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The hidden war: humanitarian surgery in a combat zone

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Abstract

BACKGROUND: Humanitarian surgical care (HSC) provided during wartime plays a substantial role in military operations, but has not been described or quantified beyond individual experiences.

METHODS: Prospective survey was conducted of all military members deployed to Iraq or Afghanistan between 2002 and 2011.

RESULTS: There were 266 responses. On average, surgeons had been in practice for 3 years at their 1st deployment and the majority were not fellowship trained. HSC was performed on all body systems and patient populations, including surgery for malignancy. Although 30% of responders performed surgeries they had never done before as a staff surgeon, 84% felt well prepared by their residency. The majority felt that performing HSC improved unit readiness (60%), benefited local population (64%), and contributed to counterinsurgency operations (54%).

CONCLUSION: Over our 10-year period, hundreds of military surgeons performed countless HSC cases in Iraq and Afghanistan and the majority felt that HSC had numerous benefits.
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Humanitarian care and assistance programs have provided both medical and surgical interventions to millions of patients worldwide and are often focused in the most underserved regions or in the face of natural or manmade disasters. Modern military conflict is one of these manmade situations that frequently creates a vast need for humanitarian care and services. Although frequently not well reported or publicized, the U.S. military has a rich history of providing humanitarian medical care during times of combat. Hundreds of thousands of patients received care through Armed Forces Assistance to Korea during the 1950s. Between 1963 and 1970, over 40 million civilian patient encounters took place in Vietnam on Medical Civic Action Projects with U.S. Army physicians and nurses.[1] In the 2010 National Security Strategy, President Barack Obama stated that “the United States must be better prepared and resourced to exercise robust leadership to help meet the critical humanitarian needs.” The Department of Defense shares this vision and stated that humanitarian relief is a core military mission given priority comparable to combat operations.[2] Likewise, the U.S. Army counterinsurgency (COIN) handbook (FM3-24) explains that stability operations, including humanitarian

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relief, are "most valuable to long-term success in winning the support of the populace."

Traditional military doctrine has separated the delivery of forward combat trauma care from humanitarian efforts and there have been no formalized policies or rules disseminated for the delivery of humanitarian care by U.S. military combat hospitals. Although not considered part of their formal mission, forward medical facilities deployed in support of the wars in Iraq and Afghanistan have been frequently called upon to deliver nonemergent humanitarian care. However, the bulk of published experience from the Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) experiences has focused exclusively on trauma care. The little that has been published has been less optimistic with regards to humanitarian medical care during combat operations. In 2006, at the 48th Combat Support Hospital (CSH), COL Beitler et al[3] illustrated that 73% of civilian patients received care that was unnecessary and unlikely to produce a cure and questioned the effectiveness of medical care during humanitarian aid missions. Likewise, a military review published in 2010 stated that "in general, battalion and brigade combat team medical forces should not attempt to provide diagnostic and curative medical care to civilians."[4] Additionally, in 2003, there were more fatal attacks on humanitarian workers than ever previously recorded.[5] It is important to note that these few series focused on the perceived futility of delivering medical care for chronic or long-standing conditions and have not described or evaluated the impact of surgical humanitarian care during combat operations.

Although some individual surgeons have published their individual experiences performing humanitarian surgical care (HSC) while deployed to Iraq or Afghanistan, currently there is no collective data on the U.S. military's HSC numbers, results, or surgeon opinions.[6–9] The purpose of this study was to collect and describe the experiences and opinions from a broad-based sample of surgeons with recent combat deployment experience. We sought to quantify the types and amount of humanitarian surgeries performed, the impact of HSC on individual surgeon and unit readiness, and the opinions of respondents regarding the benefits and drawbacks of HSC in the combat setting.

Methods

After institutional review board approval, an online survey was created. E-mail distribution lists of all active military surgeons were obtained from the Office of the Army Surgeon General and from representatives of the U.S. Navy and Air Force. E-mails were sent to all identified general surgeons of the Army, Navy, and Air Force. Additionally, an announcement and internet link to the survey were placed in the American Association for the Surgery of Trauma (AAST) newsletter to capture recently retired surgeons who had been previously deployed. All responses were anonymous and voluntary. Responses from any surgeon who had been deployed to Iraq or Afghanistan as a clinically active general surgeon between 2002 and 2011 were included.

The survey was constructed so that surgeons who had been deployed to both Iraq and Afghanistan would answer the questions twice, once regarding their experience in Iraq and again for Afghanistan. If a surgeon had been deployed more than once to the same country, they were instructed to fill out the questionnaire regarding the most recent deployment. Prior to wide distribution, the survey instrument was circulated among a panel of senior trauma surgeons with combat deployment experience for revision and editing of content and clarity. The survey had 4 major sections: Surgeon Demographics, Deployment Information, Humanitarian Surgical Care, and Surgeon Perspectives. Answer choices were in the form of check boxes or dropdown menus. Free texting was available when appropriate. Once the survey end date was reached, the questionnaire was closed to new responses and all raw data were downloaded to Excel (Microsoft Corp, Redmond, WA) spreadsheets. Each deployment experience was counted as an individual and independent response set. Descriptive statistics, chi-square test, and independent *t* test were performed as appropriate using PASW 18 (IBM Corp, Armonk, NY).

Results

Two hundred and forty-seven directed E-mails were sent out in addition to the announcement and Weblink in the AAST newsletter. One hundred and ninety surgeons (77%) completed our survey for a total of 266 deployment response sets. Fifty-seven surgeons had been deployed to Iraq, 57 to Afghanistan, and 76 had been deployed to both Iraq and Afghanistan (and filled out the questionnaire twice). Ages ranged from 31 to 64 years with a mean age of 43 (Fig. 1) years. One hundred and sixty-nine surgeons were active duty (89%) and 21 were reserve. One hundred and thirty-five were from Army (71%), 40 from Navy (21%), and 15 from Air Force (8%). Roughly half (48%) came from a Military Medical Center (tertiary referral centers), 23% from civilian academic hospitals, 19% from a MEDDAC (Community Hospital), and the remaining 10% from civilian community hospitals – the veterans administration (VA), private practice, and so on. On average, our responders had been in practice for 3 years at the time of their 1st deployment (Fig. 1). Fifty-two percent of responders were general surgeons, 26% had additional trauma/critical care fellowship training, and the remaining 22% comprised several subspecialties (Vascular, Plastics, Cardiothoracic, Colorectal, Pediatric Surgery, Surgical Oncology, and Minimally Invasive). All respondents had been deployed in a clinical position serving as a general/trauma surgeon.

In Iraq, most (66%) surgeons were deployed to a Level III (CSH) hospital, while one third (27%) went to a Level II

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