Running a Local National Medical Clinic for Special Forces/Special Operations Medical Personnel

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Abstract

The purpose of this article is to present a strategy for establishing and running a local national medical clinic in support of our counter-insurgency strategy, practiced by our Special Forces Task Force in support of Operation Enduring Freedom. In the course of multiple rotations to Afghanistan, we have acquired a feasible strategy to take advantage of the non-kinetic operations of a local national medical clinic. This article seeks to identify mission essential tasks and provides examples from Special Forces Teams (Operational Detachment – Alpha, or ODA) throughout our area of operations (AO) in different settings.

Background

As covered previously in MAJ Keenan's article, "Role of Medicine in Supporting Special Forces Counter-Insurgency Operations in Southern Afghanistan," we believe that the utilization of host national medical clinics is a valid and integral part of our non-kinetic strategy of fighting a counter-insurgency operation. Through the use of our medical talents, each firebase utilizes medical care of local nationals to help achieve the overall goal of peace and stability in their respective AO.

There are some key tenets and tasks that an individual medic should consider which are outlined below. Additionally, we seek to share the varied experiences of our seasoned medics, some of whom have spent three rotations in Afghanistan, to provide examples to practical application of these principles. We realize that individual experiences vary considerably, but given that we believe this strategy should be considered by any ODA wishing to make a significant impact on the local population while fighting counter-insurgency operations, the examples provided may help to speed the preparation and planning, and provide some insight to medical personnel wishing to incorporate this strategy.

Background and Area Assessment

In order to fully take advantage of this non-kinetic experience, the individual Special Forces medic should seriously consider establishing, operating, and managing a local medical clinic designed to address (or augment) medical care for the local populace. The rapport gained by providing a local medical clinic is the forefront of a Special Forces team in their AO. Having rapport with the local populace has been a staple for Green Berets since their inception. Looking back on the stories of Vietnam and the "G-Hospitals" a recurring theme is the provision of more sophisticated medical care to an underserved population.

The Special Forces Medic should first conduct an assessment of the area to determine the local medical capabilities, and availability of medical personnel – both host-nation and Coalition assets. The assessment should include HN medical supplies and pharmacy services available. This will vary widely depending on the firebase location, but our experience in rural Afghanistan is the complete lack of some basic services and adequate medical supply. The Special Forces Medic should establish and build rapport with the local medical personnel, and determine if they have the resources needed to carry out their responsibilities. There may be an opportunity to assist local clinics or hospitals, by physically assisting and advising, or with the procurement of local supplies and medications.

There are numerous "established" programs that a team may be able to utilize. Two programs that we have taken advantage of are the Commander's Emergency Relief Program (CERP) funding, primarily Civil Affairs project funds, or enabling earmarked host-nation funding to reach these remote projects and clin-

ics (via the Afghan Ministry of Health). There may be national or regional programs that can be promoted by the Special Forces teams in remote areas that are not being serviced as intended. Especially with a fledgling government in a primitive environment, such as Afghanistan, outreach by the central governmental organizations may be sporadic to the rural areas. An example of this is the national vaccination programs which seek to vaccinate all children in the country. By supporting and enabling the local medical clinic, it is legitimizing the local clinic and its personnel, which furthers the rapport process benefiting the ODA.

The ODA can also conduct a "mini-Medical Civic Action Program" (mini-MEDCAP) locally to introduce themselves into the area and to show support for the local populace. These visits are usually in conjunction with tactical operations into formally denied areas. As for medical care, it is far from definitive and should serve more as an advertisement for the firebase clinic or local national establishments of which remote towns may be unaware until these planned encounters. Many medics carry small boxes or kit bags to take advantage of medical targets of opportunity while out on patrols. Medical interactions with the local populace are a very safe and valuable, non-threatening encounter that should be considered as an augmentation to many tactical scenarios. These can sometimes be planned in conjunction with tactical Civil Affairs assessments and project nomination site surveys. The firebase medical clinic, however, is key to our counter-insurgency strategy.

Establishing and Running a Firebase Medical Clinic

The location of a permanent structure for a firebase clinic should be planned carefully. The Special Forces Medic should establish a clinic in a safe area and the clinic should be run purely by the team. An ideal location is outside the inner perimeter but still attached to the firebase. The firebase clinic should be accessible to indigenous personnel, yet have adequate security. Firebase clinics need a controlled access point, and the personnel entering the control point should be scanned with a metal detector or be searched physically by a host nation soldier or security. This is necessary to protect both the local civilians as well as the Special Forces personnel. From this controlled access point they should go into a waiting area that is over-watched by the host nation soldiers or security personnel. This holding area provides an excellent opportunity for interaction with the waiting patients whether for patient education, psychological operations (PSYOP) presentations, or civil affairs interaction.

Many firebases choose to have two separate medical facilities: the local national clinic (the outer clinic) and the "American" clinic (the inner clinic). The local national clinic is rudimentary and has basic exam tables and screening equipment. The bulk of its medications can be local national medications supplied by CERP funding. The inner or "American" clinic contains the traditional Class VIII supplies, monitors, and everything needed for procedures and more complicated patients. A technique is to screen the vast majority of patients at the local national clinic, and bring the sickest patients or those needing more advanced care to the inner clinic.

The Special Forces medic working in this clinical setting finds a tremendous opportunity to train ODA members, ANA medics, and interpreters to assist in medical procedures. This not only helps the medic with his daily duties, but provides vital hands-on training to first responders. Simple duties such as wound care and IV practice is a daily occurrence. This on-the-job training is a vital supplement to classroom or pre-deployment medical training for our own Soldiers. The confidence derived from this training pays enormous dividends during tactical combat casualty care.

Scope of Practice

What we are seeing in these clinics is that the Special Forces Medic has historically been the most medically qualified person in the majority of the remote AO's. With that in mind here are several points to consider:

First, medics must be cautious not to overstep their bounds in terms of scope of practice. It is important for Special Forces Medics to remain within their medical training and comfort level to avoid getting in over their heads, provide excellent care, and ultimately avoid unnecessary scrutiny from the larger medical establishment. The operational expectations placed on SF medics requires a broad scope of practice, however this should not be misconstrued as a license to practice freely. The mature medic understands his limitations, and must know when they should pass a patient to a higher medical level. The SF Medic will only provide care within his scope of practice, ultimately regulated by the Battalion and Group Surgeons. This level of trust and communication for consultations must be established early in the deployment and practiced regularly.

An understanding of the medical operational environment is essential. Each medic should be thoroughly familiar with military and civilian evacuation chains, understanding there may be a very non-permissive military or non-existent civilian evacuation system in place. This is a continual problem which should be considered early

in the treatment of medical problems, and the medics will soon get an understanding of not only their capabilities, but necessary limitations. In other words, there must be an appreciation for not "biting off more than they can chew." After working in the environment, a medic quickly realizes there are some problems best left not addressed, especially chronic problems or problems so overwhelming that intervention will only delay inevitable deterioration or death. Every provider in this austere environment goes through a period of adjustment from the way they were taught to the way they will practice – effectively modifying the "standard of care." A provider should always remember the axiom, "First, do no harm."

Second, at times the Special Forces Medic has so many people that come for treatment that he cannot physically screen, assess and treat them all. The Medics must develop a system to triage patients and refer to the local HN clinic as appropriate. This legitimizes the local clinic and local medical personnel which serves to increase the rapport in the AO, while dissuading the local populace from an over-reliance on the medical care provided by the temporary firebase, eroding the incentive for local national health care development.

Medical Supplies

The established SF local national clinic, as mandated by policy, should maximize the use of locally purchased medications. As discussed earlier, the Civil Affairs augmentees and Task Force Commander have access to Commander's Emergency Release Program (CERP) funding. This source of funding is specifically to be used on projects to bolster local economies and for projects designed to build civil infrastructure. The use of these funds is encouraged to purchase local national medications. This will serve a number of purposes. It bolsters the economy by the spending of money in the community, it discourages an over-reliance on American products and medications, and it legitimizes the local medications provided on the economy. Funding should be allocated early, and, in remote areas, medications and supplies can be purchased in larger cities then shipped to remote firebases. We have found that a small amount of money goes a long way with supplying basic primary care medications.

Cultural Obstacles

An obstacle that is presented when we are attempting to honor local and cultural customs is that there are significant cultural and religious prohibitions to males examining (or even searching) female patients. An example is a female who was brought to a local clinic with a possible broken tibia and fibula. The SF Medic was not allowed to touch the female at all, making it impossible to properly examine the patient. The Medic was allowed only to place a splint over the clothing of the patient.

Additionally, many females will not venture outside their home or neighborhood to even visit our clinics. Though not impossible to attract and treat female patients, the population served at our clinics is definitely skewed away from female patients. Ideally, the busier clinics would benefit significantly by having female medics available to examine and treat female patients. This is a continual limitation to our ability to reach the entire population and exploit this opportunity. Given the Afghan culture, the largest gains in interacting with the local populace may be through the females patients, but this is a necessary limitation overall in our application of medical care due to our male-dominated force structure.

Patient Population and Treatment Challenges

Patient demographics are greater than 50% pediatric with many of those pediatric cases being less than two years of age. This necessitates Broselow Kits (or similar weight-based treatment aids), pediatric references, pediatric medications, and good lines of communications with pediatric and higher medical consultation.

Burns are a prominent injury at most firebases. The current evacuation environment is fairly restrictive on what burn patients will be accepted. Standards of evacuation on the civilian side are not necessarily the same here. Each medic should be familiar with burn care and procedural sedation since much of the wound care will necessarily be handled at the firebase clinic. Only those severe cases (30-40% BSA burns and greater) are generally accepted for medical evacuation (MEDEVAC). In general, however, Coalition medical assets are poorly equipped to handle burn cases and are very reluctant to offer higher medical treatment. In fact, burn injuries and closed head trauma are the most contentious cases when presented for MEDEVAC to higher levels of care.

Caution needs to be exercised in medications and treatment plans. Our experience is that local national (LN) patients seldom take the medication as directed, may sell the medications you have given them, or may take dangerously large doses despite what you consider to be adequate education. Also, follow-up is sometimes non-existent, so common treatments such

as daily wound dressing changes actually become weekly. The medic should prepare for this contingency and treatment plans will frequently be modified to be even more comprehensible than you first plan for. We recommend the KISS (keep it simple, stupid) principle be foremost in every treatment and follow-up plan provided.

LN Clinic How-To Examples From RC-South, Afghanistan:

The following are specific examples from some individual firebases that seek to illustrate how different clinics operate in our area of operations. There are recurrent themes individual medics will find valuable. The following examples are provided by our team medics and physician's assistant:

Firebase Tycz, Afghanistan

We have two medical treatment facilities (MTFs) for Firebase Tycz. The first MTF is located outside of the main firebase perimeter and is primarily used for local national sick call. This is done for security reasons. This clinic is mostly stocked with locally purchased medical supplies and only equipped with a hand washing station and powered by a small generator during hours of operation.

The second MTF is a dedicated trauma room within the firebase, and better equipped for handling extensive wound care. This MTF is also well equipped with a fluid warmer, surgical sterilizer, suction, ProPaq monitor, portable X-ray (SF Battalion organic), and large oxygen bottles. Our main trauma MTF is open 24 hours a day, seven days a week, for all trauma cases that may occur. The incidences of trauma cases are quite high in our immediate area. During the process of conducting host nation sick call, interesting cases or those patients requiring more extensive procedures/evaluation (i.e., procedural sedation/X-ray evaluation) are taken to the primary MTF within the firebase for more extensive care and monitoring. These patients are necessarily searched two more times by our firebase guard.

Our clinic schedule is modified by our operational tempo. If we were out on a mission, the clinics would be closed until we return. Another unique feature at our firebase is a radio station that is used to advertise our services as well as broadcasting preventive medicine messages to help educate the populace. This is all included in our PSYOP plan arranged by the Task Force.

We have one pick-up truck specifically dedicated for the aid station and functions as our ambulance. We transport patients in and out of the firebase; from the initial check point to the outside clinic and eventually to our trauma clinic, inside the inner perimeter. Additionally, we transport serious MEDEVAC patients to the helicopter landing zones using the truck. We also hired a security guard/clinic worker specifically for the clinical support. He ensures all patients are searched at the initial check point, and again at the fire base entry control point, and also coordinates support from fellow guards during hours of operation. We have taught him basic wound care, the operation of technical equipment such as the sterilizer and the Propaq, and other various simple skills to maintain the clinics. Having this clinic worker also helps keep some continuity between team medics within the different units that rotate through this firebase.

We established and maintain good rapport with a local national doctor, who has X-ray capabilities and minimal laboratory testing in the local bazaar. We were able to refer patients (ANA, ASG, and local civilians) to get X-rays and labs prior to receiving our own X-ray machine from our Battalion Medical Section. On many occasions, we have had meetings with him to discuss many issues regarding health care in the local province. We have had a positive impact on the local populace as he spreads the word that the Americans are here to help the people of Afghanistan, which is an integral part in counter-insurgency operations. The population of the town is large enough that we are not "stealing" his patients from him, and he refers some of the more critical patients to our clinic for advanced trauma care.

On many occasions, we have been faced with the task of treating civilians that have been severely injured by a variety of means common to Afghanistan (land mines, gunshot wounds, burns, etc.). In most cases, the local populace comes straight to the firebase for primary treatment, however, they can be referred from the local doctors in the surrounding area, which are more than likely less trained and equipped to be able to handle these cases. Within the number of trauma cases that we have treated at the firebase, a small percentage may require medical evacuation to a higher level of care that cannot be provided by the Special Forces Medic. Therefore we must carefully assess and triage all casualties and decide if the case warrants MEDEVAC to higher echelons of care. Once that step is completed, the medic must choose between submitting a 9-line MEDEVAC request or the option of sending the patient via ground evacuation (taxi). These decisions are based on the availability of air assets, illumination from the current moon phase, and the possibility of other ODAs that may be in contact with the

enemy, thereby taking away vital assets from operational needs in our AO.

Currently, we are using CERP funds to purchase local medicines from the surrounding pharmacies to supply our host nation clinic. This serves a dual purpose. First, the use of CERP funds helps stimulate the local economy and growth. Second, the purchase of local medicines lessens the burden upon our own logistical supply train. We find that we can supply a large amount of primary medications (pain control, antibiotics, topical medications, etc.) for a relatively small cost. Though subject to local availability, these medications are usually readily available and relatively easy to procure, once the appropriate funding has been projected and ordered.

Firebase Anaconda, Afghanistan

There is a single LN clinic built into the corner of the firebase (FB) perimeter wall. Access to this clinic is regulated through an Afghan security guard (ASG) check point outside the FB perimeter. Once patients have been searched they are brought to a holding still outside of the clinic and FB perimeter wall. The clinic is operated for LN sick call 3 days a week and available for emergency care on a case-by-case basis.

During this rotation the clinic has been primarily operated by the team's one Special Forces Medical Sergeant (18D) with the assistance of a Special Operations Combat Medic (SOCM)-trained Civil Affairs medic, the former 18D Team Sergeant, and team members as needed for trauma or mass casualty situations.

The medic triages patients in the holding area. Those acutely ill, injured, or otherwise in obvious medical distress are brought into the clinic as first priority. Patients triaged with minor complaints are directed to seek care from the local clinic. This helps legitimize the host nation community clinic, and reduces primary reliance on the firebase LN clinic. This triage process usually results in a manageable number of LN patients – approximately 10 per clinic day seen and treated. The clinic layout is ideal in that it has six equally stocked separate "bays" that can isolate both patients with infectious diseases, as well as give female patients more privacy.

FB Anaconda has the advantage of a motivated and very capable female Category II interpreter. Her presence has helped facilitate the examination and treatment of female patients. This is a luxury that many firebases do not have, but we take full advantage of her presence to overcome the significant cultural hurdles of the treatment of female patients in this culture. She has been trained to perform basic physical exams, which the male medics and providers are unable to perform. This interpreter alone doubles our effectiveness in reaching the local populace.

The use of LN purchased medications is maximized. These meds are purchased through CERP funds as well as Civil Affairs operational funds (OPFUNDs) when available. The local pharmacist provides basic medications and can acquire scarce items when he travels to Kandahar.

In addition to the clinic operations, the team conducts civil-military operations (CMO) missions within the immediate area of operations. We have found the recently issued Special Forces Tactical (TAC) Set sick-call box, once fully stocked, is an ideal CMO/mini-MEDCAP set.

The value of HN medical treatment is substantial towards encouraging local community cooperation and timely intelligence gathering. Unfortunately, our higher level medical facilities for reasons of capacity, cost, and expertise regularly decline to accept LN patients unless there are life, limb, or eyesight threatening conditions – and even then, only if the injuries are a direct result of coalition actions. This reluctance sometimes proves to be an obstacle to care due to our limited capabilities and our remote location.

Firebase Lane, Afghanistan

Firebase Lane has two medical clinics – one within the inner SF compound and another LN-exclusive clinic co-located with a school. The clinic is within line-of-sight of the entry control point (ECP) to the main firebase.

The local national clinic is supplied with primarily host nation medications, and various humanitarian supplies, and has very little in the way of high-end medical equipment (monitors) or procedure capability. This clinic is run three days weekly based on patient attendance, and, more importantly, medic availability. The clinic security is provided by Afghan National Army (ANA) soldiers. There are no legitimate local medical options for the population in the immediate area, and therefore, we are unable to divert minor complaints back to a host nation provider at a local clinic.

The medical team for this clinic consists of a single Special Forces Medical Sergeant and a paramedic-trained U.S. Army National Guard Soldier. This paramedic, however, has other primary duties which are non-medical.

All procedures and acute trauma are handled in the inner clinic within the SF compound. Patients during sick call are triaged, and those requiring more definitive treatment or procedures are held until after sick

call when they are then searched and moved to the inner firebase clinic, unless acuity of illness dictates they be treated urgently.

As the only legitimate medical clinic within the area, the FOB Lane clinic typically sees upwards of 60 LN patients per day. The demographics are almost exclusively children or male adults, much like the rest of our clinics. With no female interpreter or medic available, local customs prevent women from seeking medical attention in this clinic – thus illustrating the desirability of having female personnel available to assist in clinic operations.

Conclusion

The areas where we find the most benefit to establishing clinics are those necessarily remote from host nation civilian medical care. At other firebases near larger population centers, the clinic operations play an important, but lesser role in host nation interaction for our counter-insurgency strategy. By doing a thorough assessment and keeping some basic principles in mind, the Special Operations Medic can quickly utilize our strategy for employing medical care directly into the larger goals of counter-insurgency operations. Done properly, running a host nation clinic in rural Afghanistan is an unparalleled unconventional warfare medical experience and directly contributes to our success on the battlefield.

MSG Blazier has been in Special Forces for 16 years. He has served as a senior medic on ODAs in 2nd Battalion, 3rd SFG(A), Battalion Medical NCOIC of 2nd Battalion, 3rd SFG(A), Civil Affairs medic and team sergeant in 96th Civil Affairs Battalion, Phase I and VI instructor for SF Qualification Course at Camp Roe, staff member at TMC 14, and most recently as the Battalion Medical NCOIC for 1st Battalion, 3rd Special Forces Group (Airborne). He is currently serving on his third combat deployment to Afghanistan in support of Operation ENDURING FREEDOM.

CPT Leach has served several years as an SF Medical Sergeant with the 1st SFG(A), prior to attending PA school. He then served two OIF deployments with conventional Army units as a Physician Assistant prior to returning to the SOF community as the Battalion PA for 1st Battalion, 3rd Special Forces Group (Airborne). He is currently serving in support of OEF in Southern Afghanistan.

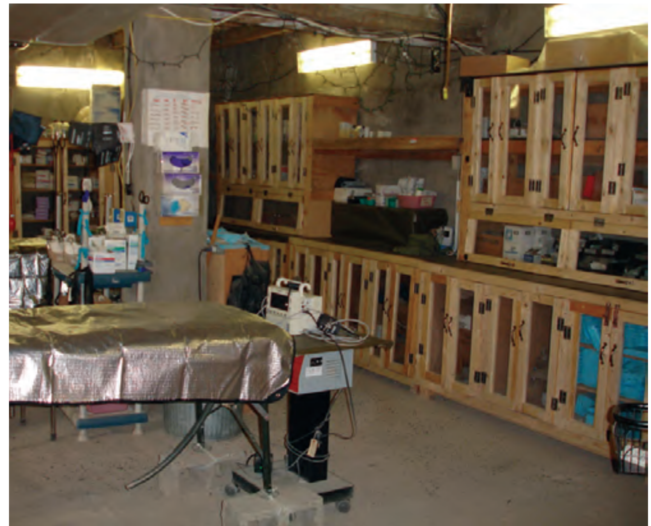
SFC(P) Perez has served on active duty for 18 years. First trained as an 18C, then as an 18D in 2004, he has deployed to Afghanistan four times. He has been based out of southern Afghanistan on three consecutive rotations. He has been a member of ODA's 351, and 344, and is currently a member of 1st Battalion, serving as a Senior ODA SF Medic.

SFC(P) Holmes has served on active duty for 13 years. He graduated from the 18D course in May, 2002, and was the Distinguished Honor Graduate from his ANCOC medic course. He has been Senior ODA SF Medic for the last four years. He has rotated to Afghanistan on four separate combat deployments.

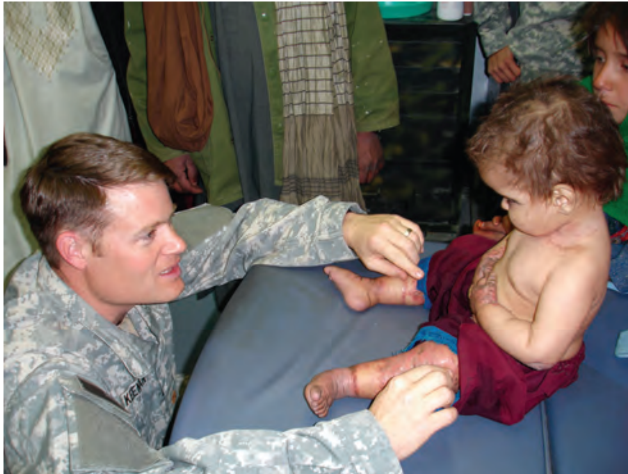
SSG Blough joined the Army as an 11B (infantryman) in 2000. In 2002 he began the Special Forces Qualification course to become an 18D. He was assigned to 3rd SFG in October of 2004. He has been deployed to Afghanistan twice in support of Operation Enduring Freedom.

MAJ Keenan received his commission in 1991 from the U.S. Military Academy, then graduated from the Uniformed Services University in Bethesda, MD in 1995. He served as the Battalion Surgeon for 1/1 SFG(A) in Okinawa, Japan from 1996 to 1999. After completion of his Emergency Medicine residency at BAMC, Ft Sam Houston, TX, he served as Staff Emergency Physician, Womack AMC, Ft Bragg, for two years. He then was assigned to his present position as the Battalion Surgeon of 1st Battalion, 3rd Special Forces Group (Airborne). He is on his fourth wartime deployment in support of Special Operations forces, and second consecutive as the Task Force 31 Surgeon.

The “outer” local national clinic has rudimentary treatment and exam facilities and is stocked with host nation medications.

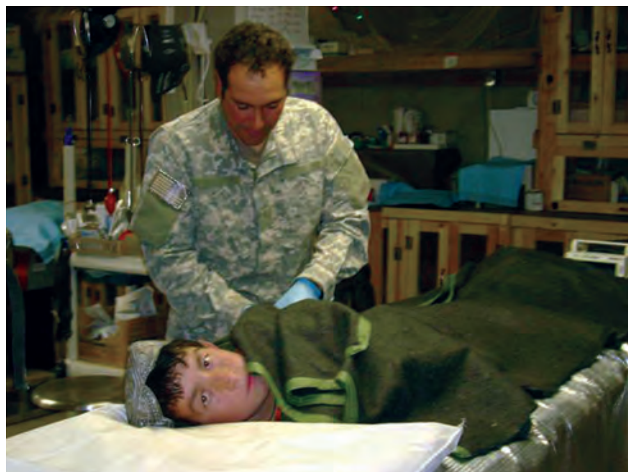


The “inner” clinic contains team equipment and is prepared for major trauma and other procedures.



Greater than 50% of our patients are pediatric.

Interpreters are invaluable as medical assistants and providing detailed patient instructions.



SFC Perez works on a trauma patient.

Burns, especially in children, are a significant part of our patient population.