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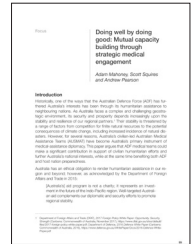
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Doing well by doing good: Mutual capacity building through strategic medical engagement

*Adam Mahoney, Scott Squires
and Andrew Pearson*

Introduction

Historically, one of the ways that the Australian Defence Force (ADF) has furthered Australia's interests has been through its humanitarian assistance to neighbouring nations. As Australia faces a complex and challenging geostrategic environment, its security and prosperity depends increasingly upon the stability and resilience of our regional partners.¹ Their stability is threatened by a range of factors from competition for finite natural resources to the potential consequences of climate change, including increased incidence of natural disasters. However, for several reasons, Australia's civilian-led Australian Medical Assistance Teams (AUSMAT) have become Australia's primary instrument of medical-assistance diplomacy. This paper argues that ADF medical teams could make a significant contribution in support of civilian humanitarian efforts and further Australia's national interests, while at the same time benefiting both ADF and host nation preparedness.

Australia has an ethical obligation to render humanitarian assistance in our region and beyond; however, as acknowledged by the Department of Foreign Affairs and Trade in 2015:

[Australia's] aid program is not a charity; it represents an investment in the future of the Indo-Pacific region. Well-targeted Australian aid complements our diplomatic and security efforts to promote regional stability.

1 Department of Foreign Affairs and Trade (DFAT), *2017 Foreign Policy White Paper: Opportunity, Security, Strength* (Canberra: Commonwealth of Australia, November 2017), <https://www.dfat.gov.au/sites/default/files/2017-foreign-policy-white-paper.pdf>; Department of Defence, *2016 Defence White Paper* (Canberra: Commonwealth of Australia, 2016), <https://www.defence.gov.au/WhitePaper/Docs/2016-Defence-White-Paper.pdf>

The Defence Cooperation Program (DCP) represents a major contribution by the ADF to the whole-of-government international aid program. The objective of the DCP is:

...to maximise Australia's security through developing close and enduring links with partners that support their capacity to protect their sovereignty, work effectively with the Australian Defence Force and contribute to regional security.²

DCP-funded activities include bilateral and multilateral training exercises, the building and/or refurbishment of infrastructure, donations of materiel and joint maritime security operations. The DCP also enables military personnel from partner nations to access learning opportunities at Australian military and civilian educational institutions. At present, around 2,000 DCP students come to Australia for training each year. Additionally, DCP relationships are strengthened by a network of internationally seconded officers posted throughout Australia and Defence cooperation education officers posted to partner nations.

Notwithstanding longstanding support and considerable funding for the DCP by all sides of politics, at present the DCP is not purposively funding any regional engagement by ADF medical personnel; rather, medical teams are deployed in support of training, construction or security tasks. On occasion ADF medical teams are given orders that specifically preclude practical engagement with host nation health services. Moreover, with reference to DCP-assisted opportunities for study in Australia, there are few training targets that specifically relate to medical education. Consequently, medical engagement is limited both at home and abroad in the sense that clinicians lack a formal framework for mutual capacity building and the strengthening of professional bonds. It would not be going too far to state that opportunities for medical strategic engagement are largely overlooked.

This paper proposes that by failing to promote strategic medical engagement in our region the ADF is missing two key opportunities:

- the first of these is to achieve Australia's stated aim of enhancing the capacity and resilience of our neighbours
- the second being to promote the ADF's aim of creating a 'capable, agile and potent force structure'.

The paper begins with a precis of ADF medical operations in our region and then seeks to establish the imperative for strategic medical engagement while

² Department of Defence, *Defence Cooperation Program (webpage), Annual Report 2015–16*, Australian Government, Canberra [cited 22 March 2019]; available from: <http://www.defence.gov.au/annualreports/15-16/Features/20-DefenceCooperation.asp>.

considering its potential deleterious unintended consequences. The paper then provides examples of how strategic medical engagement may be applied in practice.

The case for strategic medical engagement

Strategic medical engagement is a logical extension of extant foreign policy

Australia is often described as a 'middle power', whose diplomacy emphasises the development of multilateral coalitions and mutual cooperation in order to promote regional stability. This approach both enhances Australia's own security and reduces the requirement for Australia to commit finite military and diplomatic resources to address near neighbours' domestic catastrophes, which may threaten our interests.

Globalisation has rendered Australia's application of soft power increasingly important.³ Soft power takes many forms, some of which have been termed 'defence diplomacy': the 'nonviolent use of a state's defence apparatus to advance the strategic aims of a government through cooperation with other countries'.⁴ Contemporary examples of defence diplomacy include Operation Render Safe, Exercise Pacific Partnership, Exercise Olgeta Warrior and Exercise Harii Hamutuk. These deployments, tailored to the needs of both Australia and individual host nations, involve joint planning, training and engineering tasks; though with the exception of Exercise Pacific Partnership, there is limited formal contact between Australian and host nation medical personnel.

Clearly there are immediate benefits to both ADF clinicians and host nation practitioners that result from formal regular contact. But beyond this, medical strategic engagement could enhance the effectiveness of existing programs that are already a feature of the DCP. By coming to know practitioners in key clinical and administrative roles, ADF clinicians can make recommendations to Defence Cooperation Education Officers, who may then offer targeted learning and networking opportunities to those individuals within existing frameworks. In this manner, the collective subject matter expertise that may be found within the ADF is applied to ensure optimal allocation of finite foreign aid resources.

3 DFAT, 2017 *Foreign Policy White Paper*.

4 Gregory Winger, 'The Velvet Gauntlet: A Theory of Defense Diplomacy. In: What Do Ideas Do?', ed. A. Lisiak, N. Smolenski, Vol. 33. (Vienna: IWM Junior Visiting Fellows' Conferences, 2014), <https://www.iwm.at/publications/5-junior-visiting-fellows-conferences/vol-xxxiii/the-velvet-gauntlet/>; Rhett Mitchell, 'Pacific partnership: Australia's contribution and benefits' [online], *Headmark*, No. 14 (March 2013): 9–14, <https://search.informit-com-au.ezproxy-b.deakin.edu.au/documentSummary;dn=258255537653528;res=IELHSS> also available via <https://navalinstitute.com.au/headmark-back-issues/>

The 2016 Defence and 2017 Foreign Policy White Papers both affirm the government's commitment to capacity building defence engagement in the Indo-Pacific region. We contend that ADF medical clinicians and units represent a significant vector for defence diplomacy. Enduring ties between both individual clinicians and deployable health units will enhance both host nation capacity and interoperability with the ADF in a way that is entirely consistent Australia's stated foreign policy.⁵

Strategic medical engagement is consistent with Australia's humanitarian obligations

Australia has a long history of humanitarian engagement with other nations and actively seeks to promote its humanitarian credentials. From 19th Century relief for the Indian famines, to recent support provided to Indonesia, Fiji and Pakistan, Australians have been generous contributors of funds and physical assistance, both private and public.⁶

Humanitarian assistance denotes the actions taken to alleviate suffering and preserve life in the aftermath of social crises and natural disasters. For this, the government increasingly relies on AUSMAT, which comprise a federally funded civilian organisation. However, humanitarian assistance also embodies measures taken to enhance preparedness for catastrophic events and ADF clinicians are ideally positioned to contribute to this function.

ADF clinicians provided with the opportunity to work and learn alongside host nation counterparts outside of times of catastrophe would be afforded the opportunity to analyse local health systems. They could then, in light of their experiences, make suggestions as to how best practice from Australia's highly developed health system could be applied within local resource constraints. Further, the knowledge acquired through the ADF's partnerships with host nation health systems, and captured through formal health intelligence reports, could be passed to organisations such as AUSMAT to facilitate improved interoperability in the event of future humanitarian assistance missions.

Military partnerships do not challenge civilian primacy in humanitarian assistance and disaster relief, as espoused by the 2007 Oslo *Guidelines on the use of Foreign Military and Civil Defence Assets in Disaster Relief*.⁷ Rather, such relation-

5 DFAT, 2017 *Foreign Policy White Paper*.

6 Jacinta O'Hagan, 'Australia and the promise and perils of humanitarian diplomacy', *Australian Journal of International Affairs* 70, 6 (2016): 657–669.

7 United Nations Department of Humanitarian Affairs (DHA), *Guidelines on the Use of Military and Civil Defence Assets in Disaster Relief*, March/May 1994, DHA/94/95, UN Office for the Coordination of Humanitarian Affairs (OCHA), [cited 2019 22nd March]; available from: <https://www.refworld.org/docid/4289f0114.html>.

ships could function as an enabler of civilian agencies and thereby contribute to Australia's ability to meet its humanitarian obligations.

The Oslo guidelines are often cited as the basis for using civilian medical teams, such as AUSMAT rather than Australian military teams. Items 5 and 32 (ii) of the guidelines require Military and Civil Defence Assets (MCDA) be used as a last resort and Item 32 (iv) recommends that MCDA should be used, as much as practicable, in indirect roles. Item 38 explains that, 'In principle, unarmed UN MCDA, accepted as neutral and impartial and clearly distinguished from other military units, can be used to support the full range of humanitarian activities. However, their involvement in direct assistance should be weighed on a case by case basis'. Thus, logistic and force protection support appears to be the current role of ADF medical personnel deployed for Humanitarian and Disaster Relief (HADR).

Key considerations underpinning the formulation of the Oslo guidelines were the perceived neutrality of aid, the need to enhance civilian capability and the need to prevent dependence upon military forces. We acknowledge that the same principles should be applied to disaster relief in our region. Nevertheless, the Oslo guidelines were written to provide guidance on the role of foreign military and civil defence forces in large scale UN-run disaster relief missions, not to proscribe opportunities for mutual exchange of knowledge and experience. It may be argued that Australia's humanitarian obligation to our neighbours is not activated by crisis alone, but rather extends to ensuring readiness of partner nations to cope with such eventualities. Aid organisations, both government and non-government may lack the mandate and resources to mount protracted operations outside the context of a humanitarian emergency. In contrast, even on operations, the ADF is an organisation devoted to training. To that extent, the needs of ADF clinicians to experience diverse practice environments and the need of partner nation clinicians for ongoing professional development are aligned. Targeted engagement by ADF clinicians before, during and after major events that threaten public health could ensure that partner nations are at their most capable when their systems are put to the test.

Strategic medical engagement will generate regional goodwill

Strategic medical engagement represents a commitment to our neighbours and an investment in their collective wellbeing. In contemporary diplomacy, compassion has come to be seen as a status symbol and states compete to be recognised for their generosity.⁸

⁸ O'Hagan, *Australia and the promise and perils of humanitarian diplomacy*.

Natural disasters often promote an outpouring of sympathy and acts of generosity from the international community. It is widely recognised that Australia's open-handed response to the 2004 tsunami helped repair Australian-Indonesian relations, which had been severely damaged by Australia's involvement in East Timorese independence.⁹ However, the value of long-term partnerships that are not contingent upon catastrophe should not be overlooked.

Speaking about the Pacific Partnership, the US ambassador to Cambodia once said, 'This type of mission builds the U.S. relationship here tenfold over a lot of other things we do'.¹⁰ Further, by making medical interaction a key feature of the relationship between the Australian military and local communities, Australia could reinforce the benign intensions of our regional engagement.

The efficacy of this form of military diplomacy is underscored by attempts by our regional competitors to establish programs akin to Pacific Partnership. Over at least the last five years, China has developed regional forums for interaction of clinicians and health logisticians; the Peace Train series of exercises facilitates medical exchanges between China and Laos, while China's *Peace Ark* has provided medical services in Papua New Guinea, Fiji, Vanuatu and Tonga. Many of the nations targeted by China's medical diplomacy are considered important Australian regional partners.

Australia has the capacity to mount medical engagement activities in its own right, building upon historical relations with its neighbours that potential competitors such as China do not possess. However, nations such as Papua New Guinea and Fiji are not in a position to be selective about the aid they receive and will likely accept any partnerships arrangements that are offered. Australia should not thoughtlessly cede its natural advantages in this field but should embrace strategic medical engagement as an opportunity to enhance our national image in pursuit of our foreign policy objectives.

Strategic medical engagement enhances the resilience of partner nations

Many of our most significant regional partners are vulnerable to natural disasters such as earthquakes and tsunamis. Medical systems in these nations are often

9 Ilan Kelman, *Disaster Diplomacy: How Disasters Affect Peace and Conflict* (Oxford: Routledge, 2011).

10 Kristopher Regan, 'Pacific Partnership Wraps up Mission in Cambodia', 12 August, 2012, *Commander United States Pacific Fleet* (<https://www.cpf.navy.mil/news.aspx/030045>) quoted in Daniel Baldino and Andrew Carr, 'Defence diplomacy and the Australian Defence Force: smokescreen or strategy?', *Australian Journal of International Affairs* 70, 2 (April 2016):139–158, DOI: 10.1080/10357718.2015.1113229

barely sufficient to meet the daily needs of their dependencies; natural disasters cause swift decompensation and many casualties may want for adequate care.

While strategic medical engagement cannot ameliorate shortfalls in capacity without substantial additional funds, and at risk of undermining sustainable indigenous health capability, there are many ways it can help to enhance partner nation system resilience, such as through training in corporate governance and major incident management.¹¹ Programs such as the Major Incident Medical Management and Support (MIMMS) could be delivered to key staff to improve collective understanding of triage and casualty disposition. Airway management and vascular access skills could be taught to nurses in order to increase the number of trained assistants available for resuscitation teams. Crew resource management skills could be imparted through multidisciplinary simulation to improve the efficiency of communication and clinical decision-making. Medical engagement teams facilitate such education in two ways: first, they have the benefit of having received formal instruction through their military medicine training, and second, and more importantly, they are supernumerary to the normal working of the health facility. Often health facilities in the Pacific have only one doctor from each specialty and limited nursing staff, meaning that all available time is devoted to service delivery, with professional development a distant second. This is not to devalue the clinical expertise of clinicians in these countries, as their case volume in certain areas far exceeds that of their Australian colleagues. Rather, it demonstrates that the presence of Australian medical teams can enable education and training beyond that which would be possible if these nations were to rely solely on their own resources.

A further benefit of collaborative education programs is that they foster direct clinician-to-clinician relationships that can provide a source of counsel in unfamiliar circumstances. Almost every Australian clinician can count on a pool of colleagues to whom they could turn if they were uncertain how to manage a clinical scenario. Our colleagues in the Pacific are not always so fortunate. From the authors' own experience, opportunities to consolidate a professional network are taken avidly and it has well been said that 'the time to exchange business cards is not during a disaster'.

Importantly, international engagement by Australian clinicians should be supported by opportunities for colleagues in partner nations to gain experience and qualifications in Australia. With appropriate training targets, this outcome could be achieved within the existing DCP framework. Communities in partner nations

11 Jordan S. Kassalow, *Why Health Is Important to U.S. Foreign Policy* (pdf), 19 April 2001 (Washington: Council on Foreign Relations), <https://www.cfr.org/report/why-health-important-us-foreign-policy>

will benefit significantly from the enhanced skills of returning clinicians, but more importantly, regular exchange opportunities will develop the robust professional networks that support best practice response to health crises as outlined above.

Strategic medical engagement promotes the safety of ADF members deployed in host nations.

Acceptance by the host nation community and a comprehensive appreciation of local threats to health support the safety of ADF members deployed overseas; strategic medical engagement furthers both these ends. As outlined above, medical engagement is able to promote good will. An act of caring for one person is readily communicated to their extended community, thereby promoting Australia's benign reputation. Moreover, local clinicians are often best placed to advise on common hazards to the deployed force, including zoonoses, communicable diseases and the threat of interpersonal violence.

Additionally, although the ADF aims to be self-sufficient in treating its members injured overseas, it is important to understand the capabilities present within the host nation health system. If Australians were later deployed to the same location for humanitarian assistance or warlike service, local hospitals or clinics may provide redundancy where ADF facilities are insufficient to meet clinical demand. A thorough understanding of host nation capability is difficult to achieve from a single visit, but is readily achieved through a clinical placement or observership. Moreover, it is reasonable to suppose that local clinicians are more likely to provide a candid assessment of their institution's capabilities to other clinicians with whom they have a working relationship.

Thus strategic medical engagement can help to build a safer foundation for future operations by enhancing the local reputation of the ADF and supporting rigorous assessment of host nation health capabilities.

Strategic medical engagement is cost-effective and sustainable

China has already provided over \$600 million towards development of infrastructure within PNG;¹² it is also the largest foreign aid donor to Fiji, Samoa and Tonga. While Australia remains the largest overall donor to the Pacific, it is likely that this pre-eminence will not be indefinite, and it is important that Australia seeks cost-effective means of generating goodwill and maintaining regional influence.

12 Philippa Brant, Pan Jiawei and Danielle Cave, '*Chinese aid in the Pacific*' [interactive website project], 21 March 2016, Lowy Institute; available from: <https://chineseaidmap.lowyinstitute.org/> Further references via https://www.lowyinstitute.org/sites/default/files/chinese_aid_in_the_pacific_data_references.pdf

It would be possible to significantly increase strategic medical engagement without significantly increasing costs to the ADF. This is because many of the ADF's medical costs are fixed. Medical teams are frequently deployed in support of non-medical engagement activities such as explosive ordnance disposal, engineering works and live fire weapons training. Given the highly professional character of the ADF, it is unsurprising that on most occasions, there is no need for these medical teams to apply their training to treatment of exercise casualties. Understandably, in the absence of objectives relating to medical engagement, commanders planning multilateral exercises tend to maintain their medical assets in the form of a 'break glass in case of emergency' capability. Indeed, even where provision for medical engagement has been made at a higher level, individual commanders have vetoed clinical observerships because of a perception that 'health is there to support the main effort'. In consequence, a large proportion of time for medical contingents is spent attending internally organised professional development programs or engaging in non-medical activities such as labour assistance to engineering detachments.

A superior course of action would be to recognise the value of strategic health engagement and to assign it a similar priority to other regional engagement activities. Provided that health elements deployed in support of an exercise do not take on a clinical burden that would preclude them from leaving a local facility in the event that an Australian casualty requires treatment, health engagement and force preservation are not mutually exclusive. The primary purpose of such an interaction would be the exchange of knowledge or assisting local clinicians, rather than assuming primary responsibility for performing medical procedures; therefore, Australia would incur a negligible cost in consumable medical supplies.

It can be seen that, in cases where a medical team is to be deployed in a health support function for non-medical engagement activities it is possible for Australia to reap the benefits of medical diplomacy without specifically allocating funds to that purpose. An even better approach would be to augment this sort of opportunistic medical engagement with carefully considered long-term clinical relationships between ADF health units and specific host nation health care facilities. Sending individual nurses and medical practitioners, or small clinical teams, to a Pacific nation with the objective of mutually beneficial knowledge exchange would incur no greater cost than the reconnaissance parties sent to plan engineering works or a bilateral combined arms exercise. Yet in some ways, the value to Australia of medical engagement eclipses these other activities because of the potential for clinicians to engage not only with fellow clinicians but also directly with local civilians. The presence of an Australian in uniform during

a medical procedure, even if only in an assisting role, has the potential to inspire lifelong gratitude from a person suffering illness. Sadly, the same lasting goodwill is unlikely to follow from even ambitious infrastructure projects because such acts of beneficence are less personal in nature.

Strategic medical engagement is also sustainable. The ADF has a highly skilled, committed body of reservists who compete for opportunities to participate in operational deployments and exercises. Large combined arms training activities such as Talisman Sabre and Hamel do not test clinicians in the same way as many other military disciplines because of the need to maintain an out-of-exercise health support role to the exercise dependency. Even the simulated clinical training performed is unlikely to provide learning experiences significantly outside the scope of reservists' civilian practice. In contrast, exposure to the penetrating trauma and advanced surgical pathology seen in our near neighbours represents a unique opportunity for professional development. It is likely that the limited opportunities to participate in regional medical engagement activities would be oversubscribed. Further, block attendance is easier for some clinicians to integrate with their civilian practice and the total workforce model would allow strategic medical engagement to become the primary form of military participation for some reservists.

The ADF also has a permanent cadre of specialist clinicians distributed across the three services employed under the auspices of the Medical Specialist Program (MSP), which includes surgeons, anaesthetists, intensivists and emergency physicians. These doctors are full-time members of the ADF but are placed in civilian institutions when they are not engaged supporting ADF activities. As full-time members, they guarantee the ability to mount an immediate medical response. Therefore, they require clinical exposure sufficient to gain the skills needed to treat battle casualties. Such exposure is difficult to obtain in Australia. Like the health contingents deployed in support of regional engagement activities, the medical specialist program is a fixed cost for the ADF and therefore the return on the ADF's investment varies only with the extent and value of the activities in which members of the MSP participate. Our regional partners can offer us unique, and necessary, learning opportunities, while ADF clinicians both permanent and reserve can offer host nations insight into the practices of a highly developed health system such as Australia's.

Strategic medical engagement will create capable and agile ADF clinicians, units and systems

Australia remains one of the safest countries in the world with limited interpersonal violence and a low volume of penetrating trauma seen in our medical

facilities. It is exceedingly difficult if not impossible for a doctor trained solely in Australia to become highly practiced in the skills needed to manage injuries sustained in armed conflict. One of the authors undertook a trauma fellowship at one of Australia's largest trauma centres for a year and yet saw more penetrating trauma wounds in two weeks of intermittent attendance in a regional hospital in Papua New Guinea.

The practice of medicine and surgery in Australia has increasingly become sub-specialised, with trauma care being mostly managed in large and extremely well-resourced tertiary centres. The trend towards non-operative and minimally invasive management of trauma has resulted in fewer surgeons feeling comfortable with the management of a wide variety of trauma presentations. There is an ever-widening gap between the provision of medical and surgical care in a first world tertiary trauma hospital and that required in a resource-limited military deployment. By allowing ADF clinicians to work in a resource constrained facility, which sees a high volume of penetrating trauma, front-line clinicians can be provided with the best possible exposure to prepare them for the next military conflict.

At present the ADF has no similar opportunity allowing clinicians to regularly provide emergency damage control resuscitation and surgery in austere conditions. Even in remote hospitals, where clinicians might be expected to gain such exposure, the absolute number of patients presenting with major injuries is low, particularly with regard to penetrating trauma. Thus far, capability has been generated through ad hoc opportunities arranged by individual clinicians; however, this approach does not benefit a professional military. In order to meet the objective of becoming a capable and agile defence force, the ADF is now required to provide opportunities for exposure of both full-time and reserve clinicians to trauma medicine and surgery. Our regional neighbours have much to offer Australia in this area. Temporary medical registration allowing ADF surgeons to operate alongside their colleagues in the Philippines or Papua New Guinea would vastly increase their ability and confidence in managing injuries uncommon in Australia. Similarly, exposure to the emergency room in these countries would help to acclimatise Australian nurses and medics to the sometimes confronting appearance of severe trauma casualties, helping them to maintain their composure when encountering similar injuries when deployed in support of Australian soldiers.

The ADF must also acknowledge that the Australian medical system possesses only a small pool of suitably qualified, motivated and engaged clinicians prepared to perform forward damage control resuscitation and surgery in austere conditions. Multiple organisations now compete for the services of these clini-

cians. These organisations include both government (AUSMAT), non-government (International Committee of the Red Cross, Medicines Sans Frontiers) and private (Aspen Medical) organisations. Although many factors are considered when an individual chooses which organisation to work for, the ability to provide acute surgical and critical care in remote and poorly resourced regions is normally a key motivation. The development of a suitable medical engagement program with one of our near neighbours would result in a significant boost to both recruitment and retention of medical personnel. A suitable program would allow ADF clinicians to develop both individual and collective skills and corporate knowledge. The combination of technical skill development, the acquisition and maintenance of corporate knowledge and improved recruitment and retention of suitably qualified staff would result in the ADF medical community being exceptionally well placed to deal with any military or civilian medical contingency in the future.

Risks and limitations of strategic medical engagement

Even recognising the potential benefits of medical strategic engagement, some stakeholders have raised practical and ethical objections to the employment of ADF clinicians within regional partnership arrangements. The principle arguments are briefly outlined below.

Medical strategic engagement diverts ADF assets from their core tasks

Medical partnerships should not be developed in isolation of the ADF's strategic goals. However, mutual capability generation through enduring partnerships with near neighbours is entirely consistent with Defence's role in the Pacific Step-up.

Medical strategic engagement engenders dependency

Short term medical engagement programs are sometimes accused of being 'medical tourism', of benefit to the developed-world clinician but only providing temporary, geographically circumscribed benefits to the partner nation, while 'de-skilling' local proceduralists and burdening the local system with aftercare for which it is unequipped.

However, sustainable medical engagement can be achieved by following two core principles. Firstly, partnerships should be enduring. This does not mean that the engagement team should always include the same clinical disciplines, nor does it mean that an engagement team should always be present; rather, programs should commit to engagement over a period of years rather than weeks, in a manner tailored to the changing needs of both partners. Secondly, engagement teams should not introduce new clinical services and should use

local equipment. This reduces the risk of creating a ‘capability vacuum’ if ADF clinicians are redeployed to other tasks.

Medical strategic engagement is unsustainable

The ADF has a relatively small pool of clinicians from which to draw; therefore, lack of suitable personnel is a risk to enduring medical engagement. However, sustained partnerships also represent an excellent opportunity to enhance the joint integration of full-time and part-time clinicians. Also, by exercising the ADF’s ability to plan sustained clinical services for the purposes of regional engagement, chain of command at all levels is afforded the opportunity to rehearse the process of identifying, readying and deploying clinicians for other operations; this is corporate knowledge that might readily atrophy in an era of reduced operational tempo.

Medical strategic engagement exposes the ADF to reputational risk

Undeniably, medical misadventure has the potential to damage the reputation of the ADF. This risk can be mitigated in several ways. Firstly, ADF clinicians should not be ‘parachuted’ into a hospital to provide an independent clinical service; rather they would partner with an existing clinical team. This ensures that the partner nation retains primacy and that practice is in accordance with local mores. Secondly, as mentioned above, partnerships should be enduring, thereby reducing the likelihood that the ADF will be perceived as having ‘left its complications behind’. Thirdly, ADF clinicians should be formally integrated into the clinical roster of the partner nation facility and should undergo medical registration and credentialing in the same manner as local practitioners; again, this will help to broadcast ADF clinicians’ willingness to accept clinical accountability, rather than to act as ‘medical tourists’.

Medical strategic engagement is the responsibility of other organisations

On first consideration, medical strategic engagement might be considered to be the province of the Department of Foreign Affairs and Trade (DFAT). However, engagement as outlined in this paper has a different focus to that routinely taken by DFATs main medical asset—AUSMAT. AUSMAT were created as self-sufficient, rapid response teams that can be sent in support of local health resources. Between disasters, there is likely to be informal liaison between clinicians and the National Critical Care and Trauma Response Centre (NCCTRC) in Darwin hosts international students on many of its courses; however, the NCCTRC does not possess the ADF’s existing network of Defence Cooperation Education Officers and DCP alumni, who are best placed to identify meaningful engagement opportunities in their region. Nor does DFAT have the same corporate experience

of delivering training en masse that is possessed by Defence, one of Australia's largest registered training organisations. Ultimately, AUSMAT and the ADF are not competitors, rather each offers distinct strengths that allow a more holistic governmental approach to the issues of health and security in our region.

Conclusion

Australia has made important contributions to health outcomes in our region, but medical engagement has often been ad hoc and consequently we have failed to capitalise upon many potential benefits, both for Australia and for our regional partners. This paper has focused predominately on the benefits that accrue from ADF clinicians' relationships with host nation clinicians and health facilities. However, the true potential of strategic medical engagement can be unlocked when such clinical placements are part of a broader scheme that capitalises upon the strengths of existing programs such as the DCP, making full use of student exchanges, opportunities for secondment and maintenance of alumni networks.

Strategic medical engagement offers the potential to leverage an existing and sometimes under-utilised capability within the ADF that can also provide unique learning opportunities for both ADF and host nation clinicians, while remaining a cost-effective and enduring font of goodwill. We do not propose to undermine the primacy of AUSMAT or DFAT in providing the clinical component of humanitarian assistance missions. Rather we are advocating enduring partnerships of mutual benefit whose primary purpose is capability building, rather than clinical service provision. We believe that medical strategic engagement is wholly consistent with the Australian Government's Pacific Step-up. We further assert that if the ADF does not grasp the present opportunity to gainfully employ its clinicians in meaningful clinical activities, it is likely that these clinicians will be underprepared for future deployed practice.

