ADF Health

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For subscription requests and enquiries, contact Colonel Geoffrey Stacey RAADC, Director, Defence Force Dentistry, Defence Health Service, CP2-7-93, Campbell Park Offices, CANBERRA ACT 2600. Tel. 02 6266 3941. Fax. 02 6266 3933. geoff.stacey@defence.gov.au

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Strength in unity and diversity

THE TEMPO OF OPERATIONS for the Australian Defence Force (ADF), and therefore the Australian Defence Health Service, has been astonishingly high over the past decade. Some of our members continue to provide health support in the Middle East. At the completion of a long engagement of the Defence Health Service in East Timor, Bougainville and the Solomon Islands, in which multiple units and individuals deployed, often in repeated rotations, to provide comprehensive healthcare to our forces, it is important to regroup, replenish, learn the lessons of these missions, and prepare for the next deployments. It is likely that peacekeeping operations will continue, but we also need to be prepared for combat support and to help maintain the readiness of our soldiers, sailors and airmen.

The diversity of the Defence Health Service professionals is exemplified in the eclectic range of topics presented in *ADF Health*, and demonstrates to the ADF at large the comprehensive range of expertise available in the Defence Health Service. On the one hand, this diversity is a strength, providing the ADF with medical, dental and nursing officers and specialists, paramedics, psychologists, technicians, medical scientists, radiographers, pharmacists, and allied health professionals. On the other hand, the relatively small numbers of healthcare professionals in each of these groups, the large proportion of medical and nursing specialists in the reserve, the small overall number of health service members in the ADF, as well as our support role in the ADF, all place the health services at a disadvantage in terms of our influence and bargaining power in the ADF. It is vital for the ongoing development of the Defence Health Service for us to act as a cohesive and united tri-service body of professionals who are respected for our individual commitment, our professional expertise, and our significant contribution to the health and wellbeing of ADF members, both within Australia and on overseas deployments. The imminent review by Major General Paul Stevens will help to reassess the role and structure of the Defence Health Service.

Consultants and specialists in various fields are also helping the Defence Health Service to improve their existing health policies and to develop new policy. This is an important role for the full-time medical and nursing officers in the Defence Health Service, and for the reservists who hold senior positions in their civilian employment and provide specialist knowledge, experience and advice to the ADF. The Consultative Groups to the Director General of Defence Health Service provide advice on the full range of healthcare issues relevant to the ADF. They provide a valuable resource for channelling new ideas to the Defence Health Service Administration, which can then generate current and pertinent policy for the ADF and revise extant instructions and policy. Injury prevention, mental health strategies for the prevention of drug and alcohol misuse and suicide, vaccination policy,

screening for illness on the return of members from operations, testing new antimalarial drugs (as presented in the article by Elmes et al in this issue), developing new fitness tests, setting the entry criteria for new recruits, cross-training and credentialling of the non-general surgeon to provide general military surgeons to the ADF are but a few of the more recent initiatives and policies being developed.

Thank you to all our contributors for continuing to provide us with such interesting material. This issue includes a personal perspective by Beran on the impact of epilepsy on the recruitment and continued employment of members, and argues cogently for a revision of the current restrictive policies. Bridgewater and Trudgen present the increasingly recognised problem of latex allergy, which has the potential to be a serious problem for some ADF members. The implications for the ADF are well described, and encourage new policy generation as a consequence. Ward and Donald present an important article on the principles of evidence-based compensation for veterans and serving personnel, which should be read by all members of the health services.

Skin disease is commonly encountered in our deployed forces, especially in the tropics. Upjohn and Kelly provide a timely review of skin diseases in war and peacekeeping, and Spelman and Maclaren provide us with a global perspective on tuberculosis and the implications for ADF members. As this disease is on the rise and resistant strains have emerged, we need to remain vigilant.

O'Connor presents interesting epidemiological data on mortality and morbidity at sea in the Royal Australian Navy, and continues the debate about what resources and personnel are required to adequately deal with emergencies at sea.

Rosenfeld and Kossmann take a somewhat futuristic look at the new products coming on line to improve blood clotting and blood replacement. Pearn presents a delightful biographical note on Southcott, who accomplished so much in his military and medical career, and provides a role model for young military doctors to scientifically investigate medical problems that arise in their practice of military medicine. To complete the issue, Brennan briefly profiles the 1st Health Support Company, which was the last ADF Health Unit to deploy on Operation Anode in the Solomon Islands.

The articles in this issue are mostly medical, and we would welcome more articles from the other professionals within the Defence Health Service and the Veterans Health community.

May we all celebrate the diverse contribution of our brethren in the Defence Health Service, and wish them well for their future service in the ADF. They are tremendously valued by all in the ADF, by the Australian Government, and by the Australian people.

Jeffrey V Rosenfeld
MB, MS, FRACS, FRCS(Ed)
FACS, FACTM, MRACMA, RAAMC
Colonel, Royal Australian Army Medical Corps
Editor, *ADF Health*

Malaria Update

Malaria in the ADF

Twelve cases of malaria in ADF personnel were reported to the Central Malaria Register in the period 1 January – 30 June 2004.

One case was diagnosed in East Timor, and 4 were diagnosed on return to Australia from East Timor. Two were relapses from previous infection.

There were no further cases from Bougainville. A thorough audit of the data has been conducted and a detailed breakdown of the malaria numbers from the military operations in Bougainville are included elsewhere in the journal.

Seven cases were diagnosed on return to Australia from the Solomon Islands.

One case was acquired in mainland Papua New Guinea by an ADF member on leave.

Total malaria infections in ADF personnel in various deployments

East Timor, September 1999 – June 2004	
Diagnosed in East Timor	82
Diagnosed on return to Australia	386
Total	**467**
Bougainville, December 1997 – June 2004	
Diagnosed in Bougainville	5
Diagnosed on return to Australia	59
Total	**64**
Solomon Islands, July 2003 – June 2004	
Diagnosed in Solomon Islands	0
Diagnosed on return to Australia	9
Total	**9**
Iraq, February 2003 – June 2004	
Diagnosed in Iraq*	1
Diagnosed on return to Australia	0
Total	**1**

*This case appeared to be an infection acquired in Papua New Guinea before deployment to Iraq.

Major Nathan Elmes
Research Medical Officer, Army Malaria Institute

Malaria reporting

All Health Service personnel are encouraged to notify the Central Malaria Registry promptly when a malaria casualty is detected. Informal notifications preceding a PM40 can be made by telephone (07 3332 4836) or by e-mail (Nathan.Elmes@defence.gov.au).