Role of Medicine in Supporting Special Forces Counter-Insurgency Operations in Southern Afghanistan

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Abstract

The purpose of this article is to present the experiences of Task Force 31 during two rotations in support of Operation Enduring Freedom with the use of host nation (HN) medical care as a strategy to support our counter-insurgency plan in the Afghanistan theater. This policy, which consists of providing routine and basic preventive medical (sick call-type) HN care, is in direct contrast to the Rules of Eligibility, essentially only providing emergency care to local nationals. Our medical "rules of engagement" many times clash with the conventional methods of approaching medical care of local national patients, and this article seeks to explain why our strategy is valid in our Area of Operations (AO).

Note: This article does not seek to present a global strategy for the application of health care, but rather an explanation of the use of medical care in our overall strategy of fighting the counter-insurgency.

Our Area of Operations

Southern Afghanistan is a primitive collection of underdeveloped towns with the exception of some key cities throughout the region. Hospitals are only located in the larger cities (Kandahar, Lashkar Ghar, Qalat, Farah, Herat), and many are under-staffed and under-resourced. The lines of communication throughout the region are primitive at best, with paved roads only connecting the larger towns and district centers. The anti-coalition militia (ACM), the catch-all phrase for the insurgents, denies free passage on many of the main roads connecting towns and provinces throughout this region. Local health care in small towns many times consists only of a small clinic or pharmacy with a "provider" more interested in selling medications than actually diagnosing and treating medical conditions.

Non-governmental organizations (NGOs), who in other underdeveloped countries contribute significantly to the reconstruction of medical organizations and clinics in small towns, do not venture into many of these areas due to the dangerous security situation. The overriding goal of the Afghan Ministry of Health is to have a clinic within three hours walking distance to every citizen, but, in some areas, this access is not currently available. There is no quality assurance of the staffing of these clinics with qualified providers or supplying these clinics with basic necessary items to provide care. As a result, many of the towns in these areas have little or no basic medical care, and certainly no access to surgical or preventive medical care, largely contributing to reported infant mortality of 160.23/1000 live births (third highest in the world), and life expectancy of only 43.16 years.[1]

Counterinsurgency Strategy

A counterinsurgency is an operation where the military forces of one or many countries seek to bolster a fledgling local national government against a force of insurgents who seek to destroy that government.

In order to bolster and support that new government, our Special Forces Task Force relies on both kinetic and non-kinetic operations. Kinetic is the typical use of military force to close with and destroy the insurgent forces in order to ultimately physically separate them and their influence from the local populace. Non-kinetic operations include bolstering the local governmental agencies and services, and in many cases, providing much needed or absent services to the people in the hopes of "winning the hearts and minds" of the local populace and undermining ideological support for the insurgency, while gaining support for the legitimate Afghan government.

Special Forces teams are uniquely qualified to establish self-sustaining base camps in remote or hostile areas. A key element to this struggle is the establishment of rudimentary host nation medical care, in areas where adequate civilian care is absent or insufficient.

Special Forces Medicine as a Tool for Counter-Insurgency Operations

Special Forces medics, unlike most other Special Operations medical providers, are trained specifically to operate autonomously at these remote locations. Though they have a defined scope of practice, their training comprises a wide range of medical, dental, veterinary, and preventive medicine topics. They are trauma specialists, but also trained in the medical care of children, adults, and geriatric patients. At many of our firebases, due to the solid background of training and acquired experience, many of our medics are, de facto, the highest trained medical providers in these communities. The mature provider, aware of both his scope of practice and limitations, has the potential for enormous effects in these communities. The clear definitions of scope of practice of our American subspecialties of medicine are much less clear in these situations. This is not a license for medics to do whatever they think they can, but a realization that any care provided is much better, and in many cases may prove to be lifesaving, when no other care is available. This point should not be lost on the reader, and the potential for long-lasting benefit to the host nation community is great.

Though ultimately our forces and those of the International Security Assistance Force (ISAF) seek to establish a secure and self-sustaining nation, there are major security issues in our AO. Medical care provided by the regular military assets of our NATO partners are specifically resourced to care for the sick and wounded of the Coalition forces. Due to the limited nature of the planning and resourcing of medical assets, there is a need to limit the care provided to local nationals. As such, the regular military medical assets have established various medical rules of eligibility (MROE) for caring for local nationals. In general, local national patients cannot be cared for in Coalition medical facilities except for emergency care, defined as a condition that is life, limb, or eyesight-threatening, and when there is bed space available at the major Level Three facilities (as a surrogate measure of limited resources available).

In regards to dedicated local national care, traveling Medical Civic Action Program (MEDCAP) teams have been developed by the larger conventional medical support structure to provide additional benefits to host nation personnel. The experienced provider, however, will only have to participate in a few MEDCAPs, no matter how large the package and how specialized the providers, to appreciate the relative futility of showing up to a town one time and providing care. A much more effective strategy is identifying those areas that are truly underserved and providing basic services on a more regular basis, much as we do at our firebase clinics.

Many times, our medical care strategies clash with conventional medical rules of eligibility due to the operational constraints placed on each medical unit. Guidance to conventional medical units specifically prohibits these units from seeing local nationals except when they present in extremis, literally dying at their front gate. Additionally, there are some prohibitions from using medical supplies to treat local nationals, though there are funds available through Commander's Emergency Relief Program (CERP) funding that can be allocated to locally purchase medications to be used on local nationals. The use of local national medical supplies is not only cost-effective, but bolsters the local economy and provides confidence and patient education in host national medications. Admittedly, these local national medications may not look as legitimate as such things as the American decongestine capsule (generic Deconamine – a common cold symptomatic treatment) which is a highly sought-after commodity in community trading circles for its multi-colored appearance.

The non-kinetic operations of our Task Force do not intend to supplant or undermine local providers and medical operations, rather, to build confidence and support for the elected governments, and legitimate government operations. Additionally, with judicious use of medical care and application of basic comprehensive care, the local population will begin to see a true investment in their community. As an important by-product of these operations, security will be enhanced as the locals build a partnership with the Special Forces teams and their attached Afghan National Army (ANA) units.

Another benefit of running these clinics is the unparalleled level of experience and training received by our medics. The breath of trauma and infectious disease exposure alone is unlike anything seen in clinics in the United States. Many children present to our clinics who have never received medical evaluation or care in their lives. Malnutrition, childhood illness, and genetic abnormalities present in their "raw" forms. Cases sent through our electronic consultation service routinely receive praise for the unbelievable presentations

that walk in off the streets. Our medics are trained in pain control and procedural sedation skills and many are facile in the use of ketamine, opiates, and benzodiazepines for procedural sedation, without which many of our procedures would not be possible. Severe burns, abscesses, and blunt trauma are commonplace, while exposure to pediatric patients is universal. A couple of our clinics even rival the experience of big city "knife and gun clubs" in the United States.

With the rotation of our medical officers (Battalion Surgeon, Battalion Physician's Assistant, and augmentee providers), our Special Forces medics take advantage of an experience comparable to medical proficiency training (MPT) rotations in the United States. Compared with peacetime limitations on training, the daily experiences in these clinics are unmatched. Properly regulated, the medic finds a superb learning experience to build on an already solid background of education. This training experience, comparable to joint/combined exchange training rotations during peacetime, provides the Special Forces medics with as much benefit to their personal training as the benefit received by the patient themselves.

Conclusion

Though not a blueprint for conventional forces' application of medical assets in this Global War on Terrorism, our use of Special Forces medical assets is vital to our overall counter-insurgency strategy. I seek to explain the operational relevance of our seemingly permissive "rules of eligibility" with regards to the provision of local national healthcare in this austere and hostile environment. Over two rotations in support of Operation Enduring Freedom, at 14 firebase clinics, we have evaluated close to 50,000 patients, a significant portion of the population in southern Afghanistan in these remote villages. A companion article to this one by MSG Samuel Blazier et al. seeks to provide a brief "how to" guide to applying our strategy with relevant examples that can by used by the individual medic.

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References

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