

Medical support for British peacekeeping operations in Kosovo

Captain Michael C Reade, MB BS(Hons), BSc(Med)(Hons), DIMCRCSEd, DMCC, RAAMC

FOR SIX WEEKS in December 2001 and January 2002 I was attached as a general duties medical officer to A (29) Squadron 1 Close Support Medical Regiment during its operational deployment to the NATO Kosovo peacekeeping force (KFOR) in Pristina, Kosovo. During my deployment I acted as one of two (or at times three) medical officers at the UK level 2 medical facility in Pristina. This entailed conducting daily primary care clinics along the lines of a civilian general practice (and also acting as a referral resource for the UK battalion regimental medical officers), manning the immediate response trauma helicopter, acting as the primary medical officer for numerous brigade mass casualty exercises, and training combat medical technicians in both primary care and trauma management.

The British contribution to KFOR: Operation Agricola VII

Historical background

It is impossible to summarise adequately the history of the Kosovo conflict in only a few lines. While continuously recognised as the religious and cultural focus of Serbia, since the 15th century the population of Kosovo has, for complex reasons, become increasingly Albanian. In 1981, 77% of the population was identified as Albanian Muslim.¹

Accounts differ as to the degree of harmony which existed between the two communities before 1989, when, harnessing nationalist sentiment as a means of increasing personal power, Slobodan Milosovic revoked the province's autonomous status. The lives of Kosovar Albanians changed overnight: most of those employed by the State (which was the majority in an emerging communist society) lost their jobs; their children were excluded from schools; and they were denied access to healthcare and other government services.²

The passive resistance of the Kosovar Albanians to this internationally recognised injustice gradually turned to violence, which resulted in even more violent repression on the part of the Serbs. NATO and UN attempts to resolve this situation peacefully met with little success, and eventually

Abstract

- ◆ The British Army has contributed to NATO peacekeeping missions in the Balkans since 1995. The medical support provided for soldiers deployed in countries with relatively primitive infrastructure in what has become a low-threat environment has evolved into a completely new form distinct from that required in a barracks or a war-fighting environment. Recognising that peacekeeping deployments are likely to continue as a common task of armies of the developed world, this article explores the current British approach to the medical support of troops in operations other than war by critically examining the medical infrastructure present in Kosovo in 2002.

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hundreds of thousands of Albanians were forced by the Serbs to flee — to rural areas, to neighbouring countries, or even as far as Australia.

In 1999 NATO commenced a bombing campaign against Serbia and Serb military facilities in Kosovo. This was successful in forcing the Serbs to withdraw, and allowing over 1 300 000 refugees to return.³ Since the Serb military withdrawal in June 1999 Kosovo, while remaining a part of Serbia, has been governed by the United Nations Interim Administration Mission in Kosovo (UNMIK), supported by the NATO-led KFOR peacekeeping force.

The expressed aim of UNMIK is to establish a peaceful multi-ethnic democratic society in Kosovo. This would appear a most difficult task. The Albanian population blame their continuing poverty on the remaining Serbs. Kosovar politics is



Kosovo crows, which filled the sky at dawn and dusk. 'Kosovo' derives from the Serbo-Croat word for crow.

Nuffield Department of Anaesthetics, Oxford University, Oxford, United Kingdom.

Captain Michael C Reade, MB BS(Hons), BSc(Med)(Hons), DIMCRCSEd, DMCC, RAAMC, Medical Officer, 144 Parachute Medical Squadron, Royal Army Medical Corps (Volunteers), 1999-2002, and Clinical Research Fellow in Intensive Care Medicine, University of Oxford. Correspondence: Dr Michael C Reade, Nuffield Department of Anaesthetics, University of Oxford, Radcliffe Infirmary, Oxford, OX2 6HE, United Kingdom. michael.ream@brasenose.oxford.ac.uk

strongly dominated by ethnicity and, within the Kosovar Albanian community, by the degree of willingness to again resort to violence to achieve full independence from Serbia.

Kosovo is a highly urbanised society, with almost half its population living in the capital Pristina. Little industry remains as economic support for these people. However, as was the case during the 1990s, there is a considerable degree of relative wealth in Pristina, resulting from money sent home from expatriate Kosovars working in the USA and Europe. This, combined with a flourishing black market and few checks on organised crime, has led to a surprising display of visible wealth (for example, luxury European cars and satellite dishes) in the city. In contrast, those living in rural areas continue a very impoverished existence, worsened by the losses of property and people during the last months of Serbian control.



Serb Orthodox church near Pristina. Much of KFOR's manpower is occupied in preventing destruction of such sites by Albanians. The Serbs are largely too frightened to use these facilities.

Current situation

British and other NATO forces first entered Kosovo on 12 June 1999. A system of multinational brigades was soon established, with Britain as the lead nation in Multinational Brigade (Centre) (MNB (C)), encompassing Pristina and Podujevo. The British now have two battalion battle groups deployed, with battle groups from Finland, Norway and Sweden and a small element from the Czech Republic completing the brigade. The remainder of KFOR consists of MNB (N), led by the French in Mitrovica; MNB (S), led by Germany from Prizren; MNB (E), headed by the USA in the enormous Camp Bondsteel in Urosevac; and MNB (W), under Italian command in Pec. In all, 19 NATO nations and 18 non-NATO countries contribute formed units to KFOR. Individuals from other countries are occasionally attached to units of these troop-contributing nations, as has been the case for Australians attached to British units since 1999. Each



Kosovo and the Balkan region.

brigade is essentially a self-contained task force, with a mixture of motorised and mechanised infantry, armour and helicopter assets.

The mission of KFOR is "to establish and maintain a secure environment and to promote peace and stability in Kosovo". To this end, the battle groups act as a de facto police force, ostensibly in conjunction with the UNMIK civilian police, although, in practice, UNMIK does not have sufficient resources, leaving many police duties to be conducted by soldiers acting essentially independently.³ Specific attention is



Serb Army barracks destroyed by precision NATO bombing, central Pristina.



High-rise apartment blocks typical of communist-era design, central Pristina. Satellite television dishes are a common functional ornament.



Puma casevac helicopter of the Royal Air Force landing on a soccer field in central Pristina.

paid to disarming the civilian population, including random vehicle and building searches; clearance of unexploded ordnance; border monitoring; and close physical protection of minority communities and landmarks. This essentially amounts to protection of Serb civilians, their property, and the remaining Serb Orthodox churches from the very real threat of reprisals from Albanian civilians.

While UNMIK has primary responsibility for humanitarian assistance, KFOR undertakes a limited amount of this work itself. In the British sector this involved providing an ambulance service for the Serb community to the few remaining Serb health facilities in Kosovo, or to Serbia proper. There was also some engineering infrastructure work. There was no access for civilians to British military healthcare. This contrasted with the situation in Bosnia,⁴ and also to the US approach in Multinational Brigade (South), where there was an active medical and dental civilian aid program.

Australian involvement in Kosovo

Australian soldiers attached to British units as part of Exercise "Long Look" have deployed to Kosovo since the formation of KFOR in 1999. The number of Australians deployed at any one time varies from one to four. In spite of such a small presence, the Australian flag appears in many of the multinational posters and crests displayed around Kosovo, and I was surprised to find my Australian camouflage uniform recognised by a number of civilians.

Medical support to British Forces in Kosovo

General description

British medical support in Kosovo was, in theory, organised along traditional military lines. Each battalion battle group had a regimental medical officer (RMO). One of these RMOs was a junior medical officer; however, the other was a fully qualified general practitioner. Two general practitioners

staffed a level 2 facility, the Medical Reception Station (MRS), in Pristina. The MRS acted principally as a primary care facility for the support troops, multinational police, and civilian contractors in Pristina: a patient population of about 5000. Advice was also provided on more complex primary care cases referred from the battalion RMOs. Level 3 support (including two operating theatres, a CT scanner, specialist anaesthetists, physicians, a radiologist, general and orthopaedic surgeons) was provided by the Bilateral Integrated Medical Facility at the US Army Camp Bondsteel, a 40-minute drive from Pristina.

Military medical support in Kosovo

Redefinition of level 2 health care in operations other than war

The MRS in Pristina was manned by the Close Support Medical Squadron of the Brigade Combat Service Support Battalion (the equivalent of the Australian Brigade Administrative Support Battalion Medical Company), and, as such, was ostensibly a level 2 facility — inheriting the role of the Field Ambulance. However, in response to the reality of the medical support needed during prolonged peacekeeping operations, the MRS in Kosovo essentially operated as a civilian-style general practice. There was no attempt to provide a surgical facility in terms of manning or equipment, and the two "resuscitation bays" contained only the most basic of cardiac and respiratory support equipment, such as would be found in an Australian civilian general practice.

Traditionally, a level 2 health facility has a mobile light surgical capability focused on the stabilisation of serious trauma cases *en route* to specialist surgery at level 3. The need for level 2 in this form was identified during the First World War, when casualty evacuation was by stretcherbearer or slow vehicles. In contrast, the employment of general practitioners and general duties medical officers instead of surgeons and anaesthetists in a modern level 2 facility fits well with the current concept of rapid evacuation of serious trauma cases (by air if possible) directly to definitive appropriate surgical

care. This concept also works well in civilian hospitals in rural Australia. British doctrine still allows for a surgical capability at level 2, but only if required for the specific mission.

However, the theatre medical plan must recognise that the staff of such a level 2 facility no longer have advanced trauma care skills. While the employment of specialist general practitioners in our level 2 facility was very successful, these same doctors were also expected to form the medical component of the helicopter immediate response team. A moderately experienced paramedic (such as those staffing the US evacuation helicopters) would have been potentially more useful, although the ideal would be a specialist anaesthetist or emergency physician and paramedic, such as is the case in the multinational immediate response team in Bosnia. In Bosnia, the immediate response team is based at the level 3 hospital, and hence the anaesthetist has gainful employment during the time not spent on the helicopter.

Organisation of mass casualty incidents

Much of the training time in Kosovo was spent preparing for a mass casualty incident. These exercises were invaluable in developing a co-ordinated international plan — while simultaneously fostering envy of the equipment deployed by other NATO countries. The British Army has developed an extensive mass casualty doctrine, modelled on the incident plans used by the UK civilian National Health Service. While, in practice, there were some difficulties in the military implementation of the civilian design — specifically, the inexperience of the army medics compared with civilian paramedics — at least there was a plan which everyone understood. The lack of such planning was evident in some of the other nations' approaches to their exercises.

Training in prehospital emergency care

The British Army encourages its medical officers to take formal diplomas in immediate care medicine and the “medical care of catastrophes”, both of which focus on the clinical and organisational aspects of the delivery of prehospital care in an operational environment. This not only improves the general level of knowledge, but ensures everyone has a similar approach to such situations. I personally found that, having undertaken this training, I was better equipped to integrate into the British and NATO medical system. These diplomas are not restricted to British military personnel: information is available from the Royal College of Surgeons of Edinburgh (www.rcsed.ac.uk) and the Society of Apothecaries of London (www.apothecaries.org.uk).

Usefulness of full time physiotherapy support

The busiest person in the medical reception station was the physiotherapist. With many of the deployed soldiers spending their excessive spare time in the gym, training injuries were common. Additionally, many personnel were deployed with chronic conditions requiring ongoing care. In terms of “maintaining the fitness of the fighting force” the physiotherapist was our most valuable asset, running both an acute care



After a brigade mass casualty exercise involving Finland, the United States, Britain ... and Australia.

clinic and gym rehabilitation sessions in conjunction with physical training staff.

Employment of professional reserve officers

The full-time component of specialist medical officers in the British Army is very understaffed: less than 25% of anaesthetic positions, 40% of general medical positions, and 50% of surgical positions are currently filled.⁵ This is largely attributed to the closure of service hospitals and the employment of service medical officers within the civilian National Health Service on less favourable conditions of employment than their civilian counterparts. There has been increasing reliance on part-time Territorial Army (TA) specialist medical and allied health personnel. While, to some extent, TA volunteers in non-medical roles were viewed with mistrust and resentment, TA health service officers were, in my experience, respected and very well received, even though many undertook much shorter deployments than their regular counterparts.

Computerised medical records

All medical records (with the exception of radiology and specialist reports) were made in the Egton Medical Information System (EMIS) computerised medical records system, a military variant of the most commonly used British civilian general practice software. All prescriptions were written using this system, which allowed computerised pharmacy stock control.

It was the British experience in the Gulf War that paper medical records held by medical units on soldiers not serving with that unit were very often misplaced, leading to many medicolegal difficulties when compensation was claimed for injuries and “Gulf War syndrome”. The first approach to solving this problem was to issue each soldier on an operational deployment with their own pocket-sized medical record card, which was to be integrated into their permanent medical record on return from operations. My experience in Bosnia was that soldiers were often not carrying these cards

when they presented to a medical facility, or that the card was lost.

Computerised archives, still in the early phase of implementation on operations, appear to be the most successful solution to this problem. Records on disk are sent to a soldier's unit on his return home (using the "transfer patient to another practice" feature of the civilian software), and are also held in a central computer archive, greatly minimising the chance of loss. It took only a short time to become accustomed to entering medical notes on a computer, and this soon became just as quick and accurate as a handwritten record. There is the added advantage that summary statistics for the practice (or, indeed, the whole operational deployment) are quickly and accurately analysed, allowing much more efficient identification of epidemiological trends.

Separation of command and medical seniority in a squadron

The medical squadron was commanded by a British medical service officer rather than a doctor. There was consensus among the medical and allied health officers that this was a dysfunctional situation. The administrative staff felt it inappropriate for doctors to take operational or personnel initiatives. Nonetheless, they had little knowledge of the running of the MRS, and indeed rarely entered the building. In spite of this they acted as personnel managers of the combat medical technicians. This separation of command and medical functions mirrors much of British Army garrison healthcare: doctors work in medical centres, while medical squadrons train independently for their field role. This may be the most efficient system at home but it seemed not to be so on operations.

High psychological morbidity and mortality

During the six weeks of my deployment I personally dealt with one completed suicide, two parasuicides and two cases of alcohol intoxication requiring hospitalisation (on a psychiatric background). The community psychiatric nurse saw on average one new patient per day, for problems ranging from chronic alcohol abuse, depression, failure to cope adequately with interpersonal relationship difficulties, as well as deliberate self-harm and parasuicide. It is possible that many of the problems we saw might have remained undetected but for the prolonged and repeated separations from family support experienced by many British soldiers on operational deployments. We also hypothesised that, as the peacekeeping operation became more prolonged, more psychologically unfit soldiers were being deployed to make up numbers.

Poor general health of soldiers

Many of the soldiers deployed were either medically or dentally unfit. Our two dentists worked continuously every day performing routine dental examinations of soldiers, finding that many required some form of intervention to render them "fit" to army standards. Not surprisingly, this



Examining a Kosovar Albanian child with an upper respiratory tract infection in a makeshift clinic established in a rural school.

generally poor dental health was reflected in a high rate of emergency presentations. Similarly, many patients presented with chronic musculoskeletal conditions (mainly of the back and knees), for which some had been permanently downgraded — to the point of exemption from all physical training — before deployment. Some presented with conditions which must have been present at the time of enlistment. It is difficult to understand how (for example) a soldier with a history of femoral fracture and a residual 15-degree valgus deformity of the knee (who, not surprisingly, presented with knee pain) was allowed to enlist if he had been properly examined during his medical assessment on entry.

Training level of medics

With notable exceptions, the general level of training of the medics manning the MRS was poor. Much of the difficulty was that they had had practically no experience of treating real casualties. Australian Army Reserve medics with whom I have worked in regimental aid posts were similarly inexperienced, but were significantly more capable. In my experience battalion RAP medics are generally more skilled than those in medical units (in both the UK and Australia). This may reflect the more personal attention a Regimental Medical Officer is able to give to their training. Perhaps all junior medics should be posted to a battalion soon after their initial employment training.

Humanitarian assistance

While most of my time was spent in the general practice clinic, there was also the opportunity to conduct primary care clinics for Kosovar Albanian civilians in the remote mountain villages of southern Kosovo. These clinics, arranged through the US Army civilian aid program, would often attempt to treat over 100 patients in less than four hours. Many of the patients had no other access to medical care. The pressure of time, as well as available resources, limited the certainty of

diagnosis, and if the condition required a medication not included in our mobile formulary there was very little we could do. There was no ability to refer for diagnostic or surgical care. The patients seemed to accept this, and appeared most grateful for even the simplest help, such as a supply of vitamin pills. There were patients who probably benefited as much from the opportunity to tell an outsider how they had suffered in the war as from the painkillers we prescribed for their lingering injuries. The "home visits" to patients also provided a unique insight into the extreme poverty of the rural people.

Benefits of such a deployment

The benefits to Australia from even such a brief deployment are many. Australian policy regarding the treatment of illegal migrants had been vigorously criticised by virtually all European press agencies in the months preceding my deployment, albeit from a largely ill-informed point of view. In such a context, to have Australian soldiers assisting Europe tackle the fundamental causes of its own asylum-seeker problem was a powerful, if small, positive image to project.

The development of informal personal contacts within foreign military organisations can only be of benefit to the Australian Army. This is perhaps especially true of medicine, where in civilian practice there is an expectation that at least part of the period of postgraduate training will be conducted overseas. In my two deployments with the British to the Balkans, I have now worked with Canadian, Dutch, American, Swedish, Norwegian and Czech doctors, as well as soldiers and officers from many other nations.

The experience I have gained in the Balkans would be difficult to obtain elsewhere. The integration of medical assets from so many countries on such a scale is essentially only seen in large scale, non-governmental aid agency disaster relief and in military peacekeeping missions. The problems of different training, protocols, and responsibilities are all in the process of being solved, and the Australian military will no doubt learn from this experience.

Administrative points

While a six-week deployment would be too short to be of value in most command positions, it is perhaps the ideal length of time for a clinical medical officer. As a period of work overseas is almost an expected part of the training of most Australian specialist doctors, it is a pity no formal military medical exchange scheme exists. From the British point of view my relatively brief attachment as a medical officer to the British Army was extremely easy to organise.

In view of this, I was surprised by the difficulty in gaining official Australian approval for my attachment. There appeared to be considerable confusion over whose role it was to grant permission, and a lack of appreciation of the benefits

to all parties. In particular, there was a feeling that this was not an appropriate activity for a reserve, as opposed to a regular, medical officer. Throughout this process the defence staff at the Australian High Commission in London were extremely helpful. I would strongly suggest that reserve officers undertaking operational deployments with British units in future be directly administered by the High Commission in London, as is the case for regular officers.

Conclusion

The provision of medical support during prolonged peace-keeping operations is a new challenge for the military medical services of many developed countries. These new operations are characterised by a shift away from trauma-based care (while retaining a surgical and critical care capacity), an increasing role for specialist general practitioners, improved capacity to treat chronic physical and psychological disease, better record keeping, and an increased reliance on (and willingness to deploy) reserve health service personnel. The current trend towards multinational operations should be seen as a golden opportunity for the Australian Defence Force to learn many of these lessons, while at the same time providing interesting work for its medical officers and achieving a positive outcome for the countries assisted.

I thoroughly enjoyed my deployment to Kosovo. I am grateful to the officers and soldiers of A (29) Squadron 1CSMR for their warm welcome over Christmas, and would highly recommend such an attachment to other Australian defence medical officers.

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