

ORIGINAL ARTICLE

MEDICAL SUPPORT IN ASYMMETRIC OPERATIONS

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Summary

In recent years, experience from the conduct of operations has shown changes in their contemporary leadership. Increasingly, asymmetric operations step to the fore. The medical support of these operations is one of conditions for their success. Results of exploratory research methods indicate the need for adjustments with regards to education, training as well as organization of medical support of the tactical units within asymmetric operations.

Key words: Asymmetric maneuver tactics; Asymmetric operations; Specialized training; Pre-deployment training; ROLE-1; Military Medical Service; Combined training

INTRODUCTION

In the first decade of the 21st century, the military has come to fundamental changes. When the significant majority of armed conflicts of the 20th century were conducted in the manner of symmetric operations, by the end of this century and during the early years of the 21st century, new kinds of threat have arisen, mainly due to former bipolar world disintegration. It was necessary to cope with these threats, to find political and military solutions [6]. For this period of time, it is rather typical to conduct asymmetric operations, where the Company and Battalion Task Force play the key role, being able to work independently and flexibly respond to enemy actions [2]. New maneuver elements bring with it the asymmetric maneuver tactics and the associated new ways

of conducting operations. Military operations with significantly asymmetric nature include Low-Intensity Operations. Military operations in low-intensity conflicts are divided according to FM 7-98 (Operations in a Low-Intensity Conflict) into following four operational categories: 1) Support for insurgency and counterinsurgency; 2) Combatting terrorism; 3) Peacekeeping operations; 4) Peacetime Contingency Operations [3, 4]. This fact is reflected in requirements on medical support, by this time created for symmetric operations conducted by major operational wholes.

In contemporary practice, medical support of the CAF (Czech Armed Forces) is implemented within tactical units such as squad, platoon and company, by integration of healthcare personnel or combat medics (paramedics). The smallest medical units, involving medical officers, are organized at the battalion level [1,11]. This system is more acceptable at moments, when units, formations and corps are spatially and distantly in contact. However, the same system becomes unsatisfactory when small tactical units and company task force units should operate within

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the area of operations for a period of 3 to 5 days, ripped off from the main forces at the distance of hundreds of kilometers, with the necessity of having both logistics and medical support. In recent years, selected members of combat units have re-

ceived training in Combat Lifesaver Courses (CLS). After successful completion, those individuals gain the second specialty – trained non-medical personnel with the ability to provide advanced lifesaving measures on the battlefield.

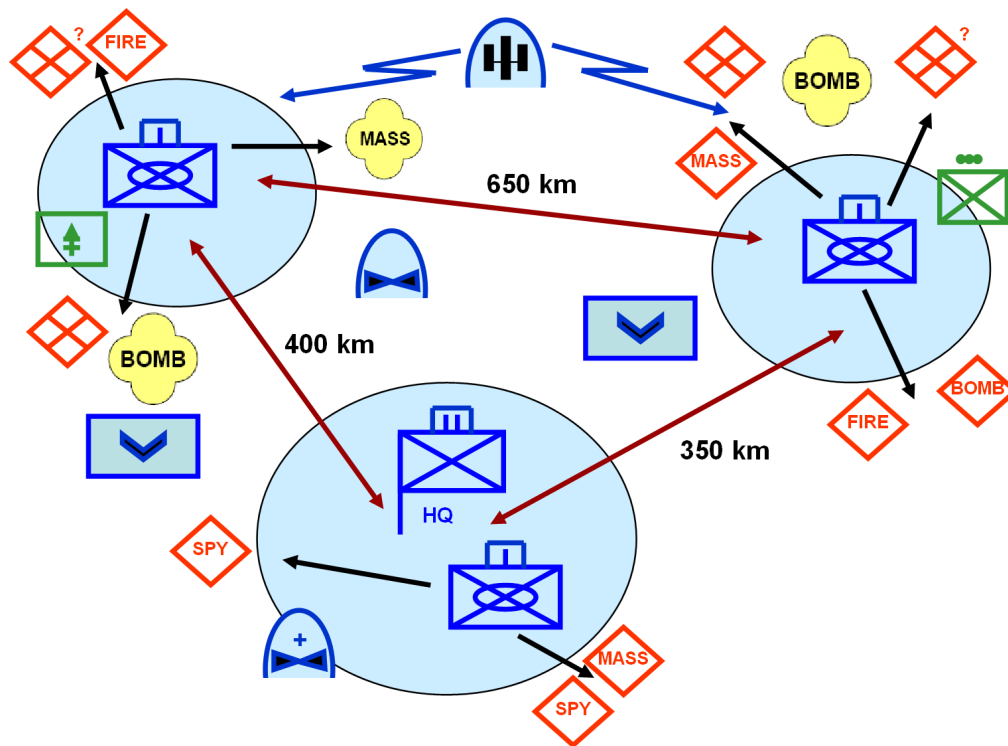


Figure 1. Scheme of Company Task Force situated separately from the main forces within the asymmetric operation.

During 2010 and 2011, a survey was carried out in order to ascertain the views of Military Medical Service personnel on issues concerning current military medical service capabilities to provide medical support to combat units in asymmetric operations. To obtain required data, exploratory research methods were employed, namely a questionnaire-survey and semi-structured interviews. While the questionnaire survey (see *Vojenské zdravotnické listy*, roč. LXXIX, 2010, č.4) was carried out across all functions of the Czech Military Medical Service, the semi-structured interview was conducted with selected ACR members, assigned to command and control functions within foreign operations during past years. Total of 6 medical officers, 2 nursing persons and 5 combined arms commanders answered 25 questions related to their experience from foreign

operations and their opinions on the development of medical support within asymmetric operations today and in near future.

SURVEY RESULTS

Results of the interviews indicate the divergence of opinions on medical support of the above mentioned operations. Some respondents pointed to a certain unpremeditated training of the Military Medical Service and the lack of clarity in its content. On the contrary, other respondents adverted to an appropriate method of medical support, however, with the necessity of incremental changes and adjustments. One issue, not meeting current requirements according to the survey outcomes,

is relatively weak representation of CLS certified soldiers and the need to lay an emphasis on accelerated training and especially maintaining received professional skills in the provision of first aid within the four-year certificate validity. Another controversial opinion arose from the inclusion of medical and nursing personnel into an organizational structure of units deployed in asymmetric operations. Interviews proved the true perception of combined arms commanders on medical staff, who often do not respect medical officers and nursing staff as military professionals and vice versa, medical officers themselves build their mission priority as first being a doctor followed by a secondary skill as a professional soldier. Also, a divided opinion prevailed on the organizational structure of the company task force in terms of medical support. It was possible to track down two points of view, either with a medical treatment facility (MTF) of ROLE-1 included, or without this MTF, but with a massive support of aeromedical evacuation assets providing patient transportation to higher levels of care. Concerning ground ambulances, a necessity of ballistic protection was highlighted. The answers of the respondents furthermore revealed an additional requirement relating to cohesive medical teams, preferably originated from "home elements" at the territory of the Czech Republic. Interviews also showed that some commanders have a vague idea of how to use the medical director for the benefit of their units, what they can expect from him and how to assign tasks to him. Conversely, medical officers have quite a clear idea of their position and responsibilities within the unit or formation. Conclusion of the interviews unequivocally pointed to a fact, that contemporary organization and management of the CAF medical units in foreign operations is also exploitable for Task Force medical support in terms of asymmetric operations; however it is usually rather about an improvisation than a systemic approach.

RECOMMENDATIONS FOR PRACTICE

The survey results can be applied to the following areas:

1. Education and training

In future, it seems to be inevitable to closely interconnect the education system of military managers at the Faculty of Economics and

Management (FEM) in Brno with the education system of medical officers at the Faculty of Military Health Sciences (FMHS) in Hradec Králové. Relating to military manager training programs, it would be useful to integrate some lectures on issues from the CAF Medical Service organization and tactics. It would also be appropriate to extend the curriculum of the Senior Officer Course and the General Staff Course through further lectures, focused on the above mentioned subject, including the opportunities to use the Military Medical Service in foreign operations [8]. The aim of this recommendation for military management students, commanders and chiefs of military branches and services in the command and control functions, is to describe the Military Medical Service, its organization and tactics, and also the place and mission of the medical director at a given level within the staff structure. For commanders, battalion and brigade staff personnel, who already have completed the mentioned courses even though without these topics, it would be advisable to arrange a several day course for these professionals to complete missing issues. This would achieve better entwinement and mutual understanding by both sides, as well as deeper awareness of Military Medical Service real capabilities, especially in foreign operations.

In the training system of future medical professionals and nursing personnel, a focus should be put on actual requirements of medical support to the troops with regard to knowledge and practical skills in urgent medicine. Curriculum should emphasize more, not only military aspects of medicine contributing to a much higher usability of medical personnel in field conditions, but also an ability to organize and manage the military medical service in terms of conducting various types of operations. Urgent medicine is an integral and the most important part of medical care provision in terms of asymmetric operations. The aim of this recommendation is to create a sufficient "reservoir" of medical officers and paramedical staff, which will be able to perform the medical support relating tasks in combat conditions, if required by the operation.

Another aim is to continue creating a training system of CLS certified soldiers, as their secondary specialty. The need for them, in terms of foreign operations, is constantly growing. This statement is supported by NATO documents, emphasizing the importance of the CLS training (see the MC 326/3 draft, stating the requirement for trained non-

medical personnel to provide first aid within the first 10 minutes)[5]. The reason is firstly their organic affiliation with the unit and their primary specialty, which allows them to be a part of an already rehearsed and synchronized team. Secondly, it is their secondary specialty, and therefore the ability to provide essential first aid to all unit members. Indeed, the mere completing of such a course is not sufficient for their practical training. It is necessary to create a system of continuous practice, so that these soldiers will be able to provide adequate medical care in the field under fire and under stress. Currently, an unofficial opinion on inclusion of one CLS soldier per squad is promoted. The goal of upcoming period is to increase this number up to two. As for military use of CLS soldiers, it is necessary to analyze a legislative support, because here the theory and practice, especially in capability of providing medical care, diverges. It seems necessary to synchronize legislation with the requirements of practice in terms of foreign operations. The aim of this recommendation is to create an optimal and functional training system for soldiers with CLS as their secondary specialty, so that each potentially deployable unit of squad level has two members, CLS course graduates, who are practically able to provide First Aid care in field conditions under fire and stress.

Based on the ongoing changes, it is appropriate to propose and implement contently and timely either new or revised pre-deployment medical units training curriculum. It should be based on the following assumptions:

- a) Preparation is aimed at the training of Military Medical Service individuals who are part of combat or support units, medical teams or ROLE-1 / ROLE-2 MTF. The preparation is based on specialists and units training curricula [7,8], addressing only specifics.
- b) In case of preparing teams, correct personnel policy is necessary. Medical officers to be sent out should have finished specialized training first. Those with unfinished specialized training should be assigned only under the condition, that an expert supervision is assured. If possible, well-coordinated teams (e.g. medical officer, non-medical personnel, driver; ROLE-1 organizational structure, field surgical team) should be deployed, which have already been cooperating in peace conditions in the Czech Republic.

Individuals within the team must meet given requirements at the time of their inclusion onto a systemized position of the unit (contingent) organizational structure, which is to be deployed. It is not advisable to rely on the fact that the teams formed up during the time of preparation prior to deployment would become tightened up and rehearsed, or that the missing individual skills would be obtained by attending appropriate course just prior to rotation. Such personnel policy is undoubtedly incorrect.

- c) The content of the preparation should be unequivocally focused on specific aspects of foreign operations which the units are trained for [10]. As far as the medical staff is concerned, during the preparation, an emphasis should be put on urgent medicine and refining activities within the higher unit (team) in continuity of ability to cooperate with coalition forces medical personnel, understanding the system of medical evacuation within the area of deployment and a proper use of a 9-line MEDEVAC request procedure. It is appropriate that the Military Medical Service staff (medical units and teams) participate in combined arms training and conduct preparation together with the combat unit which they are a part of under a common tactical scenario in real time. Medical support of this activity should be performed by a medical team coming from a peace organizational structure. An integral part of medical staff preparation is the combined arms preparation, covering issues such as ballistic protection or weapons handling procedures.

For full use of the medical director within the unit composition, it is necessary to know his/her role, place and mission in terms of medical support planning and an implementation process. It is important for the ACR personnel to familiarize themselves with the Military Medical Service organization and tactics already within the system of high school and university education, which would be followed by particular career courses. The medical director should be considered as a full member of staff, as well as a commander's adviser in the field of medical support. It is obvious that such cooperation can only work under the condition that mutual professional respect is given. This may be achieved only if there is an educational system

established, which would allow combined arms commanders to study with focus on military medical service, its organization and tactics, as well as medical directors to be acquainted with the command and control issues. The purpose of this recommendation is to create such form of cooperation, so that in conditions of foreign operations, the medical director becomes a real commander's advisor. Again, it appears that the educational system has its unique place here, but requires efficient utilization. Everything must be subjected to possible future deployment, as the most complex part of military professional lives.

2. Organization of medical support

Organization of medical support to the company task force operating at farther distances from the main forces may be achieved in three ways:

- a) Each team includes 2 CLS certified soldiers, with necessary medical equipment for providing First Aid and stabilization. In continuity of CLS, platoon medics and a company medic (paramedic – Health Science Bachelorship (Bc.), Diploma specialist (Dis.)) operate with the ability to provide extended health care, triage and preparation for transportation to a higher level of MTF. Aeromedical evacuation to ROLE-1 / ROLE-2 treatment facilities is crucial for this system in order for it to work. This system appears to be optimal in the situation of increased combat activities of the task force, operating over a large area, and unable to establish ROLE-1 MTF within the unit so that compliance with time limits is ensured; further professional medical care will be provided afterwards on a base.
- b) Each team includes 2 CLS certified soldiers with necessary medical equipment for providing First Aid and stabilization. In continuity of CLS, platoon medics and medical team with the ROLE-1 capabilities provide life and limb saving surgeries directly within the company task force composition. Also, this system is dependent on aeromedical evacuation and seems to be suitable for non-combat operations where the expected risk of losing medical team is low.
- c) Each team includes 2 CLS certified soldiers with necessary medical equipment for

providing First Aid and stabilization. In continuity of CLS, platoon medics and a company medic (paramedic – Bc., Dis.) operate with the ability to provide extended health care, triage and preparation for transportation to a higher level of MTF. Unlike the first variant, the medical team is in standby status on the base, activated upon request and transported via air directly to the assigned company task force to provide medical care. As the previous variants mentioned above, this variant relies on a massive aeromedical evacuation system, too. It appears to be optimal in a situation where at least two company task force groups are deployed over a long distance, and it is not clear in advance what requirements for medical support from which group will arise. An important factor here is the optimization of medical support without knowledge of future developments.

CONCLUSION

Requirements for effective medical support in contemporary asymmetric operations come out from alterations in tactics of small tactical units and task force groups in foreign operations. It is obvious that the possibility of using ACR Medical Service manpower and resources in asymmetric operations is influenced by many factors, from the system of training and education of military professionals regardless of their specialty, through the adequate pre-deployment training of the Military Medical Service personnel, up to creating modular medical support for a specific operation. Each of these factors has a unique place within the system. However, its progressive development will not be possible without gradual implementation of the findings mentioned above.

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