

NATO SOF Transformation and the Development of NATO SOF Medical Doctrine and Policy

G. Rhett Wallace, MD, FAAFP

ABSTRACT

The North Atlantic Treaty Organization (NATO) Special Operations Forces (SOF) Coordination Center (NSCC) is a new NATO memorandum of understanding (MOU) organization that is effecting rapid advancement in NATO's ability to efficiently utilize SOF at the strategic/operational level. The NSCC's lines of development in communications information systems (CIS), education, training, and real life support to the International Security Assistance Force (ISAF) SOF and the development of pivotal documents to develop and mature NATO SOF doctrine and policy are all occurring at lightning speed. Within this process of establishing a SOF community in NATO, the author's focus is the development of previously non-existent NATO SOF medical doctrine and policy. Many barriers to change lie ahead, but through unity of effort, we will ensure certainty of our actions.

The focus of this article is to give a brief overview of the development of the NATO SOF Transformation Initiative (NSTI), highlight the establishment of the NSCC, and discuss the development of NATO SOF medical doctrine and policy that will shape how NATO SOF operations are medically planned and supported in current and future operations.

The NSTI concept began in the spring of 2006 as a multinational call to the Supreme Allied Commander Europe (SACEUR), the commanding officer of NATO's Allied Command for Operations (ACO), Supreme Headquarters Allied Powers Europe (SHAPE). Several nations saw a need to develop a SOF capability for NATO, addressing gaps in NATO's ability to strategically and operationally employ national SOF elements in a cohesive alliance or coalition environment.

While NATO is established in accordance with Article 51 of the United Nations Charter as a political alliance with a military branch organized for collective defense, NATO's focus has historically been based on the *conventional* aspects of the alliance's military power. Because of this, NATO's motivations for change were the identified gaps in its "response to *unconventional* threats that recognize no national boundaries, show open contempt for human rights, and international rule of law."¹ As a result, in November 2006, at the Riga Summit in Latvia, President George W. Bush, as the Dean of the North Atlantic Council (NAC), announced the NAC's endorsement of the NSTI, with the NSCC, frame-worked by the United States, as the centerpiece.²

The NSCC was established as a coordination center under a memorandum of understanding (MOU) to streamline its development and implementation. The United States volunteered to be the framework nation, with Vice Admiral William McRaven, then the Commander, Special Operations Command Europe (SOCEUR), in Stuttgart, Germany, as its first "dual-hatted" Director. With an initial cadre of 17 personnel selected from the SOCEUR Joint Staff, the intent was to build the NSCC at Stuttgart, where it would remain for three to five years before relocating to SHAPE. However, realignment of organizations at SHAPE allowed the NSCC to transfer much earlier than expected, and in the summer of 2007, it was moved to SHAPE. Today, the NSCC has a staff of 110 multinational personnel, having reached initial operational capability in August, 2008, with full operational capability expected by the end of May 2009, along with the arrival of another 32 personnel. Most recently, as a result of the NATO Summit in Strasbourg, the NSCC has been tasked to plan for a way ahead to move beyond a coordination center and to establish a full SOF headquarters for NATO.

The mission of the NSCC is to enable and support NATO Special Operations Forces as the focal point for strategic SOF advice and operational planning to the NATO chain of command. This is accomplished by providing subject matter expertise to the SACEUR and Joint Force Commands (JFCs) and translating strategic estimates into operational requirements. In addition, the NSCC is responsible for coordination and synchronization of NATO SOF in the

force generation process, the development of NATO SOF policy and doctrine, and fostering interoperability and standardization. In the area of interoperability, the NSCC focuses on NATO SOF education, training, and exercises.³

The NSCC is aggressively accomplishing the goals outlined by the NAC and Military Committee. Initial NATO SOF operational concepts at the strategic and operational level were developed in the NSCC Handbook, and formalized in the development and ratification of the Military Committee's documentation of NATO SOF Policy and Allied Joint Publication (AJP) 3.5.^{4,5} Through these foundational documents, NATO has set the framework for development of a SOF structure, doctrine, and policy. As one would expect, the complexities of coordinating SOF from 23 different nations' calls for concentrating on the basics. With this in mind, the missions of NATO SOF are very straightforward.⁶

1. SPECIAL RECONNAISSANCE AND SURVEILLANCE (SR)

SR complements national and Allied theater intelligence collection assets and systems by "obtaining specific, well-defined, and possibly time-sensitive information of strategic or operational significance." It may complement other collection methods where constraints are imposed by weather, terrain-masking, hostile countermeasures or other systems availability. SR is a predominately Human Intelligence (HUMINT) function that places "eyes on target" in hostile, denied, or politically sensitive territory. SOF can provide timely analysis by using their judgment and initiative in a way that technical intelligence, surveillance, target, acquisition, and reconnaissance (ISTAR) cannot. SOF may conduct these tasks separately, supported by, or in conjunction with, or in support of other component commands. They may use advanced reconnaissance and surveillance techniques, equipment, and collection methods, sometimes augmented by the employment of indigenous assets.

2. DIRECT ACTION (DA)

These are precise operations that are normally limited in scope and duration. They usually incorporate a planned withdrawal from the immediate objective area. DA is focused on "specific, well-defined targets of strategic and operational significance, or in the conduct of decisive tactical operations." SOF may conduct these tasks independently, with support from conventional forces, or in support of conventional forces.

3. Military Assistance (MA)

MA is a broad spectrum of measures in support of friendly forces throughout the spectrum of conflict. MA can be conducted "by, with, or through friendly forces that

are trained, equipped, supported, or employed in varying degrees by SOF." The range of MA is thus considerable and may vary from providing low-level military training or material assistance to the active employment of indigenous forces in the conduct of major operations.

4. OTHER MISSIONS

Other missions include, but are not limited to, supporting counter-irregular threat activities, countering chemical, biological, radiological, and nuclear (CBRN) weapons, hostage release operations, and faction liaison.

In order to manage the wide range of missions and requirements, one of the first things the NSCC addressed was the lack of a common CIS by developing and fielding a NATO SOF common CIS network. Fortunately, an existing system, called the Battlefield Information Collection and Exploitation System (BICES), was already available within NATO. Intended to be used for the intelligence community, BICES proved itself as an ideal means for further expansion to support of NATO SOF operational activities. Because BICES has a NATO Secret and Unclassified version, it is ready-made as a system for collaboration of all allied or coalition SOF. In addition, BICES offers the ability to allow non-NATO nations to participate, enabling an even greater fusion of intelligence, and wider synchronization of operations. The development of hardware, software, and deployable container packages for NATO SOF is now ongoing. The intent is to expedite fielding to the ISAF SOF Headquarters in Afghanistan, supporting the already established ISAF SOF Fusion Cell.

On the interoperability front, the NSCC is addressing standardization and interoperability of international SOF by the development of NATO SOF Staff Officers Course, NATO SOF Combined Joint Forces Special Operations Component Command (CJFSOCC) Planners Course, NATO SOF Intelligence Course, a NATO Special Operations Air Planners Course, and the NATO ISAF Pre-trainer Course. These courses are augmented by products such as the CJFSOCC and Special Operations Task Group (SOTG) Handbooks. These handbooks cover the organization and staff functions within the CJFSOCC and at the SOTG level, their relationship to other commands, and liaison roles and responsibilities. Other areas covered include SOF planning, information operations, air support, targeting, battle tracking, intelligence, logistics, Force Health Protection (FHP), and communications. They provide tools for developing a common understanding of the CJFSOCC and SOTG structure, implementation, responsibilities, and procedures within the Combined Joint Task Force (CJTF) construct. As NATO SOF contributes to

current and future operations, these tools will cultivate future development of NATO SOF doctrine and policy.

To understand the basis for the foundational work in developing NATO SOF medical doctrine, we must first understand NATO conventional medical support, and the gaps in NATO's conventional health service support (HSS) and FHP. NATO medical doctrine can be reviewed in depth in AJP 4.10 and MC 326/2.⁷ NATO FHP is a patriarchal system primarily organized around fixed medical treatment facilities (MTFs) based on Allied Nations HSS provided to NATO operations. NATO defines roles of medical care as:

Role 1 is the lowest level at which a physician treats casualties. Role 1 provides advanced trauma/tactical medical care to stabilize and prepare casualties for evacuation to Role 2/3.

Role 2 is the first level at which damage control surgery (DCS) is performed. Role 2 has two sub-categories: Role 2 Enhanced (Role 2E) – a “mobile” MTF that it is put in place, but a logistical burden to move once in place, and Role 2 Light Maneuver (Role 2LM) – again a “mobile” DCS capability intended to support Infantry or SOF. However, National Role 2LM is often too heavy and immobile to adequately support infantry or SOF advancing on maneuvers.

Role 3 is the level at which primary surgery is located, and typically has advanced or sub-specialty surgical services associated. Role 3 MTFs generally provide area support within a Joint Operational Area (JOA).

Role 4 is generally a national fixed MTF.

NATO has standardization agreements (STANAGs)⁸ and allied medical publications (AMedP)⁹ that address medical standards for individual training and equipment. These are currently being updated and specifically identify or limit doctors as the personnel to be trained with advanced medical techniques. AMedP-17 is the first NATO publication to recognize the term “medic,” and apply it to non-credentialed providers. Medic is not a formal definition in Allied Administrative Publication-6 (AAP-6).¹⁰ For example, Annex A2¹¹ outlines what medical procedures “Independent medics” may perform; these are by exception restricted to non-invasive techniques. Annex B¹² refers to “doctors” when outlining minimum requirements for medical training of medical personnel. Within NATO's policies on individual training, many contributing nations do not have civilian equivalent “medical providers” outside of credentialed doctors or nurses. This highlights variations in acceptable standards of care within NATO; for example, Nation “X” records reservations to AMedP-

17 stating “medical and surgical treatment techniques can only be applied by physicians.”¹³

As the Senior Medical Advisor (MEDAD) for the NSCC, the author is working to establish a common description of NATO SOF medical capability, defining SOF medical doctrine and policy, developing a “scope of practice” for SOF medics, and to provide guidance to promote the highest quality, evidence-based healthcare within NATO SOF. By defining NATO SOF medical professionals, and providing a definition for standardized SOF medical capability, the author is striving to establish standards for NATO SOF medical professionals to meet relative to educational preparation, professional standing, and technical ability. These standards are met, in part, by the application for – and maintenance in good standing of – a license or certificate in nations that have civilian equivalent medical care providers, and/or a NATO SOF Advanced Tactical Provider (ATP) type registration based on the proposed “scope of practice,” along with the ACO MEDAD and the Committee of the Chiefs of Military Medical Services (COMEDS) guidance on common medical standards and clinical governance in NATO.¹⁴

The author defines NATO SOF medical professional individual tasks using the Battle Focus Training model, basing essential core tasks on the unit's Mission-Essential Task List (METL). AJP 3.5 and MC 437/1 provide the definition for NATO SOF elements, and authorize missions SOF will conduct under the alliance. NATO SOF are specially organized, trained, and equipped military forces to achieve military strategic or operational objectives by unconventional military means in hostile, denied, or politically sensitive areas. These operations are conducted across the full range of military operations, independently or in conjunction with conventional forces. Political-military considerations often shape SOF operations, requiring discreet, covert, or low visibility techniques that may include operations by, with, and through indigenous forces.

SOF operations differ from conventional operations in the degree of physical and political risk, operational techniques, modalities of employment, and independence from friendly support. Due to the nature of NATO SOF operating in remote, austere, at times primitive conditions, at the operational extremes, outside of conventional forces direct or indirect support, SOF Soldiers and SOF medical professionals should possess and maintain medical skills equal to and above those required to support conventional forces. It is critical that SOF Soldiers and SOF medical professionals be fully trained initially, and have robust medical sus-

tainment training programs on a broad spectrum of primary and emergency medical care techniques, as well as, preventive medicine, zoonotic and parasitic diseases, veterinarian care, dental care, CBRN, advanced trauma, pharmacology, life saving or sustaining invasive surgical and anesthesia techniques. These skills are essential to provide adequate medical force protection support for NATO SOF, and are the basis for promoting SOF medical professional standardized training and promoting interoperability of capability and medical equipment.

Once established, NATO SOF medical training guidance will identify the essential components for individual and collective medical training. Due to the broad definition of SOF, specific SOF units will have different training needs and requirements based on environment, location, equipment, dispersion, and similar factors. SOF operating in a variety of environments, such as hypo/hyperbaric conditions, extremes of heat and cold, mountains or high altitude, should augment the unit level medical training plan to account for medically relevant and specific diagnosis and treatments. Therefore, the SOF medical training guidance should be used as a guide for conducting unit training, not as a rigid standard, and designed to assist the commanders in preparing a SOF unit medical training plan which satisfies integration, cross-training, interoperability, and sustainment training requirements for NATO SOF medical professionals.

Within the past 10 years, SOF Lessons Learned has contributed to advancement in medical care from point of injury to primary surgery.¹⁵ Advances, such as SOF tactical combat casualty care (SOF TCCC) training, SOF individual first aid kits (SOF IFAKs),¹⁶ and development of SOF evacuation kits to create casualty evacuation (CASEVAC) platforms out of transportation of opportunity to get casualties in austere environments to DCS, have been pivotal in reducing died of wounds (DOW) rates for SOF Soldiers.¹⁷ These advances are critical to providing adequate SOF HSS. Promoting the understanding that advanced training and modernized equipment such as the single handed tourniquet and haemostatic bandages for hemorrhage control is good, but DCS or primary surgery is still required to address non-compressible hemorrhage to complete adequate SOF HSS for SOF casualties. Often conventional Role 2/3 is unable to meet SOF HSS requirements due to the great distance or the inflexibility of conventional structures to adapt to rapidly changing requirements; other issues revolve around non-existent/inadequate

host national medical support. SOF requires flexible innovative medical planners to accommodate for gaps in capability. In light of this recurring issue multiple nations have or are developing a Role 2 ultra-LM element that provides a truly light, maneuverable surgical and critical evacuation team who are familiar with SOF mission sets, tactics and techniques, are operationally ready, small and light enough to maneuver with SOF, and under the command and control (C2) of the SOF Command. The author defines this capability as Role 2 Special Operations Surgical/Evacuation Team (Role 2 SOST).

NATO comprehensive political guidance projects an environment of change that “is and will be complex and global, and subject to unforeseeable developments.”¹⁸ SOF missions and operational concepts are conducted across the range of military operations through peacetime, conflict, various stages of war, and Article 5 collective defense or non-Article 5 Crisis Response Operations. The SOF TCCC depends on an enhanced capability for first responders, SOF Combat Medic (SOCMs), SOF medical providers (SFMPs), and adaptive standard and non-standard platforms for CASEVAC in emergencies. Patients are CASEVAC’d to the nearest host nation or Role 2/3 MTF capability, but SOF TCCC capabilities are of little benefit if there is no timely resuscitative surgical care available.

As defined earlier, SOF operations by nature are remote, austere, and in primitive conditions at operational extremes outside of conventional forces or friendly direct or indirect support. SOF operate in small teams and are often cross-trained in multiple skill sets to ensure economy of effort and redundancy of capability. Advanced first responder training is essential for all SOF Soldiers. It is imperative that all SOF Soldiers be cross-trained as medical first responders.

SOF medical professionals can include a wide range of medical and paramedical professions. The following descriptions are included to assist in understanding the capability that each medical professional provides as a combat multiplier.

NATO in general does not specifically define the “medic.” Conventional medics have the skill sets to provide emergency care and entry level nursing care for patients. They attend a military/civilian medical training program that provides them with a certification (national or military) to provide medical care within their scope of practice. Course content usually includes, but is not limited to, trauma management, pre-hospital trauma management and care, basic life support (BLS), advanced life support (ALS), and inpatient nursing skills. They can perform basic medical care under the supervi-

sion of a physician, and limited preventive medicine. They can directly support combat units, ambulance teams, or Role 1 medical support facilities.¹⁹

The author purposes creating a SOF Combat Medic (SOCM) as a new definition to be applied to NATO SOF medical professionals. A SOCM is a Soldier trained in advanced medical care directly assigned or attached to SOF and who provides direct health service support to Special Operations Task Units (SOTUs) on operations. SOCMs are trained to initially treat and sustain a casualty from point of injury for up to 36 hours before transfer of the casualty to MEDEVAC or non-standard medical treatment facility. SOCMs maintain the skill set trained to medical first responders, common core tasks for conventional medics, advanced tactical providers²⁰ (the DA/SR medical skill sets), preventive medicine, and environmental/tropical medicine. Initial training for SOCMs includes courses in basic human anatomy, basic human physiology, basic medical terminology, pharmacology calculations, and basic math. The SOCM course content should include, but is not limited to, basic trauma management, pre-hospital trauma management and care, advanced trauma life support, BLS, ALS, inpatient/post-operative nursing skills, minor and invasive surgical procedures.

The author also purposes creating a SOF medical provider (SFMP) as a new definition to be applied to NATO SOF medical professionals. SFMP was chosen to highlight the “independent provider” status of the advanced training for a SFMP. A SFMP is a SOF Soldier trained in advanced medical care, or a medical professional directly assigned or attached to SOF and who provides direct health service support to SOTUs on operations. SFMPs are trained to operate independently from the direct supervision of a physician. SFMPs are trained to initially treat and sustain a casualty from point of injury for up to 72 hours, and in some mission sets for even longer periods before transfer of the casualty to MEDEVAC or non-standard medical treatment facility. The SFMPs’ medical skill sets are based on the types of patients expected in a conventional forces environment, as well as those in hostile, denied, or politically sensitive areas. By nature, SOF operations are conducted across the full range of military operations, independently or in conjunction with conventional forces. Political-military considerations often shape SOF operations, requiring discreet, covert, or low visibility techniques that may include operations by, with, and through indigenous forces. SOF operations differ from conventional operations in degree of physical and political risk, operational techniques, modalities of employment, and in-

dependence from friendly support. These mission requirements are the nexus for the following list of subject areas and specific task that are core medical skills to be initially trained and sustainment training requirements for SFMPs. Initial training requirements for SFMPs include all of the training for SOCMs, with additional training in primary, preventive medicine, anesthesia, and advanced invasive procedures as described under “primary care or emergency care doctor.”²¹

NATO SOFs’ ability to triage, treat, transfer, and recovery of casualties is critical to sustainment and regeneration of the force. Role 2 SOSTs will provide the ability to mitigate death from non-compressible hemorrhage, the leading cause of death to SOF Soldiers who die of wounds.²² The Role 2 SOST will be able to perform up to 10 DCSs without re-supply; manage two critical care patients for up to 48 hours; perform en route critical care for up to two patients at a time; and integrate seamlessly with SOF.²³

SOF medical capabilities have been invaluable in establishing rapport with allied and coalition regular and irregular forces, assisting the local populace, and countering enemy propaganda about international motives and intentions. SOF TCCC, SOCMs, SFMPs, and Role 2 SOST capabilities enhance our ability to provide life saving treatment to combatants and non-combatants affecting the outcome of any casualty situation. In addition to saving the lives of SOF Soldiers, coalition partners, and non-combatants, it plays a vital role across NATO SOF missions. The care provided to indigenous people is one of our strongest weapons in the battle for “*hearts and minds*.” It brings a universal message of NATO as liberators rather than occupiers and gains popular support, willing cooperation, and intelligence.²⁴

With an understanding of the current development in defining the capabilities for NATO SOF HSS, let’s review some identified areas that are resistant to change, or may impede the progress of NSTI within SOF HSS and FHP.

Currently, no centralized knowledge base on all alliance and coalition SOF medical capability exists. The author intends to develop this information for medical planning and is continuing dialogue with contributing nations to establish this information. Establishing working relationships with the ACO MEDAD, JFCs, ISAF, and national SOF medical staff will enable the NSCC to develop this working knowledge, and be able to advise and assist NATO SOF planners on current and future operations.

National strategic considerations have limited what information some countries are willing to share in

regard to their capabilities. The NSCC will continue to foster a climate of trust. Safeguarding national concerns is essential to information sharing within NATO.

Currently, no standardized definition exists for NATO SOF non-credentialed providers. Whereas NATO has policies for doctors and nurses, it has restrictive policies for non-credentialed providers. NATO conventional non-credentialed medical providers are based on conventional medical support systems within MTFs in direct support of or in proximity to a credentialed providers. The author is gathering national input and consensus on the proposed definitions for NATO SOF medical professionals. This work will be the foundation for development of initial and sustainment medical training requirements within NATO SOF. The lack of a certain level of SOF medical professional is not a sign of a nation's inability to support SOF, but rather a planning consideration in the force generation process.

European Union and national policies currently limit advanced medical training and sustainment training of non-credentialed providers who lack a recognized civilian equivalent medical provider. Many NATO contributing nations have patriarchal civilian medical systems, where the "doctor" is the primary decision maker and completes most invasive procedures; this is reflected in their concepts and policies relating to HSS. Medical reforms within NSTI will revolve around lessons learned and the realities of combat casualties' deaths that may ensue as the result of Cold War medical polices and doctrine based around robust host nation infrastructure and response. It is imperative that a system be developed to enable the NSCC to be a gathering point of best SOF medical practices based on lessons learned fed by input from SOF on current and recent operations.

Some contributing nations have limited or no permanent medical staff within their national SOF command structures that limits their ability to effectively influence timely change. There are also national medical structures that do not delegate authority of SOF medical training requirements and points of instruction to their national SOF commands. This can be

overcome by education of SOF specific medical requirements, best practices for joint level staffing/manning, SOF medical lessons learned, and best practices to positively influence international chiefs of medical departments, and mentor NATO SOF members who are limited by people, funding, technology, or training restrictions.

The author will be engaging NATO's conventional medical planners this spring at the NATO Medical Conference where he will highlight similarities and significant differences between NATO conventional and SOF HSS capabilities and identify current gaps in requirements. The intent will be to stimulate thought, generate dialogue, and make formal contact between the NSCC and national SOF command level medical staff. At the NATO Medical Conference in the fall of 2009, the author intends to engage NATO and Partners for Peace (PfP), SOF Surgeons, and medical planners in a NATO SOF Medical Working Group (WG) to refine and further develop NATO SOF medical doctrine and policy. The development of an ongoing NATO SOF Medical WG will be reviewed at that time.

This article gave a brief overview of the establishment and development of the NSCC, and reviewed the NSTI concept development. It proposed the establishment of new NATO SOF definitions to define SOF medical capability using the battle focused training model. Through an understanding of the definition of "SOF medical professionals," sharing medical intelligence resources, and identified best practices for medical support to SOF we can foster best practices within NATO SOF. The article discussed the development of NATO SOF medical doctrine and policy, and reviewed some barriers to change. Lastly, it set an agenda for change over this coming year to establish relationships between the NSCC and NATO Special Operations medical staff at strategic and operational levels. Please contact the author to provide input into the development of NATO SOF medical doctrine and policy. Your contributions are critical to this effort and are essential to corporate understanding, improved interoperability and to establish NATO SOF common "capability" or definitions.

REFERENCES

1. James L. Jones, "A blueprint for change: Transforming NATO Special Operations," *Joint Forces Quarterly*; Issue 45, 2nd quarter 2007, page 36.
2. George W. Bush, remarks in Riga, Latvia, 28 November 2006.
3. NSCC Handbook, 5 April 2009, page 7.
4. Military Committee Decision 437/1, Special Operations Policy, 11 Jun 2006.
5. Allied Joint Publications 3.5, Allied Joint Doctrine for Special Operations, 27 January 2009.
6. AJP 3.5, page 2-1 through 2-4.
7. Allied Joint Medical Support Doctrine, 2002, and Military Committee Decision 326/2, NATO Medical Operations, 2006.
8. STANAG 2126, Ed 5, First Aid Kits and Emergency Medical Kits. STANAG 2122, Ed 2, Medical training in first aide, basic hygiene, and emergency care.
9. Allied Medical Publication (AMedP) – 17, Training Requirements for Health Care Personnel in International Missions, 10 March 2009.
10. Allied Administrative Publication-6, dated 2008.
11. AMedP-17, Annex A2.
12. Ibid, Annex B.
13. AMedP-17, page v.
14. ACO MEDAD Medical Directive, October 2008.
15. John B. Holcombe, et all, "Understanding combat casualty care statistics," *The Journal of Trauma Injury, Infection, and Critical Care*; 60:2, 397-401.
16. Recommendations based on findings of the Committee on Tactical Combat Casualty Care, July 2008.
17. John B. Holcombe, et al. (2007). Causes of death in U.S. Special Operations Forces in the Global War on Terrorism, *Annals of Surgery*;245: 6, June.
18. NATO Comprehensive Political Guidance, endorsed by NATO Heads of State and Government on 29 November 2006.
19. AMedP-17, Annex A2.
20. Ibid, Annex B.
21. Ibid, Annex A2.
22. John B. Holcombe, "Causes of Death in U.S. Special Operations Forces in the Global War on Terrorism,"
23. USSOCOM Surgeons, CIPT for TSOST, 2009.
24. Ibid.



LTC Gary Rhett Wallace, MD, FFAFP, SFS, DMO is currently the Senior Medical Advisor and Chief, NATO Special Operations Coordination Center Medical Branch. He is Board Certified as a Fellow of the American Academy of Family Physicians. He has had the honor of working in operational billets and for U.S. Army Special Operations Command for 12 years, serving as a Battalion/Flight Surgeon, Group Surgeon, and at the USASOC/USASFC level before being assigned to NATO. He also has spent three years as a Flight Surgeon for the 1/17 (Air) Cav, and three years as a Clinic Commander in Europe. He has had three combat tours to Afghanistan where he served once as a Battalion Surgeon and twice as CJSOTF-A Surgeon.

LTC Wallace, can be reached at COM: +32 65 44 8262; DSN: 314 423-8262; or by email at unclassified: Gary.wallace@nsc.bices.org; NATO Secret: wallagr@nsn.bices.org; U.S. SIPR: gary.rhett.wallace@eur.army.smil.mil