Dual Loyalty and the Medical Profession for Australian Defence Force Medical Officers

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Abstract

Background: Military medical officers often practice in the context of dual loyalty and manage professional obligations to both their patients and the militaries in which they serve.

Purpose: This article considers specific frameworks through which Australian Defence Force (ADF) Medical Officers practice. It seeks to highlight the potential interaction between such frameworks and dual loyalty.

Materials and methods: This article is a narrative analysis of dual loyalty in military medicine and specific frameworks through which ADF Medical Officers practice.

Results: The frameworks this article considers establish the primacy of the medical profession for ADF Medical Officers. However, dual loyalty will likely render the practical application of these frameworks more complex. Furthermore, the dual loyalty in military medicine is likely distinct from that encountered in other medical fields.

Conclusion: The extent and implications of the dual loyalty of military medicine could be investigated further for ADF Medical Officers while considering the frameworks in which they practice and the civilian organisations with which they interact.

Dual loyalty and the medical profession for Australian Defence Force Medical Officers

Australian Defence Force (ADF) Medical Officers concurrently enact their medical and military professions. ADF Medical Officers also practice within specific frameworks that often, rightly, preference their medical profession. During international armed conflict, these frameworks include International Humanitarian Law (IHL) and the Australian *Criminal Code Act 1995*. ADF Medical Officers are also registered through the Australian Health Practitioner Regulation Agency (AHPRA) and have obligations within broader Australian Health Law. These frameworks are likely rendered more complex in their practical application by the dual loyalty of military medicine.

Military medical officers are afforded non-combatant status during international armed conflict under customary IHL. A distinction between combatants and non-combatants during international armed conflict was codified in The Hague Conventions of 1899 and 1907. Protocol I to the Geneva Conventions expands upon this by stating that 'members of the armed forces of a Party to a conflict (other than medical personnel and chaplains…) are combatants, that is to say, they have the right to participate directly in hostilities'.[1] This distinction is enduring, and 'today, any chaplain or medical person who takes direct part in hostilities becomes an unlawful combatant, forfeits non-combatant immunity, and becomes a lawful target'.[2] The non-combatant status of medical personnel separates ADF Medical Officers from their non-medical colleagues (with the exception of chaplains). It obligates them not to actively participate in hostilities. Medical personnel must also provide adequate medical care when treating detained persons. For Australian medical professionals, this is further outlined in the *Criminal Code Act 1995*.

The *Criminal Code Act 1995* (the Act) outlines serious offences that can be considered either war crimes or crimes against humanity. Section 628.95 of the Act considers the elements of the offence 'War crime—medical procedure', which occurs in the following circumstances:

(a) the perpetrator subjects one or more persons to a medical procedure; and

(b) the procedure seriously endangers the physical or mental health, or the integrity, of the person or persons; and

(c) the perpetrator's conduct is not justified by the state of health of the person or persons; and

(d) the perpetrator knows that, or is reckless as to whether, the conduct is consistent with generally accepted medical standards that would be applied under similar medical circumstances to persons who are of the same nationality as the perpetrator and are in no way deprived of liberty; and

(e) the person or persons are in the power of, or are interned, detained or otherwise deprived of liberty by, the country of the perpetrator as a result of an international armed conflict; and

(f) the conduct takes place in the context of, and is associated with, an international armed conflict.[3]

While this offence is not strictly limited to ADF Medical Officers, it is more likely applicable to them given the settings in which it can occur.

For civilian medical professionals to incur a 'War crime—medical procedure' offence, they would foreseeably be representing the Australian Government during an international armed conflict. This follows the broader convention that 'only regular combatants or other individuals, including civilians, who have a link to a Party to the conflict, may be subject to IHL's war crimes provisions for offences committed in international conflicts'.[4] ADF Medical Officers are more likely to confront the settings in which the 'War crime—medical procedure' offence may arise. Additionally, the offence creates an obligation to apply generally accepted medical standards when treating detained persons. For ADF Medical Officers, these standards can be considered through their registration requirements with AHPRA and broader Australian Health Law.

Like their civilian medical colleagues, ADF Medical Officers are registered as Medical Practitioners with AHPRA. This is in accordance with the Queensland-hosted *Health Practitioner Regulation National Law Act 2009* and its Australian State and Territory equivalents. This registration enables the regulation of ADF Medical Officers by the medical profession and requires them to abide by Australian Health Law. In Australia, this law is derived from a number of sources and the 'three most significant areas of law that have shaped health law are criminal law, tort law and family law'.[5] Despite the breadth of this law, there are general principles that are applicable throughout the practice of medicine. Consequently, these principles are likewise applicable to the medicine practiced by ADF Medical Officers.

One such principle is that doctors owe a duty of care to their patients when providing professional advice. The nature of this duty can be further considered through *Rogers v Whitaker*. In this case, the High Court of Australia decided that 'a medical practitioner's duty of care in providing advice and information to a patient concerning proposed treatment was primarily to provide that information which the reasonable person in the patient's position would require'.[6] This duty of care likely aligns with Section 628.95 of the *Criminal Code Act 1995*, which establishes an expectation to apply generally accepted medical standards to the treatment of detained persons. As such, ADF Medical Officers have a duty of care towards the patients they treat during their usual practice through Australian Health Law, and likely an equivalent duty when treating detained persons through the *Criminal Code Act 1995*. When considered in the context of their AHPRA registration, ADF Medical Officers' professional medical obligations are broadly equivalent to their civilian colleagues, even during international armed conflict. However, the dual loyalty of military medicine lends further complexity to the practice of military medicine depicted within the frameworks discussed above.

Dual loyalty is a contested concept for military medicine, which can become involved in considering whether physicians can ethically serve within militaries. Sidel and Levy insist that 'it is morally unacceptable for a physician to serve as both a physician and a soldier in the United States military forces, and probably other military forces as well'.[7] This assertion is based on the ethical dilemmas they believe to be inherent to service as a military medical officer. Namely, 'subordinating the best interests of the patient, overriding patients' wishes, failing to provide care, blurring combatant and non-combatant roles, and preventing physicians from acting as moral agents within the military'.[7] In contrast, Madden and Carter posit that 'there is nothing in the ethos of the professions of medicine and arms that prohibits an individual from being a member of both professions. They have different ends, yet the ends are certainly compatible, even mutually supportive'.[8] Broader considerations of whether military service and the medical profession are compatible are beyond the scope of this article; however, they provide a background to contrast dual loyalty encountered in military medicine against that of other medical fields.

Dual loyalty can also be encountered in prison medicine, and occupational and environmental medicine. However, the dual loyalty within these

professions is similar yet distinct from that of military medicine.[9] While considering prison medicine, Pont et al. suggest that dual loyalty is a 'clinical role conflict between professional duties to a patient and obligations, expressed or implied, to the interests of a third party such as an employer, an insurer, or the state'.[10] This serves as a useful definition for dual loyalty on the whole. Additionally, the conflict they describe is not easily reconciled. Pont et al. advocate that dual loyalty should be minimised by separating patient care from medical administrative functions conducted in the interest of the state.[10] Dual loyalty is likewise encountered through the practice of occupational and environmental medicine.

For Australian occupational and environmental physicians, dual loyalty involves the 'responsibilities to individual patients under their care, workers in a particular workplace, employers, the general public and specific responsibilities under legislation'.[11] Again, this can arguably be applied to dual loyalty regardless of the field of medicine in which it occurs. When weighing these potentially conflicting obligations, the Royal Australasian College of Physicians suggests that 'problems are most likely to arise if potential conflicts of interest are not recognised; particularly if one party is not aware that the [Occupational and Environmental Physician] has other responsibilities'.[11] From this perspective, dual loyalty and the potential for conflicting interests are risks that all medical practitioners should be aware of. However, the dual loyalty encountered by military medical officers is arguably different to that faced by other medical professionals due to their ethical obligations as military officers.

Military personnel must adhere to specific ethical, legal and training obligations that can be broadly attributed to the profession of arms. In general, such professional obligations are created for military personnel 'out of the oath of service taken by them, out of the general mission of military forces and out of the command structure of those military forces, which has been established in order to better fulfill the overall mission of the defense forces'.[12] This separate ethical framework is central to the dual loyalty of military medicine. It arguably further complicates it compared to the dual loyalty encountered in other medical fields. This specific dual loyalty is likely recognised within the militaries in which it occurs. Madden and Carter reflect that US Military Medical Officers 'are known (with some justification) for their less than ideal military appearance and relaxed view of military relationships and attitudes. This relaxed view is accepted because what the warrior wants to be sure of is that the physician is competent as a physician'.[8] Military dual loyalty can also be characterised by an expectation of military medicine to consider clinical benefits for individual patients and groups of military personnel.

The potential for military medicine to benefit both individuals and groups of military personnel is another contributing factor to its unique dual loyalty. Namely, this encompasses whether military medical officers should place individual patient interests over a group of personnel and vice versa. Benatar and Upshur explore two methods to think this through: 'One way is to insist on the absoluteness, with no latitude in how these are applied contextually, and on the priority of the individual over society at all costs. Alternatively, we can agree that moral reasoning is required in the application of universal principles and that although the priority of individuals is necessary, it is not always a sufficient ethical guide when the common military good or common good is seriously threatened.'[13] Clearly, there are situations in which military medical officers should preference their medical profession through individual patient care. However, there may also be situations in which military medical officers place a collective benefit to a group of personnel over the individual care of their patients. This is arguably different from the collective benefits attained by public health physicians due to the military frameworks by which military medical officers are bound and their positioning within military chains of command. For a military medical officer, determining whether they are acting in the interests of an individual patient or for the collective benefit of a group can potentially be further complicated by the risk of receiving orders in opposition to their medical profession.

Military orders that are in opposition to military medical officers' professional obligations have the potential to create both a personal risk to them and a professional risk to their medical practice. Howe considers one such case in which a US Military surgeon was ordered to withhold treatment from a wounded enemy soldier to provide care to a US soldier who was arriving later.[14] Howe recounts that 'the military physician who reported this case did not wait for the US soldier to arrive. He defied the direction of his superior and operated on the patient then before him. He did not say what happened to the US soldier and no one asked'.[14] The personal and professional consequences of such orders are arguably unique to militaries and contrast the dual loyalty encountered by military medical officers against that of other medical fields. By serving in a military chain of command, ADF Medical Officers may receive an order that is in opposition with their medical obligations, complicating the frameworks in which they usually practice. Overall, the dual loyalty

encountered by ADF Medical Officers raises broader questions for their practice and Australian Military healthcare on the whole.

There are likely further opportunities to explore dual loyalty specifically encountered by ADF Medical Officers. Further research could focus on quantifying the experience of dual loyalty by ADF Medical Officers and the perceived or realised implications it has had for their medical practice. Further research could also focus on how civilian organisations such as AHPRA and Australian Medical Defence Organisations perceive and manage the dual loyalty encountered by ADF Medical Officers during both their domestic and international practice. Finally, military-specific dual loyalty may be encountered by Australian Defence Force Nursing Officers, allied health professionals and medics. Further research could consider whether military-specific dual loyalty affects the frameworks in which these professions practice military healthcare and subsequent interactions with their respective civilian regulatory and insurance organisations.

Conclusion

Australian Defence Force Medical Officers concurrently practice their military and medical professions. Specific frameworks through which they practice often rightly preference their medical profession during regular practice and international armed conflict. These frameworks include their registration requirements through AHPRA, their obligations to individual patients under Australian Health Law and their non-combatant status through International Humanitarian Law (IHL). The Australian *Criminal Code Act 1995* and IHL also necessitate that they ensure a generally accepted medical standard is applied when treating detained persons. While these frameworks prefer the medical profession, their application is likely rendered more complex by the dual loyalty of military medicine. This dual loyalty is likely different to that encountered in other medical fields. Its potential extent and impact likely warrant further research specific to ADF Medical Officers, the frameworks in which they practice and the civilian organisations with which they interact.

Conflict of Interest

The author is a serving member of the Royal Australian Navy. He receives remuneration from the Navy and university funding through the Navy's Graduate Medical Program. The opinions expressed herein are those solely of the author and do not reflect those of the Australian Defence Force or the Department of Defence.

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