Changing Military Medical Standards – Are We Doing Harm?

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'I am trying to arrange transport for two or three thousand "B" class men; they are absolutely unfit for service. Many of them do not disclose any organic disease upon a carefully conducted clinical examination, but are in and out of hospital, and are quite useless for front line, and practically useless for Home Service….Far better no reinforcements be sent from Australia as they do no duty, and only cause congestion in our hospitals and Command Depots. The class of reinforcements you are sending are not up to the old standard. Headquarters AIF Depots report that 20 per cent are unfit for the front line.'

Major General Neville Howse, VC, KCB, Director of Medical Services, Australian Imperial Force, 30 March 1917.[i]

Introduction

Western militaries are facing an existential personnel crisis. Military personnel numbers are declining[i,ii] despite deliberate efforts by some nations to grow military capability in response to increasing geostrategic uncertainty.[2,3] This problem has two aspects—an inability to attract sufficient recruits and retain trained personnel, resulting in higher separation rates. Western militaries have two options to address these challenges. The first is to increase the attractiveness of the 'job offer', to convince more people to join, and to entice serving personnel to stay. Several initiatives attempt to do this, including increased remuneration, improved conditions of service, and use of completion/retention bonuses, but with limited success.[4,5] A key shortfall is that these initiatives are indiscriminate. In many cases, they benefit those who had already decided to enlist or those who had no intention of leaving the military.

If improving the attractiveness of a military career does not solve the recruiting and retention problem, the second option available to Western militaries is to increase the pool of personnel available for military service through initiatives such as changing military entry standards and retention of non-deployable personnel. Some recent changes to entry standards reflect improvements in the management of certain health conditions or the evolution of military roles. In contrast, others take a pragmatic approach to what were arbitrary decisions based on limited evidence. However, other changes represent a deliberate decision to lower entry standards.[6,7] While this may appeal to senior military leaders and bureaucrats who use 'head count' as a measure of effectiveness, there is increasing evidence of unintended consequences. These include increased personnel wastage, increased burden on under-resourced military health services, increased complexity for commanders and personnel managers, reduced military readiness and increased physical and psychosocial harm to military personnel.[8-11] This, in turn, results in increased incapacity among military veterans and an increased burden of care for veteran support systems. This paper examines the unintended consequences of these recruiting and retention initiatives.

Lowering entry standards

There is a long history of militaries setting high standards for enlistment and for good reasons. Military service, particularly conflict, places significant physical and psychological demands on an individual. Within military organisations, there is an imperative to preserve combat power, and one individual's incapacitation can compromise the mission and, importantly, place others at risk. Casualties (particularly non-battle casualties)

i The US Army achieved only 75% of its recruiting targets in FY 2022 and FY 2023 (see U.S. Army Recruiting Command).2 European nations are experiencing similar problems (see https://www.nzz.ch/english/europes-militaries-struggle-to-attract-the-next-generation-ld.1878300).

ii Data from the UK also shows that the UK Armed Forces have consistently fallen short of recruitment targets over the past 5 years (see https://ukdefencejournal.org.uk/armed-forces-recruitment-falls-short-of-targets).

also impose a logistic burden due to the need for evacuation. Thus, pre-enlistment fitness, medical, psychological and aptitude screening contributes significantly to the health and wellbeing of the fighting force.

Pre-enlistment screening serves two broad purposes: one, to identify candidates who are expected to complete training (i.e. screen in suitable candidates based on aptitude and physical fitness), and two, to identify candidates with health conditions that are at risk of deterioration in a military environment (i.e. screen out medically and psychologically unsuitable candidates). Pre-enlistment screening is important for other reasons. Militaries invest significant resources in recruiting and training personnel and want a return on this investment. Recruiting personnel who will not finish training wastes resources, and Western militaries set military entry standards to minimise attrition during training. There is also an ethical and legal perspective to this. Military service is physically and psychologically demanding, and this places individuals at risk of harm. The military has a duty of care (and a legal obligation under Work Health and Safety legislation) not to cause harm to predisposed individuals—*primum non nocere* (first do no harm).[iii] Military entry standards are critical in minimising harm.

There is a common adage that the military reflects the society from which it is drawn. Western societies are becoming increasingly sedentary and obese, and an increasing number of potential military candidates are unable to meet the fitness standards required for enlistment. For example, a 2020 US study found that 77% of young Americans do not meet military enlistment standards due to obesity, drug use, or mental or physical conditions.[5] To address these issues, several Western militaries have increased BMI (body mass index) thresholds for enlistment and 'lowered the bar' on fitness standards.[12] This represents a subtle change to the philosophy of pre-enlistment screening. Removing fitness and medical barriers to enlistment increases the number of candidates who can *commence* training, while accepting some may not *complete* training. However, this ignores the findings of numerous studies that demonstrate a strong association between poor physical fitness and medical discharge due to injury. For example, an Australian study found that the least fit recruits are 25 times more likely to not complete training than the fittest recruits.[13] Similarly, numerous studies have shown a strong positive association between obesity and physical injury.[14,15] By screening in unfit and/or obese individuals, Western militaries are causing harm.

To further increase the pool of candidates potentially available for enlistment, Western militaries have deliberately lowered medical and psychological recruitment standards and increased the cut-off age for enlistment.[16,17] This reflects a paradigm change in the second element of the pre-enlistment screening process (screening out unsuitable candidates). The unintended consequences of these initiatives are becoming increasingly evident. A Royal Commission into Defence and veteran suicide in Australia found that one in five serving members who died by suicide between January 2000 and January 2024, had been assessed as marginal, not recommended or not suitable for service from a psychological perspective[iv,8] It is not uncommon for pre-enlistment physical or mental health conditions to deteriorate upon enlistment due to the physical and psychological rigour of military service. A US study found that one-third of personnel discharged during initial entry training are separated due to a pre-enlistment medical condition and that individuals waived for knee pain and back pain, and depression and related disorders are at high risk of medical separation compared to their peers.[18] Lowering medical entry standards predisposes already at-risk individuals to injury. Thus, these initiatives are also causing harm.

Individuals with pre-enlistment physical and mental health conditions who complete *ab initio* training will require ongoing care during their military service and are more likely to have restrictions imposed on their employment within the military. This, too, has unintended consequences. Military health services are typically structured around ratios of care that presume the force is young and medically (and psychologically) fit. An older and increasingly complex 'military patient' demographic increases both the number and variety of clinicians required to care for the force. The increase in demand for physiotherapy and psychology services among Western militaries is evidence of this.[19-21] The cost of providing healthcare

iii This long-standing principle is reflected in the direction a senior Australian medical officer issued (in October 1915) to all medical staff conducting recruiting medical exams: 'that no man be allowed to pass the standard who is suffering from any disability, likely to be aggravated by service'. (See Butler, 1940)1

iv The Australian Royal Commission found evidence that a significant number of individuals—over 14 000 personnel (approximately 11% of total enlistees)—were assessed as 'not suitable' or 'not recommended' on psychological grounds, yet were enlisted during the 2001–2024 period (see Chapter 3, para 155).8

to military personnel will increase exponentially as enlistment medical and physical fitness standards are lowered.

A significant unintended consequence of lowering entry standards is the flow-on effect on the remainder of the force. Military posting cycles allow personnel to cycle in and out of 'ready' units and into training, staff and other roles. In addition to providing broader military experience and professional development opportunities, these roles provide respite from the physical and mental demands of operational units, and periods of family stability. Recruiting (and retaining) less deployable or non-deployable personnel limits the opportunities for 'medically fit' personnel to rotate out of operational units. Consequently, a smaller proportion of the force must shoulder a larger responsibility for operational readiness, leading to increased injury rates, burnout, low morale and adverse impacts on families and relationships.[8]

Ironically, the 'high achievers' are most impacted by this—their high performance is rewarded with a succession of (physically and mentally) demanding high-tempo roles until they abruptly reach (physical and mental) breaking point. This is the paradox of performance punishment—where purported rewards cause unintended harm—and it is an increasing phenomenon in Western militaries, particularly among NCOs, middle-ranking officers and more highly trained personnel such as special forces. These members are the organisational repository of military knowledge and operational experience. Initiatives intended to remediate military hollowness may well be exacerbating force structure deficiencies.

Lowering entry standards has significant consequences for commanders and managers, who deal with the human consequences of recruiting and personnel policy staff decisions. In addition to needing increased clinical care, these personnel need welfare support, and this is a command responsibility. Individuals with complex medical and psychological conditions require a disproportionate amount of command oversight at the unit level and personnel management intervention at the organisational level. Lowering entry standards necessitates bespoke personnel management solutions that provide increased opportunity for the individual but less flexibility for the organisation. Consequently, commanders spend considerable time managing complex individuals and less time commanding their force.[22]

Finally, lowering entry standards has significant consequences for organisations responsible for supporting veterans and the government funding that underpins this. Funding for organisations such as the US Department of Veterans Affairs (VA) and the Australian Department of Veterans Affairs (DVA) is derived from actuarial estimates that reflect previous (high) enlistment standards and are unlikely to take into account the impact of contemporary changes to recruiting standards. Lowering entry standards means the risk of physical and psychological injury increases. This, in turn, is likely to increase the number of veterans who are incapacitated at transition and unable to undertake civilian employment on discharge, leading to increased reliance on social and financial support. Further, it is well known that medical separation, chronic injury and incapacity adversely affect the mental health of veterans and are known risk factors for veteran suicide.[23,24] Lower entry standards potentiate each of these risk factors.

Retention of non-deployable personnel

Given Western militaries' difficulties attracting sufficient recruits, another method of maintaining personnel numbers is to stop (or reduce) out-flow by retaining personnel beyond (standard) retirement age and personnel with medical conditions that render them non-deployable. These initiatives mitigate the problem of corporate knowledge loss and allow military organisations to maximise the return on their training investment. However, these initiatives have flow-on effects and consequences similar to lowering entry standards.

From a healthcare perspective, older personnel and medically unfit personnel require more medical care and consume more health resources. Military health organisations have historically been oriented towards preventative medicine (treating the well) and acute care in the deployed environment (preserving the fighting force). Retaining older and medically unfit personnel introduces a requirement for chronic disease management and shifts the focus from deployed health care to garrison health care. This is evidenced by the evolution of the defence medical workforce over recent years. The number of uniformed clinicians (the deployable health capability) has remained constant, but there has been significant growth in non-uniformed clinicians supporting military forces in garrison locations. For example, an audit of health services support to the Australian Defence Force revealed a 25% increase in the contracted workforce during the period July 2019 to June 2022.[25] However, there is evidence that this workforce growth is insufficient to address the changing level of risk associated with recruitment policy, including lower entry fitness standards and use of medical waivers.[8] Many non-deployable

personnel require more medical care, which affects health staffing and resources.

Implications for defence health services

Changing military medical standards necessitate change throughout the continuum of military health care, commencing before enlistment. Initiatives to increase the pool of candidates eligible for military service and expedite the enlistment process, increase the risk of adverse health outcomes for aspiring recruits and increase the burden of care for military (and veteran) health organisations. The pre-enlistment medical assessment—physical examination, information gathering and clinical investigations—is crucial to make an informed medical risk assessment. It should not be waived nor deferred until after a candidate is enlisted because doing so places the individual at increased risk of avoidable harm and raises ethical concerns.

The recruiting crisis has led Western militaries to 'accept greater risk' regarding entry standards. However, this is disingenuous. The risk to the military is that the recruit will not finish training, and it will not get a return on its investment. However, as noted by a recent Royal Commission into Defence and veteran suicide in Australia, the real risk is being transferred to the individual, who is at increased risk of injury, increased risk of medical separation, increased risk of lifelong incapacity and increased risk of suicide.[8] While military service is inherently dangerous, military organisations have an obligation not to expose personnel to risks of unnecessary harm, yet lowering military entry standards exposes individuals to harm. This poses several ethical questions. Should an individual be enlisted if they are at increased risk of avoidable harm? If so, what number needed to harm is the military (and society) willing to accept? Further, if an individual is at increased risk of avoidable harm, is the military obliged to gain informed consent during the enlistment process?[26]

Lower entry standards make it necessary for Western militaries to have a process that links medical risk management to the safe employment of personnel across different military roles. This must be underpinned by a standardised medical classification system through which the military exercises its duty of care to the individual, based on a medical assessment of physical and psychological functional capacity, while also providing advice to commanders regarding limitations on employment. Several Western militaries use the PULHHEEMS classification system (or a derivative thereof). Developed in 1943 by the Canadian Armed Forces, it provides a concise and standardised medical assessment of potential recruits and serving personnel, particularly during en masse enlistment (e.g. mobilisation).2[7] Given the increasing complexity of the 'military patient' demographic, it is critically important that a standard classification system is applied through the recruitment process and into service. Importantly, it is critical to understand that its purpose is to inform commanders, not medical staff, because commanders are responsible for the health and wellbeing of their personnel.

Lowering entry standards and retaining non-deployable personnel results in an increased burden of military health care.[28] There is a requirement for additional resources for defence health services and a need to increase the health workforce across the military organisation, particularly at the *ab initio* (recruit) training centres and in locations where non-deployable personnel are concentrated (e.g. headquarters and training establishments). The composition of the health workforce must also change—both uniformed and non-uniformed clinicians—with an increased need for physiotherapists, psychologists, occupational physicians and vocational rehabilitation staff. The lowering of entry standards will increase personnel wastage rates. Therefore, there is also a need for a commensurate increase in the capacity of deployable health capabilities (particularly noting Major General Howse's observation that personnel of lower medical fitness '…do no duty, and only cause congestion in our hospitals and Command Depots').[1] Lowering entry standards will also increase the need for personnel to support medical discharge processes—resettlement training, post-separation health care, injury compensation claims, etc. This will extend into non-defence organisations that care for and administer services to veterans after they have left military service.

Lowering entry standards will necessitate increased health assurance checks to confirm health readiness and ensure that medical classification and employment limitations remain valid, ensuring personnel receive adequate care and that commanders are supported in their welfare and personnel management responsibilities. Unlike civilian clinical practice, where wellness is assumed and the health system is predominantly oriented towards treating the unwell, peacetime military medical practice is focused on caring for the well—confirming fitness to serve through preventative health care and early intervention. Importantly, these processes must ensure commanders at all levels (including government) are provided with a

realistic appraisal of military capability. In days of yore, military organisations required personnel to maintain a high medical classification, and had the liberty of discharging those that did not meet this standard. In the new era, an individual's medical classification is less relevant, but ensuring the medical classification is a true reflection of functional capacity is essential.

There is an urgent need for Western militaries to better understand the health and psychosocial implications of lower entry standards (and, to a lesser extent, retaining non-deployable personnel). As a relatively new initiative, the current organisational understanding of the consequences is informed by intuition, anecdotal evidence, case reports and short-term studies. While there may be a tendency to dismiss this as low-quality evidence, the findings of the recent Australian Royal Commission into Defence and veteran suicide suggest otherwise:

> *'We are concerned that reducing entry standards and granting a high number of medical waivers have the potential to increase the number of separations from the ADF, particularly involuntary separations, and increase the risk of suicide and suicidality for this cohort … Candidates who receive a medical waiver that allows them to join the ADF, by definition have … a higher risk category for physical and/or mental ill-health. The fact that defence does not monitor the progress of these recruits is frankly unacceptable.'*[8]

The defence health services are almost always the first to know when a uniformed member is suffering from physical or psychological distress. Therefore, from an organisational perspective, the defence health services are the 'canary in the coal mine' when it comes to understanding the implications of changes to military medical standards. Consequently, the defence health services should lead organisational efforts to better understand the implications of lower entry standards so this can inform changes to recruiting and retention policies. Initially, these efforts should focus on the *ab initio* training schools—the most vulnerable cohort of military personnel—as this is where trainee attrition rates are highest. Early studies should also follow trainees through the initial employment training schools (with a particular focus on the more physically and mentally demanding roles). The aim is to determine injury and attrition rates for trainees who enter the military under a medical (and/or fitness) waiver, identify those most at risk of harm, and provide the medical evidence to support changes to medical entry standards. Importantly, these findings may also inform changes to current training paradigms because it is becoming increasingly apparent that the status quo is not sustainable.

Finally, there is a need for defence health services personnel to take on an advocacy role, to represent the 'military patient' group who, under military culture, do not have a collective voice. It is critically important that defence clinicians (uniformed and non-uniformed) provide frank and fearless advice regarding potential harms arising from changes to military medical standards. This should start with a clear problem statement: military entry standards have been lowered (out of necessity), and this may be causing harm. Using euphemisms (e.g. 'We are not lowering standards, we are changing them.') fosters a culture of denial. It creates barriers to implementing changes that protect individuals from harm and improve organisational effectiveness.

Conclusion

In response to recruiting and retention difficulties, Western nations are changing personnel policies and military medical standards to increase the pool of potential recruits and to retain trained personnel who do not meet medical standards for deployment. Organisational needs, not medical evidence, drive these changes, and while these initiatives will increase the size of the force, they may not improve the effectiveness of the force. Recent conflicts in Europe and the Middle East confirm the significant physical and psychological demands of warfare. By lowering entry standards and retaining non-deployable personnel, there is a real risk of conflating personnel numbers and military capability. Recruiting and retention initiatives may fill the military establishment, but the reality is that this can hide organisational hollowness, particularly in the combat force.

Importantly, initiatives aimed at increasing the size of the force may have unintended consequences. Military medical standards are set at a high level so that individuals can withstand the rigours of military service and maintain the fighting force during conflict. High medical standards mitigate risk but do not prevent injury, and military forces accept that part of the force will be lost due to injury/illness. Lowering medical entry standards and retaining non-deployable personnel will increase injury rates, causing harm to predisposed individuals. This, in turn, will result in an increased burden on under-resourced military health services, increased complexity for commanders and personnel managers, and increased physical and psychological harm to military personnel. Ironically, initiatives

aimed at increasing the size of the force are likely to increase personnel wastage, incapacity among military veterans and the burden of care for veteran support systems.

Defence health services can (and must) play a leading role in helping commanders and personnel policymakers understand the health and wellbeing consequences of changes to recruiting standards and retention policies. Although these initiatives are relatively new, there is now sufficient data for epidemiological monitoring (albeit retrospectively) to understand the health impacts and to allow a more informed and evidence-based approach to changing recruiting and retention standards. With an obligation to 'first do no harm', defence clinicians are best placed to provide the evidence for change where it is safe to do so while also advising on the need to retain (or introduce) higher medical standards or changes to training paradigms, where it is necessary to protect individuals from harm.

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