

# Medical support to civilian populations on deployed military operations: the UK approach

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THE CHANGING PATTERN of military operations in the past 5 years, and their increasingly discretionary nature have again focused attention in military medical communities on the requirement for, and concomitant difficulties of, providing medical care to civilian populations in places where civil infrastructure has broken down or is non-existent. The resource and capability constraints of providing such care are generating new challenges for medical planners and clinicians. This article describes how those challenges are being tackled in the United Kingdom Defence Medical Services (DMS).

In the UK, provision of medical aid to a civilian population is a specified military task that would normally be delivered in one of the two distinct circumstances described in British Defence Doctrine. The first occurs in a permissive environment where humanitarian aid is the primary task of the military, known as a *humanitarian/disaster relief operation* (HDRO). The second, *humanitarian assistance* (HA), is defined as aid delivered to the civilian population when it is not the primary mission of the military commander; the force is deployed primarily for the purpose of military operations, and the military will hand over full responsibility for humanitarian tasks to civilian agencies at the earliest opportunity.<sup>1</sup>

Current UK military medical doctrine for care of military personnel is based on delivering only essential treatment in the theatre of operations (to minimise the medical footprint) followed by evacuation to Role 4 facilities in the UK (provided by the National Health Service) as soon as practically and clinically possible. Theatre-holding policy is typically 48–72 hours for surgical cases. Therefore, treatment of civilian casualties may consume scarce resources, block access to high dependency beds, and pose wider ethical dilemmas when further specialist treatment is required, but is not available from the deployed medical resources. When treating a civilian

## Abstract

- ◆ Provision of medical care to civilian populations by military medical units is subject to various resource and capability constraints.
- ◆ Compared with a military population, civilian populations include both elderly and paediatric patients, and more women. Military health professionals in the United Kingdom are not specifically trained in the relevant specialties for treating these patient groups.
- ◆ There are also problems with supply of appropriate equipment and pharmaceuticals. Military matériel “modules” are designed to provide resources for treating battle casualties and conditions likely to occur in a military population. They have not been designed for treating the full range of a civilian population.
- ◆ Current UK military medical doctrine for care of military personnel is based on delivering essential treatment in the theatre of operations, followed by evacuation to Role 4 facilities in the UK.
- ◆ Any civilian patient receiving care in a military Role 3 facility will be handed over to the host nation or humanitarian medical agencies at the earliest opportunity.
- ◆ At Role 1 and 2 facilities, emergency lifesaving interventions may be undertaken, but whenever possible, patients will be delivered to local facilities (even if these do not meet UK standards of care).

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population, the medical effort may be substantially greater (both quantitatively and qualitatively) and may require different skills and capabilities than required to support a military population. The doctrine to support and describe operations in these circumstances is still being developed.

A further problem is now being experienced during operations other than war, where medical facilities may have to provide support to a range of other personnel — such as civilian contractors, soldiers and paramilitary forces from supported nations, and detainees — who are the responsibility of operational commanders, but who may not be evacuated to Role 4 facilities. In each circumstance, there will be a demand for clinical capabilities not required when treating a purely military population: principally, additional internal medicine capability to deal with an older population, and paediatric and obstetric specialties to deal with a younger and predominantly female population.

A number of assumptions that underpin the UK position have evolved pragmatically rather than by design. They



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*The Commanding Officer of 4 General Support Regiment, Royal Army Medical Corps, provides medical attention for the father of a young Iraqi child, as British troops of 187 Squadron, 23 Pioneer Regiment, hand out food and fresh water to the local population in a village just south of Basra.*

recognise that a small deployed military medical service will never be able to meet the full medical needs of a civilian population, who may have genuine need but no alternative route to care; and that the DMS may be required to provide medical care to non-combatants to support the force commander in the mission, and to facilitate both force protection and early disengagement by positively influencing the local community's perception of the military. Provision of medical care may also be required in accordance with international humanitarian law, when UK forces make up the whole or part of an intervening force, and neutral humanitarian aid organisations are unable or reluctant to operate. Care will normally be delivered in partnership with local medical infrastructure and non-government organisations (NGOs), through a mechanism of needs assessment, and identification of capability and resource gaps, in a way that will lead to restoration of self-sufficiency. Any civilian patient receiving care in a military Role 3 facility will be handed over to the host nation or humanitarian medical agencies at the earliest opportunity. In the context of HDRO, it is acknowledged that Role 3 facilities will have a limited effect on the health of the population, compared with public health interventions. Guidelines from the World Health Organization–Pan American Health Organization articulate the limited value of Role 3 facilities in this circumstance.<sup>2</sup>

These assumptions have not changed recently, but the ability to deliver that level of care has. Following the closure of all military hospitals in the UK, military medical specialists are trained and predominantly employed within the National Health Service. They receive additional training in military specialisations (eg, in surgery of penetrating and high velocity missile wounds), but only where these are relevant to delivery of the military mission. Additional medical competencies required to treat non-combatants (eg, paediatric and obstetric specialisations) are not emphasised in training military medical personnel. These skills may be found within the medical Reserves, but even Reservists must be competent in the generalist requirements of military medicine, and that is becoming more difficult for consultants whose peacetime

practice is highly specialised. General training for military specialists and general practitioners may include paediatric and obstetric modules, but these are not mandatory, so the availability of this expertise may be patchy. Delivery of obstetric services to military personnel and their dependants is no longer a military medical function, so there are no uniformed obstetricians in the DMS.

There are also problems with supply of appropriate medical equipment and pharmaceuticals for dealing with patients who fall outside the military demographic. Medical matériel is supplied in modules designed to provide the resources to manage a number of battle casualties or treat certain conditions likely to occur in the military population. They have not previously been configured to treat patients across the full age spectrum. Emergency treatment modules were revised in 2003 to include items that would be commonly required in paediatric resuscitation and treatment. Obstetric modules are still supplied, although the expertise to use them will only be found in Reserve officers in the future. Recent operational experience has confirmed the requirement for this expertise. In Operation Agricola (Kosovo) in 1999, paediatric cases accounted for 18% of the major trauma seen at Role 3 facilities in the early entry phase (Hodgetts TJ. Major trauma: report on clinical effectiveness during Op AGRICOLA. Unpublished report). In Operation Telic 1 (Iraq) in 2003, there were 82 children treated at Role 3 facilities during the war-fighting phase, with a high proportion of seriously injured children requiring resuscitation. There was one obstetric delivery following trauma in the same period. During HDRO, the



*A Combat Medical Technician of 4 General Support Regiment, Royal Army Medical Corps, at Camp Fox in Kuwait, is pictured with one of the mobile trauma packs.*

vulnerable sections of the population will invariably be women and children (typically 80% of a refugee population).<sup>3</sup>

Although the focus of attention is on Role 3, many non-combatants present at Role 1 and 2 facilities. The problems then are often of force protection, and simple capacity to cope, when resources are configured to support only the deployed force. Except on planned HDRO, such services will be confined to opportune contact with small numbers of people, and support to local facilities, which may include environmental and public health expertise. Emergency lifesaving interventions may be undertaken, but whenever possible, patients will be delivered to local facilities (even though these may not meet UK standards of care), except if injury has been directly caused by the action of UK forces (eg, a motor vehicle accident).

There is often pressure from the military medical fraternity itself to deliver more medical support to the local population, as medical personnel are often underemployed once a mission transitions towards peacekeeping and stability. The danger of mission expansion and creating population dependence is well recognised. The Role 3 Multinational Integrated Medical Unit (R3MIMU) in Bosnia and Herzegovina (a Role 3 facility run by the UK, Canada, the Netherlands and the Czech Republic) had a stated task to provide life- and limb-saving treatment to local civilians aged 12 years and older. In a 3-year study of accident and emergency attendances, there was a fivefold increase (197 patients in 1999 to 1027 patients in 2002).<sup>4</sup> About half (52%) of all patients treated ( $n=1864$ ) were Bosnian, with an age range for all patients of 1–88 years (mean, 36 years). Eighty children younger than 12 years were treated, and 35 of these were aged 6 years or younger. Of 971 Bosnians treated, 648 (67%) were discharged home, implying their condition was not life- or limb-threatening.

The DMS policy does not fully address the concerns of all clinicians. There is a conflicting desire to do as much as clinically possible for civilian patients, while recognising that it is not possible to treat everyone. It is also not possible to provide a full range of specialist capabilities when taking responsibility for treating non-military patients. Balancing capability, demand and resources is the new challenge for medical planners and commanders, and it can only be met by establishing clearly mandated and understood “rules of engagement” for medical practitioners and facilities. These must specify not only who is eligible for initial treatment, but also subsequent care, the circumstances in which it may be given, and how it is to be funded. It poses further ethical challenges when clinicians must be prepared to hand over care of patients to local facilities that are not able to maintain the same clinical standards as military facilities, and may not have the resources to continue treatment. It increases the importance of learning to work with NGOs and other organisations which will invariably have a better understanding of local infrastructure and practice, but may not have the immediate resources or capability to act.

## Competing interests

None identified.

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