ISSUE 101

STRATEGIKA

Conflicts Of The Past As Lessons For The Present

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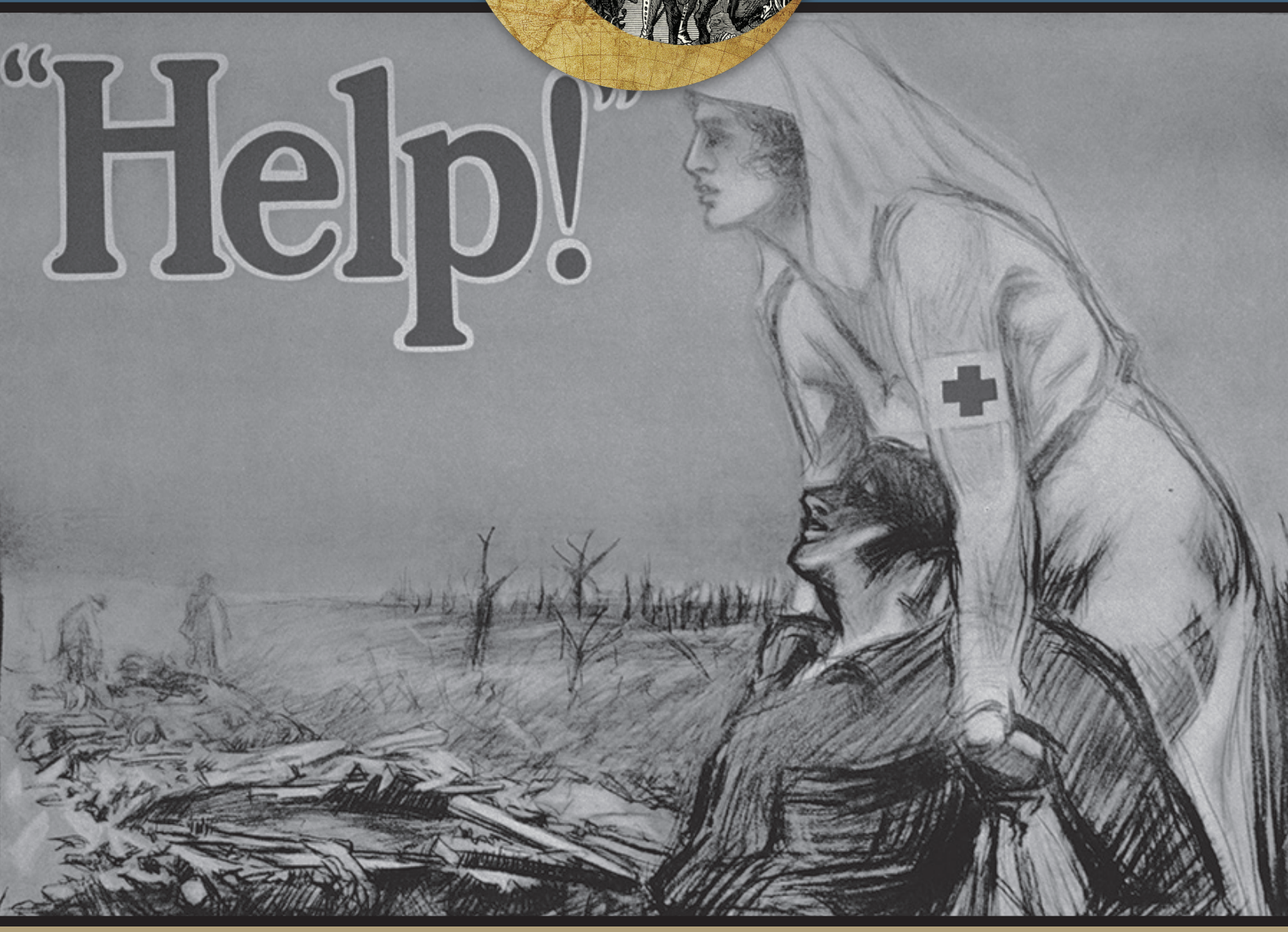

BATTLEFIELD MEDICAL SUPREMACY

IN THIS ISSUE

JEREMY W. CANNON • SHERRY M. WREN • EMILY MAYHEW

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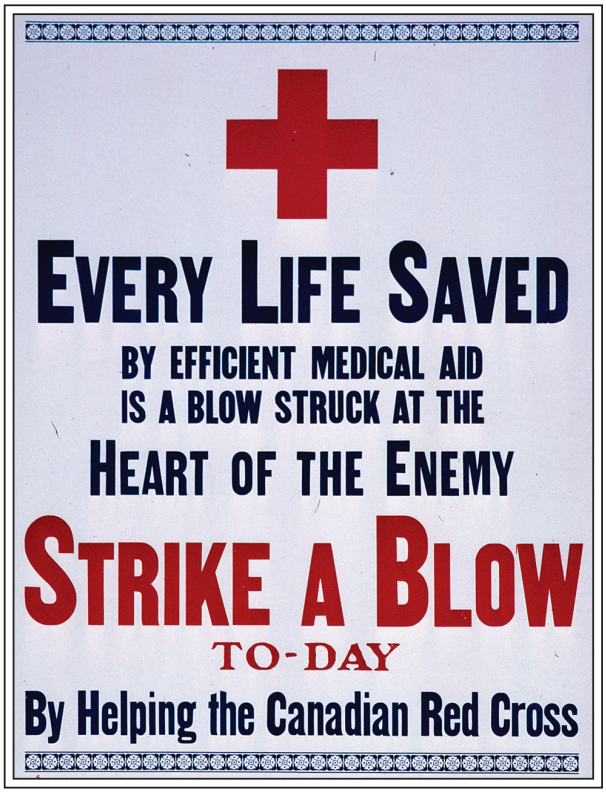
ABOUT THE POSTERS IN THIS ISSUE

Documenting the wartime viewpoints and diverse political sentiments of the twentieth century, the Hoover Institution Library & Archives Poster Collection has more than one hundred thousand posters from around the world and continues to grow. Thirty-three thousand are available online. Posters from the United States, the United Kingdom, Germany, Russia/Soviet Union, and France predominate, though posters from more than eighty countries are included.

Battlefield Medical Supremacy

By Jeremy W. Cannon



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Americans expect their sons and daughters wounded in battle to receive the most advanced medical care available. Accordingly, military medical professionals now seek to eliminate preventable combat deaths in a bid for battlefield medical supremacy. Yet the expectation of saving every life at any cost must square with the realities of combat. In large-scale conventional wars, overwhelming casualty numbers, contested evacuation routes, and logistics challenges all impinge on the lofty goal of maximizing survival.

What's more, our nation often neglects combat readiness between major conflicts. This pattern also extends to medical units at a cost measured in American lives. From the beginning of World War II through the Global War on Terror (GWOT), more than 100,000 combat deaths—roughly one in four—resulted from these lapses in medical readiness. Such preventable deaths not only impede tactical success but also inflict moral injury on the medical teams struggling to save lives. Ukraine reminds us that the scale of any future conflict will dramatically magnify the scale of these needless losses. Such gratuitous deaths violate what the ancient Greeks called θέμις (*themis*)—our deepest sense of "what is right."

So how should we approach military medical readiness? Despite our democratic public's expectations, medical planning to meet the extreme challenges of delivering care in combat often represents a distant afterthought. This haphazard approach need not continue. Rather, we should sustain military medical readiness even during peacetime by training our military medical teams to deliver expert battlefield trauma care on a moment's notice to better support operational battlefield supremacy.

A Short History of Battlefield Medical Care

Wars inflict pain, suffering, and death. Throughout history, though, commanders and their medics have sought to alleviate suffering and outmaneuver death, albeit with variable success. The Romans crafted the first recognizable system of military medical care among their legions. Soldiers doubling as field medics (*capsarii*) carried dressing boxes (*capsa*) and provided initial care for wounded legionaries. Those with severe injuries were evacuated by stretcher or ox cart to hospitals for care by a *medicus*, an experienced surgeon.

During the Middle Ages, military medical innovation stagnated. Small feudal armies had one or two physicians, but there was no organized system of care during medieval wars. Wounded combatants represented dead weight, typically relegated to the baggage train or killed by the enemy. In 1489, Queen Isabella I of Castile notably objected to this fatalistic approach. Instead, according to Italian scholar Peter Martyr, she provided bedded wagons to evacuate the wounded to hospital tents dubbed Queen's Hospitals, "not only for the succor and cure of the wounded, but for every imaginable illness."

Yet this innovation failed to take root over the ensuing three centuries. It was not until the nineteenth century when Baron Dominique Jean Larrey, Napoleon's surgeon-in-chief, was able to transform battlefield

care. A revolutionary at heart, Larrey opposed the traditional approaches of leaving the wounded for dead or treating noblemen first and commoners last. He instituted "flying ambulances" on the battlefield, modeled after "light artillery," to quickly evacuate the wounded to the rear for surgical care. Larrey's triage—from the French word *trier*, meaning "to sort"—prioritized severely injured casualties regardless of rank. He was a constant figure on the front lines of Napoleon's battles, including Waterloo, where his life was spared because of his sterling reputation for attending to friend and foe alike.

Military Medicine on the Modern Battlefield

Over the next century, new weapons delivered increasingly efficient means of destroying life. Machine guns, tanks, and bombs—conventional and nuclear—enabled killing on an industrial scale. As this lethal revolution in the kill chain unfolded, a revolution in the medical survival chain emerged in parallel. Starting with World War I and continuing through World War II, Korea, and Vietnam, military surgeons created and then refined the following formula: staunch extremity hemorrhage, transfuse blood, rapidly evacuate casualties, perform emergency surgery to repair damaged organs, and then provide supportive and restorative care.

During each of these conflicts, medical advances, including those conceived or refined in the thick of combat, complemented this basic framework and steadily improved survival. In Korea, surgeons reconstructed arteries rather than just tying them off (thus saving limbs rather than amputating). Hospital ships provided emergency dialysis to salvage those with kidney failure. In Vietnam, mechanical ventilators delivered pressurized oxygen to casualties with chest injuries and respiratory failure. Combat surgeons pushed the envelope even further during GWOT by using a cutting-edge heart-lung machine for casualty rescue.

Yet, all these advances came in fits and starts. We did not enter each conflict *planning* to use our most advanced therapies during combat. Instead, we stumbled our way into these solutions, and, at times, failed to deploy them early in the next conflict.

Battlefield Medical Supremacy on Day One

Ensuring optimal emergency and trauma care on day one of the inevitable next conflict requires deliberate planning. The dramatic events during a Monday Night Football game in January 2023 offer a salutary example. Shortly after kickoff, Damar Hamlin of the Buffalo Bills tackled an opponent, popped up to his feet, and then immediately collapsed. NFL medics rushed to his side and found him pulseless. They started CPR, defibrillated his heart, and then rushed him to a nearby medical center where he received expert critical care that restored him to full health. He was discharged a little over a week later and returned to play the next season. The diagnosis: *commotio cordis*, or sudden cardiac arrest after a blow to the chest. Behind the scenes, the NFL had deliberately trained and equipped their medical teams for this and other life-threatening scenarios. Damar Hamlin is alive today as a result.

What would it take for the U.S. military to deliver similar life-saving care on the first day of a future conflict? First, everyone in the chain of survival must train to the level of trauma expert, according to their station. This starts with the medic on the front lines like the Roman *capsarius*, continues with the modern-day equivalent of Larrey's flying ambulances, extends to the surgeon staunching hemorrhage, and ends with all members of the team tasked with ensuring a smooth and complete recovery. Professional societies serve an important role by keeping the lessons of history alive and by supporting training. The Excelsior Surgical Society of the American College of Surgeons has led the way in this regard. Expanding and deepening these linkages to all specialties involved in casualty care and ensuring command support for participation will mitigate the peacetime effect.

We can then build on this baseline of expertise to maintain a strategic advantage over our enemies by continuously pushing the boundaries of battlefield medical care—up to and then even beyond civilian standards. During one of my deployments to Afghanistan, this innovative spirit came to my attention when an enterprising orthopedic surgeon proposed an in-theater MRI. Rather than evacuating every war fighter with a concussion or a sprain, pushing MRI closer to the front lines could clarify the extent of these injuries,

allowing some to rehabilitate in place and then safely return to the fight. This kind of "medical overmatch" not only sustains morale and combat readiness but also preserves the fighting force against a determined adversary—all essential to achieving supremacy.

Military medical investments can also pay substantial civilian dividends. Historic examples include blood banks first developed in World War I, industrial-scale production of penicillin in World War II, and trauma systems exemplified in the MASH units of Korea. The war in Ukraine has again exposed the urgent need for this type of innovation: bacteria resistant to most—or even all—known antibiotics routinely infect combat wounds in this theater. For some, fatal sepsis has accomplished what Russian drones could not.

Counting the Cost

Viewed through a weapons systems lens, combat medical care can appear as a costly defensive capability—a tempting target for budget hawks. Wartime medical specialists require years of expensive training. Then, noncompetitive salaries and low case volumes in military hospitals lead these specialists to separate at the first opportunity. Beyond attrition, the scarcity of complex, combat-relevant cases directly undermines readiness. One recent study showed only 10 percent of military general surgeons—considered the anchors of these teams—are combat ready. Finally, military biomedical research also takes a hit during peacetime with predictable cuts to drug development, wound care, and organ replacement programs, despite their life-sustaining dual-use applications. True, a fighting force cannot heal itself to victory, but can we really afford to neglect this capability?

Some argue battlefield medical care interferes with offensive operations. A medic rushing to the side of a casualty—identifying wounds, applying a tourniquet, transfusing blood—loses focus on the enemy. The casualty then requires a ground vehicle, helicopter, train, boat, and/or a fixed-wing aircraft for evacuation. Critics allege such inefficient use of resources ties up crews and congests the battlespace. This argument ignores the morale-boosting effect of these teams and their potential to return some to the fight.

Finally, treacherous enemies view these medical evacuation platforms, their human cargo, and their destinations as high-value targets, despite legal protections. Attacks on noncombatants have occurred in every major conflict since the Geneva Conventions were first ratified in 1864. Even today, Russian forces routinely target Ukrainian medical facilities. Such actions offer a diabolical "triple advantage." First, striking casualties guarantees they will not return to the fight; second, taking out medical teams eliminates force multipliers; third, attacking medical vehicles and facilities degrades morale among troops and the broader public. Such realities require extreme measures to ensure these teams can perform their lifesaving work in relative safety.

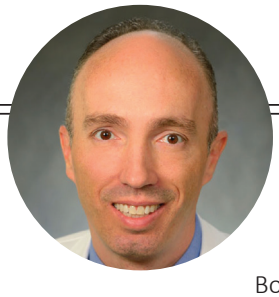
Upholding *Themis*

Why maintain medical continuity between conflicts, sustain a pipeline of combat medical experts, commission research to improve battlefield survival, deliver expensive medical equipment to the front lines, and put lives at risk to save others? In a word, *themis*. With sufficient planning enabled by well-crafted polices stiffened by political will, these challenges can be met at a scale required to face even a peer enemy. Military trauma teams can train in civilian trauma centers. Reserve and guard units can mitigate recruitment and retention shortfalls. Combat-relevant biomedical research can advance, if adequately funded. Deployed medical teams can be shielded from attack. In return, planning for and implementing battlefield medical overmatch builds confidence among our warfighters and optimizes their combat effectiveness. This ethos—regarding every life hanging in the balance as worthy of our maximal effort—leverages the intrinsic military advantage afforded by our democratic values.

The debate over acceptable operational risks versus the benefits of exerting battlefield medical supremacy erupted during the Afghanistan surge between then–Secretary of Defense Robert Gates and his commanders. For years, the military had maintained a "golden hour" medical evacuation standard in Iraq but not Afghanistan. When Secretary Gates challenged this discrepancy, he met significant resistance. Operational

leaders cited increased workload and operational risk for little benefit. Gates ultimately appealed to *themis* and mandated a one-hour limit from evacuation request to surgical care. "[It] was about the troops' expectation and their morale," he later reflected, "and by God, we were going to fix it." This bold decision saved hundreds of American lives.

As the father of a service member, I now have a new perspective beyond my sense of duty as a military surgeon. My family, including my son, accepts that he might suffer terrible wounds or even die in the line of duty. However, we refuse to accept, and I contend no American family should accept, that this could happen at the hands of an apathetic system. Establishing battlefield medical supremacy from the outset of our next conflict represents a new but achievable paradigm. The American public must simply demand it.



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The Transformation of Battlefield Medical Care and Our National Culture

By Sherry M. Wren

Image credit: Poster Collection, 00374, Hoover Institution Archives.

"Should the United States prioritize saving severely wounded service members on the battlefield in a future great power conflict, even if doing so diverts combat resources and risks strategic failure?" That is an impossible question to answer, similar to Phillipa Foot's trolley problem. This philosophical question explores the concept of double effect, wherein she concludes that negative duties (moral obligations not to harm/injure) carry more weight than positive duties (moral obligation to aid/benefit others).

This quandary arises widely, from autonomous vehicle programming to organ transplantation, and appears in popular culture, such as *Star Trek*'s Spock and Kirk's dialogue on the Vulcan phrase "Logic clearly dictates that the needs of the many outweigh the needs of the few," followed by "Or the one." Philosophers and writers continue to explore the limits of utilitarianism, which prioritizes maximizing net benefits. The challenge of battlefield medicine lies in balancing moral obligations to service members with operational and strategic requirements. The answer we choose reflects how we see ourselves as a culture.

The question does not have a singular medical answer; instead, it must balance state-of-the-art trauma care to resuscitate, transport, and treat casualties with troop morale, tactical, and strategic objectives as well as logistics and materiel resources. The crux of the question rests on two conflicting values—limitations of resources and the importance of the strategic objective. Our culture has decided that some objectives are worth dying for: numerous stories, citations, and medals honor heroes who gave all to win the day.

That said, we still prefer to win with the fewest possible casualties, and casualty care often requires high risk and high expense. Abandoning wounded fighters would degrade operational effectiveness by losing trained and experienced personnel requiring ongoing replacements. Importantly, not prioritizing care violates the implicit social contract between the enlisted and the U.S. military. Our citizens and our all-volunteer force believe that the government will care for them and have high expectations for that care. Abandoning the wounded would erode public and warfighters' trust in the military and damage morale, social cohesion, recruitment, and retention. The choice not to deliver this care risks serious moral injury, especially for medical personnel whose core moral belief is the drive to provide care.

Tangible examples of this are evident in the numerous medals awarded to both living and deceased medics for prioritizing the safety of their wounded comrades over their own. Battlefield medical care is critical to unit morale and cohesion. Knowing that the military will do everything to save them or their buddy has a profound effect on the unit and individual soldier's confidence to engage the enemy.

Balancing these resources is not a new concept; it has evolved alongside warfare. Napoleon's battalion surgeons were early pioneers in casualty care. We have many more options today, but they also require more resources and necessitate ongoing adaptation. The use of combat drones has already changed injuries as well

as casualty transport needs. Forward thinkers have brought genuine innovations and stimulated the rediscovery of older techniques.

For example, a bold vision of future battlefield surgery drove the development of robotic surgical platforms, now standard tools in hospitals. Tourniquet use represents a rediscovered technology that was abandoned after World War II and became a standard lifesaving intervention in both military and civilian medicine, and once again is undergoing evaluation and updates following improper use in recent world conflicts. Another key innovation was both real-time and retrospective evaluation of casualty care. The Tactical Combat Casualty Care (TCCC) guidelines were initially developed for special forces deployments in the 1990s to address extremity hemorrhage, the leading cause of preventable death, and subsequently became standard for all deployed service members with demonstrable results. TCCC divides care into phases: "care under fire," "tactical field care," and "casualty evacuation care," with each phase balancing medical urgency against the safety of both casualties and rescuers.

The development in 2004 of the Joint Trauma System remains a key driver in the ongoing evolution of military medicine through practice guidelines, education programs, and trauma registry analyses. These programs actively address the critical need to maintain multidisciplinary surgical team readiness during the current interwar period with few war-wounded casualties. Significant challenges exist today. Injuries received downrange bear little resemblance to civilian trauma injuries, and surgical subspecialization and procedure innovation have moved surgery away from experienced "generalists" and from maximally invasive open operative techniques to minimally invasive ones. The driving question is how surgical teams can acquire and maintain critical skills to treat complex injuries.

There will always be the need to make triage and tactical decisions, but relegating severely injured patients to no treatment will have serious consequences. Strategically, it is the will of our citizens that empowers our military to prevail. That "will" would be endangered if they thought their injured sons and daughters were not being sufficiently cared for. Therefore, the U.S. military must continue to extend significant resources to battlefield medicine. Continuous transformation of the system is crucial for maximizing the impact of battlefield medical care and minimizing the strategic operational implications.

Sherry M. Wren, MD, FACS, FCS (ECSA), FISS, is professor of surgery and director of global surgery at the Center for Innovation in Global Health, Stanford University, and director of clinical surgery/chief of general surgery at the Palo Alto Veterans Health Care System. She serves as secretary of the American College of Surgeons (ACS); professor extraordinary at the Centre for Global Surgery, Stellenbosch University; adjunct professor at the Uniformed Services University in Bethesda; and former honorary professor at the Centre for Trauma Sciences, Queen Mary University of London. She has held leadership roles across numerous national and international organizations and was the recipient of the 2017 ACS International Surgical Volunteerism Award. Dr. Wren is editor in chief of the *World Journal of Surgery* and has served on the editorial boards of *JAMA Surgery*, *Surgical Endoscopy*, *Journal of Laparoendoscopic and Advanced Surgical Techniques*, and the *East and Central African Journal of Surgery*. Her clinical and research interests include global surgery, surgical systems and technology, robotics, humanitarian surgery, trauma, and GI cancers. Clinically, her focus is HPB and gastrointestinal malignancy, surgical robotics, and conflict care. She has worked extensively as a surgeon with Médecins Sans Frontières in conflict zones.

Medic!

By Emily Mayhew

Image credit: Poster Collection, 00190, Hoover Institution Archives.

It's a disturbing thought that any military force would seek to blame battlefield failure on the distraction of resources generated by the provision of medical care for severely wounded service personnel. As a historian, I sought to find examples of this in the past. Even in times where humans lacked the knowledge of anesthesiology, antibiotics, blood transfusions, and other techniques that we would today consider standard practice in both civilian and military medical contexts, I have been unable to find an example in the modern era where defeat is ascribed to the deflection of resources from the fighting force to care of the wounded.

Indeed, military historians of the twentieth century have concluded very much the opposite. In Professor Amnon Sella's definitive analysis, *The Value of Human Life in Soviet Warfare* (Routledge, 1992), he demonstrated that Soviet attitudes to its military-medical service, its own prisoners of war, and the ethos of fighting to the death had changed completely from czarist times. The Soviet military throughout its history was much less ready to tolerate massive sacrifices of its men than had been assumed by Western strategists. Although Soviet military medical capability was not advanced, it was extensive and highly visible to all service personnel (whilst the stretchers bearing the badly wounded to medical facilities at the rear of the Eastern Front were usually pulled by reindeer or large dogs, they could be seen to be operating as part of an effective evacuation process). Sella's interpretation was that utilitarian-military logic, rather than compassion, dictated this priority on medical care for the purpose of maintaining fighting morale. Whatever the rationale, for the modern soldier, the knowledge that if they call out "Medic!" they will receive some kind of response is key to their own and their comrades' ability to fight on.

In order to fully understand the fundamental importance of the provision of medical care to fighting troops, it is necessary to go beyond the battlefield to the earliest point of engagement between each individual potential service member and the military command structure. The armies of both the UK and United States are volunteer services. No one joins up without having made a decision based on a range of factors (e.g., family tradition, military support for further education, employment prospects), but underlying them all is the understanding that the best available medical care will be available to both them and their comrades in the event of battlefield wounding. As one of the leading U.S. military medics recently put it during the Excelsior Surgical Society Conference in Rome, "more than anything else, what helps people sign on the dotted line is to know that if you have a chance of surviving [a severe injury], we'll do whatever it takes." Without that foreknowledge of medical expertise and effort, it is likely that fewer volunteers would sign on the dotted line and therefore be available to participate on the battlefield at all.

A similar principle applies to the presence of medical personnel in the military. They also join up for a range of reasons. Prime among them is the opportunity to gain and apply specialist knowledge to support their fellow service personnel through the severe challenges of surviving traumatic injury, whether at point of wounding as a combat medic or in a Role 1 facility as a combat surgeon. In both the U.S. and UK, consolidating the knowledge and practices of recent battlefield medical experiences so that they may be applied quickly and effectively in the next setting (either the Global War on Terror or the Great Power Competition) is a

Poll: Should the United States prioritize saving severely wounded service members on the battlefield, even if doing so diverts combat resources and risks strategic failure?

- ☐ The moral obligation to care for the wounded defines our national values and must not be compromised.
- ☐ Medical care should be delivered to the extent possible so long as it does not jeopardize mission success.
- ☐ In a contested battlespace against a peer enemy, resources must be focused on those who can return to the fight.
- ☐ Prioritizing the severely wounded invites our enemies to weaponize our ethical constraints against us.
- ☐ Battlefield medical decisions should reflect mission needs, evolving conditions, and ethical considerations.

key component of military medical practice. Were the medical priorities of the U.S. military to change in future conflicts, fewer of them would seek this career pathway, and ultimately there would be fewer qualified personnel available to engage with either the sick or the severely wounded on future battlefields.

It is hard to see what strategic advantages any reduction in deployable advanced casualty care would afford the military services. Instead, history suggests that there are significant disadvantages: reductions in numbers of service personnel available to deploy, reductions in available medical care across settings, and the absolute threat to the maintenance of fighting morale. Indeed, it is difficult to envisage a more damaging hazard in a military setting than a wounded soldier calling "Medic!" and silence being the only response.

Emily Mayhew, PhD, is a military medical historian specializing in the study of severe casualties—their infliction, treatment, and long-term outcomes in 20th- and 21st-century warfare. She is a historian in residence in the Department of Bioengineering at Imperial College London, working primarily with the researchers and staff of the Centre for Injury Studies.

Discussion Questions

1. What lessons can we learn from past wars about caring for the wounded, and how should we apply them today?
2. Should the U.S. military try to save every wounded soldier on the battlefield, even if it means risking the outcome of the battle or the war?
3. What might happen if our enemies know that we will always stop to rescue the wounded?
4. Is it fair to give medical help to badly injured soldiers who may never return to combat, while others are still fighting?
5. If civilians are injured during a battle, does the military have a duty to treat them? What about wounded enemy soldiers? Why or why not?
6. How do military commanders and doctors decide how much medical equipment and staffing to send from U.S. hospitals into a combat zone?

Suggestions for Further Reading

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Military History in Contemporary Conflict

As the very name of Hoover Institution attests, military history lies at the very core of our dedication to the study of "War, Revolution, and Peace." Indeed, the precise mission statement of the Hoover Institution includes the following promise: "The overall mission of this Institution is, from its records, to recall the voice of experience against the making of war, and by the study of these records and their publication, to recall man's endeavors to make and preserve peace, and to sustain for America the safeguards of the American way of life." From its origins as a library and archive, the Hoover Institution has evolved into one of the foremost research centers in the world for policy formation and pragmatic analysis. It is with this tradition in mind, that the "Working Group on the Role of Military History in Contemporary Conflict" has set its agenda—reaffirming the Hoover Institution's dedication to historical research in light of contemporary challenges, and in particular, reinvigorating the national study of military history as an asset to foster and enhance our national security. By bringing together a diverse group of distinguished military historians, security analysts, and military veterans and practitioners, the working group seeks to examine the conflicts of the past as critical lessons for the present.

Working Group on the Role of Military History in Contemporary Conflict

The Working Group on the Role of Military History in Contemporary Conflict examines how knowledge of past military operations can influence contemporary public policy decisions concerning current conflicts. The careful study of military history offers a way of analyzing modern war and peace that is often underappreciated in this age of technological determinism. Yet the result leads to a more in-depth and dispassionate understanding of contemporary wars, one that explains how particular military successes and failures of the past can be often germane, sometimes misunderstood, or occasionally irrelevant in the context of the present.

Strategika

Strategika is a journal that analyzes ongoing issues of national security in light of conflicts of the past—the efforts of the Military History Working Group of historians, analysts, and military personnel focusing on military history and contemporary conflict. Our board of scholars shares no ideological consensus other than a general acknowledgment that human nature is largely unchanging. Consequently, the study of past wars can offer us tragic guidance about present conflicts—a preferable approach to the more popular therapeutic assumption that contemporary efforts to ensure the perfectibility of mankind eventually will lead to eternal peace. New technologies, methodologies, and protocols come and go; the larger tactical and strategic assumptions that guide them remain mostly the same—a fact discernable only through the study of history.

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