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Unified Principles, Requirements and Standards of Armed Forces Medical Support

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Introduction

Successful completion of any military mission requires a proper organization of the health service support (HSS) of the troops. The principal document serving as a guide for military and military-medical commanders, planning staff and physicians, is the Military-Medical Doctrine (Doctrine).

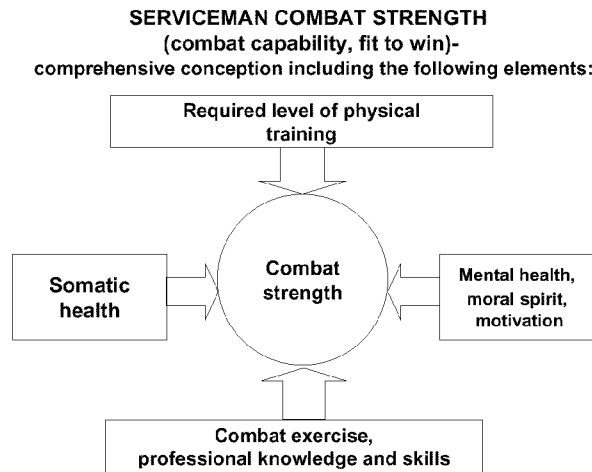
There are national (multiservice), allied (NATO) and combined (NATO and PfP) Doctrines. Allied and combined Doctrines are designed to provide the necessary level of unification and standardization allowing to carry out joint medical services tasks more effectively and at low cost. On the other hand, they should take the special nature of national systems of medical services into account. Conceptions of allied or partner Doctrines must be presented in such manner that national differences in the Armed Forces medical support of participating countries will not trouble their interaction and cooperation.

This paper focuses on the conceptual approach to the development of the Doctrine for Ukraine, and on differences and similarities with Doctrines of NATO and other countries. It will be emphasized that it is a common task for military commanders and the medical service, to ensure high standards of professional health as a crucial component of the combat strength of military personnel. Therefore, it is necessary to clearly determine the responsibilities and actions that are necessary in order to protect and preserve the health and life of military personnel.

Terminology

The concept of 'professional health' is defined in terms of absence of illness, and the availability of the necessary levels of compensatory and defensive mechanisms which will allow soldiers to maintain a high combat strength under all conditions.

'Combat strength' is a term that is applied to military personnel which is qualified to carry out combat operations in their assigned units, while the term 'operational readiness' is applied to the military organization (unit, formation, facility) which performs missions or functions in combat operations. 'Combat strength' is a comprehensive term including several elements.

Figure 1.

The Doctrine applies to HSS of all Armed Forces missions and operations, including war. This is because HSS in crisis and conflict is based on, and originates in the military health care system in peacetime, through progressive reinforcement. Medical readiness must always have a sufficiently high level, in order to allow for a smooth transition from peacetime to crisis or conflict posture.

However, during war or special missions (disaster relief, antiterrorism actions, peacekeeping missions), specific forms of HSS organization are required. To cope with this requirement, the organizational and operational sections of the Doctrine must be divided into separate chapters relating to missions other than war and to actions in the theatre of operations.

The general principles of medical care are:

- timely medical care and therapy;
- continuous, successive and consecutive care in progressive manner;
- general understanding of the nature and pathogenesis of illnesses and traumas;
- priority to measures to prevent disease, injury, stress and the development mental disorders.

These principles are common for medical support of all military services performing any of their mission (operation) in peace and war time.

The medical operational principles include:

- allocation of authority and responsibility;
- interactions between commanders, medical and other services in HSS;
- planning of HSS;
- medical supply organization;
- organization structure and management of medical support system;
- transition from peacetime to the period of war;

- progressive levels (echelons, roles) of medical care;
- the use of health manpower and means in accordance with operational and medical situation.

Military-medical doctrine content

Nowadays, there are many approaches the development of the Doctrine. The Doctrinal rules concerning military-medical services of NATO and the USA are provided in various documents with different titles and meanings. Some of them refer to principles and policies, while others describe strategic planning or conceptions of the medical support organization.

The USA Doctrine is a part of the Military Medical Readiness Competencies and it defines the fundamental principles by which military forces or elements guide their actions in support of medical objectives.

We propose that Doctrine should not be restricted to principles of medical support. To translate these principles into practical actions, it is necessary to give them a status of mandatory requirements based on unified military-medical standards.

Definition

The Doctrine encompasses the totality of general principles, single requirements and standards of Armed Forces medical support, aimed at:

- a) preservation of health and enhancement of personnel combat capability;
- b) saving life, prevention of disability, possibly quick return to duty of wounded and sick;
- c) achievement of maximum effectiveness of all medical support systems.

The Doctrine should apply to all services of the Armed forces, and be extended to all types of medical support (curative-prophylaxis, preventive medicine, NCB defense, medical supply). The Doctrine is based on advances of military and civilian medicine, public health practice, the State military Doctrine, and the nature of contemporary wars. In addition to the comprehensive medical support principles, the Doctrine may include planning directives, determines mechanism of interaction of medical service with military commanders and other services.

The next part of the paper is devoted to comparative evaluation of the main NATO, Russia and Ukraine doctrinal principles of medical support.

Levels of medical care.

Military physicians of Russia, Ukraine and other CIS countries use the term "Stage of medical evacuation". This is defined as the medical manpower needed and the means deployed on medical evacuation routes to admit, triage, provide medical care, treat the wounded and sick, and to prepare them for further evacuation.

The USA and NATO use the term "Role/ Echelon of medical support" which is applied to field medicine, and which defines four categories of medical resources, and the associated capabilities for treatment, evacuation, re-supply and other functions essential for personnel health.

The Russian definition lacks a specific description of one type of medical activity in the theatre of operations – the curative-evacuation support. Western definitions include this activity, but not fully. They use different terms (role, echelon, level) to designate stages of progressive medical support, and their contents are described incompletely.

We recommend to replace the terms "stage" and "echelon" with the standard international term "Level of medical support", because this corresponds more closely to what is referred to. The level of medical support may refer to e.g., first aid stations and treatment facilities deployed in certain order to carry out medical evacuation, to admit, triage, to provide the necessary levels and volumes of medical care, to treat wounded and sick, to prepare them for return to duty or for further evacuation, to carry out NCB medical defense care, and to re-supply.

Forms of medical care.

The classification of different forms of medical care which are commonly used in the field manuals of the USA and NATO are essentially differed from the categories distinguished in Russian and Ukraine documents.

Table 1.

Types of medical care

USA, NATO	Russia, Ukraine
- first care (aidman care)	- first care
- emergency medical treatment	- prephysician medical care
- initial resuscitative treatment	- primary physician care
- resuscitative surgery	- qualified medical care
- definitive treatment	- specialized medical care
- convalescent care	- rehabilitation
- rehabilitation	

The following allocation unifies the different classifications of forms of medical care:

- 1) resuscitation and stabilization – lifesaving measures;
- 2) emergency surgery and postoperative care – prevention of complications and disability;
- 3) definitive treatment and rehabilitation – full recovery, return to duty.

Medical capabilities (volume of medical care).

Russian and Ukraine military-medical regulations contain provisions for complete as well as reduced volumes of medical care. The latter is put into action when the capability of the treatment facility does not allow to provide care for all patients. In this case, only emergency and resuscitation procedures are performed.

According to NATO and USA policies, the capabilities of medical facilities fall into two categories:

- minimum capability, which is basic and mandatory, and which cannot be reduced below this level;
- augmented capability, when treatment facility is enhanced by selected personnel and other resources to meet specific requirements of a mission.

Our version of the categorization of volumes of medical care seems to be closer to real field medical practice. Proposed categories of capabilities of the field treatment facilities are the following:

- a) routine (complete or basic) care, implemented in ordinary situations when the capacity of the medical treatment facility is not exceeded;
- b) quantitatively extended care, by augmenting the same level of care;
- c) qualitatively augmented care, with a selected specialized team of surgeons and relevant equipment to provide specialized care as close as possible to the combat area;
- d) reduced care, limited to life-saving and emergency procedures in mass casualties situation.

Triage.

Triage is the process of sorting the wounded and sick patients into similar groups in accordance with the nature and severity of injury or illness, the urgency of the medical care needed and the character of evacuation.

Field medical manuals underline that in case of mass casualties, triage is conducted with the purpose to first provide direct medical care to patients having better chances to survive and return to duty. Some experts object to this approach as an unacceptable procedure, which leads to fatal outcomes among many persons with mortal wounds.

Table 2.

**The Red Army combat personnel losses during the Great patriotic war,
in million persons (by A. Rusakov, 1995)**

Total number of wounded (1941-1945)	30,0
Of whom died	6,0
Definitely mortal wound	3,0
Wounded whose life could be saved	3,0

Due to importance of this problem, we will discuss it more comprehensively.

Expectant category of wounded

There are patients who have received serious multiple injuries, severe head and spinal trauma, large doses of radiation, or wide-spread severe burns. Treatment of this category of patients is time-consuming, and it threatens to exhaust the medical manpower and supply, while the chances of survival are small.

According to current military-medical policy, the treatment of this category of patients is, in most cases, limited to reduce their discomfort by administering large doses of analgetics and narcotics, although they demand emergency life-saving measures. We propose that in these cases, at least three aspects of medical care should be considered: medical, ethical and legal. The medical aspect is that there are no strict criteria available to attribute severely wounded patients to a group for which there is no hope. Therefore, in many cases, their survival depends on the personal experience, responsibility and morality of the physician, rather than on the capacity of the medical treatment facility. But there is also a juridical aspect, which relates to the patient's constitutional right for adequate medical care and treatment.

In many countries, the medical jurisprudence contains the term "abandonment or withdrawal of medical care of a suffering patient", and heavy punishment of the health provider is demanded for such misconduct. This problem has recently become more important, due to the increasing number of severe, multiple and associated injuries in contemporary military conflicts.

Military-medical standardization.

Military-medical standards are official documents defining norms, rules and requirements related to different aspects of Armed Forces medical support.

The following main categories of military-medical standards can be distinguished:

- terms and meanings;
- measurement units;
- statistical values;
- devices, apparatus, tools;
- pharmaceuticals;
- medical equipment;
- credentials and privileges of health care providers;
- medical services;
- personnel health status;
- the combat strength of a soldier.

Requirements for military-medical standards are fourfold:

- a) military-medical standards should be equal to, or higher than the national health standards;
- b) standards of wartime should correspond with peacetime standards;
- c) national standards should, as much as possible, conform to international standards;
- d) unification of medical support for multinational forces is achieved by signing interstate standardization agreements (STANAG or others).

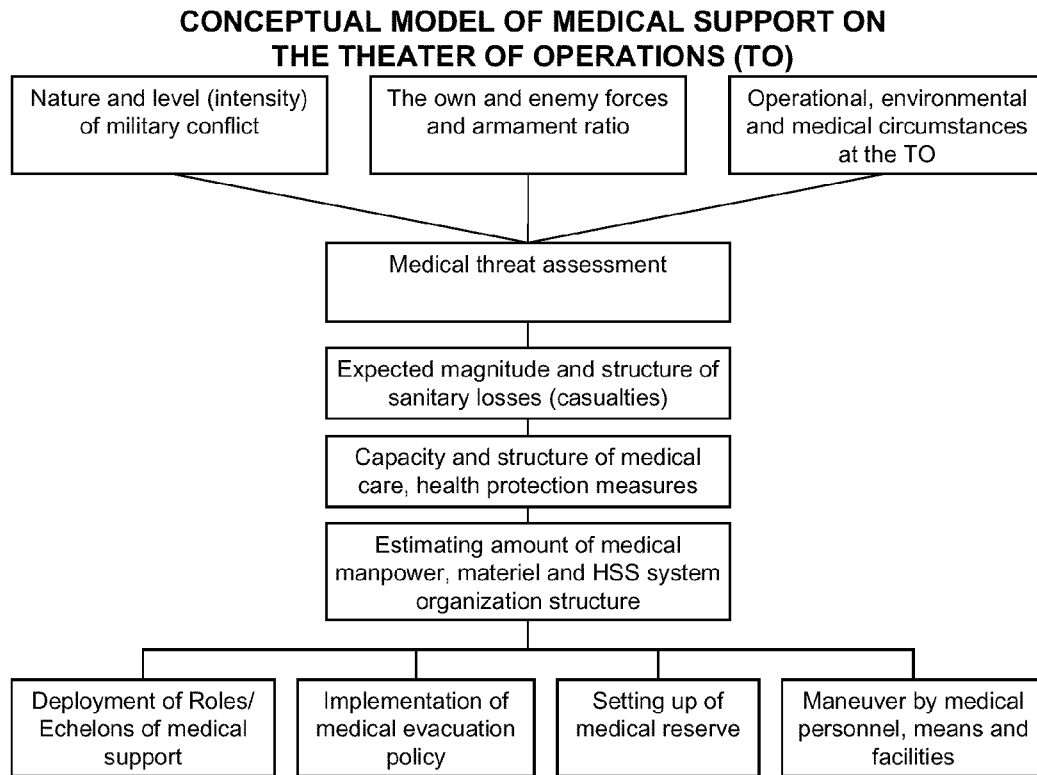
National military-medical services should make every effort to achieve the highest possible standardization in order to enhance medical interaction in joint operations. A common military-medical doctrine, in addition to standardization of equipment, terminology and procedures, validated through participation in joint exercises, provides the back-ground of force interoperability. At the international level, emphasis must be placed on the integration of medical services of contributing nations. This will have a decisive effect on the ability of multinational forces to achieve joint objectives.

Standardization of the military-medical terminology has one of the highest priorities. Our work in this area resulted in the "English-Russian-Ukraine alphabetical reference-book of military and disaster medicine" and "Abbreviations available in military and military-medical terminology of NATO".

The "Essential List of STANAGS" includes two NATO agreements of this kind: (1) STANAG 2131 – "Multilingual Phrase Book for the use by the NATO Medical Services (AMEDP-5) and (2) STANAG 2409 – "NATO Glossary of Medical Terms and Definitions (AMEDP-13)". These documents are limited to standard definitions of medical terminology, as used within the NATO military-medical services and they are based exclusively on the experience of the NATO community. It is the time to augment them with the military-medical terminology of PfP countries. To realize this idea, we suggest that NATO's Military Agency of Standardization (MAS) establish a permanent international team of experts on standardization of military-medical terminology. The final result of the activity of this team will be the publication and periodical revision of a multilingual encyclopedic reference-dictionary on military and disaster medicine.

In conclusion, let us show possible application areas of the Military-Medical Doctrine. These include: the development of a model of the military-medical system, the development of manuals and regulations, research and military-medical personnel training, the organization and management of national medical support systems for the Armed Forces, and the strategic planing of the medical support for multinational forces.

Figure 2



The scheme shown at figure 2 we define as a fragment of comprehensive model of military-medical service – 2010 which is been developing now.