

# BALANCING SECURITY AND MEDICAL TREATMENT IN LARGE SCALE COMBAT OPERATIONS

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The Brigade Support Medical Company, commonly known as the Charlie Medical Company (C-MED), presents a unique set of challenges for commanders as they balance the sustainment principle of survivability and execution of medical operations. Over the last twenty years Role II Medical Treatment Facilities were located on forward operating bases housed predominantly in protected buildings. As the Army's training focus shifts to large scale combat operations (LSCO), against a near-peer to peer competitor, the status quo becomes unfeasible. As the forward line of troops shifts significantly in a short period of time, the security and mobility of the Role II becomes ever more important. As warfare changes, so too does the need to revise security for the Role II.

The 2nd Cavalry Regiment (2CR), a Stryker Brigade Combat Team (SBCT), holds a critical strategic mission: The deterrence of aggression towards our NATO partners and European allies. It is upon this framework that the C-MED seeks to execute the commander's intent of providing forward deployed Health Service Support to the Regiment. Paramount to the execution of the mission is solving the security dilemma. Lessons learned from multiple training exercises to include Combined Training Center (CTC) rotations, reveal security gaps that must be addressed in order to achieve mission success.

## Relevant Laws and Implications

C-MED faces challenge due to constraints and requirements of International Humanitarian Law (IHL). Under Geneva Convention (I) for the Amelioration of the Condition of the Wounded and Sick, Article 19: "Fixed establishments and mobile medical units of the Medical Service may in no circumstances be attacked, but shall at all times be respected and protected by the Parties to the conflict." However, under Article 22 of Convention I, the right to bear small arms in self-defense and for the protection of patients remains. This restricts the medical company to small, portable, single operator weapons. In order to comply with IHL medical personnel can only

use the XM17 pistol, M4 carbine, and the M249 squad automatic weapon (SAW) or equivalents to defend the Role II. Other weapons, such as M2A1 or M240, would violate Article 22 if used by medical personnel.

## Securing the Role II

Security of the C-MED is vital if adequate health service and support is to be provided to the unit. The multitude of specialty medical professionals provide more advanced capabilities than the Role I. In this regard, the C-MED commander must assume risk in how personnel are employed. This creates a tenuous balance between

According to the Geneva Conventions of 1949, Protocol 1, Article 52 (2) (1977) logistics nodes are considered legitimate military targets and are likely to be attacked by the enemy.<sup>2</sup> With the current doctrinal establishment of the Brigade Support Area (BSA) the Role II is usually at the center of this arrangement of forces. In its most recent field training exercise, Dragoon Ready 20, the Regimental Support Squadron (RSS) or BSB deployed in base cluster formations. This type of base establishment is used to reduce the effect of artillery strikes that have the potential to destroy sustainment formation. (See figure 2)

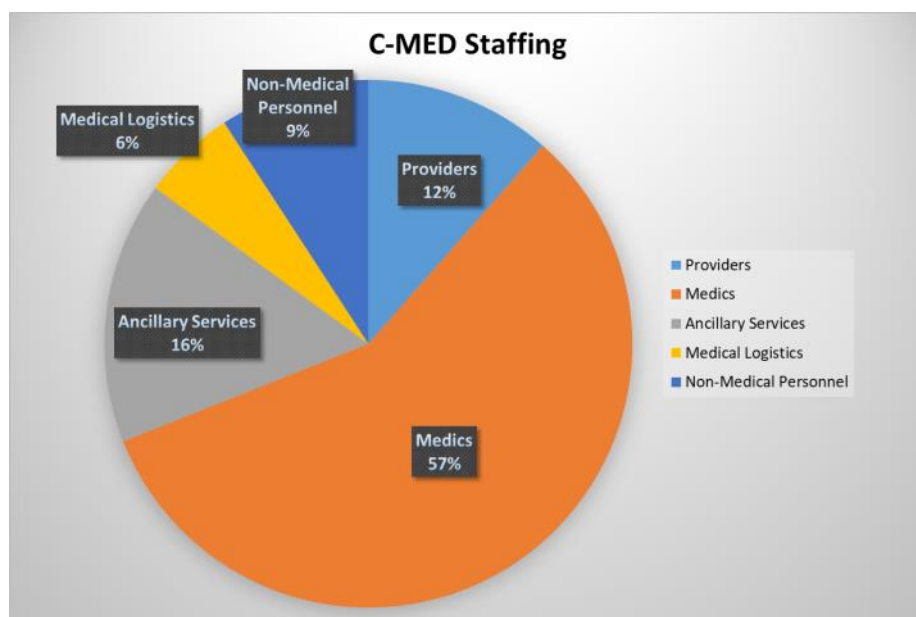


Figure 1. C-MED Staffing

patient care and security that can quickly exhaust medical providers. Furthermore, in the case of a mass casualty event (MASCAL), all medical staff, especially ancillary medical services, are invaluable to the mission of providing high-quality health care to injured Soldiers. (See Figure 1)

In 2CR's previous exercises C-MED attempted to utilize the evacuation platoon to provide security for the entire perimeter while the rest of the troop established the Role II. However, this removed all evacuation systems available to the Regiment for an extended period of time.

Subordinate company sized elements were geographically separated and in turn are required to manage their own unit security.



In this configuration, C-MED struggled with securing the Role II perimeter due to a lack of personnel and firepower. All attempts to establish security with its organic assets were

The hybrid warfare threat during Dragoon Ready 20 resulted in the died of wounds (DOW) rate of 100 percent! The majority of the DOW's were soldiers that received lifesaving

threat and the risk of losing critical evacuation assets.

**Discussion**

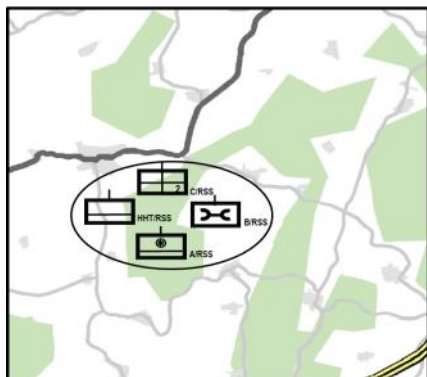
The amount of support required to secure the Role II provides commanders as battle space owners an immense challenge. The limitation of small arms significantly decreases lethality of C-MED with current vehicle authorizations. It is incapable of providing mobile security of MEDEVAC with its organic assets.

This was a lesson learned during the Dragoon Ready 20. The rear area tasked a single military police company to provide security in the support area, to include C-MED. Due to hybrid threats disrupting other units in the rear area, the battalion echelon commander was forced to divert assets away from C-MED. As the battle progressed, the hybrid engagements forced the 2CR Commander to divert a maneuver company from the front line to assist in securing the rear area.

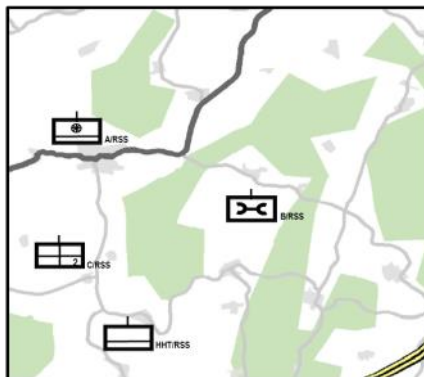
It is under this pretext that C-MED suggests a direct attachment of a security element. This will allow the commander to employ the assets as needed to meet the higher command's intent. This takes the tasked group of Soldiers out of the picture in terms of planning above company/troop level.

Another possibility is to change the current the brigade support battalions (BSB) authorizations. Currently, BSBs do not have enough Convoy Protection Platforms (CPP) to dedicate to area security, LOGPAC security, and MEDEVAC security. This problem is multiplied when units are separated in base cluster formations by kilometers or terrain features.

**Base Whole Defense**



**Base Cluster Defense**



VS

Figure 2. Two Methods of Brigade Support Establishment

futile. Only after all medical functions have been established, can the C-MED medical personnel assume security duties. Also security over a prolonged period proved unsustainable. C-MED employed all medical personnel, save for the providers, to augment base defense during enemy attacks. In LSCO the personnel authorizations of the C-MED cannot meet its security requirements.

**Providing Security for Medical Evacuation (MEDEVAC) Movements**

The capability to evacuate patients to higher echelons of care is critical to their survivability. A SBCT's ground MEDEVAC uses Stryker Medical Evacuation Vehicles (MEVs) as the primary means of evacuation to and from the Role II. Battalions provide a security escort from the Role I to the Role II; however, C-MED does not have organic assets to provide security while evacuating patients to the Role III or in an ambulance exchange point (AXP) between the Role I and the Role II. (See figure 3)

Although the Role II is likely to be miles behind the forward line of troops in LSCO, the threat of hybrid warfare jeopardizes the MEDEVAC process. "Hybrid warfare involves the coordinated use of irregular and regular military means towards different but complementary ends."<sup>2</sup> This requires commanders to plan for a security element for MEDEVAC assets or assume risk of losing the asset in case of a hybrid warfare attack.

interventions, were in stable condition, and ready to be transported via MEDEVAC but were considered deceased because they did not make it to the next echelon of care within time. The criteria for survivability of the patients during Dragoon Ready 20 was based upon outdated doctrine.

Army medicine is currently undergoing a paradigm shift that focuses on prolonged field care, which is the practice of caring for patients over a longer period of time (>4 hrs.) until they can be evacuated to the higher level of care. When CTC's adopt this method of care, the available time to conduct MEDEVAC will increase directly correlating to lower DOW rates.

On multiple occasions, the evacuation vehicles were staged outside of the Role II with patients loaded, but the battle space owner, a battalion level commander, denied security requests for the MEDEVAC due the lack of available assets. Company grade commanders made decisions not to execute the MEDEVAC without security based on the enemy

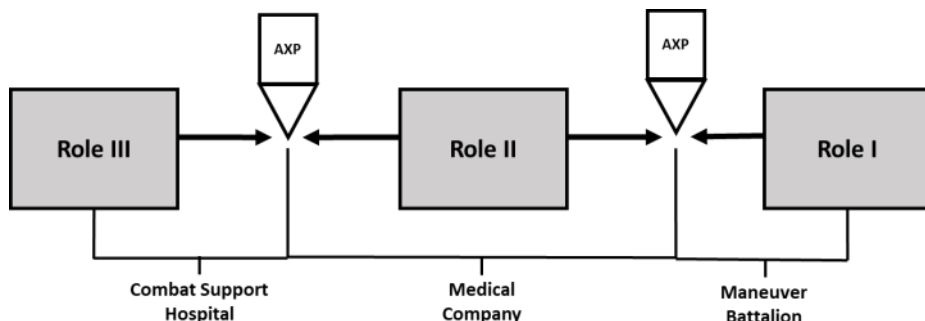


Figure 3. Roles of Responsibility for MEDEVAC Security

Additionally, mounting a weapons system on a MEV to use as security, disqualifies its protected status under the Geneva Conventions thus prohibiting the MEV from carrying patients to the next level of care. Considering a conservative casualty estimate of 30% across the Regiment, and given four MEV crews working on a rotational basis, evacuation crews would quickly find themselves struggling to keep pace with MEDEVAC requests.

Throwing manpower at a problem is not always the answer, but, in this case, giving the BSB commander more flexibility to secure sustainment formations is crucial. If the Army increases the amount of security platforms within the BSB, the competing requirements of securing BSB companies could be mitigated. An attachment of multiple CPP's, with crews, to C-MED from the distribution or maintenance company, would allow for the proper amount of assets for MEDEVAC and area security in the complex operational environment we are likely to face. The training and readiness of these crews and equipment would stay within their parent organizations, and, when time to deploy, the already established command support relationships will take effect. An example of this would be the imbedding of combat medics

from the HHC into the infantry company.

Nevertheless, the prior concern of managing security assets remains as the BSB commander maintains overall tasking authority. As operations evolve, and security postures change to ensure coverage, commanders will be responsible for allocating security assets where they deem most appropriate. Of course, commanders can choose to reallocate security resources from the C-MED to emergency logistics runs, leaving the medical unit to defend itself.

### Conclusion

Lessons learned are of great importance to the Army as an institution. Identifying a gap is the first step in trying to make us better sustainers. The security gap within the Role II is not a new one but will challenge the Army in the future. Many training exercises such as CTC rotations, although excellent training environments, still lack the ability to replicate all of the scenarios that a unit will see in a near-peer to peer war. The intent to stress systems while in a training environment is not lost on this unit, but training exercises are truly limited by time constraints. Practically, this means that units can "hold their breath" while in training instead of actually operating as they

would in a combat environment where they would endure austere settings for months to years.

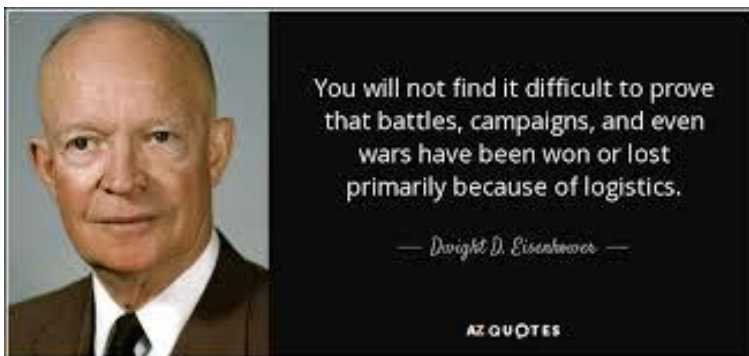
For a C-MED, performing its medical duties, while also trying to maintain a security posture, and providing security assets for MEDEVAC is not feasible. Resourcing, planning, and integrating security forces is a necessary component of C-MED's mission execution. When outside units are attached to a brigade-size element, it is at the commander's discretion how assets are employed. A combat environment is certainly a learning environment, but not the place we want to learn our hardest lessons. To achieve success, company to echelons above brigade commanders have the responsibility to advocate change for how we are equipped and how we fight.

Endnotes:

1. International Committee of the Red Cross. (1949, August 12). Convention (I) for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field. Geneva, 12 August 1949. Retrieved from International Committee of the Red Cross: [https://ihl-databases.icrc.org/applic/ihl/ihl.nsf/Article.xsp?ation=openDocument&documentId=D](https://ihl-databases.icrc.org/applic/ihl/ihl.nsf/Article.xsp?ation=openDocument&documentId=D8F87DF50E554BC2C12563CD0051A030)

8F87DF50E554BC2C12563CD0051A030

2. Lanoszka, A. (2016). Russian hybrid warfare and extended deterrence in eastern Europe. *International Affairs*, 175-195.



**Dwight David Eisenhower** was born on October 14, 1890, in Denison, Texas. As supreme commander of Allied forces in Western Europe during World War II, Dwight D. Eisenhower led the massive invasion of Nazi-occupied Europe that began on D-Day (June 6, 1944). In 1952, leading Republicans convinced Eisenhower (then in command of NATO forces in Europe) to run for president; he won a convincing victory over Democrat Adlai Stevenson and would serve two terms in the White House (1953-1961). **Died:** March 28, 1969, Washington, D.C

