JMVH Article: *'Dual Loyalty and the Medical Profession for Australian Defence Force Medical Officers'*

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The October 2022 JMVH article regarding Australian Defence Force (ADF) medical officers' dual loyalty to military patients and commanders1 is important because, aside from their conduct in extreme circumstances, it also pertains to how they perform their day-to-day clinical and other duties. While commending the author's work to that end, it requires further elaboration.

Two 'loyalties'… or three 'mandates'?

In his seminal official WWI medical history, Arthur Graham Butler referred to military medical services as having a triple mandate as follows (italics added):

> 'To the military command, it [the Australian Army Medical Service] owed service to promote and conserve man-power for the purpose of war. *To the nation at large, it was responsible for promoting by intelligent anticipation the efforts of the civil institution whose duty it should be to prepare for useful return to civil life the soldiers unfitted for further military service.* By Humanity, as represented by the nations who had subscribed to the International Convention of Geneva and The Hague, it was charged with minimising so far as possible the individual sufferings of the combatants of both sides. These three strands of purpose, inextricably interwoven as they were, in a self-contained and consistent scheme of medical service nevertheless furnished each as an end in itself—all *three* entering at every stage into the medical problem, and now one, now another, providing its dominating motive.'[2]

The author's article is not unusual: in omitting Butler's 'civilian transition' mandate, it has not considered the need for military health services to engage with operational commanders for additional reasons besides those pertaining to largely reactive clinical care.

To this end, the 'civilian transition' mandate has three elemental components from an occupational medicine perspective, each requiring bespoke attention while overlapping with the other two mandates:

- **Primary prevention** to reduce the incidence of avoidable work-related illness and injury.
- **Secondary prevention** through holistic and timely treatment and workplace-based rehabilitation to restore as much normal function as quickly as possible.
- **Facilitating the eventual transition of all ADF members to the civilian community** by effective and timely handover of their ongoing treatment to the Department of Veteran's Affairs, and enabling their compensation entitlements.

Butler recognised these three components when he wrote:

> 'Most writers who deal with the part of medicine in the war tacitly accept … that the one essential feature of the work of the medical service in the late war was to bring about a greatly diminished incidence of disease. As will be shown, close study of facts and figures makes clear that this attitude must be modified.
>
> The many problems associated with civilian participation in military activities on the one hand, and with the reinstatement as civilians of the wastage from warfare on the others, will be found… [within] the chapters of this section. They do so along two lines—positive, in the vast domain of 'reparative' treatment, surgical and medical; and negative, in the only less arduous and exacting work of the military boards and the military machinery for implementing the system of [medical] "category".'[3]

Hence, Butler anticipated the Royal Australasian College of Physicians' 2019 *Health Benefits of Good Work*™ Position Statement,[4] which explains how:

- absence from work leads to *poorer* health
- waiting for recovery *delays* recovery
- longer time off work makes it *less* likely that patients will *ever* return to work
- the most common health conditions are *not* 'cured' by treatment alone
- keeping patients in good work is a *therapeutic intervention* and, therefore, *part of their treatment.*

Therefore, the author's analysis of ADF medical officers' humanitarian' and 'command' mandates is incomplete, as it does so in isolation from their 'civilian transition' mandate, the conduct of which must entail them working with patients and their commanders together to achieve the best outcomes for both. To this end, previous articles have explained how occupational and environmental physicians are subject matter experts to this end, and why the ADF's health services have not been fit for purpose in their current form—least of all regarding their 'civilian transition' mandate—at least since the early 2000s.[5,6,7,8,9,10,11,12,13,14,15] It also seems reasonable to assert that they have since been validated by the 2019 Productivity Commission inquiry into veterans' health services[16] and the 2024 Defence and veteran suicide Royal Commission.[17]

Butler's Quo *Vadimus?*

The author's focus on ADF medical officer's 'patient' and 'command' mandates is partly reflected in Butler's final chapter entitled *Quo Vadimus*?, which concluded (italics added):

> 'The Army Medical Service seems to be at the parting of the ways. One road might lead it to complete devotion to military ends—the winning of war at any price [i.e., the "command" mandate]. If that happened, the task of keeping alive the principle of humanity *and of safeguarding the social interests of the state* and the individual [i.e., the "treatment" and "civilian transition" mandates] would be left more and more to the voluntary and civil organisations. On the other hand, in spite of the military commitments of ruthless warfare, it may *retain its triple responsibility*. Which way it goes must depend on the extent to which medicine, as a social group, tends to give its soul as well as its body to "total ruthlessness", or, (on the other hand) to cooperate with social civil influences in maintaining the human ideal…'[18]

It should be noted that Butler wrote this rather despairing passage during a second 20th-century worldwide cataclysm that saw the perversion of medical science perpetuate even greater evils than the previous conflict.[19,20] [21,22] Even so, the 2020 Brereton inquiry into alleged atrocities by Special Air Service Regiment personnel demonstrates the need for military medical officers to actively engage with commanders to at least bear witness to such incidents should they occur. [23] One might hope that doing so would not only help meet the national reputation management imperative at the higher political and strategic level, but also reduce mental health issues for personnel who not only witness but are directed to instigate egregiously preventable barbarities. The ability to stand one's ground in such circumstances necessitates strong character and mature judgement, supported by formal training that is currently lacking.

Conclusion

In short, the author's article is incomplete, as the challenges posed by ADF medical officers—even regarding their day-to-day work—pertain to balancing three mandates rather than two 'loyalties'—not just treating patients or facilitating operational capability, but also facilitating their patients' eventual civilian transition. The last of these mandates necessitates engagement with ADF commanders that is not recognised by only considering the other two.

Furthermore, Butler's 'quo vadimus?' question poses a false choice for ADF medical officers, as they have an essential role in preventing war crimes in extreme circumstances and bear witness should they fail.

I trust this letter can be considered a constructive elaboration of the issues raised by the article, and I look forward to answering any queries.

Disclaimer

The views expressed in this letter are mine alone. They do not necessarily reflect those of the ADF's health services or any other organisations mentioned. Likewise, any factual errors are my responsibility.

Yours sincerely
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