

THE ROLE OF COMBAT LIFESAVERS IN COUNTERINSURGENCY OPERATIONS

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The accomplishments, courage and dedication of the combat medic on the battlefield are legendary. Wherever an infantry platoon, artillery battery or tank troop goes, a “Doc” is always there, ready with skilled, competent hands to do his job. As good as the medic is, he can’t be everywhere at once and this is especially true in urban operations or the modern day setting of counterinsurgency operations (COIN).

Immediate far-forward first aid is essential on a widely dispersed and fluid battlefield to prevent Soldiers from dying of wounds. Medical personnel may not be able to reach Soldiers at all points on the battlefield in a timely manner. The combat lifesaver is a nonmedical Soldier trained to provide advanced first aid/lifesaving procedures beyond the level of self aid or buddy aid.

History

Up to 90 percent of combat deaths occur on the battlefield before the casualties reach a medical treatment facility (MTF). Most of these deaths are inevitable due to trauma, head injuries, and other multisystem injuries associated with combat. However, some conditions such as bleeding from a wound on an arm or leg, tension pneumothorax, and airway problems can be treated on the battlefield. This treatment can be the difference between being a combat death on the battlefield or a recovering Soldier in an MTF. It has been estimated that proper use of self aid, buddy aid, and combat lifesaver skills can reduce battlefield deaths by 15 percent. In combat, functioning as a combat lifesaver is a Soldier’s secondary mission. The primary mission is always a Soldier’s combat duties (Military Occupational Specialty — MOS). The first priority while under fire is to return fire and kill the enemy. Rendering care to injured Soldiers only begins when such care does



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An NCO with the Joint Aid Station shows Soldiers how to administer an IV during a Combat Lifesaver Course given at Joint Task Force Guantanamo’s Camp America June 5.

not endanger your primary mission. This is when combat lifesaver skills are paramount.

Training the Combat Lifesaver

The primary mode that the Combat Lifesaver Course (CLC) is offered is through the Army Correspondence Course Program (ACCP) using the group study. In this mode, instructors are provided lesson plans, student self-study materials, written (multiple-choice) examinations, solutions to written examinations, and performance checklists. Training, testing, and grading are conducted under the supervision of qualified medic instructors at the Soldiers’ home stations.

The course consists of 40 credit hours of self-study material, approximately three days of classroom instruction, and testing materials. Testing includes a proctored multiple-choice exam and performance examinations.

During the Leader Training Program at the National Training Center at Fort Irwin, California, the call went out to conduct Combat Lifesaver Courses for the 3rd Infantry Division’s 26th Brigade Support Battalion (BSB). The goal was to train as many personnel as possible to the established standards. Because the course was to be conducted during brigade focus training exercises and taught in a field environment, a change was warranted in the way these classes were normally instructed. Tents were erected to conduct the training and other CLS instructors from within the medical company were identified. Copies of the Combat Lifesaver Student Study Guide were distributed to every company for the participants to study prior to attending to the training.

Without classroom accommodations for the normal PowerPoint presentations, the concentration on hands-on tasks and full

class participation ensured that participants were able to retain the information and understand the material being taught. Instructors conducted demonstrations of all tasks and talked students through every step of how and why each treatment technique was used. Small groups, with a CLS instructor for each group, ensured the students properly comprehended each task. Students took notes, actively participated, and were quizzed constantly on the material throughout each lesson.

During testing, a standard written exam was administered. Afterward, students were moved to combat trauma lanes, set up for hands-on testing in a simulated combat environment. These lanes were similar to those encountered during testing for the Expert Field Medical Badge. Charlie Company, 26th BSB ensured the success of these trauma lanes by focusing the students' training on realistic combat injuries and patient scenarios. Pyrotechnics were employed and Soldiers acting as an opposing force attacked the students to ensure more realistic combat training experience. Soldiers played the part of injured patients, and students were expected to carry them on litters, call in 9-line medical evacuation

(MEDEVAC) requests, fill out field medical cards and successfully treat casualties.

This training methodology offered a more realistic approach than the traditional classroom-based version. Using this hands-on approach was a great success. We executed a successful CLS evolution with a 95 percent passing rate. During the after action review (AAR), the vast majority of students reported how much they enjoyed this class and how the realistic training made them feel more prepared for the upcoming deployment. Soldiers felt that they could accurately provide lifesaving care to their fellow Soldiers should the need arise.

Duties

Combat Lifesaver (CLS) 2 can be divided into three phases: the first is care under fire; the second is tactical field care; and the third is combat casualty evacuation care. The first phase is under hostile fire and only very limited care can be provided. In the second phase, the CLS and injured Soldier are safe with the CLS free to provide casualty care to the best of his ability. In the third phase, care is rendered during casualty evacuation (CASEVAC). Casualty evacuation refers to the movement of casualties aboard nonmedical vehicles or aircraft. Combat casualty evacuation care is rendered while the casualty is awaiting pickup or is being transported by a nonmedical vehicle.

Care under fire is rendered at the scene of the injury while the CLS and the casualty are still under effective hostile fire. The CLS should return fire as directed or required before providing medical treatment, determine if the casualty is alive or dead, and provide tactical care to the casualty. Reducing or eliminating enemy fire may be more important to the casualty's survival than the treatment provided. When appropriate, the CLS can safely move the casualty to a secure area. Lifesaving care, such as applying a tourniquet to stop bleeding, may be necessary before moving the casualty.

Tactical field care is rendered by the combat lifesaver when no longer under effective hostile fire. Tactical field care also applies to situations in which an injury has occurred on a mission, but there is no hostile fire. Available medical equipment is limited to that carried into the field by the combat lifesaver and individual Soldiers. The CLS must assess and secure the casualty's airway, assess and treat the casualty for chest injuries, and identify and control major bleeding. If the casualty has a significant wound to an extremity or to the trunk (neck, chest, abdomen, or pelvis), is coherent and has a palpable radial pulse, then the CLS should initiate a saline lock. If the casualty has a change in mental status or loses pulse, an IV of saline or Hextend is necessary.

The CASEVAC phase begins with the CLS preparing the casualty for evacuation. If the casualty is to be evacuated by medical transport, the CLS prepares a MEDEVAC request. If medical evacuation is not available, the CLS prepares the casualty for evacuation using nonmedical transportation. If the casualty is unable to walk, transporting the casualty using a SKED® or improvised litter is necessary.

Traditional Approach

During a conventional, linear-type conflict or engagement, the



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A Soldier with the 4th Brigade Combat Team, 1st Armored Division carries a simulated casualty to safety during a joint forces training event in Avon Park, Florida, June 16.

intent is to use the combat medic section or platoon as the treatment asset for the company teams. The company medics are attached to those companies and are with them 24 hours a day. The senior medic rides with and works alongside the first sergeant and provides the medical expertise to the company's logistics plan. The combat medic ensures that all combat lifesavers are trained and fully stocked with Class VIII (medical supplies). It is the combat medic's responsibility to run the company casualty collection point (CCP) and provide lifesaving care to patients awaiting transportation to the aid station. The company relies on the combat medic to synchronize evacuation with the aid station. In this role, the company combat medic will become the "ad hoc squad leader" for the company's medical team, which includes the pre-positioned M997/M113 ambulance. As the squad leader, the combat medic will brief the ambulance team on the company's mission and concept of operations. This medic will conduct the pre-combat inspections (PCI) of the ambulance team to ensure that all company PCIs are completed. The company combat medic will supervise all medical care until the patient is MEDEVAC'd to a higher echelon of care. The CLS traditionally provided on-site basic care until the company combat medic arrived or the patient was transported to the CCP for evaluation by the combat medic.

Counterinsurgency Medical Support – "A Technique"

With both urban and COIN operations, the traditional medical evaluation, care, and transportation of the casualty is a much harder process. Due to both the separation of smaller elements from the company and lack of a linear battlefield, it has become essential that all Soldiers are trained in the tasks of a CLS. It is the care provided by the CLS that will make the difference between life and death for some Soldiers.

The use of combat lifesavers during route-clearing operations is essential on mounted and dismounted missions. Starting with the warning order (WARNO) from the commander, mission templates were established encompassing the beginning to the end of the mission on how patient care would occur if casualties were taken on either mounted or dismounted missions.

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Before each mission, the tactical commander would give the mission brief and the senior medic would brief how casualties would be managed and whether evacuation was to be conducted by air or ground. The method of evacuation would be determined by the medic on the ground depending on the location of the casualty, weather, and the category of the injury. All of these would be relayed via a 9-line MEDEVAC request.

Mounted missions consisted of mostly convoys to other forward operating bases or patrol bases. These missions underscored the need for CLS personnel as there were many more mounted missions than dismounted missions. Medical personnel relied heavily on the CLS in each vehicle to be able to initiate self-care, buddy aid, and first aid techniques at the point of injury. The CLS personnel would evaluate the patient and initiate the appropriate care. When a medic arrived on scene, they would brief the medic and then assist under the direction of the medic. The knowledge of basic care taught in CLS classes gave them a great foundation to build on, and the care they provided saves lives. Each vehicle carried a Warrior Aid & Litter Kit (WALK), a CLS bag, a litter, and a spine board per SOP. Each vehicle was configured the same way to make locating this equipment easier and faster.

In the case of dismounted missions, squad leaders were heavily relied upon to coordinate with the medic to synchronize CLS within each squad. Considering that two medics were present on each dismounted patrol, it was easier to set up a plan of action in the event of casualties. The patrols were usually split into two groups,

each having a medic to ensure the CLS personnel in his group had the required equipment on hand. Each team had two designated CLS personnel, a WALK, CLS bags, and extra equipment to control bleeding according to the SOP for dismounted missions. The chance of encountering casualties was significantly increased on dismounted missions because Soldiers were out of their up-armored vehicles and exposed to small arms fire and dismounted IEDs. The need for CLS personnel was further emphasized due to the fact that there were only five combat medics for 148 personnel assigned. The CLS afforded the medics the additional support to accomplish their mission and also gave the Soldiers confidence that if they were wounded in action, their buddies would be there with the knowledge and skill to keep them alive until the medic could get to them and provide even more definitive care.

Discussion

Although the combat medic normally attached to each rifle platoon is the Soldier best trained in the treatment of traumatic injury, he can quickly become overwhelmed by the number of casualties needing care. The commander must train selected Soldiers within the platoons to administer enhanced first aid using the combat lifesaver program. The work of these combat lifesavers, plus the buddy-aid efforts of individual Soldiers, eases the burden of the combat medic and allows him to concentrate on the seriously wounded. The medical platoon should plan to care for the mass casualties inherent in combat in urban areas. Combat medics and lifesavers should expect a higher incidence of crushing injuries, eye injuries, burns, and fractures due to falling debris, spall from buildings, rubble, and fire hazards. Additional effects, such as concussive shock and hearing loss due to explosives, should also be expected.

One striking aspect of urban, combat operations is that small units operate independently and end in isolation because of the unusual character of the built-up area. In a city with a block-type arrangement, a rifle company is considered capable of neutralizing a single city block. At first glance, this seems to be a reasonably manageable situation; but as the 180-man



Soldiers from the 4th Battalion, 9th Infantry Regiment transport a trauma victim to a medical evacuation helicopter in Tarmiyah, Iraq, September 30, 2007.

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company melts into the hundreds of rooms of the block, the picture becomes clear — control will be difficult and Soldiers will quickly discover that they are alone.

After the Battle of Saigon in 1968, Soldiers remarked that they would often maneuver through several blocks and suddenly discover that someone was missing. Where was he? Was he wounded? Was he dead? Do we stop to look for him or do we carry on? There were similar occurrences in the Battle of Hue where entire detachments could be quickly isolated from the main body by the rapidly changing tactical situation. At no time has this phenomenon of isolation been more obvious than in modern-day Belfast and Londonderry where the size of the operational force in an entire neighborhood is maybe a squad, which hardly warrants having a full-time medic along.

This point seems to bring up some interesting questions. How prepared are our Soldiers to care for themselves or their fellow Soldiers if injured? How well does each Soldier know the part of the city in which he is moving? Enough to look for a missing unit member? Has someone assured that each Soldier carries sufficient emergency medical supplies to care for himself? Are unit members aware of expedient evacuation techniques using improvised litters for evacuation of the critically injured from the eighth floor of a building and over the rubble to a patient collecting point? These and other questions must be answered long before the campaign begins since the actions of each Soldier in these instances will directly affect the ability of the Medical Department to provide assistance. Expressed simply,

there is little which can be done medically for the dead, and that is precisely what can happen to a badly injured Soldier if he is not handled properly from the beginning.

Summary

To the extent needed to sustain skill proficiency, units should exercise CLS skills during home station training activities (to include field training exercises) and during training deployment (to include rotations through combat training centers). This is crucial in the accomplishment of any mission in the urban or COIN environment. Take the time to ensure all of your Soldiers will be properly cared for on the battlefield.

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