



AUSTRALIAN MILITARY MEDICINE

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Australian Military Medicine Association
Newsletter
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The original Newsletter editor was Major Mark Slatyer RAAMC, the current journal editor assuming the role for the March 1993 edition.

Australian Military Medicine Association

AMMA Newsletter

Volume One / Number One / February 1992

Inaugural Issue of AMMA Newsletter

This first issue of the newsletter has finally arrived after a long gestation. The purpose of the newsletter is to serve as a clearing-house of information on what is happening within the health services in the Australian Defence Forces. We are interested in news of any policy changes and initiatives from AMMA members or others. You are invited to contribute material to the newsletter which is topical and original. Scientific papers are welcome as well as less formal communication of relevance to health care practice within and outside the defence force. The newsletter will only be as good as the quality of the contributions of its members.

A Message from the Surgeon General Australian Defence Force

It is with great pleasure that I note the launch of the AMMA Newsletter. The publication of the Newsletter marks another step in the evolution of the AMMA towards the goals envisaged by the originators of the concept. In the case of the Newsletter the ultimate goal is that it will become a fully fledged journal of military medicine.

The practice of military medicine is, I believe, becoming a much more well defined form of medical practice than it has been in the past. While many of the facets of military medicine have their civilian counterparts, for example occupational medicine, public health medicine and, of course clinical practice it is the application of these disciplines to military operational circumstances which requires the special skills and knowledge of the military medicine practitioner and which distinguishes the practice

of military medicine from civilian practice.

Notwithstanding the distinction I have drawn above, there are sufficient common areas in military and civilian practice for the military medical practitioners' activities to be considered suitable and appropriate training for certain civilian qualifications. I find this extremely gratifying and acknowledge our indebtedness to those bodies who have seen fit to provide the military medical practitioners with these privileges.

I have no doubt that the Newsletter will serve as an important forum to spread the concept of military medicine as a discrete form of practice as well as a means of conveying specialised information relevant to the practice of military medicine to those engaged in that practice. I offer the Editor and those involved in its production my best wishes for a successful enterprise.

Air Vice Marshall M. Miller A.O.
Surgeon General
Australian Defence Force

AMMA PRESIDENT'S MESSAGE

An association is the sum of its constituent parts. I, and the rest of the interim council are extremely pleased that you have decided to join the Australian Military Medicine Association. For our group to flourish, it needs to develop a momentum that makes it self sustaining. We have the basis for an active and exciting society, but much still needs to be done. You will see elsewhere that regional and special interest groups are being formed. This newsletter offers a forum for original research, review articles, news and views. Whilst the association welcomes with open arms passive members, the more active you are I'm sure the more you will get out of it, and the more the association can grow, thus providing greater benefits to members. I have great hopes for the association and will be working hard to achieve them.

You will find a notice of elections with this newsletter. The process requires the proposal of members to specific positions within the council. If more than one nomination is received for a position, voting slips will be sent out. Those who nominate and miss out on being elected

may be co-opted onto the council. The first annual general meeting will be held later this year the official notice will go out shortly. This will be very important, for it will provide an opportunity to get more feedback on the direction to be taken by the association. Of particular interest will be the organisation of the first annual conference.

This is your association. Please let council members know what you would like to see the AMMA doing; even better, contribute copy to the newsletter or become involved in the organisation of some aspect of the association.

The potential is enormous I hope we can do Military Medicine justice. Enjoy your membership!

James Ross
Squadron Leader
President of AMMA

Member Biography of James Ross

A medical officer in the RAAF, currently posted to Edinburgh Air Force Base. Graduated from Monash in 1982. There have been postings to Richmond, East Sale and Pearce. A fellow of the Australasian College of Occupational Medicine, and presently in the middle of a Master of Public Health from Adelaide University. Received the Commendation for Brave Conduct in 1986. Married, with 1 child, and main interests are cricket, flying, philately and the South Pacific.

What is the Australian Military Medicine Association?

The AMMA has been created to be the scientific body representing the practice of military

medicine in Australia. This association fills a gap long left vacant in the huge and important field of military medicine. It is designed to serve all those with an interest in military medicine. It will be of particular interest to all who are members of the Australian Defence Force Health Services to whom this pamphlet is being sent, but membership is open to anyone with tertiary qualification in a health or life sciences area.

The AMMA is to be a scientific and social society which aims to:

1. promote the study of military medicine;
2. bring together those with an interest in military medicine in meetings and functions for both information and friendship;
3. disseminate knowledge of military medicine;
4. consider training in military medicine;
5. circulate a newsletter or journal; and
6. promote research in military medicine.

It is not to be a forum for discussing Conditions of Service in the Australian Defence Force. The Association will be an independent and self funding organisation. This pamphlet has been sponsored by the Royal Australian Army Medical Corps Committee, whose assistance in the establishment of the AMMA is greatly appreciated. The story so far. The Surgeon General of the Australian Defence Force has agreed to become Patron of the Association. An Interim Council has been established until elections can be held later in early 1992. All full

members will be entitled to nominate for council membership. The members of the council are:

President: SQNLDR James Ross
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SA 5065
Ph: (08) 333 0526

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Member: CAPT Darren Keating
 1 RAR
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 QLD 4813
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A constitution has been written. The association is in the process of being incorporated in the A.C.T. How is the Association to be structured? All those with relevant tertiary qualifications, or with significant standing or experience in Military Medicine will be full members. Students can join as Student Members. Qualification as a Registered Nurse will be satisfactory. All full members have full voting rights. There will be regional branches in states and regions as required by demand. There will be "craft groups" for subgroups within the association for different professional categories, i.e. Dentists, Nurses, Pharmacists etc., and different areas of interest such as Underwater Medicine, Aviation Medicine, Operational Health, Battlefield Surgery etc. There will be committees for conference organisation and others as required. There will be annual elections for all positions. The positions of President and Vice-President will be limited to medically qualified persons. There will be an Annual General Meeting in association with an Annual Conference.

What does the Association plan to do?

There are many ideas for the association which depend on both membership and enthusiasm. Plans are both short and long term. Within the first twelve months it is intended to have:

1. Regional branches organised for local meetings.
2. A newsletter, published regularly. This will have original research and review articles, as well as news. Please contribute! - contact Mark Slatyer.
3. An annual conference - the first is planned to be held in late 1992.

Later plans include a library, craft groups to promote the sectional interests of that group, a journal as a development from the newsletter, involvement in training in Military Medicine and research grants or prizes. All of these should be of direct benefit to members, while, at the same time, raising the profile of military medicine. To do all this requires members and, even better, members prepared to contribute. I appeal to you to be enthusiastic and get behind this association, and send off your application form today.

Submarine, Hyperbaric and Underwater Medicine Group

A Diving and Submarine Medicine Group has been set up within the AMMA. The purpose of this group is to improve knowledge in these fields of military medicine. To that end, the group plans to provide regular input into the Newsletter on Diving and Submarine issues, and to arrange local seminars. Two seminars have been tentatively planned:

26 March 1992 - HMAS Stirling.

**Dr John Williamson - Marine
Environment-Aeromedical Evacuation
using Blackhawk**

**November 1992 - Ballina/Byron Bay
Weekend Meeting - Diving & Submarine
Medicine - Dr C MacDonald - Meeting
Convener**

If you are interested in being part of this group, or have some suggestions for the group, please contact either the Convenor (LCDR Andy Robertson (09) 527 0561 or the Secretary LEUT Robyn Walker (09) 529 0754 at HMAS Stirling.

John S. Crawley MD, MPH

**Should Helicopter Frequent Flyers
Wear Head Protection? A Study of
Helmet Effectiveness.**

J. Occup. Med. 1991 33 (7) 766-769

Flight helmets have been recommended as aircrew head protection since 1908, yet debate continues regarding their effectiveness. Estimates of helmet use in civilian helicopter aeromedical programs range from 6.5% to 13%. The effectiveness of the Army's SPH-4 flight helmet in reducing severe head injuries sustained during helicopter accidents was evaluated using the accident data base at the US Army Safety Centre, Fort Rucker Alabama. Analysis was restricted to severe (Class A) accidents that were at least partially survivable, using US Army Safety Centre criteria. Occupants not wearing a protective helmet were significantly more likely to sustain severe and fatal head injuries than were occupants wearing the SPH-4 (RR = 3.8 + 6.3 respectively; $P < .01$). Unhelmeted non-cockpit occupants were at higher risk of head injuries (RR = 4.3 + 7.5; $P < 0.01$). All personnel regularly participating in helicopter flight, civilian or military, should be equipped with protective headgear.

Comment: You would have to have a thick head not to wear a helmet; maybe this prevented an even higher relative risk.

Gregory H Blake, MD, MPH: John A Parker Jr, MD, MS.

**Success in Basic Combat Training: The
role of cigarette smoking**

J. Occup. Med 1991 33(6) 688-690

We studied whether cigarette smoking affected a soldier's ability to complete basic combat training. Demographic and tobacco use information was collected from a cohort of soldiers before they began training. A list of all graduates was obtained and analysed against the initial questionnaire data. In this prospective study, the smoking group comprised 339 soldiers and the non smoking group comprised 535 soldiers. We found that those soldiers who smoked one or more packets of cigarettes per day were at a greater risk for failing basic combat training (Relative risk = 2.05; P = 0.902). There was no relationship observed between a soldier's education and his ability to complete basic combat training. Our data indicate that smoking one or more packets of cigarettes per day may adversely affect a soldier's ability to complete basic combat training.

Comment: Very interesting, but surely such a study belongs in an education journal.

A.W. Murrison, E.J. Lacey, M. Restler, J. Martinique and T.J.R. Francis
Institute of Naval Medicine, Gosport, UK.

Ten Years of Diving-Related Illness in the Royal Navy

J.Soc.Occup.Med. (1991) 41, 89-93.

The period from 1 January 1980 to to 31 December 1989 produced a total of 244 training and operational diving accident reports involving Royal Navy and Royal Marines personnel.

Because the incidence figures fluctuated widely year by year, a clear trend over the decade failed to emerge. However, the incidence of Type II decompression sickness, as a percentage of total decompression sickness, was greater in the second half of the decade than in the first, a trend similar to, although more moderate than, recent experience of dysbaric illness amongst sport divers. Student divers were disproportionately highly represented in the statistics, particularly with regard to pulmonary barotrauma and near drowning.

Should Defence Force Personnel receive Influenza Vaccine ?

by

James Ross

The attitude towards Influenza in Australia appears quite different to that of many other countries. Whereas mass immunisations have been conducted in the United States in response to threats of major epidemics, and there is widespread use of the Influenza vaccine in the Defence Forces in Europe and North America, there is little call for it in Australia. There are potential benefits to the defence force from mass immunisation of personnel. Both financial and medical. What is needed is a realistic scrutiny of the costs involved and the benefits accruing from an Influenza vaccination program.

The National Health and Medical Research recommendations for Influenza vaccination in 1991 were:-

A. individuals at greater risk of complications:-

1. Adults and children with chronic debilitating disease, especially those with chronic cardiac, pulmonary, renal and metabolic disorders.
2. Persons over 65 years.
3. Residents of nursing homes and other chronic care facilities.
4. Persons receiving immunosuppressive therapy.

B. Persons engaged in medical and health services, and essential public utilities if these individuals are at increased risk owing to medical disorders such as those above. In the event of a pandemic or other major outbreak, advice should be given about vaccination of staff particularly liable to exposure .

I suppose the Defence Force could be considered a public utility, but this reactive policy is at the mercy of the speed of transmission of the virus through the population and the supply of the vaccine. Even in response to the threat of a pandemic, mass immunisation is not recommended. Mr Brian Howe, the Minister for Health and Community Services, stated on 7 December, 1990 ... " The shortage of influenza vaccine experienced earlier this year gives some indication of the extent of public concern about Influenza and the awareness of the existence of a safe and effective vaccine. It is therefore important that, in implementing a vaccination strategy, the public health professionals, vaccine manufacturers and vaccine recipients understand the aims and objectives of the strategy in reducing the potential for serious morbidity in at risk groups, in promoting the role of natural immunity in the remaining population and in monitoring the efficacy of the vaccine and its potential for side-effects ... " .

When the demand for the vaccine went up, then, the response was not to reassess the recommendations,

but to suppress the demand. This is fair enough, if there is a strong argument for the policy as is. The argument alluded to by Mr Howe was that, despite the existence of a "safe and effective vaccine, natural, herd immunity should be relied on by the general population. Unfortunately, the vaccine is not wonderfully effective; the only epidemics of Influenza experienced at United States Air Force Base Lowry were when there was an antigenic shift in the Influenza virus, resulting in widespread disease in the vaccinated and unvaccinated populations . Theory goes that exposure to Influenza virus provides a stronger antibody response and better resistance to Influenza in the future for the individual, and also provides a pool of relatively protected people who should limit the spread of the virus through the community .

I consider that the arguments for vaccinating the Defence Force, and other working populations as well, are good. Firstly, it is not proposed to vaccinate the entire population; natural immunity would still be present. The extent of natural immunity for it to be effective on a population basis is not really known. The great advantage of reduced morbidity and mortality, is the economic benefit: a cost-benefit analysis for employers shows a cost saving, given certain assumptions. As this would be wholly employer funded, there would be a saving for the health care system, and improved productivity would improve the country as a whole.

A cost-benefit model requires the calculation, in dollar terms, of both expenses due to, and gains from intervention. Calculating human suffering is difficult. The effects are not only to the victim, but also to the family and others directly and indirectly affected by the illness. As such, the benefits in avoided suffering tend to be ignored, and gains underestimated.

Attempts to produce a cost-benefit analysis have been conducted, with varying conclusions. Many assumptions had to be made based on inadequate data.

The incidence of Influenza varies among populations and across years. It is only once every few years that an Influenza epidemic occurs in Australia. If a group is to be vaccinated, the costs may outweigh the benefits three times out of four, but the year of an epidemic could very well tip the balance in favour of the intervention.

At the heart of this Influenza vaccine cost benefit analysis is an estimation to be soundly based. This is an area of research that is crying out for study. A major problem with such research is that it has to continue until an epidemic occurs to be able to get a meaningful assessment of the difference between vaccinated and unvaccinated individuals. Studies estimating a reduction in sickness absence among workers have had to base their estimates on less than optimal information. To give you an idea of the sort of figures that we may be dealing with, I will outline a possible scenario. A mass vaccination campaign in the Defence Force may cost in the vicinity of \$15 per patient- including:- vaccine, materials, facilities, medical staff costs and time lost from work by the employee. If a vaccinated individual had a 0.5 days less in sick leave on average over the Influenza season than an unvaccinated individual, then using pay as a proxy for productivity in Defence Force, there is a saving of around \$75 per person. This level of saving need only be achieved every five years to make it viable, excluding savings to the health system and to human suffering.

The case for vaccination is not watertight by any means. There are problems of adverse reactions,

resistance to vaccination by some personnel, possible loss of herd immunity. However, if there is a desire to lessen the possibility of a marked reduction in the responsiveness of the Australian Defence Force due to an Influenza epidemic, and to reduce the excess morbidity and mortality due to the infection, while actually saving money, then the idea needs to be taken seriously and further investigated.

AMMA Membership List

Sub Lieutenant P.J. Aquilina
Colonel D.D. Beard
Flight Lieutenant R. Bernard
Group Captain R.B. Black
Captain L.B. Brennan
Squadron Leader G.K. Bruce
Colonel P.D. Byrne
Surgeon Lieutenant Commander G.M. Carter
Sub Lieutenant P.U. Carver
Squadron Leader N. Abou-Sief
Squadron Leader T.K. Austin
Lieutenant Commander R.G. Beran
Captain S. Birzer
Flight Lieutenant V.E. Bowden
Squadron Leader W.H. Brook
Lieutenant E.M.G. Burke
Lieutenant J. Canalese
Colonel R.F. Carter
Squadron Leader I.D. Catterson
Lieutenant Commander P.L. Champness
Flying Lieutenant J. Croft
Flying Officer J.S. Dobler
Colonel D.B. Douglas
Wing Commander M.R. Dugdale
Dr P. Faiz
Captain S.S. Farag
Major K.R. Fielke

Lieutenant Colonel R.K. Foreman
Colonel R.R. Freeman
Flight Lieutenant E.A. Coombes
Commander T.A. Dillon
Commander K.M. Donovan
Squadron Leader P. Duffy
Major D.J. Duncan
Sub Lieutenant D.J. Falbusch
Group Captain R.I. Fawcett
Lieutenant J.M. Flynn
Lieutenant Commander H. Foster
Commander J.F. Frith
Flight Lieutenant C.E. Fuller
Lieutenant A.D.S. Gibson
Major A. Gordon
Wing Commander R.A. Greentree
Wing Commander W.M. Griggs
Surgeon Captain P.G. Habersberger
Flight Lieutenant P.A. Handley
Group Captain W.K. Harrex
Group Captain M.M. Herring
Surgeon Captain T.J. Horgan
Flight Lieutenant F.A. Galea
Lieutenant Colonel W.J. Glasson
Flying Officer R.B. Green
Surgeon Lieutenant B.L. Greig
Flight Lieutenant R.C. Grimmer
Squadron Leader I. Hamilton-Craig
Lieutenant M.J. Harden
Commander W.F. Heddle
Dr B.E. Hockings
Dr W.H. Irving
Wing Commander D.W. Jensen
Captain A.J. Johnston
Lieutenant Colonel J.W. Kelly
Group Captain W.A. Land
Lieutenant S. Lee
Major M. Little
Lieutenant Commander C.J. MacDonald
Wing Commander B.A. Martin
Lieutenant Commander D.W. McKenzie
Dr C.C. Merridew
Flight Lieutenant A.J. Johnson
Commander I.S.C. Jones
Surgeon Lieutenant S.J. Kitchener
Lieutenant Commander S.A. Langford
Lieutenant Colonel I.O.W. Leitch
Flying Officer J.K. Lumsden
Lieutenant Commander C.R. Maron
Major M.J. McAuliffe
Surgeon Lieutenant Commander N.R. Menogue
Air Vice Marshall M.D. Miller
Air Commodore G.D. Moller
Commander T.M. Murphy
Dr M. Naughton
Wing Commander H. Nicolson
Lieutenant C.E. Parker
Flight Lieutenant H.E. Parsons
Lieutenant Commander G.L.D. Rawson
Lieutenant Commander A.G. Robertson
Captain P.M. Roessler
Lieutenant MDNS E.R. Royal
Colonel B.G. Mollison
Dr P.C. Myers
Professor G.C. Nicholson
Assistant Professor J.H. Overton
Commander F.J. Parkes
Group Captain R.P. Quirk
Captain K.A. Rickard
Flight Lieutenant J.W. Roe
Brigadier D.G. Rossi
Major S.J. Rudzki
Major M.J. Sandow
Surgeon Commander R.B. Schedlich
Squadron Leader D.E. Schuster
Commander G.S. Shirtley
Lieutenant SSSG R.B. Sinnamon
Flight Lieutenant T.L. Smart

Sub Lieutenant E.C. Stephensen
Flying Officer D.R. Stronich
Major M.M. Tuch
Colonel P.G. Warfe
Lieutenant F. Scalzo
Dr B.G. Schultz
Lieutenant Colonel M.J. Shannon
Commander J.H. Silver
Major M.A. Slatyer
Captain R.J. Stacey
Squadron Leader R.D. Story
Sub Lieutenant D.L. Thomas
Lieutenant D.B. Wallace
Squadron Leader D.R. Webb
Lieutenant A.J. Webster
Surgeon Lieutenant Commander N. Westphalen
Group Captain P.S. Wilkins
Squadron Leader J.A. Williamson
Sub Lieutenant C.A. Winter
Commander R.M. Wong
Wing Commander T.B. Woods
Lieutenant Colonel G. Wells
Colonel A.D. White
Colonel A.T. Williams
Flight Lieutenant G.C. Wilson
Lieutenant Commander R.J.B. Wolfe
Squadron Leader P.W.H. Woodruff

Submission of Material for the Newsletter

All members are encouraged send in articles, news or letters to the editor. There is a lenient editorial policy and anything which is not offensive, libelous or untrue will be considered for publication. All contributions should be sent to Major Mark Slatyer at the Medical Centre, Campbell Barracks, Swanbourne, WA 6010.

Formation of Craft Groups

Any members interested in forming special interest or craft groups are requested to contact Squadron Leader Marcus Skinner on (07) 280520. For instance any nurses, dentists, pharmacists, psychologists, physiotherapists or any other accepted craft group.
