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MILITARY MEDICINE AS AN INSTRUMENT OF POWER: An Overview and Assessment

BY

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It is my contention that, for the most part, substantive benefit was realized to some degree from all of these events. However, some were more effective than others in terms of promoting our national security strategy. This paper will review some military medical endeavors, comment about shortfalls as well as positive points, and offer recommendations for future success.

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Although the United States Military medical forces have historically had patient care and medical research as primary responsibilities, they have recently been afforded the opportunity to contribute to our national security by participating in humanitarian or civic action programs or by conducting ventures which lead to training of friendly nations' medical services. The Army Medical Department (AMEDD) has been involved with formal, established programs beginning at the close of World War II, continuing through Korea and Vietnam, and extending to the low intensity conflict ongoing in Central America. In addition, it has participated in a number of ad hoc exercises in various other areas on the globe.

It is my contention that, for the most part, substantive benefit was realized to some degree from all of these events. However, some were more effective than others in terms of promoting our national security strategy. This paper will review some military medical endeavors, comment about shortfalls as well as positive points, and offer recommendations for future success.

Keywords: military medicine; Military operations; (KT)

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MILITARY MEDICINE AS AN INSTRUMENT OF POWER: An Overview and Assessment

Chapter I

Introduction

The historic mission of the Army Medical Department simply stated has been "To conserve the fighting strength." This phrase includes the traditional wartime care of the fallen soldier; it also extends to the peacetime care of the soldier and his family. The soldier who knows that his loved ones will receive good health care will train and fight harder. In addition, health care for the retired serviceman may be an important inducement to pursuing a twenty-year career in the military. Although care is not guaranteed in military medical facilities for retired personnel, the AMEDD has traditionally tried to meet this challenge because of the expectations of those who have spent their lives as professional men and women of our military forces. An additional mission is imbedded in this creed: the ability to return to duty injured or ill soldiers provides the theater commander a valuable source of combat power. This is particularly important in the early phases of the war before follow-on forces from CONUS can be delivered to the battlefield to replace casualty losses.

Although they are not generally involved directly in patient care, two medical commands deserve mention as special contributors to our mission: Medical Research and Development Command operates several major laboratories which perform basic scientific research which leads to improved health care for our soldiers. Laboratory scientists work on projects such as blood-

product substitutes on the battlefield, immunizations to protect against infectious diseases, and are at the forefront in looking for information that will help us attack the Acquired Immunodeficiency Syndrome (AIDS). Medical Research and Development Command also provides command and control responsibility for the Burn Center collocated with Brooke Army Medical Center in San Antonio, Texas. The other command, the Academy of Health Sciences in San Antonio, is responsible for the many courses of enlisted training which allow soldier-medics to learn their skill and also develops medical doctrine to complement the Air-Land Battle.

The sum of the above represents what not only the average combat arms leader but even the average medical officer believes to be the scope of AMEDD activities. Furthermore, this mission statement is detailed in traditional monographs, circulars, and other documents which summarize AMEDD activities. But it is becoming more apparent that an adjunct role may lie in serving the national purpose as an instrument of power. One of the earliest examples of the Army's military medical new role can be dated to the late 1940's. Korean medical personnel began training with U.S. Forces stationed in Korea. Under U.S. sponsorship, a Korean Army Medical school was opened in 1949. The Korean Army Medical Field Service School was modeled after the U.S.'s Medical Field Service School and was staffed by U.S. instructors (assigned to KMAAG) during the school's formative months. Perhaps most significantly, Department of Army medical personnel secured spaces to train Korean personnel in U.S. medical schools. Many of these doctors have become leaders in

Korean medical society including both their military medical system and their civilian medical institutions. (1)

Even as far back as the 1950's, the U.S. Army Surgeon General hinted at a role for the AMEDD that crossed traditional boundaries. LMG Leonard Heaton, The Army Surgeon General, was sent by Maxwell Taylor when he was Chief of Staff to provide health care for the Prime Minister of Thailand. General Heaton stated in his memoirs that this service may have been instrumental in the eventual securing of Air Base rights in Thailand. He prophetically stated that " (military) medicine represents a very important part of diplomacy." (2)

Additionally, when reminiscing about the goodwill that resulted after performing a stomach operation on the Chief of Staff of the Venezuelan Army, he commented that "you can't beat good curative medicine as a diplomatic weapon." (3) Furthermore, MG

Winkler, at a time when he was Commandant of the Academy of Health Sciences, delivered a speech in which he stated

"Military medicine is perhaps the least controversial and most cost-effective means of using military forces in support of national development." (4) This tenet is such a fundamental concept that Winkler's statement has been quoted in the final draft of FM100-20 in the section describing health services support in low intensity conflict. (5) A number of medical ventures over the past three decades have benefited the national purpose through other than traditional means. It has been realized only recently that our military medical system can have a great deal to offer in terms of supporting national policy goals. What are some of those capabilities? Which ones seem to

be effective? What recommendations can be made for future planners? This paper will first provide an overview of the authorization network which permits and provides financing of medical ventures and secondly examine medical operational performance in Viet Nam and Central America. It will then focus on the experience of the USNS Mercy during her shakedown cruise to the Philippines. Finally, it will briefly address medical training in northern Africa and a contingency mission to Pakistan. Assessments and recommendations will be made as appropriate.

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Chapter II

MILITARY MEDICINE AS A PART OF THE FOREIGN ASSISTANCE ACT

In the post World War II era, the United States developed and promoted the Marshall Plan and the North Atlantic Treaty Organization (NATO). These initiatives were designed to assist our European allies to regain their economic independence and to arrest Soviet expansionism. As the international situation evolved into the Cold War, Washington evaluated the direction it thought we should pursue in continuing foreign aid. In his second term President Eisenhower appointed a commission to review our entire program of aid to other nations. This commission, which became known as the Draper Committee, provided Congress the foundation for the eventual passage of the Foreign Assistance Act (FAA) in 1961. (1)

The Foreign Assistance Act requires the Secretary of State to assume overall responsibility for the coordination of both military and economic foreign aid. (2) If the Secretary of State determines that military aid is indicated, the Secretary of Defense is charged with overseeing the generation and management of this part of the program. Interestingly, the funding for military assistance programs competes with other programs in the overall defense budget. (3) This requires the Secretary of Defense to carefully weigh the impact that military assistance programs will have on overall defense objectives. The purpose of the program was to "give vigor, purpose, and new direction to the foreign aid program". (4) The Foreign Assistance Act itself provides the legal foundation for the

implementation of this aid.

In the same year that it passed the Foreign Assistance Act, Congress generated the Act for International Development as an adjunctive piece of legislature. The "responsibility and authority for the formulation and execution of the foreign development aid programs will be assigned to a single agency---the Agency for International Development (AID)." (5) It is this agency which is tasked with the responsibility for promoting long range health care improvements in third world nations. The Foreign Assistance Act, under which military programs are authorized, does not address health care issues per se. However, it does make reference to initiatives which "promote health, education, and sanitation." (6)

The Department of Defense's execution of these initiatives has intermittently brought criticism from the General Accounting Office (GAO) which has charged that a number of the ventures undertaken have been done utilizing Operations and Maintenance (OMA) funds rather than dollars appropriated in accordance with the Foreign Assistance Act. Humanitarian assistance, which often appeared to be the principal direction of the efforts, resided within the province of the Agency for International Development. Critics also charged that the DOD activities were occurring without coordination with AID programs and that programs may in some cases duplicate AID initiatives. (7) DOD's position was that the humanitarian and civic action benefits which accrued were incidental to the basic training mission and, furthermore, were accomplished without incurring additional costs. (8)

In 1987, the authority to expend OMA funds for civic and humanitarian efforts incidental to JCS exercises was permitted by the Stevens Amendment. (9) However, the legislation authorized funds only through FY 87, and additional funds were not appropriated in FY 88.

In 1987, Congress also passed section 333 of the DOD Authorization Act which recognized the Department of Defense's role in conducting humanitarian assistance programs. (10) But the language of the amendment has stated that "nothing... may be interpreted to preclude the incurring of minimal expenditures by the Department of Defense for purposes of humanitarian and civic assistance...". (11) Debate has ensued as to what constitutes "minimal" vs "major" expenditures in support of humanitarian or civic assistance. Most recently, Humanitarian Civil Affairs (HCA) funds must be used only in rural settings and cannot be spent on U.S. or host nation military personnel. (12)

Resource shortfalls define two categories of constraints which govern the use of military medicine in pursuit of foreign policy initiatives: the first deals with the reality that the dollars which DOD spends on such ventures compete with funds which could be spent on other DOD priorities. Senior military leaders must examine whether or not medical activities which result in humanitarian assistance or improved civic works support DOD's overall mission imperatives. The second category is concerned with the fact that health care promotion is principally a responsibility of the State Department. Their chief agency in this endeavor, AID, has the mission and the resources to effect long term improvement in civilian health

care. Military medical activities should complement...not compete with...AID programs. Increasing attention will be required to ensure that our resources are being spent wisely. Duplication of effort and lack of coordination between government agencies will lead to increased Congressional scrutiny in today's fiscally constrained environment.

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Chapter III

VIETNAM

During the phase of the Vietnam conflict that can be classified as being low intensity (LIC), our government sought to support the counterinsurgency in part by providing programs which would "win the hearts and minds of the people" for their government. The Chief of the Military Assistance Advisory Group Vietnam (MAAGV) promoted civic action exercises which included several medically founded ventures, one of which was the Medical Civil Assistance Program (MEDCAP). This initiative's objective was "...to create a bond between the Vietnamese armed forces and the government with the rural population..." (1) Surgeon Neel outlined the objectives as: relief of immediate medical problems among civilians; maintenance of the favorable image of the central government of Vietnam and of the United States in the minds of the general population; and short and long-range improvement in medical and health standards and practices in Vietnam through education and precept. (2) The first teams, which were jointly composed of representatives from the Army, Navy, and Airforce, were inserted in Vietnam in 1963 with directions to provide humanitarian assistance. Programs were patterned along the following lines: medical teams, operating in conjunction with Army of the Republic of Vietnam (ARVN) forces, would establish clinics in strategic hamlets. These medical facilities would provide care for civilians as well as ARVN military personnel and U.S. advisors. The health teams would set up clinics and attempt to stay, sometimes for weeks, in an effort to establish rapport and continuity. In more

remote areas, they were not able to establish semipermanent facilities and, therefore, had to rotate out of the area after a short stay.

Medical training and selection of outstanding NCOs resulted in a cadre of independent, resourceful specialists who performed a wide range of medical treatments. Their spectrum of practice included delivering babies, taking care of wounds, treating infectious diseases (particularly skin disease and diarrheal illnesses), pulling teeth, initiating sanitation practices, and instructing citizens on pesticide usage. (3) Some enterprising medics sponsored programs which paid bounties on each rat delivered in an attempt to control pestilence! (4) Others also practiced veterinary medicine in delivering livestock and taking care of wounded or ill animals. These programs were done when possible in concert with the local health officials in an attempt to fulfill a principle of supporting the government in the eyes of its citizens.

One of the derived benefits from these MEDCAP teams was the gathering of intelligence. During the early years of the program, this took the form of political information regarding the status of the government in the eyes of the hamlet citizens. This information could then be used to provide feedback to the central government. For example, if a particular hamlet grumbled that it hadn't seen a government representative in a long time, steps could be taken to correct this deficiency and help assuage the citizenry. When the war heated up, however, the type of information gathered turned to combat intelligence. This usually took the form of grateful residents of a hamlet

divulging information such as Viet Cong whereabouts or the coercion of non-Vietcong sympathizers to convert to the cause of the insurrection. (5) At times, enemy medical equipment or pharmaceuticals were captured which, in turn, provided information about the Vietcong health care and supply systems. (6) For some of our medics, the gathering of intelligence represented an ethical conflict when information was provided by the very patients they were treating. (7)

After 1964, at which time the conflict escalated and exceeded the limits of low intensity, the scope of medical ventures expanded. Civic action programs were conducted en masse by battalion, brigade, and division medical resources as well as by field hospitals. (8) In concert with the practice of counting bodies as a measure of success, the medical efforts were recorded in number of immunizations given, teeth pulled, or worming treatments administered. Although the basic humanitarian goals still existed in the minds of the medics (9), the long-term objectives of securing a population base which supported the legal government were doomed by circumstances.

Were the medically oriented civic action initiatives in Vietnam failures or were they successes? James Taylor has suggested that for medical civic action programs to be effective, they must be applied at the lower end of the LIC spectrum when the government can control the countryside "after the sun goes down." (10) It is also imperative that they be integrated with a master plan that is coordinated by both the Departments of State and Defense. (11) These criteria were largely met during the early phases of American involvement.

The medical programs appear to have effectively worked in concert with other programs to achieve desired political aims early in the course of the conflict. As the war escalated, however, the MEDCAP program derailed and became directed towards measuring numbers of patients seen or procedures performed as measurements of success. Although humanitarian efforts were achieved, and these should not be ignored, the larger political goals receded as the effectiveness of the South Vietnam government was eroded by their own shortcomings and the ever-spreading insurrection. After the Vietnam War was ended, it unfortunately "became fashionable to denigrate the value of such services (the MEDCAP program)." (12) But the medical programs, as they were designed and implemented in the early phase of the struggle, were successful as part of an integrated plan to "win the hearts and minds" of the Vietnamese populace.

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Chapter IV
CENTRAL AMERICA

Honduras

Although joint exercises with the Honduran military began as long ago as 1965, a significant increase in the number and complexity of bilateral training ventures occurred in 1983 to discourage Nicaragua from exporting revolution. (1) In August 1983, the 41st Combat Support Hospital (CSH) deployed to Honduras under the command of COL Russ Zajtchuk. (2) Although his primary and stated mission was to provide care for U.S. soldiers, COL Zajtchuk began to develop a humanitarian assistance program that mirrored MEDCAP programs in Vietnam. His first priorities were: to provide support to American troops, to improve unit readiness by field training, and to test medical equipment in a field setting. Additional objectives included: to improve U.S. relations with the Honduran people through a MEDCAP program and to assist the development of the Honduran military medical system. (3)

The military medical community learned that two key areas must be addressed: the host nation government must be informed and brought into the operational planning and coordination must be made with other organizations to include our own Agency for International Development (AID) as well as international representation from Unicef, the European Economic Community (EEC), and the Swiss government. (4)

In the final analysis, the MEDCAP programs in Honduras were like those in Vietnam twenty years earlier. It is tempting

to apply the same kind of analysis as was done in Vietnam, namely measuring success in terms of number of clinic visits recorded and antibiotics prescribed. But this type of basis for judgment does not evaluate the qualitative characteristics of the programs. On the one hand, a reporter wrote "...they threw cardboard boxes of medicine on the ground, and, naturally, everyone rushed forward knowing the ones in front would get into the clinic and the ones behind would not. The Spanish interpreter...screamed 'Back, back...you people don't understand Spanish.' Then he clenched his teeth and mowed them down with an imaginary machine gun." But the same author later stated that once they got into the clinic, the atmosphere was totally different. American medical professionals were compassionate, competent, and caring. (5) If MEDCAPS are supposed to "enhance the popular perception of the US military involvement in a nation and of the host nation government itself," how can one explain such apparent paradoxical behavior on the part of our medical teams? (6) Part of the explanation has to do with the frustration of being involved in a situation in which not enough people and resources exist to take care of a large number of patients whose problems defy the kind of short term medicine that is inherent with the MEDCAP program. Exactly how much the MEDCAP programs have benefited both the U.S. and Honduras is thus difficult to quantitate.

Medical Readiness Training Exercises (MEDRETES) are exercises that generally involve US Army Reserve or National Guard units who deploy to Honduras for training under field conditions. They were created out of a "ramp down" of the

MEDCAP activities due to Congressional funding limitations. MEDRETEs have a primary mission to train in the environmental conditions of Central America. Any humanitarian benefit or any positive results for furthering our national strategy through means other than the training itself must be purely coincidental. With careful coordination with AID, the Ministry of Health, and Honduran military authorities, both meaningful educational opportunities for US military personnel and Honduran forces as well as humanitarian benefit can occur. The MEDRETE programs include trips to very remote or isolated villages which do not regularly receive any sort of health care, unlike the MEDCAP visits which took place nearer large installations or cities. In addition, the visits are planned for three or four days at a time with revisits scheduled when possible. This continuity of care is an important principle of such civic action programs.

A derivative of the MEDRETE program is the Immunization Readiness Training Exercise initiative (IMRETE). U.S. military medical personnel assist Honduran authorities in rural immunization programs to combat disease outbreaks. The Agency for International Development has credited this program with being the most effective of the U.S. military programs in country. (7) It is axiomatic that preventive medicine programs such as these are the most far-reaching in developing nations.

An additional type of program can be seen in specialty programs, one of which was "project smile." This program involved plastic surgery teams from William Beaumont Army Medical Center in El Paso, Texas. American surgeons worked with

and taught Honduran physicians during quarterly visits to the Comayugua Honduran regional hospital. The conditions they corrected included cleft lips and palates, hence the name "Project Smile". This program has garnered favorable comments from press coverage because of the dramatic results seen in children who prior to surgery had significant cosmetic defects; furthermore, it provided needed training for US military surgeons. (8) In ventures such as these, we must be careful that critics don't accuse us of exploiting Honduran children to train American doctors. The fact that we work closely with and train the Honduran Medical staff would help abort such criticism if it were to surface.

The MEDCAPS, MEDRETES, IMRETES, and specialty programs cited above have been/are being coordinated by the Joint Task Force Bravo medical element. In addition, spontaneous programs have been generated by medical personnel organic to other units training in Honduras. These uncoordinated initiatives run the risk of working at cross purposes with other American or Honduran medical programs. Part of our national character is that Americans are an altruistic people who enjoy helping others. But the real challenge is to recognize that the best way to help the Hondurans to enjoy better health, and at the same time further our own national interests, is not to directly provide the actual medical aid but rather to assist them in improving their own health care infrastructure. Taylor has said "The ultimate reason for medical involvement...is to assist host countries in creating and nourishing a quality of life for their people that provides a viable alternative to the situation being

developed by the Soviets and the Cubans." (9)

El Salvador

One of the most successful programs has been the Medical Mobile Training Team (MMTT) deployed to El Salvador. This activity stemmed from observations that Salvadorian Army morale was low because of the high attrition rate among those wounded in battle. Within the ranks, it was commonly held that "...to be wounded was synonymous with death." (10) Mortality figures for those wounded in action approached 45%. A visit by the Assistant Secretary of Defense for Health Affairs accompanied by a representative from the Army Surgeon General's office in 1983 corroborated findings from an earlier survey team in which the lack of a field medical system in the Salvadorian Army was noted.

In order to provide in-country assistance without violating the Congressionally mandated 55 man ceiling limit for U.S. military assets assigned in country, MMTTs were dispatched on a temporary duty status (TDY). The initial MMTT identified the principal deficit as being the lack of an effective evacuation system. The single military hospital in San Salvador was judged to be reasonably well equipped and staffed with capable, well trained medical personnel. The initial plan called for expediting delivery of four medical evacuation (MEDEVAC) helicopters and ten ground ambulances to equip a newly organized field medical service. The dramatic consequences were that over 85% of injured soldiers could expect to receive care within thirty minutes as opposed to previous conditions where as long

as twenty-four hours could elapse from time of injury to initial treatment. As a direct result of these initiatives, mortality decreased from 45% to 5%. (11) The MMTT also led to the construction of a combat support type hospital in San Miguel. This hospital is able to provide early resuscitative measures to control hemorrhaging, establish effective ventilation, and to begin fluid replacement to stabilize patients for the trip to Sal Salvador where definitive care is available. This, too, has significantly contributed to the decrease in battlefield mortality.

Other medical ventures have also met with success: working with AID, thirty-six troop clinics were set up throughout the country side to coordinate humanitarian efforts and to provide first echelon care for soldiers. Sixteen military preventive medicine technicians were trained. Improved sanitation, an enhanced immunization program, and the adoption of malaria prophylaxis have contributed to the overall improvement in health and morale. Reduced rates of malaria, typhoid, dysentery, and wound infections have resulted. Over 1500 soldiers have had amputations associated with injuries sustained from random mining. The MMTTs assisted in the creation of a rehabilitation center to treat the orthopedic casualties. The U.S. therapists and technicians have instructed the Salvadorians who are now beginning to fabricate their own orthotics and prostheses. This, too, has been a positive morale factor for the Salvadorian Army. (12) Finally, our assistance has included instruction in biomedical maintenance to allow the local medical personnel to use and to care for newly

acquired medical equipment. (13)

Although the battle is far from over in El Salvador's struggle to maintain a stable, elected government, the AMEDD contribution through well thought out planning has made a significant contribution as part of our nation's security assistance program.

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Chapter V

USNS MERCY

Part of Department of Defense's medical resources is invested in two newly refurbished hospital ships, the USNS Mercy and the USNS Comfort. These two ships provide an additional 2,000 mobile beds and twenty-four operating rooms that can be dispatched to any corner of the globe. The first of these ships, the Mercy, a 894 foot, 69,000 ton converted crude oil tanker, underwent a cruise to the Philippines and the Western Pacific in early 1987.

The purpose of the cruise was twofold: The Mercy is the first hospital ship inventoried in the Navy in the past fifteen years. Therefore, the cruise was in part a shakedown to acquaint medical personnel with the renovated sea going medical facility. In addition, ADM Lyons, CINCPAC, promoted the idea as a gesture of goodwill at an advantageous moment in Washington when Mrs. Aquino was to visit the United States. He had known that medical care was a top priority for the new Philippine President, and he realized the Mercy would make a visible statement about America's commitment to the new government. President Reagan offered the services of the ship, and two months later, Mrs. Aquino replied affirmatively. (1)

The Navy borrowed personnel to complete the ship's complement of medical professionals. The Mercy's crew proved to be a very eclectic group which included 91 Air Force medical personnel, 98 Army professionals, 3 Public Health Service nurses, and 385 Navy personnel. While in the Philippines, 65 health care workers from the Armed Forces of the Philippines

trained with the Americans. In addition to line Navy personnel, the crew consisted of 72 civilian contract Merchant Marine officers and seamen who operated the vessel. (2) The ship called on seven Philippine ports as well as several small Pacific islands during her five month voyage. Her crew provided medical and dental care to more than 55,000 people ranging from preventive medicine initiatives to major surgical procedures. Personnel and supplies were carried to shore where outpatient medicine was delivered in clinics or schools. Patients who required surgery were transferred to the Mercy herself. She also assisted in a bona fide mass casualty situation by caring for 6 out of 57 victims of a vehicle accident who were transported from a civilian facility to the mother ship. (3)

At one level, the voyage of the Mercy was a success. Hospital ships are programmed to play an important role in augmenting land-based facilities in the event of war or in providing state-of-the art, definitive care in remote areas of the world in circumstances in which Army hospitals cannot be deployed. The training that occurred benefited health professionals and assured them that they could care for complicated medical and surgical patients in a maritime environment. The mission also provided realistic joint training, an opportunity which doesn't often arise for the three medical services.

It is more difficult to comment about the efficacy of the exercise as a goodwill gesture. The Mercy, a shining white example of American state-of-the-art technology, majestically steamed from port to port and provided sophisticated care for

some citizens. Those fortunate few to receive definitive care that was not available through Filipino health resources probably do constitute a cohort of citizens who appreciate President Aquino's and President Reagan's interest in their well-being. But how about those who were not able to receive care? One must balance statements such one as made by the hospital commander "We have touched the hearts of so many people here, and have done so much good for so many more, we will carry this experience with us forever" with those such as one made by the director of surgical service aboard ship who stated "For every patient we're able to operate on, we have to turn ten or twelve away...it's the ones I have to say no to that break my heart". In Davao, for example, more than 30,000 people came to the shore clinic which, under the best of circumstances can see only 1300 per day. What did the populace think when treatment was postponed until late in the day at which time the crowds had thinned out? What did Filipino practitioners think when Americans performed sophisticated surgery and then steamed away in a few days to a new port to leave convalescence up to the local doctors? This type of itinerant surgery is avoided in the United States, and there is no reason to believe that it would be better received in the Philippines. Some of the experience with Project Hope corroborates this concern in which a palpable atmosphere of disillusionment was left in the wake of the Hope as she departed South American port cities.

Another concern has to do with the expense of the venture. In addition to the operational costs involved, the cruise removed from normal duty tours a large number of medical

personnel who otherwise would be performing their daily health care mission to eligible beneficiaries. The ninety-eight Army personnel would have been sufficient to have staffed several large health clinics or even a small hospital. Army hospitals, which are already stressed to provide adequate health care coverage, had to absorb this five-month loss of personnel without any reduction of mission. As a note of irony, when the Mercy steamed to her home port of Oakland at the conclusion of the journey, the Assistant Secretary of Defense for Health Affairs invoked the Army Medical Department's creed when he praised the principally Navy mission in saying "The Mercy serves to conserve our fighting strength" (5)

The two 1,000-bed hospital ships constitute an important, flexible portion of military medical responsiveness, and, as such, they should participate periodically in training exercises to maintain a state of readiness. But missions such as the Mercy's extended voyage to the Pacific in support of foreign policy goals should be avoided. The training involved could have been accomplished in a shorter period of time and, more importantly still, could have supported an American or NATO military exercise. From the standpoint of foreign policy goals, no lasting benefit was realized, aside from those relatively few people who profited from corrective surgical procedures. It is also possible that the Mercy's cameo appearance was viewed as an irritant by Filipino governmental and health care workers who would have preferred a different form of medical assistance which would have produced substantive improvements.

Endnotes

1. Howard G. Thomas, "A Mercy Medley", Navy Medicine, Sep-Oct 1987, p. 3.
2. Ibid, p. 2.
3. Ibid, p. 4.
4. Ibid, p. 3.
5. Ibid, p. 10.

Chapter VI

PROGRAMS SPONSORED FROM EUROPEAN COMMAND (EUCOM)

While this author was assigned to Seventh Medical Command in Germany, he had the opportunity to assist in planning several training exercises or contingency missions in which the AMEDD helped fulfill U.S. foreign policy goals. The first was a combined combat arms exercise with the Moroccan Army east of the Atlas Mountains in the fall of 1987. Seventh Medical Command sent a medical team to support our soldiers during the exercise. In addition, we were charged with the mission of performing a limited MEDCAP on behalf of the dependents of the Moroccan soldiers. The medical elements included treatment of vision problems, skin diseases, infectious illnesses, preventive medicine issues, and dental care. The consensus of those Americans who participated in the exercise was that it was a limited success. No substantive improvement was made in the health of Moroccan citizens, and no interaction occurred between their medical personnel and ours. One positive feature was the fact that this exercise was a follow-on to one from the previous year so that some continuity was appreciated. Because they were deployed to a fixed installation and practiced largely routine outpatient type of medicine, anticipated training benefits did not occur.

In January 1988, a joint team from Landstuhl Army Medical Center and the Air Evacuation personnel from Wiesbaden Air Force Base participated in a joint medical training exercise with medical forces from Cameroon. The exercise occurred over a ten day period and was designed to end up at a large agricultural

exposition in the northern part of the country where the joint military medical exercise would be visible to fair goers. The team consisted of nineteen Army personnel and approximately six Air Force medical evacuation experts who were flown on a C130 from Ramstein to Cameroon. The mission statement was clearly defined to: (1) participate in a mass casualty exercise with the Cameroonians, (2) instruct them in our techniques of medical evacuation, and (3) share with them some of our concepts of battlefield medicine. We were able to avoid a MEDCAP type mission, but we did provide several types of immunizations for the Cameroonians to use on their military personnel. The exercise covered several locations within the country and included both air and ground medical maneuvering. This operation proved to be a great success: the joint aspect of the venture was important because it highlighted the necessity for the Army and the Air Force to appreciate each others capabilities to make the exercise feasible; the training was valuable because it did allow us to mobilize one of our contingency teams and place it in a realistic scenario, i.e. a volcanic eruption near Mokolo, the site of a recent natural disaster in Cameroon; and the training that the Cameroonian medical forces realized will allow them to improve their own medical readiness. As Edwin Carns has said, "Combined training exercises, in conjunction with host country military and civilian medical personnel, promote the interoperability of forces, the exchange of technical information, and the development of professional military-to-military contacts. Equally important, such exercises help to demonstrate the proper

role of the military in a democratic society." (1) Our people established an excellent relationship with the local medical personnel, and a follow-on exercise is programmed for fiscal year 1989.

Following the tragic Marine barracks bombing in Lebanon, the Assistant Secretary of Defense for Health Affairs directed the establishment of a range of response capabilities shared by the Army, Navy, and Air Force. Different response teams were created to address any one of a number of possible contingencies. These teams can be deployed to render assistance to American personnel or to foreign nationals. For example, following the release of hostages from the TWA hijacking in Beirut or the Achilles Laurel incident, members of 7th MEDCOM's stress management team provided support and assisted in the debriefing process. A radiation protection team from the 10th Medical Laboratory was activated following the Chernobyl accident to field questions and assist in radiation monitoring.

In addition to these events, in which Americans themselves were the primary beneficiaries of the teams' services, a subelement of the triage team from Landstuhl responded to a call for assistance during the ordinance explosion in Islamabad, Pakistan. The principal expertise requested was in the treatment of the many burns that resulted from the tragedy. Our physicians were able to both take care of critical burn patients and teach American techniques to the Pakistani professionals. Several of the most severely injured Pakistani military who would require extensive grafting were flown to the Army's premier burn center in San Antonio, Texas. Our medical team was

able to experience real-time training in a burn mass casualty setting. MEDCOM planners were afforded excellent information with which to design ready-made specialty kits (push packages) to augment standard supplies for burn patients.

An interesting anecdote arose out of the experience. The initial material requested by our team to temporarily cover burned body surfaces is a product derived from swine. Fortunately, our medical logistical people realized that the Moslem Pakistani would not tolerate such a treatment, and they found a suitable non-standard substitute.

This medical response was a most successful venture from the standpoint that it provided true, requested humanitarian assistance, offered real practical experience for our physicians, resulted in training of the Pakistani medical personnel, and was at least a small step in tightening relations with this important ally.

Endnotes

1. Carns, Edwin H. and Huebner, Michael F., "Medical Strategy", Military Review, February 1989, p. 39.

Chapter VII

CONCLUSIONS AND RECOMMENDATIONS

Conclusions

In his doctoral dissertation, James Hendley advocated that "a greater role should be sought for military health personnel in foreign health assistance should be considered." He went on to state that "Many (military health personnel) are knowledgeable in the training and utilization of lesser skilled health personnel..." (1) Although the Army Medical Department has properly remained focused on its primary mission of caring for the U.S. soldier and his family through peacetime and wartime, it has also met an added responsibility of providing humanitarian assistance and medical training for friendly foreign governments. These efforts have served to advance our national interests, but not each venture has been uniformly effective.

Adequate criteria which measure effectiveness are difficult to derive, but in most cases intuition serves as a reliable guide. Requests by a host government to render humanitarian assistance in the event of a mass casualty frequently results in appreciation on the part of the victims and self-fulfillment on the part of the workers. Sometimes, information which results from such visits can provide practical, useful intelligence. Other humanitarian efforts which may be classified as showcase ventures very often reap unfavorable press for a number of reasons: our assistance may not truly be wanted in the first place; we may be competing with local forces who feel they are perfectly capable of handling the situation; brief, one-time

visits convey a lack of sincerity and genuine concern; when medications given for a condition run out and can not be renewed, the failure of the U.S. to continue to provide is perceived as abandonment and alienation; and some sophisticated, state-of-the-art care provided on humanitarian visits may be very expensive and result in no lasting health improvement. This is not to cynically suggest that the altruism connected with genuine humanitarian efforts is misplaced. Part of the American character is that we are a generous and helping people. After all, President Bush himself has suggested that "we have just begun on our journey of goodness and greatness." (2) It is just that sometimes it can be wiser to measure the full impact of what our humanitarian efforts will mean or be perceived to mean before we respond to a situation which seems to need our capabilities.

The other broad category of foreign assistance that we have rendered has centered around exercises in which the training of friendly foreign nationals occurs. These exercises often have positive results because they stem from a host country's request, and so they are genuinely desired. Activities which involve training, particularly joint training, establish professional-to-professional bonds which serve to enhance good will. Furthermore, these exercises or expeditions usually result in good training for our forces and offer the opportunity for the foreign government's image to be supported in the eyes of the populace. Finally, they tend to produce lasting results because those who are trained remain behind to utilize their new skills after the Americans have left.

Thus far, the Army Medical Department has made a small but measureable contribution to our national policy objectives as an instrument of power. If continued mission opportunities and the resources to support them are forthcoming, the AMEDD's efforts will be continue to be productive. However, it must be remembered that when critically short professionals are siphoned off for such duties, peacetime health care and medical readiness suffer.

In the final analysis, it may be economic conditions which determine a nation's well-being. The Bipartisan Commission on Central America, chaired by Henry Kissinger, quoted British Prime minister Benjamin Disraeli when it stated that "the economic health of a nation depends first on the health of its people." (3) Therefore, it is in our best interest to assist developing nations to improve their health status so that they are free to realize economic health and all the political, social, and human rights benefits that accompany it. Military medical services are an important part of national health resources which can be applied towards this goal.

Recommendations

1. Clear thinkers from the State Department's Agency for International Development and Department of Defense-Health Affairs (DOD-HA) should provide explicit strategic guidance for the development of policy to affix responsibilities for health initiatives. Close co-ordination between the on-site military commander, the Agency for International Development, and local health authorities should occur at the grass roots level where the assistance is actually given.

2. The Academy of Health Sciences should develop training courses to better prepare those who will take part in such military medical ventures. This should include language skills, knowledge of the culture and history in the country in which they will serve, as well as specialized medical skills required for the particular region.

3. The Department of Defense should ensure that military medical initiatives are adequately resourced, both in terms of personnel as well as in terms of dollars.

4. Medical operations personnel must carefully guard against overextending medical teams' capabilities in conducting civic action programs. When these teams are placed in a situation in which personnel or equipment/supply shortages are swamped by large numbers of patients, the frustrations that arise on both sides may well result in a backlash of adverse public relations.

5. Defense leaders should ensure that our military medical efforts support the government (or insurgency) with whom our national policies align. National regimes, not the U.S. government, should receive credit for accomplishments realized as the result of our efforts because this recognition will assist in bonding the people with their government.

6. Military medical leaders should resist the temptation to provide medically sophisticated services (e.g., heart surgery) for citizens of developing countries. Simple preventive medicine (public health) endeavors are more likely to yield positive results.

7. Military leaders should remember that the Agency for International Development--and not the Department of Defense--has

the the mission and is resourced for long-term civilian health care projects. Military medicine's contributions to humanitarian efforts should be approached from the standpoint that they are short range in nature.

8. Health affairs planners at the Office of the Secretary of Defense level should emphasize to MACOM planning staffs that health care operations are rarely stand-alone ventures and should be linked with other foreign policy instruments.

9. Health care operations personnel should advise military leaders who are responsible for conducting low intensity conflict campaigns that medical operations are usually more effective at the lower end of the conflict spectrum. This is because these initiatives require a stable environment from which to conduct medical programs, and it becomes increasingly difficult to guarantee stable surroundings as hostilities escalate.

10. When direct patient care programs are utilized, medical planners should ensure that continuity of care is provided either in the form of one longer stay in a community or repeated visits at predictable intervals. This commitment serves to avoid the tail-gate, itinerant syndrome which does not convey sincerity or a long-term dedication to care.

Endnotes

1. James W. Hendley, Health Services As an Instrument of United States Foreign Policy Toward the Lesser Developed Nations, University of Iowa, University Microfilms International, Ann Arbor, p. 437, 1971.

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