomy)
(Facio-maxillary and burns) - 1% of groups (1) + (11) (1st day only)
15 maximum per F.M.A.U.

C. Analgesics - injectable - doses

700 per 1,000	=	2,100 per day
(for 3 days	=	6,300 total)

Sedatives 300 per 1,000	=	900 per day
for 3 days	=	2,700 Total

D. Catheters - Group (1) + Group (11) (ignore non casualties)
½% of (1) + (11) on the 1st day
1% of (1) + (11) on the 2nd day
½% of (1) + (11) on the 3rd day
Total 2% of (1) + (11)
30 Disposable catheters per F.M.A.U.

F. M. A. U. SUMMARY (3 Days)

1. Instruments - depend on surgeon and general practitioner and his bag. These should be doctors resident in the country.

2. Stock Pile
   A. Catgut - 2 standard packs of 12 per F.M.A.U.
   B. Tracheostomy tubes (2 sizes) 15 per F.M.A.U.
   C. Syringes for :

Analgesics	2,100	(700 per 1,000)
Sedatives	900	(300 per 1,000)

   If all analgesics given by tubunic syringes and needles - then allow 1,000 disposable syringes for sedatives and other drugs.
   D. Catheters disposable (sterile) 30 per F.M.A.U.
   E. Stretchers
   (once a casualty is on a stretcher he will probably remain on the stretcher to Hospital town)
   30% may remain on stretcher <u>at</u> Hospital town.

   Stock pile at Hospital town in F.M.A.U. packages.
   Administration - Q.M.

   (Note the sterilisation will not be necessary or practicable at F.M.A.U.)

INTERMEDIATE HOSPITAL

It has been accepted that the following figures represent the total number who will be evacuated to Hospital towns (document 6)

Priority (1)	7,500
Priority (11)	180,000
	190,000

An assumption must be made of what proportion of these patients will require treatment at an intermediate Hospital. The intermediate Hospitals may be on the chain of evacuation and if so, would be rest points for some of the evacuees. They may on the other hand be in parallel with the evacuation route.

In either case only a limited number will require treatment or diversion to an intermediate Hospital. This is assumed to be 10%.

Next an assessment must be made of a possible number of intermediate Hospitals. If it is assumed that there are five routes and two intermediate Hospitals on each route then the total number of intermediate Hospitals is 10.

The total number admitted to each intermediate Hospital will therefore be of the order of 1,900. Although the intermediate Hospitals may function for quite some time the major intake for the sort of surgery that an intermediate Hospital is intended to do, will be in the first five days.

Per intermediate Hospital the admissions then will be per day -
Priority (1) - 15 per day
Priority (11) - 360 per day

The Scope of Treatment

A. Haemostasis (reactionary haemorrhage) - (forceps / ligature
Practically all of these will be admitted in the first 2 days
If 1% of the total daily admission per Hospital for the first 2 days is calculated this comes to 8 cases requiring haemostasis.
Therefore Surgeons bag for the forceps.
Catgut 2/0 x 2 packs (24 off per intermediate Hospital)

INTERMEDIATE HOSPITAL

B. Tracheostomy - (delayed respiratory obstruction
(head injuries
first 2 days only
Assumption - ½% of the total admissions on the first 2 days to each Hospital.

4 Tubes in 2 sizes

C. Analgesics

Assumption - all patients need these.
Assumption - doses needed are 3 times per day,
Total per unit = 1,900
5,700 doses per day are required
for 3 days = 18,000
Syringes for anaesthesia - 2,5 and 10 ml
(all disposable)

D. Amputation

Assumption - if 50% of groups (1) + (11) are suffering from wounds of the extremities (it may be more) then there will be a large proportion of lacerations and compound fractures. By intermediate hospital stage there may be a large number requiring amputation for

1. (anaerobic infections
2. (mangled limbs
3. (non viable limbs

this figure may be as high as 20% of the total admitted to each intermediate hospital. If this is so provision for amputation must be made for 1/5 of 19,000 cases. In round figures this is 4,000 cases. Assumption - if there are 10 units functioning and if these admissions are spread over 5 days the total number admitted in any one day is 80 to each unit. Amputation requires an anaesthetic and takes not less than ¾ of an hour. If this optimistic figure is accepted then 18 per day can be done in each theatre, 5 Theatres (15 teams). This requires for each theatre two sets of equipment capable of amputation - 10 amputation outfits. Consumables will be the materials required for 400 amputations per unit. This includes suture, materials, catgut and thread, bard parker blades, and syringes for anaesthesia together with the appropriate intravenous and possibly inhalation anaesthetic.
An additional 10% of the admissions may need incision of abscesses (etc.) Therefore 1 further theatre with 3 more teams. 200 cases (over (5 days)) = 40 per day
2 General surgical kits for the extra theatre.

INTERMEDIATE HOSPITAL

E. Craniotomy or equivalent

1/3 of 1 theatre

Assume that 1% of the total admissions to each Hospital require some form of head surgery, which will be done if it is possible to do it. The total number of admissions to intermediate Hospital is 1% of 19,000 = 190. Spread over 10 units is 19 cases and if these are spread over 5 days it means 4 operations per day.
Therefore 1 bag capable of craniotomy + the consumables for a total of 20 operations per unit.

F. Closing Chest Wounds, etc.

1/3 of 1 theatre

Again the figure of 1% of all those admitted to intermediate Hospital is taken. If the same number of units is assumed then the total per unit will be 19 and these will probably all be admitted in the first three days. This means 7 operations per day with a total of about 20 operations.
Therefore 1 thoracotomy bag + consumables for a total of 20 operations.

G. Laparotomy or equivalent

1/3 of 1 theatre

The round figure of 1% of total admissions and the total number of units at 10 is accepted. This means 19 operations (20 in round figures) spread over 5 days.
4 operations per day (1 theatre).
Therefore 1 general surgical bag + consumables for 20 operations.

H. Catheterisation

Totals - The above figures represent 35% of the total to Intermediate Hospitals. The remaining 65% would be expectant to -

1. Expectant unit,
2. Hospital town.

INTERMEDIATE HOSPITAL SUMMARY

Summary of Requirements

1. 7 Operating theatres

18 General surgical teams
1 Neurosurgical team
1 Thoracic surgical team
} 7 Theatres

General Surgical teams do:

Tracheostomy
Amputation
Laparotomy
Haemostasis

2. 14 General surgeon bags (2 per theatre)
10 Amputation bags (2 per theatre)
1 Neurosurgical bag
1 Thoracic surgical bag
7 Anaesthetic machines

Per Intermediate Hospital

400 Amputation
20 Craniotomies
20 Close Chest Wounds etc.
20 Laparotomies
200 Incisions of abscesses etc.

i.e. 660 operations per Intermediate Hospital in 5 days with the abovementioned surgical teams.
Therefore Consumables for 660 operations per Intermediate Hospital.

HOSPITAL TOWN

The number to be evacuated to a Hospital town is

Priority (1)	7,500
Priority (11)	180,000
Total	190,000

(The 10% who are diverted or held temporarily at an intermediate Hospital are ignored).

First Phase

General surgery
Thoracic surgery
Neurosurgery
Ophthalmological Surgery
E.N.T. surgery

Most surgeons will be doing general surgery no matter what their specialty.

- Haemostasis (secondary haemorrhage) - (forceps / ligature)
- Amputation - mangled limb
  ischaemic limb
  gas gangrene
- Sucking chest wounds } Close or I.P.P.R.
- Unstable chest wounds }
- Laparotomy for - delayed bleeding
  delayed peritonitis
  abdominal abscess
- Delayed primary suture
- Incision of abscess
- Ocular injuries
- Splintage of fractures
- Cranial surgery - late compression
  compound fractures and F.B.'s.

Intermediate Phase

Repair surgery of simple type involving both General and Specialist surgery and surgeons.

Late Phase

Reconstructive surgery.

HOSPITAL TOWNS

Expected casualties = 190.000 - all Group (1) + Group (11)
70% of these will have limb injuries - (lacerations
(fractures (simple)
(compound fractures
If we now add compound fractured skulls, lacerations of the head and neck and torso, and also ocular injuries then;
It is deducted that 60 to 80% of this number will require surgery.

In round figures this is 120,000 operations. (Total)

If it is assumed that of this number 50% will require an operation lasting 1 hour
50% will require an operation lasting ½ hour
then 1 team in 8 hours could theoretically do
5 x 1 hour operations +
5 x ½ hour operations = 10 operations per day per team
If there are 3 teams per theatre = 30 operations per day per theatre

Duration of Budgeting.

If it is decided to budget for only the first 14 days in which a Hospital town will be functioning then 1 theatre could do
30 x 14 operations and this in toto is 420.

The next assumption is that in the first phase most of the surgery can be done by a general surgical outfit. There should be twice as many outfits as there are theatres so far as instruments are concerned. In addition there should be in each "General" Theatre

A. one surgical outfit capable of performing amputation
B. one thoracic surgical outfit
C. one urology outfit
D. In summary in the so called "general" theatres it is assumed that all the surgery could be performed by
general surgical outfits
amputation outfits
thoracic surgery outfits
urology outfits.

It is assumed that any orthopaedic surgery and plastic surgery could be carried out with a general surgical outfit, in these theatres.
For each theatre there would be one anaesthetic machine.

HOSPITAL TOWNS

General Surgery - 1 theatre = 30 operations per day
In 14 days = 420 operations.

Total operations is 120,000

If six hospital towns = (20,000 casualties per Town)

If there were 10 theatres per Hospital town, each Hospital Town would deal with 20,000 casualties in 60 days (3 teams per theatre 30 teams per hospital town).

If 20 theatres per town (20,000 casualties per town) in 30 days.
If 40 " " " (" " " ") in 15 days.

For Victoria

General Surgery — 6 Towns — (10 Theatres per Town) — (30 teams per Town) = 60 days for 120,000 patients.

If 10 theatres per town = 20 kits per town
Total 120 kits for 6 towns.

Total operations = 120,000
Total operations per town = 20,000 over 60 days

Total 60 Theatres
Total 180 Surgical Teams
Total 120 Kits
Total 60 Anaesthetic Machines
Total 180 Anaesthetists

To deal with the problem in 15 days the above figures would have to be multiplied by 4.

Victoria (15 days) :-

15 days — Total 120,000 casualties

240 Theatres
720 Surgical teams
480 Kits
240 Anaesthetic Machines
720 Anaesthetists

6 Towns
40 theatres per town

Consumables for 120,000 operations if done in 15 days. If it takes 30 days to do all this surgery then if we budget for only 15 days as suggested before we will budget for 60,000 operations.

HOSPITAL TOWNS

The Specialties

Those which require special instruments in the first phase are probably as follows ;

1. Ophthalmology
2. Neurosurgery
3. E.N.T.
4. Obstetrics

It is assumed that 3 theatres in each town would deal with this problem.
The first would be manned by 3 shifts of ophthalmic surgeons.
The second would be manned by 3 shifts of neuro surgeons.
The third would be manned by 3 shifts of E.N.T. surgeons and this same theatre would probably also deal with any obstetric surgery needed.

This means 3 other theatres and 3 more anaesthetic machines and 9 anaesthetists.

Summary (Specialties)

Three specialist teams in 3 theatres, assuming each operation requires 1 hour would do 72 operations per day and in 14 days this would amount to 1,008 operations.

Three ophthalmology teams manning one theatre continuously for 14 days
Three neurosurgery teams manning one theatre for 14 days
Two E.N.T. teams each doing two shifts in one theatre per day for 14 days
One obstetric team doing one session per day for 14 days.

2 Ophthalmology Kits
2 Neuro Surgery Kits
2 E.N.T. Kits
1 Obstetric Kit

} per Hospital Town

PROVISIONAL SOURCES OF SUPPLY

	Instruments	Consumables Stock Pile
F.M.A.U.	Dr. and his bag	Tracheostomy tubes, syringes, consumables, stretchers.
Intermediate Hospital	Dr. and his bag (General (Amputation (Neurosurgery (Thoracic	Tracheostomy tubes, syringes, consumables, specialist consumables, intravenous anaesthetic and syringes. Stretchers.
Hospital town	Dr. and his bag (General (Ophthalmological (Orthopaedic (Plastic (E.N.T. (O. & G. (Thoracic (Urology (Anaesthetic	All general and specialist consumables including anaesthetic gases. (Not including orthopaedic internal fixation apparatus). Plus 10% for civilian needs.

Instruments - supplement both instruments and anaesthetic machines from (Country Hospital
(Interstate Hospital
(Interstate trade houses
(Interstate doctors

Stock piling to be at Hospital town for all units.

Mechanism - a quartermaster in charge situated at the Base Hospitals.

In general stock pile only consumables.

It is not practicable to stock pile instruments.

Stretcher stock piles are critical.

Consumables - a survey has been undertaken in 2 Hospitals to determine the consumables used for typical operations.

CONSUMABLES PER OPERATION

Consumption per operation - Prince Henry's Hospital (1 hr. operations)

Thread 60 linen)
or 30 cotton) = 60 feet per operation
or 3/0 mersilk)

1 or 2 plain or chromic catgut	=	2-3 tubes or wraps / operation
3/0 plain catgut	=	2 tubes / operation
Atraumatic (2/0 chromic)	=	1 / operation
Disposable blades (No. 23)	=	2 / operation
Disposable blades (No. 15)	=	1 / operation

It would be wise to budget for the loss of 2 needles per operation as follows :
1 skin needle, that is a cutting edge needle either large or small
1 round bodied or Mayo or tissue needle per operation.

For Victoria :-

The stock piling problem for this limited representative number of Consumables used at operations is therefore the above figure multiplied by 126,000 plus 10% for civilian use.

120,000	at Base Hospital
6,000	" Intermediate Hospital
126,000	

For Victoria Instruments Only

1. F.M.A.U. (45)	General Bag	2 x 45	90 General Kits
2. Intermediate Hospital (10)	General Bag	14 x 10	140 General Kits
	Neurosurgical	1 x 10	10 Neurosurgical Kits
	Thoracic	1 x 10	10 Thoracic Kits
	Amputation	10 x 10	100 Amputation Kits
	Anaesthetic	7 x 10	70 Anaesthetic apparatus
3. Hospital Town (6) (20 theatres per town) (30 days to do the surgery) (Plus 3 special theatres per town)	General Bag	40 x 6	240 General Kits
	Amputation	20 x 6	120 Amputation Kits
	Thoracic	20 x 6	120 Thoracic Kits
	Urology	20 x 6	120 Urology Kits
	Ophthalmic	2 x 6	12 Ophthalmic Kits
	Neurosurgery	2 x 6	12 Neurosurgery Kits
	E.N.T.	2 x 6	12 E.N.T. Kits
	Obstetric	2 x 6	12 Obstetric Kits
	Anaesthetic	23 x 6	138 Anaesthetic

TOTALS	
General Surg. Kits	470
Amputation Kits	220
Thoracic Kits	130
Urology Kits	120
Neurosurgery Kits	22
Anaesthetic Kits	190
Ophthalmic Kits	12
E.N.T. Kits	12
Obstetric Kits	12

For Victoria Instruments Only

1. F.M.A.U. (45)	General Bag	2 x 45	90 General Kits
2. Intermediate Hospital (10)	General Bag	14 x 10	140 General Kits
	Neurosurgical	1 x 10	10 Neurosurgical Kits
	Thoracic	1 x 10	10 Thoracic Kits
	Amputation	10 x 10	100 Amputation Kits
	Anaesthetic	7 x 10	70 Anaesthetic apparatus
3. Hospital Town (6) (20 theatres per town) (30 days to do the surgery) (Plus 3 special theatres per town)	General Bag	40 x 6	240 General Kits
	Amputation	20 x 6	120 Amputation Kits
	Thoracic	20 x 6	120 Thoracic Kits
	Urology	20 x 6	120 Urology Kits
	Ophthalmic	2 x 6	12 Ophthalmic Kits
	Neurosurgery	2 x 6	12 Neurosurgery Kits
	E.N.T.	2 x 6	12 E.N.T. Kits
	Obstetric	2 x 6	12 Obstetric Kits
	Anaesthetic	23 x 6	138 Anaesthetic

TOTALS	
General Surg. Kits	470
Amputation Kits	220
Thoracic Kits	130
Urology Kits	120
Neurosurgery Kits	22
Anaesthetic Kits	190
Ophthalmic Kits	12
E.N.T. Kits	12
Obstetric Kits	12

Doctors Return Forms

Information obtained from

	By Kits	Name	CB/Spec	Met. or C.
(i)	General surgery (A)			
(ii)	General (a) and Amputation (B)			
(iii)	General (A) and Thoractomy (C)			
(iv)	General (A) and Cranictomy (D)			
(v)	Ophthalmology			
(vi)	Plastic			
(vii)	ENT.			
(viii)	O & G.			
(ix)	Urology			
(x)	Anaesthetic			

These should be set out by states.

Indication of instruments held by private practitioners

A survey of 1,778 doctors in Victoria disclosed that a total of 345 have a kit to perform at least one of the four procedures mentioned in the questionnaire. They make up a total of 626 kits. The break up of these figures is as follows :

264 in Metropolitan Area have 475 kits

81 in Country Areas have 151 kits.

	Metropolitan	Country	Total
General	263	63	326
Craniotomy	25	15	40
Amputation	124	51	175
Thoracotomy	63	22	85
	475	151	626

The survey covers about 36% of the doctors estimated to be resident in Victoria.

Using the survey figures there will be a total of 380 kits, plus instruments in country hospitals to equip Hospital towns with expanded operating theatres, Intermediate Hospitals and F.M.A.U.

Similar survey of Queensland doctors shows the following :

Out of 308 doctors
281 have General Kits,
46 have Craniotomy Kits,
172 have Amputation Kits,
55 have Thoracotomy Kits,

from a total of 1,991 doctors surveyed.

For Victoria

Consumables only

for F.M.A.U. C.O. 24 packs of 2/0 plain x 45 FMAU's
" 24 packs of 1 chromic x " ".

for Intermediate Hospital (10)

600 consumables per operation } x 10 — 6,000 consumables / operation

Hospital Town

20,000 consumables per operation } x 6 — 120,000 consumables / operation

\+ 10% Civilian need (of hospital town) — 12,000 consumables / operation

TOTAL — 138,000 consumables per operation