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How purple will be the white coat?

by
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The forces of change impacting on the Australian Defence Force, and in particular the Defence Health Service, are making themselves felt. These changes are significant, and will produce a significant change in the way health care is delivered to the Services.

In one of the early editions of Australian Military Medicine, Tony Austin wrote an article entitled 'Would that the white coat were purple'.1 In this article, Austin argued for a much more integrated Health Service, along the Canadian Defence Force model, with personnel being appointed to positions across Service lines based on their abilities, and with a minimisation of single Service rivalries allowing greater cooperation for the benefit of the whole Defence Force. The proposals for health made by the Defence Reform Program have embraced this concept wholeheartedly.

There are many in Defence who subscribe to the view that health is health, whether you are in Navy, Army or Air Force. There are others who are not so convinced, and argue that there are important single Service differences that demand some autonomy and uniqueness of the single Service health elements.

In considering this issue, it is vital to recognise the difference between public health and the provision of individual health care. The Defence Force is involved in both, but the characteristics of each are completely different.

In the provision of individual health care, there are few obvious differences between the Services. The clinical principles in the treatment of a fractured femur are going to be much the same whether it occurs in a sailor on a ship, the soldier in the field or an aviator who has speared in an F-18. There are likely to be some marginal differences in the details of management because of the availability of differing health care facilities in an operational setting, but by and large a doctor from any Service will be reasonably able to manage any of these situations.

It is in the provision of public health, and the management of a health service, where there are, of necessity, marked differences. This is most starkly apparent in some of the very specialised areas, such as undersea medicine and aviation medicine, where differences are demanded by the physiological impact of the unique and harsh environment.

In the operational environments, the differences are quite significant. Certainly, the individual injuries or illnesses are the same, but when looked at from a population perspective there are differences in the numbers of casual- ties. The generation rate for combat casualties, and the proportions of different types of casual- ties. The environmental hazards are different, the operational methods and constraints are different, the availability of health care facilities is different, and so on. The management of casualties arising from a mortar landing in a trench in the field is a world away from the management of casualties from an antiship cruise missile in a frigate at sea.

But even 'ashore' (forgive my obvious bent), there are differences.

For example, Defence is working towards a common system of medical restriction classification. A noble goal, but one fraught with difficulties, since there will need to be a subclassification system to make the distinctions that are relevant to the way each Service operationally deploys - for Navy, whether a person can go to sea, for Army whether they can 'go bush' and for Air Force whether they can deploy to a bare Base or to fly. The criteria for each of these will always be different - someone who is fit to go bush cannot be assumed to be fit to go to sea, and vice versa.

Even with a common classification system, joint operations are still likely to demand the use of three separate classes for each component of the operation - because sailor will tend to serve at sea, soldiers in the field, etc. Certainly, there will be a small number of cases where soldiers serve at sea, sailors in the field- but the proportions will be very small, and in any case.

A further advantage of a common medical classification system is seen to be that any medical officer, from any Service, will be able to give the 'right' medical classification for anyone. This will most likely be true for all those personnel who exhibit no pathology at all, but in those with some abnormality, is it really likely that a Navy MO will be able to make the right judgement on a soldier's fitness for the field? does that Navy MO really know what the conditions are like? What the workloads are like? What medical facilities are available? He might if he has spent most of his military medical career in the Army (but then isn't he in the wrong uniform?).

Of course, the medical classification system is a tool for determining operational fitness. But what of the strictly non-operational health services? Aren't they all the same?

When it is considered that the aim of these is to return people to duty, and to operational fitness, it follows that there must be a very clear understanding by health personnel of the individual Service requirements. It is also essential that they have an intimate understanding of the Service environment, since how can they make accurate judgements on fitness if they do not?

So can the purple coat work? What is it that health professionals must practise during their careers? Is it health, or is it health in a Service environment? If the former, with only scant regard for the Services. Then an integrated solution would be appropriate. Health Services personnel can get on and become experts in health, giving the Service requirement a low priority.

On the other hand, if the aim is to be a customer focused Health Service, health professionals must surely become experts in the Service environment. In the absence of a course on each Service's environment, ethos, management practices and so on, the only way of developing this expertise is exposure - continuous and long-term exposure. By that I mean, service in the Service, and as a part of the Service.

As we move to more integration, the great danger is that we will lose sight of the fact that we have two prime customers - our patients (individual health care) and our Services (management of a health service and their personnel within it).

There is no doubt that we must move to more efficient and effective utilisation of our infrastructure. This will inevitably make sharing of common services and facilities more wide- spread. The challenge is ensuring that we do not blur the lines so much that we cease to provide an effective service to our two customers. If we lose sight of the individual customer, we will incur their opprobrium and possibly see them in Court. If we lost sight of the Service customer, we will lose their support and be destroyed.