European Security and Defence Assembly
Assembly of Western European Union

DOCUMENT A/2076 16 June 2010

FIFTY-EIGHTH SESSION

Medical cooperation among European armed forces

REPORT

submitted on behalf of the Defence Committee by Tuija Nurmi, Rapporteur
(Finland, EPP/CD Group)

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Report transmitted to: the President of the Council of WEU; the Secretary-General of the WEU; the President of the Council of the European Union; the High Representative of the Union for Foreign Affairs and Security Policy; the President of the European Commission; the EU Commissioner for institutional relations and communication strategy; the Presidents/Speakers and the Chairmen of the Foreign Affairs, Defence and European Affairs Committees of the 39 national parliaments represented in the Assembly; the Presidents of the Parliamentary Assembly of the Council of Europe, the NATO Parliamentary Assembly, the OSCE Parliamentary Assembly, the Baltic Assembly, the Nordic Council, the Parliamentary Assembly of the Black Sea Economic Cooperation, the CIS Parliamentary Assembly; the President of the European Parliament; the Secretaries General of the Parliamentary Assemblies of the Council of Europe, NATO and the OSCE.

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[1] Adopted by the Committee on 20 May 2010.

RECOMMENDATION 860[2]

on medical cooperation among European armed forces

The Assembly,

(i) Recognising that crisis and emergency medicine is a recent development and that large-scale responses to crises often necessitate deployment of military assets in civilian areas;

(ii) Deeply concerned about the increasingly frequent occurrence of Great Humanitarian Crises (GHCs);

(iii) Underlining the vital importance of cooperation between states in EU external operations, especially in the medical field;

(iv) Recognising the role that NATO has played in developing international standards of cooperation in the field of medicine;

(v) Aware that while EU external operations are of a peacekeeping nature, proper contingency planning must be in place, in case situations deteriorate and battle-trauma medicine is needed;

(vi) Underlining the importance of military medical assistance both in field medicine and in humanitarian aid;

(vii) Fully supporting civil-military cooperation initiatives in the field of peacekeeping and humanitarian assistance;

(viii) Noting with interest the discussions that took place in 2003 regarding the establishment of a European Union First Aid and Support Team (EU Fast);

(ix) Emphasising the importance of training exercises in medical cooperation, and that training, lessons-learned sessions and experience are crucial to the development of optimal medical coordination between member states;

(x) Aware of the lessons learned from previous Common Security and Defence Policy (CSDP) missions, especially EUFOR RD Congo, in 2006, and the role played by Forward Surgical Teams (FSTs);

(xi) Considering that, with regard to funding, the ATHENA mechanism is no longer satisfactory, and represents an unfair burden for troop-contributing countries,

RECOMMENDS THAT THE COUNCIL INVITE THE WESTERN EUROPEAN UNION MEMBER STATES, AS MEMBERS OF THE EUROPEAN UNION, TO:

1. Increase efforts among member states to combine the experience of civilians and members of the military who have expertise in crisis and emergency medicine, including, for consultative purposes, members of civil society;

2. Ensure that from now on, medical costs, including long-term treatment costs, such as treatment for post-traumatic stress disorder (PTSD), are included within the common costs covered by the ATHENA mechanism;

3. Launch an EU-Fast initiative in the CSDP framework, coordinated by the EU Joint Situation Centre (SitCen), based on the battlegroup concept, with EU-Fast teams and FSTs forming independent modules of battlegroups and able to be deployed within hours of a GHC occurring;

4. Draw up a list of medical staff and resources available within EU member states for external operations of the Union;

[2] Adopted by the Assembly on 16 June 2010 at the 3rd sitting.

5. Establish common EU-NATO medical training exercises, to be held in various parts of the world, so as to experience different climates, under the guidance of member states with the most experience in dealing with specific forms of regional medicine;

6. Create a structure for dialogue, exchange of ideas and strategy development, encompassing representatives of the military of EU member states, civilian institutions, and international governmental and non-governmental organisations involved in medical cooperation, to identify fields of further cooperation, areas of mutual satisfaction, and a proper institutional mechanism for cooperation and exchange of ideas;

7. Keep the Assembly informed about the status of medical cooperation between European armed forces.

EXPLANATORY MEMORANDUM

submitted on behalf of the Defence Committee
by Tuija Nurmi, Rapporteur (Finland, EPP/CD Group)

I. Introduction

1. The role of the military is evolving due to a change in the nature of missions and the need for multilateral intervention by European forces. All EU external operations, for instance, comprise both civilian and military (civ-mil) aspects.

2. The EU has concentrated its efforts on peacekeeping activities; there has therefore been a shift in the nature of injuries sustained by armed forces away from those which are directly combat-related. The Finnish Forward Surgical Team (FST), for example, "a mobile surgical asset designed to provide life- and limb-saving combat surgery in remote and austere terrains,"[3] deployed for four months in Kinshasa during operation EUFOR RD Congo in 2006, had to treat 12 patients, including five trauma cases and seven medical conditions. However, none of those cases resulted from combat injuries.

3. That shift in the type of injuries sustained reflects the nature of the mandates for EU operations. Whereas other regional organisations, such as NATO, are engaged in direct combat operations, for instance in Afghanistan, all fully autonomous EU external military operations have been peacekeeping operations. Of course, and tragically, this does not mean that EU troops are not attacked. In March 2008, for example, a French soldier was killed by Sudanese troops during operation EUFOR Tchad/RCA. There were also several incidents during the same operation of attacks from Sudanese forces, including a helicopter attack on Belgian forces.[4]

4. However, the large majority of medical interventions are non combat-related and are the result, rather, of accidents (including during training exercises), diseases, especially in tropical areas where viruses and bacteria abound, and illness.

5. The forces of European Union member states and other countries taking part in EU external military operations are often able to take advantage of training opportunities in their countries' historical areas of interest. Medical officers from Nordic countries, for instance, are used to operating in extreme cold weather conditions, whereas medical officers from the Mediterranean region, or from countries that have historical ties with Africa, benefit from training in extremely hot climatic conditions.

6. There is, however, no unified training method encompassing all the fields of specific expertise enshrined in member states' experience and contributing to providing military operations with optimal multinational medical support. There are also no common standards of procedure and care. Furthermore, there is currently no institutionalised mechanism for pulling together the lessons learned from EUFOR operations and making use of those findings for future operations.

7. The European Defence Agency, conscious of the problem, has included medical cooperation in its work programme. The following important aspects are to be tackled as part of the 2010 programme approved by the EDA Steering Board on 17 November 2009:

- developing harmonised procedures for blood and oxygen supplies;
- putting forward proposals for improving health protection;
- developing a roadmap to increase Medical C3 capability (casualty tracking and tracing tools);
- developing a telemedicine operational capability;

[3] Lauri Handolin and Teemu Elomaa, "The Finnish Forward Surgical Team Experience During EUFOR Operation RD Congo in 2006", European Journal of Trauma and Emergency Surgery, May 2007 No. 3, pages 245-250.
[4] http://www.afriquejet.com/

- assessing current MEDEVAC (medical evacuation) limitations in order to improve interoperability at the operational and tactical levels;
- establishing a "lessons-learned" mechanism for analysing the medical lessons to be drawn from CSDP operations.

8. Developing medical cooperation among European forces offers an opportunity to redefine the scope of military medicine – an opportunity which cannot be allowed to slip away, given the multiplicity of large-scale humanitarian crises (Great Humanitarian Crises or GHCs) and the global amplitude of the humanitarian assistance provided. There are many opportunities for enhancing collaboration between the civilian and military sectors and establishing patterns of cooperation that will increase overall medical efficiency.

9. International medical cooperation between armed forces can pose a number of logistical challenges in the field, as EU operations have shown. Language barriers, lack of standardised medical practices, cultural and political issues, and dealing with civilian casualties are among the obstacles to optimising medical support.

10. Other regional organisations such as NATO have established detailed and precise sets of standards that are often applied widely, even for non-NATO operations. In its joint medical support strategy, for example, NATO has classified deployable Medical Treatment Facilities (MTFs) in four categories, according to treatment capabilities:

- Role 1 medical support provides for routine primary health care, specialised first aid, triage, resuscitation and stabilisation;
- Role 2 provides an intermediate capability for the reception and triage of casualties, as well as being able to perform resuscitation and treatment of shock to a higher technical level than Role 1. It will routinely include Damage Control Surgery (DCS) and may include a limited holding facility for the short-term holding of casualties until they can be returned to duty or be evacuated. Role 2 may also include Dentistry, Environmental Health and Psychiatry or Psychology;
- Role 3 is designed to provide secondary care within the restrictions of the Theatre Holding Policy. Role 3 medical support is deployed hospitalisation and the elements required to support it. This includes a mission-tailored variety of clinical specialities including primary surgery and diagnostic support;
- Role 4 medical support provides the full spectrum of definitive medical care that cannot be deployed to theatre or is too time-consuming to be conducted there. It includes the provision of specialist surgical and medical procedures, reconstructive surgery and rehabilitation. It will normally be provided in the country of origin or the home country of another Alliance member. In many member nations Role 4 care is provided for within the national civilian health system.[5]

11. This classification model (Roles 1 to 4) is a useful tool that is used by most European armed forces. However, there are significant differences in the types of injuries that NATO MTFs have to treat, as many are combat-related. EU MTFs could be prepped to provide both civilian and military medical assistance.

12. In countries where medical specialists for external operations are volunteers, there is a lack of medical doctor volunteers for military external operations. This stands in stark contrast to the wide availability of medical doctors for the humanitarian missions organised by International Non-Governmental Organisations (INGOs), despite the increased frequency of GHCs, the large-scale humanitarian crises caused by sudden or progressive natural catastrophes or by political or civil strife and necessitating global humanitarian assistance. These have been met with a tremendous response

[5] Brig. Gen. Dr Erich Rödig, "NATO Joint Medical Support – Reality and Vision", paper presented at the RTO HFM Symposium on "Combat Casualty Care in Ground Based Tactical Situations: Trauma Technology and Emergency Medical Procedures", held in St. Pete Beach, United States, 2004.

from developed countries in terms of providing emergency aid, medical teams and emergency infrastructure. The EU has been particularly responsive, although lack of crisis-management cooperation leads to delays in deployment.

13. Since in many cases the risks associated with intervening in civilian crises are just as, if not more, dangerous than those of military operations, the reasons behind the shortage of volunteer doctors are essentially of a political nature.

14. Another important area is cost. The troops deployed by an EU member state are supported by a medical team according to a set of bilateral agreements established between the troop-contributing country and the field hospital-hosting country. The treatment costs for an injured member of the armed forces are billed directly to that person's country. The system highlights the inadequacy of the ATHENA mechanism, which makes provision only for the common costs to be shared among the 27 EU member states: all other costs "lie where they fall". Thus, a troop-contributing state has to cover not only its share of the common costs plus the direct deployment costs, but also the cost of treating its own troops.

II. Civilian and military hospitals

15. One argument regarding the differences between civilian and military medicine holds that civilian medicine focuses mainly on civilian injuries, such as domestic and road accidents, whereas military medicine is battlefield trauma-oriented, with injuries ranging from bullet and shrapnel wounds to post-traumatic stress disorder (PTSD), especially where external operations are concerned.

16. While this may have been the case historically, due to the nature of conflicts, recent developments such as asymmetric warfare and the global scope of GHCs have challenged this notion. Nowadays, civilian medicine and military medicine often cover the same ground.

17. For example, in an effort to rationalise costs and avoid duplication of effort, several European countries have opted to close down military hospitals and transfer their competencies to civilian hospitals.

18. The process of closing down military hospitals has by and large to do with a change in mentality regarding the need for operational autonomy of medical services within a military structure. However, there is no absolute correlation between the process of shutting down military hospitals and a seemingly parallel development: the fact that many states no longer insist on compulsory military service (national conscription) as a part of one's civilian duties.

19. In the UK – the country in Europe in which the military most commonly relies on civilian hospitals to take care of its wounded servicemen – the hospitals are screened and tagged with a quality label by the National Health Service, which administers healthcare. The most compelling reason why policymakers have blurred the lines of distinction between civilian and military nurses, surgeons and hospital staff is a cost-based analysis.

20. While the operational costs of a properly equipped and staffed military hospital may still be acceptable for most countries, they nonetheless have to be balanced against concerns about the quality of healthcare (assuring the same standards for civilian and military provision) and sustainability. The argument in favour of transferring treatment and hospital care to the civilian sector might therefore be convincing when there is concern about meeting those three criteria of budget, quality assurance and sustainability.

21. In essence, a military hospital ought to be able to supply the same advanced medical facilities and technologies as civilian hospitals for injured servicemen and women. Normally those standards must be attained by all relevant measures and provision must be made for them in national defence budgeting. However, the range of combat-specific injuries may require not only a surgeon's steady hand but also the unique expertise of a military surgeon when dealing with complex fractures, massive haemorrhaging or PTSD incurred during combat, reconnaissance or sentry operations.

22. Military physicians and surgeons should share experience and practice by teaming up with their civilian counterparts in NHS hospitals, in order to treat the injured during military operations or on their return.

23. Having military-conscripted medics gain experience by sharing and practising both tested and new methodologies with their civilian colleagues has numerous advantages: nevertheless, it does not necessarily prepare them to operate in Role 1 facilities or field hospitals on foreign missions, where conditions may differ greatly from the generally more "contained" conditions of civilian hospitals with round-the-clock duty staff.

24. A more restrictive spending rationale and the desire to avoid spreading resources over duplicate structures (by pooling resources and outsourcing) may therefore be the two main reasons why countries like the UK, Denmark, Estonia, Finland, Sweden, Malta and Luxembourg prefer to accommodate and treat their servicemen in domestic civilian hospitals.

25. For smaller nations like Luxembourg or Malta, maintaining or operating a dedicated single-use military hospital for their armed forces would not be cost-effective.

26. This does not mean that the treatment of servicemen following injury or trauma can only start in the home country. Wounded military receive stabilisation treatment in forward-deployed field hospitals and are transported to a lifesaving Role 1 and/or Role 2 hospital for a short period, before being shipped home for continued treatment and/or therapy. At that point perhaps, a physician can assess the results of the treatment and determine whether the soldier can be authorised to resume active service ("combat fit").

27. Also, units for the treatment of CBRN (Chemical, Biological, Radiological or Nuclear) or tropical viral diseases are at times only to be found in high-end advanced military medical centres. Before its final closure in 2007 as the last military hospital in the UK, the Royal Hospital at Haslar (Gosport, Hampshire), for instance, was equipped with a so-called zymotic (acute infectious and fever diseases) isolation ward, which functioned as a means to quarantine and isolate victims of a severe biochemical agent or concentrated epidemic virus attack causing acute infections, intense fevers and symptoms of failing body functions (lymphatic, digestion, etc.).

28. Indeed, the issue of medical civil-military cooperation in dealing with the effects of CBRN agents has gained more attention these past five years.

29. In 2004, the EU Institute for Security Studies (EUISS) published an assessment of CBR response capabilities in the EU and the military assets used for that purpose. According to the EUISS, up to 2004 the EU had carried out one large-scale joint CBR training exercise to test its level of preparedness and response. This exercise, EURATOX 2002, took place in October 2002 at the Canjuers military training facility in the Var region of France, near the Mediterranean coast. The exercise also involved activating the European Civil Protection Mechanism. Overall participation numbers were modest, with only five nations taking part (Austria, Spain, Greece, Italy, Sweden) and each contributing some 10-30 specialist respondents. The exercise involved the treatment and evacuation of about 200 simulated patients, while another 2 000 extra required particular assistance. At the helm was the EU Monitoring and Information Centre (MIC), which was in charge of overall coordination and of activating the five national components. This extra challenge incited the respondents to prioritise tasks and adjust flexibly to each individual case of medical or other aid required. The sharing of lessons learned was clearly a major achievement of this "European level" exercise.

30. During the exercise the identification of a sufficient number of hospital beds proved to be very successful (with 600 hospital beds identified the first day, most of which were available at one hour's notice, and a further 800 beds found available for allocation on the second day). Five hospital planes were used during the large-scale exercise in order to evacuate victims to the identified hospital locations which had been placed on alert and stand-by for further treatment.

31. Follow-up exercises since 2002 have not attained the scale or complexity of EURATOX 2002. Almost all follow-up activities have taken the form of smaller training courses with a view to disseminating the lessons learned.

32. Although EURATOX 2002 was characterised as an exercise for dealing with civilian disasters in a civil protection framework, there was some degree of interaction with the military.

33. In November 2009, the Council endorsed the Commission's proposals for strengthening CBRN security, supporting its idea of establishing a CBRN Advisory Group with subgroups, the launch of an EU CBRN Resilience Programme and further exchanges of expertise and knowledge on these issues.

34. These initiatives are supported in particular by MediSys, an information scanning tool set up by the European Commission. This instrument reinforces the Network for Surveillance and Control of Communicable Diseases and the early detection of bioterrorism activities. Information provided by MediSys is derived from reports produced by the European Media Monitor (EMM).

35. For complex large-scale operations, military deployments cannot remain fully autonomous: it is often necessary to call on local resources. The use of local resources and assets has several advantages.

III. Great Humanitarian Crises (GHCs)

36. In the last decade there has been an increase in the number of GHCs necessitating cooperation among global emergency and rescue services, including the deployment of European civilian and military assets. The use in such cases of military assets, including military medical services, is not atypical. The most recent GHC – Haiti's magnitude 7.0 Mw earthquake on Tuesday, 12 January 2010, whose epicentre was approximately 25 kilometres west of Port-au-Prince – clearly illustrates the interaction between the military and civilian components of disaster medicine.

37. The first urgent necessities following the earthquake were as follows:

- emergency healthcare (surgical capacity, mobile medical teams);
- water and sanitation;
- 20 000 tents to cover the severe lack of shelter;
- logistics (storage, transport, fuel), telecommunications;
- food supplies.

38. The following additional challenges also needed to be addressed in order to allow or optimise international assistance:

- establishing a humanitarian corridor to deal with logistics bottlenecks (responsibility of the United Nations);
- management of large numbers of corpses/major risk of epidemics;
- increasingly short supplies of fuel.

39. As of 17 February 2010, the EU had deployed over 800 experts and substantial assets from EU and European Economic Area countries. On 9 February, the Prime Minister of Haiti appealed to the EU for specific urgent military assistance with providing shelter, a request relayed by the UN. The French offered military capabilities consisting of two engineering platoons (more than 200 troops and 70 vehicles).

40. Regarding other military assets, as of 30 March 2010, the EU had deployed or was about to deploy the following:

- Two police units totalling 323 gendarmerie officers, mainly from France, Italy and Spain;
- The *Cavour*, an Italian aircraft carrier with an enhanced Role 2 hospital on board, an engineering task force, six helicopters, force protection elements, a military police team and a scuba diving team, docked at Port-au-Prince;
- The *Castilla,* a Spanish Landing Platform Dock (LPD) with a Role 2 enhanced hospital on board, two drinking water production units and delivery capability and engineering assets, transport and supply assets, force protection elements, 446 officers and four helicopters;
- The *Sirocco*, a logistics support ship with amphibious landing capability and four helicopters on board;

- The *RFA Largs Bay*, a British Auxiliary Vessel with amphibious landing capability that shuttled cargo between different ports in Haiti, and transported water purification tablets, fresh water containers, metal and plastic sheeting, 40 4x4 vehicles and heavy lifting equipment;
- Two French military building installations with first-aid medical facilities, as well as a field hospital and a water purification facility;
- 30 French military personnel in Port-au-Prince, and a further 135, plus four aircraft, in the region;
- Four British military personnel as Operational Liaison and Reconnaissance Team;
- Eight British Royal Military Police;
- Seven British liaison officers with the US and Canada;
- 30 Greek Infantry Platoon officers offered by Greece to MINUSTAH;
- An Irish Military Engineer Officer and a national Planning Team;
- A Bulgarian five-person medical team.

41. The EU's contribution of military assets to Haiti, while far behind that of the United States (10 000 troops), remains significant in its scope and purpose. It also illustrates the importance of civilian-military cooperation, with information exchanges and coordination being facilitated through the Haiti Coordination Cell (EUCO) in the EU's Joint Situation Centre (JSC), also known as SitCen, operating in the framework of the Common Security and Defence Policy (CSDP).

42. The GHC in Haiti has brought home the importance of rapidly deployable emergency services. One of the first units deployed to the affected area was the Belgian B-Fast team.

43. Following the earthquakes in August and November 1999 in Turkey, the Belgian Government decided to create a rapid response structure with a view "to sending emergency aid teams to a country or countries affected by a man-made or natural disaster." On 28 February 2003, the Belgian First Aid and Support Team (B-Fast) was launched.

44. B-Fast is a cross-departmental structure involving the Prime Minister's Office together with the Federal Public Services, Foreign Affairs, Foreign Trade and Development Cooperation, Public Health and Environment, Home Affairs, Budget and Defence Departments. The team's aim is to be ready to be mobilised within 12 hours following a decision to act. Action on site lasts, in principle, 10 days.

45. According to its mandate, three conditions must be fully met before the B-Fast structure can be activated:

- the crisis must be of too great a magnitude for the emergency services of the country in question to cope with and the lives or health of individuals must be at risk;
- the authorities in the country affected must request assistance from Belgium or at least from the international community;
- there must be no armed conflict under way in the country requesting assistance.

46. B-Fast was sent to Haiti hours after the earthquake struck and took part in search and rescue operations as soon as it was deployed. Within days, however, the B-Fast team's security was threatened and Belgium had to send 36 troops to protect it. Its contribution to rescue efforts was nonetheless extremely valuable at a time when no EU coordination had been achieved.

47. Although a civilian entity that relies on certain military assets, B-Fast cooperates with the military, in particular for training and exercises; it participated, for example, in a NATO exercise in Iceland in June 2002 and a NATO Partnership for Peace (PfP) exercise in Romania in 2003.

48. Following the success of the Belgian B-Fast teams, former Belgian Prime Minister Guy Verhofstadt recalled an initiative he had launched in April 2003 together with President Chirac of France, Chancellor Gerhard Schröder of Germany and Prime Minister Jean-Claude Juncker of

Luxembourg with a view to establishing a European Union First Aid and Support Team (EU Fast). That initiative had stalled, however, due to the reluctance of certain countries to involve the military in civilian matters.

49. Notwithstanding those objections, following various institutional developments, notably the creation of the EU Joint Situation Centre (SitCen), the EU combines civilian and military assets in an effective way. SitCen is divided into three units:

- the Civilian Intelligence Cell (CIC), comprising civilian intelligence analysts working on political and counter-terrorism assessment;
- the General Operations Unit (GOU), providing 24-hour operational support, research and non-intelligence analysis; and
- the Communications Unit, handling communications security issues and running the Council's communications centre (ComCen).

50. SitCen cooperates with the EU Military Staff and the EU Council.

51. As the emergency response to the Haiti GHC has shown, an EU Fast team combining civilian and military assets could easily operate in this framework, ensuring adequate protection for civilian elements while not encroaching on the civilian mandate.

IV. External Military Operations

52. The key military medical unit in external military operations is the Forward Surgical Team. The first FST was created during World War II by Dr Charles Rob, serving in the British Royal Army Medical Corps in North Africa. A similar, although larger and less easily deployable concept was that of the Mobile Army Surgical Hospitals (MASH), developed by the US Army during the Korean War. The American invasion of Grenada in 1983 highlighted the advantages of FSTs over combat support hospitals or MASH in terms of their small size, mobility and deployability.

53. The first time the FST concept was introduced into military external operations under the CSDP (or ESDP before the Lisbon Treaty was ratified) was during the preparations for EUFOR RD Congo in 2006.[6]

54. The first two FSTs deployed in the CSDP framework were provided by the Finnish Defence Forces for periods of four months in Kinshasa, the capital of the Democratic Republic of the Congo (DRC). That experience has provided valuable lessons for future CSDP military operations.

55. There had been no previous experience of an FST concept for an EU operation, and Finland itself had no readymade FST concept in place. However, Finland did have a "well-equipped battalion aid station-level facility"[7] that was easily deployable. As EUFOR RD Congo was a peacekeeping operation, casualties were expected to be low, with more injuries caused by accidents than battle injuries. Nonetheless, contingency planning also had to consider the possibility of severe battlefield injuries as well.

56. The FSTs were deployed in three tactical and four reconnaissance operations. They used air-inflatable tents as shelters, consisting of three 5x6m tent modules assembled together. The first was set up as an operating room, the second as a patient triage and recovery area and the third as an area to accommodate FST personnel and stable patients waiting for medical evacuation (MEDEVAC). The whole setup took about two hours to become combat-ready.

[6] See Document 1954 adopted on 20 December 2006: "European Union operations in the Democratic Republic of the Congo (DRC) – reply to the annual report of the Council", report submitted on behalf of the Defence Committee by Ignacio Cosidó Gutiérrez, Rapporteur (Spain, Federated Group).

[7] Data for EUFOR RD Congo from Lauri Handolin and Teemu Elomaa: "The Finnish Forward Surgical Team Experience During EUFOR Operation RD Congo in 2006", European Journal of Trauma and Emergency Surgery, 2007, No. 3.

57. There were six staff on each team, including "a trauma surgeon, an anaesthetist, a scrub nurse, a nurse intensivist, a circulating emergency nurse, and a medical maintenance technician". As there are no military hospitals in Finland, the staff were all volunteers with "thorough emergency experience".

58. By definition, FSTs are easily deployed and manoeuvrable. The deployment arrangements are crucial to their effectiveness. Three possibilities, or scenarios, were developed for their deployment. Having several scenarios makes for greater flexibility in the use of strategic EU common assets or available assets:

- first scenario: equipment is loaded on two trucks that are transported by two C-130 aircraft;
- second scenario: equipment is loaded on pallets that are transported by one C-130 aircraft;
- third scenario: equipment is loaded on and carried by two CH-53 helicopters.

59. Each scenario has its advantages and drawbacks in terms of speed, cost, ease of deployability, infrastructure needed and availability. By suggesting a range of options for FST strategic lift, Finland ensured a degree of adaptability to the results of the force generation phase of the operation.

60. The first scenario was never used in EUFOR RD Congo, as there never was any need to deploy the FST so rapidly, considering the costs entailed. The second scenario, one that provided no direct land mobility, was used in EUFOR RD Congo for the deployment of the first FST in Kananga, in the centre of the country, between 8 and 14 August 2006. The third scenario, also with no direct land mobility and relying entirely on external assistance from helicopters, was used to deploy the FST alongside a German Role-2 field hospital to reinforce emergency operating capacity, following the major clashes that occurred on 20 August 2006 in Kinshasa after the announcement of the presidential election results.

61. As mentioned previously, FSTs were also used during reconnaissance operations. An FST module consisting of one trauma surgeon, one anaesthetist and one scrub nurse took part in an Operational Liaison and Reconnaissance Team (OLRT). Equipment was limited to 300 kg and included life-support equipment, basic surgical instruments and a limited amount of fluids and packed red cells.

62. The versatility of FST modules enables them to be used for both tactical and reconnaissance deployments.

63. Following the success of the Finnish FST modules, a European FST concept should be developed on the basis of the lessons learned from EUFOR RD Congo and other CSDP operations. Flexible modules, like the Finnish units, that are easily deployable and above all compatible with larger field hospitals (such as the German Role 2 field hospital deployed in the DRC) offer cost-effective ways of supporting military missions.

64. A catalogue of available forces capable of deploying as an FST, including experienced volunteers where applicable, should be drawn up in order to facilitate and speed up the force generation phase of the operation.

65. FSTs need not be confined to military operations but could also be valuable assets for emergency response to GHCs. Costs would be rationalised and useful experience gained if FSTs were deployed in response to actual civilian or military emergencies rather than participating only in theoretical training exercises.

66. The US Army has integrated FSTs into its operations as a valuable asset. The 14 active and 23 reserve US Army FSTs are being used in combat and peacekeeping operations as well as disaster-relief operations.

67. EUFOR Tchad/RCA, a CSDP operation that began in 2007 and ended in 2009,[8] closely involved military units from EU member states as well as international governmental and non-

[8] See Document 2038 adopted on 4 June 2009: "European Union military operations - reply to the annual report of the Council", report submitted on behalf of the Defence Committee by Andrea Rigoni (Italy, Liberal Group) and René Rouquet (France, Socialist Group), Rapporteurs.

governmental organisations (IGOs and NGOs) specialised in humanitarian aid. Although the EUFOR troops had no jurisdiction inside the camps in which the IGOs and NGOs were active, their involvement in protecting convoys highlighted another aspect of civ-mil cooperation, in that the medical teams had to be ready to treat not only military personnel but also IGO or NGO civilian staff. Field hospitals deployed in Chad also treated local villagers. Thus, although this is not necessarily included in their mandate, medical units involved in CSDP operations often provide medical care to locals, refugees, and internally displaced persons (IDP) requiring extensive knowledge of local diseases and other health concerns.

V. Medical intelligence

68. Medical units deployed on EU operations must be provided with accurate, reliable and up-to-date information on the situation in the area of deployment. The preparatory and initial set-up phases of the mission rely heavily on having such intelligence in advance. With adequate MEDINT, medical staff officers are better prepared to determine functional priorities in terms of infrastructure, the logistics chain, personnel requirements and the medical science itself. They can decide in advance which special appliances, utensils, medicines etc. are likely to be required in addition to the standard resources of their unit. Such advance information is also useful for organising duty rosters, setting up encampments and communication channels, contacting local support and identifying aerial or coastal evacuation points.

69. However, the situation on the ground may change at any time, leading to shifts in the demand for specific medical resources. It must therefore be possible to put in place back-up capacity if necessary and to adjust the availability of medical accommodation (beds, operating rooms) and medical personnel within a reasonable timeframe.

70. The medical units deployed thus far on EU operations have had to deal with low-intensity conflict-stabilising situations involving small numbers of patients per day. Massive casualties at critical levels have so far been rare. The requirements for advanced trauma surgery have been relatively limited during EU missions and have therefore not posed serious problems of triage.

71. In an EU mission context, the chief of staff from section J4 of the operational headquarters (OHQ) has to be notified of all in-advance planning of medical infrastructure, supplies and staff. J4 also comprises logistics and transport capabilities. The operations commander (OpCdr) who leads the OHQ is assisted by default by a personal medical advisor to assist with the overall coordination, review, updating and allocation of medical infrastructure, supplies and personnel.

72. It should be noted that this planning capability is still at the stage of an ongoing learning process. The same is true for the development of an adaptive and responsive situational awareness capability. Regarding the latter, the European Defence Agency (EDA) has undertaken to develop a tool that integrates information derived from open sources (OSINT) and to organise intelligence training courses in both the OSINT and HUMINT (human intelligence) areas. At this stage it is not clear to what extent medical intelligence aspects will be incorporated into such an intelligence training programme.

73. Among the twelve Capability Development Plan priority actions (CDPp) mentioned in the EDA's programme of work for 2009, there is one that focuses on health and medical support and another on intelligence.

74. The EDA is also seeking to improve interoperability among medical supplies and to develop a comprehensive system for casualty tracing and tracking.

75. Under the current procedures for logging and tracking patients, the surgical or medical treatment facilities in the theatre of operations, where the patient receives initial treatment and is stabilised, simply pass on the relevant medical information to the centre that monitors the patient for the remainder of the rehabilitation process.

76. In the area of "core" intelligence the EDA is working to set up a procurement programme for a Tactical Imagery Exploitation Station. Indeed, in the absence of direct eyewitness reports on injured or fallen soldiers, high-resolution satellite imagery can help intelligence analysts to:

- track the intensity of on-location combats and assess the feasibility of sending a medical team for MEDEVAC purposes;
- give a rough estimate of the number of casualties in need of MEDEVAC;
- determine additional protection measures in order to keep medical personnel safe during "hot zone" MEDEVAC attempts.

77. Telemedecine in an advanced form could be implemented in Role 1 or Role 2 hospitals. This concept comprises all kinds of off-site "virtual" medical assistance, including a live camera and audio feed allowing instant tracking of critical surgery while it is being performed. This direct communications link enables more experienced or specialised surgeons in a remote location to meticulously monitor each stage of the operating procedure and provide ongoing advice and assistance. This is an area of applied medical sciences that the EDA has earmarked for further development.

78. Many NATO member states report that with the communications systems now in place at the lowest levels of medical support, web-based teleconsultation facilities are increasingly being used routinely. Teleradiology is also increasingly becoming standard practice. However, while a number of nations report they have deployed capabilities for conducting clinical consultations at a distance, most nations say that they do not have a formal organisational structure for the control and management of remote consultations, and that they rely on informal clinical relationships (e.g. a deployed clinician consulting with his home hospital or colleagues). Military electronic health records are in use by only a minority of nations and fewer still are capable of civilian interface. Less common telemedicine capabilities (such as telemicrobiology, telepathology, telemedical maintenance) are being increasingly used, but are still rarely deployed.

VI. NATO medical cooperation

79. According to Art. 42 of the Lisbon Treaty, "Commitments and cooperation in [the] area [of security and defence] shall be consistent with commitments under the North Atlantic Treaty Organisation, which, for those States which are members of it, remains the foundation of their collective defence and the forum for its implementation." As such, it is crucial for EU member states, and European states involved in CSDP operations to ensure close cooperation with NATO.

80. Over the last decade, NATO has focused on the issue of medical cooperation. Conscious of the importance of the topic, NATO Allied Command Transformation (ACT) opened a Military Medicine Centre of Excellence (MILMED COE) in Hungary, near Budapest, in April 2009.

81. During the opening ceremony, Hungarian Defence Minister Dr Imre Szekeres explained that the Centre of Excellence is a mutually beneficial organisation: "Similar to all other multinational cooperation projects, this Centre of Excellence generates synergies and provides all participating nations with capabilities that they would not have been able to field on their own, respectively. […] Multinational financing arrangements are the key to enhancing our efficiency and to improving our results". He added that medical care was one of the most important factors in the conduct of NATO military operations: "Deployed military personnel in any theater of operations should receive the same quality of medical services as troops in their own garrisons. This Centre of Excellence will train medics and experts to plan medical support to NATO exercises […] The prerequisite condition to joint operations involving different nations is that common rules and regulations and common doctrines as well as common concepts should be applied. The second major task of this COE is to draw up such common rules and regulations, concepts and doctrines. The third mission of the Military Medicine Centre of Excellence of the HDF is to enhance interoperability as well as to dismantle obstacles to cooperation among nations." The Military Medicine Centre of Excellence is one of 19 NATO COEs, but is the first to specialise in the provision of medical care.

82. The MILMED COE's activities are divided into three main areas:

- medical training and evaluation;
- standards development;
- lessons learned.

83. The MILMED COE's mission is to:

- "take the lead in training of multinational medical units and provide support in implementation and expedition of the necessary certification tools and procedures to Nations, ACO [Allied Command Operations], Military Health Care Working Group, Military Medical Structures, Operations and Procedures Sub-Working Group on Certification, Military Medical Training Expert Panel in their related activities;
- provide a training venue for a unit level training using the existing Medical Training Base (currently providing site for the US approved/led SF-18 Delta training) or/and our State Medical Centre for a high level state-of-the-art clinical training;
- provide a mobile training team/SMEs to assist Nations, ACO to facilitate the certification and validation of deployable multinational medical units;
- provide SMEs to develop training scenarios for NATO operations;
- conduct/assist other Medical courses in co-ordination with the NATO School".

84. The COE is also designed to provide a central repository for lessons learned. In particular, the MILMED COE will:

- "actively collect tactical level observations;
- analyze the information and make recommendations involving available expertise;
- finalize the process turning the Lessons Identified into a Lesson Learned;
- expedite incorporation of the latest Lessons Learned into concepts and doctrine;
- provide a subject matter expertise forum and venues for exchange.
- develop standards."

85. The COE will focus on facilitating and developing medical standardisation agreements especially with regard to training requirements and certification procedures, at both individual and unit levels.

86. The creation of the NATO COE is important, as many of its courses and training exercises are open not only to NATO and Partnership for Peace (PfP) countries but also to other EU member states.

87. For example, the COE's Medical Standardisation Course, to be held from 31 May to 1 June 2010, states its target audience to be: "medical personnel primarily engaged in national medical doctrine development and standardization; NATO COMEDS Working Group (WG) delegates; medical standardization specialists from NATO/EU bodies; other interested audience". The course's aim is to "introduce the NATO doctrine development and standardization process with details on medical related matters to respective medical personnel of MILMED COE Nations. The course is open to further NATO, EU, Partnership for Peace (PfP), Mediterranean Dialogue (MD), Istanbul co-operation Initiative (ICI) Nations, to NATO Contact Countries and to relevant organizations."

88. The sets of standards established, or currently being established by NATO are universal in their application. In order to avoid duplication, those standards that de facto have already been integrated into CSDP (e.g. Roles 1-4 medical units), should be officially adopted by the EU for its CSDP operations.

VII. NATO Medical Intelligence

89. The NATO Applied Joint Medical Support Doctrine outlines a definition of what comprises medical intelligence. It is defined as "the product of the processing of medical, bio-scientific, epidemiological, environmental and other information related to human or animal health. This intelligence, being of a specific technical nature, requires informed medical expertise during its direction and processing within the intelligence cycle".

90. MEDINT is important firstly to intelligence and operational staffs for the formation of strategic assessments. Secondly, medical planning, preventive medicine and operational staff will use it for:

- the assessment of health risks;
- the formation of medical estimates;
- the development and execution of preventive medicine actions and necessary prophylactic measures;
- the planning of more detailed health risk and operational risk assessments;
- the ongoing management of medical support services;
- force protection and defence.

91. In a somewhat broader context, MEDINT is useful in the following areas of military planning:

- strategic intelligence assessments;
- analysis of enemy capabilities and vulnerabilities;
- operational planning and execution;
- civ-mil medical planning and operations.

92. In a NATO context, MEDINT provides the basis for action throughout the range of military medical operations. Throughout the operation, deployed forces will be required to notify the unit medical staff of any intelligence which may affect medical readiness. This information will then be reported up to theatre level for appropriate command advice on risks and recommended responses.

93. The medical planning staff has to make sure that, in the absence of adequate or reliable intelligence, it submits a "Request for Information" (RFI) to the supporting intelligence staff. RFIs will usually be submitted in a format similar to a Priority Intelligence Requirement (PIR), intelligence requirements for which a commander has an anticipated and stated priority in the task of planning and decision making, and should be very well-defined, narrow in scope and specific to a command mission or objective. Additionally the RFI must state the highest classification required and a workable time limit.

VIII. Conclusion

94. Crisis and emergency medicine has developed only recently and large-scale responses to crises often necessitate the inclusion of military assets in civilian areas. Increased civilian-military cooperation is needed to bridge the ideological gaps, often in public opinion, that may remain and that may prevent civ-mil cooperation from operating effectively. The closing down of military hospitals and the transfer of authority to civilian hospitals prove that civ-mil cooperation exists de facto in many countries, within civilian areas.

95. The type of medicine needed to treat civilians and the military, whether in domestic cases or during external operations, does not differ much as far as the EU is concerned, as CSDP operations have until now been of a peacekeeping nature. Accidents, diseases, viruses and injuries are common to both the civil and military sectors. Therefore, the specialists needed to treat these medical issues can come from either sector. However, there has to proper contingency planning in case situations deteriorate and battle trauma medicine is needed.

96. Efforts should also be conducted in all concerned EU member states to combine the experience of civilians and members of the military with expertise in crisis and emergency medicine. Such efforts should include members of civil society, for consultative purposes.

97. Recent Great Humanitarian Crises have demonstrated the need to establish rapid reaction forces capable of being deployed within hours of a catastrophic event occurring. The Belgian B-Fast initiative proves that such initiatives are very useful. An EU-Fast initiative, as suggested by several EU member states in 2003 could be the EU's answer to this need. This would ensure a rapid coordinated approach to GHCs. Deployment of this kind of team would be done in the CSDP framework, and coordinated by EU SitCen, as the EU rescue efforts were after the January 2010 earthquake in Haiti. A coordination and cooperation model to follow could be based on the battlegroup concept, and the team should be able to be deployed within hours of a GHC occurring.

98. EUFOR RD Congo, in 2006, has been the basis for many lessons learned. The use of FSTs for example was useful and contributed to the medical coverage of reconnaissance operations, as well as tactical operations such as Role 2 field hospital support. The EU should catalogue the available FSTs that EU member states would be ready to deploy in the framework of CSDP. Such FSTs could be combined with the proposed EU-Fast units in order to ensure optimisation of speed and effectiveness and avoid duplication of effort.

99. As well as establishing or cataloguing FSTs and EU-Fast units, emergency strategic lift options should be drafted with the usual contingency planning required for emergency procedures. It would thus be necessary to follow a model similar to the battlegroup rotation system to establish which member state would be responsible for lift. The humanitarian nature of GHC rescue aid is such that the decision to deploy EU-Fast units should be made in a rapid and effective way.

100. Training, lessons-learned sessions and experience are crucial to the development of optimal medical coordination between member states. The NATO Military Medicine Centre of Excellence and its openness to allied and partner countries are valuable tools. In the framework of CSDP, the EU and NATO should develop common modules. Common training exercises should be held in various parts of the world, so as to experience different climates, under the guidance of the member states which have the most experience in dealing with specific forms of regional medicine.

101. As previously stated, the cost factor is problematic. Successive European Security and Defence Assembly reports have mentioned the shortcomings of the ATHENA mechanism, and the need for reform. As troop-contributing countries have to cover their share of common costs and their own costs, as well as medical treatment costs, while non troop-contributing countries only have to cover their part of the common costs, it would be optimal and fair to add medical costs, including long-term treatment costs, such as those for PTSD treatment, to the common costs covered by the ATHENA mechanism.

102. In order to develop proper medical cooperation and coordination across European armed forces, a structure for dialogue, exchange of ideas and strategy development will be necessary, encompassing representatives of the military of EU member states, civilian institutions and international governmental and non-governmental organisations involved in medical cooperation, in order to identify fields of further cooperation, areas of mutual satisfaction, and a proper institutional mechanism for cooperation and exchange of ideas.

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