

Foreword

It is my pleasure to introduce this Focus on . . . Primary Health Care in the RAMC Journal. It has long been acknowledged that the delivery of Primary Care to soldiers requires health care deliverers to possess a wide range of knowledge and expertise beyond that required to work in NHS General Practice.

In addition to the normal core activities of the consultation, management of chronic disease, and health promotion, AMS General Practitioners, Primary Care Nurses and Combat Medical Technicians are trained to assess and advise in areas such as Occupational Health, Force Protection, Musculoskeletal disorders, Infectious diseases and Pre Hospital Emergency Care. They are also expected to deal with complex ethical challenges on Operations, and be able to recognize when a soldier is having psychological difficulties and how to manage the situation.

The RAMC has a distinguished tradition, developed over the last

hundred years, of maintaining a strong professional training ethos for all those entrusted with the care of soldiers. In the 21st Century this tradition continues within medical centre teams in UK, Germany, Cyprus and Brunei. The main purpose of this training is to enable the teams to deliver the best care to soldiers when they are deployed on Operations.

A taste of this diversity of role and skill set is represented in the articles in this edition of the journal. I hope that you find them enlightening. The articles capture some of the enthusiasm, professionalism and commitment to the care of soldiers to be found within Army Primary Health Care teams. I am proud to recommend this reading to you.

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The Army Primary Health Care Service: From Foundation to Future

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Abstract

Following the British Government's implementation of policies to improve quality and introduce clinical governance into healthcare delivery in the late 1990s, the British Army commissioned a study into how primary healthcare for the Regular Army should best be delivered in UK. The study recommended a unitary command structure, with more central control based upon a model of a main headquarters and seven regions. The change has been largely successful and has been subject to external scrutiny. Areas still to be developed include improving information management and benchmarking standards against the NHS, improvements in practice management, plus developments in occupational health and the nursing cadres. The forthcoming Strategic Defence and Security Review and other ongoing studies are likely to have a profound influence on how the current Army Primary Health Care Service develops.

Introduction

At the end of the 1990s the new UK government introduced two seminal papers that drove quality [1] and introduced clinical governance into the NHS [2]. Concurrently, it was realised that the systems in place to deliver Primary Health Care (PHC) to the Army in UK were falling behind and were not delivering to an equivalent standard. Primary Health Care in the military context then included general practice, practice nursing, dispensing, practice based physiotherapy, practice mental health services, practice based occupational health and bedding down in Medical Reception Stations. Primary dental care was and remains separate, and is excluded from this review. In British Forces Germany (BFG), radical change had already been implemented following a "Market Test" that led to the introduction of an alliance with contractors, in turn followed by a contractor delivered service.

In UK, PHC was delivered by uniformed and civilian medical staff on regimental and garrison establishments, with loose

direction by a remote Commander Medical, guided by policy from the Army Medical Directorate and Defence Medical Services Directorate in London. The quality was variable, in general with higher quality services from the GP training practices where expert external scrutiny was applied, but with a distinctly variable quality elsewhere. In January 2000 the Army Policy and Resources Committee directed "that a study should be initiated to examine the options for delivering PHC to the army to appropriate standards and to meet operational requirements".

Brigadier Creamer undertook the well constituted study [3] and in the process was able to examine the implementation and outcomes of the contractor delivered service in BFG. Highlighted major risks were in dispensing and medicines management and the use of insufficiently qualified health professionals without adequate supervision. His conclusion was that UK Regular Army primary health care delivery should be under a single Top Level Budget (TLB), and as delivery was not core Land Command business, the Adjutant General (AG) TLB would be made the responsible owner. Other TLBs would become the intelligent customers with responsibility for auditing and setting specific targets in negotiation with the delivery organisation. The core principle that the Army Medical Services deliver a fully integrated occupational and primary health care service, using the same staff from the same premises, would remain.

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Implementation

The Creamer Report was accepted in full and largely implemented. An Integrated Project Team (IPT) with a 1* officer as Director, assisted by Army Medical Services (AMS) officers and crucially an Assistant Director (AD) level general staff Plans component, moved into part of the recently vacated Staff College in Camberley. Detailed Service Level Agreements (SLA) were devised between the IPT and major customers, namely HQ Land Command and the Army Training and Recruitment Agency (ATRA). Key professional and HQ staff were on the strength of the IPT while HQ Land and ATRA provided additional staff under Operational Control (OPCON) arrangements. These included Regimental Medical Officers (RMOs) and Combat Medical Technicians (CMTs). A symbiotic relationship was planned with key permanent staff on the strength of the IPT, and RMOs and CMTs benefiting from clinical exposure and training opportunities while reducing overall costs to Defence. The establishment was Military 310, civilian whole time equivalent 797, total 1,107, with an additional 362 OPCON from other Land Forces units. Crucially, the organisation would have a unitary command structure rather than the diverse mechanisms in place at that time.

The IPT planned a small central HQ with devolved regional structures holding delegated budgetary authority. At the HQ were the 1* Director, with 4 AD level pillars encompassing Clinical Services, Plans, Governance and Resources. There were 7 regions based largely on Regional Forces' Brigade (Bde) boundaries. Each was headed by a Regional Clinical Director (RCD), an AMS OF5 (Colonel) officer, with a mix of uniformed and civilian staff. Each region had an operations manager, the expectation being that all would have had recent substantial NHS employment. Also incorporated at major (SO2) level into the regional HQs were pharmacists, healthcare governance and occupational medicine staff, with captain (SO3) level health promotion and training, plus civilian finance and human resource staff.

The implementation was phased by Land Command Regional Forces (RF) Divisions (Div) in their old boundaries, commencing with 5th Division, moving through 2 Div and together 4 Div and London District. Separately Northern Ireland was brought into line, together with a minor redrawing of regional boundaries. This structure has largely remained, with minor alterations on changes in RF Bdes, and on arrival at steady state the IPT was changed into the Army Primary Health Care Service (APHCS). The ownership of APHCS changed in 2008, moving on the removal of AG TLB to being under command of the Director General Army Medical Services. The oversight of the

implementation was initially undertaken by a 2* Steering Group and a 1* Working Group, but on completion of implementation many tasks were taken forward by the new Unit, Brigade and Divisional Health Committees, assisted by higher level health committees at HQ Land Forces (HQLF) and Surgeon General's Department (SGD). The first Director of APHCS was a 1* officer from the general staff, subsequent Directors being an AMS Medical Support Officer and an AMS Professionally Qualified Officer.

The location of the seven Regional HQs were in Lisburn, Catterick, Colchester, Woolwich, Aldershot, Tidworth and Donnington. A map of regional boundaries, medical centres and Medical Reception Stations is at Figure 1.

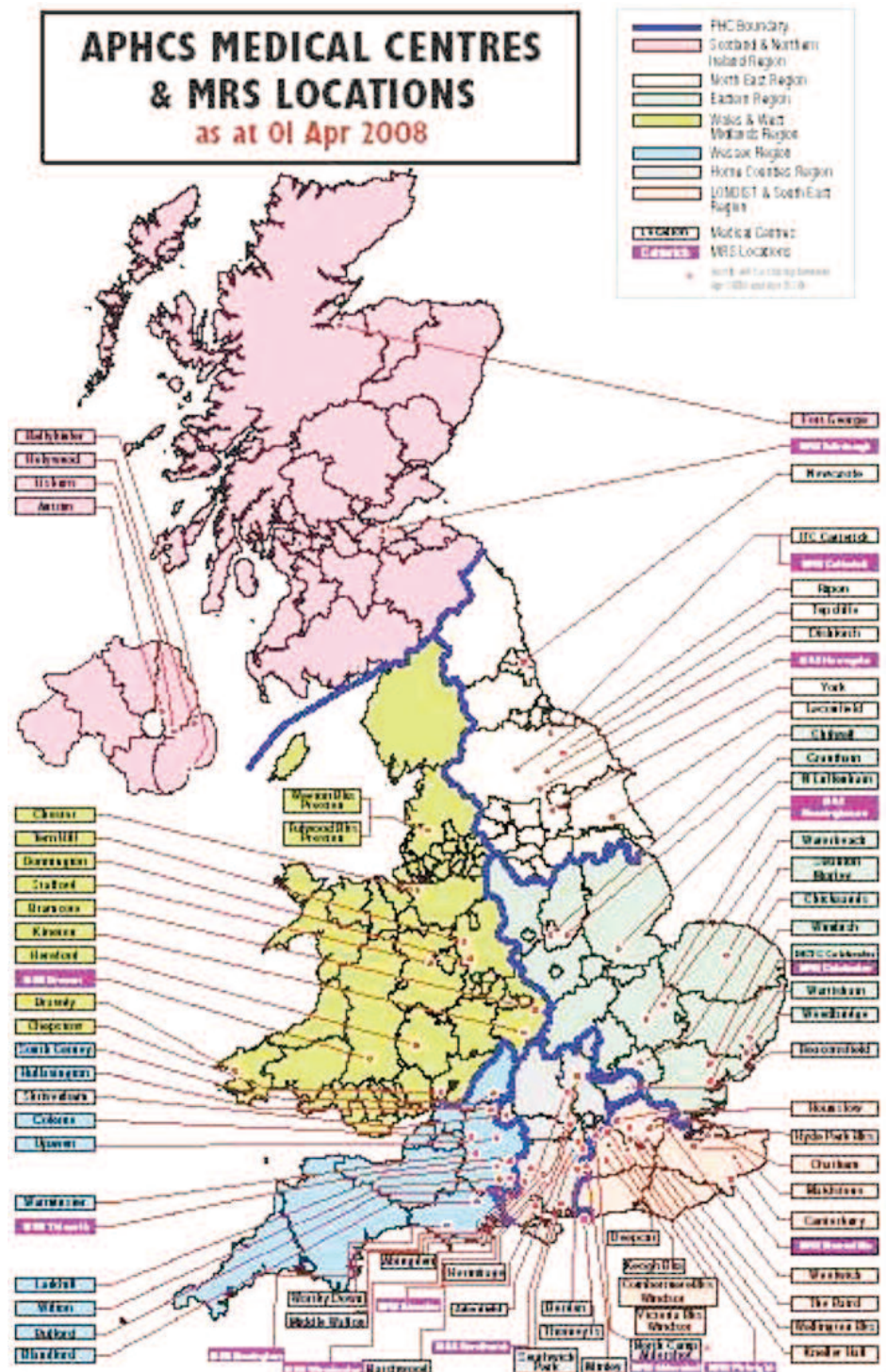


Figure 1 Map Showing APHCS Regional Boundaries, medical centres and MRSs.

Delivering an Improving and Quality Service

The assessment of quality has been based upon systems internal to MOD and external systems. At its inception, the IPT was tasked to bring in an external assessment framework in order to reassure patients and commanders of quality and standards of care. Internal systems were at three levels: SGD, Army Medical Directorate and APHCS. The internal targets have broadly and consistently been met and it is unlikely they would have been achieved had the previous structures remained.

The IPT's chosen external framework was the Quality Team Development organised by the Royal College of General Practitioners. Regrettably, there were insufficient trained assessors within the Army able to support the IPT / APHCS, and the external assessment remained incomplete. In 2008 the Surgeon General invited the Healthcare Commission to review the whole of the Defence Medical Services and their review [4] of the APHCS element scored positive for medical management and improving the health of soldiers, but negative on some of the PHC infrastructure and inadequate facilities. Medical infrastructure has in places remained poor with many small, isolated practices still inadequate for modern PHC delivery. However, recent total rebuilds have occurred in Woolwich, Leconfield, Lisburn, Colchester, Pirbright and Woodbridge, with many major refurbishments elsewhere.

The centrally funded and SGD controlled IT programme, Defence Medical Information Capability Programme (DMICP), is functioning well as an electronic record accessible across non operational Defence terminals. As a clinical record it is excellent, but as a management tool it has not yet delivered for APHCS. Its phased implementation was extremely disruptive to healthcare in APHCS with repeated system crashes and time off line. Many problems were the result of legacy IT systems, limited bandwidth and delays in the rollout of the Defence Information Infrastructure (DII). Management information is not available at HQ level and it has been impossible to demonstrate quality healthcare or improving outcomes, or to benchmark quality against NHS practice. Although electronic transfer of laboratory data occurs in many sites, integration with the NHS, including Choose and Book and electronic transfer of notes to NHS GPs, remain unachieved.

Working in Partnership with the NHS

APHCS has worked increasingly in partnership with the NHS and no more so than in the care of seriously wounded casualties from OPs HERRICK and TELIC. Prior to discharge from Selly Oak Hospital, staff from the University Hospitals Birmingham NHS Foundation Trust arrange specialist PHC with an NHS Trust where the soldier will be living. Other areas of cooperation with NHS Trusts are in the commissioning and funding of Secondary Health Care in local NHS Trust hospitals, plus the provision and funding of out of hours services. APHCS links in with local NHS health promotion activities, and has been active in joint health fairs to improve the health of soldiers and their families. The funding agreements are described in the Department of Health document: Who Pays? Establishing the Responsible Commissioner [5].

APHCS additionally uses the NHS for training of GP registrars and other staff. Some arrangements are undertaken by the Defence Deanery, some by the Army Medical Directorate and others arranged through local contacts. The NHS experience is frequently broader than that able to be offered in Military GP training practices. This is required for GP registrars and is helpful updating for all Military health professionals.

Medicines Management and Dispensing

The Creamer Report [3] highlighted pharmacy as a particular risk with a failure to meet legal requirements, inappropriate staff and poor governance. Using a mix of uniformed and civilian staff, APHCS placed a pharmacist in each regional headquarters, ensured the largest medical centres had a pharmacist on site, and that all pharmacy staff were correctly qualified. Later changes included the MOD contractorisation of UK pharmaceutical supply, together with outsourcing. Following outsourcing in the smaller medical centres, the prescriptions have been transmitted to the contractor's local pharmacy from where the medicines have been transported to the APHCS medical centre for issue to patients. This outsourcing has successfully reduced risk and errors in UK but has increased the risk on deployment, with CMTs and pharmacy technicians having less hands on experience of medicines management in UK.

Rehabilitation: at the practice level and in Regional Rehabilitation Units (RRU)

Prior to the inception of APHCS, rehabilitation occurred in local physiotherapy units at the practice level and more advanced inpatient rehabilitation at the Defence Medical Rehabilitation Centre at Headley Court. This was reviewed in a seminal report on Defence Healthcare "The Quinquennial Review (QQR)" [6] and was deemed insufficient. A centrally funded additional layer encompassing residential care and specialist clinics was established by the then SGD. New Fast Track access to investigations such as MRI and surgery bypassed the lengthy NHS waiting lists prevalent at that time. The single Services ran the RRUs in their main bases with direction from the Rehabilitation Executive Committee overseen by 1* SGD lead. The RRUs had considerable investment, with new facilities in Catterick and Tidworth as part of the new garrison sports complexes. Each Service continued to run their own local physiotherapy departments, APHCS running 68 across UK. In 2008 it was decided to bring standardisation, central direction and control, by placing all RRUs under Lead Service arrangements of the RAF.

Community Mental Health

Defence mental healthcare delivery was also reviewed in the QQR [6] which determined that the focus should be based upon local Departments of Community Mental Health (DCMH) run by single Services. The inpatient unit based within the old Military hospital in Catterick was recommended for closure, with inpatient care being delivered more locally via an independent provider. The ownership of the DCMHs in the Army was placed under APHCS with oversight from the 1* SGD Mental Health Executive Committee. The multi-professional DCMH staff of uniformed and civilian psychiatrists and specialist mental health nurses, aided by social workers and SGD psychologists, has proved successful. Ownership of the RN and RAF DCMHs was transferred to APHCS in a Lead Service capacity with full operating capability on 1 Apr 2010, mirroring the transfer of RRUs to the RAF, but delayed one year. The command structures are markedly different, with APHCS as a devolved organisation running the DCMHs as regional assets through the local RCD, with the RAF commanding the RRUs through their central HQ.

Areas for Ongoing Development

The leadership and management of practices, particularly the small ones, remains sub optimal and an internal APHCS review is in progress. The few staff in these small centres are frequently all from

different organisations, with some practice managers being on Regimental strength, the one doctor variously being an RMO, a MOD civilian, a contracted doctor from the NHS or a locum. Often the only APHCS employee is a clerk. Knowledge of equipment support and understanding of how infrastructure improvements are organised has been poor across APHCS, particularly at the practice level and in the regional HQs where there are no dedicated infrastructure and equipment staff.

The delivery of occupational health has not been in accordance with recommendations in the Creamer Report. Creamer recommended that each region should have an occupational medicine (OM) consultant, together with an SO2 occupational health nurse. The latter were established, but caps on liability prevented the establishment of an OM consultant per region. The requirement for these specialists has changed markedly with the stricter HM Treasury rules on medical qualifications for those undertaking retirement medical assessments [7]. Although the utilisation of occupational health nurses has changed, the workload of OM consultants has increased as a result of the numbers of soldiers seriously injured on Ops. It is expected this will increase further with the announcement [8] by the Under-Secretary of State for Defence on enhancements to rehabilitation, followed by the Army's restatement of the endorsed principles that not all injured soldiers can be retained in the Services.

The practice nurses in APHCS have neither developed as far nor as fast as those in the NHS, and little progress has been made on the use of more highly qualified and capable nurse specialists within the practices, the majority of whom are civilian. It is likely that autonomous nurse prescribers and nurse practitioners would be highly suitable for APHCS practices. To some extent changes have been slowed by the need to support and supervise General Duties Medical Officers, junior doctors who have completed Foundation Years 1 and 2 but have yet to enter specialist medical training.

General practitioner training is undertaken in 10 GP training practices in APHCS, but the system is fragile with insufficient uniformed or civilian GP trainers, plus the frequent deployment of trainers and registrars. The few registered dependants (9,500) and their limited morbidity does not reflect an NHS population. Although currently unknown, the forthcoming Strategic Defence and Security Review (SDSR) may impact upon Germany and Cyprus, thereby affecting the viability of GP training in these locations, and by inference UK.

The use of uniformed staff from Field Army units under Operational Control (OPCON) arrangements as laid down in the SLA has not proved wholly successful, partly because of the conflict of loyalties inherent in the arrangement. Although it provides ongoing clinical opportunities, allows regimental patients to be seen by health professionals from that unit and reduces costs of additional staff, the operational tempo means that staff are increasingly removed from medical centres. This has been disruptive to ongoing clinical care and means that patients can see a stream of different health professionals. The staffing of the bedding down facilities at night and weekends with uniformed health care assistants (HCAs) and CMTs proved impossible under the SLA arrangements and APHCS has recruited additional civilian HCAs on a permanent basis.

Possible Future Developments

APHCS is currently working on examining the feasibility of combining with British Forces Germany Health Service. Such a combination would not be simple. APHCS is an Army led organisation, mainly using uniformed and civilian MOD staff. BFGHS is a government owned, contractor operated, organisation in primary, community and secondary care, with MOD staff embedded at all levels in PHC. Merging these structurally and culturally diverse organisations would be difficult. The BFGHS contract renewal in 2013 adds opportunities.

The operational tempo with its increase in serious injuries is making APHCS address training needs and how services are delivered. Decisions will be needed on whether APHCS should refocus on the care of the seriously injured or allow experts from the NHS to provide this lifelong care, frequently on a round the clock basis. APHCS is currently only mandated to provide services to the Regular Army, specifically excluding Reserves. Unless mobilised, the Reserves retain a fragmented occupational health system controlled at Regional Force Divisional level, and although a partial trial using a contractor is underway, options will need to be examined for future structures, possibly with APHCS in the lead if not actually delivering.

Decisions will also be required on the optimal time during medical careers when the Army should recruit health professionals. An economic evaluation of the costs and benefits of recruiting medical cadets, together with their subsequent years of specialist training, may show there are more efficient methods of delivering appropriately trained medical practitioners to the Armed Forces.

The pre SDSR consultative Green Paper, Adaptability and Partnership; Issues for the Defence Strategic Review [9] is limited on health issues, but states that people in the UK expect the method of healthcare delivery to change. The SDSR is likely to make significant changes to Defence PHC, and thus to APHCS and its remit. It is possible that the SDSR will accelerate moves to merge the HQ functions and governance of UK PHC delivery into a Tri-Service delivery organisation.

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General Practice Training in the Army

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Introduction

Education in General Practice is undergoing a period of considerable change. The implementation of Modernising Medical Careers [1] resulted in radical remodelling of the structure of postgraduate medical training in the UK. In parallel, the criteria within the regulatory framework of the Postgraduate Medical Education and Training Board (PMETB) for approval of specialist training in General Practice was revised, prompting UK deaneries to review current General Practice Vocational Training (GPVT) schemes [2]. Following this revision PMETB merged with the General Medical Council (GMC), which now holds responsibility for the regulation of all stages of medical education and training. With NHS primary care evolving rapidly in response to the Tooke report [3] and other influential policies, it is inevitable that general practice specialist training will continue to face change in the next few years. So is the British Army still a good place to train to be a GP?

Background

When GPVT was formally introduced in the UK in the early 1970s, the Army developed three-year GP training schemes incorporating time in GP training practices and placements in military hospitals; the first of these was in Germany. The Armed Services General Practice Approval Board (ASGPAB), led by a civilian chairman, was established to set the standards for training in military General Practice. The standards were set at a level above the equivalent in the NHS because of the identification of a need to ensure high quality GP training in practices with large turnovers of staff and patients. In 2003 ASGPAB was re-named the DMS General Practice Education Committee and remains under a civilian chairman appointed by the Secretary of State for Defence. With 60% of UK medical graduates said to be undecided as to their final career destination 18 months after graduation [4], deaneries across the UK face the challenge of developing new general practice specialty training programmes which not only train doctors who are equipped with the competencies required for 21st century primary care, but also, by being attractive training programmes, encourage recruitment of high calibre doctors to General Practice. By offering the opportunity to delay specialty selection whilst military doctors complete their time as a General Duty Medical Officer (GDMO) and providing diverse and challenging training opportunities, a varied career and well funded continuing professional development, the military once again has the opportunity to present itself as the favoured option in comparison to civilian training schemes. Figure 1 outlines the career progression on the Army's GPVT.

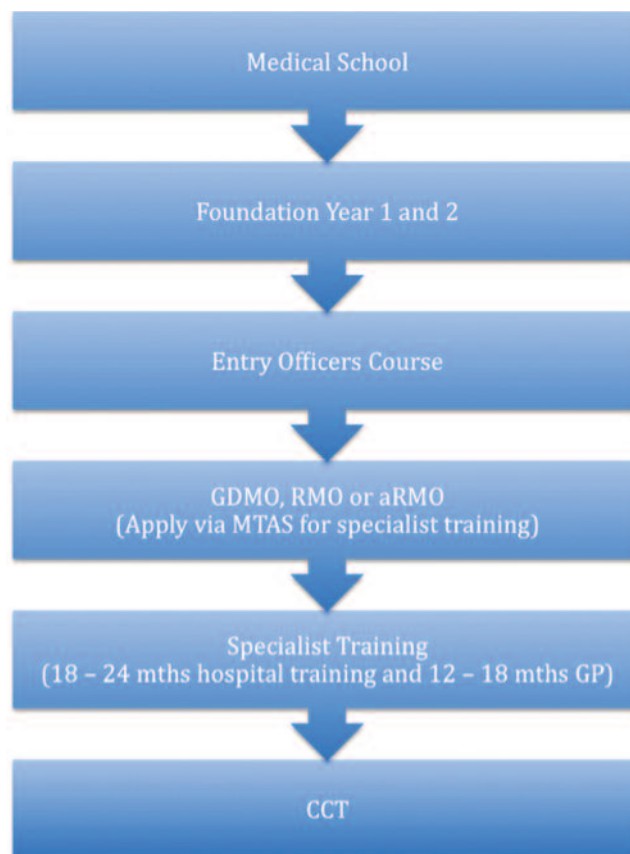


Figure 1: Clinical Career Progression for Army General Practice Vocational Trainees

Foundation Programme, Entry Officers Course and General Duties

While a small number of trained GPs join the Army fully accredited as GPs, the majority of Army GPs begin their military careers as medical cadets, receiving sponsorship through the final three years of medical school from the Army Medical Services (AMS) and opening up opportunities for completing military attachments as part of their studies and electives. To be accepted into the Royal Army Medical Corps (RAMC) as professionally qualified officers (PQOs), candidates are required to successfully complete Officer Selection at Westbury alongside non-professionally qualified applicants who will go on to complete the full year at The Royal Military Academy, Sandhurst (RMAS).

Following graduation doctors complete the Foundation Programme, a two-year programme of training rotating through a variety of specialties, which acts as a bridge between medical school and specialty training. All military doctors are required to gain experience in Emergency Medicine during these two years and are encouraged to spend time in General Practice. During the Foundation Programme multiple work based placed assessments must be completed and clinical skills and competencies need to be demonstrated and "signed off". If the core competencies are

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successfully attained trainees receive full registration with the GMC at the end of the first year of Foundation training. The majority of Army Foundation Trainees complete their placements in Military Defence Hospital Units (MDHUs) or in locations within a NHS Deanery that have a MDHU within its boundaries.

Following completion of the Foundation Programme, Army medical officers complete the five month Entry Officers Course (EOC) alongside other PQOs. This comprises military training at the Royal Military Academy Sandhurst (RMAS) (Phase 1), the Defence Medical Services Training Centre (DMSTC) at Keogh Barracks (Phase 2A), and a programme of education on the specific demands of military medicine (Phase 2B). The time at RMAS has recently been extended from four to ten weeks in response to a review of the EOC and consistent feedback from PQOs. Phase 2B of the EOC is facilitated by the Department of General Practice at RCDM and aims to prepare the medical officer for their first job. It is the envy of many civilian colleagues, incorporating certified courses in Advanced Life Support, Battlefield Advanced Trauma Life Support and Major Incident Medical Management and Support, as well as training in travel medicine, minor surgery, military psychology, occupational health, sexual health and reproductive medicine and other military-focused medical disciplines. Training objectives are aimed at providing the additional competencies required to be a military doctor working in Primary Health Care.

All medical officers, including those intending to specialise in hospital medicine, will then be posted as a GDMO, either working as a Regimental Medical Officer (RMO), assistant RMO or serving within a medical regiment. All GDMOs have an identified GP supervisor, clinical experience is overseen and doctors are encouraged to use this period to gain a greater understanding of the wider army. For many this posting will include operational experience.

Selection into Specialty Training

Since 2009 Army doctors wanting to apply for GP speciality-training scheme have been able to do so early in their time as a GDMO. Alternatively they can complete a full tour of general duties (usually 18 months) and then apply. The GP National Recruitment Office manages selection into GP training on behalf of all United Kingdom deaneries. Entry into training involves three stages of application: on-line application, short listing using a written applied knowledge and situational judgement test, and an assessment centre process. The assessment centre process comprises of three 30-minute exercises; a simulated consultation, a group exercise and a written exercise. In addition all applicants must meet the person specification and the essential competencies required for entry to GP training [5].

Unlike civilian applicants who make one application for up to four preferred deaneries, military trainees apply solely to the Defence Deanery. However they complete the same assessments as their civilian colleagues, a process facilitated in collaboration with the West Midlands Deanery, and are required to benchmark against national standards. Around 40 military doctors enter GP training each year, approximately 25 of which are in the Army.

The GP Training Programme

Applicants selected into General Practice speciality training are invited to attend an induction day prior to the start of their specialist training. Trainees are provided with comprehensive guidance on GPVT, key personalities are introduced and advice offered by current General Practice specialist trainees.

The requirements for general practice training are laid out in UK legislation. Training programmes require a minimum of 36 months of approved training and stipulate at least 12 months full time

employment as a GP Specialist Registrar (GPStR) under the supervision of an approved trainer and at least 12 months full time employment (or the equivalent part time) in hospital training posts approved for GP training. Time in hospital training posts must demonstrate an appropriate balance of relevant hospital specialties and are organised by the Defence Deanery in conjunction with single Service Advisors in General Practice and manning authorities. The majority of DMS GPVT hospital posts are located within the MDHUs.

The Defence Deanery policy is that at least 18 months of GPVT is spent in an accredited GP training practice with a GP trainer. It is also DMS policy that a minimum of 6 months of this time will be spent in a civilian GP training practice in order to gain NHS experience. This may be on a sessional basis (for example one or 2 days a week in a civilian training practice with the remaining days in a military GP training practice) or involve a full time attachment to an NHS practice as part of the GPStR period. Time in a civilian training practice is considered necessary in order to gain sufficient experience in the breadth of primary care pathology and to ensure the knowledge of NHS practice management required to pass the MRCGP examinations.

Time in an accredited training practice can be split within GPVT or taken as a single block at the end, although the final 6 months of GP specialist training is always in a general practice post. In order to complete their training all GPStRs must also complete out-of-hours experience and be assessed as competent in managing the unique challenges faced in delivering such a service.

Supervision

Throughout GPVT trainees have both a clinical supervisor and an educational supervisor. Clinical supervisors are responsible for overseeing the day-to-day work of the trainee while he or she works in a particular training post, whilst the educational supervisor is responsible for monitoring the ongoing progress of the trainee. Ideally the educational supervisor will remain consistent throughout the training programme allowing continuity of supervision, although significant geographical movement of military trainees means that this is not the most frequently used model. When the GPStR is working in a general practice training post, it is usual for both the educational and clinical supervisor role to be filled by the GP trainer.

Deployment

Deployments during GPVT are not encouraged, as the priority is to deploy trained GPs. However the Defence Deanery do have a policy in place that allows for accreditation of a suitable operational tour in certain circumstances. The period that can be accredited is limited and successful accreditation requires detailed criteria to be met, including the availability of a suitable supervisor in theatre and the maturity of the deployment. Specifics can be found in SGPL 09/07 [5] and trainees considering this option should seek advice from their single Service Advisor in General Practice prior to deploying.

Assessment

In order to practice as a GP all trainees must complete the Royal College of General Practice (RCGP) assessment (MRCGP) drawn from the RCGP training curriculum. The RCGP Curriculum is the educational framework for GP Specialty Training and for continued professional development post-certification. It is a competency-based document centred on the core statement *Being a General Practitioner* [7] and mapped against the GMCs *Good Medical Practice* [8]. It defines the key items of knowledge, skills and attitude that every GP is expected to master to work independently within the UK NHS and describes six domains of

competence and three essential application features that define general practice as a speciality. GPVTs are required to demonstrate that they have achieved these in order to complete their training. In addition they are required to successfully complete the MRCGP, a programme of assessment consisting of three components: an Applied Knowledge Test (AKT), a Clinical Skills Assessment (CSA) and Workplace Based Assessment (WPBA).

The AKT is a summative assessment testing the trainees' application of knowledge and decision-making skills. It consists of 200 multiple-choice questions in the form of extended matching, single best answer and algorithm/table format questions. 80% concentrate on clinical medicine, 10% on NHS primary care administration and informatics and 10% on research, appraisal, evidence-based medicine and statistics.

The CSA is an assessment of a trainee's ability to integrate and apply clinical, professional communication and practical skills in the context of a general practice consultation. It takes the form of an OSCE-style "mock surgery" in a purposely-designed assessment centre. Trainees are assigned a consulting room where they are visited by a series of patients played by trained actors and accompanied by an examiner. Every candidate undertakes 13 consultations each of 10 minutes. The selection of validated cases will include acute, chronic and undifferentiated problems, cases based on health promotion issues and cases incorporating psychological and social problems. A variety of patients spanning age, gender, ethnicity and disability will be presented and cases may incorporate a telephone consultation or home visit scenario.

The WPBA is an evaluation of a doctor's progress over time. Evidence is collected in an e-portfolio, a web based learning record that documents all stages of training, records evidence of specific workplace-based assessments and allows trainees to reflect on a range of learning opportunities with particular emphasis on clinical encounters. The educational supervisor reviews the e-portfolio on a regular basis, using it to inform each six monthly review and determine a learning plan in collaboration with the trainee for the next period of training.

Certification

The evidence collected by the trainee as part of the WPBA is reviewed annually by the Defence Deanery Annual Review of Competency Panel (ARCP). A final holistic judgement of the GPStR's competence to practise independently as a GP is made towards the end of training and the Deanery will then make a recommendation to the college. For doctors on a Certificate of Completion of Training (CCT) programme, the college evaluates the training and makes a final recommendation to the General Medical Council. If successful a CCT is awarded. Upon successful completion of speciality training, MRCGP and with the award of a CCT, trainees will be included on the GP Register and able to practise independently.

Challenges and Opportunities within Military Training

In contrast to civilian trainees who will complete all components of the GP training programme within the borders of one Deanery, a military trainee is likely to be required to complete their training in a variety of different locations. As well as posts within the UK, this may include time within British Forces GP training practices in Germany and Cyprus. Whether this is considered an advantage or disadvantage will depend on each individual's perspective and situation, and where possible the Deanery will accommodate personal preferences. However this does present additional challenges in maintaining oversight of training needs and progression and ensuring adequate transfer of information between supervisors.

Whilst trainees are encouraged to attend local GPVT education schemes, changes in training location can dilute the potential benefits from the relationships formed within such programmes and limit regular access to peer-led learning. This is particularly true for GPStRs based in overseas training practices. To address this the Professor of General Practice and Primary Care (Prof GP & PC) runs a week long "Highlands and Islands" course four times each year which concentrates on key areas of the RCGP curriculum and specifically, areas of the curriculum that a military GP trainer may have difficulty covering in a military practice, such as care of the elderly, palliative care and NHS practice management. All DMS GPStRs are encouraged to attend at least one course per year and those abroad should attend all courses. In addition the Prof GP & PC runs a much-applauded MRCGP preparation course available to all GPStRs, which includes exam preparation for both the AKT and CSA.

The Royal Centre for Defence Medicine also run a number of courses designed to support experienced GPs in addition to GPStRs. These include Sexual and Reproductive Health, Child Health, Men's Health, Minor Surgery, Research Methods, Sports and Exercise Medicine and Immediate Care to name a few (further details available at www.dmls.org.uk/rcdm/dgp.htm).

The chance to complete part of the GPStR period within a UK approved training practice in Germany and Cyprus, is considered by some to be a unique advantage of military GPVT. However these trainees are predominantly referring into a non-UK secondary care system and whilst all British Forces practices are expected to meet UK standards, overseas practices face specific challenges which require a robust system of quality management to ensure experience is equitable, required learning outcomes can be met and trainees are appropriately supported. Of note whilst army GPVTs training in the UK can access local counselling and support services that sit out with the military system, there is no such service for army GPVTs training in overseas practices whose local access to support is formally through the Department of Community Mental Health.

Finally, a marked variation between army GPVT and civilian GPVT is the availability of flexible training. Currently there are no routine opportunities for GPVTs to train within the army on a part time basis. Flexible training programmes have been facilitated on a case-by-case basis for a small number of trainees but have tended to respond to issues around recovery from injury or illness and are perceived as short-term measures only. Those who have wanted to train flexibly for other reasons, such as childcare, have been required to either rethink their future in uniform or accept full time training.

The Future

The period of rapid change in General Practice Specialty Training is not over. In Summer 2008 the Department of Health in England commissioned the RCGP to investigate the business case for extending GP specialty training, as recommended in the Tooke Report. Whilst a carefully constructed extension of GPVT to four or five years has the potential to bring significant improvements to GP training, allowing more time for trainees to develop the skills and confidence needed to provide optimal primary care and facilitating the early development of specialist interests, implementation would have significant regulatory and resource issues. Nonetheless the Scottish Deanery is already offering a 4 year GPVT course and others are expected to follow.

The number of GPVTs within DMS is already at maximum capacity for the number of available GP Trainers and the lengthening of training would result in more trainees in training practices at any one time. This would require an expansion in training places and significant investment in trainers and training

infrastructure. In certain locations, such as within British Forces Germany Health Service, the maintenance and possible expansion of quality GP training is likely to require a fundamental review of service delivery structures. Trainers, training practices and Deanery staff supporting training, must be properly resourced and supported for the standard of army GPVT to be maintained. The significant resource constraints envisaged for the short-term, triggered by the economic downturn, will make this a major challenge in the immediate future.

Another opportunity yet to be fully explored is the possibility of offering a limited number of Academic Clinical Fellowship programmes as part of military GPVT. This may incorporate time spent on academic projects or working in a particular area of interest.

Performance

Despite the challenges facing military General Practice, the quality of GPVT within the military is being demonstrated by strong AKT and CSA results and timely progression to CCT. The Defence Deanery pass rate for the membership examination of the Royal College of General Practitioners is consistently high when compared to other Deaneries [9]. General Practice training in the Army continues to flourish and remains, in many regards, the envy

of civilian colleagues. A commitment to innovative vocational training, robust quality management procedures, a well resourced DGP and links with the RCGP is the key to maintaining that success.

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Preparing for an Operational Tour as a Medical Officer in Southern

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Abstract

At the time of writing, Afghanistan is the pre-eminent theatre of operations for UK military forces, which form a lead element in the International Security Assistance Force. Many junior medical officers (MOs) can expect to see service on Operation HERRICK in the south of the country, in support of deployed battlegroup formations. MO's will often find themselves supporting Company Group formations, either within the Company Aid Post, or on dismounted / vehicle borne operations. This article presents some of the challenges faced by those deployed in such circumstances, and proposes possible strategies to address them.

Introduction

At the time of writing, Afghanistan is the pre-eminent theatre of operations for UK military forces, which form a lead element in the International Security Assistance Force (ISAF). Many junior medical officers (MOs) can expect to see service on Operation HERRICK in the south of the country, in support of deployed battlegroup formations. New MOs may deploy directly after completion of the PGMO (Postgraduate Medical Officer's) course, which is the common point of entry for doctors beginning their service in the field army. It has recently been revised in order to provide more appropriate preparation for the current military and clinical context, including lengthening the time at the Royal Military Academy Sandhurst from four to ten weeks.

In counterinsurgency and related operations conducted 'out on the

ground', the Company Group (Coy Gp) has been the predominant unit of manoeuvre and it is at the Company Aid Post (CAP) that MOs will conduct most of their independent practice. This article will present some of the challenges faced by those deployed in such circumstances, in order to identify successful strategies for preparation and delivery of clinical care in-theatre. NATO operational planning and execution uses nine groupings (J1-9) to address all aspects of military deployment and this article identifies the challenges facing the new MO in each of these categories as well as providing possible solutions which can be used as a framework for discussion. All italicised quotations represent the authors' (JDH &MS) personal reflections on returning from OP HERRICK 8.

Personnel / Administration and Doctrine / Training (J1 and J7)

"BATLS training certainly provided a robust and logical platform from which to provide trauma care in theatre, and at the very least, ensured

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that deploying MOs would be 'singing from the same hymn-sheet' as their CMTs"

"Of the specialties I encountered whilst on tour, I felt that I would have benefited from more teaching pre-deployment on Dermatology, ENT and Tropical medicine, in addition to paediatrics"

Challenges

In addition to providing direct medical care, MOs are expected to take responsibility for the professional development of other military medical personnel working at, and in association with, the CAP, such as Combat Medical Technicians (CMTs). Before deployment, all relevant kit, equipment and personnel may not be fully assembled for training; indeed, the MO and other elements of the CAP may join a deployed unit part-way through a tour. The Coy Gp will expect that the CAP provides training to soldiers, including Team Medics, in Battlefield Casualty Drills and, in particular, Platinum Ten Minute interventions and Novel Haemostatics [1]. CAP personnel must help to achieve effective casualty care and evacuation from point of wounding back to the CAP facility and, if required, on to more advanced echelons of care.

Solutions

Clinical Guidelines for Operations (CGOs) [2] and Battlefield Advanced Trauma Life Support (BATLS) [1] provide an overarching doctrine of military medical practice at the CAP, in which MOs must be well versed. Pre-deployment training facilitates an understanding of assets available at the CAP, not least of which are its personnel, and of how to optimise and develop them further. Each echelon of pre-hospital care (Care Under Fire, Tactical Field Care, Field Resuscitation [1]) should be exercised in a 'joined up' fashion, incorporating tactical transfer of the casualty from point of wounding into the final casualty evacuation asset. A premium should be placed on simulating realistic operational conditions, including those governing Medical Logistics (see below). The CAP must recognise that its establishment extends beyond Defence Medical Services (DMS) personnel to incorporate Combat Arms' CMTs, Team Medics and other soldiers with basic First Aid competencies. The CAP must invest in the further medical training and rehearsal of these individuals and take an active interest in their ability to provide care in their deployed roles. On arrival in theatre, standard operating procedures should be cross-referenced against current deployed working practice and rehearsed as soon as possible. Emergency care provided at the deployed CAP can later be scrutinized by the team (eg a "hot debrief"), providing a performance baseline on which improved understanding and application of skills can build. Other possible teaching strategies for the deployed CAP are detailed in Box 1. The CAP should continue to train and educate throughout the deployment, as events allow.

Medical personnel deployed at Coy Gp level require proficiency in basic military skills and must have levels of personal fitness and robustness that match those of the Coy Gp.

- Group reflection on real-life clinical events
- Individual presentations on assigned topics eg BATLS, primary healthcare
- Vehicle extraction drills in association with the Light Aid Detachment (REME)
- Practical skills work-shops (eg 'round-robin' format, peer assessment)

Box 1 – Training and education opportunities at the deployed CAP

Intelligence and Communications (J2/J6)

Challenges

CAP personnel will need to be competent communicating up both

the battlegroup and medical chains of command (CoC) and within the deployed Coy Gp itself. The CAP must be prepared to co-ordinate major incidents, including mass casualties (MASCAL), and to facilitate information flow to and from the scene. Information regarding healthcare and incident management may be demanded of the CAP some time after events, for example by a UK Coroner's Court. Medical intelligence relating to the ISAF casualty evacuation chain and the echelons of care beyond that must be augmented by knowledge of capability and capacity in the local healthcare system, applied in association with a firm grasp of the eligibility matrix.

Solutions

The CAP should be personally familiar with key individuals across the various echelons of medical support. Where it has been impossible to meet or liaise with them pre-deployment, it is essential to 'touch base' early on and to stay abreast of any changes in these key posts as the tour progresses. All CAP members should be competent in the means provided for communication both within the Coy Gp area of operations (AO) and also 'up the chain', be it the battlegroup or medical CoC. Where possible, these communications technologies should be used directly by the CAP to facilitate and enhance appropriate and timely casualty treatment and evacuation. This is increasingly possible as the HERRICK theatre infrastructure evolves, eg the provision of secure communications systems from CAP to Emergency Department (ED) mean that senior advice can be accessed immediately after initial resuscitation. The benefit cuts both ways, with the CAP able to update the ED on incoming casualties at the point of their extraction.

Use of the MIST reporting format [1], the designation of a trauma co-ordinator and location of the CAP close to the Coy Gp Operations Room are factors that enhance the flow of information on reception of casualties and expedite the evacuation process. The NATO '9-liner' [2] is the universal format used to request casualty evacuation in-theatre and the CAP must ensure that all elements of the Coy Gp are familiar with and able to effectively employ a complete 9-liner as soon as the need for evacuation had been identified. This initial request should be followed up with further information as it becomes available, to allow accurate identification of time-critical casualties throughout the battlespace. The timeliness of the initial 9-liner and the quality of subsequent information will contribute to the speed of response and prioritisation of evacuation assets. To this end, the CAP must take an active interest in all such communications sent from within the Coy Gp AO, including those submitted by outlying elements remote from the CAP. Further proposed strategies for enhancing CAP J2 are detailed in Box 2.

Every effort must be made to accurately document clinical management at the CAP and out on the ground, be it an emergency case or a seemingly trivial complaint. These records must be securely stored or passed along the evacuation chain as appropriate. A log of clinical events and the issues around them may be of later help in addressing the enquiries of casualties, their relatives, or interested authorities.

- Formal CoC briefings (BG and Coy Gp, Medical)
- Advance communication with in situ medical team at the prospective Coy Gp location
- Deliberate medical reconnaissance to assess known/potential local healthcare
- 'Opportunistic' observation of healthcare activities, eg routine patrols reports detailing the pattern of daily life and variance

Box 2 – Potential medical intelligence sources for the CAP

Operations (J3)

"I soon discovered that the existence of a medical facility within a geographically isolated District Centre would challenge.... not only because of our close work with Afghan National Security Forces and our varying levels of responsibility to them, but also our close proximity to a local population with, initially, little or no indigenous healthcare system...and the ethical and logistical dilemmas our intervention would raise"

Challenges

Figures 1 and 2 provide samples of the clinical workload seen at two CAPs, both located close to rural Helmand district centres. The primary responsibility of the CAP is the provision of care to entitled individuals, taking account of the NATO aspiration for advanced trauma care within sixty minutes of injury [3]. Battlegroup and Coy Gp 'consent-winning activities' may be extended to include medical care for local nationals and an 'expectancy' of access to care may be engendered amongst non-entitled populations. Similarly, elements of the Coy Gp may come to expect medical assistance for non-entitled individuals that they encounter. The capability and capacity of the CAP will fluctuate on the basis of physical resources (consumption versus resupply), manning (subject to Coy Gp activities and the leave plot) and operational status (degraded by multiple ongoing incidents, versus recovered start state). MASCAL incidents will challenge on all three fronts and can quickly overwhelm the CAP, rendering it unfit for purpose.

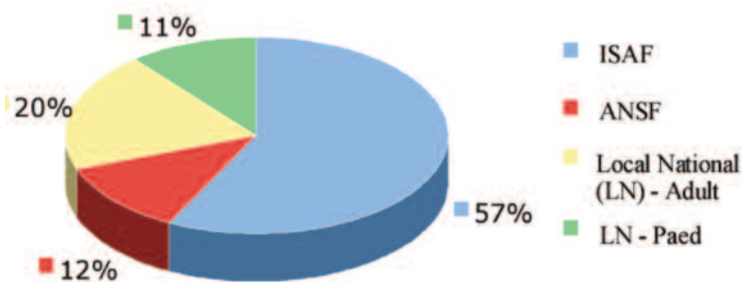


Figure 1 Demography of patients treated in two representative CAPs in Southern Helmand in a seven week period

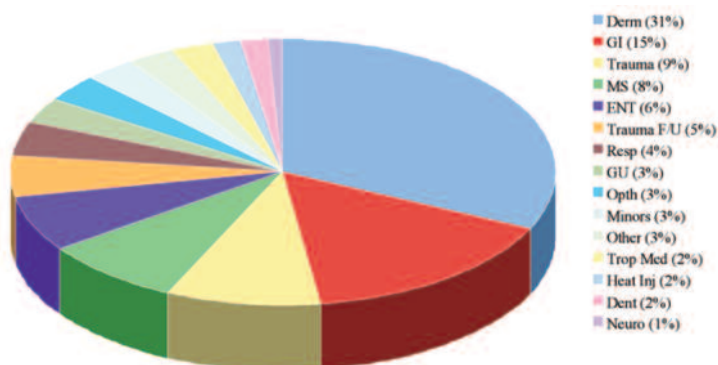


Figure 2 Seven week sample of 326 cases presenting to Role 1 facilities on Op HERRICK 8.

Solutions

MOs must have a clear understanding of care entitlement, as agreed between the medical, BG and higher formation CoCs. In accordance with the Geneva Conventions [4] emergency care and access to the casualty evacuation chain will be afforded to all military and civilian populations in cases of life, limb or eye-threatening emergencies [5]. The eligibility matrix will dictate to whom and at what level other care is provided. MOs should be robust in defending the limits of this position, but also alert to those cases that are not clear-cut or where an exception might be justified. Having selected a course of action, this must be discussed

with the CoC at the earliest possible opportunity. Prior to the reception of non-ISAF casualties by the Coy Gp, individuals first require assessment from a security standpoint. Robust standard operating procedures (SOPs) must be implemented to prevent the entry of inappropriate and potentially malicious personnel into the Coy Gp's location and thence to the CAP.

In cases of traumatic injury, which often affects multiple personnel at the same time, the nomination of a trauma co-ordinator operating a casualty tracking system can be a highly effective means of maintaining situational awareness and identifying emerging requirements. An experienced CMT of sufficient seniority should capably fulfil this function. A double-sided proforma for recording sequential vital signs and treatment information on multiple casualties, such as that provided by the Joint Force Medical Group on HERRICK 7, draws pertinent information together onto one piece of paper. This acts as a driver for the co-ordinator to seek out contemporaneous information, while reducing the risk of overlooking any of the casualties identified to the CAP. It also naturally leads to the kind of dynamic triage required when resources are finite, for example limited space on an evacuation asset. Numbering each casualty and tying this into the clinical documentation, early in the course of the incident, is particularly helpful when its scale approaches or reaches MASCAL.

When the Coy Gp are out on the ground conducting operations, the MO will need to ensure that all elements are within one hour of advanced trauma care. This may be provided by a BATLS-trained medic, a MO or the airborne Medical Emergency Response Team (MERT), which can retrieve casualties from a secure helicopter landing site (HLS). The potential for delay in a MERT mission – eg failure to secure the HLS or competing taskings – may mean that the MO has to 'safety-net' Coy Gp activities. Strategies include co-location with the effective 'centre of gravity' for Coy Gp operations, such as the Company Sergeant Major's party or Coy 'main', or by establishment of a medical Quick Reaction Force. The latter should be able to collect casualties at or near to the point of wounding and perform a stabilisation and holding function, whilst CASEVAC by air is awaited. For casualty extraction overland, available Coy Gp platforms should be carefully appraised in light of the local environment. They should be trialled over the ground in question, insofar as the tactical situation allows. The prevention of further harm to the casualty must be the paramount consideration. Although the 'medical HLS' tasking has become a combat arms tasking (ie Coy Gp Ops Officer/Sergeant Major), the CAP can inject clinical care as described in Box 3.

The operational importance of a timely, effective recovery of medical capability must be emphasized. The reception of further casualties during this period may force the CAP to think laterally or simply cope with sub-optimal resources. When there are not further casualties to manage, the recovery operation serves as an opportunity for members of the CAP to discuss the preceding events and reflect on the outcomes seen.

- Close liaison with the J3 combat arms HLS lead
- Dynamic triage and prioritization of casualties for loading and evacuation
- Appropriate packaging and maintenance of essential resuscitative efforts during transfer
- Effective handover to the MERT by updated MIST report.

Box 3 – Responsibilities of the CAP in the medical HLS tasking

Logistics (J4)

"It quickly became apparent to me that I was fairly redundant as an MO without the stock and equipment with which to carry out clinical work, and the CMTs to both project medical force protection to mobile patrols and outstations, and assist me within the RAP. I will admit to

having very little understanding of the medical modules when I arrived in Afghanistan – and I quickly realized that without a clear picture of what the RAP should hold, how much was in stock, and how to request more of it, critical shortages could quickly arise without us even noticing”

Challenges

Medical logistics are the bedrock of medical capability. So much of what is done at the CAP depends upon having the right kit, equipment and drugs, in sufficient quantities and available at the right time. Achieving effective and timely re-supply is a demanding business in southern Afghanistan, where lines of communication can be tenuous and consumption rates difficult to forecast from one day to the next. Failure to achieve adequate re-supply can pose considerable problems for CAP operations, to the detriment of the Coy Gp’s mission.

Solutions

Pre-deployment, medical re-supply is difficult to model realistically. Effective simulation might be attempted at medical squadron level, eg by requiring each exercising CAP to submit timely re-supply requests and the logistics chain to co-ordinate its own response. On operations, routine re-supply of consumables (eg drugs) might be co-ordinated by a ‘rule of thirds’: take the scaled supply of the item with you; use a third, then order a third - and expect a further third to have been used by the time re-supply arrives. Stocks of the item remain at between one-third and two-thirds of the scaling, and should never run out. For equipment that undergoes repeated use but may require replacement, such as oxygen cylinder regulators or electrical suction units, it is harder to forecast when re-supply will be required and opportunistic strategies may have to be employed. These methods include ‘dynamic re-supply’ by unscheduled flights into the Coy Gp location such as the arrival of an evacuation asset. Re-supply requirements may have been pre-empted by the medical chain and arrive in the form of a ‘set menu’ of standard materiel, or communication with the logistics chain, prior to the MERT’s departure from a rear area, may result in specific items being brought forwards. ‘Trading’ equipment with the MERT on the HLS, eg oxygen cylinders to replace those departing with casualties, should not be allowed to delay the departure of the evacuation asset. Dynamic and pre-emptive medical re-supply give the CAP the best chance of continuing its mission without significant disruption to capacity and capability. The CAP does not act in isolation and securing effective medical re-supply on Op HERRICK takes hard work and persistence on the part of all involved.

Plans and Policy (J5)

Challenges

Early access to effective battlefield first aid and BATLS care saves lives. This concept must be in the forefront of medical planning – and means that medical considerations must be in the forefront of Coy Gp planning. The CAP must develop its own medical policies, tailored to the specific circumstances and realities of the

Coy Gp’s mission. Policy directives may be issued or prosecuted by the CoC mid-deployment, such as the Surgeon General’s Policy Letter on Immunological Protection of Service Personnel [6] during Op HERRICK VIII (Box 4).

Solutions

The CAP must be pro-active in ensuring that medical support is not overlooked or over/under-estimated in Coy Gp planning. Situational awareness, at both Coy Gp and BG level, is essential. The CAP should take the lead on planning medical aspects of activities that, although executed primarily by J3 combat arms, must be grounded in sound casualty care – for example, casualty extraction, major incident management and the CASEVAC process. Standard operating procedures particular to the CAP should be agreed and rehearsed in-location, as soon after arrival as possible. All members of the CAP should be aware of and enfranchised by medical policies particular to their location, for example: resuscitation attempts in the absence of vital signs following trauma, the provision of non-emergency care to Afghan National Security Forces (ANSF) and the eligibility matrix for local nationals.

Finally, an optimally functioning Coy Gp will itself limit casualties and ‘save lives’, by virtue of its effective reactions and responses to the tactical environment. To this end the CAP should, in its policies, provide committed support to the moral component of Coy Gp fighting power. In so doing, the CAP shoulders that other doctrinal responsibility: seeking not only to restore, but also to maintain the health of the fighting formation and thus conserve fighting strength [7].

Summary

Deployment on Operation HERRICK exposes the new MO to a stimulating and constantly evolving theatre of operations. Many of the challenges that face deployed and deploying MOs will be different to those described here, but key principles will remain applicable across the operational spectrum. BATLS and CGOs provide an essential framework on which to build successful CAP practice. Keen situational awareness, the ability to adapt and the will to persevere should ensure that junior MOs makes the most of the opportunities offered by this compelling theatre.

Recommendations

1. MOs should ideally have the opportunity to work in an ‘exercised’ aid-post whilst on the PGMCO course or during pre-deployment training, in order to familiarise themselves with some of the potential logistical and practical challenges they may face once in theatre.
2. The reference and implementation of principles laid down in BATLS & CGOs as an essential framework for medical planning and delivery of in-theatre care by deploying MOs.
3. The provision of robust communication systems between the CAP and Role 2 facility, in addition to the implementation of established documentation formats such as MIST, to facilitate information flow and enhance casualty management and onward evacuation.

Immunisation against Hepatitis B virus (HBV) is offered to all British military health care workers in accordance with the Surgeon General’s Policy Letter on Immunological Protection of Military Personnel. It should also be offered to those military personnel who are not designated health care workers, but ‘may come into contact with blood or bodily fluids as part of their normal duties’. This intention was echoed in the Mounting Order for Operation HERRICK 8. A series of incidents during the early stages of HERRICK 8 led the Taskforce to recognise that soldiers who were assuming Team Medic responsibilities in-theatre might be exposed to BBVs as part of their ‘normal duties’. A programme of immunisation of Team Medics against HBV followed, with the logistics ‘cold chain’ delivering vaccines to FOBs for administration under the supervision of the MOs there. The availability of HBV vaccine at Role 1 also meant that, for those un-immunised individuals who were exposed to BBVs in the course of forward operations, ‘prophylactic’ post-exposure immunisation could be commenced in a timely fashion. The provision of post-exposure prophylaxis for HIV at Role 1 meant that a similar process could be followed with regard to potential exposure to this blood borne virus too.

Box 4 – Implementation of new in-theatre health policy

4. MOs should be made aware of, and remain current with the current operational eligibility matrix for non-ISAF personnel, with a nominated point of contact at the Role 2 Facility with which to discuss potential exceptions.
5. SOPs unique to each CAP location should be developed, rehearsed, and implemented under the guidance of the MO. These should be clearly documented, accessible to the CoC, and communicated to incumbent medical teams in advance of their arrival.

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Detecting Post-Deployment Mental Health Problems in Primary Care

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Abstract

Post-deployment mental health problems are a source of potential concern for health professionals and politicians in military forces in the world; the UK Armed Forces are no exception. This article examines practical ways in which General Practitioners in Primary Care can enhance their ability to detect post-deployment mental health problems and offers suggestions on immediate management and assessment, based on contemporary evidence and clinical experience.

Introduction

It has long been recognised that deployment to a conflict zone can be associated with an adverse effect on mental health, although there is disagreement about the scale of this impact. In the recent widely publicised article by Fear et al [1], it was found that probable Post-traumatic Stress Disorder (PTSD), common mental disorders and alcohol misuse were the most common causes of psychological morbidity in the UK Armed Forces (UKAFs). Although, earlier research had not identified any overall effect of deployment [2], this most recent paper [1] found that the prevalence of alcohol misuse was significantly higher in those deployed compared with the baseline non-deployed sample; also higher rates of probable PTSD were found in both combat troops and reservists. Interestingly, in spite of the high tempo of operations since 2003, the paper did not demonstrate any significant increase in mental health disorders since the 2003

invasion of Iraq to date and also did not find that personnel who deployed more frequently were any more likely to suffer with mental health problems.

However, in spite of the absence of a 'ticking time bomb' or 'bough wave' of mental health problems in the UKAFs, claims to the contrary are frequently made by both media professionals and politicians. So frequent are the claims that some commanders, and indeed some healthcare professionals, have come to believe of the 'inevitability' that those who deploy will become ill. At an organisational and societal level mental health disorders appear to be viewed as somehow 'special'; indeed they have been described as the "invisible wounds of war" [3]. Allied to this apparent special status, dealing effectively with mental health difficulties is part of the Ministry of Defence's (MOD) duty of care and giving proper consideration to these issues is part of the military covenant. The covenant embodies the principle of proportionality which, put simply, states that the more rights you remove from an individual the more you need to do to support them. Few would disagree with such sentiments. Politically, mental health is also a sensitive issue and the media frequently expose veterans who continue to experience problems with their mental health after leaving the UKAFs which leads to increased scrutiny and pressure from the public, and may be seen to portray the service provided to serving

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personnel as being insufficient [4,5]. In this context Dr Liam Fox, the new coalition's Secretary for Defence, stated mental health provision as a specific priority when he issued his first statement on the future direction of the Ministry of Defence (MOD) [6]. Clinically, the health of veterans is also an ongoing concern for Defence Mental Health Services and National Health Services [7].

Whilst there has been a considerable effort made over recent years to ensure that troops are sufficiently prepared for deployment and for the homecoming experience [8,9] it is still not clear how to best encourage members of the UKAFs who suffer with mental health disorders to come forward and ask for help. Stigma remains a substantial barrier to care for the UKAFs and indeed for other forces engaged in carrying out operations in Afghanistan [10,11]. The situation is further complicated by individuals presenting to services in a multitude of ways; sometimes many months or even years after a deployment. Whilst most personnel are likely to speak about their concerns informally to colleagues and/or family members, their first port of call in order to access formal treatment is likely to be a Primary Care facility. Also, many personnel who are suffering from mental health difficulties are likely to consult with a Primary Care professional for either routine consultations (e.g. PULHHEEMS) or to seek help for physical health conditions, some of which may in fact be latent presentations of mental health conditions, such as non-specific abdominal pain. This article aims to provide advice and assistance to Primary Care professionals to help them to recognise post-deployment mental health problems and to help them decide how best to deal with them.

What are the main mental health disorders seen in UK Armed Forces Personnel?

In determining the prevalence of "Common Mental Disorders", Fear et al [1] used a variety of measures including the 12 question version of the General Health Questionnaire. This measures symptoms of somatic complaints, anxiety, insomnia, social dysfunction and depression, which correspond with mood, anxiety and adjustment disorders as well as providing an indication of the symptoms of somatisation. These disorders are routinely seen in the Primary Care setting and in the military may be complicated by co-morbid misuse of alcohol and occupational difficulties. General Practitioners (GPs) who are seeing 'repeat attendees' who have deployed, may find it useful not just to concentrate on the physical health conditions but to also ask about anxiety, depression, adjustment disorders, PTSD and alcohol misuse. In a short, problem-orientated consultation, GPs are often hampered in recognising otherwise familiar mental health symptom clusters because of individual's reluctance to overtly state psychological problems as their presenting complaint. Personnel who present with vague and non-specific symptoms, or who appear to have highly atypical disorders, may in fact be communicating their psychological distress in a cryptic manner. However, by focussing on patterns of presenting behaviour in addition to symptoms, even these complex cases can be identified in Primary Care and referred on for specialist assessment. However, without a high index of suspicion such cases may simply be classed as unsolved conundrums and be associated with a frustrating consultation.

Spotting Patterns

Mental disorders, by definition, cause an individual personal distress or interfere with their inter-personal, social or occupational function. It is a change of both functioning and internal wellbeing, sustained over time, which distinguishes a "disorder" from normal adaptive reactions. Frequently the consequences of this dysfunction may be the only clue to the underlying mental health problems, and therefore a sole focus on the dysfunction may lead to failure to identify the underlying disorder. Vigilance is essential. If GPs do not have a high index of suspicion in terms of mental health problems for those presenting in the months after

deployment, they may not recognise the true problem. Conversely, if recognised and sensitively addressed, the consultation may start a chain reaction of intervention which leads to recovery in terms of health and occupational function. For instance an audit of patients referred to a military Department of Community Mental Health (DCMH) found that more than 2/3 of those seen by mental health professional returned to full occupational fitness [12]. So identifying the key indicators of incipient mental health problems is essential and the easiest of those to spot is behavioural change.

So what changes in behaviour might be expected? GPs should be aware that whilst some changes may be rapid others may be gradual, arising slowly as functionality is progressively eroded. In the military, great emphasis is placed on conforming to a standard pattern of accepted behaviour. Thus, those personnel who fall out of step with the norm, perhaps quite subtly at first, might be suffering from mental health conditions. GPs should be aware of deterioration in a service person's physical presentation such as uniform standards, grooming and military bearing. As an individual's situation deteriorates minor problems may start to arise in relation to punctuality, productivity and performance. These escalate to frank disciplinary problems and marked concerns about attitude and respect for the chain of command. One of the most dramatic presentations is an abrupt escalation of aggression and anger levels, even to the point of violence. This behaviour is likely to quickly bring the individual into conflict with the chain of command or perhaps the civilian justice system. It may also be that individuals come to the attention of a GP because of concerns expressed about domestic violence. These ying and yang changes (from good to bad) whilst not frequent should be easy to spot whether it be in the surgery or at other forums such as carer's meetings.

However, changes in functioning and psychological wellbeing may present more subtly. For instance, previously high functioning individuals may abruptly and unexpectedly resign from the military [13]. Therefore another potentially relevant marker of latent mental health problems is tendering of resignation within the first six months after a deployment; there is an argument that all those who do so should be carefully evaluated by GPs. This is especially so if the resignation is unexpected or associated with marked behavioural change. Whether resignation is a reflection of a positive move away from the military because the individual, whilst well, has had enough of being deployed or whether it may be part of avoidant behaviour, particularly associated with anxiety disorders and PTSD, is for the GP to identify.

Somatic complaints are also common in those with mental health problems [14], and in the military it may represent a more acceptable reason for seeking help than mental health symptoms. GPs should be aware of this when assessing those who present with non-specific, unexplained or medically disproportionate physical symptoms in relation to a diagnosed condition. The sole presenting symptom may often be insomnia, and this is indeed a very common presenting complaint across the spectrum of mental health problems in the wake of deployment. Therefore, extra attention is required when dealing with those presenting with insomnia.

Alcohol misuse has now formally been recognised as a significant problem in the post-deployment period, but this may come as a surprise to few GPs [1]. It is also recognised as a major problem amongst veterans [7]. The problem of alcohol is twofold: it can be a primary phenomenon, or represent an individual's method of coping with the effects of an underlying psychiatric disorder, frequently referred to as "self-medicating". Alcohol misuse may be further complicated by individual's chain of command having identified the behavioural manifestations of the alcohol misuse (e.g. disobedience or violence) and having begun to take disciplinary measures but having missed the reason for the alcohol misuse in the first place; such situations may adversely predispose distressed personnel from engaging with therapeutic services. Additionally

alcohol misuse may also alienate an individual's close support network and lead to relationship breakdown and social isolation. Therefore GPs should be aware, especially in the post deployment period, of alcohol's propensity to exacerbate the behavioural disturbances above, leading to a rapid escalation in unacceptable behaviour, violence, aggression and disciplinary problems.

How do patients present with mental health problems?

There are three potential presentation patterns which GPs need to be aware of that are suggestive of mental health difficulties in the post deployment period. The first is the standard pattern of presentation which is when an individual manages to overcome any stigma and barriers to care and presents with the usual mental health symptoms; such cases require relatively straightforward Primary Care Management and should not be hard to identify. A second mechanism is the "crash and burn" presentation. These individuals decompensate rapidly and present with out of character disciplinary problems, alcohol misuse, high emotional states, violence, aggression and/or deliberate self-harm. There is considerable evidence which suggests that personnel with lower rank, lower educational attainment and with less robust pre-service coping skills and social support structures will present in this manner [15, 16]. Lastly, some individuals may present with a "slow burn" pattern. These personnel may well have high levels of pre-morbid functioning, higher rank and educational attainment, and more settled and robust social support networks; however stigma may prevent them from coming forward [17] – especially so if they are in command appointments. They may deteriorate gradually, and only present when their considerable coping skills and functionality have been eroded past the tipping point; at times this may only be years after the deployment. Guidance on detection is summarised in Box 1.

When compared to pre-deployment functioning and behaviour there is a change or escalation in:

- Decreased attention to uniform, grooming and military bearing
- Problems at work with punctuality, productivity and motivation
- Poor attitude and respect for chain of command
- Onset or escalation of disciplinary problems
- Onset or escalation of anger problems possibly associated with aggression and violence
- Sudden escalation or onset of alcohol misuse (or other substances)
- Insomnia
- Presentation with vague or multiple somatic complaints for which there is no adequate medical explanation
- Changes in personality and social isolation
- Sudden unexpected resignation or resignation within six months of a deployment, particularly if associated with any of the above

Box 1: Potential indicators of post-deployment mental health problems.

Assessment and Management

If those working in Primary Care have a high index of suspicion in the wake of deployments it may be possible to enhance detection rates of those who suffer with mental health problems. In the first instance it is important to recognise behavioural changes as

described above. GPs will often be presented with a "snapshot" view of the problem. In other words, they may only see the current presentation of the patient and be privy to the current perception of the individual by their Unit. Based on these sources of information GPs may, erroneously, conclude that such individuals are no longer suited to the military and are simply seeking excuses for their unacceptable behaviour. This may lead to administrative actions proceeding without due regard for the psychiatric mitigation and treatment duty in relation to the mental health problems. In addition, an opportunity may be lost to retain the individual for service, which may inadvertently add to the perception that the UKAFs are failing in their duty of care for those in need of mental health treatment.

Therefore, whilst understanding the time pressures which exist upon Primary Care professionals, they should do all they can to assess post deployment patients as a "video" and not a "snapshot". In other words, consideration should be given to pre-morbid functioning, previous character and behaviour before, perhaps erroneously, forming a view. In the UKAFs this can be achieved readily, as all individuals will have previous medical and occupational reports spanning their entire career. These reports can paint an accurate picture of their functioning previously in the military and allow a GP to spot altered behavioural and functioning patterns with relative ease. Occupational reports from their Units are readily available to GPs (FMed 1041), but care should be taken in using them as the sole source of information; they too may only reflect the current situation, and may be written by individuals who are understandably vexed and exasperated by the individual's current behaviour. Collateral history from family, partners, friends and units they served with before deployment are invaluable in this process and frequently one telephone call (with consent) to someone who knew the individual before the deployment casts an entirely different light on the situation. GPs should also be aware that on occasion mental health problems will escalate previous behaviour. For example, someone who was prone to angry outbursts prior to a deployment might be highly likely to present with a marked escalation of that behaviour, including physical violence, should they develop mental health difficulties. The same argument holds true for those who misused alcohol previously.

This paper therefore argues that the most important contribution Primary Care professionals can make to post deployment mental health care is to ensure they detect problems where they are present. If underlying mental health problems are not detected, then all the extensive help that is available in the UKAFs [18] amounts to nothing as far as that individual is concerned. When an individual presents with symptoms of common mental disorders and/or the behavioural patterns described above in the months after their return from deployment, then careful assessment is required. Should a GP consider that the problem lies outside their skill set to deal with, or is moderate to severe, then early referral to the Defence Mental Health Services is indicated. In keeping with the National Institute for Clinical Excellence's guidance [19], for mild to moderate behavioural disturbance and symptoms in the first months after deployment the GP may legitimately follow a policy of "watchful waiting", provided the risks are low, reasonable functionality is maintained and monitoring arrangements are in place. During this period bolstering social support through the welfare system, chain of command, chaplaincy or approved elements of the voluntary sector may be appropriate. However, if after many months problems persist, deteriorate or a definite psychiatric disorder is detected then treatment and/or specialist assessment should pragmatically not be delayed. It is worth noting that many troops find that, unlike after exposure to a single incident where recovery is usual after a month, after deployment the trajectory of recovery may be slower, sometimes taking many months [20]. Early liaison with the chain of command is essential, with patient consent, in order to educate

and inform them about how best to support their personnel's mental health. This may well achieve a respite of administrative actions to allow for treatment and a humane disposal for disciplinary problems, in addition to engaging their help in rehabilitation and treatment. This guidance is summarised in Box 2.

- Apart from the well known symptoms of mental disorders, be familiar with possible changes in functioning and behavioural patterns that may indicate post deployment mental health problems. Be vigilant for them and have a high index of suspicion if they are present.
- Avoid reliance on "snapshot" information that shows only the current situation. Always compare behaviour and functioning with the pre-deployment era.
- Collateral information is essential. Previous Units, old reports, partners, family and friends are useful sources of information. Remember to get patient consent.
- Intervene early with the chain of command and keep them informed with the patient's permission. Explain, educate and advise in order to facilitate treatment.
- Any mental health problems that persists for months after deployment should be considered significant and treated or referred for specialist assessment.
- Any mental health problems that cause intolerable distress or marked reduction in functionality during the first month after deployment should be referred for specialist assessment or treated.
- Alcohol misuse is a major problem and should be assessed in each case.
- Engage individual with welfare provision, command support and voluntary agencies early if indicated. Try and alleviate environmental stressors where reasonable and possible.

Box 2: Guidance for GPs in detecting and managing post deployment mental health problems.

Lastly, it is of utmost importance that clinicians are not blinded into viewing post-deployment problems as being solely represented by PTSD. Such a narrow focus may lead to the majority of post-deployment mental health problems being missed. In the Fear et al study [1] the prevalence of probable PTSD was only 4.0% for regulars, but common mental disorders tipped the scales at 19.7%, which is similar to the UK general population and alcohol misuse at 13.0% compared to a 5% general population prevalence. In addition, some severely ill individuals may have very destructive post-trauma psychiatric syndromes that only partially meets PTSD criteria or not at all. By having a broad view of post-deployment mental health problems and by focussing on a comparison between pre- and post-deployment functioning, this potential clinical trap can be readily avoided.

Conclusion

Post-deployment mental health problems are a significant health and presentational issue for the UKAFs. Managing emergent mental health problems in an efficient and timely fashion is a

function of the MOD's duty of care which rightly is held to high accountability. The most common problems tend to be common mental health disorders and alcohol misuse, and to a lesser degree PTSD. Whilst detection of mental health problems in primary care can be difficult due to co-morbidity, environmental factors, alcohol misuse and presentation with physical symptoms, failing to detect problems represents a missed opportunity. This paper suggests that it is important for GPs to evaluate changes in functioning and behaviour as part of the assessment in order to avoid failure to detect these disorders in the post-deployment period. Being vigilant therefore requires GPs to be familiar with the sorts of behaviour which are common during the post deployment period and those behaviours which suggest that intervention or referral is indicated. GPs should do all they can to investigate reasons for behaviour changes and seek pre-morbid collateral history. Early treatment or referral for specialist assessment should be considered for moderate to severe cases in the initial months after deployment especially if functionality is markedly affected, and for those where problems persists.

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Opportunities in Pre Hospital Emergency Care for the Armed Forces in the UK

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Introduction

Pre Hospital Emergency Care (PHEC) provision in the UK has undergone many changes in recent years, in particular with regard to clinical standards, participant expectations and medical regulation. This article draws on the military author's recent experiences, as a general practitioner, in joining a well established PHEC team in the East Midlands as a member of BASICS, the British Association of Immediate Care Schemes. For highly motivated individuals setting out with a desire and commitment to responding alongside UK civilian emergency services, the path to becoming an established member of a team can be a long and tortuous one, with many obstacles to overcome. Outlined below is an account of recent experience to assist any prospective Immediate Care Responder.

Making contact with your local scheme

The military regularly moves trained personnel between locations which can make establishing long standing affiliations with UK BASICS schemes a challenge. Members of BASICS are given a photographic ID card on joining and a further ID card upon become accredited as a PHEC provider with the words 'Accredited' added. One way of assisting military personnel when moving from region to region would be to annotate the ID card 'Accredited (Military)' to sign post that you may need to move geographical region and change schemes on occasion. Once schemes become more aware of the movement of military personnel they may endorse new membership more readily if the individual is appropriately trained.

Most regional teams are well regulated and are normally able to send out a potential members joining pack to individuals. The joining process is often long and convoluted but not insurmountable. Immediate Care Schemes take a longitudinal view on new members for a multitude of reasons but mainly due to financial constraints. All schemes are registered charities and have finite funds from donations and a limited amount of time for continued fund raising activities. The scheme hierarchy will need to be convinced about a prospective member's dedication, commitment and time that they will be able to remain with the team and respond. Setting up a new PHEC member in a scheme costs in the region of £20,000, due to the procurement of monitoring and medical equipment, Personnel Protective Equipment (PPE) and in addition any safety features required in adapting a members vehicle. For members of the armed forces, some form of geographical stability is essential and this may be in the form of a permanent leave address or a commitment to travelling to support the scheme for dedicated sessions, depending on the type of scheme and response provided.

The majority of schemes will follow an induction pathway, which normally starts with an application form and production of evidence showing previous pre-hospital care experience and

qualifications held. Most schemes require, as a minimum the PHEC certificate from BASICS to be valid and in date, and the majority also require, or have on the highly desirable list, the Diploma in Immediate Medical Care from the Royal College of Surgeons in Edinburgh (Dip IMC RCSEd) [1]. Some schemes specify that if the diploma is not held, then the applicant is committed to seeking examination success in the near future and often wish to see evidence of continuing work towards this.

The BASICS website [2] lists all the schemes currently operational in the UK and has contact details for key members at each. The newly updated website is also a very useful source of general information on PHEC and of recent changes in treatment. Attendance on the military run courses in Birmingham are to be encouraged to gain insight in to the provision of PHEC, but these courses are not always recognised by the civilian schemes in the UK. The recently formed military faculty of PHEC may wish to look at the course content and work with RCDM to have the course formally accredited by BASICS Education. The two most relevant courses run by the Royal Centre for Defence Medicine are the Military Immediate Care Course and the Military RTC Extrication Course currently located at the Defence Fire Service Training Centre, Kent.

Type of responder and team members

Following a period of mentoring and gathering of feedback from NHS ambulance service colleagues, most schemes will allow independently registered medical practitioners, with appropriate experience, to respond on an individual basis from place of work or home address, to emergencies via ambulance control. Some schemes also run a shift system, where members cover a rota, to provide a fully manned vehicle, normally comprising of one doctor and one other immediate care practitioner. This team would normally travel greater distances to attended incidents in a region as required. BASICS schemes are not just made up of doctors; comprising a mix of both primary and secondary care doctors, nurses, paramedics, combat medical technicians and allied specialists with appropriate training and experience, such as fire service officers (Figure 1). The key to membership of a scheme is clinical competency, maintaining currency with regular clinical and non-clinical updates, participation in annual PHEC appraisal and appropriate out of hospital experience, in order to remain safe at all times.

No scheme can exist without a very close working relationship with the local NHS Ambulance Service Trust. The majority of mobilisations and requests for additional PHEC at incidents come via dispatch in ambulance control. Most control rooms man a dedicated community response, FRV (Fast Response Vehicle) or helicopter dispatch desk which normally doubles up as the focal point for assistance from BASICS members. Requests for assistance can be via pager, SMS text message or direct telephone call from the emergency dispatch officer. If available to respond as an individual, members would normally call or text in to the dispatch desk to confirm availability and vice versa when not in a position to assist.

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Figure 1 Primary care response team based at UK medical centre

Support to schemes

Support to local BASICS schemes once affiliated can be in a multitude of ways, ranging from simple responding to fund raising and attendance at regular scheme meetings and clinical training sessions. Members are normally encouraged, when appropriate, to make contact with the local media to highlight the involvement of schemes at high profile regional incidents to inform and increase awareness of the existence of schemes and their charitable status. Advice on this can always be sought from more experienced members of a scheme or press officer if one is in post. Members can also get involved in mentoring potential new members and attending local events to fund raise. The main support to schemes is making available members time to respond at all times of day and night, in all weathers and to a variety of incidents. Commitment to responding on a regular basis improves skills and knowledge, improves the profile of the schemes with local ambulance crews and leads to a cohesive team approach from all three emergency services at large incidents. The support of work colleagues and immediate family members is vital to the success of responders and should not be underestimated. Others are normally left picking up the pieces where PHEC practitioners have left to respond to requests for help. Care with selection of cases attended and targeted dispatch by ambulance control helps to maintain this good will and support on an enduring basis.

Equipment required

The financial burden of kit issue and resupply normally rests firmly with the BASICS charities. However ambulance service trusts normally provide the PPE and communication devices, such as Airwave radios or pagers. Some regional ambulance services will provide re-supply on a like for like basis for consumables used such as oxygen, ECG monitoring tabs and intravenous fluids. The bulk of the equipment and medication resupply is normally provided by the schemes and contracts are set up from suppliers to ensure timely resupply to members. The adding of visible and audible warning devices to individual member's cars is costly and should be done by professionals. This is sometimes achieved by utilising ambulance service vehicle maintenance teams or often from using specialist suppliers. Cost is normally in the region of £3000 per car and thought needs to be given by any new member to the likely time of purchasing a new car as this will increase the financial drain on the schemes finite resources. The cost of vehicle fuel is normally down to scheme members but mileage reimbursement can sometimes be requested from schemes.

Driver training and documentation

If when responding you use lights and sirens, recent changes in

road traffic legislation and the development of the national response-drivers database, all act to ensure that you are appropriately trained and re-assessed on a regular basis. Most ambulance services will provide driver training for BASICS schemes once you are committed to membership. Other schemes source driver training externally, for example, from the local police force. The driver training is very detailed and an assessment is carried out by the instructor for assurance to the ambulance services who are tasking the responder to use their car as an ambulance vehicle. Driver training is sometimes transferable between schemes and regions depending on documentation held, and this prevents the need for re-training if relocating to a different region.

You must also be adequately insured to drive using audible and visual warning devices and this should be discussed with your car insurance company. Some insurance underwriters will add the details of responding to your policy with no additional charge when the nature of the charitable work is discussed, others will charge a premium. There are specialist insurance companies who will insure vehicles and equipment of PHEC responders and details can be found on the BASICS website [2]. It is usual for schemes to refund the additional portion of emergency cover to members.

Documentation is a critical part of PHEC and ambulance trust will expect local patient report forms to be carried and used by PHEC members at all times. They will also expect responders to be fully aware of any standard operating procedures or protocols which will be used by other members of the ambulance service team.

Discussion

PHEC in the UK is an exciting area for developing previously gained emergency skills in the UK, but cannot be embarked upon in an ad-hoc and unstructured way. For the military primary care provider, PHEC provides a perfect opportunity for using, evaluating and maintaining emergency skills taught frequently throughout a military career. The types of incidents at which ambulance dispatch may desire responder back up is wide and varied, but will regularly involve attendance at entrapment road traffic collisions (RTCs), cardiac arrests, paediatric trauma, falls from height and other medical emergencies (Figures 2-4). Some examples are shown in the images throughout this article. The Annual BASICS Conference in the autumn is an ideal forum at which to meet likeminded individuals and colleagues from PHEC and is recommended.



Figure 2 LGV v Van entrapment RTC in East Midlands highlighting importance of regular team working between emergency services



Figure 3 Fire service working to release entrapped non-time critical patient



Figure 4 Author and CMT1, on left, assisting HELIMED54 crew loading a casualty after fall from a high ladder approximately 5 miles from the barracks.

The military would benefit greatly from representation on the BASICS committee to highlight lessons learnt in the military, experience from all three services especially from current operations and to assist in attempting to gain national recognition for the Military Immediate Care Course at RCDM.

As discussed throughout, schemes are located across the UK and will consider new members on an individual basis, but most desire a personal and geographical commitment to offset the initial and continued investment in the individuals. The work is at all hours, in all weathers and is difficult to predict. It is however extremely rewarding and could be considered by any interested military medical care provider. Military establishments might also consider responding as a mixed team, for mutual support and development, and this could be discussed with any local BASICS chairman.

Conflicts of Interest

The author is an accredited member of BASICS and a co-opted member on the committee for the East Midlands Immediate Care Scheme (EMICS).

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The General Practitioner Trainer Exchange as an Innovative Approach to Peer Review

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Abstract

There are various formal peer review schemes to assess the quality of primary care practices and several special approval and re-approval programmes exist for General Practitioner (GP) trainers and primary care training practices. The Defence Postgraduate Medical Deanery (DPMD) has its own General Practice Education Committee (GPEC) approval and re-approval programme. Part of this programme is related to the New Membership of the Royal College of Practitioners (nMRCGP).

There is limited published information related to GP trainer exchanges as a means of peer review and as such as preparation for GPEC in the British Forces. This paper provides a review of a GP trainer exchange involving a visit of a GP trainer from British Forces Germany (BFG) to the practices of Dhekelia and Ay Nik on Cyprus in January 2010. It concludes that a GP trainer exchange is cost neutral and may be a valuable experience for both the host and visiting GP trainer, the local GP trainers' group, the practice teams and above all, for the GP trainee.

Introduction

In general practice there is a long tradition of peer review through practice visits. The development of such structured visits started in the 1980's and there is now a large body of accreditation programmes available that set standards with the aim to protect and enhance the quality and safety in primary care [1, 2]. However, for a General Practitioner (GP) trainer ("trainer") and primary care

training practice ("training practice") there are enhanced standards, especially related to the teaching skills of the trainer and the learning environment of the training practice and hence most deaneries have developed their own specific approval and re-approval visits [3]. The Defence Postgraduate Medical Deanery (DPMD) has its own General Practice Education Committee (GPEC) and both the committee, and its process of approval or re-approval, is often referred to as the "GPEC". The GPEC is a formal visit, in which a number of eminent GPs visit the training practice and the trainer to assure that set standards are met [4]. GPEC is also interested in the work of the GP trainee ("trainee") for the new Membership of the Royal College of General Practitioners (nMRCGP) exam. From August 2007 this exam has been

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mandatory and the trainee must pass it to work as a qualified GP [5].

An important element of preparation for GPEC may be peer review in the format of attendance at an experienced trainer's course, but these courses are expensive and often modular and therefore problematic for educators stationed abroad. As part of the Tri-service GP Trainers' Conference in Gosport in November 2009, the authors discussed whether a trainer exchange could be an adequate means of peer review, whether it could provide a useful and informal preparation for GPEC and whether it could function as an adjunct or alternative for an experienced trainers' course. A literature search provided limited information regarding these types of trainer exchanges in the British Forces. Subsequently, from one author (HGJvdH) visited the other for eight days in February 2010 at the Medical Reception Station (MRS) Dhekelia and Medical Centre Ay Nik, Cyprus. This article provides an overview of some of the main issues that were discussed and addressed.

Mock GPEC assessment of documentation and practice

Every training practice is regularly visited by GPEC to assure that the practice provides high quality patient care and that there is a strong learning ethos. The standards are set in MOD form 424, often just referred to as the "424" and filling in this document is an important element for the preparation of the official GPEC visit [4]. During the trainer exchange the host trainer presented this document to the visiting trainer and was interviewed regarding many aspects of the Ay Nik practice. Important elements that were discussed were: the consultation system, out- of -hours provision, the quality of the medical records, prescribing, information technology (IT), clinical medicine, performance review and most especially the practice team. Afterwards both went through the practice as a mock inspection. The outcome was that several strong points were identified, for example the high quality infrastructure and the small but very friendly primary health care team. Weaknesses were mainly related to the prescribing structure and the lack of explicitly presented audits.

Video of the consultation

GPEC is also interested in the progress of a trainee in relation to the nMRCGP. An important element of the nMRCGP is the structured analysis of the consultation using the Consultation Observational Tool (COT), a form that offers various descriptors, for example "*the doctor encourages the patient's contribution*" or "*the doctor performs an appropriate physical or mental examination*". The assessing trainer should indicate to what extent the trainee is excellent, competent or needs further development regarding the each descriptor [5].

In MRS Dhekelia it is preferred to video record the consultations and to do the COT assessment afterwards. In the practice the rooms of both trainer and trainee are set up to video their consultations, with already fixed microphones in both the consultation and the examination room, and with a fixed place for the camera. Reception staff make patients aware that there is a "video clinic" and these patients are asked to give consent before and after entering the room, assuring they are fully aware of, and are content, with the process.

Following the 'video clinic' the videos were assessed by the trainee, visitor and host together using the COT, which provided the novel element of the trainee observing how her trainer was assessed by another trainer. It may also have been an eye-opener for her that her trainer could not provide the perfect consultation and that for any doctor there may be room for improvement.

Similarly, a video of the consultations from the trainee was assessed, this time just by the trainee and visitor to make this less threatening and the assessment was entered on her e-Portfolio.

Case Based Discussion

Another important element of the nMRCGP is the Case Based Discussion (CBD). The principle is that the trainee presents the consultation record of a patient seen by him or her to the trainer. Both trainee and trainer then independently prepare around the case, followed by a structured case discussion using a special form indicating various descriptors of competency areas, for example "*the doctor practices holistically*" and "*managing medical complexity*". The trainer then scores, as in the COT, to what extent the trainee is excellent, competent or needs further development [5].

In MRS Dhekelia the trainee presented her case to the visiting trainer. The advantage for the trainee was that she had the experience of another trainer assessing her skills and also that another case could be entered on her e-Portfolio. For the visitor the advantage was that he could assess his own performance of this CBD on video.

Trainers' meeting with ePortfolio entry calibration

A further key issue of the nMRCGP is the learning log as part of the e-Portfolio [5]. The concept of a learning log is not new, but the electronic version provides a lot more opportunities for reflection and interaction [5, 6]. For any given trainee consultation, they can enter this consultation onto the learning log where they are prompted to write what has been learned, what he or she will do differently in the future etc. but also is requested to link the entry with various parts of the GP curriculum. The trainee can opt to share the entry with the trainer when the trainer can then assess the case and provide feedback to the young doctor.

At the trainers' meeting in Dhekelia, trainers from the island, together with one of their trainees and the visiting trainer, assessed several of these learning log entries based on material presented by the RCGP [7]. A wide range of cases, ranging from ECG's, red eyes, breast cancer with metastases, psychosis, malaria, severe headaches, Crohn's disease and clinical governance were discussed. There was debate on whether a trainee should enter a minimum amount of log entries each year, but setting an explicit number was feared to go at the expense of the quality of each entry. The quality of the entries was discussed and in general it was thought that an acceptable entry should contain some evidence of critical thinking, openness and honesty regarding own performance, some evidence of learning and what needs to be learned. Also the participants indicated that log entries often contained a large list of links to the different parts of the GP curriculum and it was considered better if this was limited to a small number of crucial ones.

Multi-disciplinary training

Not only is the interaction between trainee and trainer important for fruitful learning, also the primary health care team provides a pivotal role in the learning experience of the young doctor [4]. Therefore some practices provide a multi-disciplinary training in which staff from the various disciplines can learn from each other. At the request of staff from the two medical centres, the visiting trainer provided some training regarding medical audit, which addressed key areas such as criteria, standards and the audit cycle (Figure 1). Similarly basic research principles were addressed including the research question, literature review, research methods, data analysis, bias, sampling, confidence intervals,

validity and reliability. These were interactive sessions in which staff were invited to participate and where requested to set up their own audit or small research project.



Figure 1 The visiting GP trainer facilitating training in Ay Nik

Add-on benefits of the exchange

Apart from the already mentioned elements related to GP training, the trainer exchange provided plenty of other benefits. It provided opportunities to meet up with the local ophthalmologist and part of his team, and with the radiologist and other staff from the Medical Diagnostic Centre to discuss and observe healthcare as provided on Cyprus. All were very welcoming and helped the visitor to enjoy some of the architecture and culinary culture of this amazing part of the world.

Discussion and Conclusion

The GP trainer exchange seems to provide mainly advantages. Although there is an opportunity cost for the sending practice when their trainer is away, this cost is a lot higher if the trainer were to attend an experienced trainers' course. The main advantage for the visiting trainer may be to function as an "examiner" in another

practice, which is useful for his or her own preparation for GPEC. The main advantage for the hosting trainer could be the opportunity of external peer review without the pressure of having to pass the assessment. Both the trainers' group and primary health care team may benefit from the input of an outsider. Finally, and most importantly the trainee gets the opportunity to be assessed by another trainer, observes her own trainer being assessed and the assessments provide a boost to his or her e-Portfolio. As such the GP trainer exchange may be an interesting system to use on a wider scale as part of the GP training in the British Forces.

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The Doctor vs. the Command: Can disagreement arise?

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Abstract

Doctors have long since assisted the Command on operations and in providing day to day bespoke medical care to the UK Armed Forces. Doctors and the Command work along different models that confer different obligations and priorities. For doctors the patient and their wellbeing is of primary importance and for the Command, the Unit as a whole with its military goals are of primary concern. Most of the time these two models work in harmony. However occasionally disagreement can arise. This article examines the models guiding their respective practice in order to understand the underpinnings of these disagreements, and offers some discussion of the issues, particularly as they pertain to the deployed environment. Finally, some recommendations are made to equip doctors and the Command to contain any disagreements.

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Introduction

The British Armed Forces have a long tradition of medical doctors accompanying units on deployment and providing day to day medical care for the unique requirements of the Armed Forces, and this is particularly the case when looking at the deployed environment. From the venerable start of the Ship's Surgeon to the

modern day General Duties Medical Officer (GDMO) and Senior/Principal Medical Officers, members of the medical profession have always worked side by side with the Command (those responsible for the executive and control elements of a unit) in the maritime and land-based environments. For the most part this is a very successful arrangement, and hence the Armed Forces' continued commitment to maintaining a well-trained, bespoke medical workforce. However, occasionally differences can arise, and it is likely to do so in the most controversial and difficult to manage cases, emergency situations, or when the medical requirements clash directly with operational requirements. Therefore, it is likely that such disagreement when it arises will be in a setting that is already stressful and fraught with potential for contention. It is important for both parties that some consideration is given to the reasons underlying this disagreement, in order to illuminate the position of the other party, and lead to improved skills for obtaining resolution.

Opposing Models

When considering the core of these potential disagreements, it is important to consider the models along which both parties operate, and that dictate their responses to a particular medically complex situation. The Command Model, like the Medical Model in its field, is time-tested to achieve the primary goal of the Command, which is to fight and win wars. On the other hand, the Medical Model has at its heart the restoration of health and the alleviation of suffering, putting the patient at the forefront of priorities. Both these models hold fiercely to the primacy of their core goals, and it is inevitable that the primary goals of the two models will come into conflict given the right mix of circumstances. It must be acknowledged from the outset that in the vast majority of cases these two models co-exist in a state of "mutualism", where both parties benefit from the relationship.

The core features of both models, as relevant to the military environment, are detailed in Box 1. On the face of it, these two models appear to be at opposite poles, and any compromise between the two unlikely. For instance, a person-centred approach in winning and fighting wars would be disastrous for the Command in a conflict situation, as it precludes the possibility of putting anyone in harm's way. On the other hand, adopting a goal-centred approach in medicine will strike at the very heart of medical ethics and is likely to bring the doctor rapidly into conflict with their regulating body. Equally, the Commanding Officer (CO) must at all times consider the unit's needs above that of any individual, whilst the health of the patient is the foremost consideration of the doctor. This does not mean that the needs of the unit do not feature in the doctor's considerations, or those of the individual in the Command's consideration, but that they are evaluated dramatically differently in certain cases where disagreement arises. The blending of the two models is further complicated by the fact that doctors do not, and can not, ordinarily compel an individual to receive treatment, regardless of the impact that has on the mission or unit. The doctor can only do so when the patient no longer has capacity and a medical emergency has arisen. This issue becomes particularly pressing in the fields of mental health and alcohol abuse, where the compulsion from Command may directly clash with the voluntary approach of the doctor. It may also be the case that the Command lack the appropriate knowledge to fully understand the medical issues and as such may be more inclined to expect individuals to "keep a stiff upper lip". In judging medical issues they will rely on their Subject Matter Experts (SME), which serves to bring both models into play. In some cases, particularly of mental illness, it may also be that either party may, on account of stigma, under- or overestimate the significance of the medical problem.

Command Model	Medical Model
The unit is the primary concern.	The patient is the primary concern.
Rehabilitation based on correction.	Rehabilitation based on treatment.
Compulsory engagement with model.	Voluntary engagement with model.
Fit to fight = the end goal.	Fit to live = the end goal.
Goal-centred approach.	Person-centred approach.
Conformity.	Individualism.
Retention decisions based on military considerations (manning, discipline, performance).	Retention decisions based on medical considerations (treatment and prognosis).
Guided by a Service Contract (responsibility, availability, service delivery).	Guided by a Sick Role Contract (temporary alleviation of responsibility and service delivery).
Rank-based authority.	Subject Matter Expert-based authority.
Information gathering is imperative.	Patient confidentiality is imperative.
Practise guided by the Queen's Regulations.	Practise guided by the GMC.

Box 1. Comparison between the Command Model and the Medical Model.

The Medical Perspective

Medical ethics is an evolving field, and the guidance and legal obligations arising from it can be very difficult for doctors to reconcile with their role in the military. From the ancient beginnings of the Hippocratic Oath [1] (Box 2), to very modern day guidance by the General Medical Council (GMC), it is clear that the first imperative for the doctor remains the well-being of the patient. The oath has been modernised over the years, although much of the essence of the original version still remains unchanged. For doctors today, the Declaration of Geneva [2] encapsulates the guiding principles in establishing their duties towards patients (Box 3). The Geneva Declaration was adopted by the General Assembly of the World Medical Association at Geneva in 1948, and has since been amended. Written with regard to the medical crimes committed in Nazi Germany, it is a "declaration of physicians' dedication to the humanitarian goals of medicine". Much of the essence of the original Hippocratic Oath remains in the Geneva Declaration, of which the UK is a signatory.

Although the Geneva declaration is a guideline and not a legal compulsion, it does underpin the law regarding obligations of doctors in the UK. All doctors in the UK Armed Forces are expected to hold current registration with the GMC. Without such a registration a doctor is not allowed to practise in the UK. This registration brings with it the imposition of a set of professional obligations, unlike the guidelines of the Geneva Declaration. These duties are summarised in Box 4 and the essence of Hippocratic Oath and Geneva Declarations are captured within it. It follows that any doctor found in breach of these duties, may well lose their registration and therefore the right to practise medicine in the UK and for the UK Armed Forces.

The duties imposed on doctors by the GMC have profound implications for doctors in the Armed Forces, which may not be recognised by Command. The argument that the individual is an officer first and a doctor second would not hold up when scrutinised against the duties imposed by the GMC, as it is tantamount to making the Armed Forces your first concern. For

instance, if there is a serious medical complication that could have been prevented by timely and reasonable action, i.e. diverting a ship mid-exercise, but it is found that the doctor failed to act due to Command pressure, financial considerations, career considerations etc., then that doctor could face serious questions about professional misconduct and negligence. Also, the CO as the final decision maker and the Ministry of Defence (MOD) as an organisation may find themselves in an indefensible legal position. Different considerations apply in an actual war fighting situation, as actions that would have been reasonable on an exercise or routine patrol, may no longer apply. However, outside of actual war, any decision taken on the grounds of convenience, cost, prestige, career progression, goal attainment or any motive other than the patient's interests that leads to harm coming to the patient, is likely to place the doctor and the CO in a difficult position. We may also not always be dealing with a member of the UK Armed Forces when we consider this issue. For instance, consider the case of a GDMO in Afghanistan who treats a "non-entitled" civilian for serious injuries/ illness, but is then unable to medically evacuate the patient as it goes against the Chain of Command's guidance.

I swear to fulfil, to the best of my ability and judgment, this covenant:

I will respect the hard-won scientific gains of those physicians in whose steps I walk, and gladly share such knowledge as is mine with those who are to follow.

I will apply, for the benefit of the sick, all measures (that) are required, avoiding those twin traps of over-treatment and therapeutic nihilism.

I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug.

I will not be ashamed to say "I know not," nor will I fail to call in my colleagues when the skills of another are needed for a patient's recovery.

I will respect the privacy of my patients, for their problems are not disclosed to me that the world may know.

Most especially must I tread with care in matters of life and death. If it is given to me to save a life, all thanks. But it may also be within my power to take a life; this awesome responsibility must be faced with great humbleness and awareness of my own frailty. Above all, I must not play at God.

I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person's family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick.

I will prevent disease whenever I can, for prevention is preferable to cure.

I will remember that I remain a member of society, with special obligations to all my fellow human beings, those sound of mind and body as well as the infirm.

If I do not violate this oath, may I enjoy life and art, respected while I live and remembered with affection thereafter. May I always act so as to preserve the finest traditions of my calling and may I long experience the joy of healing those who seek my help.

Box 2. Modern version of the Hippocratic Oath [1].

At the time of being admitted as a member of the medical profession:

- I solemnly pledge to consecrate my life to the service of humanity;
- I will give to my teachers the respect and gratitude that is their due;
- I will practise my profession with conscience and dignity;
- **The health of my patient will be my first consideration;**
- **I will respect the secrets that are confided in me, even after the patient has died;**
- I will maintain by all the means in my power, the honour and the noble traditions of the medical profession;
- My colleagues will be my sisters and brothers;
- **I will not permit considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient;**
- I will maintain the utmost respect for human life;
- I will not use my medical knowledge to violate human rights and civil liberties, even under threat;
- I make these promises solemnly, freely and upon my honour.

Box 3. The amended Geneva Declaration for the Medical Profession [2](bold highlights by authors).

Patients must be able to trust doctors with their lives and health. To justify that trust you must show respect for human life and you must:

- **Make the care of your patient your first concern**
- Protect and promote the health of patients and the public
- Provide a good standard of practice and care
 - o Keep your professional knowledge and skills up to date
 - o Recognise and work within the limits of your competence
 - o Work with colleagues in the ways that best serve patients' interests
- Treat patients as individuals and respect their dignity
 - o Treat patients politely and considerately
 - o Respect patients' right to confidentiality
- Work in partnership with patients
 - o Listen to patients and respond to their concerns and preferences
 - o Give patients the information they want or need in a way they can understand
 - o **Respect patients' right to reach decisions with you about their treatment and care**
 - o Support patients in caring for themselves to improve and maintain their health
- Be honest and open and act with integrity
 - o Act without delay if you have good reason to believe that you or a colleague may be putting patients at risk
 - o Never discriminate unfairly against patients or colleagues
 - o Never abuse your patients' trust in you or the public's trust in the profession.

You are personally accountable for your professional practice and must always be prepared to justify your decisions and actions.

Box 4. The Duties of a doctor registered with the General Medical Council [3] (bold highlights by authors).

Discussion

Both doctors and the Command are tightly bound by the roles and responsibilities conferred by the models that guide their practice on a daily basis. These differing models bring with them a potential for disagreement, principally as the methods for dealing with such conflict are divergent. Although disagreement does not arise in the vast majority of cases, it is likely to do so in very difficult cases, or when answering the obligations of the medical model greatly interferes with the goals and needs of the Unit. The most frequent areas of potential disagreement tend to be over patient confidentiality, matters of discipline in those who are ill (especially with mental health problems), concerns about malingering, medical downgrading of essential personnel, or where the required medical actions will interfere with the completion of the unit's tasks and obligations. This conflict plays itself out in a culture where there is significant pressure toward task completion, immediate consequences for failure and high emphasis on prestige and role fulfilment.

Box 5 describes a fictional if recognisable scenario of conflict between the needs of command and those of medicine. In playing out this conflict, doctors are bound by the duties imposed on them by the ethics of their profession, but more firmly and directly, by the duties imposed upon them by the GMC. However, they are faced with a duality in this, as they also have to function as officers where they are expected to fulfil an active role within the Command Model. It may also represent additional difficulties in that their careers are controlled by the Command, and those they have disagreements with in advocating for the patient, may also write their reports and dictate their promotion. Therefore, there may be unspoken, but potent, incentives for doctors to place career considerations, amicable relationships with the Command and unit-favourable decisions above the needs of the patient.

You are the GDMO detached to a Forward Operating Base (FOB). One of your soldiers was close to an explosion. Although he was not physically injured, he complains of deafness and tinnitus in both ears. He is the unit's only Unmanned Aerial Vehicle (UAV) pilot. He is seen at Camp Bastion where he had an audiogram which shows his hearing is below deployable standard and indicates his return to the UK. The CO of the FOB needs the soldier to stay at the FOB as he is "so essential and losing him may cost lives". He may still have to go out on patrol. The CO is adamant about this, and is getting very angry at the prospect of losing him. As a GDMO you recommend his CASEVAC back to UK.

Box 5. Unit need vs. individual need.

In cases where the medical emergency is clear and serious, the decision is often made with greater ease, as the imperatives are so clear. However, the situation is less clear when the doctor and the Command deal with potential risks and the likelihood of a situation progressing to an emergency. The doctor may have very little firm evidence at first to predict an outcome one way or the other, for instance, does this patient have pleuritis or a pulmonary embolus? Thus, the final outcome of a medical problem may be difficult to predict for doctors, regardless of their level of experience. The Command, on the other hand, is likely to require firm evidence to make a decision, particularly if that decision is likely to interfere with the unit's functioning or mission aims. These periods of uncertainty can be fertile ground for conflict, and occasionally both parties may jointly or unilaterally be required to make major decisions based on insufficient information. In the end, quality of information is the only thing that distinguishes a calculated risk from a gamble. It could also be the case that doctors are more risk-averse than their Command, as they can resort to

group decision-making which is more tolerant to risk, whilst the doctor frequently finds themselves as the sole SME, and a relatively junior and low ranking one at that. When working in isolated locations, such as ships, submarines or Forward Operating Bases (FOBs), it may be difficult for junior doctors to access senior support, thus potentially leading them to formulate major decisions in isolation, under potentially significant non-medically driven pressures.

The issue of confidentiality may be of particular concern for both the doctor and the Command. The Command relies on their SME's to give them an assessment and explanation that allows them to formulate a decision. In doing so, they can ask questions and seek clarification in an unrestrained manner, and be privy to all the available information to the level of detail they require. However, with the doctor as SME, this level of control and flexibility is removed due to the constraints of patient confidentiality. This may leave the Command feeling frustrated, and that the balance of the decision-making power is involuntarily shifted away from them, although they still remain responsible for the outcomes of those decisions for the patient and the unit. In the end the doctor is required to provide both factual information and opinion, to aid decisions that may not be medical. However, they may find themselves limited in the factual information they are able to impart to Command, and so have to rely on giving an opinion that may also be constrained by confidentiality to a greater or lesser degree. This restricts both parties in terms of communication, and it could easily lead to disagreement due to this informational void that has arisen as the scenario in Box 6 highlights.

You are the Medical Officer onboard a frigate in the Falklands. You are underway to the South Georgia Islands, as there have been reports of illegal fishing in progress there. A 21 year old female presents in acute distress, with several superficial lacerations to her wrist. She is normally high functioning. She discloses that she had been sexually assaulted by a member of the ship's company three days before, and has been feeling distressed and suicidal since the incident. She feels she cannot continue to be on the same ship as her assailant, and fears that she will harm herself or be assaulted again. She is explicit in her wishes that you do not divulge the fact that she has been assaulted or the deliberate self-harm to anyone, as she feels ashamed. You are unable to persuade her otherwise. Landing her would require the use of the ship's helicopter, which would also be needed for the upcoming operation, and it would not be able to return after landing her due to range. You advise the CO that she is no longer safe to be onboard due to an acute mental health problem, but he is adamant that he will only make such a decision if he has more information about the risk, in order to weigh it up against the operational risk of losing the helicopter.

Box 6. The issues of confidentiality.

The conflict may also at times be evident in less serious scenarios, where there may be less clarity about which model's imperatives may be in ascendancy. There are occasions where the individual may represent an administrative burden or disciplinary challenge to the unit, but also interact with the medical system. This may lead to concerns about unnecessary downgrading by doctors, or attempts to try and alter medical categories. It could be seen that doctors are a "soft touch" in some circumstances, and that their intervention disrupts the administrative course and plans of the Command, as they attempt to maintain discipline and avoid individuals "working the system". It may also be that there are

concerns from the Command whether a problem is genuine, particularly if an individual presents to the medical system during times of great pressure. In fact, these concerns about malingering may also affect an individual's willingness to present with medical problems, particularly with mental health problems. The Command's point of view is understandable, as it would be severely detrimental to morale if discipline is poor, and a culture of non-availability develops in a unit. However, this may mean that Command may enter the deliberations with preconceived judgments that may not tally with the medical interests of the patient.

In certain situations doctors may also feel that their Command is handing difficult problems to the medical system to resolve, when in fact it requires robust management by Command. In other words, the doctor may feel that the Command is confusing welfare issues with medical issues. This is an argument that can easily be seen in the reverse from the Command's perspective, and without good communication and integrated thinking, this can lead to conflict. For instance, in Mental Health Services considerable effort is sometimes exerted in moving social problems away from the medical system. There may be a gap between the perceptions of the doctor and the Command, with both looking to the other party to take ownership of the problem. However, at times there is a great deal of synergy in this interaction, with the Command clearly valuing the withdrawal of the medical professionals so that they may manage the problem executively, and vice versa.

This issue may be particularly relevant to junior doctors, particularly General Duties Medical Officers (GDMO's). They are junior, both in respect of their medical skills and as officers, thus potentially leading them to feel less confident in negotiating with more senior and experienced members of the Command. In addition, they may frequently be the bearers of bad news, some of which may be particularly unpalatable to the Command. It follows that it is an unbalanced situation whereby it may be easier for the Command to complain about the medical services, than the other way round, leaving the doctor frustrated and with a sense of helplessness. The reverse of this is also true of course, in that the actions of doctors may occasionally leave the Command experiencing the same feelings. Good communication is the key to resolving this issue, and it is important that junior doctors have the skill mix to enter such deliberations constructively. This includes realisation that ultimately the Medical Officer's role is advisory to the Command, and having given the best possible advice, they then have to accept Command's decision. Good record keeping of this dialogue would be essential for the doctor, should this ever come to review by the GMC or the medical chain of command.

Greater attention to their duties as a doctor should be given to military doctors in their training, including the ethical aspects of practising medicine in military environments and strategies for resolving conflict. They also need to have a thorough

understanding of the Command Model, in order to appreciate the approach of the Chain of Command. These goals may be achieved by introducing training into Entry Officer Course where difficult scenarios are worked through and discussed, but most importantly, where members of the Command join in the process. This can be as "role play" exercises or debates on a set scenario. Perhaps there is also scope for training for the Command, perhaps on the Senior Officers' or Command Designate Courses. In the end, good communication is the key to resolving this issue. When doctors are busy and clinics are pressured, it may sometimes be easy to forget that this communication with the Command is as important as communication with the patient about treatment, as it may in great part dictate their wellbeing and the course of their treatment.

Conclusion

Due to the differing and divergent obligations conferred by the Command Model and the Medical Model, disagreement is inevitable at times. The more serious the nature of the medical emergency or risks associated with the medical condition, the more likely it is that the imperatives of the Medical Model will prevail, at the cost of the unit's needs if necessary. The Medical Officer needs to have made a thorough assessment of the situation and be able to communicate the risks in a way the Command can understand. However, this is a pendulum that swings according to the military situation, and in times of war, the unit's needs and attaining the military objectives will usually have primacy over that of the patient. Good, open and rational communication based on mutual respect is the key to resolving disagreement when it arises. In the end, most doctors and members of the Command are reasonable, as rising to their station requires the ability to solve problems, make innovative plans and avoid negligent decisions. Thus, by understanding the approach of the other party, compromise is possible in order to find the best possible solution for the patient and the Unit. However, this knowledge brings the realisation that sometimes the weight of the imperatives resides with one party or the other, and then the test of character lies in the acknowledgment of that fact, and giving ground or standing your ground accordingly. Medical doctors, particularly those inexperienced in the military environment, need ongoing and specific training in how best to communicate with the Command, so that disagreements are contained. With this training, the Medical Officer will be better prepared for all communications with their Command.

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