OPERATION TELIC IRAQ 2003-2009: A SURGICAL PROFESSIONAL RETROSPECTIVE

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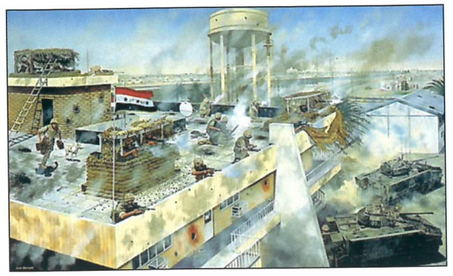
For it's Tommy this, an' Tommy that, an'
"Chuck him out, the brute!"
But it's "Saviour of 'is country" when the guns begin to shoot;
An' it's Tommy this, an' Tommy that, an' anything you please;
An' Tommy ain't a bloomin' fool - you bet that Tommy sees!

Tommy (Atkins)
Rudyard Kipling (1865-1936)



Painting: The defence of CIMIC House by 1st Bn Princess of Wales Royal Regiment, Al Amarrah, 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 outlasted the Second World War, running for six years, from March 2003 to April 2009. 179 UK service personnel who died and 1,000 or more who were seriously injured in Iraq bore witnesses to a brutal new phase of warfare, in which the suicide bomber was pushed to the fore, and the Internet propagandised the work 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 genteel but effective fashion during 2010 by the Chilcott Inquiry.

Operation Telic nevertheless spawned at least one remarkable story which should not be overlooked in the Great Yawn of History. Collectively, our Military Medical Services, in which surgeons played a significant role, have overseen 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-overdue 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 would have caused no discomfort or surprises to our predecessors at El Alamein and in the North African Desert from 1940-1943, about which the late Mr Bernard Williams FRCS had tutored me in his retirement.

I therefore resolved to seek to improve the medical corporate memory of Operation Telic. We held a study day in Kuwait in early May 2003, and subsequently I cajoled colleagues across the Forces to write down 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. The book was contemporaneous and richly illustrated with imagery and personal vignettes, and some 1,500 copies were taken up by the MoD for onward distribution. The book remains directly, fully and freely available as a download on the Internet at: **www.pangrafix.com/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 causes even more confusion 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 wholly revise ***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 official scrutiny prior to intended publication in 2011. Relevant material has also been published in 2010 by Penguin Viking in the book ***Medic*** by John Nichol and Tony Rennell.

The military events in Southern Iraq self-evidently created the framework upon which many medical advances were built. They paralleled the experience of US forces elsewhere in the country, but US casualties were an order of magnitude higher than ours, with more than 4,000 operational deaths. Our medical lessons drew heavily on this tragedy of trauma, and on the parallel suffering of large numbers of Iraqi combatants and civilians.

Operation Telic 1, the overwhelming military "entry" by UK forces into Southern Iraq, was conducted by some 45,000 UK troops, with remarkably few deaths. This was despite adverse publicity about equipment, as for example the local shortage of body armour for some forward troops. A political decision was made to draw down this force by more than a half by the end of Op Telic 1, and by half again over the next two years, such that, at the height of the insurgency in 2006-2007, a light brigade of some 7,000 troops, of whom many were not in the "fighting arms", were holding the ring against a major uprising within a population of two million Iraqis around Basra.

As the insurgency gathered steam through 2004 and 2005, UK forces withdrew progressively towards Basra, and by mid 2007 the situation in the outposts in Basra itself became untenable. Insurgent tactics, including improvised explosive devices, ambushes and suicide bombings were progressively refined, severely restricting the intended efforts at "nation building". Conventional forces were withdrawn to the Contingency Operating Base at Basra Airport, where they were under regular and heavy mortar and missile fire through late 2007 and into 2008. The field hospital at the COB itself was frequently hit during this time, and a number of injuries were sustained by staff.

The unheralded Operation Charge of the Knights by the Iraqi Army in March 2008 effectively routed the insurgency in Basra, allowing the remaining 4,000 or so UK forces personnel to draw down and extract peacefully by April 2009, along with the remaining medical support units and hospital squadron.

As the casualty rate rose, Iraq taught us much about surgical trauma, and obliged the relearning of old lessons from past military ventures into Mesopotamia. An Iraqi military doctor told us in 2003 how Basra had been regarded as a punishment posting in Saddam's Army, and as the thermometer passed 50deg C in May and dust devils tore through the hospital tentage, we understood why.

The medical and surgical lessons of Operation Telic

What were the key areas of transformation in Trauma care through 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 deploying medical units were subject to rigorous assessment and governance oversight, along with feedback of practical experience into the trauma management drills and procedures. The National Field Hospital Trainer at Towthorpe 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 the Military 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 had never been met in civilian practice 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 tentage for which 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 imagery, or specialist paediatric equipment. Teamworking among multidisciplinary professionals has been elevated to new levels, and reserve and regular personnel have integrated seamlessly.

Fortunately, preparatory work during the Balkan campaigns of the late 1990s 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 tentage, albeit that the working accommodation was "much improved". From this experience, lessons were learned which led to the commissioning of the remarkable Camp Bastion hospital in 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 consolidated through East Midlands Airport to Selly Oak Hospital in

Birmingham, where the Royal Centre for Defence Medicine was collocated.

This led to the next challenge, which was one of adaptation of a now largely civilianised NHS hospital resource to military needs, following the closure of most of the UK's remaining military hospitals through the 1990s. The early overload of Selly Oak with complex military casualties; the admixing of these casualties with civilian patients and a number of resulting problems led to critical internal MoD reports and to adverse media coverage. This pressure, in turn, produced a substantial improvement in capacity and form of care for military casualties and a drive for improved facilities in the new Queen Elizabeth Hospital in Birmingham, opened in 2010.

The next level of care to come under pressure and scrutiny was the military rehabilitation service. This was focussed upon RAF Headley Court Rehabilitation Centre, which was in danger of becoming overloaded both with the volume and complexity of its workload in its peacetime configuration. Whereas, in the past, single limb trauma has been the norm there, double and even triple amputee survivors were now posing major challenges for rehabilitation and prosthetic design. An improved national rehabilitation service was put in place with 12 regional centres, so that Iraq casualties with their particular and unique needs did not become a lost tribe, drifting alone and poorly understood through civilian health facilities.

On the academic and governance side, the collection and analysis of trauma data and injury causation has been rigorously systematised by colleagues at the RCDM, whose work has been rightly recognised in the National Honours. Weekly conference calls between the deployed trauma teams in Iraq, Afghanistan and the UK leads allowed the rapid dissemination of lessons and experience across theatres and in feedback to the deployed teams.

Wars in Peace throw up huge psychological problems for service personnel cast adrift in a seemingly uncaring civilian world, as the Vietnam Veteran experience in the US and that of the "Afghanisti" in Russia have shown us. We now have much better understanding and collective sympathy for the problems and casualties of post traumatic stress. Much work has been done in psychological Trauma Risk Management (TRIM) debriefings in the field, homeward bound decompression (in Cyprus) and in long-term support. Programmes such as "Battle Back" and "Toe in the Water" have provided teamworking and physical challenges for the badly injured, while continued employment in the Forces for all but the most severely injured has provided a breathing space for individuals to re-align their lives.

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 boom 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 Amarrah, Az Zubayr, Umm Qasr or Basra city; or who sat through mortar fire onto tented 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, subunit, 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 though 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.

Painting: 1 Close Support Medical Regiment at Bridge 4, Basra, 2003. Oil on Canvas by David Rowlands, reproduced by kind permission of the Artist

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:

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.

THE SURGICAL FOUNDATION

METROPOLITAN POLICE