Confédération Interalliée des Officiers Médicaux de Réserve

Interallied Confederation of Medical Reserve Officers

Summer Congress – Madrid

Congrès d'été - Madrid

Scientific Programme

Programme Scientific

Abstracts of Presentations

Résumés des Conférences

CIOMR Summer Congress 2016

01.08.16 **Monday Workshops -** Col Walter Henny MD - Coordinator

0930	**"Emergency Dental Treatment by Non-Dentists; part 2" by LTC Wolfgang OTTO**
1115	Coffee Break
1200	"**Medication Safety – part one" by Professor Keith Weeks**
1400	Lunch
1500	"**Medication Safety – part two" by Professor Keith Weeks**
1500	CIOMR Board Meeting at CESEDEN – *concurrent session*
1700	Break
1800	CIOMR Workshop Reception at Melia Castilla Hotel
2030	Registration and arrival

02.08.16 Tuesday

0930	**Host Nation Scientific Program** **TCol Arceiz : " STRUCTURE OF THE SPANISH MILITARY HEALTH SYSTEM "** **CURRENT OPERATIONS - TCol Hernández Abadía** **CHALLENGES OF MEDICAL SUPPORT TO OPERATIONS : SPANISH ONGOING INITIATIVES . TCol Almazor** **– Room A**
1115	Coffee
1200	CIOMR Executive Council Room A
1400	Lunch
1500	Committee Meetings Room C
1700	Transport
1930	Opening Ceremony
2100	Reception
2230	Transport

03.08.16	**Wednesday – Scientific Sessions – Room B**
0930	**Major advances in battlefield medicine and surgery as a result of mega clinical data mining and distribution to the battlefield clinicians Maj. Gen. Robert Kasulke US**
1000	**Does Kings College Hospital require a guideline for the placement of thoracic epidurals in Chest Trauma? - Lt. Cdr Kathy Shammas UK**
1030	**Collaboration across boundaries: Multinational working Maj. Helen Mackay UK**
1100	Coffee
1130	**Deployed renal replacement therapy in support of surgical teams and disaster management. - Wg. Cdr. Mike Almond UK**
1200	**Agile Strategic Planning and Execution Col. Tri Trinh US**
1230	**Emergency management of battlefield injuries: International common practices and French specificities - Col Dr. Federico Gonzalez Fr**
1300	**Standardization of Acute Trauma Care: Does It Exist?; Does It Work? Col. Walther Henny NL**
1400	Lunch
1500	**The European trauma course and its applicability to the military Lt. Col. Simon Davies UK**
1530	**The initial management of modern ballistic injuries Lt. Col. Mark Thibert**
1600	**CRM in an Austere Environment Prof. Dr. A.B. van Vugt Res. Lt. Kol Dutch army**
1700	Transportation
04.08.16	Thursday
0800	3c Competition
1400	Lunch
1430	Transport
1500	Committee Meetings Room C
1700	Transport
1930	CIOMR Dinner

07.02.14 Friday – Scientific Sessions – Room B

0930 Standardization of acute trauma care: Does it exist? Does it work? Part I
Col. Walter Henny NL

1000 Standardization of acute trauma care: Does it exist? Does it work? Part II
Col. Dominique DiDuca

1030 Lessons Learnt from Military Ops in to Civilian Healthcare
Lt. Col. Simon Davies UK

1100 Coffee Break

1130 Value and Effect of Protective Systems against IED
Sqn Ldr Graham Banks UK

1200 Re-thinking Danish Naval Medical Standard Operating Procedures.
1st Lt. Jan Honing

1230 Military Medical History – James Barry
Maj. Helen Mackay UK

1300 Military Forensic Medicine in Denmark
Surg Cdr Peter Juel Thiis Knudsen

1330 Psychological and physical aspects of resiliency training for US forces.
Lt. Col. Bruno

1400 Lunch

1500 Open session

1700 Transport

1900 Transport

2000 Spanish Evening

2359 Transport

08.02.13 Saturday

0930 Executive Committee Meeting
1115 Coffee Break
1145 CIOMR Executive Council - Room A
1200 Closing Ceremony
1400 Lunch
1500 Break
1900 Transport
2000 Gala Dinner
2359 Transport

Abstracts

Abstract (max. 150 words)

"Major Advances in Battlefield Medicine and Surgery As A Result of Mega Clinical Data Mining and Distribution To The Field

MajGEN (USA-RET) Robert J. Kasulke MD MPA FACS
International President, CIOMR

Introduction There has been a rapid evolution in the delivery of Battlefield Medicine over the last decade. These advances are directly related to the creation of the ATTS (Army Trauma Tracking System). This system mines clinical data that is gathered from treating battlefield casualties, both medical and surgical, in real time. These data, using fast Fournier Analysis techniques are immediately assessed for statistical significance. If the analysis indicates a positive result from even minor change in a clinical procedure or resuscitation technique, these results are sent back to the field and utilized from that point forward for use in battlefield casualties.

This process has resulted in markedly increased survival rates and clinical outcomes the best practice techniques that are recommended as a result of the ATTS analysis are used in treating battlefield casualties.

I will also discuss some examples of the specific changes in treating battlefield casualties and the outcomes of these treatments since the ATTS has been utilized.

Methods Clinical Review

Discussion/Conclusion I will demonstrate the usefulness, the validity and relevance of the use of Data that has been "vetted" through the ATTS process in increasing the survival rate of serious battlefield injuries.

Biography (maximum of 150 words – please do not leave this section blank as this will serve as your introduction to the various member nations)

See attached Bio

Abstract

Does Kings College Hospital require a guideline for the placement of thoracic Epidurals in Chest Trauma?

Dr Kathy Shammas MUDr.MRCP.FRCA[1], Dr Harpreet Sodhi MBBS,MRCSEd,MCEM,FCAI[1], Dr Roger Bloomer MBBS.FRCA[2]

[1] *Senior Clinical Fellow, Anaesthesia, Critical Care and Trauma,* [2.] *Consultant in Anaesthesia and Major Trauma*

King's Trauma Centre, Kings College Hospital, London

Background:

In Europe chest trauma contributes to 10% of all trauma related deaths and pain may be difficult to manage in survivors.

Studies have shown that thoracic epidural (TE) analgesia may be of use in the management of such patients and may prevent respiratory failure and infection due to hypoventilation associated with pain.

Currently no guide line exists in Kings College Hospital for the referral of patients with chest trauma for thoracic epidural analgesia. Is one needed?

Methods:

Retrospective study into the use of Thoracic Epidurals in chest Trauma

TARN – Trauma Audit Research Network searched over a 6 month period -1st January to 1st July 2015. 147 patients had associated chest trauma suitable for study

Results:

The pain team were involved in the management of all patients who received Epidurals: 19
8 were sited as a primary mode of analgesia. 11 secondarily as PCA analgesia had failed.

There were 17cases were analgesia was inadequate, 6 patients were suitable for TE, in 4 of these cases the pain team was not made aware.

2 of these 6 patients developed respiratory failure.. In one case, an epidural had been avoided due to warfarinisation for AF. This was corrected and an Epidural sited on Day 5. This patient had previously required naloxone due to opiate related respiratory depression

Conclusions:

Where epidurals were sited these were mostly plain and in combination with a PCA except for when trauma was isolated to the chest.

Non Epidural Analgesic failure corresponded to advancing age, increasing number of rib #s, and bilateral involvement.

We make the argument that by providing early thoracic epidural analgesia the trade-off between analgesia and narcosis is minimised.

The vast majority of patients that developed respiratory failure had no significant past medical history, however COPD, asthma as well old Polio were present in 2 patients, 2 patients were in AF, depression was present in 2 patients, alcoholism and HTN were also present in 2 patients.

We concluded that a guideline is needed for the referral of those patients at hi risk of poor pain relief and respiratory failure .All referrals should go through the pain team.

The use of Warfarin should not be a contraindication per se where the need for analgesia outweighs the risk of not being anticoagulated.

References:

Blunt Thoracic Trauma – pain management in – EAST. J.trauma, Nov 2005

Epidural Analgesia for the treatment of multiple rib #s Dittman et al 1975 ,

,Prospective Evaluation of Epidural and Intravenous Administration of Fentanyl for Pain Control and Restoration of Ventilatory Function Following Multiple Rib Fractures.Mackersie et al 1991

Abstract (max. 150 words)

“Collaboration Across Boundaries. Personal Reflections of Multinational Working”

H.E. Mackay
208 Field Hospital, Liverpool, United Kingdom. Southport and Ormskirk NHS Trust, UK.

Introduction
Methods
Results
Discussion/Conclusion

In Spring 2014 I deployed as an individual augmentee to Camp Bastion Role 3 Hospital, Afghanistan. Previous to deployment I had experienced an intensive pre-deployment training programme. The training programme composed of Mission Specific Assessment, Mission Specific Validation, Military Operational Surgical Training as well as generic military skills packages.
At that moment in my career I had just completed my post-graduate examinations in Orthopaedic surgery the FRCS (Trauma and Orthopaedics) and was approaching my Certificate of Completion of Specialist Training in order to gain entry to the specialist register in the United Kingdom. Before I deployed I had completed 10 years of post-graduate surgical training, 9 years of composed of orthopaedic training in specialist training posts. At times my orthopaedic training environment had been challenging. My experience in Afghanistan and my reflections were a real ‘game changer’ for me and ultimately guided me to securing my substantive consultant position.

Biography (maximum of 150 words – please do not leave this section blank as this will serve as your introduction to the various member nations)
Appointed consultant trauma and orthopaedic surgeon at Southport and Ormskirk Hospital NHS Trust March 2016, in the North of England. My practice is lower limb arthroplasty, general trauma and Paediatric trauma lead. Completed Higher specialist training in Merseyside. Fellowship trained at Guy’s and St Thomas’s Hospital in London in Paediatric Orthopaedic Surgery and Lower Limb Arthroplasty. Completed travelling fellowships to Chambery Hospital, France and an Observership in trauma surgery at LA county medical centre. I have diplomas in Occupational Medicine, Sports and Exercise Medicine, and Conflict and Catastrophe Medicine and the Diploma of the European Board of Orthopaedic and Trauma surgery. Currently working towards an MSC in Clinical Leadership and Management at EdgeHill University, Lancashire. UK. British Orthopaedic Association Examiner for the British Casting Certificate held at the Royal National Orthopaedic Hospital, London.

Abstract (max. 150 words)

DEPLOYED RENAL REPLACEMENT THERAPY IN SUPPORT OF SURGICAL TEAMS AND DISASTER MANAGEMENT

Wg Cdr M.K ALMOND
4626 (AE) Sqn, Royal Auxiliary Air Force, RAF Brize Norton, Carterton, Oxfordshire, OX18 3LX UK

Introduction: Acute Kidney Injury (AKI) during recent combat deployments has been a rare but serious complication, with mortality > 50%. AKI complicates deployment in support of disasters, where crush injury is common.
Discussion: The history of AKI in relation to trauma is traditionally recognised as being developed by Bywaters during World War II. Until the advent of renal replacement therapy (RRT) it carried a mortality of >90%. Following improvements in combat care mortality has improved, but remains high. Experience in the past two decades has led to difficulties in determining how best RRT and can be facilitated and skills and equipment maintained. The UK deployed RRT to Afghanistan in 2010 following a volcanic ash cloud preventing the rapid retrieval of patients back to the UK. This resulted in the first deployed experience of RRT in over 30 years.
Conclusion: The options available and support for RRT on deployment will be presented.

Wg Cdr Almond has been a Royal Air Force Reservist for 30 years, initially as a Volunteer Reserve pilot then as a Medical Officer. He completed his higher civilian medical training as an acute general physician and renal physician in 1994 and currently works in an average sized UK NHS hospital providing general medical care and renal replacement therapy. He was the Senior Medical Officer and subsequent Officer Commanding of the UK's reserve aeromedical evacuation sqn and has deployed both in support of tactical and strategic aeromedical evacuation operations. He deployed as a physician to the UKs field hospital in Afghanistan in 2010. He was the CIOMR International VP in 2000 – 2.

Abstract (max. 150 words)

Introduction:
Most organizations invest heavy time and resources to develop strategic plans that are overly intricate and not aligned with existing organizational framework. Often, these multi-year strategic plans do not materialize along with vision maturity, are not maintained, or abandoned altogether with a change in senior leadership. The 349 Aerospace Medicine Squadron adopted a simplified and agile strategic planning model that has proven to be effective, easily sustainable and producing respectable results.

Methods: Strategic Focus Areas and Goals (Lead People - Improve the Unit - Mange Resources - Execute the Mission) were adopted from Air Force Instruction 1-2, Commander's Responsibilities. Sub-goals under each Focus Areas have defined metrics. There are no champions for the Strategic Focus Areas. The entire unit is collectively responsible for the Strategic Focus Areas with metrics managed and developed by specific Program Managers.

Results:
The unit was able to achieve the best Air Mobility Wing medical readiness results in the Air Force Reserve for units with over 2000 Airmen. Targeted Physical Fitness Assessment currency and pass rate rapidly improved from 33% noncurrent to 100% current within 3 months.

Discussion/Conclusion:
The 349 Aerospace Medicine Squadron strategic planning framework evolved by happenstance. As problems emerged and priorities prioritized, the squadron's direction and potential became more defined with an audacious vision to be the most respected high reliability organization in the Air Force Reserve. Driven by the Air Force core value of Integrity First, Service Before Self, Excellence in all We Do, the strategic plan framework has been integrated into our military culture as we continue to build a culture of excellence.

Biography (maximum of 150 words – please do not leave this section blank as this will serve as your introduction to the various member nations)

Colonel Trinh is the Commander of the 349th Aerospace Medicine Squadron, Travis AFB, CA. His previous assignments include Chief, Administration, Travis AFB; Chief, Medical Management of Wounded, Ill, and Injured Service Members, Medical Directorate, Office of Air Force Reserve, Pentagon, Washington DC; Senior Health Services Administrator and Readiness Officer at 944th Medical Squadron and Aeromedical Staging Squadron, Luke AFB, AZ. Prior Regular Air Force assignments include, Chief, Programs Development/HQ Air Force Reserve Officer Training Corps, Maxwell AFB; Squadron Section Commander/Royal Air Force Lakenheath UK; Chief Resource Management, 369th Recruiting Squadron and Chief Quality Operations/Assessments, Space and Missile Systems Center, Los Angeles AFB; and Assistant Professor of Aerospace Studies, Embry-Riddle Aeronautical University, Prescott, AZ.

Emergency Management of Battlefield Injuries: International common practices and French specificities

F.R. Gonzalez MD
Departement of visceral thoracic and vascular surgery, Percy Military Hospital, Clamart, France and French Military Health Service Academy - Ecole du Val-de-Grâce Paris, Office of International Training and NATO Relations

The case fatality rate has positively evolved from 19% (World War II) to 8.6% (Afghanistan). Haemorrhage remaining the major cause of death, more than 95% of the wounded soldiers reaching alive a Role 2 will survive. If we review the prehospital death, 75.7% are classified non survivable but 24.3% are deemed potentially survivable.
We present the changes, implemented by most military health services that permitted these significant improvements in the management of battlefield injuries and those which still need to be developed to do better. The French military health service has a longstanding tradition of placing surgeons, doctors and nurses forward (1797, Baron Jean Dominique Larrey's flying ambulances - Napoleonic wars). The structure of our Forward Surgical Team deployed day in day out since 1948 in Africa and elsewhere has remained constant but a new surgical capacity : the „Module de Chirurgie Vitale" has been recently developped for Special Forces. With regard to our blood transfusion policy, the French Lyophilized Plasma is one major component of our armamentarium.
War and armed conflicts have always been the period in time when major advances have been made in trauma care. Military requirements are strong drivers for concept and technological advancements.

Médecin en Chef (COL.) Federico GONZALEZ *is a French civilian trained surgeon and reservist as background (Ancien Interne des Hôpitaux de Paris – Ancien Chef de Clinique Chirurgicale des Universités – Assistant des Hôpitaux de Paris). He served in the French Reserve until 2008. He was appointed as an NHS UK Consultant Surgeon in Bristol and London from 2004 and then joined the French Military Health Service in 2008.*
He has been regularly in Afghanistan, Ivory Coast twice, Djibouti, Mali with the Special Forces, Chad twice and Niger.
Still practicing surgeon in the Departement of visceral, thoracic and vascular surgery, Percy Military Hospital, Clamart, France, he leads the International Training and NATO Relations office of the French Military Health Service Academy - Ecole du Val-de-Grâce Paris,
He is NATO COMEDS Vice Chair of the Military Health Care Working Group and Course Director at the NATO Centre of Excellence for Military Medicine – Budapest.

Abstract (max. 150 words)

„Standardization of Acute Trauma Care: Does It Exist?; Does It Work? “.

Walter HENNY MD

Introduction
Care for Acute Trauma has been delivered since time immemorial; for accidents and during conflicts. At first very basic, gradually more sophisticated; with many similarities but also with differences between countries. This applies to civilian trauma care but also to military medicine. Basically every country did what it thought best.
Only after WWII can one see attempts at reaching consensus, but not before 1980, with the advent of civilian Advanced Trauma Life Support ATLS, can one speak of a generally accepted approach.
Militarily ATLS proved not to be ideal, for many reasons, as was demonstrated convincingly during the First Gulf War.
Only in 1996 did Tactical Combat Casualty Care TCCC arrive; developed for and by double-hatted US Special Forces personnel, it became very quickly an unofficial NATO standard, accepted as a “way of thinking” for the military medical services of many nations; also those outside NATO.

NATO has a complex process for standardization: the development, ratification and promulgation of STANAGs. STANAG 2122 deals with self aid and buddy aid. For the last 7 years (sic) CIOMR has been involved in trying to develop a new version (along the TCCC principles). For several reasoms that process is still on-going.

CIOMR has been trying to support and enhance standardization of self aid and buddy aid for my years: through its Combat Casualty Care Competition, which uses as a standard its Manual “Field First Aid”. This Manual follows the TCCC principles, but is not identical to TCCC, for several reasons.
The 3C Competition reaches only a small international group; this may change as 3C has been “listed” recently in ETOC, as run by MilMed Center of Excellence and Allied Command Transformation.
Hopefully we will see participants from outside CIOR who “apply to take the test”.

Conclusions
Standardization is important as it enhances cooperation; between the civilian and military arenas but also between the militaries of different nations.
A striking example will demonstrated by Col DIDUCA

Biography
Col HENNY is a retired general surgeon, who was an active reservist during his entire working life. He still is extensively involved with teaching, training and coaching (military) medical personnel and also with developing civilian and military training courses in acute and trauma care.

His involvement with CIOMR began in 1981 and over the years he has held a number of positions

Decorations: Officer in the Order of Oranje-Nassau (military branch) (NED), Medal of Merit (MoD / NED), Medaille des Services Militaires Volontaires (FRA), Southerncross Medal (SA)

THE INITIAL MANAGEMENT OF MODERN BALLISTIC INJURIES

Lieutenant-Colonel Mark R. Thibert
Plastic and Reconstructive Surgeon
Canadian Armed Forces Health Services Reserves

ABSTRACT

The initial management of modern ballistic injuries depends on an analysis of the mechanism and amount of energy exchanged to the injured tissues in the context of the overall number and severity of injuries sustained by the patient.

A high velocity round fired at close range will strike dense bone and result in an immediate displacement of much of its energy. Shattered bone and the tumbling of the round act as secondary projectiles that can cause further severe damage beyond the path of the round, also producing an avulsion of tissue at the exit wound. High velocity rounds fired at a long distance it will impart less energy to the tissues, producing effects similar to a low velocity round, with damage mostly confined to the missile tract. High energy exchange wound margins may take 5 days to declare themselves, and therefore do not lend themselves to early definitive treatment. In contrast, low energy exchange wounds, if adequately cleaned, can be successfully treated early.

The principles of battlefield surgical treatment place life, eyesight and limbs as the first priorities. Once this is accomplished, attention is directed at giving the best functional and aesthetic outcome for other wounds, thus adhering to the principles of damage control surgery.

Later definitive reconstructive surgery is greatly influenced by the surgery performed immediately following injury. Thought should therefore be given at early operations as to the likely nature of the final surgery and outcomes required. Obtaining early wound closure is paramount in preserving deep tissues, and preventing advancing infection or soft tissue necrosis. A critical balance exists between the injudicious removal of potentially compromised bone or soft tissues as this may lead to collapse and contractures from scarring, making subsequent treatment more difficult. Experienced surgical judgment is required to determine the amount of initial soft tissue and bony debridement required to adequately clean tissues and prevent infection. In select circumstances it is imperative that early definitive treatment is done to give the best final form and function. Traditionally these early methods of tissue management have existed in the realm of plastic and reconstructive surgery. With a universal shortage of military plastic surgeons throughout the allied nations, a proposed alternative is to teach these principles and procedures to all surgeons deploying to a battlefield area.

This paper reviews the principles of ballistic injuries, early tissue management, and represents my proposed program for the pre-deployment training of battlefield surgeons in procedures that enhance tissue structure, function, reduce amputations, and decrease rehabilitation times following severe, complex ballistic injuries.

Abstract (max. 150 words)

„CRM, traumacare in austere environment“.

A.B. van Vugt
[1]*Institute Defensie Relatieziekenhuizen, Netherlands*
[2]*Medisch Spectrum Twente, Enschede, Netherlands*

Introduction
Traumacare in austere environment includes many difficulties compared to the civil conditions in a level I traumacentre. These aspects and the importance of training facilities are pointed out
Methods
Importance of CRM in a multinational traumateam in a role 2E facility (MeS, Afgh) is analysed, with focus on as well non-technical as technical skills (BATLS, DCS principles).
Being prepared for a casualty as well as a potential mass-call is not an automatically generated awareness, team members are not used to performing SOP's with each other. Leadership, assertivity of all team members and adequate decision making under stress full conditions need good communication skills.
Especially high volume exposure can lead to break-down and burn out of the team, leading to poor results, but on the contrary an underload will result in inactivity, lay back and loss of awareness.
A standardised training-programm is mandatory in those conditions, involving all members of the chain of trauma care
Results
Eductational activities of Role 1 mobile platoons, ER, OR, ICU and ward are demonstrated
Discussion/Conclusion
A more standardized educational program should be developed as a SOP for all surgical team in austere environment. Optimal use of educational skills of all team members must be utilized.

Biography
Professor in traumasurgery since 1998. In civil conditions active since > 30 years as traumasurgeon in a level 1 traumacentre in the Netherlands (includes general surgery and orthopedic trauma).
Instructor ATLS, BATLS and initiator of the national program of Definitive Surgcial Trauma Care (DSTC). Special experience in polytrauma-management, damage control surgery, pelvic- and acetabular surgery, post-traumatic chronic problems.
Active as a military surgeon since 5 years (Royal Dutch Army) as a reservist. 2 Missions in Afghanistan.
> 100 pubmed publications, supervised 11 PhD studies, with main focus on diagnostic workup of the polytrauma patient and quality of trauma care.

Value and Effect of Protective Systems against IED

Sqn. Ldr. Graham Banks,
Executive Officer and 2nd in Command 4626 Sqn RAuxAF, United Kingdom

Pending abstract

Biography

Sqn Ldr Banks is the ExO and 2IC of 4626 RAuxAF Sqn, RAF Brize Norton. Sqn Ldr banks joined the RAF in Aug 76 as a medic rising to the rank of WO in Nov 98. He was predominantly employed in primary healthcare (latterly as a Practice Manager) but also spent some 12 years in aeromedical evacuation operations and training. In his non-commissioned service Banks has served across the UK but predominantly at RAF Brize Norton and RAF Lyneham. He completed 3 years at Ramstein AB in Germany on an IDO tour (1983-86). He was awarded an MBE in the 2005 New Years Honours List for his service to the RAFMS. He commissioned in Jan 05 and was appointed SO3 Medical Operations Policy before going on to become OC Medical Logistics for HQ TMW. On promotion to Sqn Ldr in Apr 08 he undertook a tour of duty in Afghanistan at HQ ISAF Kabul before being appointed to his present position in Aug 08. Since joining the RAF, Sqn Ldr Banks has served operationally in Northern Ireland (2 years) during the Falklands Conflict, in the 1st Gulf War, the 2nd Gulf War (Iraq) and has completed 3 tours of duty in Afghanistan. He has completed a number of detachments including a 6-month tour in Belize. Sqn Ldr Banks has completed ISSC, JOCC and will attend his ICSC(A) in May 10. Banks retired from the RAF in Apr 14 and joined the Reserves in May 14.

Abstract (max. 150 words)

“Military Medical History- Mr. James Barry”

H.E. Mackay
208 Field Hospital, Liverpool, United Kingdom. Southport and Ormskirk NHS Trust, UK.

Introduction
Methods
Results
Discussion/Conclusion

In the early 1800s Dr. James Barry rose through the ranks of military medicine to achieve the role of Inspector General of Army Medical Services. He studied in Edinburgh, where he excelled at anatomy, was noted to be a diligent and committed student. He was a flamboyant and fashionable ‘dandy’ on the London social scene as a junior doctor. His career took him to South Africa, Jamaica, St. Helena, and the Crimea. James Barry was committed to looking out for those who were marginalised in society, lepers, slaves, prostitutes and prisoners. Improving standards for patients was his key concern and saw him go up against senior members of the judiciary of the colonies, being arrested twice. He was a ‘real trail blazer’ in military medicine, but why did his sterling work and contribution to military medicine literally get buried along with his death in 1865?

Biography (maximum of 150 words – please do not leave this section blank as this will serve as your introduction to the various member nations)
Appointed consultant trauma and orthopaedic surgeon at Southport and Ormskirk Hospital NHS Trust March 2016, in the North of England. My practice is lower limb arthroplasty, general trauma and Paediatric trauma lead. Completed Higher specialist training in Merseyside. Fellowship trained at Guy’s and St Thomas’s Hospital in London in Paediatric Orthopaedic Surgery and Lower Limb Arthroplasty. Completed travelling fellowships to Chambery Hospital, France and an Observership in trauma surgery at LA county medical centre. I have diplomas in Occupational Medicine, Sports and Exercise Medicine, and Conflict and Catastrophe Medicine and the Diploma of the European Board of Orthopaedic and Trauma surgery. Currently working towards an MSC in Clinical Leadership and Management at EdgeHill University, Lancashire. UK. British Orthopaedic Association Examiner for the British Casting Certificate held at the Royal National Orthopaedic Hospital, London.

Abstract (max. 150 words)

Military Forensic Medicine

Peter J. T. Knudsen

Institute of Forensic Medicine,
University of Southern Denmark, Odense, Denmark
Danish Defence Health Services, Aarhus, Denmark

Forensic Medicine in the Danish Armed Forces has always been conducted in cooperation with the forensic pathologists at the three universities in Denmark. There has not until recently been a formalised set up, but with the increase in Danish military activities, beginning with the wars in ex-Yugoslavia, a need arose for this.

Inspired by the need from the Army, who wanted to gain access to the autopsy finding of casualties from vehicles, that were hit by various forms of weapons, it was decided in February 2007, that all fatalities should be handled in cooperation between the judge Advocate General's Corps, the Defence Health Services and the Institutes of Forensic Medicine.

At the same time it was decided to lay down rules in form of a manual for the Armed Forces how to handle not only fatalities, but also clinical forensic medicine in international operations. As a natural sequel to this a system of formalised training was created, where all medical and paramedical personnel, who will have to handle deaths and criminal acts, were taught the basics.

There are now courses, or lessons at courses, for physicians/surgeons at three levels, nurses, dentists, padres and paramedical staff as well as for the military police in order to be able to conduct medico-legal inquests and examinations of victims and suspected perpetrators of rape and assaults. There are no full time forensic pathologists in the Armed Forces, so the training is left to reserve medical officers, with means that it is kept up to date, both on the legal as well as the medical side.

Biography

Born 9th January 1948, graduated 1975, qualified as a general practitioner and specialist in morbid anatomy and histopathology and in Forensic Medicine. Associate Professor in Forensic Medicine and Deputy Chief Forensic Pathologist, Institute of Forensic Medicine, University of Southern Denmark. From February 2005 Senior Pathologist, The Identification Group of the National Commissioner of Police and 2011-2013 Deputy chair (Scientific) of the Interpol Standing Committee on DVI.

1982 commissioned into the Defence Medical Corps, now Danish Armed Forces Health Services, Royal Danish Navy Reserve, as surgeon sublieutenant, 2001 surgeon commander senior grade. 2008 retired due to old age, 2010 recommissioned in former rank and function.

Author of numerous scientific papers on normal anatomy, pathological anatomy and forensic medicine, particularly on wound ballistics and DVI. Participated as forensic pathologist in exhumations in Kosovo 1999 and in the identification work after the 2004 Tsunami, Thailand

Served on the Board of the Reserve Officers Association of Denmark, the Board of the Danish Society for Military Medicine and the Board of the Danish Society for Forensic Medicine. President of the CIOMR 2002-4.