Letters to the Editor

MEDICAL TRAINING FOR PEACE AND WAR

From Dr M McCracken

Sir,—Major Millar, in his haste to remedy the problem of adequate training of M.O.s (Letter, October '83) demonstrates a lack of loyalty to those whose 'lack of training' is not due to 'lack of motivation!

My final 2½ years in the RAMC yielded military training comprising ten days on Salisbury Plain, one morning on the ranges (after persuasion, since in 1981 females were not supposed to shoot), five minutes in a gas chamber, and one B.F.T. This is not atypical, but it is not attributable to insufficient motivation.

To combine adequate military training without lowering in any way professional standards in the present climate of staff shortages requires excellent administration to release the individual for training in both fields. Without an alert administration, the best that an RAMC Doctor can expect is a mediocre compromise between the two, or, as currently happens, emphasis of one aspect with sacrifice of the other.

The 'credibility' of the Corps could be said to reside in the M.O. who has contact with the rest of the Army at grass-roots level. Therefore, the problem is one of how to make best use of the life-cycle of a short-service Officer. A correct solution should in the short term, stimulate and train the M.O. while enhancing his 'perceived medical excellence' and thus the credibility of the RAMC. In the long term it would encourage Officers to remain in the Corps.

I would like to put forward a set of proposals concerning the training of the new RAMC Officer. Behind them is a set of assumptions which should first be outlined:

The assumptions are as follows:

a. The concept of the 'Regimental Medical Officer, as being part of the Regimental Family, and hence committed to it for two years or more, is no longer as important as it used to be. Many units are glad to receive any medical cover whatever, and appreciate medical expertise rather than Regimental devotion.

b. Newly registered doctors are short of practical experience and should not obtain it at the expense of their regiment without supervision. They are least placed to perform the role of the R.M.O. in the field.

c. Direct entrants are becoming numerous, but lack knowledge of the Army at grass-roots level while still expected to make sensitive judgements about a soldier's medical grading etc. which require an understanding about how units function. These decisions are often construed as unworkable by a soldier's unit, and do not lend to 'credibility'.

d. The PGMO/CMDVLP course is a familiarization course that must be backed by an appropriate period or practise in military skills while the officer is being acquainted with the many varied aspects of military life. This should occur before an individual is sequestered either with one unit for any length of time, or in the folds of a hospital existence.

The proposals are:

a. The first year for all new entrants should be spent as follows:

1. Direct Entrants (Other than newly registered):
Four months each as:
—M.O. to a Field Ambulance.
—M.O. to a Field Ambulance.
—M.O. to a Field Ambulance.
—M.O. to a Field Ambulance.
—M.O. to non-operational, in U.K./BAOR.

(There would be no requirement to a phase with roulement tours as there is a positive advantage to a unit to have ready—experienced medical cover at the start of an operational tour).

2. Newly Registered Entrants
Four months each as:
—M.O. to a Field Ambulance.
—M.O. to non-operational, in U.K./BAOR.
—M.O. to Hospital Casualty posting in U.K., BAOR abroad.

b. In the second year, both groups should be expected to start or continue their specialist or G.P. training. Those who do not need or wish to do so may opt for a year in an interesting, but not necessarily recognised-for-training, post where a commitment for longer than four months is required e.g. Nepal, Hong Kong, S.A.S., HQNI etc.

c. All recognised training posts should only be allocated to those who have a definite use for them, and only after the first year of basis 'continuation'. This particularly applies to G.P. training.

d. Any doctor who is so motivated should be allowed and encouraged to attempt 'P' Coy or similar courses and tests without the need to justify this in terms of future career.

e. The suggestions made by Major Millar could then usefully supplement the above.

The obvious drawbacks of such proposals are firstly, that they require keen administration, and secondly, that the R.A.M.C. Officer should accept that he is required to be reasonably mobile for a period of their lives.
year. This mobility is easily only equal to, or less than, that experienced by the average soldier and comes at a time in the Officer's career where tolerance of this is high, and at a point where the benefits are best offered.

The advantages of the proposals are as follows:

a. Officers are given the maximum stimulus and experience in both military and field medical matters in their first year, and those who wish to specialize are not held back, as they are now, from gaining clinical experience.

b. Operational battalions receive clinically and militarily experienced personnel.

c. Static units are not forced to tolerate 'unsuited' MO's for as long as two years.

d. Casualty posts are fully and reliably manned, with a brisk turnover.

e. Hospital specialties are manned sooner by MO's no longer committed to two years as RMO, and by specialists who can appreciate military requirements.

f. As shown in recent campaigns, the RAMC personnel of most use to fighting units are those who have had the motivation to attempt and pass a hurdle such as 'P' Coy. This credential is readily recognised by the common soldier.

g. Interesting and dull postings are more fairly shared.

RAMC doctors have every potential to gain the respect and credibility for their Corps that it deserves. Once this is stimulated, it will in turn attract and retain more Officers for the 'right' reasons. But they are busy doctors, who do have a loyalty to their patients, and need a good steer from those paid to administer them.

However, if the fruits of this recent intense introspection by the RAMC does not resolve its identity crisis, then it should at least not give rise to consternation. We are, after all, in peace preparing for War, and in War, 80% of the AMS will be drawn from the Territorial contingent. Therein lie the medical excellence that comes with often long and varied clinical experience, and the military expertise that comes from the dedication of more time in one year to military skills than most short-service M.O.'s cover in three.

I am etc.

M. McCracken

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From Colonel P J Beale, L I RAMC

Sir, I have been given the welcome opportunity of replying to Dr. McCracken's letter1 in this issue, and have, perhaps, unfairly, been given the chance to comment before any of you have been able to digest its message. I say 'unfairly' because other letters with varied views and contrasting opinions in the 'Whither the RMO?' series and now this latest 'MOs Preparedness for War' have been allowed to pass without AMD comment. However, there comes a time when an authoritarian view has to be expressed, even though it will tend to stress the practical limitations of implementing some of the idealistic ideas seen in this journal's Correspondence columns.

In previous letters, the main interrelated issues have been:

a. The RMO
b. Battle preparedness for war
c. Post graduate medical training

d. The advantages of the proposals are as follows:

Firstly, we are all military doctors, and the RMO has an early opportunity to adapt his thinking and direct his medical expertise along military lines in a way that may not necessarily come to him again. I see no advantage of delaying, beyond the PGMO course, the posting of an individual as an RMO. He may have a few painful moments learning how to integrate himself into the regimental family, but there comes a limit to the amount of instruction he can receive without actually experiencing life as an RMO first-hand. I know countless Medical Officers who have been grateful for being thrown into regimental life — they can consider the time spent as an RMO amongst the most enjoyable of their qualified lives, and after five or more years of medical training, house-jobs and PGMO, they want to get 'stuck in.'

We, in AMD3, certainly like to post PGMO's early as RMO's — this has the double advantage of allowing specialists a chance to become RMO's in their 2 year's GDMO training and for GPs to concentrate later on professional medical training with RMO experience behind them. What I am, in effect, saying is that Dr. McCracken's views that the first year of all Medical Officers should be spent in 4-monthly attachments to Field Ambulances, Northern Ireland and elsewhere in order to 'familiarise' is not AMD policy, and indeed for reasons given below, would be both turbulent and impracticable.

I will now indicate the priorities for manning medical officer posts within the RAMC. Problem areas will soon become apparent.

These priorities are:

1. To provide medical cover where and when required.
2. To ensure overall professional and military train-
ing within the RAMC (for the benefit of the majority).

3. To satisfy the needs for individual training.

Immediately it can be seen that there could be a conflict of interests where a medical officer is posted in the exigencies of the service to a location where professional training is impossible. Indeed we all know of instances where individual timetables have had to be changed in order to provide medical care on the ground. I scarcely need to emphasise that not only static locations have to be covered, but a variety of detachments to Northern Ireland, Falkland Islands and Belize etc.

Let me state the current policy. First of all, direct entry doctors are treated similarly to ex-cadets, with the very few exceptions now reduced to senior doctors in shortage specialties who are employed to make the most of their expertise. Indeed the majority of direct entry doctors are recently qualified, and should not be treated differently.

In effect, therefore, following the PGMO course, all medical officers are employed for 2 years as General Duty Medical Officers providing Primary Care. The reasons for this are both to acquaint the individuals with military medicine often as RMOS, and secondly to man the posts on the ground. The majority of hospital specialists who have held such posts have been grateful for the experience, even though at the time they may have felt frustrated by the immediate inability to train for their speciality. However, when up to two years professional training is being considered in the NHS for budding specialists, I'm sure we have not got it wrong.

Those doctors intent on General Practice for their careers are the only ones considered for General Practitioners Vocational Training (GPVT). Approval by the College Council is required for them to train in General Practice. Recently the three years GPVT has been accomplished within the 5 year Short Service Commission (SSC), give or take a few months. Sometimes this three years is over quickly but for others it may take longer depending on the availability of trainee posts and trainers at any one time. The jigsaw nature of this planning should now be appreciated.

Military Training also assumes a very high priority, but depends on the circumstances. With good manning and particularly in a Regiment as RMO military training can proceed apace. But, so often, with too few medical officers on the ground, there are conflicting calls for exercises, detachments and primary care. However hard the Commanders Medical try, the Medical Officer gets caught in the cross-fire, feeling frustrated about wishing to fulfil his duties both as a military doctor and in primary care, but finding one duty is sacrificed on the altar of the other. I sympathise with many of Major Millar's sentiments, advocating study days, training in NBC and how to handle weapons, and generally preparing the MO for war, but I think his comments on 'lack of motivation' are unfair. Nearly all the Medical Officers I have met are not only prepared to prepare themselves for war but enjoy the training. It is only sometimes when they are frustrated by events outside their control that this motivation declines.

Finally, there is the question of turbulence, above which AMD3 is particularly sensitive. Implementation of McCracken's initial year of modules would not only increase the turbulence during that year, but would fail to reduce it during subsequent years, for the reasons I have given above in fitting together the jigsaw. We do try and post people to situations entailng the least number of moves. For instance, we try and arrange all hospital modules for GPVT in the one hospital but this is not always possible because of the non-availability of desired modules.

I have tried to put in perspective the comments of correspondents over the topics of 'Whither the RMO' and 'The Training of Medical Officers in War and Peace.' The interest stimulated has been gratifying — doctors are concerned about their professional roles. We in AMD have no doubt the RMO remains a very important man, and as Colonel (now Brigadier) Shaw pointed out in his letter the RMO is far from dead. His duties have subtly changed over the years but his importance as the immediate medical contact with the regiments and battalions is undiminished.

Also, I think our training for the young medical officer is good. Sometimes I wonder whether we train them too well, in that they often leave the Army just when they can contribute much as trained MOs, and instead disappear into the NHS as highly saleable property!

All I can do is to promise that we in 'Administration' will remain as 'alert' (1) as we can, provided of course we are allowed to retain the staff to administrate!

I am etc.

P J BEALES

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REFERENCES
From Lt Col D H Wright, RAMC

SIR—Recent editions of the Journal have contained many letters on the demise, apparent or otherwise, of the RMO. Lt Col Tinsley's recent letter draws attention to, among other things, the lack of medical officers available to field ambulances for assistance in the training of Combat Medical Technicians. For a number of years this Field Ambulance has had no medical officer input at all, the Commanding Officer and Second-in-Command being non-medical officers. Of the six medical officers on establishment five are civilians and the sixth is a general practice vocational trainee. None of these is available to assist in the training of our soldiers.

The reduction in the number of medical officers on the Staff of the Training Centre is an associated worrying feature. It is now possible for Combat Medical Technicians to go through the complete training process and indeed their entire military career with little or no medical officer contact. For the soldiers of the Medical Corps to receive no direct (and increasingly no indirect) training from medical officers must be wrong.

The state of medical officer manning and the requirements of the Royal College of General Practitioners are fully appreciated, but the balance appears to have swung too far towards the civilian peacetime structure. We are gradually moving towards the situation where the field medical service has no medical officer input at all and the medical officer service is subordinate to civilian requirements. This cannot be good for our soldiers and cannot be good for the Corps as a whole; indeed it will lead inevitably towards civilianisation as indicated in your editorial.¹

I am etc.

D H Wright

5 Amd Fd Amb RAMC,
Munster,
British Forces Post Office 17
12 April 1984

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1 Tinsley M J. Dispensing in Military General Practice. J R Army Med Corps 1984; 130: 71-72.
2 Editorial J R Army Med Corps 1984; 130: 2.

PATIENT PARTICIPATION IN THE ARMY MEDICAL CENTRES

From Dr. R. Manche

Sir, In UK, Patient Participation Groups are flourishing but in the Army in BAOR, I think we are the only Medical Centre with an active Committee.

In 1979 I invited the COs of the five major Units to send representatives to a Meeting with Medical Centre Staff. Since then regular Meetings at quarterly intervals have been held. At first the staff felt threatened and resented the idea, but now, one and all, enjoy the encounters and many innovations have been made at "the other side's" suggestion.

By participation is meant "a liaison and collaboration" between patients and "their" practice. (JRCGP May 1983). The organisation and running of the Practice is explained to the members who, in turn, explain it to the people they represent.

During the Meetings we explain our problems and difficulties so that the patients can appreciate our "shortcomings," this leads to more tolerance towards us.

Opportunity is taken to accept invitations to lecture to their Wives Clubs on Preventive Medicine, Mothercraft and other Health Educational subjects.

On their part they look after the decoration of the Waiting Room with pictures drawn by children. A Creche, now run by the members of the Group but originally started by the H.V. and M.O. for the patients' benefit: gives mothers time to relax, shop or come to the Surgery without their children. One member is actively engaged raising money for extra equipment; a TV set for the Night Duty Staff, books, plants, etc.

The members also voice suggestions and complaints, and discussion of the latter, especially, has been very fruitful.

In general the Patient Participation Group has fostered more good-will and benefit than anything else.

The leading lady in the Group has been encouraged to write to the National Association for Patient Participation and it is hoped that the RCGP will include our name in their List of Practices who have a Group.

I am etc.

R Manche

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1 March 1984

From Mr. S. Rosenbaum

BOXING INJURIES IN THE ARMY

Sir, May I comment on the article by Oelman et al¹ on Boxing Injuries? By relating these and other sports injuries to the playing time, taken from the 1962 survey (Rosenbaum²), they show a relatively low accident rate for skiing, whereas I had placed it highest, on the basis of periods at risk: the explanation is that each skiing period lasted 4hr on average, as against 1hr-1½ for the other 3 sports named.

It is somewhat dubious for the figures at risk in 1962 (in the last year of National Service) to be used as a basis for injuries suffered in 1978-80. The relatively higher accident rate for rugger that is apparent-
ly now the case may be attributable to a switch from playing soccer (so that the 1962 divisor is too low to be applicable in 1978-80). The authors of course, had no choice in the matter since, as far as I am aware, no more up-to-date survey of sport exists. Would it be worth considering a repeat survey? It should be relatively cheap, being based on a self-completed diary, and have a use not only in identifying sports with a relatively high risk of injury but also in connection with the provision of sports facilities.

I am etc. S. ROSENBAUM
45 Watford Road, Radlett, Herts WD7 8LG, 21 March 1984

REFERENCES

Book Reviews

Food for thought: It is inevitable that in our professional and social lives we all have a close encounter of the third kind with episodes of nausea and vomiting, and/or abdominal pain and diarrhoea.

Included in my personal repertoire of medical reporting I recall two papers on this subject, published in this journal.

Food poisoning outbreaks affect us as individuals, our families, our units wherever we may be staying or serving and are of enough common occurrence without me having to spell out the obvious and significant importance of this subject matter.

This modest handbook is aimed as I see it at Environment Health Officers (one of the newer medical terminological categorisation of public health service workers to which I am not yet fully adjusted); anyhow I think that personnel of the Army Preventive Medicine Dept., Laboratory Technicians in our Pathology Dept. the nursing staff, the Army Catering Corps personnel and possibly the busy harassed GP may find it useful though pitched at a rather elementary basic level.

The author defines Food Poisoning or Food borne Enteric Disease as 'a disease which is produced following the consumption of unsafe food and which has the gastro-intestinal tract as its primary target. He classifies this subject under two main headings: chemical and biological.

Having dealt in the early pages with chemical food poisoning in 3 or 4 pages, and following this with the bacterial classical trio of Salmonella, Staphylococci and Clostridia, he goes on to cover the comparatively recent newcomers such as Vibrio parahaemolyticus, Bacillus cereus, Campylobacters, Viral gastro-enteritis and Fungal mycotoxins.

And what is unorthodox to a microbiologist of the old school is the inclusion of paragraphs dealing with Shigella, Brucella, Tuberculosis, Poliomyelitis, Q Fever etc and even Giardia, Amoeba, Toxoplasma and Taenia; but perhaps this may be an advantage to students in the lower professional paramedical echelons.

An interesting basic book for readers and students of the categories mentioned above.


Cholecystectomy has become the commonest elective abdominal operation to be performed in western countries where some 10 to 20% of the population may expect to develop cholelithiasis at some time. In about 50% of people the gall stones are associated with symptoms severe enough to require treatment and in army practice, as in civilian practice, cholelithiasis is increasingly a disease of young women taking a contraceptive pill. Until a few years ago, surgery was the only treatment available and is still the most commonly indicated. However, there have been exciting advances in the medical treatment of cholelithiasis, and in imaging techniques applied to the biliary tree, including percutaneous transhepatic cholangiography and endoscopic retrograde cholangiopancreatography. The endoscope can also be used to divide the sphincter of Oddi, a particularly valuable manoeuvre with recurrent common bile duct stones following cholecystectomy.

The Editors of this excellent review of biliary tract disorders are a physician and a surgeon, but 19 of the contributors are physicians and only six are surgeons. This is a reflection of where the exciting advances are taking place in this important field. Although the surgeon will find some of the sections heavy going, there is excellent advice on those common and uncommon problems of biliary surgery with which he may have to deal.

This book should be purchased by all Higher Surgical Trainees. It will be consulted often and the sound advice that it gives in the management of biliary tract disorders is unlikely to be superceded for some years.

R Scott