Letters to the Editor

YET ANOTHER MEDICAL FORM

SIR—Army Medical Records are far more manageable than the NHS envelopes, but there is still a great information dust-heap within the FMED 4 which belies its structured exterior.

The Problem Orientated Medical Record is an aide memoire of all past and present medical, psychiatric and social problems. The list could also include such data as current PULHEEMS assessment, chest x-ray and audiogram results, blood group and BFT status. The Problem List form need be no larger than an FMED 5 and could be filed loose along with the FMED 5s.

In my experience such a form saves valuable time during sick parades and clinics. There is no need to search through the notes as all the salient facts are on the list. It would be interesting to hear of other practitioners' views and experiences of Problem Lists and whether they believe there is a place for such a form in Army Medical Documentation.

I am etc.

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February 1982

REFERENCE
KERR D N S. POMR & the Curate's Egg. Update 1980; 20 1569-76.

WHITHER THE RMO

SIR—It is unfortunate that your Editorial on the changing face of army primary care does not seem to have stimulated the discussion hoped for. Neither were the points raised in Capt Finnegan's letter answer 'Whither the RMO' answered.

Capt Finnegan's main point was the nature of post-graduate medical education which precluded the employment of traditional RMOs, and this would in due course reflect on the military credibility of the army doctor. This view that the doctor's credibility might suffer was given credence at a GP meeting I recently attended when a medical officer stated that the Royal Marine "para medics" he encountered in the Falklands were more competent than him at resuscitation in the field. This view contrasts markedly with the opinions of other medical officers who had been serving as traditional field medical officers prior to the conflict.

I believe that this contrast is an indication that we have adopted a form of medical postgraduate education largely inappropriate to the field army.

If so we need a radical change in policy to prepare our doctors for their primary role which is the support of the army in the field. This could be achieved in a number of ways. The most radical would be to adopt the Royal Navy policy and replace the GP by an occupational physician. Like the GP the occupational physician is responsible for primary care; his training by definition would be orientated to the military occupation and would also suit him for command and staff appointments. Of course GPs would still be required to cater for families overseas but the numbers would be relatively small and could be provided by CMPs.

Another possibility would be to modify general practitioner training to include field medical skills. Such modification would require the agreement of the RCGP and the training period may require extending. However as prevention of illness and the saving of life on the battlefield must be defined as primary medical care agreement should be forthcoming.

I realise my views are provocative. However the last year at Staff College has taught me that the army's view of its medical services is largely based on the experience army officers have of their RMO. It behoves us to spare no effort to maintain the credibility of the Army Medical Services themselves.

I am, etc.

L P LILLYWHITE

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10 November 1982

REFERENCES
Army doctors improved in a Regiment with one doctor for the soldiers and another for the families? Is the health and welfare of the families of the serving soldier not the concern of the RMO? Can he envisage a medically and militarily satisfying job as an RMO to a military unit without families? I believe the answers to these questions, which are important, will show that the preparation of the doctor must include all the elements present in Vocational Training.

To return to the quotations in the first paragraph—I would take leave to categorically disagree that an occupational physician has the same role as the GP in primary care—I hope they are complementary but I do not believe that they can replace one another. The concepts, attitude and skills are entirely different.

Of course the GP should be trained for his military role, but if a Royal Marine para medic can carry out resuscitation better, why not LET HIM DO IT and TRAIN RAMC MEDICAL ASSISTANTS TO THIS STANDARD, TOO, thus leaving the doctor for a role more fitting to his training. Can one conceive of a career in civilian practice for a doctor who does nothing else but resuscitate patients, because that is what is implied in order to keep the expertise?

To have doctors wanting to enter an Army career, the RMO system is important but it must include care of the families in order to provide a credible service to the soldier. If we accept this we have to accept Vocational Training because we need doctors trained to that extent and we, in the past, have not been able to recruit doctors for the other role without giving this comprehensive training. We do need to keep doctors' military skills upgraded — we need to look at the role we really need for doctors in the war situation and I do not believe that this has been suitably tackled yet. Lastly, we have not recruited enough doctors to provide RMOs — i.e. we still have not found the full answer and I do believe unfortunately that Major Lillywhite or Captain Finnegan have not produced a reasonable viable solution either.

I am, etc.

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26 November 1982

SIR—I am grateful for the opportunity to read Major Lillywhite's letter (v supra) prior to publication and to have the opportunity to offer some comment.

The RMO, in the form understood by the Army at large, is the main shop-window of the RAMC and is the person who influences the opinion of all ranks, including those destined for highest office, as to the fitness of the Corps for its role as they appreciate it. There is some dispute as to the very existence of the RMO nowadays, Shaw\(^1\) refers to his experience in a BAOR Armoured Division and is satisfied that the "non-classical" RMO flourishes. In the same publication Inge\(^2\), writing as the Commander of an Armoured Brigade, remarks on "the virtual disappearance of the RMO", the original point raised by Finnegan\(^3\) at the commencement of this present debate.

My own recent experience does not qualify me to offer any opinion based on solid fact, but for what it is worth I agree with Inge, that the classical or traditional RMO is a very rare species. I suggest that this is not due to any fundamental change in the attitudes and wishes of the young Army GP but to a variety of circumstances outside his control. The most significant of these factors are:

(a) The changes in the pattern of post-graduate medical education.
(b) The shortage of doctors in the RAMC.
(c) Partly, but not entirely, due to (a) and (b), above a change in the attitude of the less enlightened members of the Army to the RAMC.

I believe that the last of these is a cyclical phenomenon, which has existed longer than the Corps and which is directly related to the time elapsed since the last involvement in armed conflict. Recent events in the South Atlantic should have produced an at least temporary improvement in this area.

The shortage of doctors is such a chronic situation, largely dictated nowadays by the direct and indirect effects of financial stringency (pace the politicians) that it seem pointless to pursue it.

The main topic of both Lillywhite's and also Finnegan's\(^3\) letters is postgraduate medical training in the Army. No one will dispute the need for the Post Graduate Medical Officers Course, nor for the recently instituted Tropical Medicine Module and other existing or projected short military medical courses. The bone of contention appears to be GPVT with or without the MRCGP, and its relevance to the needs of the field army.

While it would be a great relief to some if the Army Medical Services ceased to be responsible for the care of dependants and MOD civilians few will consider such a proposition realistic. There are more than 80,000 dependants in BAOR and to place these under the care of CMPs would result in different doctors caring for different members of the same family in the same location which is not conducive to good medicine, to say nothing of the establishment problems which would be created.
Far more to the point would be the logical move of the financial cover for such services from the military budget to that of the NHS—but that is another story. There is no way in which the AMS can concentrate on the needs of the field army and ignore those of the families. Therefore the GP in the Army, whatever he is called, must be a competent primary care physician. To achieve this the Army adopted the system of training evolved by the RCGP, with minor modifications and the result has been that at its optimum we have a system which is the envy of many, and which is used as a powerful recruiting weapon. By this means we produce, perhaps not as rapidly as our advertisements claim, young Army GPs who are qualified to take their place in civil practice. The question posed is whether this fits them for their military role, some obviously doubt this. They have my sympathy.

Lillywhite is primarily concerned with the field medical officer and suggests that the RN concentration on the occupational physician has much to recommend it. As one who spends a deal of time maintaining that the Army is an occupation in its own right, with its unique problems as well as many common to a wide range of civilian occupations, I find his words find favour. However it is proving a slow business to convince some civilians in high places of this fact, and one not helped by the proportion of time spent by some Army GPs in caring for families—a point in favour of his suggestion mentioned earlier. The syllabus for the examination for Associateship of the Faculty of Occupational Medicine (AFOM) in many respects is a job description for the traditional RMO in his role of primary physician to the occupation of soldiering. The examination can be taken only after two years of full time, or equivalent part time, recognised practice in occupational medicine. As things stand at present this means 2-3 years of Army primary care duties in an approved post or posts—any time spent caring for families will not count.

This really brings me back to the main point that while post-graduate training is essential there are no really suitable civilian qualifications which reflect the needs of the Army. This situation is not unique to "general practice," but is also perhaps reflected in Army Community and Occupational Medicine. We should not be surprised that civilian higher medical qualifications do not accord with the training needs of field medical officers as we see them.

The options open to the RAMC are few. We may continue to concentrate on the acquisition of civilian qualifications, and attempt to remedy the appreciated deficiencies in such training by in-house courses specific to military needs. With the shortage of doctors it is difficult to see how the necessary time can be found for such courses, and even when and where they should be held after the most recent assaults on the training system.

Alternatively we could approach the various Colleges and Faculties, seek to gain recognition of the demands peculiar to the Army, and somehow influence these bodies to create an appropriate higher medical qualification in military medicine. It is my personal feeling that such action is extremely unlikely of realisation in the near or middle future. The institutions concerned are still relatively young, jealous of their status and lacking in the flexibility often found in longer established bodies.

Once upon a time we undertook much of our own training of "non-specialist" medical officers, the Junior and Senior Officers Courses with in-house preparation for the DTM&H. This is now a memory, and a generation of establishment reductions renders the return of this system difficult if not impossible.

What then is the correct course? The present one is heavily criticised, the training is time-consuming and tends to divorce the young Army doctor from the units he is supposed to serve. Somewhere we appear to have gone wrong, and I am encouraged in voicing this feeling by a recent Journal Editorial. The response to this was limited, and I am not aware of any contributions from those young Army doctors whose training is being debated.

Should we sub-divide Army GPs into two groups—those who are doctors first and Army officers second, and those who are officers first and doctors second? The former would train in the existing system, the latter undertake perhaps a truncated form of GPVT which does not lead to the precious piece of paper, and would spend the time saved in in-house training courses designed to fit them more for the traditional RMO role. I certainly do not know the answer, but I do know that the passing of the RMO into the pages of history has not improved our credibility as a Corps.

I am, etc.

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REFERENCES
SIR—In recent editions of the Journal there have been various articles, editorials and letters concerning the Army Doctor and the Regimental Medical Officer. It is these and some misgivings of my own on current manning policies that have prompted this letter.

An Army doctor is a Commissioned Officer whose specialist role in the Army is the practice of medicine in one form or another. One complements the other but neither can be taken in exclusion of the other. How can an Army doctor learn about soldiers or soldiering without serving as a Regimental Medical Officer? He cannot. The PGMO course is too short to provide anything but a glimpse of soldiering. I heartily endorse the letter by Capt Finnegan in his defence of the Regimental Medical Officer. The benefits to be obtained by both Regiment and officers are numerous and have been documented recently in this Journal. It was refreshing to read Brig Shaw's letter telling us that the Regimental Medical Officer (and the traditions so attached) still exists in some Divisions.

I should however like to make some comments about the post-RMO period. Unfortunately, many doctors once moved to specialist post-graduate training no longer see any active soldiering—a situation which sadly suits too many. Despite post-graduate training and examination we must not forget that one of our prime roles is preparation for the operational role and for war. To this end it is surely not unreasonable to combine some active soldiering for short periods despite the specialist role chosen as a peace-time doctor and to ensure that those entering directly as specialists serve as early as possible for a shortened RMO period.

There will unfortunately be a minority who do not wish to undertake this duty and perhaps they would have been better employed as CMPs attached in their speciality, rather than being commissioned, with its attendant obligations. Perhaps this is an attitude which should be earnestly sought at commissioning interviews so that we have a Corps of Army doctors rather than doctors who happen to practice in the Army.

I am, etc.

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19 November 1982

REFERENCES


Reports of Meetings

Society of Anaesthetists, British Forces Germany
Autumn Meeting 1982

The 13th meeting of the Society was held at RAF Hospital Wegberg on the 8th and 9th October, 1982. Twenty one members and guests attended, and Sqn Ldr J T Cranfield RAF took the chair.

The members were welcomed to RAF Wegberg by the Commanding Officer, Gp Capt D B A Davies RAF.

Air Cdre A J Merrifield RAF, Consultant in Anaesthesia to the Royal Air Force, opened the clinical programme by describing the use of zeolite columns as oxygen concentrators. They utilise the principle of gas chromatography to produce oxygen (and a small percentage of argon) from ambient air. He outlined the use of such equipment in military aircraft, and the types of portable apparatus available for field use.

Sqn Ldr J T Cranfield RAF, Consultant Anaesthetist RAF Hospital Wegberg, described a post-operative morbidity survey carried out in his Hospital. Very few problems had been encountered, which was no surprise having regard to the relatively fit and healthy population studied. However, a large number of the patients had complained of inadequate pain relief in the immediate post-operative period. This he believed was unacceptable and stressed that the traditional method of prescribing intermittent doses of narcotic analgesics, to be administered by the Nursing Staff as required, did not work. Other methods and their limitations were discussed in depth.

Prof J F Crul, Professor of Anesthesiology at the Katholieke Universiteit in Nijmegen, outlined the history of total intravenous anaesthesia (TIA). This method of anaesthesia is free from the problems of environmental pollution, does not require any expensive equipment, and is very applicable to the