OPERATION TELIC IRAQ 2003-2009: A SURGICAL PROFESSIONAL RETROSPECTIVE

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For it's Tommy this, an Tommy that, an "Chuck him out, the brute!"
It's "Sentence of ‘is country’ when the guns begin to shoot;"
An it's Tommy this, an Tommy that, an anything you please;
An 'Tommy ain't a bloomin' fool - you bet that Tommy sees!

Tommy (Atkins)
Rudyard Kipling (1865-1936)

The military operations in Southern Iraq self-evidently created the framework upon which many medical advances were made. They paralleled the experience of US forces elsewhere in the country, by providing operational trauma care, with the development of multinational teams of military doctors, fresh from overseas battlefields, and with a strong role in the on-going medical support and trauma care. The National Field Hospital Trainer at Totworth near York has proved invaluable in this process. Specifically, in respect of surgeons, the Definitive Surgical Trauma Skills (DSTS) Course at the Royal College of Surgeons of England, and more recently in the Operational Surgical Trauma (MOST) Course, have been invaluable in developing skills, insight and experience in a workforce for whom injuries of the type seen in Iraq are not a new experience in the UK.

From the front line, advances in the training, deployment and equipping of individual soldiers and of combat medics, with much improved body armour, tourniquets, chest seals and clotting accelerators, combined with a move almost universally to rapid helicopter transit, saw the delivery of "unexpected survivors" of the immediate blast injuries. This created substantial clinical pressures for the trauma teams and for the supply of blood and blood products.

At field hospital level, Operation Telic 1 saw us enter Iraq with "Cold War" scales of equipment, in old tents erected for thermal, dust and environmental controls were impossible despite Sterling 'Make and Mend' efforts; with the old collapsible, air portable rigid McVicar operating tables; and without CT scanners, digital imaging, or specialist paediatric equipment. Teamworking among multidisciplinary professionals has been elevated to new levels, and revised and regular personnel have integrated seamlessly.

Fortunately, preparatory work during the Balkan campaigns of the late 1990's had allowed our anaesthetic colleagues to make considerable advances in preparing Field ITUs, with appropriate and ruggedised equipment. In later phases of Op Telic, all of the material deficiencies were addressed, other than for the continued use of tents, albeit that the working accommodation was "much improved". From this experience, lessons were learned which led to the commissioning of the remarkable Camp Bastion to Camp Helmand in 2008 in a prefabricated special to purpose building.

Expansion of the Critical Care Aeromedical Strategic Transfer teams allowed large numbers of ventilated, stabilised casualties to be returned rapidly and safely to the UK, where care was progressively more comprehensive, with fast and efficient transfer to the MSO spectrum, from the large military hospitalisation facilities at RAF Brize Norton and RAF Mount Pleasant to the Ministry of Defence hospitals at RAF Lakenheath and Lakenheath, and eventually to the large hospitals at Birmingham, Leeds, Manchester and London.

Painting: The defence of CIMIC House by 1st Bn Prince of Wales’s Royal Regiment, Aj Amarah, Iraq, 2004; Oil on Canvas by David Rowlands, reproduced by kind permission of the Artist

The troops have come home. The official documents are locked away in the Army's Corporate Memory Vaults. The doors are closed on Operation Telic, a campaign in Southern Iraq which lasted the Second World War, running for six years, from March 2003 to April 2009. 179 UK service personnel who died and 1,000 more who were seriously injured in Iraqi bore witnesses to a brutal new phase of warfare, in which the suicide bomber was assisted by the Internet and the propaganda of the belligerents in gruesome fashion.

Operation Telic will not be judged a military or a political success. The Iraq campaign, which was conducted against the popular mood on the basis of very suspect evidence, will become synonymous with the inner workings of the late Blair government. These were dissected in glee but effective fashion during 2010 by the Chilcot Inquiry.

Operation Telic nevertheless spawned at least one remarkable story which should not be overlooked in the Great Year of History. Collectively, our Military Medical Services, in which a high proportion of the surviving significant role, have undergone a transformation in the care of casualties from the point of wounding to long-term rehabilitation and advanced prosthetics; and in the management of the most extreme

injuries which are at, and have previously been beyond, the boundary of survivability. This experience has also transformed casualty care in the campaign in Afghanistan, which has yet to stand the judgement of history in the round. More importantly, it has helped, at last, to bring about the long-awaited modernisation of the NHS Trauma Service, a process in which military doctors, fresh from overseas battlefields, have also played a very significant role.

As a junior Surgeon Taken Up From Trade in March 1991, I stood among the burning oilfields in Northern Kuwait after a race across Southern Iraq in front of the Big Guns with the Field Surgical Team attached to 4th UK Armoured Brigade. Exactly 12 years later, as a Consultant Surgical Reservist with 202 Field Hospital (TA) in Northern Kuwait, I stood on the same ground observing the launch of Operation Telic 1. A junior doctor, observing the frenetic military activity around us, commented that "we had never done anything like this before."

In fact, not only had we done it only 12 years earlier, but much of our equipment and procedures we had found to discomfort or surprises to our predecessors at El Alamein and in the North African Desert from 1940-1943, about which the late Sir William Williams-Scriven had tutored me in his retirement.

I therefore resolved to seek to improve the military corporate memory of Operation Telic. We held a study day in Kuwait in early May 2003, and subsequently 1 compiled narratives across the force, capturing their stories and empty their digital cameras in a higher cause. The upshot was the e-book Blood Heat and Dust, which covered the Entry Campaign, Op Telic 1, from March to June 2003. This book was contemporary and richly illustrated with imagery and personal vignettes, and some 1,500 copies were taken up by the MoD for onward distribution. This book Blood Heat and Dust was freely and readily available for download on the Internet at: www.pangraf.co.uk/bhd

That account left many professional themes open ended. Events in Iraq ran for much of the decade in parallel with events in Afghanistan, which caused even more distortion and distortion in the personal and collective memory. The end of Operations in Iraq in the Spring of 2009 thus provided the opportunity and the stimulus to which revise the book Blood Heat and Dust in a Second Edition. The draft of this book is now broadly complete with such additional material as I have been able to secure, and under the advice of prior intended publication in 2011. Relevant material has also been published in 2010 by Penguin Viking in the book Medic by John Nichol and Tony Bennell.

The medical and surgical lessons of Operation Telic

What were the key areas of transformation in Trauma care since Operation Telic? In terms of the individual and collective preparation of

medics for deployment, considerable advances were made in training programmes and in predeployment hospital exercises, such that by the end of Operation Telic, all military medical units were subject to rigorous assessment and governance oversight, along with feedback of practical experience into the trauma management drills in the modulators. The National Field Hospital Trainer at Totworth near York has proved invaluable in this process.
The Management of Knife Injuries

CONSENSUS CONFERENCE

Sponsored by The Surgical Foundation and the Metropolitan Police

Monday 15th November 2010 saw 114 delegates, from across surgery, law enforcement and social work, attend the Association’s Consensus Conference on improving co-operation and effectiveness of harm prevention and crime reduction associated with knives. The event, which was held in partnership with The Surgical Foundation and the Metropolitan Police Service, received extremely positive feedback, a good deal of national media coverage and resulted in the following joint statement, laying out the major areas of agreement.

One remarkable pointer to the discontinuity between overt public antipathy to the politicians for their responsibility for events in Iraq, and public support for the troops themselves has been the remarkable boon in charitable giving, both to the established service charities, and to new start-ups. Most remarkably, Help for Heroes has raised some £50,000,000+ in five years from a standing start.

It is very difficult fully to appreciate the courage and loyalty of the young service personnel, men and women, soldiers and medics who went out on patrol or on convoy duties in the hellish alleys of Al Anbar, Al Zubayr, Unmi Qasr or Basra city; or who sat through mortar fire onto tended wards and operating theatres during the dark days of Operation Telic; and who lost life and limb for what was progressively seen at home to be a lost political cause, but which remained a matter of intense personal, regimental and military honour and pride on the ground. In crude numerical and historical military terms, deaths and casualties were relatively light across the breadth of Operation Telic. The advances in trauma care which were forced by events upon our clinical teams in Iraq and in the UK, helped to ensure that significant numbers of service personnel and Iraqi nationals survived injuries from which they might otherwise have died. Many lessons were learned, for which we owe the casualties a great debt, and our duty is now to ensure that these lessons will endure.

For many years to come, the long-term casualties of the Iraq Campaign of 2003-2009 will continue to trickle through the nation’s hospitals. The passage of the years will increase the wear and tear on broken bodies, and the exhaustion of daily activities without limbs or orientating senses will increase. Some of these people may pass through your own hands. Their care will remain our moral duty and obligation for at least another generation. They will not ask your sympathy, but they will deserve your understanding and respect for what they have sacrificed in the Heat and Dust of Iraq.

KEY PRINCIPLES

Background:

- Tackling violence needs close co-operation with police and other partners across the public, private and voluntary sectors. There is a need for all public services to work together more cohesively to break down barriers and tackle violence in the community and the role of the extended family requires support.
- There is a need for long-term policy focusing on prevention – the best evidence for prevention lies in targeting children before they become involved in violence as either victims or offenders.
- Police enforcement activity is crucial, but cannot be a long-term solution and is often not a deterrent for this group.

Extending education programmes:

- Surgeons should get involved in early years peer group education programmes involving schools, youth organisations and local police forces.
- More needs to be done to link up new local violence campaign/support groups and agencies to work collaboratively with existing organisations and pre-existing infrastructure.

Sharing of data and public health measures:

- Data sharing between emergency departments and community crime reduction partnerships must become standard practice in every hospital in the UK. ASGBI commits to encouraging surgeons to work to set this up in their local hospitals.
- ASGBI and the Metropolitan Police are of the opinion that we should go further on the quality and nature of data shared. Fears over patient anonymity are inhibiting the ability to properly target services for some hospitals. Non-anonymised data sharing between public services for violent injuries would support approaches to safeguarding children and adults. This would require ratification by the General Medical Council.
- ASGBI would support the restrictions on access to alcohol. The evidence suggests that this would have a dramatic effect on violent behaviour in the young.

Surgical training:

- ASGBI and The Surgical Foundation endorse the development of regional trauma networks – these must be supported by accredited training programmes and courses that include the management of violent injuries.
- ASGBI strongly recommends that all general surgeons involved in the treatment of trauma should attend one of these accredited training programmes.
- Surgeons should be trained to appreciate forensic requirements of the criminal justice system by preserving evidence.

A detailed Consensus Statement supporting, and expanding on, the above Key Principles will be published by the Association in the New Year.