Guest Article

The Impact of Enemy Prisoners of War on Medical Planning—Lessons From Operation Desert Storm

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"Mark my words. We're going to have 100,000 prisoners." BG Joseph Conlin, USA[1]

Relearning Lessons

Almost three years on, the lessons of Operation Desert Storm (ODS) are becoming clearer; and their application to future military doctrine more coherent. This discussion concerns a subject which, although not high on the list of lessons learned, is of significance to our future operational planning. Although the primary debate is its effect on the medical services, it involves issues fundamental to the laws of war and, therefore, of considerable importance to the operational staffs. The subject is almost as old as war itself, Enemy Prisoners of War (EPW).

At the end of the Falklands War, United Kingdom (UK) forces on the Islands were presented with over 10,000 Argentinean prisoners of war (PW), many of whom were sick and injured and whose morale and discipline was severely degraded. Most of the camp stores and resources designed for use at the end of the conflict, including the management of EPW, had been lost at sea. As a consequence, the British had little shelter other than some overcrowded, tick-infested sheep shelters, only enough food for their own troops, and a suspect water supply. These problems had to be resolved in the middle of a South Atlantic winter. It was soon recognized that the only way to avoid a crisis, which might threaten the survival of the prisoners and the health of the islanders and British troops, was to repatriate the EPW as fast as possible. The extent to which the UK went to achieve this quickly, meant that EPW were even returned to Argentina in the luxury P&O liner QE2.

Figure 1. Collecting Iraqi prisoners of war.

This episode is important because it should have served to remind us, ten years later, that EPW are a major factor in planning for conflict. In fact, although the Coalition Forces had taken into account the general issues and had attempted to cater for them arguably, they still did not have a true measure of the problem and were lucky that the expected crowds failed to turn up on the day. Even so the total number of EPW captured by the Allies was in excess of 70,000, many of whom were malnourished and in poor health. The result was a sudden logistic and security problem of considerable proportions which unquestionably taxed the Allies and affected the tempo of operations.

The commander of the 1st UK Armored Division, Major General Rupert Smith, described the effects of being inundated with EPW as "being stressed with our own success." This occurred despite a detailed plan for the management of EPW which included a large, well equipped PW Camp, known as "Maryhill," at Al Quasumah and an infantry formation of almost brigade size, the PW Guard Force, which was tasked to collect, evacuate, and hold EPW. The limitations of available transport and the need for speedy evacuation of over

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8000 captured troops required that many be moved from the battlefield to the EPW camp by Chinook helicopter.

The problems were also outlined most graphically by Lieutenant General Pagonis, Commander 22 SUPCOM, in the final chapters of his account of logistic support of the war which describes the committal of 9,000 troops from the 800th MP brigade to the construction of camps.[3] Construction began in the third week of February, and the first batch of EPW arrived within five days. Again, United States Forces experienced problems of rearward evacuations, but their preferred solution was to use the ubiquitous "low-flying, rented bus."

Medical Issues

For medical planning staff in particular, there are two key issues: Impact of wounded EPW on medical planning and medical support to the EPW plan.

The EPW Casualty

In considering the treatment of wounded and sick EPW, there are three principal issues:

Quantity
Quality
Continuity

Quantity

Quantity characterizes more than a simple total of wounded enemy; it concerns the casualty rate or flow. During offensive operations in particular, there must be the capacity to cope not only with our own wounded (at a rate predicted by the operational staffs), but also with the wounded enemy, as their positions are overwhelmed. Commanders and their staff must understand the need to plan for sufficient medical support to meet the need to treat all wounded combatants, equally and without discrimination. In past conflicts (notwithstanding the clear directions of the Geneva Conventions) when the flow of casualties overwhelmed our medical resources, our own wounded might sometimes have been given some form of priority. The critical eye of the international media would make this highly unlikely in the future.

Quality

Quality describes the patient's general condition rather than the treatment offered. Modern warfighting doctrine dictates that the enemy be cut off from his support bases and starved of essential logistic support and vital C2 – the so-called "Deep Battle" concept. Whilst there is no denying this as a fundamentally sound tactic of war, the result will very probably render the enemy unable to evacuate their wounded from the forward combat zone.

When enemy positions are taken, they will yield sick and wounded who may have received life-saving first aid and perhaps some limited resuscitation, but little more. Many will be undernourished and in poor general health and, when wounded, will present complex surgical management problems.

They will generally require more resuscitation and surgical time, more blood and antibiotics, and more intense post-operative care than those with comparable injuries from our own side. As a consequence, their management could inhibit the treatment capability and the mobility of our medical resources, particularly the deployable hospitals at Role 3.

Figure 2. *Treating wounded Iraqi prisoners of war.*

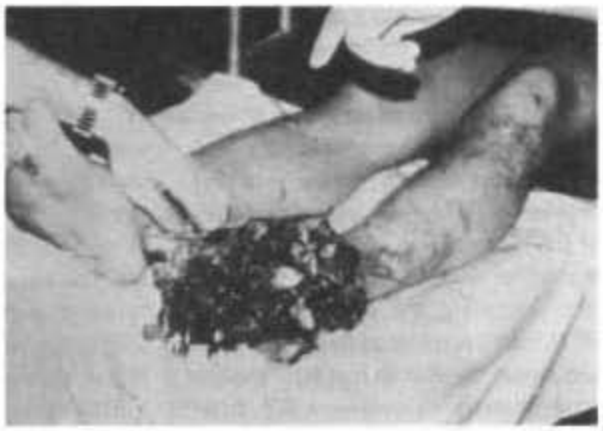

Figure 3. *Role 3 – Life saving surgery.*

Continuity

The third issue, continuity, relates to the progression of care that is fundamental to the management of the sick and wounded in conflict. Combat medical support is organized in echelons of care, from Role 1 to Role 4; the aim is to get the wounded away from further danger – the battlefield – as rapidly as possible and to limit medical treatment to the absolute minimum to sustain the casualty – termed life and limb saving surgery – until he or she can receive definitive

care. That is comprehensive repair, including, if necessary, reconstructive surgery, post operative nursing, and rehabilitation.

Future warfighting doctrine, as exemplified in Air/Land Operations, requires reorganization of medical support concepts so that definitive care can be provided where the needs of the wounded serviceman and the family can best be met and where the highest quality medical resources can be guaranteed — at home. Increased emphasis is being placed on far-forward resuscitation and rapid inter-theatre evacuation, pausing in-theatre only to undertake those life and limb saving measures essential to sustain the casualty en route.

Questions arise as to how the wounded EPW will be managed within the new concept. The system will afford the same treatment at Roles 1, 2, and 3, including life and limb-saving surgery. However, the operational doctrine for modern Role 3 Deployable Hospitals is predicated on rapid evacuation and limited holding policies. Given that it is neither operationally nor medically desirable to hold wounded EPW at this level any longer than clinically necessary, there will be a need to provide an alternative focus for their definitive treatment in future medical planning; the question remains as to how this is to be achieved.

Providing Definitive Care

Articles 109 and 110 of the Third Geneva Convention lay down, in precise detail, the procedure for the repatriation of seriously sick and wounded prisoners of war, either direct or via a neutral country.

"Parties to the conflict are bound to send back to their own country, regardless of number or rank, seriously wounded and seriously sick prisoners of war, after having first cared for them until they are fit to travel . . ."

Experience in the Gulf War showed that such a repatriation process is extremely complex to establish and generally operates very slowly. Consequently, wounded and sick EPW require evacuation from Role 3 deployable hospitals into larger, more static units that can accommodate and, in many cases, undertake definitive treatment whilst repatriation is being arranged through ICRC.

Emerging operational medical doctrine does not envisage the need for large, complex deployable medical units in the future. There is, therefore, a need to develop a system which can provide wounded EPW with the type and standard of medical care they require, whilst repatriation is being organized. A number of options are possible.

Third Parties

Again, experience in the Gulf War suggests that one option might be the employment of medical resources from neutral or nonaligned countries, what the UK called Other Nations Medical Assistance (ONMA). This plan enabled nations who were unable to commit combat forces to the conflict to contribute with humanitarian aid. A number offered medical units, including state-of-the-art field hospitals, to assist with the management of the wounded, irrespective of nationality. A significant number of wounded Iraqi PW were held and treated in "ONMA Hospitals," whilst repatriation was organized. The system worked well and is a concept worthy of further examination. One possible solution is to expand the idea, by formal arrangement with ICRC, for the provision of neutral organization hospitals to care for EPW and even refugees, in future contingencies.

Host Nation Support

Although Host Nation Support (HNS) hospitals did manage a number of wounded EPW during ODS, it was a unique situation in which the Host Nation resources were never stretched. It is unlikely that in future operational theatres, HNS will be able to provide the resources necessary. Moreover, the problems of political sensitivities, particularly over repatriation, will always remain.

Evacuation With Own Wounded

In order to provide the same standards of medical care available to our own forces, the evacuation of some seriously wounded EPW to the home base for definitive care may be considered. However, the resources and political implications will dictate that this will occur only exceptionally, if ever.

Dedicated Hospital Resources

Circumstances may dictate that neither HNS nor Third Party medical

Figure 4. Operation Desert Storm — Prisoner of war camp.

assistance is available to manage EPW repatriation and that evacuation to the home base is not possible. In this event, it will be necessary to dedicate specialist hospital facilities from our own resources. Whilst this option is feasible, two issues will have to be addressed by the operational staffs. First, in order to produce the necessary medical resources for the ORBAT, the medical liability for EPW must be calculated, in addition to our own Casualty Rate. Second, the unit or units earmarked must be tailor-made for the task, for example, provision of specialist medical and surgical capability and post operative care facilities. Critically, this must be recognized as a special task for which units will require training and equipment.

The Health of Captured EPW

The second area of concern, the health management of large numbers of captured EPW in camps, is potentially a greater problem than that presented by the wounded. Even a cursory glance at past conflicts shows that EPW can be a major drain on the resources of the captor. The UK's problems in the Falklands, already mentioned, were neither new nor unique. At times during WWII, particularly in campaigns such as North Africa, the Allied Armies were inundated with EPW to the point that it affected operational plans. History also shows that, in war, more manpower is lost to disease than to weapons, and this should be at the forefront of plans for managing EPW. When gathered together, they are an at-risk group. Debilitated by battle and defeat, they present a threat not only to their own health but to their captors too, acting as foci for the spread of disease. Recorded cases from WWII show typhus outbreaks in POW camps which caused thousands of deaths. Quite apart from the moral imperative, it is highly unlikely that such a situation would be tolerated in modern conflict.

The development of an EPW Plan must involve medical planning staff from the outset, and the medical ORBAT must include resources to meet the task. Preventive medicine advice and supervision will be necessary during the construction of camps —kitchens, latrines, sleeping accommodations, etc.

There must be strict hygiene discipline, a source of sufficient clean water, and an efficient waste disposal system. There will be a requirement for medical resources and expertise to examine every prisoner to assess what, if any, medical treatment is necessary. Measures may well include de-lousing and disinfestation, malaria prophylaxis, and even vaccination.

Apart from the minor wounded, there will almost certainly be sickness. Mainly, this will be in the form of common ailments resulting from dietary deprivation and breakdown in personal and communal hygiene prior to capture. However, a threat of disease outbreaks, such as typhus, cholera, and hepatitis, may result in life-threatening epidemics, if unchecked. Medical resources must therefore encompass a range of capabilities, including the ability to treat communicable diseases. Again, this is a specialist task. A standard Role 3 Deployable Hospital, designed for the provision of battlefield life and limb-saving surgery, would need substantial re-organizing, training, and equipping for such a mission.

CONCLUSION

Operation Desert Storm demonstrated that in modern warfare, with its emphasis on maneuver rather than attrition to defeat the enemy, EPW was a major factor. The provision of medical support to EPW planning will be a major task, with a high political profile requiring close scrutiny from neutral international agencies such as ICRC. Therefore, it must not be left to chance or developed as an afterthought once combat has begun. Neither can the medical support for EPW be given as an additional task to the supporting medical organization to manage from their existing in-theatre resources. The quantity and type of treatment involved in treating the wounded EPW could severely test our existing operational medical resources. The provision of timely definitive care and the management of EPW repatriated may present a particular problem. Even the medical management of the relatively healthy and uninjured EPW will be a considerable task, requiring specific resources. The key will lie in preventive medicine and good field hygiene. Notwithstanding these measures, disease will always be a threat to EPW Camps; and a medical treatment capability must be planned for from the outset.

As our Armed Forces continue to reduce in size and reorganize to meet the demands of future warfighting doctrine, they have less spare capacity to take on unplanned tasks. The potential size and complexity of this commitment is arguably beyond the capability of the future armed forces medical services to undertake alone. There is, therefore, a need to examine the possible role of a neutral third party.

Finally, the management of EPWs is an issue that involves the international laws of war. Medical issues pertaining to them require debate in an international forum. This debate should begin now; it will be too late to find a resolution when the next conflict begins.

REFERENCES

1. Quoted in *Moving Mountains*, Lt Gen William G Pagonis.
2. Address by Maj Gen RA Smith to Army Staff College Camberley, May 93.
3. The Geneva Conventions of August 12, 1949, Reprint Geneva, 1986. ●