Role of the Battalion Surgeon in the Iraq and Afghanistan War

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ABSTRACT The battalion surgeon is an invaluable asset to a deploying unit. The primary role of a battalion surgeon is to provide basic primary care medicine and combat resuscitation. Other expectations include health care screening, vaccinations, supervision of medics, and being a medical advisor to the unit’s commander. As many physicians who fill this role previously worked at medical treatment facilities or medical centers without prior deployment experience, the objective of this article is to highlight some of the challenges a battalion surgeon may encounter before, during, and following deployment.

INTRODUCTION
The battalion surgeon is typically the senior medical provider assigned to each deploying Army battalion. The legacy of the Army battalion surgeon dates back to the French and Indian War in the 1700s where Army physicians provided regimental battlefield medical support. This role was declared obsolete by the Army Deputy Surgeon General following the Vietnam War and reinstituted as a Professional Filler System (PROFIS) in the 1980s. The term is misleading in our current medical structure since this provider is almost never a surgeon. The role of the battalion surgeon is to provide primary care and combat resuscitation. Additionally, the battalion surgeon performs predeployment health screening, supervises training of medics, and serves as a medical advisor to the commander on all issues pertaining to health maintenance of the unit, such as vaccinations and combat readiness. Providers filling this position include family medicine physicians, emergency medicine physicians, internists, pediatricians, medical and pediatric subspecialists, dermatologists, and physical medicine and rehabilitation physicians. More recently obstetricians/gynecologists have been added to the mix of providers filling battalion surgeon roles. Since the majority of physicians deploying as battalion surgeons are first time deployers, the objective of this article is to highlight some of the difficulties a battalion surgeon may experience before and during deployment and to discuss the expectations and role of the battalion surgeon in theater. The article is by no means all-inclusive of the battalion surgeon role but provides a general overview of many of the challenges the position faces.

PROFESSIONAL FILLER SYSTEM
Although brigade surgeons may be organic (permanently assigned) to a combat unit, battalion surgeons are more commonly PROFIS providers. The concept of PROFIS was established in 1980 to counter the dwindling number of Army physicians who separated from service following the Vietnam War. It is meant to expeditiously augment a physician from a medical center to a deploying unit during combat operations. While in garrison, the battalion’s medical coverage is provided by the unit’s physician assistant (PA). Once tasked to fill a PROFIS position, the battalion surgeon should be afforded ample time to interact and work with the unit before deployment. Unfortunately, the current implementation of the PROFIS system is not operating as it was initially designed and has become a by-product of 10 years in combat. Despite the importance of this position for deploying units, the Army currently lacks a formal course that provides instruction for those preparing to deploy. Most often, information is relayed from colleagues who previously filled similar roles. One reason may be related to the Army Medical Department (AMEDD) not emphasizing military training to medical corps officers, whereas, traditionally, the main focus for military physicians has been on clinical and academic work. While there is improvement in ensuring that deploying providers receive adequate training to fulfill this position (Tactical Combat Medical Care Course, see below), there still remains an obvious need for some type of instructional material or a course to guide providers filling this important role before deployment.

PREDEPLOYMENT TRAINING
It is expected that the PROFIS provider be present during predeployment training with the deploying unit. Traditionally, light infantry units train up at Joint Readiness Training Center in Fort Polk, Louisiana, and heavy mechanized units undergo training at the National Training Center in Fort Irwin, California. This training is meant to simulate conditions in the battlefield and gives an opportunity for the deploying provider to work closely with the unit’s PA and combat medics, as well as the battalion’s chain of command. This training, which is usually conducted within
3 months of deployment, is for the entire brigade combat team and lasts approximately 30 days. It is highly recommended that the provider attempt to join the unit during this training to become familiar with the unit before the actual deployment. This requires support of the local institution and appropriate planning to ensure the PROFIS provider is able to attend. It is also recommended that the battalion surgeon contact the brigade surgeon after being tasked to seek some guidance and assistance.

**Tactical Combat Medical Course**

Tactical combat casualty care (TCCC) is a recently developed strategy, which has been applied to our current conflicts. The approach was first developed in 1996 but now is considered the standard of combat care.\(^4\)\(^{-7}\) Due to the application of TCCC, along with improvements in body armor, armored vehicles, and changed tactics, a subsequent dramatic decrease in fatality rates has been seen when compared to prior conflicts.\(^6\)\(^{,8}\) The idea is to apply the concepts of TCCC at the point of injury, therefore capitalizing on the “golden hour” rule.\(^10\)\(^{-12}\) By the time a wounded soldier reaches the battalion aid station (BAS), urgent resuscitative care, such as application of a tourniquet, has already been applied by the combat medic at the site of injury. All combat medics receive formal training on TCCC. A course teaching this concept, entitled Tactical Combat Medical Care (TMC), has recently become mandatory training for all deploying providers to level I and II facilities. The 5-day course, which is offered in San Antonio, Texas, is a combination of lectures and hands-on training. At the conclusion of the course, providers have an opportunity to practice their learned skills in trauma lanes and in a mass casualty scenario. More importantly, this course familiarizes deploying providers with the gold standard taught to combat medics, allowing them to better train and educate their medics. In order to maximize effectiveness, battalion surgeons should continually retrain their medics during deployment.\(^8\)

**Army Regulation 40-501**

One of the first items a battalion surgeon should become familiar with is Army Regulation (AR) 40-501, which outlines the medical conditions precluding deployment. The battalion surgeon can decide whether a soldier can deploy with the unit; however, the first general officer in the soldier’s chain of command can overturn this decision.\(^13\) Some commanders may disagree with the battalion surgeon’s decision; nonetheless, guidelines regarding certain medical conditions and deployments are clearly stated. Furthermore, in the long-term, this will not only save the unit and commander from negative health outcomes but save soldiers from unnecessary evacuation from theater. In our experience, soldiers who should not have deployed in the first place often end up redeploying early. Therefore, it is recommended that battalion surgeons establish a good rapport with the battalion’s senior leadership and discuss these issues with commanders and senior noncommissioned officers. This in turn will facilitate their understanding of the soldier’s condition.

Realizing that units prefer to deploy in their full capacity, certain medical conditions preclude service members from serving overseas, much less a combat zone with limited medical resources.

**Profiles**

Profiles are another important issue battalion surgeons need to become familiar with. This commonly comes up in the days preceding deployment. One would expect that the unit’s medical personnel and chain of command track records of these throughout the year; however, this is not often the case. We recommend that battalion surgeons mandate that an ongoing list exist and be maintained by each battalion with oversight at the brigade level. Another recommendation would be for the battalion surgeon to review all service members’ profiles with company commanders and first sergeants. By identifying these issues upfront, referrals to specialists can be facilitated if required to determine if there may be a change in deployment status. The command will appreciate this extra effort, and it helps the battalion surgeon justify if a soldier is indeed not deployable. It is also recommended that battalion surgeons become familiar with geographic restrictions. Many are outlined in AR 40-501 (Chapters 5–14), and others pertaining to combat zones are outlined in MOD (modification) X restrictions. Certain medical restrictions require special waivers before deployments into a combat zone.

**BATTALION AND BRIGADE MEDICAL CAPABILITIES**

A brigade combat team or Assist and Advise Brigade consists of 5 battalions. Each battalion is comprised of approximately 300 to 1000 soldiers. Historically, infantry battalions have the largest number of soldiers, whereas field artillery battalions and cavalry squadrons are the smallest in size. Each battalion is assigned a physician provider and a PA, except for field artillery battalions, which traditionally employ a PA as their sole medical provider. The Battalion Support Brigade is a level II facility, which has slots for 2 battalion surgeons on their table of organization and equipment. Female battalion surgeons are usually assigned to a level II facility. Historically, the BAS or level I facility has been closest to the front line of the battlefield. This is not always the case with the current conflicts in Afghanistan and Iraq, where a level I station may be in close proximity to a level II and even level III facility. The BAS is often a highly mobile facility, meant to provide basic primary care medicine and combat resuscitation, to include preservation of life, limb, and eyesight. Additionally, with company sized elements deploying to command outposts, a small contingency of medics may form a forward aid station (FAS).
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Preventive Medicine

Although a preventive medicine officer is assigned to each brigade, the battalion surgeon may be regarded as the preventive medicine expert for the unit. Platoons should have soldiers trained in field hygiene, but this is not always the case. Once in theater, you can request the brigade preventive medicine officer, as well as the veterinary officer, conduct a site visit to assess your base and provide recommendations. Before deployment, the battalion surgeon should ensure that service members in the unit have treated their uniforms (fire-resistant army combat uniforms cannot be treated) with permethrin and that soldiers have been issued appropriate personal protective equipment to include personal bed nets and N,N-diethyl-m-toluamide (DEET). They should plan for the worst as the mission and environment may change. Once in theater, acquiring personal protective equipment may be challenging. Additionally, each soldier should be issued a collapsible bed net before deployment depending on where the unit is deploying to. If deploying to a malaria endemic region, providers should specifically discuss this with their commander, who is ultimately responsible for the health and welfare of the soldiers. These issues may not be a top priority for commanders but can cause significant loss of troop strength if preventive measures are not in place once in theater. Additionally, recent evidence suggests that incorporating preventive medicine training could improve the readiness and health of the Afghanistan National Army.

Medical Supplies

In theater, medical supplies are referred to as class VIII. The supplying and resupplying of class VIII in theater can be a frustrating process, especially for providers deploying from a medical center where this has not been experienced before. One needs to understand the potential limitations of the ordering process in the deployed setting. Medication orders are often routed through the battalion’s medical officer to the brigade medical supply officer, whose responsibility is to supply the entire brigade. This brigade medical supply officer does not have any medical training; therefore, communication with this officer is very important. Depending on the battalion surgeon’s location, it may take up to 1 month, and in some instances even longer, to acquire class VIII supplies. Consequently, units need to plan in the event they do not fall on existing equipment, such as trauma and sick call supplies. The provider along with the medical platoon leader and platoon sergeant should ensure that all medics have fully stocked aid bags. Ideally, this would involve a layout of their bags for inspection to ensure that they have all appropriate items.

Prescription Medications

All deploying service members are required to hand-carry a 180-day supply of medications. During predeployment health screening, the unit’s leadership should ensure all service members have their medications. This will prevent soldiers from requesting a large supply of prescription medications in theater that may be available only in limited quantity or entirely unavailable. The theater formulary is not all-inclusive, especially at a level I facility, and as a result, it can be difficult to obtain certain medications. In addition, there may be a significant lag in obtaining medications once ordered; therefore, early into deployment, the battalion surgeon should inquire as to which service member will need refills and when. Another option is to use the Tricare Mail Order Pharmacy. A prescription can be filled on-line and usually takes approximately 30 days to deliver to deployed service members.

Narcotics

During deployment, the battalion surgeon is responsible for handling the unit’s narcotic inventory, which includes transporting all medications into theater. This requires secure boxes that should be padlocked. Ensure proper coordination with the unit’s supply officer regarding timing of the pick-up of the narcotics before deploying. We recommend that either the battalion surgeon or the PA deploy with the main body since missions may start immediately upon arrival into theater, depending on the operation tempo. Line medics will likely need narcotics up front, and plans should be in place to facilitate this process. Therefore, medics should be provided padded small portable boxes to store the narcotics. Morphine allergies are rare; yet, a small quantity of a substitute narcotic, such as fentanyl or meperidine, should be available in the event such an allergy is encountered. Each medic should be tested on the indications and contraindications of each medication they are prescribed with documentation of training kept on file. Narcotics must then be issued via hand receipt (DA form 2062) to each medic who becomes responsible for the narcotic for the mission. Weekly inventories are expected to be performed on the line medics by the senior medics. Monthly inventories, which are required by units to ensure accountability, are
to be performed by the battalion surgeon. Narcotics should be considered just like other sensitive items, such as weapons and night vision goggles. There are existing forms (DA form 3949), to help facilitate tracking and inventory of narcotics. We recommend that a written prescription be used for each narcotic prescribed and signed by the patient on the back of the prescription when possible and kept for record. For trauma patients, this is not always possible; however, prompt recording should be performed at all times to avoid losing track of the amount of narcotics used. A narcotic policy should be developed for each battalion aid station and followed strictly.

**Medics Training**

Medics play a crucial role in combat as they are usually the first responders to an injury. One of the reasons for the sharp decrease in fatality rates in our current conflicts has to do with battlefield first aid.8,11,12 Medics undergo extensive training on the core principles of TCCC, such as application of a tourniquet, needle decompression, and administering resuscitative fluids. However, the battalion surgeon can augment and reinforce these technical skills. For example, a medic may correctly identify that an injured limb is in need of hemostatic control; however without proper application of tourniquet, the limb may not be salvaged. A medic may also recognize that an injured soldier may need resuscitative fluids, however may not be educated on the newer generation of fluids or on the benefits of the administration of antibiotics. The battalion surgeon will have many opportunities and ample time during predeployment training and in theater to review the core principles of TCCC with medics. Senior medics who have experienced multiple deployments are invaluable in training junior medics.16 It is important to ensure that each line company reviews basic combat life support skills with all its soldiers. Often, the line medic assigned to that company can teach these skills, which will further reinforce their knowledge base. The battalion surgeon should work with the senior line medics and commanders to continue to incorporate first aid training during the deployment. We recommend some type of first aid or evacuation training for the line component of the unit at least once a month. These can be done on a large scale, such as platoons, or smaller scale taught by the medics at the squad level.

**Medical Evacuation**

One of the most important aspects of the battalion surgeon’s role following patient stabilization is appropriate transfer to the next level of care. The medical platoon leader (MEDO) is primarily responsible for this, but the battalion surgeon can offer valuable insight into what makes medical sense, as the MEDO has little to no actual medical training. Most patient evacuations in our current conflicts are by air; however, depending on the current situation on the ground and weather, ground evacuation planning should also be in place. Units should continually rehearse patient movement between the helicopter landing zone and BAS.

**Mass Casualty Planning**

Each forward operating base will require a mass casualty plan. There are multiple examples of these, and each unit should have a preexisting format. The battalion surgeon works in conjunction with the MEDO and platoon sergeant to develop this upon arrival to the forward operating base. This plan needs to be incorporated with the base defense plan and needs to be rehearsed under multiple conditions varying patient scenarios and including nighttime rehearsals. Training should be frequent and at least once a month to ensure that it works.

**REDEPLOYMENT AND EXCEPTION TO POLICY**

Since many battalion surgeons are subspecialists, the office of the surgeon general published an ALARACT (All Army Activity) in 2010 allowing medical subspecialists to curtail their deployments to help prevent degradation in medical and/or procedural skills.17 This concept is similar to a previous change in policy regarding general surgeons and surgical subspecialty deployments to forward surgical teams and combat support hospitals. All surgical deployments are now 6 months in length. The initial approving authority for this process is the line unit brigade commander. The exception to policy (ETP) is initiated by the deployed soldier through the chain of command by submitting a personnel action form along with an approving letter from the brigade commander to division headquarters. Theater commanders will then forward the request with their recommendation of approval or disapproval to the United States Forces theater commander. This in turn is routed to the army medical command (AMEDD) in San Antonio, Texas. The final approving authority is the assistant surgeon general for force protection. Once the U.S. Army Medical Command approves the ETP packet, the deploying soldier’s MTF (medical treatment facility) usually identifies a replacement provider who reports to the continental United States replacement center (CRC) at Fort Benning, Georgia, for 1 week of training. According to the ALARACT, replacements should have at least a 30-day notice before reporting to CRC. If back-fills are given adequate notice, it is highly recommended that they attend the TCMC course. Once in theater, it is usually expected that providers will overlap for a short period of time before the front-half provider is released from theater.

**REDEPLOYMENT TRAINING**

The transition of practicing medicine from a deployed setting back to an MTF or medical center can be a challenging process. Clinical and procedural skills may have been affected during deployment. To help mitigate this skill degradation, the U.S. Army Medical Command developed a policy (Memo 09-078) which allows providers to retrain in...
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their area of expertise. According to the policy, MTF and hospital commanders should assess for this need, and if required, endorse funding. Examples include medical education courses through professional societies and off-site training at affiliated civilian institutions.

CONCLUSION
The role of the battalion surgeon can be one of the most rewarding in a military physician’s career. It gives providers an opportunity to work in close proximity with soldiers in a deployed setting and truly provides an appreciation for what service members experience in a line unit. This article offers a framework for battalion surgeons; however, there remains a need for more standardized training for all providers filling this role in the battlefield.

REFERENCES