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MEDICAL ENGAGEMENT AS NATIONAL SECURITY TOOL
A PRESCRIPTION FOR JOINT DOCTRINE

by

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Abstract

Military medicine has the potential to play a leading role in national security matters in the 21st century. Its inherent capabilities and the emerging environment make it a potential tool of choice for decision-makers.

This paper shows military medicine has been a key instrument of national policy in the past, in both supporting and supported roles. The paper reviews US military medical operations in three conflicts where military medicine was closely linked to the national objectives. The strategic lessons learned are distilled and then compared to current joint military medical doctrine. The paper concludes many of the lessons are incorporated into today's doctrine – but many are still missing. The most significant missing lesson is the ability of military medicine to be a primary tool for the achievement of national policy objectives. By highlighting military medicine's potential as an independent element in doctrine, command authorities will be more aware that the tool exists and more likely to use it to constructively engage within their areas of responsibility. The paper recommends each of the missing lessons be incorporated into joint military medical doctrine.

Chapter 1

Military Medicine and the Emerging Security Environment

Just as the military itself is an instrument of national policy, military medical assets are resources that can be used in coordination with and independently of other military operations.

—Major General P. K. Carlton

The United States (US) will use its military forces across a wide spectrum of conflict intensities in the foreseeable future. At the highest end of the continuum will be two nearly simultaneous major theater wars. At the very low end of the range, there will be multiple ongoing peaceful engagements involving only a handful of military personnel each. Somewhere in between these two extremes, less intense engagements are designated with the ambiguous label, military operations other than war (MOOTWs). These include such efforts as humanitarian missions, peacekeeping operations, civic assistance actions, and drug interdiction activities.¹

The diversity of the potential uses of the American military has two main causes. First, the US is the only remaining superpower in today's post-cold war environment. With no peer on the horizon, the world expects America to be a major player shaping the international environment. Quite simply, the US is the only nation with the economic and military resources to lead. It is also the only nation that exhibits the occasional "will" to do so. Allies often participate, but when America chooses to act, America leads.

The second reason flows from the first. Recognizing its leadership role, the national security strategy calls for “engagement” in world affairs.² If the US is going to execute this engagement strategy, it is going to use its military frequently in many diverse situations. This increased use of the military to achieve national objectives has been condensed into the phrase, “shape, respond, prepare.”³

An important tool America has at its disposal to effectively pursue its engagement strategy and to respond across the spectrum of conflict is the medical capabilities that reside within its military forces. Unfortunately military medicine is often overlooked as a tool of national policy. Current joint doctrine does not recognize that military medicine can be used as a primary, or even the key tool of national policy. This is despite the fact that it has been effectively used this way in the past.

The employment of military medicine is generally a low-risk, non-controversial, and cost-effective means of using the military element to support US national interests in other countries.⁴ Military medicine is flexible. It is easily deployable anywhere in the world. It can bring cutting-edge science to bear in a very short time span. Military medicine offers a way to engage without violence. It can change the destinies of whole populations – often dramatically with relatively few resources. When closely linked with national policy, it can create strategic change that furthers America’s interests. Of course, military medicine also has its limits. It can be ineffective when not used appropriately, or when objectives are set that are beyond what it can deliver.

Military medicine’s capabilities and limits as an engagement tool have been clearly demonstrated in the past. To be the most effective in this role and to limit potential

failure, joint military medical doctrine must adequately reflect the strategic lessons of history. This is the goal of this work.

This paper distills lessons learned from selected medical operations of the past and compares them to existing joint medical doctrine. It assesses how military medicine contributed to the national objectives in each operation. The paper highlights the strategic lessons that have been included in today's doctrine and most importantly, the lessons that have been overlooked. Finally, the paper recommends changes to existing joint doctrine.

The paper does not focus on the care of American forces. Rather, it assumes that caring for American troops is a sub-objective of the operation itself – not a key component of national policy. The paper focuses on joint doctrine because medical operations, like military operations in general, are most often joint and not service specific.

The operations selected for study, were chosen for their instructive value. First, the paper reviews the four medical civic action (MCA) programs created during the Vietnam War in the 1960s and 1970s. These programs were chosen because they collectively constitute the largest effort America has ever undertaken to try and influence strategic outcomes with military medicine. During Vietnam, medical operations were designed mirroring national strategies and offer many interesting lessons similar to those learned by the military as a whole. These programs also represent the traditional view of military medicine as a supporting function of a larger element. Next, the paper analyzes military medicine's involvement in the conflict in Haiti from 1992 to 1994 including both refugee care at Guantanamo Bay Cuba (GTMO) and during Operation Uphold Democracy. The

operation at GTMO clearly shows how military medicine can be a key enabling tool for decision-makers. Operation Uphold Democracy offers a lesson in objective setting and clarifying expectations. Thirdly, the paper reviews US medical actions in response to the 1994 Rwandan civil war. This was the first time military medicine was the entire national strategy and is therefore very instructive.

For each of these conflicts, the paper describes the medical aspects of each operation. It presents a brief overview of the political aspects of the conflicts where necessary, highlights the goals and linkages to national interests, and offers an assessment of each operation. Finally, the paper draws conclusions from these operations and points out where these lessons are included or excluded from current joint medical doctrine.

Notes

¹ Air Force Doctrine Document 2-3, *Military Operations Other Than War*, 5 October 1996, p. 6.

² *A National Security Strategy for a New Century*, The White House, October 1998, pp. 1-3.

³ Ibid, pp. 8-28.

⁴ Joint Publication 3-07.1, *Doctrine for Foreign Internal Defense*, The Joint Chiefs of Staff, 26 June 1996, p. G-1.

Chapter 2

Vietnam – Medicine as a Component of Civic Action

By encouraging and helping the Air Forces of friendly governments make their full CIVIC ACTION contribution, we can demonstrate increasingly the superiority of free government on the basis of hard achievements, as well as moral values.

—General Curtis E. LeMay

The Vietnam War was the first insurgency the United States had been involved in since the Philippine Insurrection over a half-century earlier. Aware that the success of the war effort depended ultimately on the people's support for the government, American counterinsurgency experts developed a number of programs designed to grow support among the South Vietnamese population. One tool was the provision of medical care to increase the civilian population's support for the South's fledgling government and the American forces fighting in the country. This effort was known as medical civic action, or MCA.

On the surface, the role of MCA seems to be simply a way to win the hearts and minds of a target population and thus assist an ongoing war effort. The Vietnam experience, however, shows us MCA is considerably more complex in reality. The various MCA programs the United States put in place at different times during the Vietnam war did play the hearts-and-mind role, but they were also used for many other reasons. They were reactions to domestic pressure within the United States, they helped

bored, underutilized medical personnel keep busy, and they fed the American desire to provide humanitarian assistance to a people not as fortunate as themselves. At least one author has concluded that, “Indeed, it is difficult to determine which reasons were paramount.”¹ Below are brief descriptions of the four major MCA efforts of the war highlighting each program’s objectives, and linkages to policy. An assessment of each is provided.

Medical Civic Action Program I (MEDCAP I)

In the beginning of the American involvement in Vietnam, the national policy was not to fight the war, but to provide advisors to the South Vietnamese effort. Planners believed success depended primarily on the effectiveness of the Vietnamese forces and the support the South Vietnamese government could generate among its own people. The American effort was primarily focused on increasing these two factors. Medical assistance was seen as a viable strategy to help achieve these ends. Mimicking the national approach, the early Medical Civic Action Program (later known as MECAP I) was designed for South Vietnamese forces to provide medical care to Vietnamese civilians. The goal was to increase its popularity among its own people. Americans were to be used in primarily advisory roles.² In today’s doctrinal language, this would be called indirect support for foreign internal defense and is adequately described in joint doctrine.³

In this endeavor, the Americans had to build on the existing Vietnamese medical assets which were minimal at best. In May of 1961 when a lone American public health officer arrived, all of South Vietnam had only 1,400 physicians. One thousand of these were in the army leaving the remaining 400 doctors to care for 16 million civilians. These

few physicians were poorly distributed leaving some provinces with none and others with doctors only in the largest towns.⁴ There were about 60 hospitals ranging from 35 to 1,500 beds; most were built around the turn of the century.⁵ Doctors were held in high esteem and never questioned, not even by other doctors—consequently learning from experience suffered. South Vietnamese physicians generally supported the cultural propensity to turn to massive amounts of drugs for symptom relief. Fluid replacement therapy was virtually unknown and routine laboratory equipment was frequently absent.⁶

By early 1963, the United States Army had 127 medical personnel working the MCA program. The American medics were divided into teams and assigned to South Vietnamese Army (ARVN) divisions and regiments. Typically these teams consisted of one or two physicians, a dental officer, three to eight enlisted men, and an interpreter. They often divided themselves further to assist other units and cover more territory. Eventually, the number of these teams reached twenty-nine.⁷

Although their role was to advise, the Americans provided about 30% of the care that South Vietnamese civilians received through MEDCAP I.⁸ There are many reasons for this. The most prominent was it was often easier to care for the civilians themselves than to rely on the South Vietnamese. The South's logistics system did not provide responsive medical supply support. Many medicines were in short supply or unobtainable. The supporting medical system was primitive by western standards. Doctors were few and poorly trained. There was almost no support staff, and hospitals did not meet rudimentary plumbing or sanitation standards.⁹

The teams performed many functions, mostly in rural areas where ARVN forces could provide adequate security. They worked with the village chief to notify the

population of their visit, and they typically worked in public buildings. The teams concentrated on “strategic hamlets” and displaced persons encampments. Where possible they worked with village health workers and assisted in the training of medical aid personnel for paramilitary forces. The teams also provided care to ARVN and paramilitary personnel and to American advisors.¹⁰

To increase the psychological value of the program, the caregivers were identified with the ARVN, not the United States. For example, medications were dispensed in South Vietnamese-marked containers and simple self-care handouts and posters were distributed in the Vietnamese language.¹¹

The MEDCAP teams were phased out in early 1965, and American medical personnel were strictly limited to advisory and supervisory roles. The results of the effort are hard to measure. Objectively, MEDCAP I provided over 914,000 treatments in 1963 and nearly 3 million in 1964.¹² Undoubtedly it positively effected the health of many South Vietnamese civilians. It most likely had a positive, but minor, effect on South Vietnam’s medical system. But, did it accomplish its primary strategic goal of winning hearts and minds? This question is unanswerable, but the results are doubtful.

There are two striking issues with MEDCAP I. First, its strategic results are unknown. The program seemingly had a clear purpose yet there appears to have been no specific objectives or identified end state. Consequently, mission attainment is not measurable. Second, MEDCAP I contained what today is known as, “mission creep.” The host nation’s ability to care for its own population was so limited that the Americans provided much of the effort.

The doctrinal remedies for the MEDCAP I ills should have been in its planning process. There must be an adequate environmental assessment to include host nation capabilities. Every effort's purpose must be clear. Desired end states must be identified. Specific objectives must be set based on the environmental assessment, the purpose, and the desired end state. Rules of engagement that recognize tactical realities must be developed. All of the above must be updated, and widely communicated as the operation progresses.

Of the issues above, only the environmental analysis is currently addressed by joint doctrine. Clarity of purpose is implied in joint doctrine, but not specifically stated. It does not mention the need to specify end states. Nor does it recognize the necessity of medics engaged in operations to have clear understandable rules of engagement to guide their actions. Current doctrine does not address the importance of communicating the above to all involved. The issues are summarized below in Table 1.

Table 1. MEDCAP I Issues and Doctrine

Issue	Has the Issue Been Addressed Doctrinally ?	If Yes, the Reference is:
Environmental Analysis	Yes	Joint Pub 4-02, Chapter II
Clarity of Purpose	Implied	Joint Pub 4-02, Chapter I
Specify Desired End State	No	NA
Rules of Engagement	No	NA
Communication	No	NA

MEDCAP II

Later in 1965 American troop strength grew significantly as the United States began to shoulder more responsibility for the actual conduct of the war. To support the

increased number of troops, larger numbers of American medical personnel were sent to Vietnam. Although the nature of the war which was fought with guerilla tactics in 1965 kept casualties low on most days, the medical system had to be large enough for surge requirements when casualties might be high. Consequently, American medics were largely underutilized and often bored. The Army quickly took advantage of these new untapped resources and created MEDCAP II. Air Force units and Navy medical units who were ashore supporting base and Marine operations also participated.¹³

The program's goals were essentially the same as MEDCAP I. They were to increase popular support for fighting forces and the South Vietnamese government by providing medical care to the civilian population, provide humanitarian assistance, and increase the morale of American medics by giving them useful work during times they were not needed treating their own casualties.¹⁴

Two features distinguish MEDCAP II from its predecessor. First, it was designed for Americans to directly treat South Vietnamese civilians, not just to act as advisors.¹⁵ This broadening of the medical role mirrored the increased American role in the war at large. Today, doctrine would label this type of operation as direct support for foreign internal defense.¹⁶ Secondly, MEDCAP II was a more sophisticated operation. This is because it built on the lessons learned from MEDCAP I, and it minimized the weaknesses of South Vietnam's medical system. For example, MEDCAP II was specifically designed to conduct the bulk of its operations in more urbanized areas where civilian medical resources were more plentiful and of higher quality.¹⁷

Each United States unit of battalion size or larger with organic medical resources had the option of implementing a MEDCAP II program. Many line units quickly initiated the

programs. Army hospitals, which were organized separately from line units, also participated.¹⁸ Air Force medical units operated their MEDCAP programs as part of each base's overall civic action effort. The USAF initiatives were coordinated theater-wide by 7th Air Force.¹⁹

Reflecting the new higher level of sophistication, participating units were required to create a plan for their program. The plans included how their programs would be used in conjunction with tactical operations, how they would coordinate with psychological warfare operations, how patients would be referred to local province hospitals, logistical support, and the identification of specific geographic areas to be covered. The plans also specified special projects to be undertaken such as working with orphanages, refugee camps, and church-supported hospitals.²⁰

Units quickly became skilled at their tasks. They grew in their cultural awareness and a short language course designed specifically for MEDCAP use was developed. Medical teams would typically setup in a small building such as a schoolhouse and announce their arrival from a loudspeaker-equipped jeep. They brought supplies with them and used South Vietnamese District Health Nurses to screen patients. Evacuation and referral systems matured and became easier to operate.²¹

Command relationships were always clear, but technical supervision, funding and logistics were confusing. Coordination was required with South Vietnamese district health officials, the South Vietnamese provincial authority, the US Overseas Mission representative, and the Military Assistance Command Vietnam (MACV) district advisor. The MACV Surgeon had overall responsibility for medical direction of the program.

Funding for expendable supplies came from the US government's Agency for International Development (AID). Durable goods were funded by the parent unit.²²

Unfortunately, medical logistics was one function that did not improve between MEDCAP I and II.²³ The South Vietnamese were to provide medical supplies for the program and the US Army; Republic of Vietnam (USARV) Surgeon was committed to growing the South Vietnamese capability. He placed stringent controls on the procurement of MEDCAP supplies through the US logistics system to encourage this growth. He was also trying to reduce the black market, reduce US stock levels, and reduce South Vietnamese reliance on American supplies and equipment. In an apparent attempt to make things better, all MEDCAP II supplies were centralized into one depot in Saigon; during MEDCAP I, supplies could be drawn from seven different South Vietnamese depots.²⁴

Despite these actions and American assistance, the South Vietnamese depot was never able to meet the demand. In mid 1967 the US found it necessary to shift over 300 tons of medical supplies into the MEDCAP supply system. Supplies for MEDCAP activities were to be used solely for civilians, not military personnel and vice versa.²⁵ Running dual supply lines probably contributed to the problems.

MEDCAP II was at its height in 1968 when it provided over 2 million outpatient treatments and 143,000 immunizations and trained nearly 3,500 civilians as rural health workers.²⁶ These health workers attended a basic course and were trained in sanitation and the use of thirteen basic drugs.²⁷ Over 2 million visits were also conducted in 1969. As the US policy began shifting to "Vietnamization" of the war, MEDCAP II began to draw down as the South Vietnamese Ministry of Health assumed responsibility for

treating the majority of South Vietnamese civilians. Treatments dropped to 1.3 million in 1970 and 140,000 in 1971. MEDCAP II formally ended in 1972.²⁸

Even though the tactics of MEDCAP II differed significantly from MEDCAP I, the goals and strategic results were essentially the same. Many South Vietnamese citizens benefited from medical care they would not have gotten otherwise. Some growth of the South Vietnamese medical system occurred. Many American medics kept their skills and spirits up by performing worthwhile work. But, did MEDCAP II fulfill its reason for being? Did it win the hearts and minds of the South Vietnamese? Again, the question is unanswerable, but doubtful.

Planners obviously used many lessons learned from MEDCAP I while designing MEDCAP II, but the inability to determine if the operation succeeded reemphasizes one of the key lessons learned in the previous operation – an end-state must be specified. As stated previously, this is still a doctrinal shortcoming.

Because MEDCAP II was such a large operation, it highlighted the need to reduce confusion in the medical logistics system. The doctrinal prescription for this affliction is today's Single Integrated Medical Logistics Management System (SIMLS).²⁹ This is depicted in Table 2.

Notes

¹ Jeffery Greenhut, "Medical Civic Action in Low-intensity Conflict: the Vietnam Experience," in De Pauw, John W. and Luz, George A. ed., *Winning the Peace: The Strategic Implications of Military Civic Action*, (New York, N.Y.: Praeger, 1992) pp. 139.

² Ibid, pp. 140-141

³ Joint Publication 3-07.1, *Doctrine for Foreign Internal Defense*, The Joint Chiefs of Staff, 26 June 1996, p. G-1.

⁴ Greenhut, pp. 140-141.

⁵ Colonel Wallis L. Craddock, "United States Medical Programs in South Vietnam," *Military Medicine*, 135(3), March 1970, p. 187.

Notes

⁶ Captain Arthur Mason Ahearn, "Problems of Medical Rapport in Vietnam," *Military Medicine*, 131(11), November 1966, pp. 1402-1403.

⁷ Craddock, p 187, and Grennhut, pp. 140-141.

⁸ Greenhut, pp. 143.

⁹ Craddock, pp. 187-188.

¹⁰ Colonel Spurgeon Neel, "The Medical Role in Army Stability Operations," *Military Medicine*, 132(8), August 1967, pp. 606-607, and Eloise Engle, *Medic: America's Medical Soldiers, Sailors and Airmen in Peace and War*, (New York, N.Y.: The John Day Company, 1967) pp.237-238.

¹¹ Greenhut, p. 143.

¹² Ibid.

¹³ Ibid, pp. 143-144.

¹⁴ Ibid, pp. 144-145.

¹⁵ Craddock, p. 187.

¹⁶ Joint Publication 3-07, p. G-1.

¹⁷ Greenhut, p. 143.

¹⁸ Ibid.

¹⁹ 7th Air Force, 7AFRP 28-1, *Civic Action Newsletter* Number 11, 30 November 1968.

²⁰ Greenhut, p. 143..

²¹ Ibid, p. 145.

²² Ibid, p. 144.

²³ Craddock, p. 188.

²⁴ Greenhut, p. 147.

²⁵ Ibid.

²⁶ Ibid, p. 148.

²⁷ Captain David N. Gilbert and Lt Colonel Jerome H. Greenberg, "Vietnam: Preventive Medicine Orientation," *Military Medicine*, 132(10), October 1967, p. 775.

²⁸ Greenhut, p. 148.

²⁹ Joint Publication 4-02.1, *Joint Tactics, Techniques, and Procedures for Health Service Support Logistics in Joint Operations*, 30 December, 1996.

Table 2. MEDCAP II Issues and Doctrine

Issue	Has the Issue Been Addressed Doctrinally ?	If Yes, the Reference is:
Logistics Relationships	Yes	Joint Publication 4-02.1

Military Provincial Health Assistance Program (MILPHAP)

While both MEDCAP efforts concentrated on winning hearts and minds by providing care to individuals one at a time, the Military Provincial Health Program (MILPHAP) was a systematic attempt to improve the overall quality of health services in South Vietnam. The MILPHAP evolved from an effort by AID dating from the early 1950s.¹ In 1962 AID expanded its medical presence by sending American surgical teams to South Vietnamese provincial hospitals. Their goal was to increase the capabilities of the government's provincial health service. The intent was to temporarily use American medical personnel and material to achieve permanent improvements. The teams were to focus on the provincial health system's management and training functions. They targeted specific areas for improvement including planning and organization, personnel and materiel, in-service training, and the technical performance of medical procedures. AID wanted a team for each of the forty-three provincial hospitals.²

In 1965 officials began to look to the military to help support the program. Security concerns were growing and AID had been unable to field the desired number of teams. Several of the AID teams had proved to be ineffective. By Autumn, military MILPHAP teams from the Army, Air Force, and Navy began arriving in Vietnam. The initial teams were composed of three physicians, a medical administrator, and twelve enlisted persons. Later in the program the team size and composition was tailored to the local needs. Throughout the effort, AID continued to draw teams from other American

organizations and contracted from non-US sources, but eventually, the number of AID teams dwindled and the military came to dominate the program. By mid-1966, there were twenty-one military teams covering eighteen provinces. By 1968, the military effort had grown to twenty-seven teams.³

The MILPHAP approached its goals in a three-phased, “hub-and-spoke” fashion. First the teams focused on developing a solid base for service in the provincial hospitals. Next, their emphasis shifted to district health centers. Here they targeted public health measures and developed a patient referral system back to the provincial hospital for specialized care. Finally, the system was extended out to the hamlets and operational assistance was phased out as the South Vietnamese took responsibility for providing services.⁴ In many respects, the system they were trying to create is similar to today’s managed care systems that operate in rural American markets.

Although the program’s strategic concept was intellectually pleasing, it suffered from many of the same tactical implementation issues as the two MEDCAP efforts. The multiplicity of US and South Vietnamese agencies involved in the program created confusing command and logistics relationships. The teams often arrived in country with little or no orientation to Vietnam or the program itself. The MILPHAP labored under the same medical supply problems that plagued MEDCAP I and II. These were probably further exacerbated by the agency relationships. Against policy, the teams frequently turned to US medical supply channels for support. Personnel authorizations were steadily cut in 1971 as American involvement in the war decreased and the program was terminated in mid-1972.⁵

Like the MEDCAP efforts, the results of the MILPHAP are mixed. According to the MACV Surgeon and other observers, the program had been successful in their medical goals and helping establish improved military security.⁶ The teams had upgraded the quality and quantity of care at provincial hospitals and at district and hamlet dispensaries. They had initiated many immunization and public health programs. MILPHAP personnel had supervised the construction of new warehouses and implemented new supply and accounting procedures.⁷

Did the MILPHAP achieve its strategic purpose—a permanent improvement in the South Vietnamese medical system with temporary American help? Again, the strategic question is unanswerable. First, the American help was not temporary. From the time the military was called to assist, American medics stayed as long as there was significant involvement in the war. Secondly, since South Vietnam eventually fell we have no way to know if any permanent improvement was realized. While the MILPHAP came closer to specifying an end state than the MEDCAP efforts, we simply can not assess it.

What can be said about the MILPHAP is that it suffered from logistical confusion and supply under-nourishment like the other Vietnam programs. As previously noted, this has been largely remedied by today's joint doctrine.

Other ailments included confused command relationships and personnel who were unprepared to deal with a culturally complex situation. The prescription for these issues include a clear chain of command and complete orientation programs for medics entering cultures with which they are not familiar. The first of these issues is solved. The chain of command is clearly established in current doctrine. Services retain military chains of command while Joint Forces Surgeons provide technical direction to attached units and

planning expertise and advice to the Joint Task Force Commander. The responsibilities of these individuals and others is well delineated in joint doctrine.⁸ The cultural orientation of medics is not addressed. These items are summarized in Table 3.

Table 3. MILPHAP Issues and Doctrine

Issue	Has the Issue Been Addressed Doctrinally ?	If Yes, the Reference is:
CLEAR CHAIN OF COMMAND	Yes	Joint Pub 4-02
CULTURAL ORIENTATION	No	NA

Civilian War Casualty Program (CWCP)

In 1966 it became clear that the South Vietnamese medical system could no longer cope with the volume of wounded civilians. The number of wounded was estimated at 50,000 persons per year, twice the medical system's capacity of 25,000 patients per year. To care for the unserved half of the wounded population, and to relieve growing political pressure on this issue, particularly from Senator Ted Kennedy, President Johnson assigned this new mission to the Defense Department (DOD) in March of 1967. DOD assigned the mission to the US Army in April.⁹

To accomplish its new responsibilities, the army designed the Civilian War Casualty Program (CWCP). The army intended to create a medical system for civilian wounded that was separate and distinct from its military system. The army did not want American soldiers lying next to wounded South Vietnamese civilians, some of whom might be Viet Cong. The army was also concerned about the transfer of parasitic infection to US personnel, security compromises, and the potential ethical dilemma should competition for beds arise between South Vietnamese civilians and American military personnel.¹⁰

Planners estimated patients would have an average hospital stay of 14 days generating a requirement for 1,400 additional beds. These were to be distributed among newly established hospitals throughout the country. The system was to be integrated with the South Vietnamese Provincial Health Service and coordinated with AID. The intent was to use the American hospitals as referral centers. Patients were to be admitted through the South Vietnamese system, transferred to the American hospital if needed, then discharged back to the South Vietnamese system for convalescence. To support the effort, planners wanted a group headquarters, two ambulance detachments and a supply detachment. In August 1967, the Secretary of Defense approved this plan but refused to provide additional personnel. Funding was also short. To support the program in this fiscally constrained environment, the army planned to build hospitals that were primitive by American standards.¹¹

The separate system was never really implemented. The army insisted civilians be cared for while the separate system was still in its planning stages. Local commanders had no choice other than to co-mingle patients in military hospitals. Once this point had been breached, the army quickly abandoned the idea of a separate system. It reasoned it would save considerable building, personnel, and administrative costs, and reduce the need for air evacuation redundancy.¹² Given that additional personnel were non-existent and funding was small, this appeared to be the only practical solution.

Problems quickly developed that resulted in all available beds being full. South Vietnamese medical personnel used the program as a way to “patient-dump” non-acute chronic cases. These patients were transferred with little or no medical records. Many had serious problems and gross infections. Most required hospital stays greater than 30

days—not the expected 14 days. Compounding the problems, American medical personnel often bypassed procedures and directly admitted patients without coordination. Consequently, provincial officials would often refuse to accept patients for convalescence after treatment was complete.¹³

Cultural issues also caused difficulties. Often entire families arrived with patients. They wanted to provide their traditional family-style nursing care as was done in the South Vietnamese system. This was in direct conflict with American norms of professional nursing. Relatives took up beds and other resources. Their sanitary practices were a danger to patients. Hospitals had to make special arrangements for Vietnamese dietary practices that included buying rice and spices from unofficial sources. When families were not present, disposing of remains proved to be a bureaucratic nightmare between governments.¹⁴

Clinical outcomes for South Vietnamese were not as good as those for Americans. The average US mortality rate was 1.4 percent while the South Vietnamese rate was 4.7 percent. Since the South Vietnamese received essentially the same care in the same hospitals as the Americans, analysts attributed this to a higher percentage of South Vietnamese patients with severe burns and head wounds, and to widespread malnutrition.¹⁵

Despite its tactical problems and relatively high mortality rate, when measured against its strategic goals, the CWCP was the most successful Vietnam medical MCA program. Its goals were limited—to treat civilian war wounded and to reduce domestic political concerns about the issue. By the time the program ended with the withdrawal of American medical personnel in 1972, almost 24,000 South Vietnamese civilians had been

admitted to US military hospitals. American medical expertise saved the lives and limbs of many. American domestic political pressure regarding civilian casualties eased.¹⁶

The CWCP offers several unique doctrinal lessons. First, resources must be adequate for the mission. In the CWCP, the army could not implement the program in any way other than simply mixing all civilian war wounded with US soldiers. While this may have avoided some fixed costs such as constructing stand-alone hospitals, it undoubtedly still generated significant expenses—they were just hidden because they were mixed with the costs of treating American soldiers. Mixing the patients significantly complicated the responsibilities of the medic in the field forcing them to deal with everything from Vietnamese spices to remains disposal. The potential mismatch of resources and mission is addressed by current doctrine. Today, it is the Joint Forces Surgeon's responsibility to assess the requirements and resources available and then to tailor his response appropriately.¹⁷

Another lesson is that coordination between officials of separate nations must occur at all levels. For example, high-ranking officials may determine how a patient referral system between systems should work, but local officials must work out the details to ensure continuity of care across both systems' sub-components. These referral arrangements must also be simple with few process steps. The system must be responsive to the needs of the patients and staff, or the staff will bypass them creating more problems. Today's doctrine does recognize the need for coordination with US, host nation, and non-governmental agencies, but it does not discuss the need to do this at multiple levels. Nor does it address the need to keep processes as simple as possible.

The CWCP also points out the need to for an agreed upon method to dispose of remains of persons other than US personnel. This is not addressed by doctrine today.

The above issues are summarized in Table 4.

Table 4. CWCP Issues and Doctrine

Issue	Has the Issue Been Addressed Doctrinally ?	If Yes, the Reference is:
Resources Match Mission	Yes	Joint Pub 4-02, Chapter II
Coordination of Agencies	Yes	Joint Pub 4-02, Chapter IV
Coordination at All Levels	No	
Process Simplicity	No	
Disposal of Remains	No	

Notes

- ¹ Craddock , p. 188-189.
- ² Greenhut, p. 9.
- ³ Ibid, p. 149-150.
- ⁴ Ibid, p. 150-151.
- ⁵ Ibid, p. 150-152.
- ⁶ Ibid, p. 151-152, and Craddock, p. 190.
- ⁷ Greenhut, p. 152.
- ⁸ Joint Publication 4-02, pp. I-1 – IV-7.
- ⁹ Ibid, p. 152-153
- ¹⁰ Ibid.
- ¹¹ Ibid.
- ¹² Ibid, p. 154.
- ¹³ Ibid, p. 155-156.
- ¹⁴ Ibid.
- ¹⁵ Ibid, p. 156.
- ¹⁶ Ibid, p. 157.
- ¹⁷ Joint Publication 4-02, p. II-5.

Chapter 3

Haiti – Medicine As A Key Enabling Tool

The humanitarian, political and security dimensions of crises need to be faced in tandem

—Boutros Boutros-Ghali

Haiti has a long history of political instability, revolution, and repression. In the 111 years from 1804 to 1915 there were twenty-six heads of state. Fourteen were overthrown, nine died in office, one committed suicide – only two completed their terms. The constant turmoil led Woodrow Wilson to dispatch US Marines to Haiti in 1915. They remained until 1934, creating a positive image of the US military that remains influential to this day. The three heads of state between 1915 and 1941 all completed their terms largely due to the US presence. From 1941 to 1957, all five heads of state were overthrown. Francois Duvalier ruled from then till 1971 when he died in office. His son, Jean-Claude Duvalier then governed till 1986 when he was overthrown.¹

In an election monitored by former US President Carter in December of 1990, Jean Bertrand Aristide became the first democratically selected president of Haiti. Aristide took office in February 1991 and was ousted in a coup led by the head of the Forces Armees d’Haiti, Lt Gen Cedras, seven months later.² These events eventually led to the introduction of US military forces into Haiti two years later. Military medics, however,

were used a key instrument of national policy much earlier and remained long after most other troops had returned home.

Military medicine played two distinct roles in US national policy toward Haiti in the 1990s. First, military medics were used for refugee care. They handled thousands of refugees fleeing Haiti by boat at a makeshift camp in Guantanamo Bay Cuba (GTMO) in 1991 and 1992. In 1994, when diplomatic efforts produced no results after three years of shifting United States policy, the US threatened to intervene in the crisis militarily. This produced another wave of boat refugees, and the camp at GTMO was pressed into service again. Secondly, military medics accompanied US troops into Haiti in 1994 in Operation Uphold Democracy where they provided care for the American military and performed some limited MCA.

Refugee Care at GTMO

The military coup of September 1991 produced an almost immediate wave of Haitian refugees trying to reach the United States by boat. Fueled by chronic poverty in Haiti made worse by economic sanctions and damaged hopes for a brighter future, thousands of Haitians risked their lives in overloaded boats of questionable seaworthiness trying to reach Florida or the US Naval base at GTMO. Although some reached their destinations, most were rescued by US Coast Guard or Navy vessels and taken to GTMO for immigration status determination and processing. From 1 November 1991 till 15 June 1992, approximately 38,000 attempted the trip. About 34,000 of these were taken to GTMO.³

Some refugees were reporting Haiti had become a “killing ground for the military,” where soldiers and police “shot people on the streets seemingly at random.”⁴ Arguing

that the boat people were economic and not political refugees, the Bush administration pursued a repatriation policy linked to a 1981 agreement between the Reagan and Duvalier governments.⁵ This policy produced a court battle, beginning in November 1991, that left no clear answer to the question of what to do with the refugees. They were kept in the camp and became semi-permanent residents at GTMO. Thus military medics served the national interest by providing humane care to refugees which bought time for the decision-makers to untangle national policy.

The US Atlantic Command (USACOM) formed a Joint Task Force (JTF) in early November 1991 to cope with the immediate humanitarian crisis, public health dangers, and the complicated administrative issues of the growing number of refugees. The JTF consisted of personnel from the US Army, Navy, Air Force, Coast Guard and Public Health Service, Immigration and Naturalization Service (INS) and the Department of Justice.

US military personnel rapidly constructed a “tent city” holding camp at the site of McCalla Field, an out of service airstrip at GTMO. In an area of less than 1 square mile, over 600 General Purpose Medium tents provided shelter for all of the refugees. Depots for potable water and bathing, and facilities for eating and waste were established.⁶

Uniformed members of the Army, Air Force, Navy and Public Health Service were to perform the medical operations.⁷ The medics provided necessary medical and dental care to the refugees, operated a comprehensive public health system for the refugee population, and supported medical screening requirements for immigration.

Medical operations began before the refugees reached GTMO. Corpsman on board Coast Guard and Navy vessels immediately treated refugees suffering from prolonged

exposure and other life and limb threatening conditions. Upon arrival at GTMO, the refugees went through a rapid physical assessment to identify those with acute needs.⁸

A medical system of five echelons was established. The first of these, which handled the vast majority of patients, was the aid station. There were six distributed throughout the camp. They were manned by Navy Independent Duty Corpsman who provided daily sick call to the population and performed basic treatment consistent with their training and military guidelines. A surveillance system for communicable diseases was also established at these locations. When care needs exceeded the capabilities of the corpsmen, patients were sent to the next level of care.⁹

The second echelon was a five bed containerized surgical shock trauma (SST) unit designed for use by the Navy and the Marines as a receiving point for casualties. At GTMO, the SST was the first level of care where a patient would see a physician, physician assistant, or nurse clinician. It provided care similar to that available in a civilian minor emergency center in the US. Dental care was provided at this echelon in an adjoining unit.¹⁰

Refugees requiring routine inpatient care were treated at the third echelon in the camp infirmary. This was a hastily modified restaurant building with adjoining tents. Care was provided under the supervision of primary care physicians. At one point, the infirmary operated 150 beds.¹¹

Patients needing surgery, intensive care or obstetrical care were transported to the 11 bed fixed facility, US Naval Hospital in Guantanamo Bay, which constituted the fourth echelon. Those with needs beyond the capabilities of the Naval Hospital were air transported to tertiary care facilities in the US.¹²

Public health measures implemented included disease surveillance, food preparation and sanitation monitoring, vector control, and mass immunizations. Preventive medicine technicians made twice daily site inspections within the camp. High rates of HIV, tuberculosis, and syphilis infection among the refugees required extensive patient tracking and follow-up.¹³

Haitians selected by the INS to pursue their claims for asylum in the US were required to be medically screened. In May alone, this was 2,080 refugees. Overall, about 6,000 were processed for asylum.¹⁴

By the time the Supreme Court ruled that the refugees could be repatriated on 31 January 1992, over 11,000 refugees had collected at GTMO. The US began returning refugees not accepted for asylum in early February but Haitians continued to flee their country faster than they could be repatriated.¹⁵ The refugee population continued to grow and the situation hit a crisis point in May 1992 when 11,400 Haitians (34% of the total) arrived at GTMO. During this time, as many as 1,200 refugees arrived on a single day. The GTMO facilities were overwhelmed, and President Bush ordered that intercepted Haitians be directly repatriated. Bush's order, and the ongoing repatriation efforts quickly diminished the operation's scale. By 1 July 1992, fewer than 1,000 refugees remained at GTMO.¹⁶

The results of the medical operations at GTMO are impressive. During May 1992, the busiest month, there were only two deaths; one stillborn and one due to hemoptysis secondary to tuberculosis. Based on the average camp population of 9,100 the crude mortality rate for May was 0.2 deaths per 1,000 persons. The rate for other refugee populations in the past 10 years has ranged from 6 to 90 deaths per 1,000 per month.

The five echelon system of care worked well meeting the medical and dental needs of the Haitians. The vast majority of care was provided at the aid stations. This easily accessible primary care undoubtedly prevented many medical problems from becoming more complicated. In May 1992 alone, there were 19,317 patient encounters at the first echelon. In the same month, there were 1,131 encounters at the SST, 571 at the infirmary, 23 at the Naval hospital and only two evacuated to the US.¹⁷ The right type of care was provided close to the patients.

Public health measures proved effective. Communicable disease rates within the camp were comparable to the Haitian population at large. Early in the operation a cluster of measles was detected. Since measles is a major public health issue in refugee populations and obtaining accurate immunization histories from the refugees proved impossible, all children age 6 months to 15 years were given measles-mumps-rubella vaccine. An epidemic did not occur.¹⁸

Several factors favorably impacted the results. The refugee population did not show clinical signs of malnutrition. The population was young averaging 24 years old.¹⁹ Since the operation occurred on a US military installation, security and logistical concerns were minimized enabling the medics to focus almost exclusively on their mission.

Most of the doctrinal lessons of Guantanamo Bay were not new. The echelon concept of care in military medicine dates at least to the Civil War and is adequately described in current doctrine.²⁰

The value of preventive medicine is also widely recognized although it generally does not have the same level of attention devoted to it as curative medicine.²¹ Perhaps more emphasis could be given to preventive measures by including them in the echelon

concept. By recognizing preventive medicine as the first medical force protection measure in the wellness-illness continuum instead of a separate issue, the chances of neglecting these important issues would be lessened. In lieu of renaming the five echelons, perhaps preventive medicine should be called “Echelon Zero.”

What was different about the operation was how closely tied the effort was with national needs. The medical action at Guantanamo Bay had a direct impact on national policy. By minimizing the human suffering of the refugees, military medicine blunted potential world opposition to American policy. This was at a critical time when policy was in great flux. Had military medicine been unable to keep the refugees healthy and to treat the few that needed care, world opinion of American policy could have significantly changed. The medical operation at Guantanamo Bay came close to being the primary instrument of America’s Haitian policy in 1991 and 1992. It clearly demonstrated its public relations value to prevent world opposition to US policy. These lessons are summarized in Table 5.

Table 5. Guantanamo Bay Issues and Doctrine

Issue	Has the Issue Been Addressed Doctrinally ?	If Yes, the Reference is:
Echelons of Care	Yes	Joint Pub 4-02
Preventive Medicine	Yes	Joint Pub 4-02
World Opinion Shaper	No	NA

Operation Uphold Democracy

On 23 September 1993, the United Nations (UN) passed Resolution 867 paving the way for the transfer of Haiti’s government from Cedras to Aristide. To aid in the

transition the Haitian Assistance and Advisory Group (HAAG) was formed of American and Canadian personnel. When the HAAG sailed into Port-au-Prince harbor in mid-October aboard the *USS Harlan County*, they were met with an angry crowd of Cedras supporters.²² The HAAG personnel were unable to disembark creating a major embarrassment for the US. President Clinton ordered the *USS Harlan County* to return to the US Naval Base at Guantanamo Bay and directed planning for Operation Uphold Democracy.²³

Two top secret compartmented plans were created for the operation. One was a forcible entry option; the other was for a permissive entry. Planning for a forced entry started in November of 1993 while the permissive entry planning did not begin till June of 1994. The plans were significantly different. One was for combat, the other for peace operations. The latter required very different rules of engagement and more interagency planning. Both plans went through substantial changes as time passed and conditions changed.²⁴

The events of the summer and fall of 1994 were dramatic. Increasing tensions in June of 1994 resulted in a new wave of boat refugees. In the week of 24 June, over 2,000 migrants were intercepted at sea forcing the US to reopen the facility at GTMO. On 31 July, the UN passed Resolution 940 authorizing the US to use all means necessary to remove Haiti's military backed government. Military preparations continued and by September forces were moving into place for a forced entry.²⁵ In a last minute effort to avoid armed conflict, Clinton dispatched former President Carter, retired General Colin Powell, and Senator Sam Nunn to negotiate a possible permissive entry of 20,000 US troops. Cedras agreed and left Haiti for exile in Panama. On 15 October jubilant crowds

welcomed Aristide back to Haiti.²⁶ Within a month of the troops' arrival, the commander-in-chief (CINC) USACOM said the US military had created, "a relatively safe environment in Haiti."²⁷

Medical involvement in the operation was relatively limited. One fifty-two bed US Army Combat Support Hospital (CSH) with 178 personnel was used.²⁸ The *USNS Comfort* provided medical support afloat until the CSH could be established on shore. Since the *USNS Comfort*'s capabilities were greater than the CSH's, all services used it throughout its deployment. Other medical assets accompanied line units, and a few medical personnel were used in Civil Affairs efforts.²⁹

The mission of the CSH and the line medics were to treat US military personnel.³⁰ Medics spent most of their time trying to keep US troops healthy. Poor living conditions, insects, rodents, and a lack of toilets and other sanitation equipment plagued the force early in the operation. This was due in part to the shifting of entry plans. This change confused supply lines and challenged the flexibility of the logistics system.³¹ Successful operations were initially jeopardized when non-medical personnel made changes to the planned logistics flow without notifying the medical planners.³² Preventive medicine teams were hampered by this lack of equipment and supplies and by frequent lock-downs for security.³³ Despite the poor conditions, US troops remained fairly healthy. A few scattered diseases occurred mostly among troops from other nations. There were no outbreaks, and no pattern of diseases. The deputy task force surgeon credited the results to, "Keeping to our own food and water supply..."³⁴

The CSH and line medics were not to treat Haitians unless they were injured by American troops or equipment. This policy proved restrictive when US personnel

happened upon the aftermath of a grenade attack on 29 September 1994. The troops followed their instincts and sent the wounded to the CSH. Once the victims arrived, medical personnel had no time to debate the issue. They treated 38 Haitians; two required immediate surgery.³⁵ By the end of the operation, the CSH treated 175 Haitians under special circumstances.³⁶

Equipment and procedure interoperability between the services became an issue. Some communication equipment was not compatible between the *USNS Comfort* and Army and Air Force units. Air Force and Army unique air evacuation procedures hampered operations as well.³⁷

Civil affairs activities were purposely limited to those that would gain support for the legitimate government, benefit all Haitians not just the ruling elite, and ones that would be sustainable after US forces departed. They were also to dovetail with efforts of the more than 400 non-governmental relief agencies already working in Haiti.³⁸ Civil affairs priorities in Haiti were the restoration of a legal system, including police and a court system, and restoring critical infrastructure such as electricity and public sanitation systems.³⁹ Medical civil affairs actions were targeted to upgrading Haiti's existing health care system. American medics trained local ambulance and emergency teams, provided advice on case management and performed hospital assessments.⁴⁰ This approach frustrated some line commanders who expected medical personnel to perform more "classic MEDCAP" type missions treating the population in the countryside.⁴¹

On 31 March 1995, operational control was transferred to a multi-national UN force and Operation Uphold Democracy came to a close. Haiti was relatively safe, its politics

were stable, its government ministries were operating and basic services had been restored.⁴²

The outcomes of medical efforts in Uphold Democracy were mixed. The health of the US troops were maintained. If the goal of the modest MCA effort was to “wave the flag,” then it probably succeeded. It also succeeded in upgrading some basic public health systems such as water provision and sewage disposal. But if it was to make a lasting difference of the health of Haitians, it was never resourced to make it reality. As late as 1997, US medics still in Haiti as part of the UN force reported that rudimentary health care is unavailable and unknown to most of the population.⁴³

Lessons that have been included in today’s doctrine include communications equipment compatibility between medical units of different services, the meshing of service air evacuation procedures, and the development and coordination of a joint civic assistance program.⁴⁴ Missing from joint doctrine is the notion that only medical planners should make changes to medical plans. Also missing is consideration for how to treat patients who present for treatment that may be from portions of the population that the operation was not designed to care for. This is a very practical problem that is likely to increase the more desperate a situation becomes or the more chaotic the environment. These issues are summarized in Table 6.

Table 6. Operation Uphold Democracy Issues and Doctrine

Issue	Has the Issue Been Addressed Doctrinally ?	If Yes, the Reference is:
Compatible Communication	Yes	Joint Pub 4-02, Chapter II
Air Evac Procedures	Yes	Joint Pub 4-02.2
Coordinated CA Plan	Yes	Joint Pub 4-02, Chapter IV
Medical Planner Primacy	No	NA

How to Treat Unintended Patients	No	NA
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Notes

¹ United States Atlantic Command (USACOM), *Operation Uphold Democracy; Joint After Action Report*, (Norfolk VA, USACOM, 1995) pp. 5-7.

² Ibid

³ Commander Scott R. Lillibridge, Commander Kenneth Conrad, Commander Nathan Stinson, Commander Eric K. Noji, "Hatian Mass Migration: Uniformed Service Medical Support, May 1992," *Military Medicine*. 159(2), February 1994, p. 149-153.

⁴ William Matthews, "Services Struggle to Aid Haitian Refugees," *Air Force Times*, December 9, 1991, p. 24.

⁵ Alex Deupuy, *Haiti in the New World Order: The Limits of the Democratic Revolution*, (Boulder, CO.: Westview Press, 1997) pp. 175-176.

⁶ Ibid.

⁷ Commander Scott R. Lillibridge, Commander Kenneth Conrad, Commander Nathan Stinson, Commander Eric K. Noji, "Hatian Mass Migration: Uniformed Service Medical Support, May 1992," *Military Medicine*. 159(2), February 1994, p. 149.

⁸ Ibid. p. 150

⁹ Ibid.

¹⁰ Ibid.

¹¹ Ibid. pp. 150-151.

¹² Ibid. p. 151.

¹³ Ibid. pp. 151-152.

¹⁴ Ibid. pp. 149-153.

¹⁵ William Matthews, "Despite Ruling, Haitian Camp Stays Open," *Air Force Times*, 17 February 1992, p. 24.

¹⁶ Lillibridge, et al, p. 152.

¹⁷ Ibid. p. 151.

¹⁸ Ibid. p. 150.

¹⁹ Ibid. p. 151.

²⁰ C. Keith Wilbur, *Civil War Medicine 1861-1865*, (Old Saybrook CT.: The Globe Pequot Press, 1998) pp. 40-42, and Joint Pub 4-02, p. I-1.

²¹ Ibid p. v.

²² USACOM. P. 6

²³ Deupuy. P. 180, and USACOM. P. 7.

²⁴ USACOM. Pp. 7-8.

²⁵ USACOM. Pp. 9-14.

²⁶ Deupuy. pp. 182-183.

²⁷ William Matthews, "A New Role for Warriors," *Air Force Times*, 7 November 1994, p 34.

²⁸ Soraya S. Nelson, "Medics Help Despite Policy," *Air Force Times*, 31 October 1994, p. 27.

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²⁹ Phil Gunby, "Medicine's Role Evolves in Haiti Restoration," *Journal of the American Medical Association*, 272(21), 7 December 1994, p. 1638, and Colonel Eric A. Droerrer, "Operational Vignette: Civil Affairs Haiti," *Military Review*, 76(2) March-April 1996, pp. 73-78.

³⁰ Nelson, p. 27.

³¹ Captain Timothy L. Napora, "Medical Logistics Support For Haiti," *Army Logistician*, November-December 1995, pp. 16-17.

³² USACOM, p. 64.

³³ Soraya S. Nelson, "Medics Fight to Keep Troops Healthy," *Air Force Times*, 24 Oct 1994, p. 26.

³⁴ Soraya S. Nelson, "So Far, Most Troops Escape Illness," *Air Force Times*, 24 Oct 1994, p. 26.

³⁵ Nelson, "Medics Help..." p. 27.

³⁶ Captain Nancy C. Henderson, "Civil Affairs Logistics in Haiti," *Army Logistician*, May-June 1996, p. 23.

³⁷ USACOM, p. 64.

³⁸ Major Aaron L. Wilkins, *The Civil Military Operations Center (CMOC) in Operation Uphold Democracy (Haiti)*, Research Paper, Air Command and Staff College, Maxwell AFB AL., March 1997, pp. 20-21.

³⁹ Droerrer, p. 74, and Lt Colonel Stephen R. Bowers, "Restoring Normalcy," *Armed Forces Journal*, March 1995, p. 18.

⁴⁰ Henderson, p. 23.

⁴¹ USACOM, p. 67.

⁴² Ibid. p. 38.

⁴³ William Matthews, "We're Definitely Making A Difference," *Air Force Times*, 17 November 1997, p. 18.

⁴⁴ Joint Publication 4-02, *Doctrine for Health Services Support in Joint Operations*, 26 April 1995, pp. II-10 and IV-4, and Joint Publication 4-02.2, *Joint Tactics, Techniques and Procedures for Patient Movement in Joint Operations*, 30 December 1996.

Chapter 4

Rwanda – Medicine As The Strategy

Medical services have been and will be used in humanitarian roles as the primary instrument of action.

—Major General P. K. Carlton

The ethnic violence in Rwanda in the 1990s is a complex tale of economic exploitation, racial distrust, and scarce resources. Rwanda is the most populated country in Africa. Although its agriculture practices are advanced by African standards, food production per capita has been declining and poverty has been increasing since 1985. There is intense competition for land between ranchers and farmers, including a history of seizing lands after ethnic cleansings. The vast majority of the population are from one of two groups—either majority Hutu or minority Tutsi.¹

Conflict between these two groups has existed for hundreds of years. Overtime, the ethnic labels have come to be more associated with occupation and economic class rather than point of origin – the Hutus are farmers and poorer while the Tutsis are cattle ranchers and more wealthy. During the colonial period, a ruling class called the Bazungu exploited the ethnic differences and did much to create the tension that still exists today. The Bazungu gave Tutsis favored status and treatment for many years but when the Bazungu gave up control in the early 1960s, they installed a Hutu government to appear more egalitarian. The Hutu government's hold on power was always tenuous and in

1990 a small but well-trained guerilla army of Tutsis called the Rebel Patriotic Front (RPF) invaded Rwanda. The rebellion was repelled, but the RPF retained control of a portion of northeastern Rwanda.²

On 6 April 1994, Rwanda's president Juvenal Habyarimana and Burundi's president Cyprian Ntaryamira died in an airplane crash. The cause of the crash remains a mystery. Both Habyarimana and Ntaryamira were members of the Hutu ethnic group. Some Hutus blamed the Tutsis for the crash.³

Civil turmoil embroiled the nation and many Hutus feared the Tutsis would try to seize control of the nation. To maintain power, the Hutu government began broadcasting messages of ethnic hatred against the Tutsi population. These led to unrestrained violence and genocide of the Tutsis. During the three weeks following the plane crash, more than 200,000 people are believed to have been killed. By the end of June, an estimated 500,000 Rwandans were dead as a result of the violence.⁴

The RPF responded by attacking the capital city of Kigali. By mid-July the RPF has seized control of the country driving Hutu forces into neighboring Zaire and Burundi. A fragile cease-fire emerged in late July, but by then, between 500,000 and 1 million of Rwanda's 8 million persons were dead. The majority of casualties were Tutsis. More than 2 million were homeless, most of these Hutus. Fearing the Tutsis, they fled toward Zaire in a pathetic wave of humanity. Many of the refugees died of starvation and disease en route. Once they reached refugee camps around Goma, Zaire, the death toll continued to climb due to epidemic cholera and dysentery.⁵

President Clinton directed the commander in chief of the US European Command (CINCEUCOM) to help with humanitarian efforts in Zaire and Rwanda on 24 July 1994.

EUCOM activated Joint Task Force Support Hope (JTF SH) to aid the world relief community. The JTF SH mission was to, “provide assistance to humanitarian agencies and third-nation forces conducting theatre relief operations intended to alleviate the suffering of Rwandan refugees.” The priority tasks were to provide water purification and water distribution, establish an air bridge and a materiel distribution capability at Entebbe, Uganda, provide 24-hour airfield support services to Goma, Kigali, and other airfields as necessary, and ensure protection of its own forces.⁶

Within 72 hours, US troops delivered the water purification equipment, and distributed food and medicine to the outlying refugee camps. Within days, the death rate was cut from and estimated 3,000—6,000 per day to 250 per day. US Army and Air Force troops established round-the-clock operations at the airports in Goma, Entebbe, and Kigali enabling the flow of aid to the region. In ten weeks, the force satisfied the immediate needs of the crisis and built a two-week stock of essential supplies. In all, the USAF delivered 15,000 tons of materials and flew more than 1,220 sorties during the operation.⁷ Seventy-seven days after it began, the operation ceased.⁸ All operations were turned over to indigenous groups, private contractors, or relief agencies.⁹ By all accounts, the mission was a tremendous success.

For the first time, military medicine was the primary tool of national policy. By implementing preventive medicine measures that are simple by US standards, American medics saved many lives and achieved the national objectives. The primary doctrinal lesson is that military medicine, like the military itself, is an instrument of national strategy. Not only is military medicine an asset that can be used in coordination with military forces, it can be used independently as a strategic engagement tool—military

medicine can be the supported force. This is not addressed in today's joint doctrine. Current doctrine assumes military medicine is always in support of military forces. Even when the medic's primary focus is humanitarian or civic assistance (HCA), doctrine states, "HCA activities are designed to provide assistance to host nation populace in conjunction with US military operations or exercises."¹⁰ The prescription for this deficiency is to include this concept in joint doctrine. See Table 7.

Table 7. Operation Support Hope Issues and Doctrine

Issue	Has the Issue Been Addressed Doctrinally ?	If Yes, the Reference is:
Military Medicine as Supported Force	No	NA

Notes

¹ Peter Uvin, "Tragedy in Rwanda: The Political Ecology of Conflict," *Environment*, 38(3) April 1996, p. 7-15.

² Ibid.

³ Lt Colonel Stephen O. Wallace, "Joint Task Force Support Hope: The Role of the CMOC in Humanitarian Operations," *Special Warfare*, 9(1) January 1996, p. 36.

⁴ Ibid.

⁵ Ibid.

⁶ Ibid, p. 37.

⁷ Steven Watkins, "Troops Leave After Aiding Rwandans," *Air Force Times*, 55(11), 17 October 1994, p. 24.

⁸ Wallace, p. 41.

⁹ Watkins, p. 24.

¹⁰ Joint Publication 4-02, *Doctrine for Health Services Support in Joint Operations*, 26 April 1995, p. IV-4.

Chapter 5

Conclusion

Medical roles may transcend the functions of health service support. Our medical personnel serve as ambassadors of American goodwill... Military medical teams are often welcomed by nations who would not accept other forms of US assistance.

—CINC USCENTCOM

This paper reviewed US military medical operations in three conflicts where military medicine was closely linked to the national objectives. The strategic lessons learned were distilled and then compared to current joint military medical doctrine. Many of the lessons are incorporated into today's doctrine – but many are also missing. These lessons have been highlighted through out the paper and are summarized below in Table 8. Each of the missing lessons should be incorporated into joint military medical doctrine.

The most significant missing lesson is the ability of military medicine to be the primary engagement tool for the achievement of national policy objectives. Health service support is potentially the strongest ground for engagement because it is the major determinant of quality of life in most societies. Engaging with other nations in a way that brings people together in constructive efforts to improve their health and quality of life helps break destructive cycles of conflict. Constructive engagement with other militaries and governments gives the US a platform for encouraging such American ideals as openness, the rule of law, and military subordination to civilian authorities. Constructive

engagement satisfies the American desire to help others in need and helps shape international opinion.

Military medicine has the potential to play a leading role in national security matters in the 21st century. Its inherent capabilities and the emerging environment make it potential tool of choice for decision-makers. As this paper has shown, military medicine has been an important tool of national policy in the past, both as a supporting instrument and as a supported tool. By highlighting military medicine's potential as an independent element in doctrine, command authorities will be more aware that the tool exists, and more likely to use it to constructively engage within their areas of responsibility.

Table 8. Summary of Issues and Doctrine

Issues That Have Been Addressed Doctrinally	Issues That Have <i>Not</i> Been Addressed Doctrinally
ENVIRONMENTAL ANALYSIS	SPECIFY DESIRED END STATE
Clarity of Purpose	Rules of Engagement
Logistics Relationships	Communication
Clear Chain of Command	Cultural Orientation
Resources Match Mission	Coordination at All Levels
Coordination of Agencies	Process Simplicity
Echelons of Care	Disposal of Remains
Preventive Medicine	Ability to Shape World Opinion
Compatible Communication Equipment	Medical Planner Primacy
Air Evacuation Procedures	Treat Unintended Patients
Coordinated Civic Action Plan	Military Medicine as Supported Force

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