

Contract health practitioner to the Australian Army

A personal perspective

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THIS ARTICLE describes some of the work, pitfalls, learning needs and benefits for a civilian general practitioner (GP) working for the Australian Army in the Northern Territory. I am employed as a Contract Health Practitioner (CHP). This is a salaried general practice position. CHPs are not deployed on operations or exercises; this is left to the doctors who are Regular or General Reserve Army Officers.

I have worked as a rural GP in several States for 30 years. I have plenty of experience in health administration, project work and injury prevention and rehabilitation, particularly with farmers. The work environment and work ethics of farmers have much in common with soldiers and this has helped in my current job.

My direct military experience is limited to my time in the school cadets, but I have various other connections with the Army. My father served in World War Two, and was in Darwin when it was bombed. My son-in-law is at the “sharp end” of the Australian Army. I worked at Woomera for 4 years when the rocket range was active and, as a civilian GP, was involved with a reserve unit for many years. I therefore have some understanding of, interest in, and respect for the ADF and the military ethos. I also have a reasonable understanding of how Government works, Commonwealth–State relationships and the frustrations of bureaucracy.

The job

I am the Regimental Medical Officer (RMO) for the 1st Combat Engineer Regiment (1CER) which, being part of 1 Brigade, is based at Robertson Barracks, Darwin. The 400 soldiers I care for train and work as infantry first, sappers (ie, engineers) second and specialists (eg, explosives experts, armoured personnel carrier drivers, dog handlers) third. They work on foot, from trucks and tractors, in specialised vehicles and even boats. They are experts in building things and blowing them up. They also train dogs to detect explosives.

I am stationed in the Regimental Aid Post (RAP) with a registered nurse, a senior medical assistant and (if lucky) 1 or 2



Sappers on a bridge-building exercise.



junior medical assistants. There is a waiting room, reception area, consulting room, offices, storage areas and a casualty/treatment area. There is a large medical centre with inpatient beds on base about 1 km away.

My patient population is vastly different from the usual general practice population: almost exclusively male (one female) and mostly between the ages of 16 and 30.

Soldiers are injury-prone, not only from combat, but because physical training, contact sports and general work take a heavy toll. There are hazardous substances to which soldiers can be exposed that are unique to their profession, ranging from explosives to capsicum spray. They are also expected to work and live under much harsher conditions than their civilian counterparts, except perhaps some people engaged in primary industry.

Elite athletes subject themselves to huge physical pressures, but this is usually under optimum conditions and their body type is suited to their activity. However, in the Army, soldiers

	<p>Dr Peter Morton, preparing to cut a large fishhook embedded in the finger of a patient.</p>
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Regimental Aid Post in the bush.



practise extreme physical activity while carrying heavy gear, in conditions that are often the opposite of “optimum”. Furthermore, “one size fits all”: a 20-year-old natural runner and a heavily built 40-year-old may be expected to cope with the same level of physical activity. Knee, shin and shoulder injuries — both acute and overuse — are particularly common. The average annual reported injury rate in the Australian Army from 1987 to 1991 was about 150 per 1000.¹ Lower limb, upper limb and back injuries were responsible for 74% of injuries in that period. The August 2000 ADF Health Status Report cites almost 50% of working days lost as being due to soft tissue and joint injuries.² Over 60% of these injuries were caused by physical training, running, touch football, Australian rules football or soccer.

The Army provides excellent human and physical resources for rehabilitation from injury and there are no restrictions on medications, investigations or referrals (except that interstate referrals require special permission). Like injury management in civilian practice, great emphasis is placed on active return-to-work programs under the supervision of doctors, physiotherapists and specialised physical training instructors.

Some surgical procedures (eg, tibial tendon transfers) that are popular and successful for civilians may not work as well in soldiers because of the huge stresses they place on their bodies.

ICER has an almost bewildering array of machines, equipment and specialised tasks for its soldiers. As Medical Officer, I have had to develop a working knowledge of all of these so I can manage the rehabilitation of injured soldiers and issue proper instructions about what a recovering soldier can and cannot do. This is particularly important, as there is a strong work ethic among most soldiers, who may continue working when injured, risking further injury.

Psychological problems and problems with drugs or alcohol are not as common as physical injuries, but can have huge consequences clinically, emotionally and administratively. The suicide rate within the ADF, while lower than the

Australian average, still represents a significant cause of death (the national suicide rate in 1998 for males aged 15–58 was 31.5 per 100 000; the rate for male ADF personnel aged 17–55 was 16.8 per 100 000).² Marital discord is more common among Defence families than civilian families,³ and this may be related to the amount of time soldiers have to spend away from home on duty. Soldiers are likely to be away for at least 4 months of each year on training missions, and active service overseas can be much longer. Some personnel from ICER spent 6 months in East Timor from late 2002, then 2 months on exercise in Queensland (with no time off except one long weekend), and were then deployed to the Solomon Islands. I had to brief the soldiers on health aspects of that deployment with 2 days’ notice; fortunately, I was provided with good notes. The challenge to soldiers and their families when faced with deployment into a hazardous environment at such short notice is much greater.

Clinical practice in the Northern Territory

Living and working in the Northern Territory has significant implications for clinical practice. The climate is hot and there are other hazards. Medical staff must have detailed and specific knowledge about such things as water requirements, avoidance and management of heat stroke, vaccination needs and protection against arthropod vectors of disease, as getting things wrong can have major adverse consequences for individuals and military missions.

Dr Arnold-Nott, the NT Director of Public Health, once described, in a lecture, the different pattern of infectious disease in the Northern Territory compared with elsewhere in Australia. Nationally, there are 40 notifiable diseases, but 70 in the Northern Territory. Influenza has 2 peaks per year. Melioidosis, Ross River fever, Japanese encephalitis and malaria are all potential threats in the Northern Territory. Bats, which often are



Magnetic ant hill aligned north–south.

found tangled in barbed wire, must not be handled as they may carry lyssavirus.

The Northern Territory also has a considerably higher rate of sexually transmitted disease than other States — similar to a Third World country. Alarmingly, last year's statistics for HIV, although few in numbers, are showing the characteristics of the sub-Saharan epidemic (ie, heterosexual spread and a high percentage of females among the infected).

Ethical concerns

Patient advocacy and respect for the traditional doctor–patient relationship are an integral part of the CHP's job, but the boundaries may need to be redrawn. Sometimes commanders can intrude unnecessarily upon the privacy of subordinates, but they often need to be consulted, particularly if a patient has work limitations or problems that may put others at risk.

For example, in civilian practice if a patient has depression or a substance-abuse disorder it is usually a private matter; in the Army, it may be absolutely essential that the soldier be prohibited from handling a weapon. Deciding when and how far to breach strict patient confidentiality can be very difficult; querying who has a “need to know” is a constant requirement.

The difficulties

The bureaucracy and pettiness of working within the Army system can be almost intolerable. Patience must be learned and ways found to work around the system and individuals! Basic supplies can arrive months after ordering, be over- or undersupplied, or not supplied at all. I have been waiting almost a year for a binocular loupe and no-one, including a Warrant Officer Quartermaster, seems to be able to secure one for me.

Providing vaccinations is a very important part of the CHP role, particularly when troops deploy overseas, and yet other activities may prevent this or at least make the logistics difficult.

A civilian doctor needs to gain a working knowledge of the military health system as soon as possible, as from the first day patients need medical classifications, chits written out, duties defined and so on.

It is particularly important to know how various medical examinations are done and what they mean in terms of a soldier's day-to-day work, rehabilitation, deployment or career. The Employment Standards provide a functional assessment of a soldier's ability to carry out military duties, define the physical and mental attributes appropriate to particular trades and employment, permit proper placement and indicate the member's suitability for deployment. There is also the closely related Medical Employment Classification (MEC).

Deciding the MEC is often straightforward, but can become a matter of great sensitivity when soldiers have complex or long-



Saltwater crocodile — one of the larger environmental hazards in the Northern Territory!

standing conditions that may compromise their careers.

How can the ADF help newly employed civilian doctors?

I was fortunate in that I worked at Robertson Barracks for a month before a more permanent move and was mentored by a colleague who is a Major in the Reserves and had been a permanent officer of that rank. He was very patient and helpful, as were other colleagues and nursing staff. I also had some idea from past experience of how such things as the PULHEEMS classification of physical and mental fitness worked. I also had the advantage of working in a medical centre with other doctors before I took up the position of solo RMO at a RAP. Altogether my orientation was most useful.

However, I do think that a more structured induction program should be developed. This might involve a lecture(s), mentorship and written materials. The material should include an introduction to day-to-day activities, such as medical examinations, and briefings on the role of the unit and the current operations under way.

It is also helpful to have presentations or written information on environmental factors potentially affecting the health of the unit (eg, fluid requirements in hot climates, local infectious diseases).

The ADF can and should keep its civilian doctors up to date with health developments and policies, particularly as they affect soldiers. Recently, CHPs have had the opportunity of attending courses in the management of alcohol and drug problems and in the prevention of suicide. These courses are consistent with National Goals and Strategies in the field of mental health, and I certainly believe that my management of soldiers with these problems will improve as a result of attending these courses.

It may be time to help even further with medical education. It is easy to avoid this subject, as most military doctors are contractors, but it is likely that there will be increasing requirements for quality certification of practitioners and health units in the future. It may well be in the Army's interest to consider this if it sees civilian doctors as being important in the future.

Doctors must learn as much as they can about the regiment they serve, where the soldiers train and work and what equipment and facilities they use. In this regard, I suggest that the ADF show doctors as much as is feasible, safe and allowable. To feel the weight of an unloaded .50 calibre machine gun, ride in an armoured personnel carrier or tank and climb over, touch, walk around or look at other equipment adds an important dimension of understanding to the management of patients and — dare I say it — adds an element of fun to the CHP's role!

Benefits of working as a CHP

Some factors that may attract general practitioners to work for the Australian Army as contract health practitioners (CHPs):

- The satisfaction of doing something for Australia at a time when military resources are stretched very thin.
- The chance to have some knowledge of and minor participation in military matters.
- The insight it provides into the problems of veterans.
- The challenge to develop new skills and thinking. Soldiers really test the limits in the way they push their bodies, often under extreme climatic and psychological pressure, and they need medical support to match.
- There is time to deal with problems in depth and to become informed about new clinical areas (eg, sports medicine, dermatology in the tropics).
- High rates of follow-up and patient compliance with therapy are easy to achieve because of the Army structure.
- There is no need to worry about recruiting patients, sending and paying bills, obtaining prescribing authorities and the many other tedious aspects of civilian general practice. CHPs are paid at an hourly rate that compares favourably with the returns of urban general practice.
- CHPs are paid to live in fascinating parts of Australia, which a tourist can only skip over. It can be a lot of fun and new experiences are to be had at work and play.

References

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The CHP needs more than technical knowledge. Equally necessary is good communication with the chain of command and the soldiers. Any doctor who does not make the effort to work with the non-commissioned officers is about as foolish as a junior doctor who doesn't make the very best use of senior nurses' knowledge and experience.

Probably the single most important thing that can happen to a "stranger" is to be accepted professionally and socially as part of the regiment. This has certainly happened to me. Unfortunately, administrators can sometimes view us as the same as any other contractor, rather than as members of the team. But close communication between CHPs and commanders, padres, psychologists, uniformed medical officers and other personnel is the key to a fighting fit unit.

The bottom line

As a CHP, I find my work environment and the clinical aspects of my job interesting and challenging. It is financially rewarding and there is no requirement for practice management and no costs except medical indemnity insurance. I would particularly recommend this employment for someone who wants a change from general practice or for young doctors who want to have a look around without being tied down.

It is a great way to see a fascinating part of Australia and I am pleased to be able to help the ADF at such a time, albeit in a small way.