Sir, I read Lieutenant Colonel Hawley’s paper (1) regarding 23 PFA’s deployment to Rwanda with great interest. Humanitarian operations to Rwanda, have multi-faceted and demand a flexible but realistic approach. The paper clearly describes the importance of mission definition without which confusion as to what can or cannot be achieved within a specific time frame is inevitable. It must be stated, however, that it is difficult to pre-plan totally before deployment when the local circumstances are not quite clear.

From the clinical point of view the treatments specified were virtually all non-surgical. The largest group was described as “Others”. For clarity’s sake this group deserved greater definition. Nevertheless, the point to be made is to consider a wider clinical input within a medical team deployed on humanitarian operations. DCS15 reduced our capabilities for example in Paediatric support, although it is agreed that the war role of Paediatricians before DCS15 was as Physicians, and RSCNs as general nurses. Presently two Service Consultant Paediatricians remain, plus several RSCNs. If the individual war-role concept is to remain then such a role surely exists for Paediatric staff within humanitarian operations. Various discussions involving outside agencies continue to try to develop an appropriate response to consider the affects of war on children. A co-ordinated response involving Non-Governmental Organisations (NGOs) is necessary. When the cause of the humanitarian emergency is war, as in Rwanda, there is an ethical problem sometimes in deploying military personnel as part of the co-ordinated team. The military, however, have good logistics, including communications (2), and their capabilities have been proven in Operation Safe Haven 1992 and in Operation Nightingale in 1988 (3). Admittedly the Army Medical Services were very well placed to offer assistance to the Nepalese population because the epicentre of the earthquake triggering Operation Nightingale was very close to the base hospital (BMH Dharan).

Lieutenant Colonel Hawley’s paper further confirms the need to co-ordinate services to include NGOs and, despite possible ethical considerations, assistance to humanity should include military medical staff if the defined mission requires them.

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HUMANITARIAN OPERATIONS
From Surgeon Commander CR Kershaw, RN

Sir, The review “Rwanda 1994: A Study of Medical Support in Military Humanitarian Operations” is a timely analysis of the medical contribution to an important peace enforcement deployment. As in Operation Safe Haven, this deployment involved the securing of a United Nations Humanitarian Protection Zone during the emergency phase of a disaster which involved a massive Displaced Population. In many ways it can be seen as comparable in International military/civilian co-operation to Operation Safe Haven, but it appears to have been approached medically in a manner which differs in a number of significant ways. Nevertheless, the “interim doctrine” is clearly influencing current medical planning and training in a positive and encouraging manner.

Lieutenant Colonel Hawley has succeeded well in highlighting concepts which are likely to have increasing relevance to many in the DMS and his description of the Disaster-Development continuum, capability mix, spectrum of military utility and force maintenance are excellent. Furthermore in a number of similar operations Operation Gabriel appears to have started with some confusion of initial mission statement and an assumption that contribution to medical humanitarian relief would be likely. Interestingly, it appears to have been the 23 Para Field Ambulance Group CO who “drafted” the two separate mission statements formalising the humanitarian relief work. This raises a number of questions as to the scope that exists for the improvisation of mission statements of this kind once the military medical team are deployed in the field. Bearing in mind the possible complications which Lieutenant Colonel Hawley described namely “politicization”, escalation of violence, problems concerning over-treatment of DPs, conflict within Unrealistic elements, both civilian and military, that can arise, these missions would appear to be potential minefields at the present time, particularly if one considers the actual medical tasks which Service personnel are called upon to perform in this situation. Unfortunately, these are not easily discerned from the text and the breakdown in Table 1 which gives no indication as to how many of the treatments were actually undertaken by PFA group as opposed to staff from NGOs alongside whom they operated. The same can be said of the account of the 95,453 vaccinations.

If, however, the age distribution of morbidity and mortality was in any way similar to that we assessed amongst the survivors during the emergency phase in Zikwa...
Northern Iraq 1992, ie approximately 50% under 5 years and 50% under 2 years respectively (1, 2) then one wonders whether lessons learned include the need for trained children’s nurses to once more be included in these groups. The problem with relying on the generalist, however skilled, is that training of doctors and nurses in child health is increasingly being separated from training in adult medicine.

A special committee of the United Nations, under the leadership of Mrs Graca Machel, has issued an important report on the impact of armed conflict on children. During the last 10 years, 90% of casualties in war have been civilians; two million children have been killed, four to five million children have been injured and twelve million are homeless. Where refugee and internally displaced persons are assisted through the setting up of camps, mortality and morbidity are maximum in the first two months of the camp formation. Young children under 5 are the most vulnerable and 95% of the deaths are from starvation and illness compared to only 5% from trauma (UNICEF 1997).

The rationale for including trained children’s nurses is not only for efficiency but also to avoid constituting a violation of International Humanitarian Law by not providing a sick or injured person (in this case a child, or rather many young children) with adequate care in accordance with Article 3 para 3 of the United Nations Convention on the Rights of the Child:

“States Parties shall ensure that the institutions, services and facilities responsible for the care or protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health, in the number and suitability of their staff, as well as competent supervision.” (3, 4).

All the more so if, as Lieutenant Colonel Hawley states, “The lead in creating the correct climate of trust and cooperation between uniformed and civilian humanitarian players will lie with the military” ... in the next medical deployment, the tasking mission of which becomes humanitarian?

Nevertheless, Lieutenant Colonel Hawley’s analysis, his insights and influence and especially his emphasis on a cooperative approach to pre-deployment training with the non-Governmental organisation community are greatly to be applauded. Let us hope that his training can be extended from PJHQ level through to the few RSCNs who remain in the Service who joined with such high ideals and aspirations and who wish to continue to serve. Their morale, as well as their knowledge, would be boosted if this were to be the case.

I am etc

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RWANDA 1994: A STUDY OF MEDICAL SUPPORT IN MILITARY HUMANITARIAN OPERATIONS.
From Lt Col A Hawley, RAMC.

Sir, I greatly welcome the comments of Brigadier GE Ratcliffe QHP and Surgeon Commander CR Kershaw. It was reassuring to see that both the correspondents had no severe difficulty with the concepts contained within the paper. However, their reasonable criticism of the lack of detail contained in the clinical data requires some explanation.

The mission to Rwanda was mounted at great speed. The advance party was on the ground within 3 days of the warning order and was rapidly reinforced by balanced packages from the rest of the contingent. At the same time, a massive amount of re-training, re-equipping and loading was being completed. Inevitably in the rush to deploy in as short a time frame as possible, the finer details of clinical data collection were relegated to a lower priority.

On arrival in Rwanda, operations began immediately. Simultaneously, HQ UNAMIR was absorbing the new increments to the force and evolving new procedures. One of the medical requirements was to develop a reliable and robust set of returns and reports. This took time to develop and so for humanitarian tasks, the available system used by the NGO community was used. This was the background to the data collection and collation, which was sufficient to meet the needs of the mission but not necessarily for the rigours of clinical and epidemiological research.

In answer to Surgeon Commander Kershaw’s specific question; the total of vaccinations performed included 25,000 completed by the unit alone and the remainder jointly with Medecin Sans Frontieres and MERLIN. This co-operative approach was productive and helpful. However, it does not come easily and demands patience and understanding on all sides. As to the treatments listed, all of those were carried out by 23 Para Fd Amb alone.

Both the correspondents have highlighted the need for specialist expertise in humanitarian operations. Whilst it is certainly true that some specialist advice will probably be needed, it is by no means certain that deployment of a full range of specialists will be required. Once again, it is the mission which should define the requirement. The skill
Defence Medical Services represents a capability gap for the necessary to meet that mission. Nevertheless, the current dearth of dependant care specialists within the regular Defence Medical Services represents a capability gap for the successful completion of humanitarian operations. It is to be hoped that the production of appropriate authoritative doctrine for humanitarian operations will provide the impetus for resolving this shortfall.

I thank Brigadier Ratcliffe and Surgeon Commander Kershaw for their comments and like them trust that the lessons of Operations HAVEN and GABRIEL have been absorbed. If not then we will be condemned to repeating the mistakes and relearning the hard way.

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“THE BATTLE OF WATERLOO WAS WON ON THE PLAYING FIELDS OF EATON”
From Maj P Harrison, RAMC

Sir, I read with much interest the lengthy article on sports related injuries by Majors Adams and Croft in J R Army Medical Corps 1997; 143: and must state how fundamentally I disagree with its tone and advice. The quote above by Lord Wellington perhaps argues my case more eloquently and it is clear that the authors of the said article completely fail to grasp the ethos of it. Football is by far the most popular game amongst the non public school graduate male population in the UK. This population is from where we recruit the bulk of our servicemen; these individuals have grown up with football as a way of life and perhaps for some a more important issue than that! There is no more an ad hoc version of the game than that played with a tennis ball, or even a coke can, in a school playground.

To suggest and even recommend that soldiers should be prohibited from taking part in organized football matches whilst serving on operations is both shortsighted and ludicrous.

Whilst deployed on operations soldiers experience long periods of inactivity punctuated by short periods of hectic work. During the periods of inactivity much work must be done by commanders at all levels to ensure they remain fit, operationally effective and occupied. The most effective method of doing this, in my experience, is by organizing sports for them which they enjoy. There is a level of danger involved in most competitive sport. Restricting this danger to a responsible level is quite clearly a function of command.

If the advice as offered in the said article were to be taken I firmly believe that whilst the sports related injuries would decrease, so too would the operational effectiveness and morale of the force, perhaps to a greater degree. Furthermore, I believe that a sharp increase in disciplinary cases, due to the men being bored, would be experienced.

The advice which should be forthcoming from the plethora of graphs and statistics in the said article, could perhaps be that sports should be properly organized.

As an officer who has been, and will be in the future, involved with the command of soldiers on operations, I would totally disagree with Majors Adams’ and Croft’s advice. I am firmly of the opinion that the advantages of playing organised competitive team games on operations far outweigh the disadvantages and will continue to consider football well worth “the risk”.

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FAILED MOUNTAIN SICKNESS PROPHYLAXIS
From Lt Col JS Crowley, US Army Medical Corps, Straughan, Dr V Lee, Maj PA Johnson, RAMC

Sir, For centuries it has been recognised that travel to high terrestrial altitude can result in incapacitating illness (1). The most common high altitude syndrome is acute mountain sickness (AMS), which can have dramatic effects on military effectiveness (2). Acetazolamide, a carbonic anhydrase inhibitor, is generally acknowledged to be the drug of choice for prophylaxis (3). We wish to report a recent adventurous training expedition in which inadequate prophylaxis resulted in a high incidence of disabling AMS.

Our laboratory was first contacted by expedition planners some months prior to deployment for advice regarding high altitude health and fitness. Eleven serving military personnel (average age 26.7 years, range 21-45) were to take part in a series of climbs over a 5-day period including two nights at 2775m, one night at 4350m and final 6-hour morning climb to 5700m. Mountaineering health information was provided to the team leader including the recommendation that the climbers should approach their local military health provider for appropriate AMS prophylaxis (i.e., acetazolamide). A copy of the Environmental Symptoms Questionnaire (ESQ) (4) was also provided in response to their request for a self-administered measure of well-being.

Upon the team’s return, the leader contacted us with the news that seven of the 11 climbers failed to reach the summit because of AMS symptoms, and an additional two climbers were forced to abandon the effort so that they could assist the ill. All recovered promptly after descent and rest. Analysis of anonymous ESQ questionnaires provided by the team leader revealed that all 11 climbers met criteria for AMS during the final summit attempt.
the physician was unfamiliar with this indication for the drug, and, according to the team leader, appeared reluctant to prescribe it. As a result, drug self-administration was virtually random - - three soldiers took two doses (500 mg qd x 2), four took one dose (500 mg), and four took no medication. (Usual regimens call for acetazolamide had been provided by the unit two days at altitude.) Not surprisingly, we found no difference in AMS severity among dosage regimens (one-way ANOVA, p>0.05).

Directly or indirectly, AMS caused 9 of the 11 members of this small training expedition to fail in their climbing objective. Had this exercise been a real world mission, the unit would have been rendered ineffective. Military physicians must be familiar with operational environmental medicine issues, including those related to high terrestrial altitude (4). In a young healthy population (e.g., active military), acetazolamide is a well-suited prophylactic agent and should be in every military physician’s armamentarium.

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From Lt Col A Hawley, RAMC.

Sirs, It is always stimulating and gratifying when debate ensues from published papers, particularly those which have a possible impact on future thinking and structures. After all, doctrine is produced and maintained by an iterative process. Thus, the interesting letter from Lieutenant Colonel Singer RAMC and Flight Lieutenant Howell is welcomed as is the opportunity to comment further.

Firstly, it is appropriate to be clear on definitions. In their criticism of my original paper Lieutenant Colonel Singer and Flight Lieutenant Howell use the term therapeutic nihilism as either a paraphrase of my concept of therapeutic minimalism or as an attributable implication of the paper. Both of these meanings I refute. Nihilism is defined in the Collins dictionary as “an extreme form of scepticism that systematically rejects all values, belief in existence”. This is a concept which is very far from the triad proposed in the original paper and cannot reasonably be ascribed historically to the clinical activities of the medical services throughout the battlefields of history.

Lieutenant Colonel Singer and Flight Lieutenant Howell make a very reasonable point about the required intensive care support needed postoperatively for patients subjected to damage control surgery. Equally reasonably they question whether such support is feasible on the modern manoeuvre battlefield. It will come as no surprise to them that similar questions were raised in North Africa in 1942 when the concept of forward surgery was being discussed for the mobile battles of the desert (1). Such clinical concerns were well intentioned but were ultimately conservative, cautious and therapeutically minimalist in effect. They were allayed by the improved clinical performance in the desert after the deployment of forward surgery. It is this development that drew Ogilvie’s comments about the context of surgery on the battlefield being generally more pertinent that surgical technique (2). That hard won truth, founded on the bitter experience of 6 year’s fighting, should be remembered when today’s battlefield is being considered.

A quick look at the Gulf War will illustrate the problem. In the words of a recent paper at the RUSI, “Absolute information dominance was achieved. Coalition ground forces could redeploy for the key flanking attack without detection or fear of disruption. Complete command of the air was established from the outset” (3). Even with this extremely favourable state of affairs, which it is difficult to see could be improved, there was a prolonged period from point of wounding to surgery for a large proportion of the casualties. Conceptually, it is thus easy to see the delayed removal from the battlefield will be the norm and that a shorter corridor of care is likely to require forward positioning of medical assets rather than reliance on CASEVAC means. This is where the proposed triad comes into play.

It was with some surprise that I read Lieutenant Colonel Singer’s and Flight Lieutenant Howell’s comments on the restrictions and constraints of damage control surgery to the battlefield. This is especially so since Mattox in an editorial in the British Journal of Surgery espoused the approach as being eminently applicable to military operations (5). This was a view which had previously been expressed by Ryan in the Journal of the RAMC (6). Given the combined
professional and military experience of these 2 authors, I personally feel loath to dispute the contention that damage control surgery does have an application on the battlefield. The point of my paper was to provide philosophical and operational context for this application. Hence, the development of the triad and the reconciliation of the tactically feasible and the clinically ideal.

The real concerns that Lieutenant Colonel Singer and Flight Lieutenant Howell expressed about inadequate resources available postoperatively seem to imply that unless all of the BATLS failures needing damage control surgery can be salvaged, then none should be. Clearly, this is a philosophically flawed argument. The casualties presenting for surgical resuscitation will themselves form a spectrum. Some will be eminently salvageable, others will demand additional resources while yet others will be beyond realistic assistance. It is for the medical commanders and the surgical personnel to apply suitable protocols in the tactical situation in which they find themselves. This is a familiar approach to military surgeons. Casualty selection through triage will continue to be an essential and continuing requirement of battlefield surgical intervention. We should guard against the best becoming the enemy of the good. War is the province of hard choices, and military medicine bears its share of difficult decisions. The inevitable environment of clinical austerity merely adds extra point to these.

Finally, I am uncomfortable with the idea that it is unethical to attempt surgical resuscitation unless there is the full suite of an intensive care facility immediately available. On the battlefield, this is to condemn many potentially salvageable casualties to an avoidable death. It is also a military nonsense and one which would rightly be denounced by the rest of the forces who will be intimately involved in the hazardous and demanding business of closing with the enemy. Far from being unethical to use the triad approach, it is ethically unacceptable to continue with a system which effectively allows men to die unnecessarily.

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ABSTRACTS OF PUBLICATIONS

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Abstract:
The British Army has encountered significant morbidity due to skin disease from the eighteenth century to the present time. The young age and pre-deployment screening of soldiers coupled with adverse environmental conditions produce a predominance of infective and eczematous conditions. The dermatologist still has a significant contribution to make in keeping the individual soldier healthy.

MAJ HR SMITH RAMC, MAJ AM CROFT RAMC


Abstract:
During the winter of 1995-1996, there took place a major deployment of North Atlantic Treaty Organisation peacekeeping forces to Bosnia. Epidemiological surveillance of British troops through the ARRC-97 programme has provided detailed information about their dermatological health. Skin disease was responsible for 12.7% of primary care consultations. Dry skin proved a common problem for troops. We recommend that emollients be placed on general issue during winter deployments to the Balkans. Dermatology should be included in pre-Bosnia training for all medical personnel.

MAJ AM CROFT RAMC


Abstract:
Objective: To evaluate the research evidence on the efficacy and tolerability of mefloquine chemoprophylaxis. Search strategy: Any potentially relevant trial from the Cochrane Infectious Disease Group’s register of controlled trials; systematic searches of Medline, Embase, Lilacs and Science Citation Index; scanning citations; and consulting drug companies and key investigators. We considered studies in all languages. Inclusion criteria: Trials carried out in non-immune adult travellers, and in non-travelling volunteers, where an attempt had been made to conduct a randomised comparison of mefloquine against placebo or against alternative standard prophylaxis. Results: 37 potentially eligible trials of mefloquine prophylaxis were identified, and 10 met the inclusion criteria. These 10 trials comprised a total of 2750 non-immune adult participants randomised to mefloquine or to a control. One placebo controlled trial examined malaria incidence directly and showed mefloquine to be highly effective in preventing malaria in an area of drug resistance. However, four placebo controlled trials showed that mefloquine was not well tolerated, and withdrawals were consistently higher in mefloquine treatment arms than in placebo arms (odds ratio 3.49 (95% confidence interval 1.42 to 8.56)). Five field trials compared mefloquine with other chemoprophylaxis. Mefloquine was no worse tolerated than other chemoprophylaxis, although there was possibly a trend towards higher withdrawals in mefloquine arms (odds ratio 1.33 (0.75 to 2.36)). Conclusion: One trial showed mefloquine to be effective in preventing malaria, but withdrawal rates, presumably from side effects, were high across most studies. This is likely to impair mefloquine’s effectiveness in general travellers, and it may therefore not be useful for routine prophylaxis. Mefloquine may be useful in specific situations such as for groups travelling to regions with a high risk of chloroquine resistant malaria and only limited access to effective medical care.