TCCC

14 Medical Lessons Learned from The Battle of the Black Sea that are Still True Today

Date: March 6, 2019 Author: Max 0 Comments

Medical lessons learned have a habit of fading from memory as wars draw to a conclusion. Valuable knowledge can be lost if these hard earned lessons aren't passed down to new providers. Below are 14 lessons learned from the 1992 battle which occurred in Mogadishu, Somalia, known today as the Battle of the Black Sea.

All information has been drawn from Butler FK, Hagmann JH, Richards DT. Tactical Management of Urban Warfare Casualties in Special Operations. Military Medicine. 2000;165(10) (Supplement 1). doi:10.1093/milmed/165.10.via and is arranged roughly according to the phases of care.

1. Response Training for Leaders

Many of the decisions regarding the management of casualties in Mogadishu had important tactical implications. Instruction in tactical medicine should be added to training courses for small-unit mission commanders and their senior enlisted leadership.

2. Good Tactics IS Good Medicine

Treatment of casualties on missions involves a combination of good medicine and good tactics. Controlled, prospective human studies that address the entire spectrum of issues peculiar to battlefield trauma care are not likely to ever be accomplished. In general, interventions of questionable value should not be undertaken when they entail significant additional risk to mission personnel or the mission itself.

3. Add Casualties in Training

Imposition of casualties at various points in the mission should be a routine part of rehearsals and training for missions. It is important to consider not only how the casualty's injuries should be treated, but also the tactical implications of the casualty upon the ongoing mission.

> *"We need to take a particular casualty, put it into a tactical context, and then determine how to solve the problems such that we get the best possible outcome for both the man and the mission."*
>
> **— CAPT FRANK BUTLER (RET)**

4. No Plan Lasts Past First Contact

Despite the large amount of time and effort that has gone into developing a combat-appropriate trauma management plan, the bottom line remains that no single plan is optimal for all situations.

5. Finish the Fight First

Optimum care of casualties maybe in direct conflict with maximum prosecution of the mission in the urban warfare environment. The impact of delays to evacuation on the expected outcome of specific injuries is a critical element of information for small-unit commanders responsible for making tactical decisions after casualties have been sustained by his unit.

The fire provided by casualties whose wounds are relatively minor may be very important in maintaining fire superiority, but there are a number of reasons that combat casualties might have an altered mental status. Among these are stress or panic reactions to the wound, a head injury, hemorrhagic shock, and analgesic medications. Casualties who have a significantly altered state of consciousness from any cause should be disarmed immediately, but this decision must be individualized for each casualty and situation. Training in this aspect of tactical decision making should be added to combat medical training programs for both combat medical personnel and small-unit leaders.

6. Plan Before You Run

Retrieval of casualties from open areas was often complicated by intense small arms fire in Mogadishu. Improved casualty retrieval and area-denial methods to include smoke, diversions, custom-made or field-expedient casualty retrieval devices (such a length of line with a snap link), pursuit deterrent munitions, use of vehicles for cover, and improved gunfire support plans for the urban environment need to be developed and used.

7. Prepare for What Will Kill You

The need for immediate access to a tourniquet in such situations makes it clear that all personnel on combat missions should have a suitable tourniquet readily available at a standard location on their battle gear and be trained in its use. Mission commanders are

reminded that because this is an equipment item for every man in the unit, it is the mission commander's responsibility to ensure that a tourniquet is part of the routine pre-mission equipment check.

> *Civil War history buffs will recall that General Albert Sidney Johnston was one of the leading Confederate generals. He was killed in action at Shiloh on 7 April 1862. Before the battle, his surgeon, Dr. David Yandell, directed that everyone in the Confederate force have a tourniquet and be trained in its use. During the battle, General Johnston sustained a gunshot wound to the knee during the battle with an injury to his popliteal artery. He went on to bleed to death despite having a tourniquet in his pocket.*

8. Prepare for the Long Haul

There was a prolonged (15-hour) delay to evacuation for most of the casualties injured in Mogadishu. Plans for managing combat trauma on the battlefield should take the probability of such delays into account.

The prolonged (15-hour) delay to evacuation for most of the casualties in Mogadishu serves to emphasize that [civilian pre-hospital trauma management techniques] (in which the delay to arrival at the hospital is usually 15 minutes or less) may not be applicable to the combat environment.

9. Save Treatment for the Wounded

Not all individuals injured in combat need IV fluid resuscitation. Combat medical personnel should not generally initiate fluid resuscitation in individuals who are not in shock in order to: (1) minimize interference with combatants who can continue to participate in the engagement; (2) conserve limited IV fluid supplies; and (3) attend to casualties with more severe wounds. All significantly injured patients should [be treated appropriately] when tactically feasible [including] IV fluids, analgesia, or antibiotics.

10. Don't Let 'em Get There

Even with optimal care in civilian trauma centers, trauma patients who present with low systolic blood pressures as a result of trauma have a survival rate of only approximately 50%. The presence of hemorrhagic shock on the battlefield is a grave

prognostic sign.

11. Don't Hold Up the Team

The time required to perform interventions on combat casualties may result in additional injuries to the casualty, the combat medic, or the other members of their unit. This underscores the need to do only those things that have been shown to be beneficial.

12. Have a Plan for the Weapons

The medic should give consideration to what will be done with both his weapon and that of the casualty when presented with a wounded individual who is still under effective hostile fire and who requires emergent movement to cover.

13. Evac Isn't Always an Option…

Helicopter evacuation of casualties in Mogadishu was not feasible because of the threat of RPG fire and a lack of adequate Landing zones due to the narrow streets. Vehicle evacuation was difficult because of road blocks, ambushes, and RPG fire.

14. … Unless You Get Creative

Where transportation for evacuation or maneuvering is not readily available, the urban environment may provide many vehicles of opportunity that can be commandeered. Training and appropriate technology to take advantage of these opportunities should be provided.

There are many more great insights contained in the source article. I encourage everyone to grab a copy, give it a read, and start integrating some of the lessons learned into your training.

Also, let's take a moment to remember Medal of Honor recipients SFC Shughart and MSG Gordon as well as the other 19 Soldiers killed that day. These lessons were written

in blood and it is our profound responsibility to learn them and integrate them into our practice.

Army Sgt. 1st Class Randall Shughart (left) and Master Sgt. Gary Gordon. Army photo

IRENE LESSONS LEARNED MOGADISHU MOUT TCCC URBAN

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I am a pre-med student, Paramedic, and EMS instructor, former Army DUSTOFF flight medic, and SOCOM tactical medicine instructor. I believe in the power of education done right. I write for the Operational Medicine and Next Generation Combat Medic blogs. View all posts by Max