
EDITORIAL

The Roles Of The Army Medical Services – Shaping The Battlespace?

The effects of globalisation, urbanisation and population growth mean that future operations are likely to take place in close proximity to civilian populations, so that the future operational environment is more likely to resemble Grozny than the Iraqi desert. Our own forces will come increasingly in contact with the civilian population, whether they remain at home, or become internally displaced persons or refugees, and this will be most pronounced in urban operations.

In cities many precision weapons will not be fully effective. This, together with the increasing lethality of weapons, as described in the last issue of the Journal (1), and the use of civilians as a human shield by opponents, will increase the risk of non-combatant casualties. At strategic and operational levels, such casualties will undermine domestic and international political support, and prejudice host nation support.

At the tactical level, commanders will wish for maximum freedom of action in order to fight effectively, and the most liberal rules of engagement. They will also wish to avoid the experience of the commanders in Grozny, who became drawn into civil administration:

“There are no empty cities, and the ground commander should conduct contingency planning in case he must care for the needs of the civilian population and restore critical services. The military commander may become the *de facto* city manager and should be prepared to keep the civilian populace alive and healthy, should this be required. To limit the time spent in this area, the commander should learn to work effectively with other government and non-government agencies. (2)”

These aims can only be achieved by managing the civilian population. This may include non-combatant control measures to encourage the population to remain in place, or on the other hand it may include measures to encourage the civilian population to leave an area, and to separate them from combatants. In either case, the provision of life support, much of which will be logistic and engineer based, but include medical support, will be part of the process.

This life support will ideally be delivered by host nation resources or by non-

governmental organisations (NGOs). In a hostile environment, however, or in rapidly developing circumstances, host nation resources may be destroyed or overwhelmed, and NGOs may be unable or unwilling to operate. Where they do have capacity, ethical constraints may deter NGOs from close co-operation for military ends. In these circumstances, Army Medical Services are likely to be the only elements capable of providing support, at least during early stages. Once the initial effect has been achieved, and a degree of stability established, NGOs are likely to become increasingly involved.

To a large extent this is not new and much experience has been gained in treating civilians over recent years. Army medical services have long been prepared to treat civilian casualties within existing capabilities, as required under principles of humane treatment as enshrined since World War II in the Geneva Conventions and Protocols (3,4). More formal humanitarian relief operations, whose purpose is principally humanitarian, have been mounted, again from within existing capabilities. “Hearts and minds” support to civilian populations on peace support operations is also well established, as activity in support of the commander’s wider aims, but also delivered from spare capacity.

In the face of urbanisation and other changes to the threat and in political direction since the end of the Cold War, the British Army has become smaller and more focussed on a range of defined military tasks. Changes in the structure and organisation of the Army Medical Services have followed Army trends, and have resulted in a considerably smaller force structure. The roles of the Army Medical Services remain unchanged, however: to contribute to conservation of the fighting strength and morale of the Army (5), by advising commanders on the maintenance of health and prevention of disease and by collecting, classifying, evacuating and treating the sick and wounded in war. Should this be expanded to include medical support of the sort described above?

The idea of providing medical support to the civilian population during warfighting, in order directly to support the commander’s aim, is new. Even where support is provided by others, such as

NGOs, there will be a need to manage its delivery, to ensure it conforms to the operational plan. This is the medical contribution to the shaping of the battlespace – already an established concept in peace support operations (6), but not hitherto in warfighting.

Various issues arise out of such a concept, including ethical concerns over exploitation of medical resources to directly support warfighting aims and resource implications. At first sight the resource requirements to support the civilian population could be potentially vast: however, the resource bill would be driven by military planning assumptions over the extent of population management required and its duration, which is likely to be short.

Clearly there would be much more to do in developing the tactical concepts and doctrine for a new role, although at the tactics, techniques and procedures level the overlap with existing humanitarian practice is substantial. There would be a need for some personnel with specific skills, but these would be few. The training needs would be more significant, but given the increasing civilian component of professional and allied training at all levels, adaptation of existing training might serve to meet much of the need. Equipment would also be required to support the

concept, but this would be commercially available civilian equipment and supplies, much of it available in theatre or at short notice as part of standard medical equipment packs.

When the needs of the British Army in the urban environment are under scrutiny, the ability of the Army Medical Services to fulfil their conventional role is clearly our first priority. There appears to be a need, nevertheless, for the Army Medical Services to be capable of supporting the commander's aim directly, and to contribute to the shaping of the battlespace – a new role, to add to existing responsibilities.

References

- 1 Galbraith K. Combat casualties in the first decade of the 21st Century – new and emerging weapon systems. *J R Army Med Corps* 2001;147:07-14.
- 2 “Soft Log” and Concrete Canyons: Russian Urban Combat Logistics in Grozny. L Grau and T Thomas. Foreign Military Studies Office, Fort Leavenworth, KS.
- 3 Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field, Geneva, 12 August 1949, Articles 3 & 12.
- 4 Protocol Additional to the Geneva Conventions of 12 August 1949, and Relating to the Protection of Victims of International Armed Conflicts, Articles 10 & 75.
- 5 Queen's Regulations for the Army, 1975, Annex B to Chapter 4.
- 6 JWP 3-50.

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