

The Australian Defence Force Medical Specialist Program: Past, Present and Future

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Abstract

The Australian Defence Force (ADF) aspires to provide high-quality medical care to personnel deployed on operations. Medical procedural specialists are key enablers of this capability. In the late 20th Century, the ADF relied upon Reserve clinicians to staff deployed health facilities. Though generally successful, this approach is limited in the extent to which it can guarantee the availability of specialists at short notice or for prolonged durations. Consequently, from the early 2000s, the ADF has worked to create a more robust, high-readiness specialist staffing model. As a result, several schemes were established, culminating in the extant Medical Specialist Program (MSP). This paper examines the evolution of the MSP and the contemporary employment of its members. Consideration is also given to challenges encountered during the MSPs early years and how these challenges may be overcome. Particular issues include the imbalance of MSP specialties, refinement of command frameworks and formalising career pathways for procedural specialists. If these challenges are met, the MSP will continue to grow as a repository of corporate knowledge and generate value beyond the contribution of its individual members.

Introduction

Health support is a key enabler of combat power. Through effective management of injuries and disease, health support preserves the deployed force, enhances morale and contributes to the willingness of personnel to perform their duties in dangerous operational environments. Indeed, Australian deployed personnel serving overseas expect that, if they are wounded, they will receive the highest possible standard of care.

In order to meet this expectation, the Australian Defence Force (ADF) must possess an expeditionary health service capable of the assessment, stabilisation and evacuation of battle casualties. To support such a capability, the ADF must maintain a pool of high-readiness medical specialists able to apply their subject matter expertise to the planning, conduct and evaluation of operational health support. For most of the ADF's history, such specialists have been drawn from the Reserve forces. However, in recent years, greater attention has been given to the development of a Permanent Force specialist cadre.

This paper will examine the past, present and future of medical specialist capability within the ADF. We begin by outlining considerations for providing specialist medical capability on operations before exploring historical models of health specialist

employment within the ADF. We then discuss the extant Medical Specialist Program (MSP) in detail, focusing on its inception, structure and relationship to supporting capabilities. Comparisons are made with specialist employment models in the armed forces of other closely aligned nations. Finally, the MSP's strengths and growth opportunities are outlined, canvassing several potential directions for its future development.

Considerations for the provision of specialist medical support to operations

Military forces from developed nations aspire to provide a standard of care on operations that mirrors, as closely as possible, the standard of care in their domestic health systems. Achievement of this goal relies upon several key capability enablers, including the provision of appropriate health matériel and personnel, resources for individual and collective training, suitable command and organisational arrangements, and the operation of an effective system of clinical governance.

Any system designed to guarantee the supply of specialist clinicians for operational employment must balance several factors, including recruitment, retention, clinician availability and operational readiness. Addressing each of these factors comes

at a cost; therefore, further key considerations are the financial resources required to sustain a given medical specialist workforce model and the opportunity cost of not allocating these resources elsewhere.

In recent decades, the ADF has experimented with several models for the employment of medical procedural specialists. All models have had the same goal: to create a responsive and agile specialist health support capability, while minimising the costs of keeping highly trained clinicians 'on the shelf' between deployments and other tasks. The evolution of one program into another has been driven by all of the factors noted above as well as by the nature and tempo of the ADF's operations within our region and further afield.

Specialist medical support in the late 20th Century Australian Defence Force

While the Australian Army Medical Corps provided surgical forward and general hospitals in various locations throughout the World Wars I and II, the emphasis shifted to primary care from the Korean War onwards. Medical staffing is recorded as a chronic problem, as documented in the history of the Royal Australian Army Medical Corps¹ when generating support for the 1st Commonwealth Division in Korea, 'The RAAMC was in a desperate situation. ... When a young Doctor Trousdale and four colleagues offered their services to the Corps in 1953, the then ADGMS warmly welcomed them "as we almost doubled the number of Army MOs"'. No Australian military surgeons were deployed to either Korea or the Malayan Emergency. The 100-bed 1st Australian Military Hospital in Vung Tau during the Vietnam War provided a surgical service that was staffed by Citizens Military Force physicians, psychiatrists, surgeons and anaesthetists on three-month deployments with the official Corps history recording considerable administrative difficulties in deploying Reserve officers.¹ At times, positions were impossible to fill, necessitating drawing upon personnel from visiting Australian civilian aid teams, until from 1970 onwards, Reserve specialists from the RAN and RAAF were also deployed. In 1973, there were no medical specialists in the Permanent Forces. This remained almost exclusively the case until February 2008, when the first official training scheme detailed below graduated its first consultant.

Medical Officer Specialist Training Scheme

The Medical Officer Specialist Training Scheme (MOSTS)² was approved in 2001 by Chief of the Defence Force, Admiral Chris Barrie, AC, RAN.

MOSTS focused on maintaining a small group of 'key medical specialists in the full-time element of the ADF and retention in the Specialist Reserve [aiming to] guarantee that essential members of deployable specialist teams are available at short notice to move'. MOSTS was sponsored by the Director-General Defence Health Services (DGDHS) and developed by a working group of medical officers (MOs) over two to three years. It was acknowledged that medical specialists were a critical component of deployed health capability and that there was a need to ensure availability at short notice to move. Accordingly, the policy aimed to 'encourage a select number of military medicine trained MO, who would ordinarily leave the ADF, to retain Permanent Force status whilst being sponsored for specialist training'. It was the first official medical specialist training scheme of its kind in the ADF. However, some MOs were trained to become specialists in the Permanent Force prior to this scheme under local ad hoc arrangements.

The range of specialties identified for sponsorship under MOSTS were general surgery, orthopaedic surgery, anaesthetics, intensive care and emergency medicine. Eligible for selection were MO, who had acquitted all outstanding Return of Service Obligation (ROSO) or those who had completed at least four years of ROSO. These MO must have completed at least two years of effective service as a military clinician, have completed all Service-specific training courses for MO and remained fully fit to deploy.

The clear advantage of MOSTS was the retention of experienced military MO into deployable medical specialist roles. It utilised the existing personnel policy to achieve this by allowing the MO to undertake clinical refresher training in civilian health facilities over 12 months to become eligible and competitive for selection into an approved specialty training pathway. During both refresher and specialty training, the officers selected would work full-time in training hospitals and retain all ADF conditions of service.

Disadvantages of the scheme were a lack of dedicated funding, pay issues, a lack of clear employment models following training and no defined career pathway. Reimbursement of associated training and examination fees were capped at A\$2000 through the continuing professional development arrangement at that time. The length of ROSO was determined on an individual basis and was to be acquitted in a part-time leave without pay (PTLWOP) arrangement in jointly funded positions in civilian hospitals over several years. The specialist salary at that stage was not equivalent to the pay received by staff specialists in a public hospital.

The first entrant into MOSTS in February 2004 was a naval medical officer who was successfully selected for advanced training in orthopaedic surgery with the Royal Australasian College of Surgeons (RACS). Also, a naval medical officer, the second and final candidate, entered the MOSTS as an orthopaedic surgery registrar in February 2005. At the five-year review in 2006, it was determined that MOSTS would be cancelled at the end of that year while both officers were still under training. The reasons cited for discontinuing the program were lack of interested candidates and insufficient Service-level support; Navy sponsored only two participants, and Army or Air Force supported no applicants. Despite MOSTS being cancelled, the agreement with the two active participants was honoured.

The first MOSTS candidate attained fellowship in February 2008 and was posted to the Primary Casualty Reception Facility (PCRF) Cell of the Amphibious and Afloat Support Group (AASG) as the inaugural orthopaedic surgeon and Senior Medical Officer. He was soon followed by the second candidate, who completed orthopaedic training in February 2009 and was posted to Balmoral Naval Hospital in HMAS *Penguin*. Both officers completed their ROSO under individualised PTLWOP arrangements. Of the two MOSTS members, one transferred to the Navy Health Reserve in December 2012, and the other has remained in permanent full-time service, assisting in the development of the Swift Incision Program that evolved into the current Medical Specialist Program.

Military Surgical Team

The Military Surgical Team (MST) was established in 2012 at the Royal Brisbane and Women's Hospital (RBWH) as a result of Joint Health Command Project Swift Incision, initiated by MAJGEN Paul Alexander as a component of the comprehensive reform of the ADF's health services. Staff specialist positions in intensive care, anaesthetics, emergency medicine, general surgery (trauma/burns) and orthopaedics were advertised to the Defence Force Reserve members in September 2011. Four consultant MST members were appointed (in emergency medicine, general surgery, anaesthetics and intensive care medicine) in addition to the appointment of the Defence Professor of Military Medicine and Surgery at the University of Queensland and RBWH. The orthopaedics position in the MST was left vacant as there were no applicants, and there were already two Permanent Force orthopaedic surgeons from MOSTS. The MST consultants remained in the Reserve component of their service, and their primary employment remained with either the hospital or university. Defence reimbursed these institutions for

the cost of employing each MST member in return for an agreement that these clinicians would be released at short notice for up to four months' Defence Service per year. This was a period of high operational tempo, and all MST clinicians deployed overseas at least once. At the completion of their five-year contracts, two MST officers chose to return to Queensland Health, whereas the other two MST consultants had transferred to the Permanent Force MSP prior to the completion of their five-year contracts. Only the Defence Professor remains on the original contract. Alongside the MST, in 2012, the first four Permanent Force registrars were appointed to positions at RBWH, some of whom went on to become accredited registrars in the MSP.

Swift Incision Program

The Swift Incision Program (SIP) commenced in 2012 concurrent with establishing MST. Unaccredited registrar positions were created at the RBWH as a posting for full-time MOs hoping to enter into accredited specialist training positions. In addition, one unaccredited position in each of the five MST procedural specialties was created with the hope that sufficient experience would be gained to be competitive for selection into accredited training positions. This was the direct precursor of the current MSP by a name change in 2014.

Present

The Medical Specialist Program

The Medical Specialist Program (MSP) is the extant framework for the employment and training of full-time specialists within the ADF.

The MSP was commissioned in 2014, subsuming the Permanent Force registrars who had commenced in unaccredited positions under the predecessor SIP but who had become established in training positions around Australia. This included the two MST consultants who chose to transfer to the Permanent Force, plus accredited registrars who transferred to Permanent Force from Reserves. Five procedural specialties were represented: general surgery, orthopaedic surgery, anaesthesia, intensive care and emergency medicine. Additionally, a staff position was allocated within Joint Health Command to administer the MSP and maintain the supporting network of clinical placement deeds.

Beyond its core role, the supply of procedural specialists to operations, the MSP was seen as having a second important function: recruiting and retention of general duties MOs. It was intended that the MSP would provide an incentive for those

MOs approaching the end of their ROSO to remain within the Permanent Force rather than separating in order to pursue civilian opportunities for career advancement. Accordingly, the initial target population for the MSP was MOs within 12 months of completing their ROSO. However, it was soon recognised that MOs who had been working outside the civilian hospital system, often for many years, did not always have recent exposure to the clinical rotations and referees needed to gain selection into an accredited training program. Therefore, in recent years expressions of interest for the program have been disseminated more widely within the Reserve and Permanent Force chains of command. Additionally, qualified candidates have been accepted as 'pre-MSP' members and, at the discretion of their single Services, have been afforded the opportunity to undertake prolonged civilian placements to enhance their chances of selection into specialty training programs.

By design, MSP positions were allocated between Services in proportion to their strength. However, growth of the MSP cohort was uneven, both in the distribution of members across Services and the specialties represented. In particular, anaesthesia and critical care positions were quickly filled by the RAAF and RAN, while all three Services were unable to recruit a general surgeon prior to 2015. Surgical positions still have high vacancy rates.

Awareness of the MSP grew among ADF health service leaders following the inaugural MSP Forum in 2015. This forum was particularly significant in enhancing understanding of the MSP among ADF personnel agencies. It was instrumental in the appointment of Army candidates to the program later that year. The annual MSP Forum continues to be an important vehicle for disseminating information about the program to technical and command stakeholders.

Employment of the MSP within civilian hospitals

MSP registrars compete for entry into specialist training programs and complete their training in accredited hospitals in the same manner as their civilian counterparts. MSP registrars are relatively 'quarantined' from military activities and are not expected to undertake duties that would interfere with or prolong their specialty training. However, registrars are different to ADF students on sponsored long-term schooling. They must remain compliant with the individual readiness conditions of their Service and are encouraged to maintain a relationship with their unit, their career manager and the broader MSP cohort.

MSP consultants serve as staff specialists within approved civilian health services under a clinical placement deed detailed in the Military Personnel Manual (MILPERSMAN). In order to sustain a meaningful clinical practice with an acuity and case mix suitable for a military trauma specialist, MSP consultants must be allocated to shifts or sessions where such cases might reasonably be seen. Civilian hospital departments generally roster several months in advance; thus, while MSP consultants are present in addition to the minimum staff required to run a particular hospital service, they remain highly integrated within their civilian departments. Accordingly, clinical placements must develop mechanisms to reallocate patients in the event of short-notice deployment of the MSP member. This issue is more pronounced for surgeons than critical care specialists because surgeons often manage their own waiting list of patients for major non-emergent procedures. In contrast, critical care specialists have limited long-term individual responsibility for patient care.

MSP members often form longstanding professional relationships of mutual benefit with a single health service. Civilian health services gain a highly-skilled clinician, often with broad leadership, management and instructional skills, at commonwealth expense. On the other hand, MSP consultants can gain access to necessary learning opportunities by fostering an understanding of their role among their civilian colleagues. As mentioned above, MSP members still rely upon their civilian colleagues to backfill regular and on-call clinical responsibilities when tasked with military duties at short notice. To this extent, the MSP relies upon collegiality and goodwill. While the financial benefits of retaining an MSP member are largely realised by hospital and departmental leadership, the consequences of short-notice absence are borne by fellow clinicians. For these reasons, MSP members are often afforded greater locational stability than other military doctors. This both enhances the development of supportive professional networks and allows MSP consultants to cultivate a clinical practice tailored to their needs as military clinicians.

Employment of the MSP on exercises and operations

The ADF has a need to provide specialist medical capability on exercises and operations. This capability may be delivered by Permanent or Reserve clinicians from all three Services. The MSP offers the ADF a high-readiness, rapidly deployable specialist capability for a prolonged duration, while the Reserves afford depth and the capacity for sustained support to operations.

These roles overlap, and historically, many Reserve specialists have deployed at short notice and for long periods. However, in developing a permanent specialist capability, the ADF has achieved certainty of immediate availability for contingency operations that was not possible previously. Recent examples where this capability has been called upon include Op OKRA, Op FIJI ASSIST, Op BUSHFIRE ASSIST and Op COVID ASSIST. Additionally, in late 2020 when an Australian surgical team embedded with the US Role 3 Hospital in Iraq, three of the four doctors in the first rotation were MSP members and the MSP is represented on all planned future rotations.

Employment of MSP in non-specialist roles

Generally, it is expected that MSP members will be given duties that best utilise their specialist qualifications both on exercises and on operations. Similarly, MSP members have previously served in clinical leadership roles in addition to their specialty when appointed as the Director of Clinical Services of a deployed hospital or as health staff officers. According to extant policy, MSP consultants expect to be absent from civilian clinical placements for around three and up to six months per year. To date, military commitments have varied substantially according to MSP consultant specialty, Service branch and pre-specialisation medical qualifications. Emergency Physicians, for example, have been afforded a varied array of opportunities to contribute, owing to the broad nature of their speciality. Nevertheless, as previously noted by US colleagues, a careful balance must be struck with the employment of MSP members in non-specialist roles because time away from hands-on clinical care is a real threat to clinical currency and competency.^{3, 4}

Command and control of the MSP

The MSP is a joint asset *coordinated* by the Director-General Operational Health (DGOH) on behalf of Commander Joint Health (CJHLTH). DGOH has a role in managing MSP members, overseeing their selection, training and clinical placement needs to develop and maintain a ready specialist workforce. However, MSP members are *commanded* and *administered* by single Services, monitoring individual readiness and performing career management functions.

The management of MSP members differs slightly between the Services. Specialists in the RAAF are held at formation level, within Headquarters Health Services Wing (HQHSW). In contrast, RAN and Army specialists are held at unit level within the Maritime Operational Health Unit (MOHU) and 2nd General

Health Battalion (2 GHB), respectively. Both MOHU and 2 GHB are responsible for staffing a deployed Role 2 Enhanced (R2E) facility, while HQHSW does not fulfil this purpose directly; rather, this role within the RAAF falls to the expeditionary health squadrons.

In the nascent phase of the MSP, unit level command of MSP members introduced elements of complexity. Commanding officers were not always sure of the extent to which they directly commanded, versus administered, specialists within their unit. In addition, where full-time and part-time specialists have been segregated within different units, it has not always been clear whether the MSP were to be 'first out the door', ahead of Army Reserve clinicians 'kept on the shelf' for contingency operations, with Reserve clinicians carrying responsibility for the majority of tasks, or some pragmatic middle ground. 'Horizontal' direct liaison of full-time and part-time specialists, which can support a more integrated specialist workforce, has historically been viewed with unease by some commanders who felt that such dialogue subverts established command and control structures with deleterious consequences. Notwithstanding these observations, maturation of command and coordination frameworks, and unit and formation leaders' increasing awareness of the role of the MSP, have led to a progressively closer collaboration of Permanent and Reserve specialists from all three Services on both exercises and operations.

International models of health specialist employment

Currently, ADF medical specialists are employed in two contexts: exercises and deployments. Garrison health arrangements are such that ADF members are directed to the civilian public or private health systems for secondary and tertiary care. Thus, notwithstanding the limited need for surgical support to exercises, ADF medical specialists do not provide care for military personnel domestically. For both Permanent Force and Reserve specialists, acquisition of clinical experience and maintenance of procedural skills occurs in civilian hospitals.

Perhaps the closest parallel to the ADF MSP is the specialist training model of the Canadian Armed Forces. Canada has a similar sized military to Australia, with geographically dispersed defence facilities limiting the potential for designated military hospitals. Canadian military specialists are embedded in tertiary civilian hospitals, but like MSP, they also provide consultative support to military primary care doctors and may be involved in research and educational activities.

In the UK, like in Australia and Canada, all serving personnel receive hospital-level care from the civilian National Health Service. Military specialists are mainly concentrated within five individual NHS facilities and can care for military members in a domestic environment alongside civilian colleagues. Despite the broad clinical exposure afforded by the UK system, our UK colleagues have noted that, as in Australia, civilian practice can be an imperfect vehicle for learning the skills required in combat surgery.

In contrast, the US military relies predominantly on a full-time, 'active duty' medical specialist workforce almost exclusively employed in Department of Defense (DoD) facilities when not deployed. This system has at least two potential advantages. Firstly, it affords health commanders superior knowledge of the exact case load and case mix of specialist clinicians, a surrogate marker of clinical readiness to deploy. Secondly, it provides a workforce that is available for garrison healthcare yet remains more rapidly deployable than a Reserve-dominated force. Specialist garrison capabilities are necessary because of the scale of the US military and because the DoD provides healthcare to both serving members and their families. However, DoD facilities are rarely trauma centres and afford relatively limited clinical exposure compared to their civilian counterparts. Thus, although the ADF is too small to justify the US full-time specialist model, even if this approach was viable in Australia, there would be a need to overcome limitations in learning opportunities available to military specialists in garrison roles.

Analysis of international military medical specialist workforce models demonstrates that the precise arrangement of clinical placements may be less important than a clear understanding of what is required of Permanent Force specialists. Even an extensive and comprehensive military healthcare system, as seen in the US, cannot consistently provide clinical exposure that guarantees specialists will be ready for operational practice. Recognising that deployed medicine incompletely overlaps with civilian practice, we must consider what other features the MSP must have in order to maximise the quality of deployed specialist care.

Future

The contemporary MSP, building upon the legacy of previous programs, represents a significant step towards a robust deployable medical specialist capability. As part of a Total Workforce Model, it can guarantee a reliable supply of experienced, high-readiness clinicians for operational health support.

Nonetheless, the program continues to evolve. In the final section of this paper, we pose several questions to help inform the debate about the MSP's future.

How might the ADF address the imbalance between MSP specialties?

Presently, the MSP trainee and consultant workforce are heavily skewed towards anaesthesia and emergency medicine specialists. This is a problem because availability, particularly short-notice availability, of Reserve surgical specialists is an acknowledged issue for health planners. In an ideal world, applying the Total Workforce Model, full-time MSP surgical consultants should be available for short-notice deployments, allowing part-time clinicians to prepare their civilian practices for their absence and deploy when ready. Likewise, full-time clinicians should be available to bridge gaps in Reserve capability. A close approximation of this ideal is observed in current task allocation practices for MSP and Reserve critical care specialists. However, there is a risk that over commitment of the relatively small permanent surgical workforce, particularly to tasks where there is a low clinical tempo, will negatively affect retention and clinical capability.

Several MSP registrars are training in intensive care, but there is a dearth of both consultants and registrars for general surgery and orthopaedics. Successive rounds of recruitment to the MSP have not redressed this imbalance. There are several potential reasons why surgical specialists may be harder to recruit into the MSP. Firstly, in its initial years, the MSP explicitly targeted serving MOs within one year of completion of ROSO. These candidates would have spent years working in primary care and may not have secured accredited civilian training positions. Even those MOs who have been offered 'pre-MSP' positions to enhance their competitiveness have often required several years in civilian hospitals prior to selection. Secondly, there may be a greater perceived disparity between military and civilian remuneration for surgeons than for the critical care disciplines. Thirdly, there may be a perceived lack of flexibility regarding options for surgical fellowship training for those in the MSP; in particular, full-time members may not be able to avail themselves of opportunities to pursue subspecialty training overseas, which is a common civilian development pathway.

The competitiveness of ADF MOs for selection into specialist training is particularly an issue for surgery, but potential solutions to the problem apply equally to all MSP disciplines. To an extent, the problem can be bypassed by expanding the pool of candidates eligible for selection into the MSP.

Following refinement of the expression of interest process, applications from Reservist specialists and specialists-in-training are now welcomed, and entry is also open to suitable civilian specialist candidates.

Remuneration is a more complex issue. ADF medical procedural specialist pay remains competitive with public sector work in many regions of Australia. However, it is undeniable that some specialties will incur an opportunity cost by choosing military over civilian practice. Therefore, to attract high-quality candidates to the MSP, it is desirable to demonstrate that full-time service can be rewarding in other ways. One means for the ADF to achieve this would be to facilitate streamlined access to high yield learning opportunities such as overseas courses, foreign military exchanges and trauma-oriented sabbaticals, thus affording full-time clinicians professional development opportunities beyond those that would typically be accessible to civilians or Reservists. This approach addresses some weaknesses noted in allied militaries' medical specialist workforce models. It has the potential to enhance both retention *and* clinical readiness, with effects that are likely to persist following the transition of full-time members to the Reserves.

How might the ADF balance retention with the need to maintain an experienced deployable force?

A significant goal of the MSP was the retention of military MOs beyond their initial ROSO. This goal implies that MSP members must transfer to a different Service category to vacate positions for the next generation of specialists. Unfortunately, this approach has the potential to result in a continually renewing pool of junior consultants; this would be a missed opportunity to use the MSP as a collective repository of corporate knowledge.

Without abandoning the worthy goal of medical officer retention, several options for specialist career progression and promotion are available to allow the ADF to retain some senior consultants within the MSP. Firstly, there is a long-recognised need for inter-Service and inter-SERCAT coordination of specialist capability; this role could readily be performed by delegating elements of technical control to one or more senior Permanent Force specialists. Secondly, there is a need to mentor specialist registrars within each Service. Therefore, MSP supervisor positions could be created within each relevant health unit or within a separate organisational structure. Thirdly, senior MSP consultants could be considered for health leadership positions within each Service and at Joint Health Command. However, in taking on

these positions, it would be necessary to ensure a working model that preserves individual clinical readiness.

How might the MSP be best employed within the Total Workforce Model?

The MSP must be a force-multiplier for Reserve clinicians, not a barrier to their service. Reserve clinicians have a proud history of health support to operations, and the advent of the MSP does not detract from this contribution. Rather, the existence of Permanent Force specialists acknowledges that when there is a need for short-notice deployment, a proportion of Reservists will not be immediately available. Likewise, when deployment windows 'slide left', 'slide right' or broaden, some clinicians who would gladly have served are no longer able to do so.

The MSP was not the only model suggested for providing certainty of supply of medical procedural specialists. One alternative option was a rotation of Reserve specialists through different readiness states, with an on-line member of each of the five specialties guaranteeing their availability at any one time.⁵ Acknowledging this, it behoves all MSP members to consider how the existence of a Permanent Force specialist cadre can offer value to Defence beyond that which might be accrued through a rotation of 'ready Reserves'.

One potential advantage of Permanent Force specialists is fostering long-term professional relationships between individual practitioners and the deployable health units: 2 GHB, the EHSs and MOHU. MSP consultants are often among the longest-serving members of Permanent Force health units and thus are well positioned to manage long-term quality improvement projects and help train new unit members. It has previously been suggested that the MSP could be restructured so that members are directly administered at Joint level, perhaps from within Joint Health Command, to facilitate a more streamlined specialist contribution to health planning and health care provision. However, such a change could produce an MSP workforce less highly integrated with the units with which they will most commonly deploy. So a balance must be struck between Joint capability coordination and strong working relationships at the coalface.

To maximise the scheme's potential, MSP members should be champions of the Total Workforce Model. MSP members who serve with the same unit for extended periods and have contact with a wide pool of Reservist colleagues are ideally positioned to assist their chain of command in finding candidates

for a given task. Similarly, MSP members can draw upon the experience of working with a variety of experienced Reservist colleagues when contributing to health units' clinical protocols and guidelines. In the future, it is hoped that there will be further opportunities for specialists to use SERCAT 6 and SERVOP D work patterns to facilitate project work and professional development. This may serve as a model for transition from the MSP to the Reserve Force and vice versa.

It must be acknowledged that, despite the theoretical benefits of Permanent Force specialists, there are some health commanders and Reserve clinicians who have misgivings about the program. It is imperative that opportunities for employment and deployment are allocated equitably and that the MSP is not perceived as acting as a barrier to rewarding Reserve service. Collectively, the authors have observed the benefits of selecting clinical teams to achieve a mixture of service categories, and we highly commend this practice. In the future, it is hoped that clinicians leaving the MSP will transition to the part-time forces, and in doing so, they will promote awareness and acceptance of the program.

What developments are occurring in this area?

The DGOH has commissioned a comprehensive review of specialist capabilities with broad terms of reference that will address many of the areas of discussion mooted in this paper. From this review will emerge considered recommendations, formed through consultation with experienced health commanders, medical specialists and other key stakeholders. This review will set the conditions for the ongoing maturation of the MSP, its alignment with the evolving operational health requirements of the ADF and its integration with supporting capabilities.

Conclusion

The ADF will always require experienced, high-readiness medical specialists to ensure best practice care for our deployed personnel. Currently, the MSP contributes to this need as part of the Total Workforce Model for health. The MSP has matured significantly since its inception, and MSP members regularly contribute to operational health support. In the future, the MSP would benefit from rebalancing specialist disciplines and formalising career development pathways for specialist consultants. Capability can also be enhanced closer links between Permanent and Reserve clinicians. Joint Health Command has initiated a process that promises to consider many of these challenges, giving confidence that the MSP will continue to grow as a repository of corporate knowledge and will generate value beyond the contribution of its individual members.

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References

1. Tyquin MB. Little by little / Michael Tyquin. Australia. Department of Defence. Army History U, editor. Loftus, N.S.W: Australian Military History Publications; 2003.
2. Defence Instruction (General) PERS 05–31—Medical Officer Specialist Training Scheme, (2001).
3. Hall A, Qureshi I, Gurney J, Shackelford S, Taylor J, Mahoney C, et al. Clinical Utilization of Deployed Military Surgeons. *J Trauma Acute Care Surg*. 2021.
4. Tadlock M, Carr M, Diaz J, Rhee P, Cannon J, Eastridge B, et al. How To Maintain The Readiness of Forward Deployed Caregivers. *Journal of Trauma and Acute Care Surgery*. 2020; Publish Ahead of Print.
5. Reade MC. Matching supply and demand in ADF specialist health support: a proposal. *Australian Army Journal*. 2011;8(1):51-61.