

## President's Message

As I write this message, Australia is in its sixth month of responding to the threat of the Pandemic (H1N1) 2009 influenza virus. This has been an extensive test of our ability to respond to a nationwide threat from an infective agent.

The pandemic has evolved in a way that has been different to that predicted. This has been fortunate and has also demanded innovation.

Fortunate, because the strain has so far not been as virulent as might have been expected (although a significant number of Australians have still died as a result of the disease). Innovation, because a whole new phase for the Australian pandemic response needed to be developed quickly once the nature of the disease had been identified.

Of course, the impact has still been significant. In addition to the deaths, large numbers of patients have been admitted to Intensive Care Units across the country, requiring additional resources and also the rapid establishment and expansion of new technologies – such as extracorporeal membrane oxygenation.

The vaccination programme is now being rolled out, and the success of this may well affect the risk and impact of a second wave of the pandemic. The lessons of history remain with us – the second wave of the 1918 “Spanish” flu pandemic was significantly worse than the first, and we must hope that this is not the case at this time.

Not only have the deliverers of health care been impacted by this pandemic. All of the jurisdictions have established disaster management organisations to support and coordinate their responses. The next step will be to learn the lessons from the response and prepare structures and processes to facilitate future responses.

As if the pandemic has not been enough, nature has recently struck again in our region, with earthquakes in the Pacific and the Indonesian archipelago.

The earthquake in the Pacific Ocean resulted in a tsunami that devastated the southern coasts of Samoa and American Samoa, as well Niuatoputapu, one of the outlying islands of Tonga. The numbers of dead were small in world terms (about 150 in Samoa and nine in Niuatoputapu), but for these island nations the proportionate impact on their communities is huge.

Tonga has been further impacted by the sinking in August of the country's inter-island ferry: not only did this result in the loss of over 90 people (mostly women and children), but there is now no regular supply service to the outlying islands.

In Indonesia another earthquake, only a few days after the Pacific event, has resulted in devastation (but fortunately no tsunami) off the south coast of Sumatra. The death toll – over a thousand – and infrastructure damage has been extensive, and much rebuilding is required.

Australia has responded to both of these disasters, with civilian medical teams being despatched to provide initial assistance, assessment and support to local services. Additionally, HMAS Kanimbla, with its logistic support and medical capabilities, has been sent to Sumatra.

These various aspects of disaster response have their principles and practices founded in the mass casualty and disaster principles that are fundamental to military health support. The people that have been involved in all these responses – both the clinical teams deployed and the management teams coordinating responses – have included significant representation from both the Permanent and Reserve Defence Health Services.

That the skills and expertise that those in the military health services gain are easily translatable to these scenarios is a credit not only to the individuals but to the Defence Health Services organisation that has trained and nurtured them.

And the contribution of the Association to providing a forum for the exchange and development of professional knowledge and understanding of the science and practice of these skills must also not be underestimated.

Russ Schedlich  
President