

# Fitness to Serve

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Steve Sponberg is ex- RAN and has a broad aviation and engineering background working as both a pilot (Helicopter) and contract engineer throughout the world over the past 20 years.

While working in the Solomon Islands and Timor, he carried out numerous medivac flights including winning 3 critically injured sailors from deep water fishing vessel and delivering them safely to medical facilities.

Steve Sponberg is currently Senior Project Manager for the MEC Implementation and Project Team.

Having managed a number of large Defence projects throughout Australia and combined with his aviation medical background, the author brought significant experience and assisted with the success of the MEC Implementation project



Captain O'Connor is the current Editor of ADF Health and a practising obstetrician and gynaecologist. He is also Section Editor of the Journal of Law and Medicine. Before joining the RANR in 1982 he spent 6 years as a Regimental Medical Officer attached to 31 Signal Regiment in London.



Brigadier Rudzki joined the Army Reserve in 1975 after completing high school. He became an officer cadet in Adelaide University Regiment in 1977 while completing his medical studies, and graduated as a 2<sup>nd</sup> Lieutenant in the Royal Australian Army Infantry Corps in 1980. He joined the undergraduate scheme in his final year of medicine and on receiving his medical degree from Adelaide University in 1982 he transferred to the Royal Australian Army Medical Corps.

Brigadier Rudzki has served in a variety of junior Medical Officer postings, including the 2<sup>nd</sup> Military Hospital, Regimental Medical Officer in the 3<sup>rd</sup> Battalion (Para), 8/12 Medium Regiment (Artillery) and the 1<sup>st</sup> Recruit Training Battalion. Brigadier Rudzki took a year of leave without pay in 1986 to work with the British Army as a Senior House Officer in Rheumatology and Rehabilitation at the Queen Elizabeth Military Hospital in Woolwich.

Command and staff appointments have included SO2 Medical at Headquarters Second Military District (1988-89), Officer Commanding Medical Company and Medical Support Company 1<sup>st</sup> Field Hospital (1989-1991), Officer Commanding Albury-Wodonga Medical Centre (1994-95) and Commanding Officer of Canberra Area Medical Unit (1997-1999). Brigadier Rudzki served as an exchange with the United States Army at the US Army Medical Department Centre and School in San Antonio Texas (2000-01). While there he worked in the areas of Telemedicine and electronic health records.

Higher education achievements include a Graduate Diploma in Sport Science (Cumberland College 1986), Master of Public Health (Sydney University 1997), and Doctor of Philosophy (Australian National University 2009). Brigadier Rudzki has had a long standing interest in reducing injury in military recruits, and has published a number of research papers on the subject. He was awarded a Defence Force Fellowship in 1993 to document and compare injuries in the Australian Army with Allied Forces. He was also responsible for the introduction of the Defence Injury Prevention Program in 2003, and his PhD thesis was titled "The Cost of Injury to the Australian Army". He was awarded a foundation Fellowship of the Australasian College of Sports Physicians in 1991.

Senior staff appointments have included Director of Preventative Health, Defence Health Services Division (2003-2005), Director of Occupational Health and Safety – Army (2005-2008) and inaugural Director of Army Health (2008-09). As the inaugural Director of Occupational Health and Safety, Brigadier Rudzki was responsible for the introduction and implementation of Army's Safety Management System and oversaw the introduction of Army's Risk Appreciation process.

Operational postings have included Indonesia (2 Field Survey Squadron, May-Aug 1983), Western Sahara (MINURSO April-Nov 1992), Bougainville (Officer Commanding Combined Health Element Oct-Dec 1999), East Timor (Chief Medical Officer for the United Nations UNTAET, July 2002 - Jan 2003) and the Middle East (J07 HQJTF633 July-Nov 2009).

Brigadier Rudzki received a Commander Logistics Command Commendation in 1994 and was awarded membership of the Order of Australia in 2005. He is currently Director General Strategic Health Coordination in Joint Health Command.

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## Introduction

Physical fitness and medical standards in the military are intended to ensure that recruits are able to meet the rigorous demands of service life (1) To determine whether a soldier was fit to serve in the United Kingdom or overseas during the South African War of 1899-1902 a system of medical classification was developed (1) This classification was subdivided during WWI following the gazettement of the *Military Services Act (1916) UK*: a series of lettered categories was introduced.

The United States Army introduced a screening program in 1917 for its officers, draftees and enlisted men to identify by psychological testing those men whose defective intelligence would make them a menace to the military organisation' (2) The modified system in the UK was chiefly designed to assess traditional infantry soldiers but failed to meet the demands for



AUSTRALIAN Idol judge Ian "Dicko" Dickson broke into a sweat under the discipline of an Army Physical Training Instructor (PTI) during his recent visit to East Timor. Dicko visited East Timor for a series of live broadcasts from Operation ASTUTE in July 2009 for Melbourne's Vega FM. Dicko was entertaining the troops of Timor Leste Battle Group 6 (TLBG6) as part of a Forces Entertainment Tour which also included performances from Australian music legend Ian Moss.

more specialised technology-skilled manpower during WWII. This was because: 1) it did not adequately define physical or mental limitations 2) it failed to describe any emotional or mental weaknesses and 3) it failed to adequately describe specific disabilities. As Fletcher explained:

*The range of employments available in the modern Army is extremely wide and varied, and each individual job brings into use different mental and physical functions (1).*

These weaknesses prevented posting staff from selecting suitable roles for soldiers with disabilities and thus maximising their utilisation in the total manpower. Minor disabilities were compatible with training jobs in a home base but were not acceptable for a soldier posted into an active combat role. So the lettered system was wasteful.

The Canadian forces under the leadership of MAJGEN Brock-Chisholm, Director General of Army Medical Services, introduced a new Army medical classification in 1943 called PULHEMS. This 7-category system of physical and mental 'qualities' included assessments of physical capacity (P), upper limb function (U), locomotion (L), hearing (H), eyesight (E) or (EE) in the subsequent British PULHEEMS system, mental capacity (M) and emotional stability (S). After a practical evaluation of the Canadian system among British forces, a similar system was introduced by the British Army in 1948.

Each of the seven 'qualities' were graded (up to 8 levels). If a soldier was classed as P6 he would be fit for ordinary work but would not be deemed to have the stamina even after training

to endure the strain and fatigue of full combatant duties. He could however be posted for restricted duties in a temperate climate. The RAF and RN insisted that for their respective personnel each eye be tested separately, with and without the aid of spectacles. So visual acuity was quantified bilaterally (EE).

If a serviceman was assessed as virtually deaf (degree 8 for "H") then he would be unsuitable for any military service. If a soldier's eyesight was at least degree 3 in each eye (visual acuity =6/12) or he had one eye equal to grade 1 (6/6 vision) and the other eye equal to grade 6 (6/36 vision) then he could be deemed suitable to both drive and shoot.

The PULHEEMS score could be used to designate soldiers' eligibility for service by means of a 2-letter code: FE (Forward Everywhere); FT (Forward Temperate); LE (Lines of Communication, Everywhere); LT (Lines of Communication in Temperate Zones); BE (Base Everywhere); BT (Base temperate) and HO (Home only). For example climatic restrictions to temperate zones were introduced by the British Army for men who had sustained eye, ear, skin and psychiatric illness in the tropics. This prevented unnecessary losses to their manpower. The PULHEEMS system catered for such restrictions by downgrading such soldiers under the P, S and M qualities.

In Australia the PULHEEMS system was adopted by the Army but subsequently incorporated as an adjunct to a Joint system of Medical Employment Classification (MEC). PULHEEMS described the physical and mental qualities of Army personnel, whereas the MEC system describes the suitability, in all three

Services, for employment and deployment, with short or long term physical restrictions and/or medical support.

Under the old MEC system, MEC 1 personnel had no restrictions, MEC 2 personnel were deployable with restrictions, MEC 3 personnel were temporarily non-deployable and MEC 4 personnel were permanently non-deployable.

In the ADF there has been a 4-5% decrease in the proportion of personnel deemed fully fit over the past 4 years. (6) Since April 2007 Navy personnel with a MEC1 category have fallen from 75% to 69%, personnel in Army have fallen from 74% to 70% and in Airforce MEC 1 personnel have fallen from 75% to 71%. There have been commensurate rises of between 2-6% rises in MEC2 personnel. Those with the lowest category MEC4 have remained static with between 1-2% of the workforce represented. The total permanent uniformed service personnel was 59,541.

### The new MEC system (2)

Before introducing the new MEC system in July 2011 there were extensive discussions with stakeholders in November and December 2010. These involved the MEC Implementation Project team and regional health professionals. It was a key driving force for the new MEC design. The new emphasis is on rehabilitation and return to work.

"MEC policy is being reviewed to provide greater flexibility for employment for members with permanent injuries. A key principle of the revised MEC structure is to focus the allocation of a classification not solely on the physical restrictions and health support requirements, but also on the inherent physical requirements necessary for employment in specific operating environments. In this way, the revised MEC structure seeks to maximise flexibility in employment options for Army's workforce managers and commanders."

[http://www.army.gov.au/woundeddigger/Welfare\\_Boards.asp](http://www.army.gov.au/woundeddigger/Welfare_Boards.asp) viewed 20 Aug 11

The ADF recognises its obligation to wounded or ill members and favours rehabilitating its own personnel rather than transferring them to the Department of Veterans' Affairs or into private rehabilitation facilities. This is one reason for the 20 year low rate of separations in 2010:7% (6). The new system further extends this principle.

The new MEC system has 5 categories:

- MEC1: Fully Employable and Deployable
- MEC2: Employable and Deployable with Restrictions dependent on available health support and the exact physical demands of a member in certain employment environments and location.
- MEC3 Rehabilitation. Member not fit for operational deployment. It signifies that there is an injury or illness or a pregnancy. The expectation is that the member so categorised will eventually return to a deployment classification.
- MEC4: Employment Transition: This means that the member will not recover sufficiently to return to their original occupation but may be offered an alternative occupation or a limited return to their original occupation.

- MEC5: Medically unfit for further service. The member is in the process of separating from the ADF because of their medical condition.

The new Extended Rehabilitation classification (MECJ32) is more closely aligned with the *Rehabilitation and Compensation Act 2004* (C'th). It allows members more extended time to recover (up to 24 months) and return to their former occupation. If complete recovery is impossible then members will be retrained for similar jobs nearby or at worst completely new jobs. Each of the 5 categories has a number of new sub-classifications which are based on the member's primary military occupation. These environmental categories will include:

- a. Joint (J). *This is the default environment code for all personnel within the ADF.* It is predominately used for all 'unrestricted' deployment personnel
- b. Land (L). This is used for Army personnel only with significant employment restrictions
- c. Maritime (M). This is used only for ADF personnel attached to a maritime environment who have employment restrictions

So for example J11 & J12 will replace the former MEC101. This will include members who are fully employable and deployable. The J12 category will include personnel wearing spectacles, foot orthotics and taking anti-cholesterol medication. Those members who are deployable with restrictions would include representatives from 5 Land and Maritime employment restricted categories as well as 4 Joint categories. : J21, J22, J23, M24, M25, M26, L27, L28 and J29.

Formerly those members would have belonged to one of 5 codes: MEC201, 202, 203, 204 and 205.

### Surveillance

Currently the ADF requires full time members to undergo a Comprehensive Preventative Health Examination (CPHE) every five years to annually, depending on age. A briefer Annual Health Assessment was conducted between CPHE.

From 1 October 11 this will be replaced by a new Periodic Health Examination and MEC Review. The frequency of this PHE/MECR will be based on age and Service. At each episode the MEC will be allocated or confirmed.

In between Preventative Health Examinations members employed in specialist occupations such as clearance divers and aircrew will be required to undergo an annual examination now called the Specialist Employment Classification Annual Health Examination (SPECCHA).

For Reservists Annual Health Declarations (AHD) will be introduced for those years that do not require physical examinations.

### Sources of Information about the new system

Training modules are available to all ADF members with more specific instructions available to:

1. administrative staff, nurses and medics - this details the roles and responsibilities of these health staff

2. Doctors and MEC Conductors-this outlines the methods for assessing and allocating MEC
3. Confirming authorities-this details the requirements for assessing and allocating an MEC

In addition two further training packages are planned:

- for Commanders informing them of the MEC System and outlining their responsibilities
- for ADF members outlining the processes of the MEC Review Board from a medical perspective

For those readers with DRN access please access the Joint Health Command website or use the link:

<http://intranet.defence.gov.au/vcdf/sites/MECSysyem/comweb.asp?page=67323&Title=Home%20Page>

For those readers without DRN access information can be sought online at: [Mec.Implementation@defence.gov.au](mailto:Mec.Implementation@defence.gov.au)

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### AURORA AUSTRALIS TRAINING CRUISE TO MACQUARIE ISLAND

Seaman Medic Danielle Dickinson, takes a blood pressure reading from a patient for their annual medical, onboard the RSV Aurora Australis. Thirty-one trainees from various categories of employment within the Royal Australian Navy (RAN) are on board the RSV \*Aurora Australis\* for an Antarctic trip-of-a-lifetime. The group, which includes Marine Technicians, Medics, and Communications Information Systems sailors under-training, ten General Experience 'Gap Year' sailors, and their supervisors, are sailing on the RAN leased P&O Icebreaker \*Aurora Australis\* to Macquarie Island, located in the subantarctic region, north of the Antarctic continent. The voyage is being conducted to pick up a group of Australian Antarctic Division employees who have been stationed at the world heritage listed island to carry out pest eradication activities. It will give the Navy's embarked trainees the experience of serving in extreme weather and oceanic conditions, rarely ever seen by Navy personnel.