
EDITORIALS

Doctrine, Dogma and Debate

There is a traditional approach within peacetime military medical practice that views wider developments in the profession of arms with some scepticism. After all, “the Big Army” has limited relevance to the workload at the clinical work face; we are professionals in our own right answerable only to our own civilian regulating bodies. What can the rest of the Army know about the complexities of clinical practice? Similarly, their business is of no concern to us. After all, what can doctors contribute to discussion on tactics or strategy?

This oft repeated mantra has a superficial attraction not least because it allows many to avoid the effort and trouble required of engagement in the doctrinal debate. However, it is fundamentally flawed since it is based on a misappreciation of the significance of doctrine. This is now the basis of all programming and development work within the Army. Increasingly, it will form the driver for such work throughout the breadth of defence programmes. So what is doctrine? The authoritative publication explains it thus:

“Military doctrine is a formal expression of military knowledge and thought, that the Army accepts as being relevant at a given time, which covers the nature of current and further conflicts, the preparation of the Army for such conflicts and the methods of engaging in them to achieve success.” (1)

This approach is essentially based upon debate and a careful consideration of all the available evidence and thinking. In this it resembles the contemporary debate in the medical profession about the centrality of evidence based practice. It is a search for the most appropriate method of using the military and the pursuit of excellence. The methods by which this is achieved have been refined to match more closely the tried and tested methods of academic life. As such it is a move away from the traditional approach described by Liddell Hart, “It is a military convention that infallibility is the privilege of seniority.”(2) The point of this exercise is to eliminate the tyranny of the orthodox and replace it by an understanding of the nature of conflict. This will lead to the education of all in the best way to approach problems rather than dictate a pre-set answer to tactical, operational and strategic problems.

Fundamentally, the process is intended to bring clarity and simplicity to the complexities of the battlespace and to allow the exercise of educated initiative in a co-ordinated fashion. It is not designed to act as a strait-jacket confining original thought and action.

Doctrine publications have mushroomed over the last five years as the Directorate General Doctrine and Development has matured and warmed to its task. This work has been the product of considerable intellectual and staffing effort. It has necessitated the use of relevant historical study as well as operational analysis. Consequently, it represents the distillation of best efforts from all the important and significant elements in the widest defence community. A component of this process has been the contribution made by medical staffs to the whole as well as the production of specific medical doctrine. The first part of this authorised medical doctrine is due publication in autumn 2000 as an additional volume in the series on logistics. This volume will set the principles of health care support in the battlespace and will form the definitive authority for consideration of medical operations using the foundations evinced in the volume. Its correct use will require operational planners and commanders (not just medical staff but general staff as well) to consider the principles when preparing for deployments and operations. However, the doctrine may be set aside provided there has been a conscious and considered reason for so doing. This is entirely in line with the general usage of doctrine and prevents it becoming a predictable and confining practice; the full exploitation of doctrine is inconsistent with the march of the thought police. It is as well to remember another of Liddell Hart’s insights in this regard.

“In practice the cult of a common mode of thought is apt to mean the suppression of all other modes as heresy, and so the end of free thought. Inevitably in an army, rank acts as a gag. The gag may be loose or tighter according to the disposition of the superior, but it remains in the mouth of the subordinate as a hindrance to the articulation of his ideas.”(3)

Nor is this unique to the military. How many junior medical staff have experienced

the same phenomenon in the course of their professional practice? However, the clear hierarchical nature of military society lends itself more easily to this failing. Yet, it is a development which is profoundly unhelpful and quite counter to the iterative requirement of doctrinal development.

On the other hand there is both a duty and an obligation on behalf of military medical staff to use the doctrine in an appropriate manner. It has not been developed and staffed so that it can be dismissed as either an irrelevance, or worse still, an attempt to control and confine practice. Rather, it requires us all to use it intelligently and carefully in our military practice. It is a philosophy that has relevance to all medical personnel engaged in the military. Its successful usage will ensure co-ordinated, coherent and synergistic action producing the best results for all involved in the ethical and clinical maelstrom of the modern battlespace. It is a requirement of all that they consider and use the doctrine in their practice. There is no place for clinical or professional arrogance that sets an individual above the doctrine. Indeed, such action should be seen for what it is; the absolute reverse of truly professional practice.

Similarly, the further development of doctrine requires the active participation of all. No-one has a monopoly of wisdom and so it is vital that all are engaged in this process. Without participation, there are very few grounds for complaint at the resulting doctrine. The resulting philosophy may well be impoverished because of the limited involvement. In addition, this doctrine is owned by all since it is used by all. It therefore behoves us all to contribute to the debate.

Yet this runs us up against another potential difficulty. The Army Medical Services are the broadest of broad churches. Thus, as far as medical officers are concerned there seem to be two separate philosophical strands. One clings to the view that "War or not, I am a doctor", whilst the

other competing view would say, "Doctor or not, this is war." Such a broad spread of opinion is both healthy and necessary. Nevertheless, it has some drawbacks, one of which is the access to formal higher military training and education which is necessarily restricted to a few. This renders the completing of a military education problematic for most in the Army Medical Services. Such an inevitability is unhelpful to the quality of the debate since it serves to increase the tendency to polarisation which the professional differences have underpinned. Once these circumstances are recognised and the contribution to the debate by all is welcomed, then real progress can be made on the development and refinement of doctrine. As a final thought, it is worth recalling the concept exposed in the Times of 1951:

"Army doctors are members of two professions, and unless they have mastered them both they fail in their duty. They must be soldiers knowing something of the structure of armies and of their ways in peace and war, lacking that essential knowledge they cannot give their full service in keeping troops healthy at all times and in saving life under fire."(4)

Despite being written nearly fifty years ago, its relevance to all military medical professionals is timeless. It endorses the need for all to get engaged in the debate and to ensure its full evolution and usage. Doctrine is truly the basis for operational excellence and coherence not a basis for clinical constraint.

References

1. British Military Doctrine. Army Code 71451. 1996: 1-1.
2. Liddell Hart Sir B. Thoughts on War. Padstow. Spellmount Classics, 1999: 102.
3. *ibid.*
4. The Times, 10 Aug 1951.

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Farewell Field Ambulance, Hail Medical Regiment

1st April 2000 has seen the passing of the field ambulance from the order of battle of the Regular Army. Whilst four field ambulances remain in the Territorial Army, two will be swept up into a new organization by 2002 and the remaining two are now being examined for a final structure to complete the Strategic Defence Review process and Land Command's review of medical support behind the divisional rear boundary.

Field ambulances were first created in March 1906 from the bearer companies and some hospitals that formed the back-bone of field medical support in the Boer War. The bearer companies, in turn, had arisen from reflection of the experiences, and inadequacies, of medical support during the Crimean War. Much of their development came from innovation within the volunteer movement. Field ambulances were scaled initially as three per division plus one for corps troops. There were variants for cavalry formations. The key essentials of unit organisation were command and control to effect the collection and transfer of casualties by stretcher bearer or ambulance from fighting units and sections for sustaining first aid and medical treatment of casualties prior to transfer to a surgeon. Sections could come together to form larger treatment facilities, subsequently known as dressing stations, and a feature of the unit was its mobility, commensurate with the formation it supported. The field ambulance came of age during WW1 and proved remarkably successful in meeting the, at times, inordinately large demands placed upon it. Units came from both the Regular and Reserve forces.

After the War, with the drawing down of both the Regular and Territorial Armies, the field ambulances almost disappeared from the order of battle, indeed it did so completely from the Territorial Army until in the 1930s the Army started to prepare itself once more for major conflict. During WW2, further innovation saw the introduction of surgical teams to field ambulance establishments for those units supporting airborne and amphibious formations as there were, otherwise, no timely means of evacuation of the wounded back to a surgeon. The process of evacuation from the dressing station to the surgeons of the casualty clearing station in the corps area had been reassessed following on from the lessons identified in the wake of Dunkirk when the ambulance car companies were moved under the auspices of the RASC.

Since WW2, field ambulances have accompanied formations on operations in Malaya, in Korea, at Suez, in Kenya, in Cyprus, in Borneo, in Aden, in Northern Ireland (Operation Motorman), in the capture of the Falkland Islands and the recovery of Kuwait. They have also been deployed over the last eight years in the Balkans on peace support operations. Humanitarian operations have been conducted in Africa. However in between times they sat in two distinct groups in peace, one equipped with armoured vehicles in Germany in support of armoured formations facing the Warsaw Pact, with the other more lightly equipped for wider deployment purposes and based mainly, but not exclusively, in UK. A shrinking number remained in the Territorial Army. As time went on units were increasingly cadreized and began to lack critical mass for training and equipment management. The traditional role of the commanding officer as a brigade senior medical officer receded as the management of peacetime primary care developed along a separate pathway. At one stage, in the 1970s when the brigade level of command was temporarily removed from the Army, field ambulances were amalgamated into hybrid medical regiments called armoured division field ambulances or field force field ambulances. Even when the brigade reappeared in the early 1980s, these hybrid units whilst maintaining critical mass, did not sit comfortably within the formations they supported and some form of squadronization, in order to provide a 'brigade medical slice', had to be manufactured. There were a couple of abortive attempts to bring all of a division's medical support together into full medical regiments but these were resisted at Command and MOD level. The RAMC's response to further draw-down, following the end of the Cold War and the peace dividend, was to revert to partly cadreized small brigade aligned field ambulances again in order to preserve the maximum number of command appointments possible.

Elsewhere, the Army was moving onto a capability base from the previous threat based structure. The manoeuvrist approach to military operations was firmly being embraced in a new doctrine. Engineer, Logistic and Equipment Support refined their own concepts of operations on the new ideas of close support, ie intimate support to fighting units within the brigade area, and general support, ie depth support in the division rear area. There were many lessons identified in the campaign to liberate Kuwait

in 1991 that needed to be addressed. Quite clearly medical support had to be reconstructed to meet these emerging concepts as well as pay proper attention to the imperative of reducing the time delay before the battle injured reached the surgeon and to maximise their survival rates and minimize their disability rates. A framework for enabling the rapid regrouping of both treatment and casualty transfer assets was needed so that the divisional main effort was adequately and timely supported. Emerging concepts of adopting the airborne approach of surgery at the dressing station in close support to the armoured division and advanced rescue work by paramedical ambulance crews had to find an organizational home. The idea of continuity of care, particularly during the casualty transfer stages, had to find proper expression.

Thus in 1997, the Army finally accepted that the field ambulances and the RLC ambulance squadrons had to be realigned into coherent regimental structures in order to meet these new concepts, and match both military and medical imperatives. The chosen model is for firstly a close support medical regiment to work within the brigade areas. It has a squadron per brigade. Arguably the squadron looks remarkably like an old field ambulance with command and control, sections and a dressing station (now with a brace of surgical teams). However the treatment assets can easily be regrouped with another squadron on the main effort whilst still leaving a planning and rump treatment element with its supported brigade. The ambulances are held centrally and managed as a large fleet with flexible grouping. Sustainment and administration is simplified by having a regimental echelon. The division also has a general support medical regiment that subsumes the old ambulance squadron function and will deliver medical supply. This form of regiment will also provide close support for the divisional rear area. Behind the divisional rear boundary variations of the general support medical regiment will provide close support on a point and area

basis and enable direct casualty transfer to local field hospitals. General support coaches will provide the casualty transfer function out of the back door of the field hospital to the air/rail head or port. Units will now be all Regular or a mix of Regular and Territorial squadrons.

Today's business now sees the gelling together of these new units that are equally placed to serve peacekeeping operations as war fighting ones. They are modular and elements of them can be grouped together and mission tailored to meet the need across the spectrum of conflict. Most importantly they, at last, offer an opportunity to train and develop fully regimental officers and soldiers through a major unit structure comparable with all the other Arms and Services of the Army. There may be fewer command appointments and RSM positions than previously but those that get to them will be of a better quality than ever before and properly trained. The associated challenge will be to develop a TA commanding officer for at least one of these units for it should be noted that increasingly Regular officers have had to be appointed to command TA field ambulances. The medical regiment is thus simply a new model for the command and control of medical support in front of the field hospital. Most of its constituent parts have lineage back to the bearer companies of yore even though communications, treatment and transport means have radically developed since then. The regiments should now serve the modern Army well into the next decade but will they last as long as the field ambulance? As doctrine develops, perhaps the increasing digitisation of the battlefield will itself demand further organizational adjustment? Military technological progress has a continuously reducing half-life and thus 94 years is an unlikely life span for our new organizations.

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