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U.S. MEDICAL IMPERATIVES FOR LOW INTENSITY CONFLICT

BY

LIEUTENANT COLONEL PETER B. CRAMBLET
United States Army

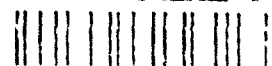
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U.S. MEDICAL IMPERATIVES FOR LOW INTENSITY CONFLICT

AN INDIVIDUAL STUDY PROJECT

by

Lieutenant Colonel Peter B. Cramblet, MS

Colonel John N. Sloan
Project Adviser

U.S. Army War College
Carlisle Barracks, Pennsylvania 17013

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ABSTRACT

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Military imperatives provide a framework for concept and professional development by highlighting key elements or attributes characteristic of successful operations. This paper will endeavor to develop a set of medical imperatives for Low Intensity Conflict (LIC) based on accepted doctrine and recent medical experience. Over the past decade emerging LIC doctrine began to establish parameters within which medical operations would be conducted. Low Intensity Conflict imperatives from FM100-20 coupled with sustainment imperatives from FM 100-5 provide the initial basis from which to develop a consistent and appropriate LIC medical doctrine. Vietnam and more recent medical operations conducted in various low intensity environments to include: Beirut, Honduras, El Salvador, and Panama provide practical experience from which we can evaluate lessons learned and formulate concepts. The result is a set of medical imperatives that include: integration, legitimacy, continuity, responsiveness, medical intelligence, and simplicity. These imperatives are consistent with published military doctrine and tend to characterize key elements of successful medical operations in low intensity conflict.

U.S. MEDICAL IMPERATIVES FOR LOW INTENSITY CONFLICT

Just Cause--Medical disaster averted once again. For ten years the Army Medical Department has been supporting low intensity conflict without a doctrine. As the Army Medical Department became increasingly involved during the 80's in support of low intensity conflict in Central America there was a rush to review the medical operations of the Vietnam era in search of an appropriate medical doctrine. After all, the Army Medical Department (AMEDD) provided remarkable health service support that maintained the lowest mortality rate of any major U.S. conflict and became a symbol of military civic action. As a result, our evolving medical support of low intensity operations has tended to reflect historical trends rather than a doctrinal basis. After a decade of experience and discussion some medical imperatives have begun to evolve.

As the Army struggled to develop its Airland Battle Doctrine (FM 100-5) based on traditional military theory, a European scenario, and the principles of war, so too has the AMEDD. As a follow on, the development of a doctrine for low intensity conflict based on historical theory and some aspects of FM 100-5 has only recently begun to emerge with the publication of FM 100-20, Military Operations in Low Intensity Conflict (1 December 1989) and JCS PUB 3-07, Doctrine for Joint Operations in Low Intensity Conflict

(January 1990). It would follow that the development of medical doctrine for low intensity conflict should align itself and support the same principles, tenets, and imperatives of published combat and combat service support doctrine.

To develop medical imperatives or key operating requirements for successful support of LIC it is important to understand that low intensity conflict transcends the bounds of traditional armed conflict. It is a "political-military confrontation between contending states or groups below conventional war and above routine peaceful competition among states." (1) As such, the principles of war, tenets, and imperatives of FM 100-5 characterize successful operations at the appropriate level, but additional LIC imperatives are applied to encompass the full spectrum of this type of conflict. Low intensity conflict imperatives from FM 100-20 include:

- political dominance
- unity of effort
- adaptability
- legitimacy
- perseverance

Like all imperatives, they are supported historically and are used to describe fundamental requirements for successful planning and operations. (2) These imperatives

are applicable to each of the four operational categories used to describe the LIC environment: support for insurgency and counterinsurgency, combating terrorism, peacekeeping operations, and peacetime contingency operations.(3) These categories are normally characterized by indirect and cost-effective programs which typically encompass activities like security assistance, military civic action, humanitarian assistance, and combined training and exercises, but which also have potential for direct action and intervention. Medical imperatives should encompass this entire arena.

Health service support is one of the main sustainment functional areas of combat service support and contributes to manning the force. As such, sustainment imperatives that are key to successful combat service support operations would apply to medical operations as well. Sustainment imperatives as listed in FM 100-5 include:

- anticipation
- integration
- continuity
- responsiveness
- improvisation

Their use or consideration seeks to overcome the inhibiting effects of the logistics "tail" thereby providing the maneuver commander more flexibility and advantage.(4)

Their relevancy for operations in low intensity is valid but not all inclusive. JCS low intensity doctrine, JCS pub 3-07, provides additional sustainment characteristics and guidelines that place premiums on: intelligence, security, simplicity, economy of resources, flexibility, and host nation support, as keys to all logistic functions in underdeveloped nations.(5) With so many doctrinal sustainment imperatives and guidelines available, the medical community is just beginning to focus on those that are relevant for health service support in LIC.

We can begin to distill those key operating functions, or imperatives, that characterize successful medical operations based on published doctrine and recent relevant low intensity experience. We will start by selecting those doctrinal imperatives that are appropriate and particularly relevant to health service support and augment with lessons learned from the past decade. It will become apparent that the economic, social, and political nature of low intensity conflict has elevated the role of medical operations from a supporting role to a more operative arm of the military.

Six medical imperatives were selected from the cited doctrine and the remainder of this paper will be dedicated to a review with examples of the rationale for their selection. In theory, planning and conducting successful medical operations in LIC will depend on the application of the following imperatives: integration, legitimacy,

continuity, responsiveness, medical intelligence, and simplicity. They represent factors for success that the medical planner or commander can influence or control.

Integration

Medical commanders must understand the first principal of war, objective, and integrate their efforts with other elements of national power to ensure accomplishment. Unfortunately, in the LIC environment clear mission statements for medical units are often lacking. As a result, well meaning commanders with highly trained, but sometimes bored, medical staff assume implied medical missions which do not always support LIC objectives. Our evolution of medical and humanitarian assistance to Honduras is a case in point. Starting in 1983 with joint exercise AHUAS TARA II (BIG PINE) with the deployment of the 41st Combat Support Hospital and followed by the establishment of JTF-Bravo Medical Element, Medical Civic Action Programs (MEDCAPS) sent medical teams into the surrounding countryside to treat local inhabitants. At times, while JTF-B Medical Element was coordinating activities with the Honduran Ministry of Health, the medics of the 27th Engineer Group, Task Force 111, which was building roads, were independently conducting their own "clinic" for civilians along the project route. Additionally, Special Operations Humanitarian Assistance Team (SOFHAT) operations by the 7th

Special Forces were conducting their own one day MEDCAPS in the north-east regions. This was compounded by the non-military efforts of other agencies like USAID, UNICEF, the European Economic Community (EEC), and the Swiss government.(6) They were described by the 7th Special Forces Group Surgeon as "totally independent uncoordinated civic action/humanitarian assistance activities.(7) U.S. medical personnel were busily providing clinical support to Honduran civilians all over the country without coordination, host country approval, or a common objective. The potential for waste or misuse of limited foreign aid and counterproductive operations was great. There appeared to be little control by the principle U.S. proponent for coordinating in-country development or nation-building programs, the U.S. Country Team.

The fault can not be entirely blamed on a bureaucratic organization such as the Country Team. Rather, it is incumbent on all medical commanders from platoon level to theater surgeon to align their decentralized operations in support of established LIC objectives in accordance with accepted medical principles. Integration of medical activities ensures well meaning and innovative medical personnel will be making a contribution to the overall effort and not Americanize the host country health system. Combined medical operations with other services, government agencies, and nations are the norm in low intensity

conflict. It is important for medical commanders to understand this concept and integrate their efforts with the overall LIC plan to achieve the desired goal.

Continuity

Continuity of care has always been a basic premise of military medicine but its implications have added significance in Low Intensity Conflict. Continuity requires that sustainment functions cannot be interrupted without diminishing the commander's power of force. Nor can it become hostage to a single source or line of support which when cut off would jeopardize operations.(8) Whether for a leader of an allied force fighting insurgencies or a U.S. commander directing contingency operations, sustainment continuity is paramount for successful military operations. From both a political legitimacy and a military sustainment point of view it is essential for the host nation to have or develop a medical infrastructure and medical logistics capability during LIC. Military medicine's role in this effort should be to assist in its development and foster its continuity.

Programs conducted or dominated by U.S. medical units that provide direct health care to indigenous civilians, despite their humanitarian nature, provide little sustainment value for a host country struggling for legitimacy. MEDCAPS and Medical Readiness Training

Exercises (MEDRRETES) that accumulate impressive statistics for patients treated are a meaningless method of management by body count. In Honduras during the mid-80's, despite efforts to involve Honduran military personnel, these types of operations were obvious American initiatives. They used American equipment, were located around American troop concentrations, and were conducted normally in one day with little or no follow-up. They became basically medicine handouts because of the large numbers of patients to be seen in such a limited visit.(9) While their principle value was training U.S. military medical personnel they basically violated the concept of continuity of care and LIC sustainment.

An excellent example of military medicine's understanding and development of continuity of care in a low intensity environment was the deployment of a Medical Mobile Training Team (MMTT) to El Salvador in June 1983. By the end of 1982 the Salvadorian Army had sustained an annual attrition rate of 7%, 2,903 casualties out of a force of 39,923. Soldier morale was dangerously low because the lack of a continuous field medical system often meant death if a soldier was wounded in the field. The mortality rate of those wounded in action was over 45%. As a result, DOD directed the Army to send a Medical Mobile Training Team to El Salvador and train combat medics and develop a medical evacuation and responsive medical logistic system. Between

June 1983 and December 1984 the MMTT trained 1391 health care providers, helped organize a medical battalion, and expedited delivery of four MEDEVAC helicopters and ten ground ambulances. Following their efforts, 90% of the wounded were able to reach a hospital within three hours and the mortality rate for those wounded in action decreased to 5%.(10) Not only was continuity sustained on the battlefield but it also was planned for in the long term after withdrawal of U.S. assistance.

Legitimacy

"Legitimacy is the willing acceptance by a people of the right of their government to govern or of a group or agency to make and enforce decisions."(11) There are two aspects to legitimacy that involve U.S. medical forces. One, is the legitimacy of U.S. medical forces to operate within the constraints of U.S. law. The second is the objective of their efforts within a defined theater.

Congress and the American public have demonstrated deep concern for U.S. military involvement in Low Intensity Conflict. As a result, legislation has been enacted that places limits on military involvement and provides for Congressional oversight. This affects medical operations in LIC. By law (22 U.S.C. 2751), the United States must be reimbursed for goods and services provided a third country unless otherwise specifically authorized. In some cases,

Congress enacts nation or issue-specific legislation to proscribe U.S. military activities in countries like Nicaragua, El Salvador, Guatemala, Peru, or over issues like Contra support. There is legislation that does provide for authorized medical operations in LIC, to include: International Military Education and Training (22 U.S.C. 2347); Humanitarian and Civic Assistance Provided in Conjunction with Military Operations, (10 U.S.C. Chapter 20, Paragraph. 401); and there is limited authority to use O&M funds during combined training exercises. Basically, because foreign assistance is an integral part of U.S. foreign policy the majority of funds and the legal authority to conduct nation building operations rests with the Department of State. (12) As a result, authority and funding for military medical operations in the low intensity environment is legitimately constrained and requires extensive coordination and planning.

Legitimacy is an imperative and valid objective in LIC. One study shows that in addition to popular support, limited corruption, and periodic elections, a government's ability to deliver basic services-security, health, economic opportunity, education and so forth is one of the four measures of political legitimacy. (13) This is the basis of civil-military operations. Key is the understanding that legitimacy for an ally is marked, not by its dependence on

U.S. capability, but rather, by its own internal ability to provide basic services to include health services,.

A conscientious effort not to compete with, but to work within the host nation medical system and to train host nation personnel can have positive results. In Vietnam the U.S. Military Province Health Assistance Program (MILHAP) was established in 1965 as a major part of an U.S. Provincial Health Assistance Program that sought to develop in-country medical infrastructure. The three phased program established fifteen man military training teams. Phase I sought to train staff and develop provincial hospitals. Phase II shifted emphasis to district health centers and public health measures. Phase III planned for withdrawal of the U.S. teams as the services were integrated down to hamlets. The program was successfully terminated in June 1972 having upgraded the quality and quantity of care and medical logistics system. Indicative of its success was the substantial decrease of Vietnamese civilian war casualties treated in U.S. military hospitals from 1969 to 1972 despite beds made available to them.(14) The Vietnamese people's willing acceptance of their government's ability to provide basic health service became one of the contributing factors to the legitimacy of the South Vietnamese government.

Responsiveness

In crisis the medical sustainment system must react rapidly. This is only possible if medical units are trained to respond on short notice and surge their capabilities for brief periods. The mental and physical agility to cope with such requirements must be built into an organization ahead of time with careful planning and solid training.(14) This is particularly true for combating terrorism and conducting contingency operations such as: noncombatant evacuation, strikes and raids, peacemaking operations, and disaster relief. Because of military medicine's unique deployment capability and specialized training in evacuation, mass casualty, triage, emergency medicine, preventive medicine, chemical and biological warfare, and command and control, it is a valued national asset for quick response.

The primary medical aspects of combating terrorism involves developing and exercising responsive mass casualty plans with the capability to surge. Military medicine surpasses its civilian counterparts in planning and training for mass casualties. As the 1983 Beirut bombing of the Marine barracks demonstrated, the military had planned for, trained, and was able to mobilize medical and evacuation forces quickly in response to terrorist action. Despite its multinational "peacekeeping" mission, the U.S. naval task force's organic medical capability had been augmented by a surgical team of nineteen. A disaster plan was developed and regularly exercised to accommodate the specific floating

facilities and resources available to enable the medical staff of four different ships to consolidate quickly into the mass casualty teams. Following the blast, evacuation aircraft were mobilized worldwide and on the ground within five hours to evacuate patients to British and U.S. medical facilities in Cyprus and Europe. In all, they treated and evacuated 96 seriously injured survivors of a tragic blast that had already killed 234 Marines.(16) Although criticized for not considering civilian facilities in Israel, there can be no doubt that the medical team planned for and demonstrated a responsiveness essential for successful sustainment in the LIC environment.

A breakdown of any link in the medical chain between initial treatment, evacuation, and secondary care can compromise an entire effort and make it unresponsive. Anticipation, planning, coordination, and mental agility are the key ingredients. It is an imperative that requires conscientious planning and continual training of all our medical assets.

Medical Intelligence

Because of the unique nature and separateness of medical information from the rest of the armed forces, the medical commander's ability to generate and develop medical intelligence is key to successful operations. Medical intelligence in LIC is critical because of the higher

incidence and exposure to endemic disease in developing nations and its impact on both the capabilities and vulnerabilities of friendly and enemy forces.. In addition, the proliferation of nuclear, biological, and chemical agents and their possible employment as political or terrorist instruments of war has significant implications for medical operations. Their psychological value even in small amounts makes them ideally suited for politically dominated low intensity conflict(17). For logistics and political reasons, information on friendly medical capabilities can often play a role in the U.S medical support concept. Unfortunately, there is little expertise or interest outside the medical community that can effectively evaluate, develop, and utilize this sort of intelligence so essential to successful medical operations.

Incumbent on the medical planner is the responsibility to understand the total nature of the medical threat and its impact on future operations for the theater as well as the medical commander. No line commander would consider operations against a hostile force without a clear intelligence estimate. Conversely, no medical commander should consider operations in a hostile environment without an equally comprehensive medical intelligence estimate.

Medical intelligence is generated with the development of an estimate and sustained with a comprehensive collection plan. Initial information is obtainable on a national level

through the Armed Forces Medical Intelligence Center (AFMIC), the Medical Capabilities Studies (MEDCAPS), and Diseases Occurrence Worldwide (DOWN), and the World Health Organization (WHO).(18) In addition, the nature of medicine to freely exchange scientific data worldwide through publications and academia makes these important alternate sources. A military preventive medicine team is uniquely qualified to not only consolidate the estimate but also capable of conducting surveys to verify or develop the situation. This has repeatedly been demonstrated on deployments and is characterized by the team that accompanied the 32nd Marine Amphibious Unit into Beirut in August 1982. There they conducted initial water, vector, and sanitation assessments and repeatedly provided epidemiological surveillance throughout the peacekeeping mission to target and reduce the disease non-battle injuries.(19) There are numerous sources of medical intelligence but it generally resides outside the traditional military lines and requires initiative to secure it. It is equally important to sustain this effort with continual re-assessments and a collection plan with carefully designated priority information requirements.

Simplicity

Simplicity of medical operations is essential because of constrained logistic capabilities and the less

sophisticated nature of the LIC environment. This does not insinuate any less requirement for advanced technology or application of up to date medical practice. But it does imply that their non-judicious application in low intensity conflict may compromise stated objectives or lead to outright mission failure.

In conjunction with AID, military medical operations conducted to develop host nation infrastructure whether through civil-military operations or the Military Assistance Program are technically simple. LTC James Taylor, formally of SOUTHCOM's Command Surgeon Directorate, describes third world countries' basic health needs to be: potable water, waste disposal, vector control, immunizations, safe pesticides, sanitation, primary care training, and development of medical logistic and evacuation systems.(20) Advisory efforts must reflect the host nations' needs and capabilities and not necessarily mirror US practice. Care must be taken to limit the adverse effects on the local economy by overloading its capacity for high technology material and the requirements for its maintenance and logistical support.(21) Medical evacuation helicopters are responsive evacuation vehicles but their logistical and financial requirements may limit their use, whereas ground ambulances requiring less resources might provide greater, more reliable service. Medical equipment to be used and sustained in difficult environments should be simple to use,

sturdy, reliable, compact, easily repaired, standardized, and inexpensive if host nation resources are severely constrained.(22) There is a steep line of diminishing returns as medical equipment cost and sophistication goes up. It is key to LIC military medical advisors to understand this delicate balance and recommend pragmatic solutions.

Simplicity is also essential to concepts of medical support for U.S. contingency operations. This is often driven by constraints imposed by operational commanders based on limited airlift, political considerations, or time available. Units will routinely deploy with their organic medical elements capable of providing limited primary care. However, the majority and most extensive state-of-the-art medical capability located at echelons above corp are immobile and too heavy for contingency operations. The medical planner must envision a simple concept of support because he knows, and past operations have demonstrated, that it is unlikely a total medical package will ever arrive in country.

Operation Just Cause is an excellent example. Whereas the normal allocation for a two divisions plus force of 26,369 soldiers would be allocated one Mobile Army Surgical Hospital (MASH), two Combat Support Hospitals (CSH) at least four Medical Detachments (Air Evacuation), and a ground evacuation capability; not one of these units was planned

for nor arrived in country complete. Despite the number of U.S. health care facilities in Panama, to include Gorgas Army Hospital, these facilities were not given a major role in the operational plan. Operational security and airlift dictated a minimal medical force on the ground which would triage and evacuate casualties directly to CONUS. The medical support concept was simple, all casualties would be evacuated and consolidated at a Joint Casualty Collection Point at the end of the Howard AFB runway, stabilized, and pre-regulated and evacuated directly to San Antonio, Texas. The plan's simplicity recognized a limited medical evacuation capability (three UH-60s) and compensated by providing a single well known collection point for tactical and dedicated evacuation vehicles. The evacuation policy (0-days) acknowledged mobility constraints of military hospitals and allowed a small Forward Surgical Team from the 5th MASH and augmented by Air Force personnel to be pre-positioned in country.(23) The result was a simple but effective plan that complied with the commander's imposed constraints and efficiently and effectively treated and evacuated 365 wounded servicemen and hundreds of Panamanians.

Conclusion

Emerging doctrine for Low Intensity Conflict has begun to expose the significant differences between it and

conventional conflict. It requires the military to operate differently in an environment dominated politically, constrained in resources, and over contrasting periods of time. Sustainment imperatives are weighted differently and augmented to compensate for a more indirect approach of conducting campaigns. Medical support is likewise effected by this change in doctrinal perspective.

Over the past decade the military medical community has been able to update its experience in LIC and learned important lessons on how to support it. The medical imperatives of Low Intensity Conflict: integration, legitimacy, continuity, responsiveness, medical intelligence, and simplicity have characterized key elements of successful medical LIC operations. They alone will not ensure success but they do serve as a framework to develop support concepts, promote changes in organizational structure, and guide discussion in pursuit of professional development.

ENDNOTES

1. U.S. DEPARTMENT OF THE ARMY, FM 100-20, Military Operations in Low Intensity Conflict, P.1-1 (hereafter referred to as "FM 100-20").
2. Ibid., pp.1-8 - 1-9.
3. The Joint Staff, JSC PUB 3-07, Doctrine for Joint Operations in Low Intensity Conflict, p.1-14. (hereafter referred to as "JSC PUB 3-07")
4. Ibid. p. VII-9.
5. Ibid. pp.VII-3 - VII-9.
6. Col. Elray Jenkins, Medical Civic Action Programs(MEDCAPS) and Medical Readiness Training Exercises(MEDRETES) as Instruments of Foreign Policy, pp.15-20.
7. Interview with Maj. Charles H. Gleaton, MC. 7th Special Forces Group Surgeon. 15 March 1988.
8. Department of the Army, FM 100-5, p. 62 (hereafter referred to as FM 100-5).
9. Jenkins, p. 21.
10. Col. Russ Zajtchuk, "Medical Success in El Salvador," Military Medicine, February 1989, p. 59-61.
11. JSC PUB 3-07, p.1-26.
12. U.S. Army War College. Theater Planning and Operations for LOW INTensity Conflict Environments, A Practical Guide to Legal Considerations, pp. 13-24d.
13. John T. Fishel and Edmund S. Cowan, Civil-Military Operations and the War for Political Legitimacy in Latin America," Winning the Peace: The Strategic Implications of Military Civic Action, ed. by John W. De Pauw and George A. Luz, p. 40.
14. Jerrrey Greenhut, "Medical Civic Action in Low Intensity Conflict: The Vietnam Experience" in Winning the

Peace: The Strategic Implications of Military Civic Action,
ed. by John W. De Pauw and George A. Luz, pp. 120-125.

15. FM 100-5, p.63.

16. LCDR Eric R. Frykberg, CDR Patrick M. J. Hutton,
Richard H. Balzer, "Disaster in Beirut: An Application of
Mass Casualty Principles," Military Medicine, November 1987,
pp.563-565.

17. U. S. Department of the Army. FM 8-42, p. B-1.

18. Ibid., pp. A-1 - A-3.

19. F.D. Daniell, et al., "Field Preventive Medicine
and Epidemiological Surveillance: The Beirut, Lebanon
Experience, 1982," Military Medicine, April 1985, pp. 59-61.

20. LTC James A Taylor, "Military Medicine's Expanding
Role in Low-Intensity Conflict," Military Review, April
1985. p. 30.

21. JSC PUB 03-7, p.VII-2.

22. LCDR Christine E. Whitten, "Experiences in Third
World Anesthesia: Peacetime Trainint for Operational
Deployment," Military Medicine, December 1988, p.630.

23. Department of the Army, Academy of Health
Services, Operation JUST CAUSE Lessons learned Report.
pp.3-8.

BIBLIOGRAPHY

- Boehm, Col. Timothy M.; James, Col James J. " The Medical Response to the LaBelle Disco Bombing in Berlin, 1986," Military Medicine, May 1988, pp. 235-238.
- Daniell, F.D. et al., "Field Preventive Medicine and Epidemiological Surveillance: The Beirut, Lebanon Experience, 1982," Military Medicine, April 1985, pp. 171-175.
- De Pauw, John W. and Luz, George A., ed. Winning the Peace: The Strategic Implications of Military Civic Action. Carlisle Barracks: U.S. Army War College, 1990. Pp.40-49 Civil-Military Operations and the War for Political Legitimacy in Latin America," by John T. Fishel and Edmund S. Cowan.
- De Pauw, John W. and Luz, George A., ed. Winning the Peace: The Strategic Implications of Military Civic Action. Carlisle Barracks: U.S. Army War College, 1990. Pp.113-130: "Medical Civic Action in Low Intensity Conflict: The Vietnam Experience," by Jerrey Greenhut.
- Frykberg, LCDR Eric R., CDR Patrick M. J. Hutton, Richard H. Balzer, "Disaster in Beirut: An Application of Mass Casualty Principles," Military Medicine, November 1987, pp.563-566.
- Gleaton, Maj. Charles H., MC. 7th Special Forces Group Surgeon. recorded interview. Ft Bragg: 15 March 1988.
- Jenkins, Col. Elray , Medical Civic Action Programs(MEDCAPS) and Medical Readiness Training Exercises(MEDRETES) as Instruments of Foreign Policy, Thesis. Carlisle Barracks: U.S. Army War College, 24 May 1988.
- Summers, Harry G. Col., "Principles of War and Low Intensity Conflict," Military Review March 1985, pp. 43-49.
- Taylor, LTC James A , "Military Medicine's Expanding Role in Low-Intensity Conflict," Military Review, April 1985. pp. 26-34.
- The Joint Staff, JSC PUB 3-07: Doctrine for Joint Operations in Low Intensity Conflict, Washington D.C.: January 1990

U.S. Army War College. Theater Planning and Operations for Low Intensity Conflict Environments, A Practical Guide to Legal Considerations, Carlisle Barracks: November 1990.

U.S. Department of the Army, Academy of Health Services, Operation JUST CAUSE Lessons learned Report, Ft. Sam Houston: 1 June 1990.

U. S. Department of the Army. FM 8-42: Medical Operations in Low Intensity Conflict (Advance Copy). Washington D.C.

U.S. Department of the Army, FM 100-5, Operations: Washington D.C.: May 1986.

U. S. Department of the Army, FM 100-10: Combat Service Support. Washington D.C. February 198.

U.S. DEPARTMENT OF THE ARMY, FM 100-20, Military Operations in Low Intensity Conflict, Washington D.C.: 1 December 1989.

Whitten, LCDR Christine E. , "Experiences in Third World Anesthesia: Peacetime Trainint for Operational Deployment," Military Medicine, December 1988, pp. 629-632.

Zajtchuk, Col. Russ , "Medical Success in El Salvador," Military Medicine, February 1989, pp. 59-61.

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