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Operational Lessons Learnt – Fact or Fiction[2]

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Operational art is the skilful employment of military forces to attain strategic goals.

Introduction

Between the end of the Vietnam War and 1991, Defence Health personnel had little opportunity for overseas deployments. The only chances to practice their skills under operational conditions, at unit and sub-unit level, was on unit exercises and major Joint and Combined activities such as the Diamond Dollar series and the Kangaroo Exercises of the 1980s. Since the early 1990s, however, the number of operational deployments have escalated and as we enter the 21st century some critics would say that there has been an overabundance of operational exposure for some personnel. Such real-time operations have provided the opportunities for Defence Health Services (DHS) personnel to put into practice all their training and to enhance health skill competencies.

Each exercise or operation has mandatory 'lessons learnt' produced. In fact, there is currently a proliferation of databases designed to capture such information. However, over time when these captured pearls of insight have dimmed in our minds, do we in DHS really take any notice of them? Furthermore, once inertia and individual egos take control, do we have a very limited understanding of the thought and effort our colleagues have put into the provision of these writings? Keeping this in mind, I decided to discuss explore these issues as I see, on a daily basis, the results of lessons that are not learnt. I have concentrated throughout this paper on Rwanda and East Timor (EM) as I have first-hand knowledge of these two areas.

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The aim of this paper is to provide comment on procedures observed, potential improvements identified and what, if anything, has been done to implement these improvements.

Lessons Learnt

Some would say the term 'lessons learnt' is a misrepresentation of fact and that 'lessons observed' would be a far more accurate term. When one examines a number of operational post-activity reports there is a certain logic to this comment as the replication of the same issues hardly indicate that a learning process having taken place. Given the many presentations, at a local and international level, on this topic, I will concentrate on the deployment of a fit and healthy force, casualty prevention, the deployment of formed units and jointery, provision of Reserve Medical Specialists, health logistics and 'Lessons Learnt' databases.

Deployment of a Fit and Healthy Force

Today, the Defence health focus is firmly on maximising the numbers of fit personnel for deployment. The focus of health care has shifted from intervention to prevention and there is increasing recognition of the importance of psychological health as a component of health and fitness. Identification of health risk factors and the availability of appropriate care levels contribute to this focus. Such an approach provides commanders and operational planners with the operational health and fitness standards for their troops. Operational orders designate the health fitness standard for deployment. Which is normally medical classification one (no medical restrictions) and dental class one (fully dentally fit and not undergoing any dental treatment); appropriate health countermeasures, and other health specifics for that operation. Waivers for personnel who do not meet these health requirements can only be recommended by the mounting/designated operational authority. This task has usually been allocated

to Colonel Health, Land Command Health Services, as many of the operations are land-based. Navy and Air Force make recommendations for their own Services. Frequently, this task has been allocated to the senior medical officer of the formation who becomes the recommending authority for the waivers to the Commander. So how are troops kept at operational preparedness?

For Army, there is the Army Individual Readiness Notice (AIRN) which indicates that an individual is supposedly ready to deploy, on 30 days notice to move, into an operational area. For Air Force, there is the Operational Readiness Badge (ORB) which means they to are right to be taken off the shelf, dusted off and ready to deploy. Navy will also come online with a Service Readiness Badge (SRB) for individual readiness in January 2001. However, operational reports indicate that individual readiness notices cannot be entirely relied upon. For example, for East Timor, waivers were sought for Japanese Encephalitis Vaccination (JEV). JEV had been introduced as a standard Australian Defence Force ADF) vaccination two months before the ADF deployed into this area. Consequently, some 11,260 personnel on twenty-eight days notice to move were to be vaccinated. The three Services were requested to provide accurate figures so that an effective immunisation program could be instigated. For a variety of reasons this did not occur, reduced vaccination schedules were requested and medical waivers subsequently sought. This begs the question as to why DHSB pre plans and revises vaccination schedules on a frequent basis to ensure that appropriate schedules are provided in a timely manner? Waivers for medical classifications will always be sought for limited skill sets and, as the ADF continues to downsize, this will continue; however, for vaccination schedules, there should be no requirement to seek medical waivers. ADF personnel should be aware of their health pre deployment standards.

There are exceptions. When the ADF deployed into Irian Jaya in 1998, an immunisation waiver was given for JEV under strict guidelines requiring personnel not to deploy to areas under 300 metres. Therefore, it is imperative that educational and advertising programs are used to provide updated and changing health information. This is not an isolated issue as medical classification and vaccination waivers are and will continue to be requested for all deployments.

Another example was the recent impending deployment of ADF personnel into the Solomon Islands just a few months back. The short warning order highlighted the requirement to have health countermeasures ready to go. However, Operational staff 'edited' some aspects of the health countermeasures when including them in the Warning Order and Operational Instruction. Consequently, malaria prophylaxis medication was not included in the preparation of deploying personnel. This was subsequently rectified when health planners identified the omission. Whilst Defence health has a responsibility to recommend health countermeasures, it is a command decision as to whether they should be carried out. It is important that operational planners take note of these recommendations and do not arbitrarily change information provided without rechecking with health planners.

So just what can DHS do to influence operational planners? The Joint Publication 2060 (JP2060). Chapter Six, Paragraph 6.27 states' that failure to identify personnel who do not meet health and fitness standards will have effects ranging from degraded individual performance to mission-critical failures.' Therefore, the aim should be to ensure a fit and healthy force and to develop a system whereby this standard can be maintained to optimise individual health readiness. If DHS progresses along these lines in the long term, there will be a conservation of manpower from reduced injury, illness, disability and premature death. Only by continually promoting health issues at the strategic, operational and command levels, and the ongoing education of these personnel will Defence health develop the profile that is needed to bring about effective change. Health is a major component of operational planning and indeed can, and has been, a major war stopper, such as JEV in the initial stages of EM. JEV requires a 38-day immunisation schedule. Therefore, for the adequate preparation of deploying personnel, this needs to done in a timely and appropriate manner. Commanders at all levels need to be cognisant of such requirements.

Implications for Pre-deployment and Post-deployment

While there is a need for a fit and healthy force before and during deployment, there is a continuing requirement to provide a seamless extension of a pre-deployment mechanism that will optimise individual readiness prior to deployment as well as continuing post-deployment. Currently Defence Health Services Branch DHSB) is developing

a tri-service medical assessment process that will facilitate this. This will include a five-yearly medical with an annual health assessment.

Casualty Prevention

Effective casualty prevention conserves deployed force manpower and enhances combat effectiveness. On the other hand, inadequate casualty prevention degrades individual and unit health and performance, becoming, at times, the leading casualty cause as it has throughout history. For as long as there have been warring factions, mortality and morbidity from disease has often decided the battle before it began. Casualty prevention must focus on minimising the impact of operational, environmental and occupational threats which ADF personnel will be exposed to on operations. ADF overseas deployments are very seldom to countries which one would usually choose as a vacation destination. Therefore, it should be mandatory that environmental/preventative health teams and Health and Safety Management personnel deploy on operations as early as tactical considerations allow.

A comparison between Vietnam and EM indicates the incidence of malaria is higher in the current operation in Timor than it was in South Vietnam thirty years ago. This is in spite of the significant leap in knowledge about the disease. In less than a year there had been 300 cases of malaria amongst Australian troops deployed to EM. This compares most unfavorably with a similar number of malaria cases in Malaya over six years and 933 malaria cases in Vietnam over seven years. In Vietnam, ADF personnel were hand-fed their malaria prophylaxis which was signed off in a roll book. Whilst not to the same extent, the battalion group in EM started to closely supervise compliance with malaria prophylaxis when large numbers of the unit became ill. However, drug prophylaxis alone is not sufficient and effective utilisation of preventative assets is essential. This may be difficult when the security situation is uncertain and in the heat of battle personnel will not, and probably should not, see preventative health as a high priority. It is interesting to note that within the first forty days of the deployment to EM, there were large numbers of Non-Battle Casualties injuries as well as a large number of unauthorised discharges of weapons. This may be due in some measure to fatigue and working conditions; however, as history shows, appropriate training can greatly assist in overcoming these situations.

Deployment of Formed Units and Jointery

One of the principle findings from Rwanda was that formed units or sub-unit manning was the preferred option for any operational deployment. Many will be only too aware of the disruption and angst caused by the formation and deployments of composite units. For example, the first rotation to Rwanda in 1994 was comprised of ninety-three health personnel from twenty-nine different tri-service units around Australia. It took about six weeks for the integration of this group before there was a truly effective working hospital. This is not the best way to do business, particularly with the first group in which is expected to hit the ground running. This integration doesn't necessarily get any better with subsequent rotations.

Jointery is a notion which what DHS should be, and is, aspiring towards. However, to impose jointery from above causes extreme anxiety at many levels. In particula, is the disappointment of those members, integral to their health units, who are not deployed for the sake of jointery. Formed units who have worked together should deploy together. Commodore Dowsett, in his presentation of Hospital Ship GRANTALA in World War One (WWI), made the point that the selection of nursing staff for this deployment was purposely from one hospital department. As early as WW I this observation was made and documented. Team integrity and cohesiveness is still important today. It is disappointing that years later we have not heeded this lesson. There would be no consideration ever given to an infantry battalion being dissected prior to an overseas deployment. As it currently stands, Commanding Officers of the lead Service are required to ask the other Services for the competencies they require to support this joint deployable unit. The consequence of this notion means that some staff will miss out, which does nothing for the morale of the unit nor, I suggest, for longevity of service as many join the ADF is to participate in an overseas deployment. Cohesive, formed units need to deploy and jointery needs to be embraced from the tactical level up. The only way jointery will work well is to grow this notion from the tactical level up.

However, not all is bleak on the horizon. From January 2001, 1 FD Hospital in Sydney, 2 FD Hospital in Brisbane and, as of September 2000, 3 Forward General Hospital in Adelaide will become Health Support Battalions

(HSBs). This is the first step in achieving joint Level Three health units, 115 of the 153 clinical positions will to be designated as 'may be filled by RAN or RAAF.' However, this will go only part way to solving the problem as the joint positions provided in the HSB are limited to non-command positions. Command positions are to remain Army. A truly joint unit should have joint positions within the HQ elements.

There is currently one joint health facility and as of 1 Jul 1997 Duntroon Medical Centre became the Canberra Area Medical Unit - Duntroon (CAMU-D). Currently, the commanding officer position is filled by Air Force, the senior nursing position is filled by Army and Navy, whilst unable to fill the medical officer positions does have some Petty Officer and Leading Seaman positions filled. CAMU-D also takes in HMAS Harman and RAAF Fairbairn. However, outside of this unit jointery is in its infancy. At HMAS Penguin, there is a Medical Officer (MO) from Air Force who is preparing for her surgical training in Sydney. This posting to Penguin provides the opportunity for this MO to undertake increased surgical cases in preparation for such training. In 2001, another Air Force MO is to be posted to 3 Brigade Area Support Battalion (BASB) in Townsville for two years. This is an Army unit.

Reserve Specialist Medical Officers

DHS relies heavily on reserve specialist medical officers for surgical capacity to support both exercises and overseas deployments. If we look at the twelve-month rotations to Rwanda in1994 -1995, some specialists rotated through both rotations. This is the current situation for Bougainville (BGV) and EM with some specialist medical officers rotating several times. Furthermore, for Rwanda, a couple of civilian medical officers were given temporary rank and position in the reserves for the deployment because ADF was unable to fill the medical roster rotations for this operation.

There remain ongoing problems with filling medical rosters for the concurrent operations in BGV and EM and the time has come, particularly for the EM roster, that DHS will need to bite the bullet and actively start to contract specialist medical officers into the area of operations to support the surgical team. As unpalatable as this may be to uniformed personnel, Australia has a contract with the United Nations (UN) to provide a surgical team. Whether such services are provided in or out of uniform is of no consequence to the UN as long as Australia meets their part of contract.

The valuable contribution that Reserve medical specialist and other Reserve health personnel make towards the success of an operation is well recognised within Defence circles. To that end, a number of initiatives have been instigated to compensate in some way for their loss of income and the disruption to their practices and lives. For example, the Defence Personnel Executive (DPE) has initiated the civil practice allowance, which from June 2000 is $1600 per week. There is a minimum of four weeks eligibility and it may be paid up to eight weeks consecutively. This can be repeated as often as required. However, for those members who deploy for less than four weeks, there is no financial assistance. DHSB has challenged this decision with Director General Personnel Policy Employment Conditions (DGPPEC) as recently as June 2000; however, DGPPEC has stated that he will not renegotiate this minimum eligibility period as to deploy personnel for shorter periods is not seen as cost-effective. This lack of willingness of agencies external to health is preventing improvement in conditions of service for this group of personnel.

Other areas being addressed include the accelerated appointment scheme for medical officers to fill operational requirements. Currently, there is agreement between Army and Air Force; however, as Navy has particular induction training requirements for ships, they have not signed up to this scheme. The issue of temporary rank is also being addressed so medical officers would come into the ADF can be given rank commensurate with their professional qualifications, postgraduate experiences, and so on.

With regards to the pre-deployment training requirements for both permanent and part-time medical officers, DHSB has paid for some reserve members to attend the inaugural Definitive Surgical Trauma Course (DSTC) conducted at the Royal Melbourne Hospital in August this year. It is proposed to conduct these courses on a yearly basis with the focus being on military trauma surgery.

Health Logistics

Again lessons from Rwanda include the requirement that health logistic support to a mission should be a fully integrated logistic responsibility, and should be manned, equipped and controlled accordingly. Further, planning must include consultation with specialist areas to ensure all operationally necessary health materiel is provided. When 'spare capacity' is being used, consumable items must be allocated to this activity. In fact, since Oct 1999, AusAID has continued to pay to Defence Health $30,000 per month for the use of humanitarian stores in BGV. Furthermore, there is a requirement to have an experienced health logistician, ideally a pharmacist, in the planning HQs. In the early days of EM, the battalion group deployed without its logistic component. As the force continued to grow, it became very obvious that the deployment of second-line Class 8 stores to the force were in disarray. The Logistic Support Force (LSF) at Randwick, Sydney, supplemented its HQs with a health logistics officer who subsequently deployed to EM as part of the newly formed Force Logistics Support Group (FLSG). All didn't go to plan after arrival in country. This officer became dual-hatted as the operations officer and health materiel officer working out of the Forward Surgical Troop in Dili. He did, however, put in place a workable plan for distribution and subsequently, a pharmacist was deployed from 9 Force Support Battalion (FSB) to take over the logistics function.

For any operation there is a requirement to have in place a medical logistician and this position needs to be actively bid for. When planning for this key position, there is a requirement to understand the mission. In Rwanda, a health logistician was posted to the HQs in Kigali, his task being to act as a quality controller as Class 8s provided through the UN logistic supply chain were variable to say the least. EM, on the other hand, was focused on the timely distribution of the product as this was a war zone. In the 'early days of EM, Class 8 contributed to less than 100% the stores required; however, for Rwanda Class 8 was the bulk of the stores required. For the above reasons, Class 8 stores should never be deployed without a medical logistician.

Health Lessons Database

I mentioned at the beginning of this paper that there were a growing number of databases to capture lessons provided. Two key ADF 'Lessons Learnt' databases have been identified that provide useful information for ADF personnel and operational planners. They facilitate the management of "lessons learnt" reports and provide a compendium of useful reports from functional elements of the ADF. They include the ADF Warfare (ADFWC) managed, ADF Activity Analysis Database (ADFAADS) and the Army Combat Arms Training Centre (CATC) managed, Centre for Army Lessons Database (CAL).

ADFAADS receives input from predominantly NORCOM, DJFHQ, HQAC, LHQ, HQAST and ADHQ. It was developed following a 1998 COMAST directive. It is the official ADF Post Activity Reporting System and is the official repository of lessons learnt out of EM. Issues submitted to ADFAADS are prepared by units and staffed through the normal chain of command. The reports are reviewed to confirm their validity and the forwarded to a Functional Area Action Officer at the appropriate HQ or the departmental head for staffing. For example, I am the Action Officer for DHSB and I am authorised to receive and staff strategic health reports. Such actions can be viewed on the ADFAADS database at any stage of the staffing process. Unfortunately, ADFAADS is constrained in that it has limited access and is not generally accessible to health personnel.

The CAL database was formed to record experiences during OP Warden/OP Stabilise in EM. Subject Matter Advisors (SMA) except for health, were deployed to EM to collect data for lesson development across the full range of Army Tactical Tasks and across all elements of capability Personnel, Support, Training, Equipment and Doctrine (POSTED). CAL is accessible through the Army Web Site or on DEFWEB. There is now a selection of health lessons from Timor available on CAL.

There are also several overseas military lessons learnt websites, which allow global access to their information. These include the Centre for Army Lessons Learned, US Army Medical Department Centre and School, and the Canadian Army Lessons Learned Centre. The UN also has a lessons learned database, sectioned into different UN operations including Somalia, Rwanda and Slavonia.

Currently, DHSB does not have a lessons learnt database; JP 2060 - Deployable Medical Capability has the development of a functional specification for a DHS knowledge network as one of its objectives. This will not commence until FYs 04/05- 06/07. DHSB is looking at the establishment of a lessons database with Directorate of Health Capability Branch acting as a repository of health information. Perhaps when there is a single health database available to health personnel of the various lessons observed from operations, more effective planning with better outcomes will be facilitated.

Conclusion

The operational deployments of the 1990s have provided DHS with a wealth of knowledge as to how it should do its business. So how far have we come in the application of these operational lessons learnt? Are they fact or fiction? The cynic would say that in many cases DHS, payslip service to these lessons as repeatedly the same issues arise. However, there are changes taking place, albeit slowly. My aim in this paper is to provide comment on procedures observed, potential improvements identified, and what, if anything, has been done to implement these improvements. DHS has identified significant issues and is endeavouring to address these. However, it is up to each of us who work within the uniformed health service to observe, monitor and comment on how DHS can promote and improve our input into how the ADF meets its commitments. Having a central repository of health lessons available to health areas will help in some way. At the end of the day, we are the folks who have to put up with the uncertainty, threat and imposition if the conditions are not right so use your voice to bring about the changes you believe will enhance the system we have to work in.