

Command versus technical authority: lessons from the 2nd General Health Battalion

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Introduction

Historically, military medical units were commanded by senior doctors. All of the renowned hospitals that form the heritage of the ADF had medical commanders: for example, Colonel Thomas Henry Fiaschi of the 3rd Australian General Hospital at Lemnos; Lieutenant Colonel Wilfred Giblin of the 1st Casualty Clearing Station at Gallipoli; Lieutenant Colonel Henry McLorinan of the 2/1st Casualty Clearing Station in the Middle East during the Second World War; and Major W.B ('Digger') James, Officer Commanding of the 8th Field Ambulance in South Vietnam.

Even though these doctors were no doubt reliant on non-clinical staff officer support, there was an expectation that seniority in technical (usually surgical) skill equated with authority and that the public, soldiers and the Defence Force expected final responsibility for the running of a hospital should rest with the most authoritative deployed clinician. This situation closely mirrored that in Australian civilian hospitals, where 'administrators' were responsible for only business process and logistic functions well into the 1980s.

From the 1980s in Australia and elsewhere, driven by a need for efficiency and the professionalisation of business management, civilian hospitals became increasingly reliant on non-clinical managers to develop hospital operating systems running along business lines. As senior doctors became progressively isolated within their clinical units, a new medical specialty of 'medical administration' emerged that bridged the business and clinical functions of the hospital.

Today, every major Australian hospital has (using these or similar titles) both a Chief Executive Officer, usually with a background in public sector administration, and a Chief Medical Officer, a doctor, usually with the specialty Fellowship of the Royal Australasian College of Medical Administrators. The Chief Executive Officer is responsible for delivering

a targeted scope and quantity of healthcare, staffing and the logistic and business functions of the hospital, while the Chief Medical Officer is responsible for the quality and safety of healthcare, the maintenance of professional standards, the coordination of medical specialties with the nursing and allied health professions, and compliance with legal and ethical community expectations.

Neither the Chief Executive Officer nor the Chief Medical Officer is subordinate to the other; rather, both have such clearly-defined functions that the relationship is (ideally) symbiotic. However, as the Chief Medical Officer is essentially responsible for standards and the Chief Executive Officer for productivity and efficiency, competing demands can occasionally cause tension. Ideally, this is a collaborative tension, with the fundamental shared goal of delivering the best health outcomes for the community.

Healthcare in the ADF is in a process of transition towards a command/administrative and clinical leadership structure that mirrors civilian hospitals. The Surgeon-General of the ADF for many years has been the ultimate technical authority responsible for guaranteeing to the Australian community the highest standard of clinical practice; essentially the equivalent of a Chief Medical Officer. With the appointment of the Commander Joint Health Command in 2008, the ADF created the equivalent of a Chief Executive Officer. However, unlike in civilian healthcare, since the inception of Joint Health Command these two positions have been held by the same person.

Lower levels of clinical and command authority follow no clear pattern. Each of the single Services has both a Director General (1-star) and Director (O-6) of its health functions but neither of these positions is solely command/administrative or clinical. Army Senior Medical Officers at most of the manoeuvre brigades no longer exist, having been replaced by Senior Health Officers who may or may not have a nursing or allied health background. Senior RAAF

medical officers occupy largely administrative and occupational health rather than clinical roles.

In contrast, other areas of the ADF have clearly recognised the need for clinical authority. For example, Navy's Fleet Medical Officer is responsible for clinical advice to health elements at sea. The Senior Medical Officer (J07) at Joint Operations Command has technical authority—but no command authority—over all deployed clinicians. Joint Health Command has several senior (O-6) officers with responsibility for clinical policy, such as the Directors of Military Medicine and Mental Health. However, command of health assets technically controlled by these positions is devolved to individual unit commanding officers or operational and formation commanders. Not surprisingly, this can lead to uncertainty when solving problems or designing plans that have both technical and operational considerations.

In Army, the clearest distinction between command/administrative and clinical authority is in the positions of Commanding Officer and Director of Clinical Services at the 2nd General Health Battalion. The 2nd General Health Battalion was last commanded by a medical officer in 2009. The 1st Health Support Battalion, when it operated as a Role 2E hospital prior to the Combat Health Restructure, last had a medical officer as commanding officer in 2005.

The change to General Service Officer command of Army's Role 2E hospitals was, in part, driven by the lack of suitably-qualified medical officers and, in part, by the emergence of very well-qualified General Service Officer candidates for the position. The requirement to deliver, day-to-day in a busy hospital, both clinical and command/administrative leadership functions no doubt acted as a catalyst to the adoption of the civilian model.

The rationale for the appointment of a Director of Clinical Services was to provide technical leadership and governance. As a respected subject-matter expert, the Director of Clinical Services could exercise authority over clinicians held individually responsible not only to the military chain of command but to the Australian community through external regulation by the Australian Health Practitioners Authority and the specialist medical colleges.

This article outlines the responsibilities of the Commanding Officer and Director of Clinical Services at the 2nd General Health Battalion and highlights how the tension inherent between the two roles, when properly understood, works to enhance the clinical capability of the organisation. It also highlights the potential broader application of such a relationship

between command and technical functions in the other Services, and in other ADF technical fields.

Responsibilities of the Commanding Officer and Director of Clinical Services

Command and technical responsibilities within the Role 2E capability differ markedly between the training and operational environments. Although the 2nd General Health Battalion has a 'live dependency' on major exercises, in reality few (if any) very seriously ill patients are treated during these brief periods, leaving the majority of the year to providing primary care (general practice) in garrison health centre augmentation or on field exercises, or conducting individual training, equipment maintenance, and administration. In contrast, even on low-intensity operations, the focus of the deployed hospital is the provision of clinical care up to the level of complex surgery, with the implicit requirement to meet or exceed Australian civilian hospital standards.

In garrison (including support to major field exercises)

The Commanding Officer generates a unit capable of deploying on operations in accordance with the Chief of Army's Preparedness Directive, and provides personnel and subunits in support of domestic exercises and programs such as the Army Aboriginal Community Assistance Project. The Commanding Officer is responsible for all the non-clinical functions of the hospital, including security, personnel, logistics, and planning for exercises and operations. This requires personnel leadership, discipline and administration, oversight of the Technical Regulatory Framework for equipment, financial governance, input to health doctrine and training, and liaison with higher headquarters.

The Director of Clinical Services is the unit representative of the chain of technical control that leads through 17th Combat Service Support Brigade to the Surgeon-General of the ADF. In garrison, the four main responsibilities of the Director of Clinical Services are maintenance and enhancement of the clinical workforce, including training, technical performance management, and selection and mentoring of clinical teams; advice on equipment resources; development of clinical policy; and oversight of the (usually limited) 'real life' clinical work of unit staff supporting exercises.

The major tool used by the Director of Clinical Services to harness the multidisciplinary expertise of the hospital is the Clinical Governance Committee. This includes representatives from all hospital

departments, and might be better understood as a 'clinical leadership committee', as it is the primary means by which the clinical functions of the unit are directed. The committee structure is effective as there are frequently issues that can be solved within the technical resources of the unit that might not be visible to individual departments.

The 2nd General Health Battalion's establishment rank for the Director of Clinical Services is Colonel, in order to exercise authority over clinicians of the hospital who usually hold ranks between Captain and Colonel, whereas the rank of the commanding officer of a battalion-sized unit is Lieutenant Colonel. This rank disparity has no bearing on the command authority of the Commanding Officer. Until now, the Director of Clinical Services has been a Reservist as for many years there have been no Regular Army hospital specialists; however, this is likely to change with the introduction of the full-time Medical Specialist Program.

On operations

The current ADF operational construct deploys subunits, units and formations that are constituted specific to particular requirements. In recent decades, task-organised health units have occasionally been the primary focus of such deployments (such as Operation TAMAR, the 1994-95 response to the Rwandan genocide), more often a principal component of the multifaceted response to humanitarian emergencies (such as Operation SUMATRA ASSIST, the response to the 2004 Indian Ocean tsunami) and most often a small part of the force protection element for a peace enforcement operation (Operation STABILISE, East Timor, 1999-2000) or training task in warlike conditions (Operation OKRA, Iraq, 2015-present).

The health elements of Operation TAMAR and the first UN hospital in Dili were commanded by doctors. However, by the middle of the decade 2001-2010, the command of such units had passed to non-clinicians. The experience of officers embedded in the Dutch Role 2E hospital in Tarin Kot in 2007-10 and the NATO Role 3 hospital at Kandahar Airfield, 2012-14, suggested that a deployed doctor with overall responsibility for the clinical work of the hospital would be a valuable addition to the ADF's hospital deployed command team.

The first time the ADF deployed a Director of Clinical Services on operations in one of its own hospitals was on Operation OKRA in Iraq in 2015. The 37-strong (including 6 doctors) Australian and New Zealand staff of the ANZAC Role 2E Hospital

Taji was commanded by a Major, with a Lieutenant Colonel as the Director of Clinical Services. Drawing on the 2nd General Health Battalion's doctrine in the garrison environment and limited experience on major exercises, as well as building on experiences while embedded in deployed coalition hospitals, a delineation of responsibilities rapidly emerged.

The Officer Commanding performed essentially the same functions as listed above for the Commanding Officer of the 2nd General Health Battalion in garrison, with overall responsibility for achieving the mission of the hospital within the medical rules-of-engagement and imposed resource limitations. Major tasks included personnel command, leadership and management; controlling the logistic functions of the hospital, such as resupply of pharmaceuticals and other stores; generating and maintaining hospital facilities (including designing the layout of the hospital) and major equipment systems (for example, surgical instrument sterilisers and anaesthesia machine); and setting the daily schedule and priorities of effort.

Unlike the Officer Commanding, the role of the Director of Clinical Services in a functioning hospital with 'real' (as opposed to exercise) patients was quite different to that in garrison. There was essentially no requirement for credentialing or selection of staff for particular postings, as all this had been decided prior to deployment. Rather, the Director of Clinical Services had to use the capability of the hospital to the greatest clinical effect. This frequently required interpreting the medical rules-of-engagement as they pertained to the treatment of individual patients.

A common question was what constituted 'emergency' healthcare, for which all patients presenting to the hospital were eligible, and what was 'routine', for which many coalition soldiers and contractors were ineligible. Whether fluid resuscitation for infectious gastroenteritis or surgery for acute appendicitis are treatments for 'life-threatening emergencies' were decisions that could only be made with clinical knowledge of the risk of alternatives.

The Director of Clinical Services took ultimate responsibility for triage in and out of the facility (understanding the risks of all options), and for all treatment decisions, most notably those relating to potential conflict between the medical rules-of-engagement, resource limitations and medical ethics. Tasks supporting these responsibilities included setting expectations of the clinicians, including establishing a process for resolving disagreements on clinical issues; developing clinical policies that encouraged uniformity of practice within agreed

clinical practice guidelines; handling healthcare complaints and investigating critical incidents; and leading a process for identifying and mitigating clinical risk, with particular focus on infection control.

The Director of Clinical Services had to create an understanding among clinicians that waiting for decision by consensus could lead to being overwhelmed, and that occasionally the Director of Clinical Services' authority would need to be respected regardless of individual dissenting opinions. The scopes of practice of individual clinicians had to be defined, taking into account both individual skills and the risk of evacuating patients from the facility.

In the deployed environment more so than in garrison, there is an inherent tension between the roles of the Officer Commanding/Commanding Officer and the Director of Clinical Services. The latter must aim to provide the best clinical service to individual patients; the former sets the limits on what can be achieved with the resources available, the tactical situation and the higher commander's intent. Except in the unusual situation of unlimited resources, the Director of Clinical Services should be highlighting areas in which the hospital could improve its clinical performance through the acquisition of equipment, the reallocation of personnel or the redesign of procedures. The Officer Commanding/Commanding Officer must fight for this prioritised list of requests but must ultimately declare when no more can be done. The Director of Clinical Services then uses the resources made available to the best advantage—accepting that this will sometimes require compromise of usual civilian standards of practice. Clinical responsibility for such pragmatic decisions rests with the Director of Clinical Services. Therefore, the Director of Clinical Services' role is 'aspirational', in so doing fulfilling the Australian public's and external regulator's (that is, the Australian Health Practitioners Authority's) expectations of healthcare practitioners, while the Officer Commanding's/Commanding Officer's is 'pragmatic'.

The Director of Clinical Services is subordinate to the Officer Commanding/Commanding Officer in all but one domain. To the greatest degree possible, the Director of Clinical Services is responsible for the hospital's adherence to the external regulations that apply to all Australian healthcare practitioners. This transcends the authority of the Officer Commanding/Commanding Officer and the responsibility of the Director of Clinical Services as an Army officer, being instead a responsibility to the Australian nation, which expects the same standards of the doctors in

its Defence Force as it does of all Australian doctors. ADF doctrine recognises this by stating that 'medical personnel ... cannot be ... compelled to carry out any act incompatible with their humanitarian mission or medical ethics' (Commonwealth of Australia, 2006).

The practical application of this responsibility is that the Director of Clinical Services must advise the Officer Commanding/Commanding Officer on things that should or should not occur (taking into account the command prerogative to accept a greater than usually tolerable risk in order to achieve a mission) and things that must or must not occur, which are beyond the authority of the Officer Commanding/Commanding Officer and indeed Defence.

Examples of things that should or should not occur include not allowing staff to work beyond their scope of practice; not transferring patients to hospitals with inadequate resources to treat them; not attempting resuscitation of unsalvageable patients; and ensuring that only medical officers perform duties that are legally the sole responsibility of doctors, including prescribing medications, ordering and interpreting diagnostic tests, and performing surgery or administering general anaesthesia.

Examples of things that must or must not occur, regardless of operational commands, include not permitting euthanasia; not treating patients without their consent (unless in the emergency treatment of an unconscious patient when consent cannot be sought and would reasonably be expected to be given); and reporting instances of practitioner impairment or unethical behaviour to the Australian Health Practitioner Regulatory Agency, even if this risks compromising the clinical capability of the hospital.

Higher responsibility to an authority outside the ADF is perhaps a confronting notion to many within Defence. However, this is essentially an extension of the non-combatant status afforded medical personnel since armed forces first incorporated physicians and surgeons. ADF doctrine states that the role of the Royal Australian Army Medical Corps is 'to contribute to the Army's operational capability through the conservation of manpower by promoting health and well-being, through the prevention of disease and injury, and through the care, treatment and evacuation of sick and wounded' (Commonwealth of Australia, 2016a). The RAN and RAAF are less prosaic but have similar intent. These roles are potentially in conflict with the duty of Defence clinicians, as 'every ADF doctor is a non-combatant and remains obliged to treat all patients (including enemy combatants) equally and with

primary regard to welfare rather than operational capability' (Neuhaus et al., 2001). This accords with the Medical Board of Australia's code of conduct, which requires that doctors must 'make the care of patients their first concern' (Medical Board of Australia, 2014a). The inherent tension between the roles of the organisation and the clinicians who serve in it are similar to the tension between the Director of Clinical Services and the Officer Commanding/Commanding Officer.

Knowledge/experience required of the Director of Clinical Services

Both Australian and UK experience suggests that the Director of Clinical Services must have a broad understanding of military healthcare structures and processes, at least some understanding of the operational environment, and be skilled at negotiating with staff officers and commanders (Mahoney et al., 2011).

Specific knowledge and experience includes a technical understanding of modern combat casualty care (including the principles of damage control surgery and when to apply them; blast/ballistic wound patterns and their treatment; and the imperative to move casualties rapidly through the continuum of care); an understanding of resource limitations in the deployed environment, and how these might be overcome; an understanding of at least the basics of every hospital specialty, so as to be able to provide governance of clinical decisions and a 'second opinion' when needed; and experience in triage and managing the resources of the hospital during times of near or beyond capability workload, as occurs during mass casualties.

Key relationships

ADF doctrine identifies the Surgeon-General of the ADF as the technical authority for all health matters (Whelan, 2012). From the perspective of the 2nd General Health Battalion, this authority is delegated through Director Army Health, the Command Health Officer of Forces Command, the Senior Health Officer of 17th Combat Services Support Brigade, to the Commanding Officer of 2nd General Health Battalion. While the Surgeon-General has always been a medical practitioner, many of the other positions in this chain are now occupied by non-clinicians without the knowledge to judge clinical decisions against anything other than written policy.

As written policy cannot take account of all possible individual circumstances, an informal technical reporting chain has developed in garrison: from the

Director of Clinical Services of 2nd General Health Battalion to the Director Clinical Governance 17th Combat Services Support Brigade to the Surgeon-General. On operations, clinical necessity has formalised this technical reporting chain, which is through the deployed Senior Medical Officer to Joint Operations Command's Senior Medical Officer and thence to the Surgeon-General.

Nurses and medics form the bulk of the clinicians of the hospital. The Director of Clinical Services relies heavily on the leadership and technical expertise of the Senior Nursing Officer and the Senior Medic to generate nursing- and medic-specific policies and procedures, and governance of these respective workforces. Similarly, the Senior Allied Health Officer takes responsibility for pathology, radiology and physiotherapy. The Director of Clinical Services relies on the leadership and technical expertise of the Deputy Director of Clinical Services, a senior nursing posting, to enact day-to-day functions of credentialing, clinical governance and training across the span of clinical craft groups.

On major domestic exercises in the absence of the Director, the Deputy Director of Clinical Services is required to fill the Director's role and, as such, has encountered similar tensions described when working with command. An often misunderstood position is that of the Senior Medical Officer, a term with different meanings in different organisations. While the Senior Medical Officer in a headquarters is its lead clinical authority, within the 2nd General Health Battalion the Senior Medical Officer is subordinate to the Director of Clinical Services and is usually a general practitioner with responsibility for the clinical supervision, professional development and workforce coordination of the non-specialist medical officers of the unit.

Examples of actions taken by the Director of Clinical Services on deployment

Examples of responsibilities undertaken by ADF and coalition Directors of Clinical Services on recent deployments include:

- Triage during mass casualty incidents;
- Declaring patients to have unsurvivable wounds, given the constraints of care able to be delivered in the medium term, with consequent immediate palliation;
- Deciding to transfer local national patients immediately after operative surgery to local civilian facilities, rather than allowing the surgeon involved to provide post-operative care;

- Deciding not to transfer local nationals to civilian hospitals unable to provide an adequate standard of care, even when this conflicted with a commander's intent;
- Recommending to the Officer Commanding/Commanding Officer that clinicians be removed from the operational environment due to inadequate technical skills or dysfunctional work within a multinational team context; and
- Supervising junior doctors (general duties medical officers) providing resuscitation and ward care beyond their level of training (Mahoney et al., 2011).

Illustrative vignette

In East Timor during Operation CITADEL, a Health Supplementation Team comprising a Role 2E (Light) was deployed in a forward operating base near a moderately-sized town with a derelict and poorly-staffed civilian hospital. A small boy suffered a fractured femur in an accident, and was brought to the ADF facility where there was an orthopaedic surgeon. However, the medical rules-of-engagement prevented even emergency treatment of local civilians. The non-medical Officer Commanding of the Health Supplementation Team would not allow the boy to be treated.

The medical and nursing officers present were unwilling to transfer him to the local hospital (where the chance of death or permanent disability from this usually readily treatable fracture was high), as this conflicted with their professional duty of care. Confrontation transformed into 'collaborative tension' as a mid-ground was achieved, in which hospital staff accompanied the boy to the local hospital, applied traction, and were permitted to visit every day to ensure his care was optimal. In so doing, the capability of the local hospital and positive engagement with the local community were enhanced.

International comparisons

The ADF role of the Director of Clinical Services on deployment developed in the light of the highly-successful model that evolved in the UK's Role 3 hospital at Camp Bastion in Afghanistan (Mahoney et al., 2011). Prior to 2009, this hospital had a Clinical Director, who was simply the senior deployed medical officer. The work required was secondary to that person's primary clinical specialty, and limited

to being the clinicians' advocate to the command chain.

However, recognising the need for empowered clinical authority in a rapidly-evolving environment, unfamiliar even to the many permanent-force clinicians deploying, after 2009 the position was retitled Deployed Medical Director, with responsibilities for oversight of patient management, improvement of hospital procedures, and advice to the Commanding Officer on equipment and personnel issues. The Deployed Medical Director had no role in direct patient care and could be drawn from any specialty.

US military doctrine, as applied in Central Command's Role 3 hospitals in Iraq and Afghanistan, essentially split the Director of Clinical Services' role between 2-3 people. The Chief of Trauma was responsible for triage into and out of the hospital, clinical policies, and oversight of individual patient management decisions. The Senior Medical Officer and Senior Nursing Officer were responsible for credentialing, oversight of individual practitioners, and ongoing training.

The requirement for a Chief of Trauma arose partly because, unlike in Australia, trauma/acute care surgery is a discrete subspecialty in the US in which few US surgeons are trained. In some rotations, the Chief of Trauma (a trauma surgeon) was required to oversee the work of surgeons unaccustomed to trauma. This arrangement worked very well for trauma patients but, as the intensity of combat operations diminished and proportionately more non-trauma patients were admitted, there were at times instances of dysfunctional interference in other medical specialty decisions. Unlike the ADF's Director of Clinical Services (and the UK's Deployed Medical Director), the Chief of Trauma was not characterised as a consultative position providing oversight but rather as the sole 'captain of the ship' who took (or decided not to take) advice from subspecialists.

Wider implications: health

This article contends that the separation of clinical and command functions within a Role 2E hospital, both in garrison and on operations, provides the optimal structure for collaborative deliberation, professional oversight, and decisive action when required. Unlike the UK example, limitation of personnel in an Australian Role 2E hospital requires the Director of Clinical Services to have a direct patient-care role within their specialty. This structure may be applicable to the newly-established

Maritime Role 2E hospitals aboard the Canberra-class Landing Helicopter Docks, and perhaps also in the evolving concept of the RAAF Fly-Away Surgical Team.

It is further contended that at the level of higher headquarters, separation of the functions of Senior Health Officer (responsible for generation of equipment and personnel capability) and Senior Medical Officer (responsible for clinical policy, governance of the clinical workforce, advice on acquisitions and interaction with civilian regulatory authorities—and perhaps better termed a Director of Clinical Services) would be a logical extension of this concept.

To develop collaborative tension between the technical authority and command chain, these roles should not be filled by a single person. Commander Joint Health is essentially responsible for the facilities and personnel required for garrison healthcare, while the Surgeon-General is responsible to the Australian community for the standard of healthcare provided in both these facilities and on deployment. A collaborative tension between those who hold these positions would seem to be beneficial.

Conclusion

The term Director of Clinical Services is creeping into doctrine without the position having a formal description outside the internal standard operating procedures of the 2nd General Health Battalion (Commonwealth of Australia, 2014b, 2016b). This article has outlined the role and the complexity of its relationship with command in order to fill this gap.

The model that has matured at the 2nd General Health Battalion over the last six years, and which has now been implemented on operations, is relevant to other health units. It potentially is also relevant to non-health units heavily reliant on officers with externally-regulated technical expertise working in an ADF environment in which command priorities may conflict with the ideals of civilian best practice.

Colonel Michael Reade was commissioned as a General Service Officer in 1990 and, after qualifying in medicine, has deployed to Bosnia and Kosovo (attached to the British Airborne Brigade), Timor, the Solomon Islands, twice to Afghanistan and most recently twice to Iraq, where he was the first Director of Clinical Services of an operational ADF Role 2E hospital. A specialist intensive care physician and anaesthetist, he has a doctorate from Oxford and a Masters in Clinical Trials from Pittsburgh. He is the Joint Health Command Professor of Military Medicine

and Surgery at the University of Queensland and the current Director of Clinical Services at the 2nd General Health Battalion.

Lieutenant Colonel Clark Flint joined the British Army in 1983 and graduated from the Royal Military Academy Sandhurst in 1989. He transferred to the ADF in 2006. He was the Commanding Officer of the 2nd General Health Battalion from 2013-15. He deployed on Operation GRANBY (1st Gulf War), with UN Peacekeeping Force (Cyprus) in 1995, in the Balkans in 1997 and 1999, on Operation TELIC (2nd Gulf War), Operation QUICK STEP (Fiji) in 2006 and Operation SLIPPER in 2009. He completed a Masters degree in Strategy and Management at the University of NSW in 2010.

Major Sean Kennaway graduated from the Royal Military College Duntroon in 1993 and has since spent 20 years as a General Service Officer in the Royal Australian Army Medical Corps. He has held the full range of appointments in training, operations, command and staff roles. He has deployed on six operations including Operation TAMAR (Rwanda), Operation CITADEL (East Timor), Operation NIUE ASSIST (Niue), Operation RESOLUTE (PNG and Nauru), Operation SLIPPER (Middle East Area of Operations) and Operation OKRA (Iraq) in 2015, where he was the first Officer Commanding of the Role 2E hospital. He holds a Bachelor of Applied Science and is a graduate of the ADF School of Languages in both Bahasa Indonesian and Tetum.

Lieutenant Colonel Nicholas Duff was commissioned in 1994 as a direct entry officer and, until 2016, was the Deputy Director of Clinical Services at the 2nd General Health Battalion. He is currently the manager of the Enoggera Health Centre. He has seen operational service in Bougainville in 1999, East Timor on four occasions between 2000-03 and Indonesia in 2005, as well as defence aid to the civil community tasking. As a Nursing Officer, he has specialised in intensive care and emergency nursing, and subsequently achieved a Masters in Health System Management from Griffith University.

Colonel Brad McCall was commissioned into the Army Reserve in 1992. A Public Health Physician, he has served in preventive medicine roles, as Senior Medical Officer in deployed headquarters and, from 2010 to 2014, was the first Director of Clinical Services at the 2nd General Health Battalion. He is the past Director of the Centre for Military and Veterans Health at the University of Queensland and Director of the Metro South Public Health Unit in Brisbane.

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