PERSONAL VIEW

# Cold Steel and Warm Hearts: the Professional Ethics and Strategic Planning of Expeditionary Warfare

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*"Despite recovering some of the essential public utilities to pre-war standards, it is startlingly apparent that we are not delivering that which was deemed to be promised and is expected. 1 (UK) Armd Div have reached the limits of their technical capabilities and desperately need subject matter experts – judicial experts, civil engineers, power workers, water workers, public health specialists, additional doctors and nurses, interpreters and medical supplies…"*

– General Sir Mike Jackson, reporting to the Chief of the Defence Staff on 13th May 2003, and in evidence presented to the Chilcott Inquiry into the conduct of the Iraq War.

The events of the past decade have brought profound changes to the permissive conduct of expeditionary warfare, which have yet to be widely recognised or understood. Digital cameras, the Internet and the 2continuous audiovisual media have brought intense scrutiny to the events of distant battlefields and to the lives of individual combatants.

The histories of medicine and warfare are inextricably linked. Health professionals have an implicit and explicit duty to bring civilising processes to the battlefield and to moderate the callous and cruel consequences of war for those caught up in it. With a decade of brutal expeditionary warfare behind us, the time has come to consider once again our strategic responsibilities and the imposition of our moral authority as medical professionals on the planning and conduct of war.

Some wars are fought for national survival, or for the protection of critical economic resources, and some are conducted away from centres of population, as on the flat plains of Northern Arabia in 1990-91. Expeditionary warfare has a voluntary aspect. Where it is conducted electively among civilians, whether in the townships of Iraq or in the villages of Helmand, it has a different moral dimension and set of obligations. These must be met, if the incumbent populations are to welcome the overthrow of despotic dictators or "mediaeval" theocrats.

The UK's Defence Medical Services command considerable national respect for the work of the past decade, both in modernising our practices and in achieving remarkable clinical outcomes. Our stock is high, and this opportunity to argue for change is rare.

Traditionally, the role of the military medical services in war has been to make and mend with the resources made available to them, and to play a subservient role to the fighting formations in sweeping up the human casualties, and there are many who are still conditioned to this view. However, in campaigns where the strategic victory is sought for liberal democratic values, hearts and minds are won by the soft power to which health care delivery is a key contributor. Thus, civil health care planning becomes a strategic factor in campaign planning rather than a bolt on afterthought.

Uncomfortable and unusual as this concept may appear to some, if the politicians and planners cannot find the resources for "CivMed", then perhaps the plan should be modified or vetoed by medical commanders with strategic authority and influence.

No clinician or medical commander who has deployed to Iraq or Afghanistan in the past decade can have escaped decisions relating to the allocation of scarce resources for health care; in respect of children turned away at the gate; of civilians in need who have had limited access to our advanced healthcare capabilities; of host nation combatants discharged prematurely and to what we would generally judge as substandard aftercare or to inadequate or dysfunctional local facilities; or of the inescapable disparities between the overall treatment of coalition and local casualties. We do our best with what we are allocated, but is this sufficient and is our best good enough?

Such issues are frequently presented as moral and ethical dilemmas in debate and in private conversation, but they are usually no such thing. They are simply consequent upon insufficient healthcare resources to address the task in hand.

British military medical doctrine has imbued generations of military doctors and medical planners with the instructions and the resources to provide for the needs of our own personnel on deployed operations, but not for the indigenous population. This may have been good enough during expeditionary wars of earlier centuries, at Waterloo, Blenheim, the Crimea and in nineteenth century forays across the North West Frontier. It is a doctrine which is no longer fit for purpose, during the elective and optional "nation building" wars of the early 21st century.

The Geneva Convention of 1862, to which we are signatories, obliges us to accept responsibility and to treat the wounded, the sick and the civilian population in areas under our operational control. This issue is addressed tangentially in less than two pages in the most recent edition of UK Military Doctrine (JDP 4-03, Annex 1A) on the issue of medical support of joint operations. The official book does not directly address the material consequences or the logic of this position, other than to

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say: *"The nature and extent of the medical treatment administered to individuals will be governed primarily by medical judgement and ethics, within the constraints of Armed Forces' medical policy".*

The imprecision on resource allocation inherent in this directive is no longer good enough. The moral and ethical logic is clear. If we choose to undertake expeditionary operations for ethical foreign policy reasons and in the search for hearts and minds, then we must make adequate and generous provision in advance planning and preparation for the healthcare of the subject population under our immediate control and influence.

We must plan this provision to last explicitly for the duration of our presence or occupation and put in place the framework for an enduring system thereafter, with credible and measurable outputs. We must plan this provision at a standard which is reasonably equivalent to those standards which the indigenous population perceives that we apply to our own forces.

Thus, for example, we should not wish again to find ourselves turning away civilians with solvable medical problems at the gates, as at Shaibah Camp in 2003 when the medical footprint was rapidly downsized. How rapidly did we lose the peace and moral authority in Iraq, to the point that the hospital was considered fair game for a missile barrage? How do we play into the hands of the Taliban propagandists, by passing Afghan amputees back into an ill prepared local healthcare system, where heroic care could be misrepresented as mistreatment?

There is thus a strong case to be made for increasing the military medical footprint at the outset of expeditionary operations. This would give much greater and explicit capacity for the treatment of local nationals under our influence, whether casualties of war or not, as directed by our prior medical intelligence. It might take the form of an additional field hospital, designated and appropriately equipped and manned for the treatment of local nationals, and for the education of local civilian medical staff. It might include a larger primary health care footprint, ensuring a more robust presence and effect until the civilian agencies move in, if indeed they can or are able to do so.

This is not to be misrepresented as arguing that a fully formed National Health Service be parachuted into Southern Iraq or Afghanistan; or that foreign national civilians should be med-evac'ed for care in large numbers to Western centres of excellence. It is to argue that from the outset of operations, medical provision must be perceived to be at the centre of the "soft power" which alone is capable of winning and sustaining the ultimate peace in any campaign.

Only in this way will be minimise the moral and ethical dilemmas which we have created for ourselves. We must address these issues with clarity and head on at the highest operational and policy making levels. We must consider the (minimum) medical resources needed to make effective inroads into civil health care need over the period of our presence; to raise local standards of governance and education. If these resources and strategies can be delivered with free movement around the area of operations, then that is all to the good. If they can only be delivered from within defended perimeters, then that is better than nothing.

What about the cost and impracticalities of additional medical provision? Many will mutter that these are show stoppers. In practical terms, the costs of "Med" are relatively small in relation to overall campaign costs. If we cannot or will not make adequate provision for the healthcare of the indigenous population for the duration of the occupation and beyond, then the campaign is in any case likely to end in defeat. As military doctors, we must be prepared to explain why at the outset. Failure in strategic planning to recognise the medical steel in soft fighting power will lead to repeated strategic failure.

The time has now come for a mature debate on the resources required to solve the problem. It is not enough to say that "it can't be done" and "we haven't got the resources". In reality, we don't know, because we haven't seriously tried it; or where we have had the opportunity to try it, as in Southern Iraq in early 2003, when we were richly resourced for the task, we shied away from it. So far as the personnel are concerned, the NHS is richly endowed with highly motivated individuals who might respond very positively to a new strategy and reserve recruitment policy.

As military doctors, we recognise and accept the challenges and austerities of war, and the compromises that are invariably made. We know better than any the immediate physical effects of war. As responsible professionals, we also carry the moral authority and intelligence within the military hierarchy to impose common sense and humane direction at the strategic level. By deploying the hard headed intellect and argument at the highest level, we can make a serious contribution to military campaign strategy and outcome, and to the development of nations.