

LETTERS TO THE EDITOR

HEAT ILLNESS IN THE SERVICES

From SSgt P Gibson, QARANC, Capt J Harker, QARANC and Lt Col W F de Mello, RAMC

Sir, we wish to comment on Colonel Dickinson's paper 'Heat Illness in the Services' *J R Med Corps* 1994; **140**: 7-12.

We recently audited retrospectively the notes of all patients (n=27) admitted to the Intensive Care Unit at the Cambridge Military Hospital with heat related illness from 1985-1992. We can confirm that often valuable clinical information is not recorded. For this reason, we have designed a dedicated proforma to standardise information to be recorded in the initial hospital phase for these patients.

One of us (PG) asked 25 doctors and nurses at our hospital about heat illnesses and for what they felt was the best method of cooling these patients. We were not surprised that the best method (evaporative method without inducing shivering) was not widely known. This method was successfully used in four cases of hyperthermia (rectal temperature >40C) during Op Granby. A Scottish medical missionary was using similar methods for South African mineworkers with heat illness over fifty years ago! (personal communication).

Irrespective of its aetiology (be it heat stroke, neuroleptic malignant syndrome or malignant hyperpyrexia) after the ABCs of first aid, the specific management must be to cool the patient rapidly to a core temperature of 38.5C.

We hope to publish further details soon.

We are etc
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THE ROYAL ARMY MEDICAL CORPS MUNIMENT COLLECTION

From Shirley Dixon and Julia Sheppard

Sir, the collection of manuscripts and memorabilia which had been accumulated in the library and museum of the RAMC was placed on permanent loan with the Wellcome Trust in October 1991 and is housed in the Contemporary Medical Archives Centre in the Library of the Wellcome Institute for the History of Medicine. The Trustees of the museum were glad thus to be able to provide suitable storage and adequate catalogues for the material, also enabling researchers to enjoy the remarkable facilities of the Wellcome Institute Library. The formal agreement was signed by Lieutenant General P J Beale FRCP, Director General of the Corps, and Dr P O Williams on

behalf of the Wellcome Trust at a ceremony held at the Royal Army Medical College, Millbank. This agreement also covered the pre-1850 collection of books of historical value and the post-1850 medical textbooks, both of which collections are also now in the Wellcome Library.

The origin of this collection is largely undocumented. It dates back to the foundation of a library for medical officers and a museum of morbid anatomy specimens in the early 19th century by Sir James McGrigor, who was Director General of the Army Medical Department in 1815-1851. When the Army Medical School was set up, the library and museum moved into it, and the library became a repository for collections of material, published and unpublished, relating to British military medicine. In the 1920s the collection was moved to Millbank and in 1984 it moved again to Keogh Barracks because of pressure of space. At about this time negotiations were opened with the Trust to house the historical collections.

The 'Muniment Collection' is an important one, not least because it contains records and personal papers of a number of medical officers who made significant contributions to medicine. It also covers a long timespan, some records dating back to the Peninsular War and a few documents from earlier times, although the bulk of the collection is 19th-20th century. The earliest document is a draft letter of appointment of John Knight, Surgeon General to King Charles II, dating from 1657; the most recent material is from the Falklands conflict in 1982. The collection in fact comprises over 2,000 separate accessions of documents, publications, photographs, charts, material and memorabilia which have been placed with the Corps by individual officers and men and their relatives over the last 100 years. In spite of its title, the 'Muniment Collection' is not the official record and archive of the Royal Army Medical Corps; such records will be found at the Public Record Office.

A glance at the catalogue reveals how rich and varied is this material and how valuable it will be for students of medical, military and social history. Whilst some accessions are single items only, others are collections, some very large, of papers ranging from pay books and albums of photographs to major reports on medical administration. The more significant include:

Correspondence of William Fergusson (1773-1846), Inspector General of Hospitals in Portugal during the Peninsular War.

The papers of Sir John Hall (1794-1866), Principal Medical Officer in the Crimea.

Papers of Sir Thomas Longmore (1816-1895), Professor of Military Surgery and delegate at the Geneva Conference of 1864.

Laboratory notebooks of Sir David Bruce (1855-1931) as Assistant Professor of Military Medicine at the Army Medical School, and his photographs of research into brucellosis and trypanosomiasis.

Papers of Sir John Boyd (1891-1981), Deputy Director of Pathology in the Middle East and later in North West Europe during the Second World War.

There are small collections of papers of Florence Nightingale (1820-1910), Sir William Leishman (1865-1926), Sir Anthony Bowlby (1855-1929), Sir Percy Tomlinson (1884-1951), Sir Ernest Cowell (1886-1971), Sir Neil Cantlie (b 1892), Sir Norman Talbot (1914-1979) and many less eminent members of the medical services, giving fascinating insights into many aspects of the development of medicine in the armed forces.

Numerous diaries and memoirs, especially of those on active service, of all ranks of the medical services, as well as collections of letters, mostly from officers, throw light also on the peace-time life of the army. These often include marvellous details of 'foreign' stations to which British troops were sent, including Ireland. Some interesting informal reports can be found, such as Dr John Buchanan's 'Short history of diseases (*sic*) common to his Majesty's Own Royale Regiment of Horse Guards' detailing the problems encountered by a medical officer in Flanders during the War of the Austrian Succession. Formal reports and war diaries are also found throughout the collection; the earliest are William Fergusson's reports on Portuguese hospitals in the Peninsular War, and others include the reports commissioned by the Pathological Board after the massive mortality in the early months of the Crimean War, and reports kept secretly by captive medical officers in the Second World War prison camps of the Japanese.

Pictorial material abounds: there are many collections of photographs, including teaching collections of lantern slides, such as General P H Henderson's collection on army health. Few are as significant as Sir David Bruce's, but even the most ephemeral illustrate uniform, hospital design, camp arrangements or the impact of European incursion into very different cultures. There are interesting artistic works, notably clinical watercolours made by Sir Charles Bell after the Battle of Waterloo and lithographs of casualty evacuation at the Battle of Loos in 1916.

The collection is available for consultation by bona fide scholars who have signed an undertaking. A two-volume detailed index and catalogue has been prepared by Shirley Dixon, Assistant Archivist in the Contemporary Medical Archives Centre. Copies of the list may be consulted at Wellcome Institute Library, 183 Euston Road, London NW1 2BE. Readers are strongly advised to contact the Centre in advance of a visit. The Archivists can be contacted by telephone on 071-611 8482.

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Contemporary Medical Archives Centre

FIRST LINE MEDICAL SUPPORT

From Maj M C M Bricknell, RAMC

Sir, The two recent editorials on current and future developments in medical training and battlefield surgical care represent significant statements of doctrine for future operational medical support (1,2). The clear requirement for forward advanced trauma life support (ATLS) provided by medically and militarily competent personnel has been fulfilled by an integrated, tiered training package. This encompasses training from ATD5 to consultant surgeon. Substantial progress has been made since, though not because of, my paper in the British Army Review and supporting documentation submitted via the chain of command (3). I would like to contribute some personal views on possibilities for future development.

It must remain frustrating to many that the Regimental First Aider (RFA) concept has yet to come to fruition. However many units warned for operational tours eg. Northern Ireland, Bosnia, Falkland Islands etc recognise this requirement and produce a RFA equivalent using their own training resources. With the new intergrated, hierarchical medical training system in place Regimental Medical Assistants (RMAs) would be in a position to teach the ATD5 and RFA syllabuses using the ATLS concepts from their own training. Maybe the value of the Unit First Aid Instructors (UFAI) courses should be closely examined as previously suggested (4) particularly as UFAIs will now need to be retrained in the new first aid concepts. Resources released by abolishing the UFAI courses could be used to train RMAs to instruct on locally organised RFA courses. This would reflect what already happens in unit training cadres for signallers, milan operators, drivers etc. Thus the RFA could be created without significant additional resources.

Previous work has questioned the validity of the RMA training system; particularly the requirement for supervision up to the level of RMA 1 (5). This limit to the employment of RMA 2 and 3 personnel is impractical and these personnel are often used to provide company aid posts (CAPs) and medical cover. Perhaps the RMA classification should reflect the 3 separate skill levels required at first line, namely; Regimental Aid Post (RAP) medic, CAP medic, and RAP SNCO (3). Thus the training objectives and tests would match the job requirement. Individuals would be trained in designated skills and would not need supervision unless performing tasks at 'an enhanced level of responsibility' (2) which would require medical supervision in peacetime.

In spite of the experience from Op Granby the establishment of the RAP remains unchanged. Most Armoured Infantry Battlegroups saw the size of the RAP substantially increased by regimental bands, an additional doctor, RAMC reinforcements, a field ambulance section, a casualty evacuation controller etc. It is likely that such reinforcement of the RAP in line with expected casualty

rates will be the model for the future rather than relying on the establishment tables. Regimental Medical Officers (RMOs) need to have the opportunity to develop the military skills and flexibility to cope with this responsibility. Consideration should be given to the continuing military education of army doctors after the PGMO course.

The progress that has occurred in military medical training will also be reflected in the provision of medical equipment (6). A medical side-pouch has also been developed which is compatible with the 1990 pattern military rucksack. At last there is provision for medical equipment to be integrated with the training system and to be 'manportable'.

In conclusion much has happened to make the integration of manpower, training and equipment (3) at First Line a reality. Over the past few years there has been a trickle of published ideas and research to stimulate developments in military medical doctrine. This is insubstantial compared to the number of papers published in Military Medicine - the US Army equivalent to the Journal of the RAMC. Perhaps stimulating young military doctors to develop ideas for operational medical support and publish them is the greatest opportunity for the future (7,8).

I am etc

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REFERENCES

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BMA MEMBERSHIP

From Surg Cdr C N Warlow, RN

Sir, as the Armed Forces Member of Council of the BMA may I through your columns encourage and exhort all

Service Medical Officers to join the Association, or, if having previously resigned, to consider re-joining.

The BMA is the only body that the Government recognizes with which to negotiate and, in my opinion, it is important that the Association has maximal support from all doctors.

Our subscription is discounted due to our service commitments, but we must realise that at some stage we will all retire from our Service, albeit Navy, Army or Air Force, and possibly be seeking civilian employment.

I am etc
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ROYAL SOCIETY OF MEDICINE - UNITED SERVICES SECTION - BAYER DIAGNOSTIC PRIZE COMPETITION

From Surg Capt A P Steele-Perkins, RN

Sir, I am writing in my capacity as secretary to the United Services Section. The President and Council are keen to increase membership, and would wish to make you readers aware of the excellent facilities, including eating and overnight accommodation and the fact that you may join up to 3 Sections at no extra cost.

The United Services Section has an exciting programme for the 1994-95 session as listed below.

13 October 1994 - Joint meeting with Coloproctology Section.

1 December 1994 - Bayer Prize Competition. Two papers for each service will be chosen. Bayer have kindly agreed to increase the prize money. All finalists get £50 and the winner £100.

27 January 1995 - Joint meeting with A&E section.

1 March 1995 - Section Away Day (RAF sponsored).

June 1995 - AGM, Annual Guest Lecture and Dinner.

For more details on joining the United Services Section of the Royal Society of Medicine, contact:- Ms Lisa Raine, Sections Office (071 290 2983).

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HEAT ILLNESS IN THE SERVICES

From Lt Col T P Finnegan, RAMC

Sir, Lieutenant Colonel J G Dickinson produced a most interesting paper in your February 1994 Journal (1). His

data, which was provided by the Defence Analytical Services Agency, were limited to those cases reaching hospital. He comments that there "there will certainly be a number of additional cases that did not reach hospital, being managed solely in the field or in Medical Centres, but these were probably minor cases". I can elaborate a little on the extent of some of these additional cases.

In 1990 I collected some data on heat and cold casualties for the period of 1986-1989 inclusive for the Army in UK(2). The source of the hospital cases was the same as that used by Lt Col Dickinson, but I was also able to collect some data from the then ten military District Headquarters in the UK. The figures from the Districts and for the hospitals are summated in the Table. Certain personnel appear in both series of figures, namely 34 for the heat casualties and 51 for the cold casualties. These are only counted once in the total figures. There do remain 6 heat casualties and 10 cold casualties from the Districts who could not be identified and the District figures may be inflated to this small extent. However the figures do illustrate the substantial hidden morbidity from climatic illness which amounts to at least 29% of the total for heat casualties and 38% for cold casualties.

Given the enormous changes taking place within the Armed Forces at present, these figures merit being reviewed continuously. Lt Col Dickinson's suggestion of a centrally co-ordinated, tri-Service prospective study using dedicated proformas has much to recommend it, but who will pay for such a project to be sponsored and undertaken?

I am etc
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Number of Climatic Illnesses in the Army in UK 1986-1989

Type of Illness	Cases from Military District HQs	Cases from Hospitals	Cases from both Sources	Totals	% District HQ/Total
Heat Casualties	146	259	34? + 6	365/371	≥ 29
Cold Casualties	203	227	51? + 10	369/379	≥ 38

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- DICKINSON J G. Heat Illness in the Services. *J R Med Corps* 1994; **140**: 7-12.
- Finnegan T P. Climatic illness of soldiers in the United Kingdom. 23rd International Congress on Occupational Health. Montreal 1990.

PART-TIME STUDYING

From Maj J D C Bennett, RAMC

Sir, Readers of the Journal will be interested to learn of the course and exam run by A J Wade (Diploma in Sports Medicine for Doctors Only 1994; 140:99), but this is not the only way whereby a qualification in Sports Medicine may be obtained. The Worshipful Society of Apothecaries (incorporated by Royal Charter 1617) has granted a Diploma in Sports Medicine DSMSA since 1988, as well as diplomas in subjects such as Philosophy DPMSA and History of Medicine DHMSA. For those for whom the cachet of extra post-nominal letters in the medical register is not too important, the Open University has many subjects of interest which can be studied as an associate student. Particularly pertinent to officers in the Corps is *A318 War, Peace and Social Change: Europe 1900-1950*. By these means Wednesday sports afternoons might be profitably spent by RAMC doctors who through infirmity or on-call commitments cannot take part in the usual recreation.

I am etc
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Note from the Editor

I would hope that the term 'Infirmity' does not apply to many RAMC doctors who should in order to perform their uniformed roll, be fit. Wednesday sports afternoons to my mind, should be regarded as an opportunity to maintain this requirement whenever possible.

ERRATUM

LETTER: HYGIENE, ARMY HEALTH AND APHOM *J R Army Med Corps* 140; 2: 1994

- Para 2, line 13, Reference number should be (2) not (1).
- Para 3, line 4, 'by the quality' NOT 'to the quality'.
- Reference 1. '*J R Army Med Corps*' NOT *J P Army Med Corps*.