Dear Editor,

COMMAND VERSUS TECHNICAL AUTHORITY: LESSONS FROM THE 2ND GENERAL HEALTH BATTALION

This letter replicates my response in Issue No. 203 of the ADF Journal, regarding the article by Reade et al, 'Command versus technical authority: lessons from the 2nd General Health Battalion', in Issue No. 200 of the ADF Journal (and reprinted in JVMH Vol. 25 No. 3). In short, Reade et al advocated that the command and control arrangements of the 2nd General Health Battalion (2GHB) should apply elsewhere within the ADF, which would entail health units being commanded by a nonclinical general staff officer, while health technical control would be provided by a medical officer Director of Clinical Services.

While the article contends that these arrangements replicate the management structure of every major Australian civilian hospital since the 1980s, this is not necessarily true for many rural and remote civilian hospitals of comparable size to 2GHB. Furthermore, it is understood the current arrangements for 2GHB stem from a shortfall in suitable medical officers in the late 2000s, rather than a conscious decision to reflect civilian hospital practice. It is suggested that ex post facto justification should not preclude Army clinical officers with the appropriate abilities and interest from undertaking future command roles.

The article also arguably perpetuates an ADF health care model that prioritises treatment services at the expense of other military health functions. It does not address ongoing management shortcomings, such as the ADF's environmental hazards in its base settings, or assessing medical suitability for employment and deployment, or the ADF's aviation, diving and submarine and medicine services.

Unlike Army, all Navy and RAAF health officers have a clinical background. Even so, many of these officers have successfully performed deployed and non-deployed health command roles over many years. In so doing, they continue to demonstrate the benefits of military health officers not only having consummate clinical expertise but also a comparable understanding of the relevant operational environment. This particularly includes providing clinical advice to operational unit commanders, without filtering through a non-clinical third party.

The article correctly indicates that clinical expertise alone does not translate into the ability to command. Furthermore, many—but not all—clinical officers prefer clinical rather than management roles. Even so, the experience of all three Services validates the contention that it is easier to teach command skills to clinicians, than clinical skills to commanders.

Managing military health services requires a combination of clinical and non-clinical skills which, depending on the size and scope of the health services being provided, may be beyond the capacity of a single individual. If achieving the full range of managerial skill sets requires two people, the nature of military service implies that one will be subordinate to the other.

It is therefore contended that maximum benefits accrue to ADF operational capability, maximum flexibility accrues to career managers, and maximum benefits accrue to individual personal aspirations, if all ADF clinical officers have an opportunity to assume command roles, technical control roles or both. If these roles have to be split, selecting who performs which should be based on the best combination of the candidates available. Sometimes, the best health and operational outcomes may be achieved with a clinical commander supported by a non-clinical staff officer; otherwise, vice-versa may apply.

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