

WHICH END DOES THE THERMOMETER GO? APPLICATION OF MILITARY MEDICINE
IN COUNTERINSURGENCY: DOES DIRECT PATIENT CARE BY AMERICAN SERVICE
MEMBERS WORK?

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Military History

by

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The opinions and conclusions expressed herein are those of the student author and do not necessarily represent the views of the U.S. Army Command and General Staff College or any other governmental agency. (References to this study should include the foregoing statement.)

ABSTRACT

WHICH END DOES THE THERMOMETER GO? APPLICATION OF MILITARY MEDICINE IN COUNTERINSURGENCY: DOES DIRECT PATIENT CARE BY AMERICAN SERVICE MEMBERS WORK?, by Major Robert Franklin Malsby, III, 123 pages.

Counterinsurgency is the most common conflict that America engages in. From the Mexican-American War to the Philippine Insurrection and small wars of the early 1900s, the U.S. Army Medical Department (AMEDD) focused on sanitation, hygiene programs and infrastructure engineering to help alienate insurgents and bolster the local government's claims of legitimacy. Such programs provided continuity and a unity of effort that was consistent with counterinsurgent principles.

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Like many Americans the 11th of September, 2001 was a life changing day for me. This was the day I stopped being a doctor in the Army and started being an Army Doctor. My country was going to war and I with it. I was supporting a conflict I had no training in. I had heard the word “counterinsurgency” in the past but only in casual passing. If asked I would not have been able to define or explain its concept, let alone its principles or doctrine. During my first deployment I had pictures in my head from Vietnam of Army GIs treating local civilians, so that’s what I did. It seemed the right thing to do, and as the “medical expert” no one questioned this. I treated thousands of local civilians over my three tours in Afghanistan and the more I endeavored the more I began to question what I was doing.

It has taken me three tours and one year at CGSC to realize that just as the Army is changing its operational priorities, so should the AMEDD. This research will hopefully shed light on this issue and effect a change within our great organization. This research however was not possible without the guidance and mentorship of many friends and colleagues.

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ACRONYMS

| | |
|---------|---|
| AAR | after action report |
| AIA | Afghanistan Interim Authority |
| AMEDD | Army Medical Department |
| ARVN | Army of the Republic of Vietnam |
| CA | civil affairs |
| CAP | Combined Action Program |
| CENTCOM | Central Command |
| CERP | Commander's Emergency Response Program |
| CGSC | Command and General Staff College |
| CIA | Central Intelligence Agency |
| CJCMOTF | Combined Joint Civil-Military Operations Task Force |
| CJSOTF | Combined Joint Special Operations Task Force |
| CJTF | Combined Joint Task Force |
| CMA | Cooperative Medical Assistance |
| CMOC | Civil Military Operations Center |
| COIN | Counterinsurgency |
| CORDS | Civil Operations and Revolutionary Development Support |
| DA | Department of the Army |
| DENTCAP | Dental Civic Action Program |
| DHHS | Department of Health and Human Services |
| DIA | Defense Intelligence Agency |
| DOD | Department of Defense |
| DRA | Democratic Republic of Afghanistan |
| FRAGO | fragmentation order |
| GNP | Gross National Product |
| IED | improvised explosive device |
| ISAF | International Security Assistance Force |
| MAAGV | Military Assistance Advisory Group, Vietnam |
| MACV | Military Assistance Command, Vietnam |
| MAF | Marine Amphibious Force |
| MEDCAP | Medical Civic Action Program |
| MIIA | Medical Intelligence & Information Agency |
| MILPHAP | Military Provincial Hospital Augmentation Program, later renamed Military Provincial Health Program |
| NATO | North Atlantic Treaty Organization |
| NHSPA | National Health Services Performance Assessment |
| NVA | North Vietnamese Army |
| OCO | Office of Civil Operations |
| OEF | Operation Enduring Freedom |
| OHDACA | Overseas Human, Disaster, and Civic Aid |
| PA | Physician Assistant |
| PDPA | Peoples Democratic Party of Afghanistan |
| PF | Popular Force |
| PHAP | Provincial Health Assistance Program |
| PRT | Provincial Reconstruction Team |
| POW | prisoner of war |
| RAND | Research and Development |
| RPG | rocket propelled grenade |

| | |
|----------|--|
| SOF | Special Operations Forces |
| SOUTHCOM | Southern Regional Command |
| USACAPOC | U.S. Army Civil Affairs and Psychological Operations Command |
| UN | United Nations |
| UNSC | United Nations Security Council |
| U.S. | United States |
| USMC | United States Marine Corps |
| USSR | Union of Soviet Socialist Republics |
| VC | Viet Cong |
| VETCAP | Veterinary Civic Action Program |
| VMO | Village Medical Outreach |

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CHAPTER 1

INTRODUCTION

Prologue

The convoy crawled through the Mirah Khal village along a narrow dirt road in a deceptively peaceful part of the Tagab Valley in central Afghanistan. Tall mud walls hugged the sides of the Humvees as the element moved back to its home firebase after another successful medical mission. This unit of doctors, physician assistants, nurses, and medics treated over 800 children from the valley and surrounding villages that day. This included immunizations, hygiene education, warm weather clothing, school supplies and acute medical care. This mission, lauded as another successful operation in a series that had put this column in the valley four months earlier, was part of an ongoing pacification program in this once Taliban haven. As the vehicles pulled out of the school compound the children and school master waved with smiles all around. This was in sharp contrast to what laid ahead just three kilometers down the path.

The first rocket propelled grenade (RPG) hit five feet behind the second vehicle, missing the trailer being pulled, obviously the biggest target. The classic echo of the propellant and white smoke streak led no one to question what was happening. As the crackle of small-arms fire rained down on the caravan shouts went out in all vehicles, "contact, left side!" "They're on both sides moving all around," reverberated in the intercom as the senior noncommissioned officer surveyed the mountains while navigating through the bottle-necked road. More explosions followed as the gun-fight continued to unfold with another rocket propelled grenade narrowly missing one of the lead vehicles that would have cut-off their sole avenue of escape. All crew served weapons in the six vehicle convoy began returning relentless fire with M240 and .50 caliber (M2) machine guns. All drivers attempted to increase speed but it was soon evident that the terrain was against them. Soon the Humvees moved from a crawl to a slow walk around the bending road.

Small arms fire continued to pour down from a stone wall approximately seventy meters

south and from a ridgeline 200 meters north. Automatic gunfire echoed off the hillsides. The only interruption was the sound of the second, third, fourth and fifth RPGs screaming into the convoy.

Fire continued at all elements, one round hit a soldier's front site post on his rifle, peppering his face with shrapnel, cutting his shooting thumb and whipping him back into the vehicle like a rag doll. The attack was getting closer with enemy as close as five feet from the trail vehicle. The last machine gunner in the column threw his hand grips as high in the air as he could to lower the barrel onto the enemy; he killed three hiding in a ditch just off the road, sending a cloud of dirt, flesh and blood flying into the air.

Calls for ammo echoed from all gunners prompting soldiers, sailors and airmen from each vehicle to cut the cords holding extra rounds and sending them up to the machineguns in the turrets. The silence, which marked the end of the attack, came as quickly as the initial fire when the caravan reached a main supply route outside the chaotic and claustrophobic road. The vehicles carried on in silence as they sped down the dusty road. "At least the children got their medicine," one soldier said breaking the momentary silence.¹ After all this was for the good of the people, we are helping them...right?

This mission was a Medical Civic Action Program (MEDCAP) and part of a bigger counterinsurgency strategy conducted by the Provincial Reconstructive Team (PRT) and the Combined Joint Task Force (CJTF) of Afghanistan in an attempt to win the proverbial "hearts of minds" of the local populace. This activity, originally developed during the Vietnam War, has gone by many names and acronyms, but the concept has been the same and defended as a viable method for combating insurgencies. Irrespective of the name, these programs have placed uniformed U.S. medical personnel, veterinarians and dental providers into the rural countryside of

¹ Timothy Dinneen, "Enemy engages Bagram PRT after MEDCAP visit," *Combined Joint Task Force-76 Public Affairs*, February 22, 2007. Additional information provided by the Bagram PRT after action report and the author who fought in this engagement.

a host nation where they provide direct patient care to the indigenous population. As already mentioned, this is not a new concept, from counterinsurgency operations to disrupt Viet Cong safe havens in South Vietnam, to stability operations in once Taliban controlled Afghanistan, these programs have been lauded as a “legitimate” stability operation with a positive end state. But has it? Ironically, the engagement described earlier occurred five years into the Global War on Terror (GWOT) in a country that had witnessed American stability and security efforts. Such examples would question whether direct patient care by U.S. personnel has a viable role in counterinsurgency operations. It also questions whether this type of mission is validated by previous American counterinsurgencies.

The traditional Army medical wartime structure gave way to certain historical assumptions. One is that the U.S. Army Medical Department (AMEDD) is designed to support U.S. conventional offensive and defensive operations. A fundamental tenet was that U.S. forces “take care of its own.” That only Americans provide care for Americans. Unfortunately this underlying assumption breaks down when the mission is against unconventional or insurgent forces. The AMEDD, historically, was not designed to support host nation civilians, or children. This led to a second assumption that the U.S. did not expect to support or to coordinate with non-governmental organizations or host nation medical providers.² With the publication of the new Operations Field Manual (FM) 3-0 in March of 2008, the United States Army pushed stability operations to the forefront, giving such missions equal importance as offensive and defensive operations.³ One tool considered for such stability operations is the MEDCAP.

Originally coined during the Vietnam War, the MEDCAP was developed jointly by the American Embassy, Saigon, and the United States Agency for International Development (USAID) in 1962. Initially implemented in January of 1963, this was the precursor to the modern

² RAND Organization, “Traditional Army Medical Wartime Structure,” http://www.rand.org/pubs/monograph_reports/MR773/MR773.chap2.html (accessed November 6, 2008).

³ Department of the Army, Field Manual (FM) 3-0, *Operations* (Washington DC, March 2008). Henceforth FM 3-0, *Operations*.

day MEDCAP mission. The mission statement of the MEDCAP was to provide outpatient care for civilians living in rural areas; its main objective being to increase mutual respect and cooperation between the military and the civilian populace.⁴ From their inception in 1962 to current operations in Afghanistan these programs have been used and justified as a legitimate aspect of stabilization.

Currently, MEDCAPs are conducted all over the world by U.S. forces and Department of Defense providers. In the Southern Regional Command (SOUTHCOM) alone, over seventy MEDCAPs are performed annually.⁵ These missions deploy medical units in Central and South America for two week intervals. These projects provide limited, usually one-time visits, to local underserved populations as part of a host nation building program. They also provide subspecialty surgical care including plastic/reconstructive and cataract surgery. These missions are part of a larger humanitarian assistance program to aid developing allies and to build stronger relationships with these countries. This study does not address such programs and any analysis of MEDCAPs is limited to their historical support of counterinsurgency operations.

Counterinsurgency

To address these programs effectively, counterinsurgency must first be defined. Counterinsurgency, just like its antithesis insurgency, is as old as warfare itself. U.S. Army Field Manual 3-24 defines an insurgency as an “organized movement aimed at the overthrow of a constituted government through the use of subversion and armed conflict.” Stated another way, an insurgency is an organized, protracted politico-military struggle designed to weaken the legitimacy of an established government. Counterinsurgency then, is the military, politico-economic, psychological, and/or civic actions taken by a government to defeat an insurgency; otherwise known as irregular warfare.⁶

⁴ Neel Spurgeon, *Medical Support of the U.S. Army in Vietnam 1965–1970* (Washington, D.C.: Department of the Army, 1991), pp. 163–4.

⁵ E. Loomis, “Humanitarian and Civic Assistance Program”, *DISAM Journal*, Winter 2000.

⁶ Department of the Army, Field Manual (FM) 3–24, *Counterinsurgency*, (Washington, DC: December 2006), p. 4-1.

Three guiding principles come from historical counterinsurgency campaigns; legitimacy, continuity, and unity of effort. Legitimacy is the main objective, with security, both from internal and external threats, as its foundation.⁷ Continuity maintains this legitimacy with a prepared long-term commitment. This should all be coordinated within a unity of effort that is synchronized between all participants including civilian agencies, non-governmental organizations, the host nation government, and other coalition allies.⁸

Measures of Effectiveness

One problem is the lack of data to support such missions. Objective analyses, doctrinally known as Measures of Effectiveness, are lacking with most information anecdotal and primarily through after action reports (AARs) from units conducting the activities. Evaluations, historically, were limited only to number of patients treated.⁹

By U.S. Army standards the definition of a *measure of effectiveness* is “a criterion used to assess changes in system behavior, capability, or operational environment that is tied to measuring the attainment of an end state, achievement of an objective, or creation of an effect.” These creations focus on the results or consequences of actions taken. They answer the question, “Is the force doing the right things, or are additional or alternative actions required?” This becomes the benchmark against which commanders assess progress toward accomplishing the mission.¹⁰ Unfortunately such methods of evaluation are rare or non-existent, but worse, are invalid, when applied to these types of direct patient care programs in counterinsurgency operations. The question would beckon as to what happens when they are held up to this standard and evaluated.

So to investigate such medical programs, this study uses set measure applied to the civil medical programs in both Vietnam and Afghanistan. This criterion will incorporate the basic

Henceforth FM 3–24, *Counterinsurgency*.

⁷ Ibid., p. 1-22.

⁸ Ibid., p. 1-22.

⁹ Douglas Lougee, "Can We Build a Better Medical Civic Assistance Program? Making the Most of Medical Humanitarian Civic Assistance Funding." *DISAM Journal*, February 2007: pp. 68–9.

¹⁰ FM 3–0, *Operations*, p. 5-17.

historical principles of a successful counterinsurgency, and add elements that are specific to the discipline of medicine and the Army as an institution. These criteria are legitimacy, continuity, unity of effort, doctrine, resourcing, intelligence, and ethics. They are described below.

Legitimacy

The concept of military legitimacy brings together elements of history, culture, ethics and leadership, and applies them to U.S. military operations. It is a study of military means and methods, both destructive and constructive that can best achieve mission success.¹¹

When discussing legitimacy in counterinsurgencies it is in the context of the legitimacy of the host nation's government in the eyes of its people. Put in another way, the people's ownership of any program by means of their own system. Direct patient care programs, including MEDCAPs, conducted by the U.S. military during the Vietnam War and operations in Afghanistan will be evaluated specifically for this legitimacy. To shed better light however and to compare/contrast their results other medical programs will be addressed as well.

In the end, what these programs did in Vietnam and Afghanistan was to establish a false sense of expectations by local people that the U.S. military could not live up to. The U.S. seeded a continued sense of entitlement by local indigenous communities that it could not meet. This occurred in Vietnam and Afghanistan. U.S. directed patient care programs were consistent in their ability to de-legitimize counterinsurgency goals. However, what will also be explored are other options that do shown potential for success but are focused more on training, education, and infrastructure development.

Continuity

Follow-up is a frequently used phrase in the medical community to describe continuity. Other phrases such as "long-term commitment" or "sustainability" are bantered around, but in the end it is whether or not such assistance programs can be maintained by the host nation upon U.S.

¹¹ Rudolph C. Barnes, Jr., COL, USA (Ret), MPA, JD, *Special Topics in International Politics: Military Legitimacy and Leadership*, The Citadel Military College, Department of Political Science & Criminal Justice (Course syllabus, Fall 2008).

personnel removal. The concept of continuity is spoken of in Army doctrine and its importance in marginalizing insurgent claims to governance.¹²

During Vietnam and Afghanistan this idea of continuity was not addressed by direct patient care programs like the MEDCAP. MEDCAP missions could not provide follow-up nor was it emphasized by leadership. Many defended this due to a lack of security with repeat visits, but this echoes back to the foundation of legitimacy, which is security. In retrospect, such programs did not possess the means to continue such care and by not doing so with a permanent system addressing the chronic disease processes that they treated these programs were ineffective and sometimes a detriment.

Unity of Effort

Current U.S. Army doctrine says unity of effort is “essential.” This concept has been referred to as synchronization or integration. Whichever term is used, Army doctrine states that it must be present at every echelon of a counterinsurgency campaign. It warns of “well-intentioned but uncoordinated actions” that can cancel out efforts and provide insurgents avenues and vulnerabilities to exploit.¹³

Current U.S. Army doctrine advocates that any and all programs should be conducted “by, with, and through” the host nation and civilian agencies; long term sustainment of the host nation’s infrastructure is the end-state. Keeping in mind:

- Operations and Programs should be joint ventures.
- The host nation military and civilian governance should gain a capability.
- Capabilities should be transferable at a given end-state to the host nation.
- The local populace gains ownership of the finished product.
- The host nation government, in the eyes of the people, is the lead agency.¹⁴

¹² FM 3–24, *Counterinsurgency*, p. 8-13.

¹³ *Ibid.*, p. 1-22.

¹⁴ Department of the Army, Field Manual (FM) 3–07, *Stability and Support Operations* (Washington, D.C.: February 2003), p. A–15. Henceforth FM 3–07, *Stability and Support Operations*.

In Vietnam, the U.S. government was unclear of its own goals or objectives. Senior leadership was confused as to whether MEDCAPs were in place to relieve human suffering or to politically win over the population. The two thoughts had conflicting methods and end-states. If the goal was political then Civil Affairs or Psychological Operations should have received overall control. If the main effort was to stop human suffering and improve health care, then the AMEDD and USAID should have taken control.¹⁵ To improve this and synchronize efforts a new experiment was launched with the establishment of the Civil Operations and Revolutionary Development Support (CORDS). Discussed later in chapter three, CORDS attempted to unify this endeavor but was still considered a “successful failure.”¹⁶

In Afghanistan, the Civil-Military Operations Center (CMOC), an *ad hoc* coordination center, was established to direct and coordinate unity of effort. The CMOC goal was to legitimize all these assets within the host nation system. This included non-governmental agencies. Unfortunately, there was no single military command, and most coalition forces respond to different operational limitations with no unified approach.¹⁷

Doctrine

Commanders have historically viewed MEDCAPs and other health services as valuable, low-risk options for Civil Affairs planning. Generally considered non-controversial and cost effective, these services are an enticing element to support U.S. national interests in host nation countries.

In Vietnam, this concept became clear to senior leaders. The thought was that medical contributions to political stability are viable and can promote theater objectives. The idea was that the massive capabilities of America’s medical system could have positive influence on a

¹⁵ Robert J. Wilensky, *Military Medicine to Win Hearts and Minds: Aid to Civilians in the Vietnam War*, (Texas Tech University Press, 2004), pp. 90–1. Henceforth noted as Wilensky, *Military Medicine to Win Hearts and Minds*.

¹⁶ Richard W. Stewart, “CORDS and the Vietnam Experience: An Interagency Organization for Counterinsurgency and Pacification,” *Project on National Security Reform: Case Studies, Volume I*, (Washing, DC: Center for the Study of the Presidency, 2008), pp. 472–3.

¹⁷ After Action Report on Afghanistan by General Barry R. McCaffrey, USA (Ret), on his visit to NATO SHAPE Headquarters, 26 July 2008.

counterinsurgency. Unfortunately, senior leaders did not address the question of who gets the credit for this care, U.S. uniformed personnel or the host nation's government.¹⁸ There was no clear guidance or doctrine to fall back on to answer this question

Current publications view these activities as non-curative and recommend focusing on long-term developmental programs. Today, doctrine is very explicit in that independent, unplanned direct patient care programs like MEDCAPs should not be undertaken but yet this is the most common medical mission seen in Afghanistan up to 2007.¹⁹

Joint Publication 3-07.6, *Joint Tactics, Techniques and Procedures for Foreign Humanitarian Assistance* goes further to state that U.S. military medical personnel will not routinely care for host nation people unless specifically authorized. It authorizes U.S. forces to provide health care to foreign civilian populations but on an urgent or emergent basis, and "within resource limitations."²⁰ The basic principle of joint doctrine is to return these services back to their national health systems at the earliest opportunity or to avail services that can be provided by other agencies and non-governmental organizations.²¹ The primary consideration given to supporting and supplementing whatever medical infrastructure exists. Joint Publication 4-02, *Doctrine for Health Service Support in Joint Operations* reiterates that no operation should be considered that would or could have the effect of supplanting the existing medical infrastructure.²²

Unfortunately, this concept is written in the operational confines of humanitarian assistance and disaster relief, with no dedicated doctrine to medical support in a

¹⁸ Wilensky, *Military Medicine to Win Hearts and Minds*, p. 123.

¹⁹ Department of Defense, *Joint Publication (JP) 3-57, Joint Doctrine for Civil-Military Operations* (Washington, D.C.: Department of Defense, 2001), p. 2-12. Henceforth JP 3-57, *Joint Doctrine for Civil-Military Operations*.

²⁰ Department of Defense, *Joint Publication (JP) 3-07.6, Joint Tactics, Techniques and Procedures for Foreign Humanitarian Assistance* (Washington, D.C.: August 2001), pp. 4-20-30. Henceforth JP 3-07.6, *Joint Tactics, Techniques and Procedures for Foreign Humanitarian Assistance*.

²¹ *Ibid.*, pp. 4-20-30.

²² Department of Defense, *Joint Publication (JP) 4-02, Doctrine for Health Service Support in Joint Operations* (Washington, D.C.: October 2006), p. 4-2. Henceforth JP 4-02, *Doctrine for Health Service Support in Joint Operations*.

counterinsurgency conflict. Humanitarian assistance and disaster relief are fundamentally different from counterinsurgency. Commanders and Command Surgeons are ultimately accountable for any medical support in these theatres but many are unaware of the limitations or fundamental flaws in current doctrine.

Resourcing

In Vietnam, hundreds of millions of dollars were expended though field commanders did not have the resourcing insight to address the core issue. South Vietnam needed a complete overhaul of the medical delivery system.²³ What was done was direct patient care by U.S. uniformed personnel. By the end of 1970, no basic change or improvement had occurred in the Vietnamese health care system. The results of such direct patient care actions produced impressive figures of funds spent and number of patient visits but no objective data or successful outcomes.²⁴

In Afghanistan, Humanitarian and Civic Assistance (HCA), Section 401, Title 10, United States Code is the “catch all” that financially justifies most civil medical programs and authorizes funding to conduct HCA activities to include MEDCAPs. Under this section one such activity is defined as, “medical, dental, and veterinary care provided in rural or underserved areas of a country.” This is further described in U.S. Army Field Manual 3-05.40 as categories of assistance that may be rendered by U.S. military personnel.²⁵ So on paper it would seem that congressional resourcing is available for current counterinsurgency operations in Afghanistan.

Such resourcing, however, is poorly accounted for with a large amount dedicated for direct patient care programs like MEDCAPs. Responsible and proportioned spending was not present. Despite slow changes in the more secure provinces, infrastructure development,

²³ ElRay Jenkins, “Medical Civic Action Programs and Medical Readiness Training Exercises as Instruments of Foreign Policy,” Military History Institute Archives (MHIA), Carlisle Barracks, PA (24 May 1988), pp. 43. Henceforth Jenkins, “Medial Civic Action Programs.”

²⁴ Raymond H. Bishop Jr., “Medical Support of Stability Operations: A Vietnam Case Study,” MHIA, (18 February 1969), p. 13.

²⁵ Department of the Army, Field Manual (FM) 3–05.40, *Civil Affairs Operations* (Washington, D.C.: September 2006), p. 3-7–8. Henceforth FM 3–05.40, *Civil Affairs Operations*.

characteristic of a resourced state, remains absent. Afghanistan still relies on international compassion to provide basic healthcare services.²⁶

Another issue is the gross discrepancy of resourced capacity between the State Department, USAID, and the Department of Defense. As of 2007, the State Department, together with USAID, possessed a budget of less than \$30 billion with total employee strength of 57,000. Half of this employee force was foreign nationals. Compare this to the Department of Defense with its \$480 billion budget and a 3,000,000 strong workforce. One common complaint is, “we have more IRS tax collectors than people in the State Department.”²⁷

Intelligence

One dilemma to be addressed is the issue of intelligence gathering at MEDCAPs. Many have voiced this as a valid “ends” to justify its “ways and means.” Ironically though, history has not demonstrated a clear instance where medical support, especially MEDCAPs, have proven of any significant value toward intelligence collection, or for that part, a successful counterinsurgency.²⁸

In Vietnam, medical intelligence utilized MEDCAPs to gain a picture of the health of enemy forces. However, though informally lauded as a reason for conducting MEDCAPs, non-medical intelligence collecting was not effective except in limited success at the tactical level. Dr. Robert Wilensky looks at this topic specifically in his analyses of MEDCAPs during the Vietnam War and concludes that none of these assistance programs affected decision making at the operational level.²⁹

²⁶ David P. Cavaleri, *Easier Said than Done: Making the Transition Between Combat Operations and Stability Operations* (Fort Leavenworth, Kansas: Combat Studies Institute Press, 2007), pp. 72–3.

²⁷ Gary Luck and Mike Findlay, *Focus Area: Interagency, and Nongovernmental Coordination, (A Joint Force Operational Perspective)*, Insights & Best Practices, July 2007, Joint Warfighting Center, United States Joint Forces Command, p. 4.

²⁸ Arthur M. Smith and Craig Llewellyn, “Humanitarian Medical Assistance In U.S. Foreign Policy: Is There A Constructive Role for Military Medical Service?” *The DISAM Journal*, (Summer, 1992), p 73. Henceforth Smith & Llewellyn, “Humanitarian Medical Assistance In U.S. Foreign Policy.”

²⁹ Wilensky, *Military Medicine to Win Hearts and Minds*, pp. 119–21.

In Afghanistan, the MEDCAP program was considered as an avenue for passive intelligence gathering. This is not to say that medical intelligence was not collected for public health issues and force protection, but like Vietnam, actual gathering of passive tactical or operational intelligence, which many lauded as a reason for such missions, was rarely demonstrated.

Ethics

Over the past century, with the emergence of stability operations as a stated mission for the U.S. Army, civic actions are now more interdependent than ever. This has placed a premium on careful design of any given intervention. U.S. military physicians are eager to help as a moral imperative. However, this moral energy cannot be single-minded and must address the “bigger picture.” Flexible pragmatism is the underlying rule.³⁰ Ethically, if aid is performed incorrectly, it can reinforce conditions it was meant to repair. What seemed a simple humanitarian assistance, can lead to numerous complications when related to an insurgencies’ goals. It has also shown that single minded medical assistance can foster local dependency and exacerbate a conflict.³¹

In Vietnam, this led most providers to feel unable to practice anything but the most shallow and inadequate form of medicine which contradicted their medical oath. This dissatisfaction became obvious with patients and providers alike. In the end, the intervention did more harm than good.³²

The life expectancy in Afghanistan is forty-three years. This is the result of non-existent potable water, poor nutrition, and the lack of waste management and immunizations. These problems cannot be addressed with a single-day MEDCAP.³³ This had led to providers feeling morally trapped; especially in the absence of any guidance. The National Security Strategy does provide guidance on the moral principles and values that are considered at the “forefront” of what

³⁰ Jonathan Moore, *Hard Choices* (Rowman & Littlefield Publisher, 1998), pp. 6–7. Henceforth Moore, *Hard Choices*.

³¹ Mary B. Anderson, *You Save My Life Today But for What Tomorrow?* (Rowman & Littlefield Publisher, 1998), pp. 137–155. Henceforth Anderson, *You Save My Life*.

³² Moore, *Hard Choices*, pp. 6–7.

³³ Information Paper, *Cooperative Medical Assistance (CMA) Planning Considerations in Afghanistan*, (Combined Joint Task Force–82, Bagram, Afghanistan: March 2007) p. 2.

we do as a nation and a military.³⁴ MEDCAPs, or any other direct patient care programs for that matter, have operated outside of this guidance.

Before the Vietnam War and operations in Afghanistan are analyzed further it is important to take a look at how the U.S. military utilized medical assets in support of counterinsurgency and stability operations leading up to initial U.S. involvement in Vietnam. Such pre-Vietnam assessment can then help to compare and contrast the medical programs used in both of these campaigns. How did the U.S. military medically support counterinsurgency campaigns before Vietnam?

³⁴ The White House, *The National Security Strategy of the United States of America*, (Washington, D.C.: 2002), pp. 1–3.

CHAPTER 2

PRE-VIETNAM & DOCTRINE DEVELOPMENT

The U.S. Army and sister services have focused most of their organizational and doctrinal energies preparing for conventional warfare against a similarly armed and configured opponent. Nevertheless, the U.S. military, and especially the Army and Marine Corps, have not historically spent the majority of their time in conventional conflicts but rather in the performance of a multitude of operations that would be considered “other than total war.” Much of the Army’s combat experience prior to World War II was gained not on the conventional battlefield against regular opponents, but in unconventional conflicts against a bewildering array of nonconventional opponents. From the American Indians in the 1860s onward to the Bolshevik partisans in 1919, this form of limited conflict was eventually referred to as “small wars.” Current doctrine refers to these adversarial actions as insurgencies, with the opposite being a counterinsurgency. By definition, proper counterinsurgency strategy incorporates all of the political, economic, social and military actions taken by a government and uses these assets to suppress such insurgencies, resistance or revolutionary movements.³⁵ This strategic awareness, and subsequent doctrine, did not occur instantaneously, but evolved through innovation and experience. Doctrine is important because it helps soldiers navigate through the “fog of war.”³⁶

The U.S. military’s role in counterinsurgency traditionally embraces two broad categories: combat, frequently counter-guerrilla or pacification, and civil administration functions. The latter establishes governance, infrastructure development and constabulary

³⁵ Andrew J. Birtle, *U.S. Army Counterinsurgency and Contingency Operations Doctrine 1860–1941* (Washington, D.C.: Center of Military History Publishing, 1998), p. 3. Henceforth noted as Birtle, *U.S. Army Counterinsurgency 1941*.

³⁶ *Ibid.*, p. 5. For the purpose of this study, doctrine is defined as that body of knowledge disseminated through officially–approved publications, school curricula and textbooks that represents an army’s approach to war and the conduct of military operations. Well written doctrine offers a distillation of experience, furnishing a guide to methods that have generally worked in the past, and are thought to be of some enduring utility.

support in areas which are threatened by insurgents.³⁷ One of the aspects of the second category is medical assistance.

Innovation has been paramount to the progression of warfare for the U.S. military, both as an art and a science. When one thinks of “innovation” one ponders thoughts of “high tech” gadgets, unmanned aircraft, and smart bombs. These form only one aspect and a short-sided view; many innovations occur outside the realm of technology. This is no more apparent than in the area of counterinsurgency and its innovative doctrine. Such doctrine, whether called “irregular warfare”, “guerrilla” campaigns or “small wars”, was influenced by historical demonstrations which sparked the innovation necessary for all aspects of counterinsurgency, including medical assistance.

U.S. counterinsurgency operations generally had two main characteristics: they frequently occurred in relatively underdeveloped areas where transportation systems are rudimentary, and topographical and climatic conditions posed significant obstacles to the conduct of operations. The second was that combat in such situations usually pitted the Army against irregular or semi-irregular forces. Such considerations played a central role in the activities at both the operational and tactical levels. Ultimate success of these operations depended on the interaction of soldiers with the indigenous civilian populations and thus was inherently civil military in scope.³⁸

At the heart of this was legitimacy. Legitimacy is confidence built and loyalty established between the host nation’s government and the local populace. Key to this is host nation representation during such civil military activities. The concept is that such activities are not effective unless performed by the sovereign government. This necessitated the development of working relationships with local civil authorities, and included augmenting civilian

³⁷ Andrew J. Birtle, *U.S. Army Counterinsurgency and Contingency Operations Doctrine, 1942–1976* (Washington, D.C.: Center of Military History Publishing, 1998), p. 4. Henceforth noted as Birtle, *U.S. Army Counterinsurgency 1976*.

³⁸ Birtle, *U.S. Army Counterinsurgency 1941*, p. 4.

infrastructure with military government programs to include social engineering. All these programs designed to reshape the subject society.³⁹

Before venturing further, it is necessary to clarify the definitions and differences of two aspects of these operations: “Civil Affairs” and “Civic Action.” Civil Affairs describes the work of the military in providing governmental services and support to a host nation. Civic Action is those individual stability missions and programs the military uses to aid the local populace. Such aid can be food, water, clothing, construction projects or medical care. Therefore Civic Action can be a part of Civil Affairs.⁴⁰

American medical civic action has its roots from the beginning of the United States. In 1798, Congress established the United States Public Health Service (USPHS), to support the Merchant Marine Fleet and provide care to all its sea-going members. As part of their mandate this organization, which included Marine Hospitals and physicians, was authorized to assist local governments in combating epidemics such as cholera, yellow fever, and malaria. Forward deployed Marines and Navy personnel were at risk from exposure to such diseases, and medical civic actions were initially developed to protect these service members from this threat. Civic actions provided the means of defensive medicine when contact with the surrounding population was inevitable.⁴¹ This attitude toward civic actions changed as America began to occupy larger pieces of territory.

Antebellum (1820–1865)

The antebellum Army spent the bulk of its time policing the nation’s ever-changing western boundaries. The frontier was thus an integral part of the Army’s existence, and consequently it inherited a rich heritage of experience in warfare against Indians that dated back to the colonial era. Several problems inhibited the dissemination of such experiences. There was a general immaturity in the military educational and doctrinal development systems at the time.

³⁹ Birtle, *U.S. Army Counterinsurgency 1941*, p. 5.

⁴⁰ Wilensky, *Military Medicine to Win Hearts and Minds*, p. 7.

⁴¹ *Ibid.*, p. 17.

Another problem was the tendency of soldiers to dismiss “savage” warfare as a form of conflict less worthy of study than “civilized” (e.g. European) wars. These problems led to a reluctance of Congress to allocate sufficient funds for the establishment of a professionally trained counterinsurgent military force. All of these factors contributed to early doctrinal shortcomings.⁴² Fortunately, many soldiers served in more than one campaign and were able to apply lessons from one operation to another. For example, Brigadier General William Henry Harrison utilized methods during the Indian campaigns after 1810 that he learned in the 1790s as aide-to-camp to Major General Anthony Wayne. Officers and soldiers alike passed such informal knowledge by word and example from one generation to the next. Another example comes from the 1858 war with Indians of the Washington Territory. At that time Colonel George Wright applied techniques of pacification first observed during his experiences in the Second Seminole War (1835–1842). Wright’s knowledge was subsequently passed onto to a young Second Lieutenant Philip H. Sheridan, who later employed the same techniques over the next thirty years against Native American irregulars. Thus, through a combination of personal experience, word of mouth, and informal writings, enough frontier lessons were preserved to produce a basic continuity in the approach to Indian warfare, which would later serve as a basis for counterinsurgency.⁴³

Educational institutions eventually caught up. Swiss diplomat Emmerich Vattel, considered one of the most important theorists of his time in the laws of war, originally argued in his 1758 work *The Law of Nations*, that wars should be conducted with as much justice and humanity as possible. He urged that soldiers should treat civilians with every consideration and shield them from the lawlessness and disruption that normally accompanies war. He decried the damage to civilian infrastructure as counterproductive. This included any acts that unnecessarily harm the inhabitants of an area. His point was that moderation redounded to an army’s benefit

⁴² Birtle, *U.S. Army Counterinsurgency 1941*, pp. 7–10.

⁴³ *Ibid.*, p. 11.

and that by maintaining discipline over its soldiers, an army reduced the chances that the populace would take up arms against it. He recommended that government should speed toward reconciliation.⁴⁴

Another innovator to set the stage for civic action doctrine was Dennis Hart Mahan. In 1835 he introduced Indian warfare into West Point's curriculum. This was the Army's first formal training in unconventional warfare. Between 1836 and 1840, Indian warfare was a standard part of Mahan's lecture series, which he continued to address throughout his forty years as a West Point professor. He taught that good soldiers adapt their methods to the characteristics of their enemies.⁴⁵ Mahan focused his discussion on how to use partisans and small elements of regular troops to conduct counter-guerrilla operations in what military theorists at the time commonly coined *petite guerre* ("small war"). This principle resonated in the halls of West Point. This was not only through the teachings of Vattel and Mahan but also through Antoine Henri Jomini. Jomini counseled his readers to "calm popular passions in every possible way, exhaust them by time and patience, display courtesy, gentleness, and severity united, and, particularly, deal justly."⁴⁶ None addressed medical assistance specifically, but it was foremost in campaign strategy.

The earliest actions which resembled later civil affairs programs embodied many of these philosophies and included medical assistance. One early example dates back to the Mexican-American War of 1846–48 when Major General Winfield Scott's assistance programs contributed to the Mexican people's opposition to General Antonio Lopez de Santa Anna.⁴⁷ Scott held out

⁴⁴ Birtle, *U.S. Army Counterinsurgency 1941*, pp. 11–15.

⁴⁵ Conrad E. Harvey, *An Army without Doctrine: The Evolution of U.S. Army Tactics in the Absence of Doctrine, 1779 to 1847* (Fort Leavenworth, KS: Command and General Staff College, 2007), pp. 72–3. Dennis Hart Mahan, noted American military theorist, was a professor at the United States Military Academy, West Point from 1824–1871. Mahan graduated from West Point in 1824, first in his class, but had such academic acumen that he was appointed acting assistant professor of mathematics during his third year. After graduation, he started teaching at the Academy the very next year in 1824. He resigned his commission in 1832 but remained on as Chair of the Department of Engineering.

⁴⁶ Antoine Henri Jomini, *The Art of War* (Philadelphia: J.B. Lippincott, 1862), p. 33.

⁴⁷ Wilensky, *Military Medicine to Win Hearts and Minds*, p. 7.

the hand of reconciliation toward the people of Mexico. Shortly after beginning the campaign he issued proclamations pledging to protect the lives and property of Mexican citizens. He attempted to gain favor with the Catholic Church in Mexico by ordering his soldiers to salute priests. In areas that Scott occupied, he encouraged municipal officials to remain in office and exercised his full power to restore to normal the economic and social life of the country. Scott preferred to pay for supplies rather than risk alienating the people. He maintained schools, hospitals, clinics, and other public institutions; emphasizing public services and sanitation systems. However, American forces dealt harshly with any rebellion.⁴⁸ So by applying this “carrot-and-stick” approach, Scott demonstrated to the local population that they had more to lose by resisting U.S. authority.⁴⁹

These early civic actions and their supporting medical programs from the Mexican-American War continued during post-Civil War operations with the establishment of the Freedman’s Bureau in March of 1865. Though not a counterinsurgency by definition, this post-Civil War medical program was important because it demonstrated one of Americas’ first attempts at reconstruction and stability operations. The Freedman’s Bureau worked alongside the Army Medical Department for the “betterment of health and welfare.” This was an example of the blurring of the lines between military care to soldiers and aid to civilians. This bureau provided limited medical services with an emphasis instead on long-term programs. One such program established the first medical schools for African Americans. This continued throughout the reconstruction period with the creation of several medical programs to include institutions like Lincoln University, Oxford, Pennsylvania in 1870, Straight University, New Orleans, in 1873, and Leonard Medical College, Raleigh, North Carolina in 1882. Though most are no longer active two are; Meharry University, Nashville, Tennessee (1867), and Howard University,

⁴⁸ Birtle, *U.S. Army Counterinsurgency 1941*, pp. 16–17.

⁴⁹ Brian McAllister Linn, *The Philippine War, 1899–1902* (Lawrence: University Press of Kansas, 2000), p. 323.

Washington, DC (1868). Both of these institutions remain to this day as well known medical training programs.⁵⁰

These programs promoted legitimacy and continuity with long-term sustainable projects. Activities like Scott's in Mexico focused on medical infrastructure, and locally operated hospitals and clinics. Reconstruction efforts after the Civil War focused on medical education as a means of long-term stability. Scott demonstrated unity of effort with his attempts to court the local government, though the concept of non-governmental organizations and interagency participants were ideas not yet developed. Theorists like Vattel addressed ethics and the idea of humanity, but the concept of intelligence gathering as a reason for such activities had not emerged.

The military continued to evolve what might be termed an “informal” doctrine; comprised of customs, traditions, and accumulated experiences that were transmitted from one generation of soldiers to the next through unofficial writings and other means.⁵¹ American officers and soldiers alike would take this informal doctrine and wisdom with them as they ventured overseas to new territories.

Philippine Insurrection

In April of 1898 the United States had a “splendid little war” with Spain of only eight months duration. The United States invaded the Spanish colonies of Cuba, Puerto Rico and the Philippines, although by the time peace came in December 1898, the U.S. controlled only small portions of all these islands. In the ensuing Treaty of Paris, Spain ceded the islands of Guam and Puerto Rico; relinquished its claim to Cuba, placing it under American control; and sold the Philippines to the United States for \$20 million. With little preparation or forethought, the United States found itself responsible for the long-term governance of over seven million Filipino

⁵⁰ Earl H. Harley, “The Forgotten History of Defunct Black Medical Schools in the 19th and 20th Centuries and the Impact of the Flexner Report,” *Journal of the National Medical Association*, vol 98 (September, 2006) pp. 1425–6.

⁵¹ Birtle, *U.S. Army Counterinsurgency 1941*, pp. 5–6.

people.⁵² Since the 1880s this population had struggled for independence; thus, the U.S. found itself fighting against a mature insurgency.

Nearly every officer in the U.S. Army served in either Cuba, Puerto Rico, or the Philippines between 1898 and 1902. Their experiences in what today would be called “nation building”, and, in the case of the Philippines, counter-guerrilla warfare, became the model on which the Army based its approach to counterinsurgency for the next forty years. Ideas like economic reform and democracy were unknown in Spain’s former colonies. Instead, class relationships dictated socioeconomic affairs, and politics were little more than a vehicle for ruling classes to compete among themselves for political power. President William McKinley’s guiding principle was that the United States had a duty to free the “benighted” peoples of Spain’s former colonies and show them the “fruits of Western civilization.” In accordance with this ideology, he directed the Army to conduct its occupations as “benevolently” as possible. The goal was to install a prosperous, self-governing democratic society in the former colonies. Fortunately, the president chose not to micro-manage Army commanders with restrictive guidance on how to achieve this goal. The War Department and commanders in the field thus had the freedom to formulate occupation policies as they saw fit.⁵³

The American officials most responsible for the development of this occupation policy were two of the Army’s “rising stars,” Major General Leonard Wood and Brigadier General John J. Pershing.⁵⁴ Wood was a Harvard trained physician who cut his operational teeth in the American southwest against Geronimo and his Apaches; receiving the Medal of Honor for his actions. Wood had learned early on the importance of stability operations to support a

⁵² Birtle, *U.S. Army Counterinsurgency 1941*, p. 99. The Philippines were purchased because Manila surrendered after the armistice and could not be demanded as war reparations.

⁵³ *Ibid.*, p. 100.

⁵⁴ Charles A. Byler, “Leonard Wood, John J. Pershing, and Pacifying the Moros in the Philippines: Americans in a Muslim Land,” *Turning Victory Into Success: Military Operations After the Campaign*, ed. Brian M. DeToy (Combat Studies Institute: 2004), p. 89.

campaign.⁵⁵ The principles of international law and the Lieber's code of 1863 discouraged commanders from drastically altering the rules and customs of an occupied territory unless military priorities mandated a change.⁵⁶ Consequently, it was no accident that when the time came to formulate the occupation policy in 1898 the Army adopted procedures upon those first employed in the Mexico-American War of the 1840s. Further, the Army's approach was heavily influenced by its experiences in "pacifying" the American Indians and by the reform impulses of contemporary American progressivism.⁵⁷ Otherwise called the "white-man's burden," the Army derived lessons in "benevolent paternalism" and the "firm-but-fair" approach to governing indigenous people.⁵⁸ In line with the developing social Darwin theories of the time, the Army wanted Spain's former colonies to change via a quiet, evolutionary process. The government would provide as much of a level playing field as possible. It would be up to the people to pull themselves up "by their bootstraps in the finest of American traditions."⁵⁹

Many officers considered educational reform key to success or failure of the entire nation-building program. By providing universal public education, the Army believed it was laying the framework for political, social, and economic infrastructure evolution for Spain's former colonies. Army officers were aware that such changes, in light of the centuries of corrupt colonial rule, could not be achieved by riding roughshod over the customs and traditions of the indigenous population. The belief held that government needed to be designed not for American

⁵⁵ Mary C. Gillett, *The Army Medical Department 1865–1917* (Center of Military History, U.S. Government Printing Office, Washington D.C.: 1994), pp. 78–9.

⁵⁶ Andrew J. Birtle, "The U.S. Army's Pacification of Marinduque, Philippine Islands, April 1900–April 1901," *The Journal of Military History* 61, (1997): pp. 255–282. Lieber's Code (General Order 100) of April 24, 1863, was an instruction signed by President Abraham Lincoln to Union Forces during the Civil War. This dictated how soldiers should conduct themselves in war time. It was named after the German-American jurist and political philosopher Francis Lieber, then a professor of Columbia College in New York. This code addressed martial law, military jurisdiction, treatment of spies and deserters, and how prisoners of war should be treated.

⁵⁷ Birtle, *U.S. Army Counterinsurgency 1941*, pp. 101–2.

⁵⁸ Linn, *The Philippine War, 1899–1902*, p. 322. The "White Man's Burden" is a poem published by Rudyard Kipling in February of 1899. Ironically on the very month that fighting broke out between American forces and Filipino insurgents. Published in the *McClure's Magazine*, Kipling urged the U.S. to assume the responsibilities of an imperial power but warned of the long-term costs that this may entail.

⁵⁹ Birtle, *U.S. Army Counterinsurgency 1941*, pp. 101–2.

satisfaction but for the prosperity of the people. That the measures adopted should be made to conform to their customs, habits, and even prejudices.⁶⁰

Unfortunately, this purist view did not come to fruition for the Philippines. Cuba and Puerto Rico had been relatively peaceful reforms. The Philippines, an archipelago of 7,000 islands and over seven million people, consisted of a patchwork of tribal and religious groups, many of which disliked each other immensely. Some of these groups had organized into revolutionary elements that previously assisted U.S. forces in the overthrow of the Spanish. Unlike Cuba, where the U.S. had been able to convince rebel forces to disband, the Filipino revolutionaries refused to accept American governance. Instead, under the leadership of Emilio Aguinaldo, these groups rose up once again as an insurgent force against their American “occupiers.” The Philippine Insurrection began and lasted over three years; costing the U.S. over \$4,000,000 and 7,000 U.S. casualties.⁶¹

Medical support became a major component of the pacification program to win over the population. This support concentrated on preventive measures and an extensive public health program.⁶² Such activities offered a clear, long-term commitment and brought the local government in as an active participant.

The city of Manila was a good example. The threat of epidemic disease was apparent, so the U.S. Army developed a comprehensive public health program. Established by the U.S. and termed “the Board of Health,” this organization had both Filipino and American experts. The program completely changed the face of the health care infrastructure. It appointed municipal health officials at fixed salaries, and hired local physicians and midwives to provide free medical care to the indigent population. The Board of Health ran leper hospitals and arranged for public clinics. The military government also purchased supplies for hospitals not under direct control of

⁶⁰ Birtle, *U.S. Army Counterinsurgency 1941*, pp. 102–4.

⁶¹ *Ibid.*, p. 108.

⁶² Wilensky, *Military Medicine to Win Hearts and Minds*, pp. 18–19.

the Board. The Board vaccinated thousands of Filipinos during a smallpox outbreak in 1898. City officials vaccinated over 80,000 people, and succeeded in averting a potential epidemic catastrophe.⁶³

Venereal disease was also a significant threat to indigenous people and U.S. soldiers. By 1901 an aggressive inspection program began weekly with certificates of cleanliness issued to the working women. These women paid a standard fee for the inspection, with proceeds used to support a portion of the San Lazaro Hospital for the treatment of “infected women.”⁶⁴

The Board of Health expanded its activities to other urban areas; the primary goal being restoration of potable water and sanitation. Unfortunately, the Spaniards had done little toward sanitation or public health and the Board had to reform the whole sanitation infrastructure. As a result, sanitation departments increased in manpower and garbage was no longer dumped outside the city, but was burned appropriately.⁶⁵

These preventive medicine actions continued outside the cities with the establishment of a Philippine Board of Health in September of 1898. Colonial rule and years of rebellion had impoverished the population, and even the most simple remedies were absent in most towns. The Army began a comprehensive program of “medical charity.” It supplied essential drugs and surgical care and focused on prevention of outbreaks like plague, cholera, and smallpox. Nationwide vaccination was one of the Army’s most important projects. At the insistence of the chief surgeon of the Philippines, Brigadier General Patrick Henry Birmingham, the number of U.S. medical officers increased markedly with a ratio of one surgeon per 176 men.⁶⁶

These programs and initiatives led to a decided reduction in the country death rate, cutting it in half within the first year.⁶⁷ At the cornerstone of all these programs was a unity of

⁶³ John Morgan Gates, *Schoolbooks and Krags, The United States Army in the Philippines, 1898–1902*, (Westport, Connecticut, Greenwood Press: 1973), pp. 57–60. Henceforth Gates, *Schoolbooks and Krags*.

⁶⁴ Ibid.

⁶⁵ Ibid.

⁶⁶ Ibid., pp. 134–6.

⁶⁷ Ibid.

effort between U.S. forces and the Filipino government. Resources were focused on such projects and grounded in doctrine, even if that doctrine was informal.

There were, however, some ethical criticisms of these actions. Sometimes U.S. forces had to counter cultural and ethnic practices; often colliding with long-held traditions and cultural habits in these rural areas. For instance, the burial practices of these communities often included the opening of graves for second internments of additional deceased family members.⁶⁸ Coercion was sometimes needed by patrols of the provost-marshal to enforce these new sanitary regulations. Such regulations were in direct conflict, although the people eventually accepted them over time.⁶⁹

U.S. senior military leaders, both in the Philippines and in Washington, concluded that the widespread distribution of doctors and the immediate statistical evidence of their effectiveness showed that the Army's public health work was an important element for pacification, bringing to the Filipinos vivid evidence of the "benevolent" intentions of the United States.⁷⁰ Such programs were lauded by military commanders as significantly depriving the insurgency of support and winning the local population over to the Filipino government. Senior U.S. military leaders and AMEDD officers realized the legitimacy of these actions.⁷¹ Mary Gillett, in her official history of the Army Medical Department from 1865 to 1917, commented that those activities offered a unified, legitimate strategy that demonstrated continuity to the local population and results that were seen as beneficial with the Philippine government as an active participant.⁷²

The Philippine Insurrection introduced a new concept; medical services to support interrogation. During some events medical corps officers were present for torturing and information extraction. Their job was to supervise and prevent any permanent damage or injury

⁶⁸ Paul A. Rodell, *Culture and Customs of the Philippines* (Greenwood Publishing Group, 2001), p. 93.

⁶⁹ Gates, *Schoolbooks and Krags*, pp. 57–60.

⁷⁰ *Ibid.*, pp. 134–6.

⁷¹ Wilensky, *Military Medicine to Win Hearts and Minds*, pp. 18–19.

⁷² Gillett, *The Army Medical Department 1865–1917*, pp. 203–217.

to the detainee. Certainly such supervision, in this day and age, would be a violation of medical ethics and even during its time it was in clear violation of the laws of war, yet it still happened and apparently not hidden in the historical texts.⁷³ Other types of ethical dilemmas can be traced back to Wood, who consciously used the implementation or denial of public health measures to combat insurgencies among certain ethnic groups; withholding such services to resistant areas while granting them to others.⁷⁴

In the end, medical aid had helped, but the U.S. Army was victorious only after making the conflict as distressing and hopeless as possible for the insurgents. Army officers firmly believed by the end that positive incentives alone could not overcome a strong rebellion. The principal lesson of the war was that decisive military action and the policies of chastisement, with humanitarian action, rather than just policies of benevolence alone, were the ultimate keys to a successful campaign. It was only when insurgents were pushed by coercion that the policy of benevolence played a significant role in ending the insurrection. At that point, benevolence helped to reconcile the remaining insurgents. Leaders emerged from the conflict convinced of the importance of separating the population from the guerrillas through a combination of population control and civic actions.⁷⁵ So even while American forces engaged in combat operations, soldiers would build schools, clinics, and sanitation systems. In an attempt to “cultivate friendships” the Philippine campaign has been considered the most successful counterinsurgency in U.S. history.⁷⁶

“Banana Wars” and the Interwar period (1920-1941)

With the end of the Philippine Insurrection the U.S. military began a series of small foreign campaigns that were limited, but carried significant geopolitical consequences. These operations again pitted U.S. Army and Marine Corps elements against insurgents and guerrilla

⁷³ Gillett, *The Army Medical Department 1865–1917*, p. 216.

⁷⁴ Wilensky, *Military Medicine to Win Hearts and Minds*, p. 108.

⁷⁵ Birtle, *U.S. Army Counterinsurgency 1941*, pp. 135–7.

⁷⁶ Linn, *The Philippine War, 1899–1902*, pp. 327–8.

forces within local populations with radically different traditions, cultures and beliefs. These campaigns, interrupted briefly by the First World War, included the Mexican Punitive Expedition 1916–1917, Vera Cruz 1914, Panama 1918–1920, 1921, 1925, Cuba 1906–1909, Nicaragua 1912–1933, Haiti 1915–1934, Honduras 1915–1934, Dominican Republic 1916–1924, Rhineland Germany 1918–1923, North Russia 1918–1919, Siberia 1918–1920, China 1900–1905, 1912–1938, and Shanghai 1932.⁷⁷ At the heart of most of these campaigns was the Monroe Doctrine, which included the interventionist policies of the Roosevelt and Wilson administrations.⁷⁸ These policies dictated that the Marine Corps and the Army should prepare for such missions. This included nation building, infrastructure assistance and other stability operations, all within the confines of a counterinsurgency. This dictum left no doubt that service-related doctrine was necessary.⁷⁹

Previous campaigns, including the Mexican-American War (1846–8), Civil War Reconstruction (1865–77), the Indian Wars and the Philippine Insurrection, brought about a professional development with a “preparedness ethos.” Although many experienced soldiers had died or retired, the historical data of their experiences contributed greatly to counterinsurgency doctrine development. This continued into the 1920s and 1930s. Any fading memories were supplemented by education and historical records at all of the American military institutions. This included studies of special interests like Thomas E. Lawrence⁸⁰ and Lettow von Vorbeck⁸¹

⁷⁷ Birtle, *U.S. Army Counterinsurgency 1941*, pp. 8–9.

⁷⁸ U.S. Department of State, “Monroe Doctrine, 1823,” <http://www.state.gov/r/pa/ho/time/jd/16321.htm> (accessed October 30, 2008). The Monroe Doctrine, articulated to congress on December 2, 1823 by President James Monroe, stated that the newly independent states of the Americas were off limits to European colonization or interference. Though actually written by Secretary of State, John Quincy Adams, this doctrine had the caveat that the U.S. would not interfere with existing European colonies in the Western Hemisphere. Any attempt by European nations to gain control of nations in the western hemisphere would be seen as an act of aggression by the U.S. and open to intervention. Considered a defining moment in U.S. foreign policy this was supplemented by the Roosevelt Corollary. Added by President Theodore Roosevelt this invoked a reason to intervene militarily in Latin America to stop any possible spread of European influence.

⁷⁹ Birtle, *U.S. Army Counterinsurgency 1941*, p. 245.

⁸⁰ Lieutenant Colonel Thomas Edward Lawrence, known professionally as T.E. Lawrence, was a British officer during World War I. He is renowned for his liaison role during the Arab Revolt of 1916–1918. His flamboyant writings and breadth of knowledge in counterinsurgency actions would later endow him with the name “Lawrence of Arabia.”

and their works on guerrilla actions during World War I. These institutions studied the post-war pacification campaigns of the French and Spanish in Morocco, and the British in Iraq and India. As a common practice, the Command and General Staff College (CGSC) reviewed all U.S. operational after action reports on a regular basis. This included the incorporation of small wars and special warfare as part of the curriculum periodic review and required readings. All of which was integrated into the Army's small wars curriculum.⁸²

U.S. Army Infantry School at Fort Benning was another institution that paved the way for counterinsurgency innovation. Studies and operational experiences had shown small wars to be a “distinct genre” within the broader art of war. These experiences led all branches of U.S. forces to adopt enemy tactics and to discard certain aspects of their time-honored conventional philosophy. Other innovators like Colonel Harry A. Smith in the 1920s pushed such thoughts as “Military Governance”; deriving new principles and doctrine development. Smith and other experts gave a degree of continuity and evolution to the doctrine of civil affairs, and administrative support for small wars and counterinsurgency. These innovators, with their academic research, led to further doctrine development and the first publication of official counterinsurgency doctrine; Training Regulations (TR) 15-70, *Field Service Regulations – Special Operations* of 1922. This publication reflected a significant foreign influence; especially from the British. This even included older texts like Colonel Charles E. Callwell's *Small Wars* from the 1890s. All of this would eventually coalesce into Field Manual (FM) 27-5, *Basic Field Manual, Military Government*, 1940, and the USMC, *Manual of Small Wars*, 1940.⁸³ The latter will be discussed later in the chapter.

⁸¹ Paul Emil von Lettow-Vorbeck was a German general and commander of the East Africa campaign of World War I. He directed the only colonial campaign of the war and remained undefeated against far superior British forces. Vorbeck used guerrilla tactics and insurgent warfare to tie down British forces that could have contributed to the European campaign. Using a small detachment of highly motivated German officers and some 12,000 Askari soldiers, Vorbeck engaged in guerrilla raids into the British provinces of Kenya and Rhodesia. He targeted railways, infrastructure, and lines of communications.

⁸² Birtle, *U.S. Army Counterinsurgency 1941*, pp. 244–6.

⁸³ *Ibid.*, pp. 246–52.

Earlier publications, including TR 15-70 and later FM 27-5, addressed medical operations. The primary focus was support to the populace by sanitation and preventive medicine initiatives, and so included support to civilian hospitals, disposal of sewage, food inspections and potable water production systems.⁸⁴

Motivation for these publications came from many areas. One had been the five-year U.S. presence in post-World War I Germany. This occupation forced an understanding of the tenets of civil affairs and military governance, re-emphasizing the importance of nation building as an integral part of the military art. Operational focus specifically highlighted reconstruction operations and infrastructure development. This became the catalyst for greater attention to civil affairs.⁸⁵

Despite these efforts, many soldiers were unprepared for these duties. After World War I, most of the underdeveloped world had challenged the dominance of industrialized nations. This raised the chances of civil uprising and nationalistic movements.⁸⁶ The prospect of waging extensive pacification campaigns was no more evident than in Mexico, and thus provided stimulus for studying irregular warfare and counterinsurgency during the interwar period. This dictated that the Army should be prepared to conduct such operations and led to an open dialogue between the Army and USMC; sharing experiences and collaborative ideas. Marine officers were routinely invited to Army schools, as this collaboration gave aid to formulate the USMC's *Small Wars Manual*.⁸⁷

Doctrine development had additional motivations. Some occupations had been perceived as oppressive by some U.S. congressional members and the media. The Army needed acceptance from home.⁸⁸ This need for American support would necessitate innovative approaches and new

⁸⁴ War Department, *United States Army and Navy Manual of Military Government and Civil Affairs* (Washington, D.C.: 1943).

⁸⁵ Birtle, *U.S. Army Counterinsurgency 1941*, pp. 244–5.

⁸⁶ *Ibid.*, p. 245.

⁸⁷ *Ibid.*, p. 258.

⁸⁸ *Ibid.*, p. 252.

doctrine for future operations. Another concern was the rise of communism, and with this a new sophisticated model of warfare. In 1941 Marine observers warned Army colleagues in the *Cavalry Journal* of the introduction of new small wars tactics by communist leader Mao Tse-tung.⁸⁹

The AMEDD became an active participant in the campaigns in Central and South America. Some had even voiced the need for an increasing role for the AMEDD in all aspects of civil affairs. For example, Army Brigadier General Frank R. McCoy was critical of the way the Marines were conducting themselves operationally in Nicaragua. A veteran of General Wood's campaigns in the Moro Province of the Philippines, McCoy was instrumental in increasing the size and activity of the Marine force in Nicaragua. He was a strong advocate of the restructuring of the Nicaraguan military into a constabulary organization. McCoy felt that the Marines were handicapped by an insufficient emphasis on civil programs. He maintained that the drive should be toward developing communications, eliminating corruption, improving health conditions, and modernizing schools. He recommended that any action needed slow and methodical preparation with a long-term sustainment plan.⁹⁰

The Marines took these observations to heart which became evident in their experiences in the Caribbean, and Central and South America in the early 1930s. This culminated in their publication of the *Small Wars Manual* in 1940, which focused on civic action principles and how they should apply to medical activities. The Marines emphasized using commissioned medical and dental officers and the importance of highly trained corpsmen. They felt that in a "small wars operation" the number of health care providers needed to be greater than that required for a

⁸⁹ Birtle, *U.S. Army Counterinsurgency 1941*, p. 261. Original citation from James Griffith, "Guerrilla Warfare in China," *Cavalry Journal* (September–October 1941): p. 12.

⁹⁰ *Ibid.*, pp. 247–9. Frank R. McCoy had served General Wood in the Philippine Insurrection. He later returned to the islands while Wood was governor general. McCoy was known to have a talent for diplomacy. His assistance was significant to Henry Stimson when Stimson was special envoy to Nicaragua for President Coolidge. In 1927 McCoy was instrumental in the resolution of the revolutionary movement in Nicaragua that involved USMC intervention. Cited from William M. Wright, *Meuse-Argonne Diary; A Division Commander in WWI* (University of Missouri Press, 2004).

conventional conflict due to small units being dispersed throughout the theater. They realized that they should exercise special care in selecting hospital corpsmen to accompany such forces because of the extraordinary autonomy they would need. In many cases, these corpsmen made diagnoses and administered medications normally prescribed by a medical officer. Commanding officers were responsible for the enforcement of sanitation regulations within an operational area. Each commander needed to be thoroughly conversant with the principles of military hygiene, and sanitation. Marine elements paid particular attention to local hygiene inspections, washing practices, vaccinations, vector eradication, water purification, and prevention of venereal diseases. Operational planning included medical officers who were responsible for implementing training programs to Marines and the local populace alike. The manual went further, saying that medical personnel were one of the strongest elements in gaining the confidence of the local inhabitants. If the campaign plan contemplated the organization of armed indigenous troops, then additional medical personnel were recommended.⁹¹

The USMC advocated aggressive preventive medicine measures for both human and veterinary patients.⁹² Haiti (1915–1934) was one good example. Sanitation conditions of the whole island were dismal at best. Edward R. Stitt⁹³ (Navy Surgeon General) and L.F. Drum (Assistant Theatre Surgeon) noted this in the early 1920s. Both understood that such conditions and practices were not fixed immediately. It was only through long-term education and training that Haiti was going to change for the better. An aggressive training program was implemented with sanitation and preventive services, like refuse collection, put into practice. Health officials

⁹¹ Department of the Navy, *United States Marine Corps Small Wars Manual* (Washington, DC: Government Printing, 1940), Ch. II, pp. 59–60. Henceforth noted as *Small Wars*.

⁹² *Ibid.*, p. 7-23.

⁹³ Edward R. Stitt, M.D. was Navy Surgeon General from 1920 to 1928. He was a Professor of Tropical Medicine at Georgetown and George Washington Universities, and was a lecturer on Tropical Medicine at Jefferson Medical College, Philadelphia, Pennsylvania. Navy Medical History, "Edward R. Stitt," http://navyhistory.med.navy.mil/Exhibits/SurgeonGeneral/SG_Stitt.html (Accessed November 8, 2008).

enforced regulations like the prohibited practice of urinating and defecating in public. These new programs also corralled all stray hogs, goats, and dogs.⁹⁴

Nursing care and training received particular attention in Haiti. Post-partum infections and malnutrition played an enormous role in the mortality of women. At the request of senior theater medical officers, members of the Navy Nurse Corps arrived and developed a school of nursing for local women and Catholic nuns. This also provided a desperately needed career opportunity for the women of Haiti.⁹⁵

In the 1920s and 1930s, Army and Navy medical elements used a similar preventive template in Nicaragua. In a campaign to address “destitute natives”, medical personnel needed to address public health issues with frequent visits to the villages and support camps. These visits focused on the supervision and implementation of health and sanitation for the local populace. Because of this, sanitation was not a significant problem in American held areas. This left elements free to address other security and stability issues.⁹⁶

Other activities included the Malaria Survey program. This, conducted with the permission and cooperation of the local town “*commandantes*,” established Malaria and preventive medicine clinics in local schools. In these schools, every child under the age of twelve received an exam and thick film blood smears. Adults who gave a history of recent symptoms also were examined with additional blood smears. Those found positive were treated and followed up. These actions created an appreciation and respect for “*El Doctor*,” with local civic leaders and populace alike realizing the long-term improvements from these interventions. Medical personnel performed emergency procedures and surgeries, but no elective cases. Preventive training programs, like the Malaria Survey, saw real progress with a substantial

⁹⁴ Ivan Musicant, *The Banana Wars*, (New York: MacMillan Publishing, 1990), pp. 207–8. Henceforth Musicant, *The Banana Wars*.

⁹⁵ *Ibid.*, pp. 207–8.

⁹⁶ Stuart A. Cameron, “Medical Service in Nicaragua,” *The Military Surgeon*, no. 70 (1932): p. 45. Henceforth Cameron, “Medical Service in Nicaragua.”

decrease in malarial cases. Departing Captain Stuart Cameron in 1932 stated, “the Medical Department has undoubtedly secured many friends for the Army and for the United States as well, among the natives of Nicaragua and Costa Rica.”⁹⁷

By 1934, the “Banana Wars” had ended with President Franklin Delano Roosevelt’s signing of the Good Neighbor Policy. The general consensus was that medical efforts had been effective. Since preventive medicine, sanitation infrastructure, and education were the priorities then many of the principles of counterinsurgency and subsequent measures of effectiveness were met. All of these programs promoted legitimacy and emphasized host nation cooperation and participation. Continuity and long-term commitment was the norm with a unity of effort between the U.S. military and the local government. This made resourcing simple as all programs had a unified theme with one goal; community health. Unlike future operations in Vietnam and Afghanistan, direct patient care was not in competition with these public health measures. Altruism was placed on the backburner and substituted with a more pragmatic approach towards population medicine. There was some direct patient care, but this was limited and usually nested with the overarching intent of public health and infrastructure development. Interestingly, intelligence collection was not an issue.

The next five years saw little in additional counterinsurgency development as the world began to move toward its next World War. On the eve of World War II the U.S. had institutionalized many of the lessons learned from the past forty years. This was the traditional “carrot-and-stick” doctrine that attempted to balance aggressive military action with nonmilitary programs to appease the local population. So by 1940, with the publication of FM 27-5 and the Marines *Manual of Small Wars*, the War Department had doctrine based on decades of counterinsurgency and small wars experience. There were no dedicated publications to medical support for such operations, though medicine was used and thought paramount to success. Its

⁹⁷ Cameron, “Medical Service in Nicaragua,” pp. 52–6.

utility was understood and supported the broader concepts. These ideas consisted of host nation participation with long-term sustainable programs.⁹⁸

Post World War II

During World War II the U.S. Army had little occasion for fighting guerrillas. In the closing months of the war Germany's Adolf Hitler launched the "Werewolf" movement which harassed the Allies to a limited extent. This movement fizzled after Germany's surrender. Subsequently, the war had produced only a small cadre of guerrilla warfare practitioners, and counter-guerrilla warfare evaporated from the curriculums of wartime service schools. With the disappearance of most of the Army's small wars veterans, due to death or retirement, the Army emerged from World War II with virtually no expertise in the conduct of counterinsurgency save for the two manuals from 1940. Fortunately, the Army did maintain an expertise in two doctrinal areas: military law and military government.⁹⁹

In May of 1942 the Army established the School of Military Government in Charlottesville, Virginia. The move drew immediate criticism, with many people believing that such institutions presented a dangerous intrusion of the military into civilian affairs. The Army, for its part, was not enthusiastic either. Still, it maintained that as a practical matter it was the only agency with the training, organization, and personnel to fulfill this mission. Experience would ultimately validate this thinking.¹⁰⁰ This dictum recognized the value of courting the population through proper troop conduct and governmental/politico-social reforms. With new global responsibilities, and Cold War threats the Army found itself under greater pressure. This pressure was based on a complex blend of American, and Western political and moral thought disparagingly referred earlier in the chapter as "the white man's burden."¹⁰¹

⁹⁸ Birtle, *U.S. Army Counterinsurgency 1941*, p. 260.

⁹⁹ Birtle, *U.S. Army Counterinsurgency 1976*, pp. 9–11.

¹⁰⁰ *Ibid.*, pp. 13–14.

¹⁰¹ *Ibid.*, pp. 6–8.

U.S. Army counterinsurgency activities during the post-World War II period incorporated an array of both advisory and direct action campaigns. The direct action campaigns included the First and Second Indochina Wars (1945–1975), Korea (1945–1954, 1966–1969), Lebanon (1958), and the Dominican Republic (1965). Advisory actions included Iran (1942–1975), China (1945–1949), Philippines (1945–1955), Greece (1945–1949), Latin America (1960–1975), and Thailand (1962–1975).¹⁰²

During World War II the AMEDD was not used as an arm of foreign policy or an instrument to combat counterinsurgency, but this changed quickly after cessation of major combat operations.¹⁰³ After World War II, Congress passed a series of laws authorizing aid to other countries and establishing a civilian bureaucracy to administer any programs. This resulted in greater Army and DOD Medical participation in foreign assistance than ever before.¹⁰⁴ Although not counterinsurgency, post-World War II Japan deserves mentioning as a good example of medical civic action and its value in the nonconventional sense. General Douglas MacArthur instituted an aggressive medical stability and reconstruction program. He established public health centers and preventive medical stations that reached out to every corner of Japan. These programs went far in establishing goodwill between U.S. forces and the local population; greatly contributing to the recovery effort. Another example was the rehabilitation of the Japanese pharmaceutical and medical supply industries by the United States. Rehabilitation of

¹⁰² Birtle, *U.S. Army Counterinsurgency 1976*, pp. 6–8.

¹⁰³ Several examples of military aid as an instrument policy can be demonstrated from other countries. Leo Heiman in his work “Guerrilla Warfare: An Analysis,” in *Military Review* (July 1963) comments on such actions in Finland during World War II. Finnish Army physicians would conduct medical missions to Karelian Villages in the rural areas of bordering the Soviet Union. Providing medicine and food in exchange for information on Soviet Raiding parties proved to a valuable tool. Some accounts report villages traveling miles in deep snow to warn Finish outpost of pending attacks. Another example from World War II is the Japanese assistance to the Vietnamese people. David G. Marr cites in his work, *Vietnam 1945: The Quest for Power* (1995), that the Japanese Imperial Army opened two hospitals, one in Saigon and the other in Hanoi, bringing “gifts of medicine, food, and money from the [Japanese] home islands to ill or injured Vietnamese.”

¹⁰⁴ Gaines M. Foster, *The Demands of Humanity: Army Medical Disaster Relief* (Washington D.C.: Center of Military History, 1983), p. 146. Henceforth Foster, *The Demands of Humanity*.

this industry significantly aided in the stability of not just Japan but also South Korea. This was noted as an industry whose rebirth was critical in both countries' survival.¹⁰⁵

In the late 1940s, with the majority of physicians having left the Korean peninsula after World War II, the U.S. military began an aggressive medical training campaign and infrastructure rebuilding in South Korea to stabilize this fledgling democracy. These programs began training Korean medical personnel alongside U.S. Army Medical Units on the peninsula. In 1949, with the assistance of U.S. military medical personnel, a Korean Military Medical School was opened. This was followed by the establishment of the Korean Army Medical Field Service School. This school was staffed by instructors from the U.S. Army Medical Department in San Antonio, Texas. All these stability programs were established prior to the outbreak of hostilities in 1950 and aided in Korea's ability to support itself under catastrophic times. During the Korean War these services suffered, but unlike counterinsurgency conflicts, military medicine was not needed as a means to gain popular support as the local people viewed the enemy as invaders who needed to be expelled. U.S. involvement with medical aid and training continued after the war by means of a long-term sustainment training policy. This policy spanned a twenty-year period. Senior officers later commented that this relationship was only possible through these medical programs and not from any military achievement.¹⁰⁶

In May 1947, Congress passed an appropriation for unilateral aid to the people of war-torn Europe, primarily Yugoslavia. As expected, this compassion mingled with the need for diplomacy. Preservation and development of new democracies was the national strategy. Such principles left one policy maker to state, "every morsel of food that goes into Europe from

¹⁰⁵ Wilensky, *Military Medicine to Win Hearts and Minds*, pp. 21–22.

¹⁰⁶ *Ibid.*, pp. 21–22. The actual term *Civic Action* was coined by Ramon Magsayay during his campaign against the Huks in 1950–55 during the Huk insurrection of the Philippines. He conducted a "program of attraction" where every soldier had two duties: one, to act as an ambassador of goodwill, and second, to kill or capture Huks. The Economic Development Corps Program (EDCOR) grew from this during discussions Magsaysay had with his American advisor, LTC Edward Lansdale. The end-state was the surrender of more Huks than were killed during the campaign. Wilensky, *Military Medicine to Win Hearts and Minds*, p. 7. This is further cited in Arthur M. Smith and Craig Llewellyn's work "Humanitarian Medical Assistance in U.S. Foreign Policy: Is there a Constructive Role for Military Medical Services?," *DISAM Journal*, Summer 1992, pp. 71–2.

American, every kernel, was another golden seed of diplomacy.”¹⁰⁷ Over the next twenty years the AMEDD was viewed as a diplomatic tool as the U.S. engaged international communism in the Cold War. American medicine was envisioned as a means of demonstrating the superiority of American democracy and building the strength of the free world. The idea was that Army medicine would help remove the sources of totalitarianism and thereby make a more secure world. Medicine had assumed a larger importance than ever.

For the next two decades this new form of “medical diplomacy” was used mostly in the arena of disaster relief. From 1946 to 1950 American planes delivered medicines and supplies to disaster areas in the Dominican Republic, Bolivia, Ecuador, and Mexico. In 1954 U.S. officials used this concept to assist Pakistan after major flooding. This was repeated in 1960 when humanitarian assistance personnel and supplies deployed to Chile after a devastating earthquake. All actions were documented with successes and set-backs. Other examples of aid were during earthquakes in Iran and Yugoslavia. These missions focused on large disaster relief packages of short duration with an end-state that was visible from the onset. Because of such successes, an “activist foreign policy” was adapted by the Kennedy administration in the early 1960s. Subsequently, in 1961 Congress passed a comprehensive foreign aid bill, one provision of which established a contingency fund to finance disaster relief and “other emergency measures.” That same year, the State Department created the Agency for International Development (AID) and assigned it responsibility for such coordination.¹⁰⁸

The U.S. was now firmly involved with the idea of humanitarian assistance. This started with the reconstruction efforts of post-World War II Japan and Europe. From this U.S. foreign policy makers ventured further into humanitarian programs in an attempt to support delicate democracies during times of need. This included natural disasters from across the globe. These programs met most of the measures of effectiveness. They put host nation administrations up

¹⁰⁷ Foster, *The Demands of Humanity*, p. 147.

¹⁰⁸ *Ibid.*, pp. 147–64.

front with a long-term commitment that had a unity of effort. Senior leaders like McArthur and Marshall had adequate resourcing though doctrine was never changing.

Even natural disaster assistance missions showed merit since such programs were of short duration with a set end-point that did not interfere with local government systems. Altruism was present but with such a limited time table no damage could be done with such an ideology. None of these actions were conflict related though, let alone a complex counterinsurgency.

Unfortunately such foreign aid policies would become the “square peg” used for the next decade in the “round hole” that was the Vietnam War.

CHAPTER 3

VIETNAM

Introduction

America was involved in Vietnam since World War II. The Office of Strategic Services (OSS) worked with the Viet Minh to rescue downed Allied flyers during the campaign for the Pacific. The leader of the Viet Minh, Nguyen Sinh Cung, better known as “Ho Chi Minh”, a French-educated communist and former advisor to the People’s Liberation Army of China, fought the Japanese throughout the war and after cessation of hostilities declared independence.¹⁰⁹ Reversing Roosevelt’s policy, President Harry Truman supported the return of French colonial rule due to ongoing Cold War pressures. The source of this reversal was escalating fears of Mao Tse-tung’s communist revolution on mainland China, and the growing threat from the Soviet Union. In 1950, the French requested American assistance in Indochina and President Truman obliged.¹¹⁰ French presence culminated with the defeat at Dien Bien Phu in May 1954, leading to the Geneva Conference of Indochina and subsequent Geneva Accord of the same year. The country was officially divided at the seventeenth parallel, with plans for reunification and elections in 1956.¹¹¹ These elections never took place due to fears from South Vietnam’s Prime Minister Ngo Dinh Diem that the elections would never be fair. Though true, this was a cover, as America realized that the Communist Party under Ho Chi Minh would win. Eisenhower made the decision to support the South Vietnamese Prime Minister, and pledged both military and economic aid. Elements of the Viet Minh then began movement back to the north to join their colleagues and form the National Liberation Front, often called the Viet Cong (VC). Founded in 1960, and exploiting nationalist sentiments, this was the umbrella organization for insurgent

¹⁰⁹ Sophie Quinn-Judge, *Ho Chi Minh: The Missing Years* (University of California Press, 2002).

¹¹⁰ Jeremi Suri, *Power and Protest: Global Revolution and the Rising Détente* (Boston: Harvard University Press, 2005), p. 135. Henceforth Suri, *Power and Protest*.

¹¹¹ The country was already divided after World War II, with the British occupying the south and the Chinese in the north before the French returned.

groups opposing Diem's government. It received support, both economic and military, from North Vietnam, China, and the Soviet Union.¹¹²

The year 1960 was also the year that formal U.S. civil affairs and counterinsurgency operations began. American military forces under the Military Assistance Advisory Group Vietnam (MAAGV) grew throughout 1961. Despite recommendations from American ambassador, Henry Cabot Lodge Jr., Secretary of Defense Robert McNamara continued to increase American troop strength to over 4,000 by the beginning of 1962. Lodge feared that even the insertion of a small number of combat forces would lead to "mission creep" that would result in the engagement of large American ground forces.¹¹³

Until 1965, President Robert F. Kennedy kept American troop strength below 25,000. Kennedy worried about America becoming the new colonial force and "bleed as the French did." This dictum changed though with the decisive defeat of the Army of the Republic of Vietnam (ARVN) by Viet Cong forces in the January 1963 Battle of Ap Bac. This proved that VC guerrilla forces could defeat a multi-battalion conventional South Vietnamese force. After Kennedy's assassination, and a rapid succession of coups and regime changes, President Lyndon Johnson decided to increase U.S. military aid. Retrospectively this commitment gave the South Vietnamese government a sense of dependency and a belief in the permanence of U.S. assistance. Soon thereafter in 1965, Operation ROLLING THUNDER started the first bombing campaign against North Vietnam. That same year U.S. Marines arrived in Da Nang, followed by the U.S. Army; the war was squarely on American shoulders.¹¹⁴

Earlier, in September 1961, Congress established the United States Agency for International Development (USAID) under the State Department for the development of health care systems in third world countries. This left the military in a unique position as the supporting

¹¹² Suri, *Power and Protest*, pp. 137–138.

¹¹³ Frances Fitz-Gerald, *Fire in the Lake* (New York: Random House, 1972), p. 330.

¹¹⁴ Wilensky, *Military Medicine to Win Hearts and Minds*, pp. 13–16.

organization for the State Department.¹¹⁵ These programs, originally organized into the Provincial Health Assistance Program (PHAP), incorporated the majority of the USAID resources for public health development. USAID worked closely with the South Vietnamese Ministry of Health, and Social Welfare and Refugees program. Its main objective was to train and develop a South Vietnamese medical infrastructure which was considered one of the worst in the world; the premise being that the South Vietnamese, rather than the U.S., should render all care to the people. This venture included multinational civilian physicians, nurses and medical technicians. These first groups arrived in 1962.¹¹⁶ Unfortunately, as the conflict progressed the military gradually dominated and controlled these activities.

Civic (or civilian) medical assistance began with the mass evacuation and medical care of the over 450,000 French-speaking Vietnamese Catholics from North Vietnam to the south following the Geneva Accords in 1954. This marked the first American civic medical assistance action in support of South Vietnam.¹¹⁷ Ironically, the first American service member killed in the Vietnam conflict was a medic on 22 December 1961, SPC4 James T. Davis. At war's end in 1973, twenty-one American military physicians were killed in Southeast Asia.¹¹⁸

By 1973, when all U.S. forces withdrew from South Vietnam, multiple programs had American military physicians, nurses, and medics providing care to host nation civilians. These programs, based on ideas of altruism, were supplanted with U.S. governmental policy goals. Almost 700,000 civilians were treated in 1963, reaching an annual peak of over ten million by 1967.¹¹⁹ At war's end an estimated 40 million encounters occurred between American providers

¹¹⁵ ElRay Jenkins, "Medical Civic Action Programs (MEDCAPS) and Medical Readiness Training Exercises (MEDRETES) as Instruments of Foreign Policy," *U.S. Army War College*, (1998): pp. 3–5. Henceforth Jenkins, "Medical Civic Action Programs."

¹¹⁶ Wilensky, *Military Medicine to Win Hearts and Minds*, p. 51.

¹¹⁷ James T. Fisher, *Dr. America: The Lives of Thomas A. Dooley 1927–1961* (Amherst: University of Massachusetts Press, 1997).

¹¹⁸ Wilensky, *Military Medicine to Win Hearts and Minds*, p. 9.

¹¹⁹ *Ibid.*, p. 145.

and the Vietnamese populace.¹²⁰ To U.S. policy makers these direct patient care activities were not a medical effort, but rather a psychological aid in combating the VC insurgency.

Unfortunately, this was not conveyed to the altruistically minded providers implementing these activities. In the eyes of senior leaders this was a vehicle to establish contact with the local populace. Though buildings, bridges, roads, and schools could be destroyed by insurgents it was impossible to destroy medical care already rendered.¹²¹ Such programs set the stage for an investigation on U.S. direct patient care in a counterinsurgency.

Medical Civic Action Program (MEDCAP) I & Special Forces

The first initial attempt at medical civic action programs (MEDCAPs) occurred simultaneously by both U.S. Army Conventional and Special Forces.¹²² Conceived in November 1962 and under the control of MAAGV, the MEDCAP program was implemented two months later in January of 1963. Considered by MAAGV to be a political and psychological tool, this was a nationwide program to establish a spirit of mutual respect and cooperation between the Vietnamese armed forces and the civilian population. U.S. forces supported an element of this purpose. The objective was to convince the local populace in the rural areas that the South Vietnam government was vested in their wellbeing.¹²³ Put another way this program was to create a bond between the government in Saigon and their rural population. Any American participation was supposed to be temporary and only until the Vietnamese proved capable of continuing on their own.¹²⁴ The medical need for Vietnam was apparent. Vietnam had no national health system as of 1960. South Vietnam had only 1,400 physicians nationwide with

¹²⁰ Robert J. Wilensky, "Medical Civic Action Program in Vietnam: Success or Failure?" *Military Medicine*, (September, 2001), p. 1. This should not be confused with Dr. Wilensky's text, *Military Medicine to Win Hearts and Minds: Aid to Civilians in the Vietnam War*. The larger text is cited repetitively as Wilensky, *Military Medicine to Win Hearts and Minds*.

¹²¹ Wilensky, *Military Medicine to Win Hearts and Minds*, pp. 102–4.

¹²² Though the Special Forces civic actions were considered outside the formal conventional Army, both organizations utilized the Medical Civic Action Program (MEDCAP I). Because of this their outcomes are historically assessed collectively.

¹²³ Wilensky, *Military Medicine to Win Hearts and Minds*, p. 53.

¹²⁴ Jenkins, "Medical Civic Action Programs," p. 9. Citation from Jeffrey Greenhut Ph.D. in his work "Medical Civic Action in Low Intensity Conflict: The Vietnam Experience," paper presented at the 40th Annual Civil Affairs Association Conference, (June 4–6, 1987), Capitol Hilton, Washington. D.C.

approximately 1,000 of them in military service. This left only 400 physicians available to care for the some sixteen million citizens.¹²⁵

Legitimacy

To promote host nation legitimacy these programs attempted to build confidence between the government and the local populace. This confidence had to start with security. One of the advantages of the U.S. military providing these programs was that it had the resources and delivery systems to provide such security. This was particularly evident in the remote and rural areas of the country. No sustainable civic action program was possible without security.

Special Forces teams especially, though small and underfunded, understood this need for legitimacy and that local acceptance was critical. There were some 4,600 practitioners of Chinese traditional medicine, as well as local sorcerers and healers, among the population. These individuals provided most of the health care in the country; westerners needed to respect these cultural practices and traditions to gain local confidence. They knew that these rural healers were essential to their success and chose to work with them and not around them. Termed “credit sharing,” this proved to be an effective tool to not only treat the local population but win the confidence of the elders. For instance, a Special Forces team working in the Central Highlands built a well for a local village. It was well constructed and away from sources of contamination. The well pump, however, continued to break for unknown reasons. The team eventually learned that the old well was under the control of local Buddhist monks, which required a fee when used. Since not consulted or included in the contracting of the new well, the monks lost face, as well as income, within the community. With this issue identified, and the monks given control of the well, the pump worked appropriately without further repairs.¹²⁶

¹²⁵ John W. DePauw and George A. Luz, *Winning the Peace: The Strategic Implications of Military Civic Action* (Greenwood Publishing Group, 1992), pp. 140–142. Henceforth DePauw and Luz, *Winning the Peace*.

¹²⁶ Karl A. Zerner, “Cultural Considerations in COIN,” *Medical Aspects of COIN*, (Office of the Surgeon General & John F. Kennedy Center for Special Warfare: April 1964), p. 101.

Continuity

Continuity was also critical for host nation infrastructure progression and eventual self-sustainment. Unfortunately, the French never planned for Vietnamese self-government, so there was no infrastructure available with which to work. Senior American planners identified early that any evolution toward a modern medical system would require aggressive changes in the economy, infrastructure, culture and medical education system. Due to this, the primary difficulty was the near-complete lack of sanitation services, and primary/preventive care. This proved to be the most significant health risk for the local population because in the absence of a waste management system, the country was constantly under the threat of endemic diseases. So the goal quickly became the development of public health programs that the Saigon government could implement in rural areas and to educate village health workers.¹²⁷ Even with limited funding, these initial elements were long-term self-sustaining programs.

One example was the use of simple tools like soap and the emphasis of sanitation practices. Special Forces Medical Sergeant, Staff Sergeant Scott Herbert, in his after action report from 1964, commented on the use of soap in their program. This utilized the large distribution of soap, which the detachment trained the local population to use. At that time the only medicine the detachment had, in significant supply, was soap, so they established a “soap economy” with the Special Forces team paying workers with this as a form of currency. Eventually the villagers began bartering and trading with bars of soap, which everyone was now using to good effect.¹²⁸ The difficulty with these missions was that when a Special Forces detachment rotated home or a MEDCAP team return to home station, since these initial groups

¹²⁷ Wilensky, *Military Medicine to Win Hearts and Minds*, pp. 28–30.

¹²⁸ *Ibid.*, p. 35. Originally cited from Scott S. Herbert, MHIA, AMEDDS Oral History Collection, Box 13, File 228–01.

where sent out on temporary duty not to exceed 150 days, their medical programs effectively ceased.¹²⁹ So continuity was attempted but never achieved with inconsistent follow up visits.

Unity of Effort

Integration and synchronization efforts were problematic as these early programs and activities developed into a quagmire of *ad hoc* organizations and funding. Some programs were U.S. military only, some U.S. military in conjunction with the South Vietnamese military, and some U.S. military with American civilian assistance. All were under autonomous control that answered directly to its own Washington headquarters. No clear lines of communications were established, and funding came from multiple resources via the Ministry of Health, the South Vietnamese military, the U.S. military, and USAID. These programs overlapped in both responsibility and in geographic areas.¹³⁰ CORDS would attempt to fix this problem and is discussed later in the chapter.

Doctrine

The U.S. strategic guidance for Vietnam had deep roots. Shortly before leaving office, President Eisenhower sent Lieutenant Colonel Edward Lansdale, a pioneer in U.S. military special operations, to meet secretly with the Central Intelligence Agency (CIA) station chief in Vietnam. He presented his findings to President Kennedy later in 1961. Lansdale recommended a concentration of strategic military civic action programs to gain the support of the population.¹³¹ Taken to heart, by 1962 Washington planners formally drafted guidance addressing counterinsurgency civil support. This became National Security Action Memorandum (NSAM) 124 which established a new interagency group to coordinate the “subterranean war.” This organization was to ensure maximum effectiveness and synchronize counterinsurgency

¹²⁹ The medical teams that the Department of the Army provided were 127 members divided into 29 teams and assigned to different ARVN divisions or corps. These initial groups were sent on temporary duty from Japan and Okinawa for a period not exceed 150 days. This would change however with the introduction of U.S. combat forces in 1965. There was a short-lived program called the Volunteer Physicians for Vietnam Program. The American Medical Association (AMA) conducted 60, 90, or 120 day tours in country. Unfortunately this program could not be sustained, especially as hostilities escalated. Excellent work was noted with only limited long-term impact.

¹³⁰ Wilensky, *Military Medicine to Win Hearts and Minds*, p. 44.

¹³¹ *Ibid.*, p. 122. LTC Lansdale would later advance to the rank of Major General in the USAF and was known as a pioneer in U.S. military special operations doctrine development.

operations throughout the world and especially Vietnam.¹³² Unfortunately this program was “top down” driven from the White House and imposed on the military, which had no involvement in its development or the concepts behind it. The medical portion of this focused solely on sanitation needs as this had the greatest effect on the population as a whole.¹³³ Special Forces were the first to implement this new guidance. These units noted some benefits from the new program, if only on an anecdotal level. Special Forces operators on the ground commented that these programs were the most significant and fruitful of all the civic actions conducted. After action reports cited these programs as producing the “biggest successes” during the early years of the conflict, winning communist sympathizers over to the South Vietnamese government.¹³⁴

Intelligence

During the early years, Special Forces programs emphasized the use of medical care for intelligence collecting, whereas future programs did not. Special Forces considered their medic as their “most valuable anti-guerilla asset.”¹³⁵ These civic actions allowed Special Forces medics to learn about the health conditions and medical problems of the enemy by looking at the kinds of medicine they were trying to acquire from the local villagers. On occasion Special Forces detachments would put a “tail” on suspected Viet Cong personnel and follow them to a drop-off man waiting outside the village. On occasion operatives from the CIA accompanied these missions. Special Forces teams used money at times to pay informants who were training as medics. Lieutenant Colonel Gerald Foy, 5th Special Forces Group Surgeon felt these medical programs were of little medical benefit but useful for intelligence collecting. Noted only in conjunction with these Special Forces programs, these techniques were not utilized with later

¹³² Lawrence Freedman, *Kennedy's Wars: Berlin, Cuba, Laos and Vietnam* (New York: Oxford University Press, 2000), pp. 289–290.

¹³³ Raymond H. Bishop Jr., “Medical Support of Stability Operations: A Vietnam Case Study,” Military History Institute Archives (MHIA), Carlisle Barrack, PA (18 February 1969), p. 5.

¹³⁴ Wilensky, *Military Medicine to Win Hearts and Minds*, p. 37.

¹³⁵ *Ibid.*, pp. 32–3. Original citation from COL Clyde R. Russell, CDR 7th SFG (A).

conventional activities. Still, at the end of the day these Special Forces missions produced only sporadic intelligence that was only local in nature.¹³⁶

Resourcing

With most money going to combat advisory operations, funding had been tight and resourcing minimal, with expenditure for 1964 totaling only \$583,091 through Special Forces funds and USAID (approximately \$4 million today).¹³⁷ Despite these financial limitations, the MEDCAP program made progress, even with fifty-four medical spaces eliminated from the program by 1964. A South Vietnamese take over was intended for June of 1964, based on the assumption that the Saigon's MEDCAP teams were ready to assume full ownership. U.S. involvement extended temporarily through the end of 1964, but as of January 1965, MEDCAP became a completely South Vietnamese program with U.S. personnel only functioning in an advisory role. By 1966, some eighty-six percent of all personnel operating in MEDCAP teams were Vietnamese and by June of 1967 this program became the full responsibility of the South Vietnamese Army. Thus the circle was complete. The U.S. was out of the MEDCAP business with overall guidance met. Though not what the U.S. would call a success, this was a completed program under total South Vietnamese control. The program had improved the image of the South Vietnamese Army in the eyes of the civilian population and trust was beginning to build among the general population. This program recognized early on that uniformed U.S. medical providers, treating local citizens, did not contribute to a successful counterinsurgency.¹³⁸

Medical Civic Action Program (MEDCAP) II

On March 8, 1965, 3,500 U.S. Marines began to arrive in South Vietnam. This marked the introduction of large numbers of American conventional forces into the war. This made numerous American military providers available to render medical care to the local populace.

¹³⁶ Wilensky, *Military Medicine to Win Hearts and Minds*, pp. 38–44.

¹³⁷ Samuel H. Williamson, "Six Ways to Compute the Relative Value of a U.S. Dollar Amount, 1774 to present," MeasuringWorth, 2008. Calculations provided through www.measuringworth.com via U.S. price index. Accessed September, 2008.

¹³⁸ Wilensky, *Military Medicine to Win Hearts and Minds*, pp. 54–5.

This new program became known as MEDCAP II. The purpose of this program was also to win the confidence of the local populace in areas where U.S. forces were located. These activities focused on direct patient care to the local villages, hamlets, and orphanages.¹³⁹ This was direct participation by American military units of battalion size and larger. MEDCAP II retained the original MEDCAP I objective of having the South Vietnamese system eventually assumed the complete burden of medical care.¹⁴⁰

Legitimacy

MEDCAP II was quite different from MEDCAP I in that it attempted to establish rapport between U.S. forces and the local people.¹⁴¹ MEDCAP II did not rely on Vietnamese governmental involvement or participation. This was a major departure from counterinsurgency principles of the past which based programs on host nation represented infrastructure development. MEDCAP II operated completely under the auspices of the Military Assistance Command Vietnam (MACV) instead of MAAGV. Interpreters were the only Vietnamese involved and it did not give the appearance of South Vietnamese ownership. This was a radical change from the initial MEDCAP I program which had U.S. advisors in the background while the Saigon government or Ministry of Health took all the credit.¹⁴² This discrepancy was further complicated by U.S. mentality and culture, as frequently American personnel could accomplish the same task quicker and more efficiently. Efficiency and speed were not the goals though.¹⁴³

¹³⁹ Jeffrey Greenhut, "Medical Civic Action in Low Intensity Conflict: The Vietnam Experience," *Winning the Peace: The Strategic Implications of Military Civic Action* (Greenwood publishing: 1992), pp. 143–4. Henceforth Greenhut, "Medical Civic Action in Low Intensity Conflict."

¹⁴⁰ Neel, *Medical Support of the U.S. Army in Vietnam 1965–1970*, pp. 165–6.

¹⁴¹ Wilensky, *Military Medicine to Win Hearts and Minds*, pp. 109–110.

¹⁴² One example to demonstrate this was from elements of the 25th Infantry Division. These units chose to see patients in their own aid station instead of venturing out to the hamlets that were deemed insecure, citing that inadequate care was worse than no care.

¹⁴³ One such example was the 1st Battery, 40th Artillery Regiment. This unit, in conjunction with local Vietnamese communities, constructed a village aid station which held weekly, regular scheduled clinics staffed by Vietnamese medical attendants and trainees. Continuity follow ups was encouraged and a subjective improvement was noted in the local health of the populace. Though no data was available for validation, a problem throughout all areas of operation (AO), security and total community outlook toward the GVN was viewed as positive. Later, as part of this continued development of the program, the abandoned French Hospital in Dong Ha was reconstructed the next year using supplies from U.S. donations. One year later, the unit was still supporting the clinic and hospital to include both inpatient and outpatient care. Such an example is rare though and was not the norm.

In the retrospective opinion of now Major General Edward Lansdale, these large U.S. units commonly stumbled over themselves and were “rarely effective.”¹⁴⁴

Continuity

What became evident was that lack of continuity hurt legitimacy. The ultimate success of civic actions depends on the permanence of improvements and that these improvements contribute to positive rapport between the host nation government and their people. Lieutenant Colonel Joseph R. Territo, programs officer in the MACV surgeon’s office, actually warned against this and the use of such “traveling circuses.” He stated that one-time MEDCAP missions accomplished nothing and were not “good medicine.” The MACV surgeon’s office recommended recurring activities with patient follow-up and stressed the importance of involving the local health care workers. This recommendation was ignored at the tactical command level. The resistance to follow-up missions deflected due to fears of attacks with subsequent visits. Such fears however were exaggerated and not historically supported.¹⁴⁵

Nonrecurring activities were worse than no civic actions at all. The belief was that any program that left some in a village untreated would create feelings of animosity. Wilensky took this further with the opinion that ending such activities, once started, will raise future expectations of the local populace only to be dashed when seen for what they are; short-term superficial programs. It became evident that MEDCAPs were a mixture of impatience and goodwill; becoming counterproductive to the goal of building confidence in the host nation and its infrastructure. Specifically MEDCAP II built expectations that could not be met after the U.S. withdrew. Many hamlets, communities and orphanages realized that their support would end as soon as the U.S. left the country; this created anxiety that was constant and palpable.¹⁴⁶

¹⁴⁴ Cecil Currey, *Edward Lansdale – The Unquiet American* (Boston: Houghton Mifflin, 1988), p. 280. Henceforth Currey, *The Unquiet American*.

¹⁴⁵ Wilensky, *Military Medicine to Win Hearts and Minds*, p. 86.

¹⁴⁶ *Ibid.*, pp. 110–12. Original citation from Edward B. Glick, “Military Civic Action: Thorny Art of the Peace Keepers,” *Army 17* (September 1967): p. 69.

These programs had another significant side effect. Due to cultural differences there was a tendency for South Vietnamese employees to allow U.S. personnel to do the work rather than establish their own services and infrastructure. This dependency was mirrored by commanders on the tactical side as well, and the more U.S. personnel did this the more dependent the South Vietnamese became.¹⁴⁷ Lansdale stated later, “We came in so powerfully as a people, as a nation so organized in management that we overwhelmed the problem. We continued to take the initiative away from the Vietnamese.”¹⁴⁸ During this conflict, like many others, the U.S. had forgotten which army and government was at issue.

A new supply system came about in July of 1967 to support these efforts logistically. Previously, medical supplies were furnished through the South Vietnam medical depot system, but difficulties with remoteness and coordination made this means of sustainment increasingly unmanageable. Under the new procedure, MEDCAP units requisitioned materiel directly through the regular U.S. Army supply system. By changing to the American sustainment system, supplies were easy to acquire, but this did nothing to address the intrinsic program that was the Vietnamese’s own infrastructure.¹⁴⁹

Unity of Effort

With the creation of USAID the premise of any military involvement in medical assistance was that it would be integrated and synchronized through civilian departments and the host nation. This unity of effort brings all participants into one integrated endeavor. Many State Department and non-governmental officials, however, believed that the DOD should not participate in such activities, as their basic foundation and mission is contrary to such endeavors. Critics held that both government and private civilian organizations were capable and structured to do this mission.¹⁵⁰ The fundamental counter to this was the problem of security. This was

¹⁴⁷ Wilensky, *Military Medicine to Win Hearts and Minds*, p. 92.

¹⁴⁸ Currey, *The Unquiet American*, p. 302.

¹⁴⁹ Neel, *Medical Support of the U.S. Army in Vietnam 1965–1970*, pp. 165–6.

¹⁵⁰ Wilensky, *Military Medicine to Win Hearts and Minds*, p. 125.

paramount and the cornerstone of any counterinsurgency or civic action. In Vietnam, like many other conflicts, the civilian programs were incapable of providing such capabilities internally and lack the funds to facilitate. Security was the major obstacle to the issue of legitimacy and continuity. Both sides tried to build on this with the Viet Cong controlling the villages and hamlets at night, and the Saigon government controlling them during the day. This was a security vacuum that left the local population unstable as Saigon and U.S. soldiers withdrew to their firebases and safe houses at night. Secretary of State Henry Kissinger stated it well when he said that there were two conditions that needed to be met. First, security provided by the government, and a political and institutional link established between the villages and Saigon. Neither of these conditions were accomplished.¹⁵¹

Duplication in services and inefficiencies quickly became apparent with rivalries generated between the military services and USAID.¹⁵² Although these programs were under the command and control of MACV, conflicts soon arose between the U.S. Embassy in Saigon, USAID, and MACV. With no synchronization or unity of effort, medical treatment teams would show up at the same village or hamlet. One example of this was when five different U.S. civic action programs occurred in the same village on the same day. This proved not only a lack of unity of effort but also an absence of unity of command with MACV only in charge on paper. On most occasions there was no coordination with local ministry of health officials. Visits were usually unannounced to avoid attacks. There was no coordination with the local dispensary or hospital and no Vietnamese medical providers participated in the majority of these activities.¹⁵³

Navy Captain Arthur M. Smith and Colonel Craig Llewellyn commented on this in their work, "Humanitarian Medical Assistance In U.S. Foreign Policy: Is there a Constructive Role for Military Medical Services?" They noted these as "cosmetic" efforts which amounted to little

¹⁵¹ Wilensky, *Military Medicine to Win Hearts and Minds*, pp. 8–9.

¹⁵² H.R. McMaster, *Dereliction of Duty: Lyndon Johnson, Robert McNamara, The Joint Chiefs of Staff, and the Lies that Led to Vietnam* (New York: Harper Collins, 1997).

¹⁵³ Wilensky, *Military Medicine to Win Hearts and Minds*, pp. 56–7.

more than a “hit-or-miss” uncoordinated activity. They concluded, in their final analysis that these programs did more harm than good in the long run.¹⁵⁴

Another problem was the Vietnamese government’s cavalier attitude toward civic action as a whole. Vietnamese troops appeared unwilling to commit full support to these civic actions. One reason was evident; most ARVN soldiers and their families lived in worse conditions than the people they were supposed to support. This created situations of looting, theft, embezzlement, and rape. One peasant put this into these words, “Why are the American soldiers so good to us while our own government and soldiers do nothing for us?”¹⁵⁵ Compare this to the VC and NVA forces, whose strict guidance did not permit such atrocities. This is not to say that VC and NVA forces did not commit such acts, but their routine conduct was intended to win over the peasant population and not alienate them.¹⁵⁶

In 1966 Ambassador William Porter established the Office of Civil Operations (OCO) to address these discrepancies in unity of effort, especially at the interagency level. This placed civilian advisors under unified representation at both the provincial and military regional levels. This organization never took hold though, as it was a voluntary program for USAID and other interagency departments. General William Westmoreland, MACV Commanding General, cited later that Porter “had an impossible job and wasn’t staffed to do it.” Fearing that the OCO could not fulfill its mission, Westmoreland stepped in to facilitate interface between the MACV and OCO. This set the stage for the eventual movement of authority over to the MACV and the establishment of the Civil Operations Revolutionary Support Development organization (CORDS) under the direction of Brigadier General William Knowlton. President Johnson later signed the National Security Action Memo creating CORDS in 1967 which integrated some 1,200 civilians under MACV command. The goal of this new organization was the improvement

¹⁵⁴ Smith & Llewellyn, “Humanitarian Medical Assistance In U.S. Foreign Policy,” p. 73.

¹⁵⁵ Hoyt R. Livingston and Francis M. Watson Jr., “Civic Action: Purpose and Pitfalls,” *Military Review* 47 (December 1967), p. 25.

¹⁵⁶ Wilensky, *Military Medicine to Win Hearts and Minds*, p. 115.

of synchronization and security across operational lines.¹⁵⁷ CORDS incorporated teams of specialists from the State Department, Department of Defense, CIA, and Department of Agriculture. They believed that military oversight would increase security and allow forward progress. Unfortunately, this created a situation where civilians were rating career officers, causing animosity and many officers to avoid such assignments.¹⁵⁸

One noted success was the establishment of the National Institute of Public Health in Saigon. Under CORDS, this improved public health services. The institute put the government in Saigon in direct authority of the program with American personnel limited to advisors only. Unfortunately, the nation-building potential of such civic action programs never received the attention that they deserved. Westmoreland later said there was no real change at the ground level. This was felt due to the limited scope or resources of the program. In addition, officials at both the senior tactical and medical level commented on the lack of objective data or criteria to evaluate these programs.¹⁵⁹

Doctrine

U.S. planners developed guidance for MEDCAP II using three basic assumptions. One, bored, underutilized medical professionals must be kept busy. Two, Americans have a basic altruistic desire to help those less fortunate. Three, provide humanitarian assistance. They thought poverty stricken third world communities, caught in the middle of a counterinsurgency, might come over to the government's side due to the care they receive.¹⁶⁰ Whether assumptions one or two were viable rationales for strategic guidance and doctrine is questionable.

¹⁵⁷ Wilensky, *Military Medicine to Win Hearts and Minds*, pp. 44–5. Original citation from FONECON between GEN Wheeler and GEN Westmoreland, 31 December 1969, NA, RG 319, Box 24, Folder: Close Hold Communications, April–December 1969, Folder 444.

¹⁵⁸ *Ibid.*, pp. 46–7.

¹⁵⁹ *Ibid.*, pp. 107–17.

¹⁶⁰ Greenhut, “Medical Civic Action in Low Intensity Conflict,” p. 145. Medical commanders felt MEDCAP II had the advantage of keeping bored and underutilized medical personnel busy. Since casualties were generally low, with periods of surges in trauma, medical systems needed to be robust to handle large amounts of potential casualties. Most professionals were draftees and without equanimity to the discomforts of Southeast Asia this was considered a morale issue. The thinking was MEDCAPs gave providers purpose during periods of low operational tempo.

Lieutenant Colonel Don Bruss stated in his work, “We were dealing with an unpopular war, and MEDCAPS provided the perfect setting to show the good we could do for a people engulfed in conflict.”¹⁶¹ This was not a sentiment shared by all and on many occasions there was a discrepancy between the evaluation of the combatant commanders and the medical community. Physicians and medical providers often felt pressure to conduct clinics that they perceived were inefficient and uncoordinated but would “look good” for command reporting. This was evident when missions were compared to unit reporting. Commanders spoke enthusiastically about these missions while providers criticized them. Commanders inevitably emphasized the importance of these activities, unaware of the opinions of the medical staff under their command.¹⁶²

Physicians participating in such activities shared a uniformed agreement that these single-day drop in visits were of no medical value. Many providers made observations such as, “I am convinced that fly-by-night MEDCAPs, without the approval and support of the local Vietnamese health officials, do more than harm than good to the U.S. Army and the Republic of Vietnam.” Another said, “I think that most of us who were doing MEDCAPs realized after ten to fifteen of them, or probably realized after one of them, that this was not a very productive long range program.” Other comments referred to this program as of limited value medically but good propaganda; likened to “medical show business.” One poignant evaluation was from Dr. David Rioch, Director, Division of Neuropsychiatry, Walter Reed Army Institute of Research after a visit to Vietnam. He said that the MEDCAP program was no more than a “traveling medicine show.” He went on to state that, “Although such activities collect large numbers of villagers, the procedure appears to confirm the peasant’s belief in magic merely with the statement that Western magic is more powerful than local magic. Such a procedure may win an election, but in the long run it is truly dangerous and represents an inexcusable prostitution of medical

¹⁶¹ Jenkins, “Medial Civic Action Programs,” pp. 8–9. Cited from Don Bruss, “The Emerging Role of US Military in Low-Intensity Conflicts,” *Low Intensity Conflict and Modern Technology*, 1985, p. 229.

¹⁶² Wilensky, *Military Medicine to Win Hearts and Minds*, p. 81.

facilities.”¹⁶³ Unfortunately, providers were not asked if they wanted to conduct activities, they were told.

The operational guidance and informal doctrine for this program was regrettably in line and consistent with Secretary of Defense Robert S. McNamara’s system of evaluating the entire war. That is, the more patients seen, the more medications dispensed, the more supplies distributed, and money requested was seen as a function of success.¹⁶⁴ Staff officers and planners were delighted at the statistics: 914,000 treatments to Vietnamese civilians in 1963 alone; nearly three million treatments the following year at a cost of only twenty-two cents per treatment.¹⁶⁵ They equated high numbers with progress and each unit commander felt he needed to surpass his predecessor to maximize his evaluations.¹⁶⁶ This form of evaluation drove informal doctrine and theatre guidance.

One problem noted with using the AMEDD as a tool for this guidance was that such civic actions possess the greatest benefit in the pre-insurgent phase. Once the insurgency began these assets were devoted to the support of conventional forces and battlefield casualties, thus diverting resources away from the people and missions that had a permanent effect on the stability of the host nation. What became critical was recognizing if such a conflict was truly a “limited war.” American commanders did not realize that after the Tet offensive of 1968 the Viet Cong were no longer a fighting force. At that point, Vietnam was no longer a counterinsurgency.

A change in attitude and command climate was also noted at the senior level. In 1964, Westmoreland felt that this conflict could be won at the village and hamlet level, where the battle was waged for the “hearts and minds.” This opinion changed after the 1965 Battle of Ia Drang, when the strategy changed to focus on main force confrontations and attrition. This evolution

¹⁶³ Wilensky, *Military Medicine to Win Hearts and Minds*, pp. 91–4.

¹⁶⁴ *Ibid.*, p. 102.

¹⁶⁵ Jenkins, “Medical Civic Action Programs,” pp. 10–11.

¹⁶⁶ Wilensky, *Military Medicine to Win Hearts and Minds*, p. 102.

continued and by 1967 Westmoreland voiced doubts of the effectiveness of these programs. He also noted that the majority of the people in rural areas appeared apathetic.¹⁶⁷

Resourcing

Resourcing was difficult to supervise. During the early years of American involvement all actions were conducted under the MAAGV. Often these programs were conducted with only minimal resources. In 1965, however, President Johnson allocated seven million dollars to the new MEDCAP II program. This was a considerable increase from MEDCAP I and equivalent to fifty million American dollars in today's economy.¹⁶⁸ Unfortunately, due to the bureaucratic approval process for such money, many missions were replaced with *ad hoc* ones using the medical supplies at hand. This practice distorted any real accounting of such activities and made accurate expenditures of the program difficult to report or justify. USAID, MAAGV, MACV, Department of the Army (DA), and DOD estimated expenditures for civilian aid at \$350,000,000 for the period 1963 to 1973 (approximately \$1.9 billion today). This included all programs to include MEDCAP I, MEDCAP II, MILPHAP, and CAP. These figures were only an approximation as no unity of accountability existed.¹⁶⁹

Equipment was another problem. Despite the significant increases in resourcing and money, no concerted effort was placed on modernization or standardization of Vietnamese medical equipment. Most being a mixture of old, refurbished French equipment and a hodgepodge of modern donations from other countries. No maintenance was addressed during fielding either. This frustration was compounded by hospital facilities that dated from the late 1800s with little to no power, sewage management, or running water.¹⁷⁰

¹⁶⁷ Wilensky, *Military Medicine to Win Hearts and Minds*, pp. 105–7.

¹⁶⁸ *Ibid.*, p. 55. Calculations provided through www.measuringworth.com via U.S. price index. Accessed September, 2008. [see earlier use/change]

¹⁶⁹ *Ibid.*, p. 113.

¹⁷⁰ *Ibid.*, p. 53.

Intelligence

Colonel ElRay Jenkins, in his study of medical care for civil populations at the U.S. Army War College, noted that these programs could be used for medical intelligence gathering; stating that such programs could play a role in counterinsurgency operations.¹⁷¹ By collecting information on the prevalence of common medical conditions, units could get a good picture of the general health of the indigenous population and that of local enemy forces. This included vitamin deficiencies, intestinal disorders and dermatological problems related to poor hygiene and sanitation.

In 1941, the first U.S. medical intelligence unit was established. This unit, originally under the control of the U.S. Army Medical Department's Preventive Medicine Division, was tasked organized by the early 1950s into its own separate entity by the office of the Surgeon General, and renamed the Medical Intelligence and Information Agency (MIIA). Eventually this was taken out of the AMEDD, becoming a part of the Defense Intelligence Agency (DIA) in 1961.¹⁷²

There are two types of medical intelligence: *friendly forces medical intelligence*, whose function is to collect data on health problems where service members are operating to further force protection;¹⁷³ and *tactical medical intelligence*, reviewed to assess the physical and mental condition of enemy forces in the area. This primarily consists of interrogating prisoners of war (POW), looking for evidence of disease or malnutrition. In addition, captured medical supplies and equipment are useful to gain insight on enemy logistical and sustainment capabilities.

MEDCAPs offered an avenue to study the general health of the local communities. For example, the finding of a certain strain of malaria that is endemic to North Vietnam indicated an increased presence of North Vietnamese Army elements in the area and foretold of possible

¹⁷¹ Jenkins, "Medical Civic Action Programs," pp. 49–50.

¹⁷² Defense Intelligence Agency, <http://www.dia.mil/history> (accessed September 2008). Medical intelligence was first proposed by a Russian named Leodardov in 1931 and later recognized by the U.S. Army in 1933. Cited by Wilensky, *Military Medicine to Win Hearts and Minds*, p. 118.

¹⁷³ Peter B. Cramblet, "U.S. Medical Imperatives for Low Intensity Conflict," U.S. Army War College (Carlisle Barracks, PA: 1991), pp. 13–5.

attacks or pending enemy offensive operations. Dr. Wilensky, in his work on MEDCAPs from Vietnam, cited historical intelligence summaries from the 25th Infantry Division from 1966 to 1968. Captured medical supplies and enemy hospitals were discovered in multiple tunnel complexes. These summaries cataloged the permanence of such facilities and documented inpatient stays of up to six months. The documentation of wounds was also important in evaluating the effectiveness of munitions and weapons platforms.¹⁷⁴

Another form of intelligence was operational and not medical in nature. Its use was to counter or react to enemy forces. An example of this was the volunteering of information by indigenous personnel on the location of enemy mines, booby traps or pending attacks. A good example of this also came from the 25th Infantry Division where children led soldiers to seventy-two separate booby traps and mines. One S-2 officer cited another example of this while in a local community which was initially hostile towards their presence. He noted that the community became cooperative after seeing the positive outcomes of the MEDCAP program. The villagers volunteered information on the locations of mines and booby traps. The caveat to this success however was having units remain in one location for a significant period.¹⁷⁵ Successes like this were limited though since permanence was not emphasized.

Historically any operational intelligence collected dealt with the locations and movements of small local VC units, potential ambushes, or booby traps. No strategic intelligence was noted. Unfortunately these medical civic activities decreased as enemy activity increased. For instance, during the Tet Offensive of 1968, all MEDCAP activities essentially stopped with most units offering no assistance to the civilian population during or immediately after the offensive.¹⁷⁶ So right when intelligence gathering seemed the most critical, the American means of collection stopped. So the question is, if this was such an important vehicle for intelligence

¹⁷⁴ Wilensky, *Military Medicine to Win Hearts and Minds*, pp. 119–20.

¹⁷⁵ *Ibid.*, pp. 118–20.

¹⁷⁶ *Ibid.*, pp. 80–1.

gathering, then why was it halted at a time when it was most critical for countermeasures and stability operations?

Ethics

When evaluated, one criterion was purely humanitarian, that is, an altruistic motivation. This was the need to help people because it is the right thing to do. The overall consensus at the time was such programs were altruistically successful. It was only after the war did opinions change.

In this case, there was some general health improvement with a monthly average of 17,686 Vietnamese immunized from 1 December 1967 to 31 March 1968 alone. There was a monthly average of 188,441 civilians receiving outpatient treatment from this program in the same period. By 1970, the MEDCAP II program alone treated an average of 150,000 to 225,000 outpatients per month. This was care that these people would not receive if not for MEDCAP personnel. The dental program, often termed “DENTCAP” alleviated dental defects of the Vietnamese people by well-meaning dental officers and enlisted technicians. During the 1967–68 periods previously mentioned, dental treatments under the program averaged approximately 15,000 per month.¹⁷⁷ Veterinary military personnel participated in the MEDCAP program also with equally gratifying results.¹⁷⁸

Unfortunately the health care assessments and evaluations of such programs were subjective with no merited weight. Often these missions reported evaluations by means of only biased adjectives like, local villagers accepted the medical team with great “enthusiasm” or “much exuberance.” These impressions were often matched with number of patients treated and given as a final report with no evidence to support their claims and no objective improvements in

¹⁷⁷ Spurgeon Neel, *Medical Support of the U.S. Army in Vietnam 1965–1970* (Washington, D.C.: Department of the Army, 1991), pp. 165–6. Henceforth Neel, *Medical Support of the U.S. Army in Vietnam 1965–1970*.

¹⁷⁸ In a country predominantly rural and agrarian as Vietnam, veterinary activities were of great importance. U.S. Army veterinary personnel provided much aid in swine husbandry and animal disease control as early as 1966. Sometimes called VETCAP, these missions treated sick and wounded animals, vaccinated livestock, and provided guidance in the care of swine and cattle. A rabies control project was emphasized and in 1967 alone, a total of 21,391 animals in civilian communities were immunized against rabies, and 2,254 farm animals were treated for various diseases.

population health or treatment outcomes. In a war where progress was measured, from the Secretary of Defense down to the battalion level, by numbers of enemy killed, it became easy for command to view these medical civic action programs through a similar lens.¹⁷⁹

The numbers used to evaluate these programs had no commentary on whether these activities were delivering quality care or if the surrounding population was benefitted. Reporting was questionable at best with numbers being rounded up to support inflated agendas. These large numbers often were generated by including vaccination programs where hundreds to thousands were seen just to receive an immunization shot. There was no other evaluation of the program. Number of patients seen and amount of medication dispensed served as the only means of evaluation with no attempt at measuring efficacy. Medications were frequently sold on the black market instead of taken as directed. As most of the problems were due to poor hygiene, inadequate sanitation, and communicable processes, the treatments prescribed routinely lead to re-infection.¹⁸⁰

Generalizations abound in after action reports (AARs) with no substantial conclusions produced. One such example which highlights this was AARs from the 58th Medical Battalion in 1968. The reported number of “local nationals” treated also included those people that worked on base. Though treating these employees was good altruistically, it did nothing for the surrounding community. The 58th reporting ranged from 2,200 in March to 6,900 in April for a year total of “approximately” 40,000.¹⁸¹

Another example was the 9th Infantry Division. They reported a total of 15,500 patients seen during formal MEDCAP missions. They went on to cite additional “informal” MEDCAPs that were performed in different areas. No numbers given for such activities with no discussion on the difference between “formal” and “informal” missions. The report only concluded that all

¹⁷⁹ Wilensky, *Military Medicine to Win Hearts and Minds*, pp. 59–61.

¹⁸⁰ *Ibid.*, pp. 58–9.

¹⁸¹ Accounts are taken from divisional oral histories and archived AARs that were accumulated from the 9th and 25th Infantry Divisions during rotations in Vietnam as cited in Dr. Wilensky’s text pp. 82–3.

programs contributed “significantly” to the pacification program without citing any basis for this conclusion. These examples go on and on from unit to unit with no real conclusion or legitimate end-state, neither medically nor militarily. Due to the lack of any diagnostic equipment or radiological support, the treatments during these missions were limited to short-term strategies rather than long-term programs. The majority of the patients seen suffered from chronic diseases that were not managed with a single visit. Still, these missions were lauded by commanders as a valuable tool.¹⁸²

These ethical issues became evident. Article One of the First Geneva Convention states that medical care in war/conflict must be provided in a “nondiscriminatory” and non-coercive fashion.¹⁸³ Over the past century, with the emergence of counterinsurgency as a stated form of operation, political responsibilities, military activities, and humanitarian actions were more interdependent than ever. This placed a premium on careful design of any given intervention and Vietnam was no different. U.S. military physicians were eager to help and felt the need to “jump in” to any crisis as a moral imperative. This was apparent in Vietnam. However, this moral energy cannot be single-minded and should accommodate both idealism and the realism of the situation. Addressing morality explicitly without a clear “bigger picture” can be dangerous. Jonathan Moore discussed the “theme of constraint” when developing medical assistance actions like MEDCAPs. The emphasis was not to do too much or go too fast in fear of a program collapse from overweighed ambitions. Moore advocated that priority should include the capability to withhold or withdraw assistance when such interventions are doing more harm than good.¹⁸⁴

¹⁸² Wilensky, *Military Medicine to Win Hearts and Minds*, pp. 82–3.

¹⁸³ James W. Kirkpatrick, “Military Medicine in Low Intensity Conflict: A Strategic Analysis,” MHIA, student paper (April 1991), p. 16.

¹⁸⁴ Jonathan Moore, *Hard Choices* (Rowman & Littlefield Publisher, 1998), pp. 6–7. Henceforth Moore, *Hard Choices*.

Historically, humanitarian assistance, whether wartime, peacekeeping or natural disaster, are grounded on three basic principles: understand the realities of the situation as fully as possible; comprehend the interrelationships of the various groups and the standard of care that is realistically achieved; and all elements of any intervention need to be integrated and synchronized together for maximum benefit. For U.S. policy this includes interagency, non-governmental agencies and all host nation assets. Pragmatism is the underlying rule which requires compromise and flexibility.¹⁸⁵

For most societies in history, war was central, characterizing politics as the “continuation of war by other means.” Clausewitz’s dictum, now reversed in most developed and western societies, is alive and well in other areas of the world.¹⁸⁶ So like any civil-military operation these missions needed to be viewed as a complex situation and treated as a whole; addressing the root cause, and not superficial gains. Whether these objectives are local, regional, or global, these societies have to be given the chance to take care of themselves rather than being under permanent control of an interdicting force. As Ernst Haas poignantly put it, “ambitious multilateral coercion is wrong” because “to promise the unattainable is immoral.”¹⁸⁷ Vietnam, and specifically the MEDCAP II program, demonstrated this well.

At fault, was the gap needed to be overcome in respect to the “ends, ways, and means.” Stated another way, any organization had to address the intended end-state, the guidance to implement, and the necessary resourcing needed to achieve the desired effect. This gap should have been closed by lower the expectations or by escalating the means (resources). So as the ends were prioritized but not understood to change, then this initial commitment became an incentive to persevere or get more involved. This was what Haas termed the “slippery slope” and

¹⁸⁵ Moore, *Hard Choices*, pp. 6–7.

¹⁸⁶ Carl von Clausewitz, *On War*, ed. Michael Howard and Peter Paret, (Princeton, NJ: Princeton University Press, 1976).

¹⁸⁷ Ernest Haas, “Beware the Slippery Slope: Notes towards the Definition of Justifiable Intervention.” *Emerging Norms of Justified Intervention*, ed. Laura Reed and Carl Kaysen (Cambridge, MA: American Academy of Arts and Sciences: 1993).

many have coined “mission creep.” This was demonstrated by Vietnam as the conflict escalated. MEDCAP, like any other assistance program, was both immoral and ineffective when officers did not plan for failure.¹⁸⁸ The French philosopher Paul Ricoeur referenced this in comparison of the amount of suffering alleviated to the amount of suffering inflicted in the process.¹⁸⁹ With most MEDCAP providers feeling this inability to treat anything but the most simple and superficial medical problems adequately, this parody became obvious among the medical community, with both patients and providers feeling unsatisfied. This led many physicians to object due to ethical grounds.

One military physician, Richard A. Falk, concluded that physicians should refuse to participate in such civic actions and objected to any use of military medicine to aid civilians on both medical and ethical grounds. This would lead to his eventual general discharge.¹⁹⁰ Barry S. Levy and Victor W. Sidel in their work *War and Public Health* imply that any use of medical care to contribute to the war effort is immoral. These authors cite the trial and court-martial of Howard Levy, M.D. He was an Army dermatologist who refused to train Special Forces medics under the argument that political use of medicine by military forces jeopardized the entire tradition of the noncombatant status of medicine.¹⁹¹

Combined Action Platoon (CAP)

Other civic medical programs conducted during the conflict deserve mention as a comparison to the MEDCAP programs. On such program is the U.S. Marine Corps’ Combined Action Platoon (CAP). This program, more analogous to the earlier Special Forces activities, was based on the limited combat power the Marine Corps had available. Marine Corps’ area of operation was vast with limited tactical troop strength to affect a change. The program’s mission

¹⁸⁸ Pierre Hassner, “From War & Peace to Violence and Intervention,” *Hard Choices, Moral Dilemmas in Humanitarian Intervention*, ed. Jonathan Moore (Rowman & Littlefield Publisher, 1998), p. 22.

¹⁸⁹ Paul Ricoeur, *Academie Universelle des cultures: Intervenir? Droits de la personne et raisons d’Etat*. Paris: Grasset, 1994.

¹⁹⁰ Richard A. Falk, Gabriel Kolko, and Robert J. Lifton, eds., *Crimes of War* (New York: Vintage Books, Random House, 1971), pp. 434–8.

¹⁹¹ Barry S. Levy and Victor W. Sidel, *War and Public Health* (New York: Oxford University Press, 1997), p. 286.

attempted to make up for this lack of combat power. The Marines used this concept in previous small wars such as Haiti (1915-1934), Nicaragua (1926-1933) and Santo Domingo (1916-1922).¹⁹² The program began in 1965 under the direction of Major General Lewis W. Walt, commander of 3rd Marine Amphibious Force (MAF). This evolved as the war escalated. Each platoon was task organized with fourteen Marines, one medic (U.S. Navy Corpsman), and thirty-five Popular Force (PF) Vietnamese personnel. The PF were local paramilitary from the hamlet or village. Physicians and additional Corpsman augmented these elements as needed.¹⁹³

Legitimacy & Continuity

To build the legitimacy and continuity needed for such a mission the CAP teams lived, trained, ate and fought with their local Vietnamese hamlet. Each platoon had a Marine infantry battalion in direct support to provide fires if necessary. These Marine platoons tried to avoid single day clinics and chose a more focused approach; education and medical training. CAPs and their supporting elements established fixed medical training programs with the emphasis on governmental medical training. They established the Rural Health Workers Education Program which concentrated on training Vietnamese cadre to care for the local community. This included a “train the trainer” concept. This allowed for the growth needed for sustainment. They understood that medical education was essential and to do this a system needed to emphasize continuity and permanence. Every CAP corpsman trained his Vietnamese counterpart. Though the PF medic candidate had little to no education, his U.S. Navy corpsman counterpart had eighteen months to train him to a reasonable standard. This Navy corpsman walked a tight rope between instructing and maintaining “face” for his local candidate. Any public action to correct an error could be considered a reprehensible insult and breach of confidence. So the Navy corpsman had to instruct and encourage active participation, all the while keeping himself distant from any position of authority. Understanding these cultural practices and traditions were

¹⁹² Musicant, *The Banana Wars*, p. 137–40.

¹⁹³ Peter Brush, *Civic Action: The Marine Corps Experience in Vietnam, Part I* (University of Kentucky, 1994), accessed at <http://www.capmarine.com/cap>.

paramount. There was no separation between the Marines and Vietnamese PF. All team members were volunteers with at least one speaking Vietnamese.¹⁹⁴

Their prolonged presence within these rural areas and villages created a feeling of security and unity with the local populace. This trust came from the local belief that the American presence was long-term. Eventually this trust translated to information on insurgency activity and locations. This produced even better security and moved these areas under stable South Vietnamese control.¹⁹⁵ The success achieved was from the bonds that were established between the Marines and their local community. Their long term continuous presence worked well to establish a long term security program and platform for infrastructure building. Multi-tour veterans of this program noted a significant positive change in the local population. One such corpsman, HM2 Jerome McCart, said that during his first tour it was difficult to get the locals to see the medical team, but that on his second tour the local people sought out the medical team for treatment. Another such account that describes the entire CAP concept well was from the medical staff of Alpha Medical Company, 3rd Medical Battalion, 3rd Marine Division in Da Nang. These providers lectured on a regular basis at Hue` University, making rounds at the Provincial Hospital. In this case, medical knowledge and collaboration worked both ways with the Dean of the Medical School, a tropical disease expert, helping the American physicians with cases and treatment challenges.¹⁹⁶

Unity of Effort

Unity of effort was apparent. The CAP program in conjunction with its South Vietnamese partners formed the Joint Action Company. Considered a logical extension of the CAP, these integrated units would provide communication and synchronization with other non-governmental organizations. The local farmers and hamlet leadership viewed this as a Saigon vetted program which significantly aided in any anti-American sentiments. Resourcing was

¹⁹⁴ Wilensky, *Military Medicine to Win Hearts and Minds*, pp. 62–4.

¹⁹⁵ *Ibid.*, p. 42.

¹⁹⁶ *Ibid.*, pp. 62–3.

adequate also and at its peak this program had 114 platoons throughout the Marines operational area (I Corps). From March 1965 on, this medical civic action program was the highest priority civic mission of the Marine Corps. This began to show in the development of intelligence, with platoons and their activities beginning to move the “fence sitters” in the community over to the South Vietnamese side. The local community began to see the VC as oppressive, especially with tax collecting and food requisitioning. This eventually set the conditions for intelligence collecting. Now people began seeking out the legitimate South Vietnamese forces and warning them about pending attacks and booby traps. This led to more successful combat operations and continued security improvements.¹⁹⁷

Doctrine

As a source of strategic guidance and informal doctrine these platoons had a significant effect. The primary mission of every CAP was security to the local population. They quickly noted that the local people were neither friend nor enemy. They were just individuals seeking survival and their support was more important than winning any battle. Marine Corps guidance was in sharp contrast however to Army guidance. At the onset, Marines emphasized the idea of straining the insurgents out of the population. Their philosophy was well in keeping with Mao Tse-tung’s concept of guerrilla warfare – the “people are like the water and the army is like the fish.”¹⁹⁸ From November 1967 to January 1968, fifty percent of all enemy initiated contact in I Corps was done against CAP units. These platoons quickly became the primary target of VC insurgents, indicating their vulnerability, but also their visibility as a legitimate and measureable threat. Unfortunately the Army insisted on a more aggressive course of action which focused on offensive combat operations, pushing pacification programs into secondary status. Such civic action programs were time consuming and time was a precious commodity to a linear orientated Cold War Army. So what the communist insurgents put first, the U.S. Army put second, and

¹⁹⁷ Wilensky, *Military Medicine to Win Hearts and Minds*, pp. 61–4.

¹⁹⁸ Mao Tse-tung, *On Guerrilla Warfare*, trans. Samuel B. Griffith II (University of Illinois Press, 1961), p. 8.

while the Marines felt strongly regarding their approach to counterinsurgency, the issue never boiled to a show stopper. Westmoreland instead, using specific orders and programs, kept the Marine Corps along Army operational lines. Despite this, Marine leaders continued to defend their program. They stated that large ground offensives were only effective if supported by stability operations that advanced the South Vietnam government. Secretary of the Navy, John Chafee, later commented in 1971 that no village or hamlet with a CAP presence ever came under VC control.¹⁹⁹

These rural based direct patient care programs like MEDCAP I, MEDCAP II, and CAP were not the only activities conducted. One program did focus exclusively on training and education to the South Vietnamese civilian healthcare system.

Military Provincial Health Program (MILPHAP)

A separate program was needed to improve the hospital care and to upgrade Vietnamese hospital base medicine. This required the augmentation of civilian medical services and systems. The increase in U.S. military medical resources which accompanied the buildup of U.S. combat troops in 1965 permitted such an expansion to improve the health of Vietnamese civilians. In conjunction with the buildup, the Secretary of Defense directed the services to prepare a program to aid the civilian health infrastructure in Vietnam. Given the title Military Provincial Hospital Augmentation Program (MILPHAP), this program employed U.S. Army military medical teams as direct trainers to civilian facilities. USAID and MACV developed the program jointly and was later renamed the Military Provincial Health Program but kept the same acronym.²⁰⁰ It had two objectives: increase services available to civilians, and relieve pain and suffering; and portray a positive image of the U.S. and its armed forces.²⁰¹ The three-phased program established fifteen man military training teams. Phase I sought to train staff and develop provincial hospitals. Phase

¹⁹⁹ Peter Brush, *Civic Action: The Marine Corps Experience in Vietnam, Part II* (University of Kentucky, 1994), accessed at <http://www.capmarine.com/cap>.

²⁰⁰ Neel, *Medical Support of the U.S. Army in Vietnam 1965–1970*, p. 163.

²⁰¹ Wilensky, *Military Medicine to Win Hearts and Minds*, p. 66.

II shifted emphasis to district health centers and public health measures. Phase III planned for withdrawal of the U.S. teams as the services integrated down to the villages and hamlets.²⁰² This program had the best chance to make a long-term difference in the South Vietnamese medical infrastructure and was oriented toward education and training. This had the potential to develop permanent benefits.

Legitimacy & Continuity

This potential was no more evident than in the aspect of legitimacy and continuity. The MILPHAP teams stressed the fact that they were Americans though their goal was to promote the Saigon government and prove its interest in the civilian welfare. These teams, sent to both provincial hospitals and district dispensaries, provided continuity in medical care at permanent civilian medical facilities. By augmenting Vietnamese medical staff, MILPHAP teams, assisted in clinical, medical, and surgical care. They provided a permanent source of support for the host nation's healthcare infrastructure. As part of this these teams established an evacuation program for patients to those Vietnamese and American medical installations which had a greater capacity for extended treatment.²⁰³ This program was hospital based and training only. By regulation these teams were prohibited from engaging in MEDCAP type clinics. They worked directly with the province medical chief (local civilian administrator). The province medical chief remained in control and had veto power over any decision or activity.²⁰⁴

These training programs saw many challenges. One was the training of nurses. In 1970 alone, more than 700 Vietnamese nurses received training in hospitals supported by MILPHAP teams. Through this training, the program advanced toward its primary goal, the development of an independent, self-sustaining health service program in Vietnam.²⁰⁵ Unfortunately, U.S. nursing instructors met with increasing resistance to even the most simple of sterile techniques for

²⁰² Peter B. Cramblet, "U.S. Medical Imperatives for Low Intensity Conflict," Military History Institute and Archives, U.S. Army War College Paper, (1991), p. 11. Henceforth Cramblet, "U.S. Medical Imperatives for Low Intensity Conflict."

²⁰³ Neel, *Medical Support of the U.S. Army in Vietnam 1965-1970*, p. 164.

²⁰⁴ Wilensky, *Military Medicine to Win Hearts and Minds*, pp. 67-8.

²⁰⁵ Neel, *Medical Support of the U.S. Army in Vietnam 1965-1970*, p. 165.

wound management. Frequently Vietnamese nurses would use one forceps on ten to twelve patients. When nursing advisors would attempt to educate their Vietnamese students on such issues, the students would disappear leaving the American instructors to manage the patient. Eventually the more work the American advisors did the less the Vietnamese students were willing do for themselves. These tendencies persisted with American trainers doing more than their Vietnamese counterparts. American advisors feared that as soon as they would leave, the Vietnamese trainees would go back to their old ways. The parallel to other aspects of war fighting is remarkable.²⁰⁶

Another training aspect was the education training, and improvement of hospital surgical capabilities. MILPHAP deployed surgical teams to local hospitals in this endeavor. This allowed for the training of hospital staff and physicians in the latest surgical techniques and procedures.²⁰⁷

With some success seen in the improvement of inpatient and surgical capabilities by the Vietnamese hospital based system, these training efforts were then directed at preventive medicine and public health by 1971. At that time, the main effort focused on rural health development and public health. Successes hindered though by a bureaucratic and corrupt South Vietnamese infrastructure. Outcomes were considered “spotty” at best with inadequate support from the Vietnamese government. These problems constantly plagued MILPHAP despite repeated pressures from USAID.²⁰⁸

The issue was to what criteria to hold this program to. Thomas Dooley, who was criticized for running third world hospitals not up to Western standards, stated “In America doctors run 20th century hospitals. In Asia I run a 19th century hospital. Upon my departure the hospital may drop to the 18th century. This is fine, because previously the tribes in the high valleys lived, medically speaking, in the 15th century.” Dooley went further, “if you compare this

²⁰⁶ Wilensky, *Military Medicine to Win Hearts and Minds*, p. 31.

²⁰⁷ Raymond H. Bishop Jr., “Medical Support of Stability Operations: A Vietnam Case Study,” MHIA, Student Paper (18 February 1969), p. 27.

²⁰⁸ Wilensky, *Military Medicine to Win Hearts and Minds*, pp. 66–8.

to a modern American hospital, then yes it's very primitive, but if the level of care began in the dark ages and is brought forward several hundred years, your mission was worthwhile."²⁰⁹

When held to this standard, such training programs do have potential. So while MEDCAP II had only limited medical value, MILPHAP contributed significantly to the health of the Vietnamese people.²¹⁰ While this contribution was not to Western standards, it was definitely to a better standard. The real test would come with U.S. withdrawal in 1973. Would this program result in a real sustainment and improvement of the health care system? Unfortunately, no documentation of this program was noted after U.S. withdrawal in 1973.

Other organizations saw this program in a different light. USAID assessment of the MILPHAP program saw several flaws. One-year tours prevented adequate continuity, which required teams to constantly re-invent the wheel and re-develop the same program.²¹¹ South Vietnam had inadequate internal funds and limited personnel resources to implement these programs. Such programs were implemented before a thorough assessment was done on what the South Vietnamese government needed, and what they were capable and prepared to support. There was never a long-range health plan conveyed and synchronized with all parties. This led to an ineffective delivery of public health and preventive medicine measures to the majority of the population's rural communities. David Brown, five year Vietnam Veteran and assistant director of Public Health for the USAID mission, conveyed a final analysis. He stated that these programs should be regarded as a "failure as far as the average Vietnamese has been concerned."²¹²

²⁰⁹ James T. Fisher, *Dr. America: The Lives of Thomas A. Dooley 1927–1961* (Amherst: University of Massachusetts Press, 1997).

²¹⁰ Raymond H. Bishop Jr., "Medical Support of Stability Operations: A Vietnam Case Study," iii.

²¹¹ This has been demonstrated much earlier in counterinsurgency, "The Army realized that frequent rotations harmed its pacification efforts." Birtle, *U.S. Army Counterinsurgency and Contingency Operations Doctrine 1860–1941*, pp. 162–3.

²¹² Wilensky, *Military Medicine to Win Hearts and Minds*, p. 127. Quote and assessment obtained from David V. Brown, "Civilian Public Health Programs in Vietnam 1966–1970 – A Review," *Medical Survey Vietnam – 1970, USAID Medical Programs*.

Unity of Effort

President Johnson lauded this program as the “higher priority.” USAID maintained operational control though this program came under the direct management of the MACV Surgeon. This was in express objection of USAID, who desired overall civilian control of the program. The major debate, that if security was critical for mission success, then the military should have direct control and operational decision making.²¹³

In 1965, to help alleviate this tension, both sides agreed to establish a medical policy coordinating committee to plan and coordinate the growing number of medical training sites involved. Headed jointly by the Assistant Director for Public Health, USAID, and by the MACV Surgeon, the committee included the surgeons of the MACV component commands. Efforts to eliminate duplication in the administration of civilian health programs between USAID and MACV resulted in the establishment of the joint USMACV-AID working committees in 1968. The committees formulated joint plans for hospital construction, medical logistics, education and training, preventive medicine, and public health. By including military and civilian Vietnamese medical officials as members of the committees, senior planners laid a basis for the future assumption of responsibility for these programs to the Vietnamese themselves.²¹⁴

Unfortunately, this organizational structure meant that logistical sustainment came from multiple sources via USAID, forcing the program to deal with multiple bureaucracies. Another integration problem was the lack of continuity between teams. Originally intended as a system where teams replaced each other *in toto*, this soon degraded into a piecemeal replacement process. The final assessment as per integration and synchronization was that MILPHAP was poorly organized and referred as a “organizational nightmare” with the Commander of MACV, USAID, and the United States Overseas Mission (USOM) all sharing command and control.²¹⁵

²¹³ Wilensky, *Military Medicine to Win Hearts and Minds*, p. 66.

²¹⁴ Neel, *Medical Support of the U.S. Army in Vietnam 1965–1970*, p. 165.

²¹⁵ Wilensky, *Military Medicine to Win Hearts and Minds*, pp. 68–9.

Resourcing

In reference to resourcing, there was always a duality that started when the first MILPHAP teams went into operation in November 1965. All medical supplies were funded by USAID and by 1967 there were twenty-two MILPHAP teams in Vietnam; eight Army, seven Air Force, and seven Navy. By this time, six teams functioned in provincial centers with the decision made to add fifteen additional teams to the program. Each team composed of three physicians, one medical administrative officer, and twelve enlisted technicians. A MILPHAP team was assigned to each Vietnamese provincial hospital where its work was under the supervision of the provincial chief of medicine.²¹⁶

The MILPHAP teams were reorganized in 1969 to make them more responsive to the requirements of the varying sizes of the medical installations to which they were assigned. The reorganization provided more surgeons and nurses with levels of skill appropriate to the medical facility in which they served. By the end of 1970, the program supported a total of thirty Vietnamese Ministry of Health hospitals, in addition to its work in district and smaller Vietnamese medical installations.²¹⁷

Unfortunately, these efforts and expenditures did not match the host nation. Dr. John H. Knowles, superintendent of Massachusetts General Hospital, as part of a survey team of American physicians with the MILPHAP program, noted that less than one percent of the Vietnamese budget was allocated toward health care. This was less than any other country, with or without conflicts. The consequences of this were apparent with local physicians, nurses and medical technicians earning more money as interpreters than they could work in their medical field.²¹⁸ This lack of Vietnamese commitment doomed the program from any sustainable future.

²¹⁶ Neel, *Medical Support of the U.S. Army in Vietnam 1965–1970*, pp. 163–4.

²¹⁷ *Ibid.*, pp. 163–4.

²¹⁸ Wilensky, *Military Medicine to Win Hearts and Minds*, pp. 31–2. Cited from Hendrick Smith, “More Health Aid for Saigon Urged,” *New York Times*, 22 September 1967, p. 3.

Doctrine

When the Office of the Surgeon General (OTSG) looked at MILPHAP as an instrument of strategic guidance and doctrine it assessed its abilities for nation building. It concluded that training programs, like MILPHAP, lie at the heart of any successful counterinsurgency agenda and was capable of making significant contributions to this effort. This was much different than addressing the question of U.S. directed patient care like MEDCAPs.²¹⁹

Ethics

Ethically this program posed problems. One was the training of possible enemy personnel. An example of this came at the end of a host nation medical training program. On graduation day two students did not show up. One of whom was the honor graduate. It was found later that both were VC and managed to sneak into the program.²²⁰ Another argument voiced about such activities was that these programs did not consider doctors as apolitical, but rather an instrument to promote a political agenda by treating civilians. Physicians, traditionally considered supporting of troops, were more and more used in a direct political role. Medicine became an extension of a larger strategic campaign.²²¹ This meant that political use of medicine can jeopardize the entire legality of the noncombatant status.²²²

Considered by senior medical advisors to be of medical value, the MILPHAP program was in sharp contrast to the direct patient care activities of the MEDCAP II program. Critics considered the MILPHAP program far superior to the single visit MEDCAPs, even though this program lacked publicity or extravagant numbers of patients seen.²²³ 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.²²⁴ Unfortunately, short tours, lack of continuity and use of young inexperienced providers limited this program's potential.

²¹⁹ Wilensky, *Military Medicine to Win Hearts and Minds*, p. 106.

²²⁰ *Ibid.*, p. 37.

²²¹ Howard Levy, "The Military Medicinemen," in John Ehrenreich, ed., *The Cultural Crisis of Modern Medicine* (New York: Monthly Review Press, 1978), pp. 287–300.

²²² Barry S. Levy and Victor W. Sidel, *War and Public Health* (New York: Oxford University Press, 1997), p. 286.

²²³ Wilensky, *Military Medicine to Win Hearts and Minds*, p. 96.

²²⁴ Cramblet, "U.S. Medical Imperatives for Low Intensity Conflict," p. 11.

Though the plan was solid, the implementation was faulted by these discrepancies and a lack of communication with local ministry of health personnel.²²⁵

In the end, MEDCAP II was a flawed experiment in the use of direct patient care by U.S. uniformed providers. Other programs, though not perfect had far better outcomes and did not contradict the time-tested principles of counterinsurgency. Ironically, this form of civic action went unchallenged in the decades after the Vietnam War and became the template for America's next great attempt at a counterinsurgency.

²²⁵ DePauw and Luz, *Winning the Peace* p. 152. Another program that was not addressed in this analysis but deserves comment is the Civilian War Casualty Program (CWCP). Established in March 1967 by President Johnson, with responsibility given to the U.S. Army, the program attempted to manage the thousands of civilian personnel that were often caught in the line of fire. As this program dealt with direct trauma care and not primary or preventive management of a population such activities were tabled for another debate.

CHAPTER 4

AFGHANISTAN

Introduction

“All roads lead to Rome” is an iconic phrase that refers to all paths or activities that lead to the center of things.²²⁶ Nowhere is this truer than central Asia, and specifically Afghanistan. Sitting astride the convergence of the major trading routes between the Indian subcontinent, Europe and East Asia, this region enticed conquerors throughout history. The most well known was Alexander the Great who conquered this area in 329 B.C. on his way to India.

After Alexander’s passing, the historic light over Afghanistan dimmed for the next thousand years until the spread of Islam.²²⁷ The Muslim influence in Afghanistan began in the 7th century with several short-lived Islamic dynasties; the most powerful of them being Mahmud of Ghazna in the 11th century. In the 18th century the Persian Nadir Shah extended his rule north of the Hindu Kush and after his death in 1747 his lieutenant, Ahmad Shah, an Afghan tribal leader, established a united state covering most of present-day Afghanistan. His dynasty, the Durrani, gave Afghans the name (Durrani) that they themselves frequently use. The reign of the Durrani line ended in 1818, with no predominant ruler emerging until Dost Muhammad became emir in 1826. During his rule, the status of Afghanistan became an international problem, as Britain and Russia contested for influence in central Asia. Aiming to control access to the northern approaches to India, the British tried to replace Dost Muhammad with a former, more subordinate, emir. This caused the First Afghan War in 1838 and ended with the annihilation of an entire British Expeditionary Force in 1842. With Russia acquiring more territory bordering on northern Afghanistan, the British continued to quarrel with Afghan successors leading to the Second Afghan War in 1878. In the following years Afghanistan's borders became more

²²⁶ E.D. Hirsch, Jr, Joseph F. Kett, and James Trefil, Eds. *The New Dictionary of Cultural Literacy*, Third Edition. . Houghton Mifflin Company, 2002.

²²⁷ Stephen Tanner, *Afghanistan: A Military History from Alexander the Great to the Fall of the Taliban* (Da Capo Press, 2002), p. 53. Henceforth Tanner, *Afghanistan*.

precisely defined through agreements reached with Russia in 1885, British India via the Durand Agreement in 1893, and Persia in 1905. The Anglo-Russian agreement of 1907 guaranteed the independence of Afghanistan, but under British influence. Despite British pressure, Afghanistan remained neutral during World War I. In 1919 King Amanullah, attempted to free himself from British influence. This culminated at the end of the Third Afghan War in 1919 with the signing of the Treaty of Rawalpindi on 8 August 1919. Amended on 22 November 1921, this gave Afghanistan full control over its foreign relations. Over the next fourteen years Afghanistan saw numerous attempts to modernize and multiple assassinations. This ended under King Muhammad Nadir Shah who ruled, after the assassination of his father in 1933, until 1973. Afghanistan was neutral in World War II and joined the United Nations in 1946.

During the Cold War, Afghanistan was neutral until the late 1970s, receiving aid from both the United States and the Soviet Union. In the early 1970s, the country was beset by serious economic problems, and particularly a severe long-term drought. With accusations of corruption and economic mishandling, a group of young military officers deposed King Nadir in July of 1973, proclaiming the Peoples Democratic Party of Afghanistan (PDPA). The king's cousin, Lieutenant General Sardar Muhammad Daud Khan, became president and prime minister but a group led by Noor Mohammed Taraki deposed Daud by 1978. On 1 May, Taraki declared himself prime minister and president of the newly formed Democratic Republic of Afghanistan (DRA). This new government instituted Marxist reforms and aligned the country closer to the Soviet Union. These reforms included controversial policies like freedom of religion, centralized land reform and women's rights. Though the majority of the people, including Kabul, were ambivalent to these new policies, the secular nature of the new government made it unpopular. Religious conservatives favored traditional Islamic law which contradicted the reforms. According to noted Afghan historian Larry P. Goodson, "These new reforms struck at the very heart of the socioeconomic structure of Afghanistan's rural society; indeed their sudden

nationwide introduction, with no preliminary pilot programs, suggests that this was their real purpose.”²²⁸

In September of 1979 Moscow summoned Taraki. His deputy Hafizullah Amin arrested and summarily executed him on return in a bid for power. With revolts and governmental breakdown beginning everywhere, it became increasingly apparent to Moscow that their new communist experiment was disintegrating. So in December of 1979, citing the 1978 Treaty of Friendship, the Soviet Union deployed troops into Afghanistan. Soviet special forces executed Amin, and the Kremlin replaced him with the Soviet-supported Babrak Karmal.²²⁹

As early as 1975, guerrilla opposition forces, popularly called *mujahedeen* or “Islamic warriors,” were active in much of the country, fighting both Soviet forces and the communist Afghan government. The country was devastated by the war which ended with a Soviet withdrawal in 1989. Although taking an enormous human and economic toll, the DRA remained in control after the departure of Soviet forces, but with the collapse of the Soviet Union and loss of communist economic aid, the DRA steadily lost ground to guerrilla forces. In early 1992, the guerrilla alliance captured Kabul and established a new government. The victorious guerrillas proved unable to unite the country’s various factions, dividing the land into independent zones, each with its own ruler or warlord. Beginning in late-1994 a militia of Pashtun Islamic fundamentalist students, the Taliban, emerged as an increasingly powerful force. By early 1996, the Taliban gained control of Afghanistan, capturing Kabul, and declared themselves the Islamic Emirate of Afghanistan. They imposed a particularly puritanical form of Islamic law in the two thirds of the country they controlled.

In August of 1998, as the Taliban appeared on the verge of taking over the whole country, U.S. President Bill Clinton ordered a cruise missile strike on a terrorist training complex

²²⁸ Tanner, *Afghanistan*, p. 231. Larry P. Goodson holds the Dwight D. Eisenhower Chair in National Security Studies at the U.S. Army War College. In 2004, he made two research trips to Afghanistan as the U.S. Central Command Fellow.

²²⁹ *Ibid.*, p. 233.

near Kabul. This complex was controlled by a new and growing organization called al-Qaeda. Saudi born al-Qaeda leader Osama Bin Laden ran this camp. Bin Laden, a rich construction company owner turned militant, was the mastermind of the 1998 bombings of the American embassies in Kenya and Tanzania.

In March of 1999, the Taliban and their major remaining foe, the Northern Alliance reached a United Nations-brokered peace agreement. The Northern Alliance was led by Ahmed Shah Massoud, an ethnic Tajik and former Mujahedeen leader. This peace was short-lived however, and fighting broke out again in July of the same year. By November the UN imposed economic sanctions on Afghanistan for their ties to al-Qaeda terrorist training camps and Afghani refusal to turn over Bin Laden. Though not recognized by the international community, the Taliban controlled some 90% of the country by 2000. The UN recognized President Burhanuddin Rabbani and the Northern Alliance as the legitimate ruling organization.

On 9 September 2001, Taliban suicide bombers posing as Arab journalists assassinated the Northern Alliance leader Massoud. Two days later, al-Qaeda attacked the World Trade Center in New York and the Pentagon in Washington, D.C., resulting in the deaths of over 3,000 American citizens. When the Taliban refused to extradite bin Laden, the U.S. launched attacks against the Taliban and al-Qaeda positions in October of 2001. The U.S. also provided financial aid and assistance to the Northern Alliance and other opposition groups. Assisted by U.S. air strikes, and Special Operations Forces (SOF), opposition elements of the Northern Alliance ousted the Taliban and al-Qaeda from Afghanistan's major urban areas by December 2001. Several thousand U.S. troops began entering the country to concentrate on the search for Bin Laden and senior Taliban leader Mullah Muhammad Omar.

In early December a pan-Afghan conference in Bonn, Germany, appointed Hamid Karzai, a Pashtun with ties to the former king, as the nation's interim leader. By January 2002, the Taliban and al-Qaeda were largely defeated, although most of their leaders and unknown

numbers of their forces remained at large in the rural country side and in the Pashtun controlled region of western Pakistan. Britain, Canada, and other NATO countries provided forces for various military, peacekeeping, and humanitarian operations. Many other nations also agreed to contribute humanitarian aid. The UN estimated that \$15 billion would be needed over the next ten years to rebuild Afghanistan.²³⁰

Rebuilding started with a new internationally-supported Afghan government—the Afghan Interim Authority (AIA) in December 2001. Following country wide elections in October 2004 the AIA became the new Islamic Republic of Afghanistan. This new government was assisted by significant U.S. and coalition support, that coalesced by May of 2003 in the creation of the International Security Assistance Force (ISAF). This force, provided primarily by NATO countries and the U.S., has remained in Afghanistan to affect the reconstruction process and eliminate remaining Taliban and al-Qaeda forces.²³¹

Cooperative Medical Assistance

By 2001, the health care infrastructure of Afghanistan was devastated by Taliban rule. Afghan public health statistics were among the lowest in the world and nearly seven years later it still ranks at the bottom.²³² Afghanistan remains one of the poorest countries on Earth despite massive amounts of international foreign aid and assistance. The numbers speak for themselves. As of 2007, Afghanistan still ranks 210 out of 221 countries for life expectancy with an average age of forty-three. Infant mortality per 1,000 live births is the third highest in the world at 165.²³³

From the onset of combat operations, Civil Affairs units deployed to support maneuver elements and assist with the task of reconstruction and stability. Initially all U.S. Army Civil Affairs and Psychological Operations Command (USACAPOC) assets, including medical

²³⁰ The preceding paragraphs offer a brief review of Afghanistan's history leading up to U.S. medical interventions. References include: Lester Grau's, *The Bear Went over the Mountain* and its sequel with Ali Ahmad Jalali, *The Other Side of the Mountain*.

²³¹ Department of the Army, "Legal Lessons Learned from Afghanistan and Iraq, Full Spectrum Operations," *Center for Law and Military Operations*, vol. II (2005): p. 5. Henceforth noted as CLAMO.

²³² Information Paper, *Public Health in Afghanistan*, (Combined Joint Task Force-82, Bagram, Afghanistan: 2007) p. 1. Henceforth cited as CJTF-82, *Public Health in Afghanistan*.

²³³ Statistical information obtained from UNICEF at <http://www.unicef.org>.

elements, were tasked organized into SOF. At the core of these Civil Affairs assets were the Provincial Reconstruction Teams (PRTs).²³⁴ Starting in 2003 these assignments were SOF-specific and Civil Affairs controlled all PRTs. In practice however both SOF and conventional forces utilized these assets. By 2005 though, Civil Affairs was no longer task organized to SOF and became primarily a conventional asset, being assigned to the Combined Joint Task Force (CJTF) in Bagram.²³⁵

To assist with the medical aspects of stability and reconstruction, Civil Affairs incorporated medical support via the Cooperative Medical Assistance (CMA) Cell. CMA was an umbrella term used to describe all medical civil-military operations. The CMA program, later re-termed Village Medical Outreach (VMO), incorporated many assets including veterinary services, traveling dental clinics, limited immunization administration, and also the traditional MEDCAP. Additionally, this cell conducted seminars at both veterinary and medical universities. They arranged for the donation of supplies and transport of medical equipment from international organizations to veterinary schools and hospitals. Other tasks included the collection of immunization and water purity data for the Ministry of Public Health and the Ministry of Agriculture, Irrigation and Livestock. The CMA program was deliberately developed as a broad organization which supported all aspects of medical civil military operations. Even during the later years of 2006–2007, the CMA cell still supported SOF with approximately half of

²³⁴ The Provincial Reconstruction Teams (PRTs) are a mixture of military and civilian personnel from U.S. and Coalition countries. They consist of sixty to one-hundred or more civilian and military specialists working to deliver aid and perform reconstruction projects as well as provide security for others who are involved with these activities. These units give reconstruction assistance and direction to infrastructure development.

²³⁵ Colonel Dalton Diamond, Combat Studies Institute, Command and General Staff College Oral History Collection, interviewed by author, 13 June 2008. COL Diamond is currently the United States Army Special Operations Command, Command Surgeon at Fort Bragg, North Carolina. He deployed to Afghanistan as the Coalition Joint Civil–Military Operations Task Force (CJCMOTF) Surgeon in 2003. During this time he oversaw the CMA program for Afghanistan. He later returned to Afghanistan in 2006 for another tour as director of the CMA program till 2007, working for CJTF–76, later renamed CJTF–82. He has the unique distinction of seeing the CMA program and MEDCAPs in Afghanistan at the both their inception and later during its reorganization. Henceforth noted as Diamond Interview, 13 June 2008.

their missions going to support elements of the Combined Joint Special Operations Task Force (CJSOTF).²³⁶

Medical Civic Action Program (MEDCAP)

The MEDCAP element, like its predecessor from Vietnam, involved doctors, physician assistants (PA), nurses, medics and health educators. These assets came from the CMA cell. The mission was usually a one to five day event, requested by the local maneuver commander. The unit would enter a village or area, and conduct a “come one-come all” clinic with usually 200 to 800 individuals being seen for a constellation of ailments; most being related to a lack of basic health services. This included everything from weakness from chronic malnutrition, headaches, gastrointestinal disorders and visual problems. Each individual, regardless of age, got approximately two minutes with a doctor, nurse or PA. The patient went home with a one week supply of medicine. This was usually a multivitamin, antacid, or over-the-counter pain reliever. During these “events” the cell’s veterinarian treated the local herd animals and the dentist, if present, performed dental treatments; almost exclusively tooth extractions.²³⁷

Unlike the Vietnam conflict, where multiple commands conducted several direct patient care programs, U.S. forces in Afghanistan used a single source for its MEDCAP program. Whether utilizing the CMA cell for personnel support or conducting their own clinical missions, units still vetted their actions through the CMA process to validate funding and resources. So like Vietnam, Afghanistan’s MEDCAPs will be evaluated within seven categories for measures of effectiveness--legitimacy, continuity, unity of effort, doctrine, resourcing, intelligence and ethics.

Legitimacy

According to senior CJTF medical planners if host nation medical representation was provided it was rare and usually in the form of the Afghanistan National Army providing outer security. Participation by local physicians, if identified, was rare and an afterthought. Any

²³⁶ Diamond Interview, 13 June 2008.

²³⁷ Ibid. If veterinary services were provided exclusively then the mission was termed a VETCAP and if dental procedures were available then it was a DENTCAP.

significant Afghan participation was almost exclusively through interpreters, which were usually U.S. hired and sometimes even U.S. citizens. To date, there are no Afghan CMA units or MEDCAP type programs operating in country. Unlike the MEDCAP I program of Vietnam, there was never an attempt to transition this capability to an Afghan-run mission. Such activities probably made the local health provider feel inferior also and looked down upon by the local populace. A CJTF-82 Surgeon's Cell analysis determined that many Afghans refused to seek medical attention from their own healthcare system. Instead local villages would wait on the next American clinic that never came. This problem extended to VETCAPs and DENTCAPs as well. This proved extremely counterproductive in building the people's trust and confidence in their own government which is vital to counterinsurgency operations. Many villagers just did without medical assistance, even critical assistance, until the next MEDCAP. Even though there may be a basic or comprehensive health clinic nearby, these people refused to patronize them.²³⁸

Due to this lack of confidence in their own system Afghan villagers walked past district hospitals to receive care from U.S. units. This was especially obvious when MEDCAPs were taken further out of context and actually placed as permanent structures on U.S. firebases. Some of these U.S. clinics were operated by local Afghan personnel at substantially higher wages than the Ministry of Public Health could offer. This created a competitive system and a loss to the local healthcare infrastructure.²³⁹

Even the types of drugs used jeopardized legitimacy. As a policy the CMA cell utilized American pharmaceuticals; the rationale being the efficacy and questionable safety of local medications. Locally procured medications were potency tested by ISAF personnel with three out of five having no potency whatsoever. These drugs came from China, Iran or Pakistan. The ISAF research also documented anecdotal evidence from western Afghanistan that drugs given to

²³⁸ Lieutenant Colonel (Retired) John Gordon, former director of CJ9, CJTF-82 from February 2007 through April 2008, e-mail message to author, July 6, 2008. Henceforth cited as Gordon, 2008.

²³⁹ Diamond Interview, 13 June, 2008.

children, especially cough syrup, contained ethylene glycol with some fatalities as a result. So the dilemma became, does one risk possible fatalities or issues with efficacy, or does one risk undermining Afghan confidence in their own system? This resulted in a “catch-22” with, as in the case of U.S. efforts in Vietnam, the local populace seeing their own system as inferior and American therapies as an exclusive right.²⁴⁰

Like MEDCAP II from Vietnam, another problem was with the method senior AMEDD and tactical commanders used to evaluate the utility of these missions; as with commanders of the past, “statistics ruled the day.”²⁴¹ Most missions were measured by the number of people or animals treated, so the higher the number, the better the outcome. Lieutenant Colonel David P. Ferris, CMA Senior Medical Operations planner, termed this “piñata medicine.” Where one hangs the piñata in the middle of the village and let the locals whack at it till it breaks, then everybody grabs what they can and runs away. Commanders and medical officers alike became infatuated with higher and higher numbers as a measure of success. The end product though was usually frustrated villagers, infuriated non-government organizations and irritated Ministry of Public Health personnel in Kabul.²⁴²

Leading AMEDD and Civil Affairs officers concurred that U.S. MEDCAPs in no way proved to have lasting effect on the legitimacy of the host nation’s medical infrastructure.²⁴³ Most concluded that until Afghans start helping Afghans a sense of dependence and entitlement would continue which historically has never benefitted a counterinsurgency. For this reason, the current CJTF in Afghanistan has reorganized the CMA cell and effectively ended MEDCAP

²⁴⁰ Diamond Interview, 13 June, 2008.

²⁴¹ Jenkins, “Medical Civic Action Programs,” p. 11.

²⁴² Lieutenant Colonel (Retired) David P. Ferris, Combat Studies Institute, Command and General Staff College Oral History Collection, interviewed by author, 13 June 2008. LTC (R) Ferris was senior medical planner, senior logistician and eventual commander of the Cooperative Medical Assistance (CMA) Cell, Operation Enduring Freedom, Bagram, Afghanistan. He commanded this element during its inception from 2003 to 2004 and again in 2006 to 2007 prior to its restructuring. Henceforth noted as Ferris Interview, 13 June 2008.

²⁴³ Diamond Interview, 13 June, 2008.

missions. If MEDCAP missions are done they are now on a much smaller scale and conducted by the local PRT in conjunction with a long-range plan.²⁴⁴

The Soviet occupation and how they viewed medicine in relation to counterinsurgency operations is worth examining in this section. The Soviet Union's occupation of Afghanistan used civil medical operations primarily for intelligence gathering. Nation building was a secondary task. The primary agency responsible for such actions was the Soviet military intelligence branch, the GRU²⁴⁵. This organization conducted numerous MEDCAPs throughout Afghanistan. All activities used local providers and incorporated local governmental leaders, and were similar to the propaganda teams of the South Vietnamese government during the Vietnam War. These units used doctors, dentists, veterinarians and musicians in a traveling "road show" concept to gain support for the Democratic Republic of Afghanistan. Its primary objective was actually intelligence gathering and deep intelligence team insertions.²⁴⁶

The DRA had similar Afghan teams that worked with the same objectives. Called "ideological action groups", they were special organizations that worked in rural villages. Each action was between one to ten days and included the same configuration of doctors, dentists, veterinarians, and propaganda specialist. These were similar to the U.S. MEDCAP I missions in Vietnam.²⁴⁷ These direct patient care activities were part of the overall Democratic Republic of Afghanistan's psychological operations effort. Preparation for a psychological operations "raid" was ideally ten days. During that period, they coordinated the effort between the participating agencies, and conducted reconnaissance on the target. The targets were usually the civilian populace but could also include the Mujahedeen. These psychological operations raids, planned

²⁴⁴ Ferris Interview, 2008.

²⁴⁵ Glavnoje Razvedyvatel'noje Upravlenie (GRU) or Main Intelligence Administration.

²⁴⁶ Lester W. Grau, interviewed by author, 3 June 2008. Lester W. Grau is the author of *The Bear Went over the Mountain* and its sequel with Ali Ahmad Jalali, *The Other Side of the Mountain*. Both works are historical and operational accounts of combat operations between Soviet/Afghan Forces and the Mujahedeen from 1979 to 1989. He is also a Russian linguist. Henceforth Grau Interview, 3 June 2008.

²⁴⁷ N.I. Pikov, *Views of Special Propaganda Activities of the Army of the Republic of Afghanistan* (Moscow: Institute of Military History of the USSR, 1990), p. 151.

in conjunction with a military operation, were usually conducted along major road networks; primarily between Mazar I Sharif-Andkhoy-Maimene, Kabul-Baghlan-Kunduz, and Kabul-Jalalabad-Asadabad.

One example of a psychological operations raid, conducted along the Kabul-Kunduz stretch of highway, lasted twenty-five days. It covered four provinces, seven villages, and seventy-eight hamlets. They conducted thirty-five meetings, 120 group visits and seventy-five individual visits. They gave thirty concerts, showed movies, and distributed 65,000 brochures and pamphlets. They treated over 3,000 medically, provided aid to 5,680 needy families or families of dead revolutionaries—and veterinarians treated over 3,000 animals.²⁴⁸ MEDCAPS like this also included local government organizations, local leaders, elders and mullahs.²⁴⁹

The Soviets did not use civil medical programs in their stability operations; improvement of medical infrastructure was not the goal. Still, upon complete Soviet withdrawal in 1989, the DRA remained stable, surviving several attacks and coups by Mujahedeen insurgents. It was only with the collapse of the Soviet Union and complete loss of outside aid did the government dissolve.²⁵⁰

Continuity

The CMA program started in 2003 and continued essentially unchanged till its restructuring in early 2008 by CJTF-Afghanistan. Originally a central PRT-supporting agent, this is superseded now with medical personnel assigned to each PRT.²⁵¹ The numbers of PRTs have increased considerably, from about six in 2003 to twelve in 2008 U.S., and numerous others under ISAF control. Now almost every province has at least one. The PRTs are now under regional commands, belonging to the maneuver commander, and not to a civil affairs task

²⁴⁸ Pikov, *Views of Special Propaganda*, p. 154–9.

²⁴⁹ Pikov, *Views of Special Propaganda*, p. 160–72.

²⁵⁰ Grau Interview, 3 June 2008.

²⁵¹ Diamond Interview, 13 June, 2008.

force.²⁵² Such efforts have produced some improvement. A USAID report from 2006 listed 539 new health clinics built with another 128 under construction. This included 7,575 new health care workers trained.²⁵³

Ferris noted these infrastructure changes from 2003 to 2007, including an improvement in pharmacy access and more primary clinics. Repairs on older clinics were observed with a significant increase in non-governmental charitable activities. The changes were slow but existent. Moreover, none of these changes were from MEDCAP missions, but facilitated through better security and public safety. Ferris concluded that safety and security allowed for other necessities. Through security the local populace now had extra time to work on their infrastructure and public systems. The end-state was more paved roads and more secure avenues to acquire essential materials.²⁵⁴

In early 2007 ISAF initiated a program throughout Afghanistan to “coach, teach and mentor” local healthcare providers. This was an attempt to move away from direct patient care. This program placed ISAF and U.S. providers with local doctors, nurses, and other medical personnel in a training relationship. Implemented at all levels, including the CMA cell and MEDCAP, this was described as a “noble effort” but considered unrealistic by providers unless significant support was brought to bear, with an equivalent clinical staff dedicated to such a program. Although this program continues, as of December 2008, there is no medical configuration to support this in theater and is considered an additional duty. Added to this is that high volume clinics, like MEDCAPs, are an unreasonable platform from which to train local providers. This made the legitimacy part of MEDCAPs more difficult given the inadequacy of training local healthcare providers while seeing hundreds of patients in one day.²⁵⁵

²⁵² Diamond Interview, 13 June, 2008.

²⁵³ CJTF-82, *Public Health in Afghanistan*, p. 3.

²⁵⁴ Ferris Interview, 13 June 2008.

²⁵⁵ Ibid.

The U.S. military is known for its ability to teach, but such a program proved unrealistic during MEDCAP operations. The difficulty lay in the ability to teach local providers clinical practices and complex diagnoses when even basic skills, such as taking vital signs, were ignored. The “coach, teach, mentor” program curriculum pushed complicated subjects like kidney dialysis, with the most basic skills being ignored or overlooked. At the operational level there was no plan developed and no clear guidance or specific tasks to put such a program in place. Some regarded this as a waste of time and forced down to the MEDCAP level from higher echelons. Many noted that no structured program existed to provide a long-term capability.²⁵⁶

To see long-term gain the parent unit had to keep up the relationship after the MEDCAP mission. The CMA cell did not have the ability to provide continuity of care to these areas. Even when continuity existed, if not with the right planning, it too was detrimental. One such example was a mission to Miri in South Ghazni recounted by LTC (R) David Ferris.²⁵⁷

Miri is in the south Ghazni area. It was Miri District Clinic in a really nice area and was one of the better clinics we saw. It was actually a compound with several buildings. They had an X-ray machine and a dentist. They had a lab as well. It was a pretty well-run place. The physicians were trained in Pakistan. There was even a women’s clinic. When we got done working with them, we asked if there was something else we could do for them and they asked for some training. They didn’t ask for money or drugs; they asked for training. So, we tried to get them back to Bagram for some training. I thought that fell right into the coach, teach and mentor idea pretty well, but it never went anywhere and nobody did anything with it. The U.S. Combat Support Hospital wasn’t interested in bringing them there, so it went right out the window. Well, six months later, in the middle of a combat operation, they decide to send us back to work with that same clinic again and do some teaching. They want teaching on emergency medicine procedures. They’ve already stated. Here’s the after-action review. What is it we’re supposed to teach them, with my physician assistant, my one physician and my vets? It actually did some damage to the relationship we had with the Norwegian Afghan Committee that was sponsoring that particular clinic. They didn’t think we should be going back to the same clinics, and for the same reasons I did: because we weren’t really providing anything; we were just there. We actually got rocketed three times on the second trip to that clinic and we had to leave.²⁵⁸

²⁵⁶ Ferris Interview, 13 June 2008.

²⁵⁷ Ibid.

²⁵⁸ Ibid.

Although results are anecdotal, Special Forces showed better longevity and continuity with MEDCAPs. These missions were small and limited to usually a single Special Forces Medical Sergeant who had the ability to conduct follow up visits. These missions, utilized more in the role of intelligence collecting and relationship-building, were not aimed at infrastructure development or sustainment of a host nation medical system.

Unfortunately, like other MEDCAP missions performed by conventional units, these lacked any proven beneficial effects. On some occasions such actions were even detrimental to the counterinsurgency campaign. One example was the case of the Asadabad firebase in the northeastern part of the country on the Pakistan border. By the fall of 2006, this firebase operated three host nation clinics seeing an average of 150 patients daily. This included a woman's/pediatric clinic, one men's clinic and another general-purpose clinic. The employees included four doctors, four nurses, three pharmacists, one dentist, two laboratory technicians, and seven ancillary staff. Management of these clinics fell to the Special Forces medic who was supervising twenty-one employees along with salaries, medical supplies, and all the usual personal problems that employees have. This was a taxing load to say the least on this Special Forces medic and complicated operational plans. Initially established as a means to collect intelligence, these facilities demonstrated "mission creep" and tactical planners recognized that such clinics were not sustainable and were a hindrance toward combat operations. Unfortunately, the current detachment did not know how the clinics started or how long they had been there. Ironically, the district hospital was one kilometer down the road which the local populace walked passed to receive care from the American clinics. Eventually phased out by late 2006, these facilities produced no actionable intelligence and did nothing for Afghan sustainment.²⁵⁹

One problem, cited by Colonel Dalton Diamond, United States Army Special Operations Command Surgeon and former CMA commander, was that gathering good statistics in

²⁵⁹ After action report (AAR), 3rd Battalion 3rd Special Forces Group (Airborne), Operation Enduring Freedom, Afghanistan, August 2006 to March 2007. Henceforth AAR, 3rd Group, 2007.

Afghanistan, even after seven years, is extremely difficult.²⁶⁰ The National Health Services Performance Assessment (NHSPA), the organization tasked with evaluating such measures, could not even perform surveys in the southern provinces of the country due to poor security conditions.²⁶¹

At the root of the continuity problem was that U.S. efforts did not focus on a comprehensive reconstruction of the healthcare system. Dr. Donald Thompson, former Command Surgeon for Combined Forces Command-Afghanistan and Combined Security Transition Command from March 2006 to April 2007 commented on the MEDCAP program. He stated that too much effort was wasted on MEDCAP missions. That the delivery of health care directly to the Afghan people by U.S. and ISAF uniformed personnel weakened the confidence of the local government, and their ability to provide this service. That instead of focusing on sustainable health care reconstruction U.S. forces dedicated themselves to direct patient care.²⁶²

One would expect the appropriate focus should be the PRTs and their reconstruction efforts. Unfortunately this has been “woefully inadequate.”²⁶³ Currently medical manning for U.S. led PRTs consist of one physician assistant, one non-commissioned officer and two enlisted medics. All providers are either United States Air Force or United States Navy personnel, come from military treatment facilities in the U.S. and have little or no deployment experience. Though qualified medical professionals, these individuals usually had not worked in an austere environment, had little experience with maneuver forces, and had never operated in a civil-

²⁶⁰ Diamond Interview, 13 June, 2008.

²⁶¹ CJTF-82, *Public Health in Afghanistan*, p. 3.

²⁶² Donald F. Thompson, “The Role of Medical Diplomacy in Stabilizing Afghanistan,” *Defense Horizons no. 63* (Center of Technology and National Security Policy, National Defense University: May 2008), p. 3. Henceforth Thompson, “The Role of Medical Diplomacy in Stabilizing Afghanistan.”

²⁶³ Diamond Interview, 13 June, 2008.

military role.²⁶⁴ Such teams did not have the experience or operational understanding of how medicine should work in a stability operation or a counterinsurgency.²⁶⁵

Unfortunately, in the absence of supporting doctrine, pre-deployment training for these PRT providers addressed only basic trauma skills and some cultural awareness; civil-military or medical reconstruction training was absent. These teams were required to be experts in public health and Afghan infrastructure construction when they arrived. They liaised with local officials, facilitated resource allocations for health care delivery projects, and functioned as a trainer and mentor to the local host nation healthcare providers. Unfortunately, they received no training in any of these areas. Currently, the U.S. Army has no training curriculum to address this deficiency despite seven years of stability operations in this theater.²⁶⁶

Pre- and post-deployment surveys of Medical PRT teams show this deficiency in training.²⁶⁷ One medical officer said, “I did not recall much mention of anything at Ft. Bragg concerning the medical mission. I didn’t get any orientation to the Afghan Healthcare system, and no discussion of being required to meet with, assess, or mentor the provincial health officials. I didn’t get any civil affairs training either.” “There was little explanation of the PRT role or mission prior to arrival in country,” another medical officer recalled, citing “the assumption was the mission would be garrison-type care.” Many interviewed stated they were unprepared for the PRT mission and had to make things up as they went along. Colonel Martin Bricknell, ISAF IX Surgeon, expressed his frustration to what he saw as a nearly universal failure to train medical personnel properly prior to their deployment to PRTs in Afghanistan.²⁶⁸

Direct patient care programs, like MEDCAP, were not intended to aid in healthcare infrastructure development. One principle reason is a lack of continuity in the program. Add to

²⁶⁴ Information Paper, *Provincial Reconstruction Teams (PRTs) in Afghanistan*, (Combined Joint Task Force–82, Bagram, Afghanistan: March 2007) p. 1. Henceforth cited as CJTF–82, *PRTs in Afghanistan*.

²⁶⁵ Diamond Interview, 13 June, 2008.

²⁶⁶ CJTF–82, *PRTs in Afghanistan*, pp. 1–2.

²⁶⁷ Center for Army Lessons Learned, *Medical PRTs: Collection and Analysis Visit to Afghanistan*, February 18, 2007. Henceforth cited as CALL, *Medical PRTs*, 2007.

²⁶⁸ CALL, *Medical PRTs*, 2007.

this, a well meaning but inadequately trained PRT medical system, it was evident how no broad effect has been seen on the host nation infrastructure or healthcare delivery system. Only in areas with established permanent security is improvement seen. In these areas some infrastructure development is occurring with the help of interagencies and non-governmental organizations. In most areas this is not seen, especially where they are uniformed providers rendering direct patient care.²⁶⁹ Even during the height of the U.S. drive to apply direct patient care to the people of Afghanistan a Department of Health and Human Services (DHHS) report cited that intrapartum fetal mortality, maternity post-operative infections and neonatal mortality increased from 2004 to 2006. There were thirty-one cases of Polio in Afghanistan in 2006 after only four in 2005.²⁷⁰

Unity of Effort

On 11 August 2003, the conduct of the ISAF mission became the responsibility of the North Atlantic Treaty Organization (NATO). This was the first time NATO had conducted an operation outside of Europe. With its mandate broadened by UN Security Council (UNSC) Resolution 1510, ISAF now had responsibility to support the Afghan Interim Authority and its successor [Islamic Republic of Afghanistan] in the maintenance of security throughout the country. This security allowed Afghan authorities, as well as UN personnel and other international civilians, to engage in reconstruction and stability operations. As a result ISAF began Civil Military Operation projects in Afghanistan through the use of the already established but expanding PRTs. This reconstruction, though slow, continued, and as of late 2004, they had repaired over 7,000 kilometers of rural roads with an additional 1,000 kilometers of new provincial roads under construction. The U.S.-sponsored repair of the Kajaki Dam restored power to the city of Kandahar and large parts of southern Afghanistan. During this time, the

²⁶⁹ Diamond Interview, 13 June, 2008.

²⁷⁰ CJTF-82, *Public Health in Afghanistan*, p. 3.

USAID built or renovated 205 schools, trained 4,400 teachers and provided over twenty-five million textbooks, as well as constructed 140 medical clinics.²⁷¹

The requirement of providing reconstruction and civil military assistance over long distances in austere and remote locations challenged coalition unity of effort. The Kabul government and ISAF had direct control over only portions of the country. Afghanistan's power base was so decentralized that there was no functioning centrally-controlled infrastructure. In an effort to change this Combined Joint Civil-Military Operations Task Force (CJCMOTF) centralized civil affairs operations in Afghanistan to establish a new central governmental template.²⁷²

Though centralized under this new task organization, ISAF command did not understand the CMA Cell or the MEDCAP mission, and by 2005 this asset was placed under control of the medical command. This move out of civil affairs significantly hampered unity of effort. Although this was a medical asset it was really, for operational purposes, a civil affairs tool that medical commanders had no experience using. Just as with constructing a road or putting in a well, the CMA Cell and MEDCAP missions seemed to have their place but only when used properly and in context. Unfortunately, medical commanders used it for the sole purpose of providing healthcare. Ferris stated, "You can't treat all of Texas with 15 guys." This was eventually identified and the command structure was changed back to civil affairs control by the summer of 2006.²⁷³

This centralized process had positive points however. The goal of the PRTs was to provide regional stability through the construction of schools, clinics and wells. It permitted charitable and international organizations to coordinate their relief efforts with the Islamic Republic of Afghanistan. Though there were challenges trying to communicate over long

²⁷¹ CLAMO, pp. 6–8.

²⁷² *Ibid.*, pp. 264–5.

²⁷³ Ferris Interview, 13 June 2008.

distances in an austere environment with a nonexistent civilian infrastructure, the vertical command and control between the CJTF, and field PRTs were more reliable and the lanes of coordination were clearer than if this had been a decentralized system.²⁷⁴

Unfortunately, over the later years, with the introduction of more NATO-sponsored PRTs, this centralized process blurred with a collapse of central synchronization. Each PRT essentially “did their own thing.”²⁷⁵ This breakdown made unity of effort between the U.S. military, non-governmental organizations, ISAF, the Islamic Republic of Afghanistan, and USAID tenuous at best. This was thought due to the inherent bureaucracy of combined operations with fragmented responsibilities and very narrow lines of control. All participants had splintered agendas.²⁷⁶

One common thread at the heart of this deficiency was a lack of security. Diamond notes, “In areas where we don’t have good security, our interagency partners like USAID won’t be there.” He clarified further,

There’s a lack of capacity out there and, in large part, it’s because there’s still a shooting war going on and many civilian members of society don’t want to get in the middle of it. We did have some luck working with interagency partners and in other areas we didn’t have any success at all. It all tended to be personality dependent, too, which is unfortunate. I’ve been sitting on an Assistant Secretary of Defense for Health Affairs (OSD-HA) working group looking at stability operations. There are interagency partners there and when I talk to some of them, it’s clear that they don’t know a thing about the military, just like we don’t know much about USAID. We’ve got different corporate cultures, we don’t socialize and we don’t work enough interagency exercises to overcome that.

Another problem is poor connectivity between the central government in Kabul and the provincial ministries. Diamond noted the difficulties inherited within the Afghan society where, “there isn’t one single, consolidated Afghan voice. There’s a chorus and most of the time they’re out of tune. The same can be said for our interagency partners. We’re out of tune, too.”²⁷⁷

²⁷⁴ CLAMO, pp. 264–5.

²⁷⁵ Diamond Interview, 13 June, 2008.

²⁷⁶ Thompson, “The Role of Medical Diplomacy in Stabilizing Afghanistan,” p. 1.

²⁷⁷ Diamond Interview, 13 June, 2008.

This began to improve, albeit slowly. Interagency representation, to include a greater role for the U.S. Department of Agriculture, was increased at every PRT. NATO forces have also contributed to the PRT mission with multiple teams working on CMA programs geared toward infrastructure and training. One such example is in Mazari Sharif, where Swedish and Norwegian PRTs have conducted joint CMA operations with the local Afghan National Army Corps Surgeon.²⁷⁸

There has also been a significant attempt to work with non-governmental organizations. Most planning now includes non-governmental organizations and interagency, which has proven to be a paradigm shift in military thinking. This planning is beginning to develop synchronization and this growing paradigm shift is showing better outcomes but it is all dependent on planning. The current trend appears to be that when planning includes the local government and needs of the community, it converts into unity of effort and eventually builds legitimacy. Unfortunately, when planning does not include synchronization, it wastes resources and puts people at risk.²⁷⁹

Doctrine

Billed with a primary objective to win the “hearts and minds” of the people, senior commanders and planners regarded MEDCAPs as an effective instrument for U.S. stability operations. This is now a symbol of American intervention, with the classic picture of U.S. uniformed doctors treating indigenous people in far off lands. Doctrinally MEDCAPs, like other medical civil military missions, are effective when used in the limited role of disaster relief and humanitarian assistance. Unfortunately, such direct patient care missions were not designed to bring durable medical, dental, and veterinary services to the masses of an impoverished country like Afghanistan.²⁸⁰

²⁷⁸ AAR, 3rd Group, 2007.

²⁷⁹ Ferris Interview, 13 June 2008.

²⁸⁰ Information Paper, *Village Medical Outreach (VMO) in Afghanistan*, (Combined Joint Task Force-82, Bagram, Afghanistan: April 2007) p. 1. Henceforth cited as *Village Medical Outreach (VMO) in Afghanistan*.

CMA operations and specifically MEDCAP missions were conducted across Afghanistan; when planned appropriately, such missions fulfilled a limited function of buying political capital or supporting a commander's intent in shaping the battle-space. Many, however, were *ad hoc* with little-to-no operational or strategic guidance. This set the conditions for the abuse of humanitarian assistance doctrine. In such cases, these operations created unrealistic expectations among the public, undermined trust in the local health care system, and generated economic competition for Afghan physicians and pharmacists. This ran contrary to the strategy of the Ministry of Public Health or Ministry of Agriculture, Irrigation, and Livestock. All this did nothing for the confidence and trust of the Afghan people, or to support U.S. interests. Any medical benefits noted were minimal and transient with debatable merits.²⁸¹ Further, these issues hurt the overall counterinsurgency campaign by ultimately degrading Afghan trust in ISAF, NATO, and the U.S.; while simultaneously delegitimizing the Afghan government.²⁸²

Lieutenant Colonel (Retired) John Gordon, former director of CJ9, CJTF-82 from February 2007 through April 2008, concluded that MEDCAPs have a place in operations, primarily in their ability to respond in support of recovery operations. Doctrinally these are operations to assist countries that are completely incapable of providing internal healthcare delivery and require a limited period of support. The best examples of such operations are natural and man-made disaster relief activities. For Afghanistan, this includes areas where there is no medical access available. In places such as this it is still appropriate to provide direct patient care. Still, the priority for such areas is to assist the Ministry of Public Health in developing its capacity. Gordon goes further to conclude that MEDCAPs in Afghanistan had a role, but only in

²⁸¹ CJTF-82, *VMO in Afghanistan*, pp. 1-2.

²⁸² Publications that do address medical support for humanitarian assistance include *Department of Defense Directive 3000.05* (November, 2005), *Joint Publication 4-02, Health Service Support* (October, 2006) and *Joint Publication 3-57, Civil Military Operations* (July, 2008).

the first few years. Unfortunately, as the country became more capable of delivering medical care MEDCAPs undermined and inhibited this ability.²⁸³

By 2007, CJTF-82 developed guidance for partnering with the Afghan healthcare providers instead of conducting MEDCAPS. This strategy was the fifteen month CJTF-82 analysis of CMA and MEDCAP programs since 2002.²⁸⁴ Designed to provide more organized structure to the ISAF initiated “coach, teach and mentor” program, this new guidance put American and ISAF teams to work with local Afghan doctors who occupied the basic and composite health clinics. Psychological Operations units announced these events prior and had coalition professionals work side by side with Afghans at these clinics. This placed Afghans in the front, treating other Afghans who then gained credibility with the local populace. According to CJTF-82 personnel this strategy met a lot of resistance at first, primarily because MEDCAPS were easier to conduct and could be measured. Gordon accounts,

In my experience, most American military health professionals would rather personally provide treatment over coaching and teaching. It is difficult to stand back and watch someone else doing something that you love to do. "We treated 1,000 patients today!!!" OK - our response is "so what!" "What does that prove?" How effective was your activity? Did you help build or break down?" How about this one - "we handed out X amount of meds today!" What does that mean? What does it measure? It measures how many pills we handed out. But if you think about it, it really doesn't mean much. Afghans who need nothing will take the pills from you if you are handing them out. So what does it measure when you hand out pills to people who don't need them? What are you measuring when you treat an Afghan who doesn't need treatment, but shows up because you are doing something for free?²⁸⁵

A more sustainable measure of effectiveness would be to measure the number of patients seen at a local health clinic per month after a few ISAF engagements. This would demonstrate trust in the local system.²⁸⁶

²⁸³ Gordon, 2008.

²⁸⁴ Major Joseph K. Weaver, Afghanistan Health Development Officer, CJTF-82, Bagram, Afghanistan, email message to author, July 9, 2008. Henceforth Weaver, 2008.

²⁸⁵ Gordon, 2008.

²⁸⁶ Ibid.

At the core of this problem is an absence published doctrine on how to conduct CMA or MEDCAP programs in a counterinsurgency theater. A literature search demonstrates a robust body of peer-reviewed articles that go back decades on these kinds of operations, but the only doctrine published, by the Army or joint forces, has been under the heading of Humanitarian Assistance for foreign disasters; there is none addressing MEDCAPs or CMA activities in support of counterinsurgency. Such publications, if ever undertaken should be written by Civil Affairs and not AMEDD personnel as Civil Affairs training is focused toward stability operations, infrastructure development and counterinsurgency support.²⁸⁷ The AMEDD has little-to-no training in such areas and relies on altruism as the core of their education.

Another problem was that most tactical commanders did not know how to use MEDCAP missions in a counterinsurgency. Many maintained a philosophy that at the bottom of their “bag” they have this “MEDCAP thing”, so they should use it. This led to uncoordinated and misused activities with no pre-mission research and no follow up visits. Essentially these missions wasted time because it was evident that many commanders had little knowledge of counterinsurgency in general, let alone how to use medical assets in a counterinsurgency.²⁸⁸

A 2006 RAND Corporation study cited the absence of unified guidance as a major barrier to success. Instead, units conducted “drive-by” medical clinics to no effect.²⁸⁹ In fact, no documented instance as come to light where medical civil military action made a significant impact on counterinsurgency operations.²⁹⁰ The traditional MEDCAP frequently represented American impatience and naiveté.²⁹¹

²⁸⁷ Ferris Interview, 13 June 2008.

²⁸⁸ Ibid.

²⁸⁹ Thompson, “The Role of Medical Diplomacy in Stabilizing Afghanistan,” p. 1.

²⁹⁰ Smith & Llewellyn, “Humanitarian Medical Assistance In U.S. Foreign Policy,” p. 73.

²⁹¹ James Taylor, “Military Medicine’s Expanding Role in Low-Intensity Conflict,” *Military Review*: (April, 1985): p. 33.

Resourcing

General David H. Petraeus summed up the resource issue well when he said that, “Money is the most powerful ammunition we have.”²⁹² For a number of reasons, including lack of management capacity, inability to coordinate funds and donor distrust, the bulk of relief and reconstruction for the health care sector is still controlled through international organizations and USAID. The Ministry of Public Health has no direct control of these funds. Instead, non-governmental organizations, such as the World Health Organization, the International Medical Corps, and Ibn Sina manage these funds. American funding is through USAID, U.S. Department of Health and Human Services, and private donors.²⁹³ Funding mechanisms today are considered archaic.²⁹⁴

Appropriations are outdated and designed by the Department of Defense’s Overseas Humanitarian, Disaster, and Civic Aid (OHDACA) to support short-term humanitarian assistance missions in emergency situations. Funding avenues are restricted by to humanitarian assistance only and are not authorized for use in nation building for tenuous new democracies. Such bureaucratic obstacles have made OHDACA useless as a funding mechanism.²⁹⁵

In an attempt to circumvent this bureaucracy the U.S. military created and administered the Commander’s Emergency Response Program (CERP). The genesis of CERP was the collection of seized enemy cash, supplemented by U.S. Congressional funding, into an Office of Reconstruction and Humanitarian Assistance account known as the Commander’s Discretionary Fund. The CERP defined reconstruction broadly as “the building, repair, reconstitution, and reestablishment of the social and material infrastructure.” This funded goods and services to support a non all-inclusive list of projects to address the humanitarian needs of the host nation people, including: water and sanitation infrastructure, food production and distribution,

²⁹² Ariana Eunjung Cha, *Military Uses Hussein Hoard for Swift Aid*, WASH POST, Oct. 30 2003, (quoting Major General David H. Petraeus, then commander of the Army’s 101st Airborne Division (Air Assault)).

²⁹³ CJTF-82, *Public Health in Afghanistan*, p. 3.

²⁹⁴ Thompson, “The Role of Medical Diplomacy in Stabilizing Afghanistan,” p. 1.

²⁹⁵ *Ibid.*, pp. 3–4.

healthcare, and education. Commanders' use of the CERP, and the immediate benefits this program provided to the local population, gained national media attention. The CERP was popular with commanders and expanded to include Coalition Forces. Commanders approved literally thousands of CERP-funded projects in the first few months of the program's inception, spending tens of millions of dollars in the process. To help maintain the CERP's success Congress appropriated \$180 million to fund CERP projects as part of an Emergency Supplemental Appropriations Act on 30 September 2003. CERP dollars permitted commanders to implement projects quickly, without the administrative strictures normally associated with government acquisitions. They purchased pharmaceuticals and medical supplies through this program on the local economy.²⁹⁶ Unfortunately, these funds were unavailable for long-term nation building, and so, became perfect funding avenues for limited missions like MEDCAPs.

Another funding source was the Civil Military Operations Cell, or CMOC, at the CJTF in Bagram. This followed a CENTCOM policy that, when properly vetted, allowed the use of U.S. medications procured through normal U.S. medical logistical channels. Whether through CERP funds or from this CENTCOM policy MEDCAP missions and the CMA program had no difficulty in funding missions.²⁹⁷ Commanders, as well as planners, considered resourcing as unlimited, even when vetted through the CMOC or funded through CERP. But this vetting process was superficial with no accountability process once missions or projects were conducted.²⁹⁸

Meanwhile, hundreds of millions of dollars have been spent in the development of an Afghan National Army health care system that is restricted to military personnel only. This has created a disparate system that continues to alienate the local population. Such restrictions continue to stall any development of a sustainable health care delivery system for the local

²⁹⁶ CLAMO, pp. 168–171.

²⁹⁷ Diamond Interview, 13 June, 2008.

²⁹⁸ Ferris Interview, 13 June 2008.

populace.²⁹⁹ For these reasons any objective accounting of such programs is difficult at best with donors spending more time trumpeting their successes and lobbying for more money than working toward a synchronized and sustainable effect.³⁰⁰

Intelligence

As mentioned above, Special Forces used direct patient care, but primarily as a venue to collect intelligence passively. It is logical to ask if the MEDCAP program contributed to intelligence collection.

Although intelligence collecting was never the intended mission for conventional U.S. MEDCAP missions, they became a useful vehicle for tactical intelligence gathering. While collection was never active, it proved useful in the realm of passive information exchanges. Diamond reported on a number of occasions where MEDCAP activities resulted in maneuver elements being led to arms caches or given information about high-value targets. By going to a village and showing good intent toward the local populace and their animals this would sometimes give returns in the form of unsolicited information.³⁰¹ Diamond noted, during both rotations as CMA director, that the majority of this information was obtained from veterinary missions whom he regarded as more useful and valuable as a passive collection tool than any human medicine activity. Human MEDCAP clinics rarely produced such results.³⁰² The reason for this discrepancy is unknown, but one would anticipate low local motivation to divulge information if such programs were viewed as superficial and illegitimate, with no local government representation. Another logical reason was the monetary wealth associated with herd size and livestock.

One such example came from the province of Ghazni in February 2003, where the MEDCAP mission had been planned for ten days. Unfortunately, this area had seen a lot of

²⁹⁹ Thompson, "The Role of Medical Diplomacy in Stabilizing Afghanistan," p. 4.

³⁰⁰ CJTF-82, *Public Health in Afghanistan*, p. 3.

³⁰¹ Diamond Interview, 13 June, 2008.

³⁰² Ibid.

improvised explosive devices (IEDs) and the team was unable to leave the local firebase to conduct missions because each time it attempted to leave it encountered IEDs. There was only one day that the team was able to make it out of the wire and to their mission site. During the one successful mission a local herder, who had brought his animals to the veterinarian, kept stating that the coalition needed to look at a specific building in the area. This individual persisted and the local combat escort unit finally relented and investigated the site. They had cleared the building in question earlier the day before, which added to the reluctance. Inside, the security detail found the largest weapons cache of the rotation. The Taliban had observed American soldiers clearing the building and so returned to use it as a cache depot later in the day. At the complication of this CMA mission all IED activity in the area ceased for the next six months.³⁰³

Later in 2003, during a mission near Jalalabad, the veterinarian of the unit received an urgent call from a government representative in Kabul. This representative, who was a member of the tribe, needed to speak to the veterinarian right away because this provider was taking care of the tribes' animals. He wanted to tell the veterinarian that one of the local warlords in a neighboring province was moving his armored vehicles south. Apparently this warlord had felt slighted by a neighboring warlord and was looking for retribution. This action occurred years into Operation Enduring Freedom (OEF) so ISAF thought no warlord had functioning armored vehicles. This was the first tip that ISAF and U.S. forces received about such a major movement, and it came through a veterinarian that was highly regarded due to the care the tribe received for their herd.³⁰⁴

The first vehicle-borne IEDs (VBIEDs) brought into Afghanistan targeted the CMA Cell and their MEDCAP missions. During the summer of 2003 ISAF Intelligence had noted its movement and that it was following a MEDCAP convoy on its way to Jalalabad from Kabul. The MEDCAP mission was bound for the Village of Sarobi in support of a local U.S. Marine unit.

³⁰³ Ferris Interview, 13 June 2008.

³⁰⁴ Ibid.

The Marines tracked it and captured it before it was employed. This was the first documented VBIED brought into theater and it specifically targeted a MEDCAP.³⁰⁵

An old adage has it that imitation is the sincerest form of flattery. The enemy is also using medical care as a means to win over the local populace. Taliban-owned and operated hospitals along the Pakistan border are now providing care to the people in these areas.³⁰⁶ This was such a concern that from 2003 to 2004 a Defense Intelligence Agency representative was assigned to the CMA cell. The agent was responsible for collecting information about how the Taliban and al-Qaeda were duplicating the American CMA cell and were conducting similar MEDCAP missions on the Pakistan border. The intelligence sections wanted to find out why it became important for the enemy to duplicate such efforts.³⁰⁷

Active intelligence gathering was never allowed by these elements and if any was done by supporting units it was not with CMA knowledge.³⁰⁸ Any intelligence gained was at the tactical level, and like Vietnam, limited in only local small unit enemy activity.³⁰⁹ Like Vietnam, when intelligence was obtained it was not considered significant or operationally useful at anything but the tactical/local level. Wilensky looked at this topic specifically in his analyses of MEDCAPs during the Vietnam War and concluded that none of these assistance programs affected decision making at the strategic or operational level.³¹⁰

Diamond though noted that such activities and knowledge of the community helped commanders craft larger projects more effectively. This allowed maneuver commanders to focus resources and money to more sustainable projects and redirected millions of dollars due to good passive intelligence done in conjunction with the MEDCAP missions.³¹¹

³⁰⁵ Ferris Interview, 13 June 2008.

³⁰⁶ Thompson, "The Role of Medical Diplomacy in Stabilizing Afghanistan," p. 3.

³⁰⁷ Ferris Interview, 13 June 2008.

³⁰⁸ Diamond Interview, 13 June, 2008.

³⁰⁹ Ferris Interview, 13 June 2008.

³¹⁰ Wilensky, *Military Medicine to Win Hearts and Minds*, pp. 134–5.

³¹¹ Diamond Interview, 13 June, 2008.

Ethics

Like the MEDCAP programs of Vietnam, U.S. military physicians were eager to help and felt the need to “jump in” as a moral imperative. But as with all counterinsurgency activities, pragmatism is the underlying rule, with compromise and flexibility at its core. Such programs should not be allowed to collapse under the weight of their own ambitions. Because of this, the priority should have included the capability to withhold or withdraw assistance when such interventions were doing more harm than good.³¹² So, like any civil-military operation, the CMA element in Afghanistan needed to be viewed as a complex endeavor. This required addressing the root of the cause and not superficial effects like direct patient care programs. The CMA program fell into this trap.³¹³ The ends were not prioritized or understood and the initial commitment became an incentive to persevere or get more involved. This was the “slippery slope” in Vietnam repeated in Afghanistan.³¹⁴

The National Security Strategy states that the U.S. global dictum is not to use its strength to press for a unilateral advantage, instead, to create a balance of power that favors human freedom. These are conditions in which all nations and all societies can choose for themselves “the rewards and challenges of political and economic liberty.” This is based on the idea that people will be able to make their own lives better. The ethical high ground was not intended to be symbolic, but rather grounded in terms like, “championing human dignity”, and “building infrastructures for democracy.” If such moral principles and values are to be at the forefront they must be embodied in sound guidance and nested in doctrine.³¹⁵

There are several consensus views that apply historically. Since the basic principles of insurgency operations have not changed, the same can be said for medical planning in support of

³¹² Jonathan Moore, *Hard Choices* (Rowman & Littlefield Publisher, 1998), p. 6–7.

³¹³ Ernest Haas, “Beware the Slippery Slope: Notes towards the Definition of Justifiable Intervention.” *Emerging Norms of Justified Intervention*, ed. Laura Reed and Carl Kaysen (Cambridge, MA: American Academy of Arts and Sciences) 1993.

³¹⁴ Pierre Hassner, “From War & Peace to Violence and Intervention,” *Hard Choices, Moral Dilemmas in Humanitarian Intervention*, ed. Jonathan Moore (Rowman & Littlefield Publisher, 1998), p. 22.

³¹⁵ The White House, *The National Security Strategy of the United States of America*, (Washington, D.C.: 2002), pp. 1–29.

counterinsurgency operations. There can be little doubt that what seemed to be a simple medical assistance to a local population, that at one time seemed a neutral and a pure “act of mercy,” can lead to many complications when applied to insurgencies goals. Single-minded medical assistance can lead to local dependency and can exacerbate conflicts. This aid, if provided incorrectly, does nothing to alleviate the suffering and can reinforce circumstances it was meant to repair. Just as with Vietnam, this became apparent in Afghanistan.³¹⁶ As Civil Affairs personnel and medical providers planned for such actions they were unaware of the moral conundrum that was developing. There are several possible responses.

The first response that some providers took was the “primacy of the humanitarian imperative.” This concept concluded that, despite the negative consequences of aid, it is imperative to respond to these urgent needs. These individuals accepted the possible negative side effects, but believed that any good intent outweighs the possible harm done. Understanding this concept will help to appreciate how doctrine can be warped by well-intended people.³¹⁷

Another precept is that no aid is better than aid that does harm. Noted humanitarian assistance expert and author Mary Anderson refers to this as a “moral fallacy,” and explains that, “aid done wrong is not the same as demonstrating that no aid would do no harm.” Nor is the act of no aid considered good. So are providers morally trapped? Can history demonstrate that medical aid can affect counterinsurgency in positive ways and still be ethically grounded?³¹⁸ The answers are no, providers are not morally trapped, and yes, medical intervention can have a positive effect on counterinsurgency operations.³¹⁹

This chapter examined intelligence gathering as a viable mission for CMA activities and specifically MEDCAPs. These raise potential ethical and legal issues as well. The International

³¹⁶ Mary B. Anderson, *You Save My Life Today But for What Tomorrow?* (Rowman & Littlefield Publisher, 1998), pp. 137–155.

³¹⁷ Anderson, *You Save My Life*, pp. 137–155.

³¹⁸ Anderson, *You Save My Life*, pp. 137–155.

³¹⁹ These answers will be examined in more detail in Chapter Five.

Committee of the Red Cross as well as the Geneva Convention and United Nations are very clear on the issue of human intelligence collection during medical assistance programs. Any effort to actively collect is against international law and U.S. governmental policy; but if information is gained through passive delivery, of which the assistance program is not a part, then this is permissible. This means that intelligence personnel cannot pull people out of patient waiting lines to question them, but if someone has local information they would like to offer voluntarily away from the clinic, then this would be appropriate.

Provisions from the 1907 Hague Convention and subsequent Geneva Convention of 1949 set the rules and guidelines for occupying powers. Of special significance to Afghanistan are the provisions on guaranteed rights and the treatment of protected persons. Reflecting the negative experiences with “puppet” governments set up by the Nazis in occupied Norway and France during World War II. Under this Convention, the occupying power is required, *inter alia*, to: ensure education and care of children; ensure hygiene and public health; protect and respect property; and permit relief consignments. Section IV of Part III of the Convention contains the regulations for the treatment of such persons, e.g., the location of the internment, food and clothing, hygiene and medical attention, and religious, physical and intellectual activities.³²⁰ Like other counterinsurgency operations, Afghanistan presented a unique admixture of war and law enforcement that did not always fit neatly into established humanitarian paradigms. Units struggled to apply the international laws of belligerent occupation for the first time since the end of World War II. International law issues concerning reconstruction and proper handling of civilians on the battlefield were significant ethical issues confronted by the PRTs and maneuver commanders.³²¹

The U.S. has spent much of its time validating these conventions and attempting to justify its actions to the world with rules of engagement that separates it from its enemy. One major

³²⁰ CLAMO, pp. 15–6.

³²¹ *Ibid.*, p. 3.

platform to do this is through U.S. direct patient care. Added to this is the need for doctors, nurses, physician assistants, and medics to feel good about the medicine they are practicing. The fact is each provider holds a license and has sworn an oath do no further harm. The dilemma is that MEDCAP missions were not intended to be medical in nature and were utilized more as a method of showing good will to the local populace. One officer commented that they were selling “hope” one person at a time, but admitted that clinically these missions were a waste of time. This is where the ethical rubber meets the hard-life road. When villagers come to a MEDCAP with chronic, sometimes untreatable, conditions and leave with a multivitamin the provider has to ask this question. “Is this what I would do to any of my patients back home?” The answer would be an emphatic no; “so why am I doing it to this human being?”³²² Even in austere environments like Afghanistan U.S. providers are still bound to practice within their professional scope and limits as well as international law. This makes all military medical personnel personally responsible for their practice conduct and the conduct of those working under their license.³²³

Some providers view this in a more positive light and conclude that one way to combat an insurgency is to have the local people see the future in a better light than the past. The conclusion is if the past was a very poor standard of living, and in Afghanistan it obviously has, then one can demonstrate that the future holds a better standard of living. In this view, MEDCAPs can be positive if placed in this light.³²⁴

The result of all this has been a joint initiative by late 2007 between the CJTF-82 Surgeon and the CMA Cell-Bagram resulting in CSTC-A FRAGO which has placed significant limitations

³²² Ferris Interview, 13 June 2008.

³²³ CJTF-82, *VMO in Afghanistan*, p. 2.

³²⁴ Diamond Interview, 13 June, 2008.

on MEDCAP activities in theater. This has reorganized the centralized CMA program and ended most direct patient care missions in Afghanistan.³²⁵

³²⁵ CJTF-82, *VMO in Afghanistan*, p. 3.

CHAPTER 5

ANALYSIS AND CONCLUSION

Prior to the Vietnam conflict, U.S. forces utilized community and preventive medicine programs as a means of nation building and a tool to combat insurgency claims of legitimacy. U.S. forces demonstrated this from the Mexican-American War of the 1840s, to the Philippine Insurrection of 1900 and the Marine Corps' small wars of the 1920s and 1930s. While U.S. forces used direct patient care in these counterinsurgencies, they significantly limited this concept in their operational campaign. Direct patient care was not the primary tool for medical counterinsurgency or host nation medical development. Security was the foundation with medical support focused on immunization, sanitation, and infrastructure development.

The U.S. saw direct patient care humanitarian assistance as successful during the 1950s and early 1960s. These missions had American uniformed personnel providing direct care in support of disaster relief. This included relief efforts to Central and South America, Yugoslavia, Pakistan, and Iran. During these two decades this form of "medical diplomacy" focused on large disaster relief packages of short duration with a visible end-state. In part, because of such successes, an "activist foreign policy" emerged from the Kennedy administration. This also led to the formation of USAID in 1961.³²⁶ As mentioned in chapter two this concept became the "square peg" applied to the "round hole" that is counterinsurgency. This application continued throughout Vietnam and thirty years later in Afghanistan.

This chapter brings together the common elements of these types of missions, historically demonstrates their operational outcomes, and presents an idea of how such operations can be successful.

Vietnam

Medical civic action programs throughout the Vietnam War had three overarching objectives established by MAAG and MACV; continuity, participation, and improvement. These

³²⁶ Foster, *The Demands of Humanity*, pp. 147–164.

three objectives stressed that all medical civic action had to have a level of commitment that the local government could sustain after U.S. forces withdrew. MACV stated that any program must have local government involvement and training participation. Any advanced medical care would be introduced only to the extent and sophistication that the South Vietnamese medical system could maintain.³²⁷ U.S. medical planners attempted to meet these objectives through a combination of programs including medical training programs such as MILPHAP and clinical treatment programs like MEDCAP I, MEDCAP II, and the Marine Corps' CAP units. The majority of these activities involved uniformed U.S. and civilian personnel providing direct patient care to the people of South Vietnam. The three MACV objectives were similar to the measures of effectiveness used in this study. So, in the final analysis, how did these programs compare to the principles of legitimacy, continuity, unity of effort, doctrine, resourcing, intelligence and ethics?

Legitimacy

The ultimate goal of medical assistance in Vietnam was to have the South Vietnamese government independently capable of maintaining an adequate level of preventive and therapeutic medicine. Legitimacy of the South Vietnamese government was the ultimate goal. MILPHAP and other training programs contributed to this goal, most especially in support of the medical schools and training programs. Some earlier treatment programs, like Special Forces, MEDCAP I and the Marines' CAP program encouraged reasonable legitimacy, and a sustainable effect. However the largest program, MEDCAP II, resulted in only temporary respite and contributed little-to-nothing in regards to long-term improvement of the health care infrastructure.³²⁸

Continuity

Hospital based programs, like MILPHAP, provided sufficient medical care. This program had the potential for improving the quality of care with a sustainable program for long-term infrastructure development. This was due to it being based on education with Vietnamese

³²⁷ Wilensky, *Military Medicine to Win Hearts and Minds*, p. 60.

³²⁸ *Ibid.*, p. 117.

doctors and nurses at the point of delivery, and U.S. medical providers supporting as advisors.

MEDCAP I had continuity and was sustainable when handed over to the South Vietnamese government. The Marine Corps' CAP elements were also successful to an extent because they focused on paired "train the trainer" programs and mentorship was the foundation. Unfortunately, the direct patient care system adopted by MEDCAP II established no change in the Vietnamese medical infrastructure as it was not equipped for such an endeavor. The MEDCAP II mission was to establish rapport between U.S. forces and the host nation people, and follow up missions were not a priority. This ran contrary to the stated objectives of MAAG or MACV. This type of direct patient care program was suited poorly for any long-term program to address the chronic diseases or the systems needed to effect a long lasting change.³²⁹

Unity of effort

Unity of effort was disjointed from the onset. To improve this and synchronize efforts with USAID, a new experiment was launched with the establishment of CORDS, as detailed in chapter three. For the first time the full power of U.S. military and civilian stability elements were focused under one interagency manager who was at the top of the chain of command. This brought U.S. military and State Department personnel under one organizational structure. Unfortunately, this was a "successful failure" according to a recent 2008 National Security Reform analysis. This analysis determined that CORDS unified stability elements under a single organization, but it failed in its end-state which was the survival of the South Vietnamese Government.³³⁰

Fundamentally, the U.S. government was unclear of its own goals or objectives. They never determined whether the ultimate objective was the relief of human suffering or gaining the political support of the population. These two thoughts had different and conflicting methods and

³²⁹ Wilensky, *Military Medicine to Win Hearts and Minds*, p. 94.

³³⁰ Richard W. Stewart, "CORDS and the Vietnam Experience: An Interagency Organization for Counterinsurgency and Pacification," *Project on National Security Reform: Case Studies, Volume I*, (Washing, DC: Center for the Study of the Presidency, 2008), pp. 472-3.

end-states. If the goal was political, then civil affairs or psychological operations should have received control with the AMEDD and USAID as supporting members. If the main effort was to stop human suffering and improve health care, control should have gone to the AMEDD and USAID with an emphasis on preventive medicine, hygiene education, and sanitation development.³³¹ When they attempted to do both, they attained neither.

Doctrine

It became clear to senior leaders, including medical, military, and administrative officials, that medicine was a potential tool for counterinsurgency operations and nation building. Medical contributions to political stability are viable and can promote theater objectives. Thus the massive capabilities of America's medical system could have positive influence on the war in Southeast Asia. Legitimacy became the problem. Senior leaders did not address the question of who gets the credit for this care, U.S. uniformed personnel or the host nation's government.³³² There was no clear guidance or doctrine to fall back on to answer this question.

Resourcing

Although America expended hundreds of millions of dollars, in reality, field commanders did not have the resources or stability operations insight to address the infrastructure dilemma that lay at the core of the problem. Such programs required a comprehensive strategy. This begins with the overhaul of the medical delivery system as a whole.³³³ There was never a resourced objective to evaluate. By the end of 1970, no basic change or improvement had occurred in the Vietnamese health care system. The results of such direct patient care actions were difficult to evaluate, although they had impressive figures of funds expended and number of patients treated, there was little reflection on quality of care provided, or amount of villages won over to the South Vietnamese cause.³³⁴ As stated previously in chapter three, "Statistics ruled the day."³³⁵

³³¹ Wilensky, *Military Medicine to Win Hearts and Minds*, pp. 90–1.

³³² *Ibid.*, p. 123.

³³³ Jenkins, "Medical Civic Action Programs," pp. 12 and 43.

³³⁴ Raymond H. Bishop Jr., "Medical Support of Stability Operations: A Vietnam Case Study," MHIA, (18 February 1969), p. 13.

³³⁵ Jenkins, "Medical Civic Action Programs," p. 11.

During the peak of American military involvement in Vietnam (1966-1970), all three services and the Department of State produced numerous anecdotal reports and statistics in an attempt to publicize these programs and to cast a favorable light on the U.S. involvement. While these provided good human interest stories and the occasional good press release for home town newspapers, little objective value could be extrapolated from these reports. The MEDCAP programs especially, with their single one short visit clinics, provided little information and no significant data. Reporting only generalizations about care rendered and the number of patients treated.³³⁶ In one of the few analytical studies of medical imperatives in counterinsurgencies, Lieutenant Colonel Peter B. Cramblet stated in his War College analysis, “exercises that accumulate impressive statistics for patients treated are a meaningless method of management by body count.”³³⁷ True records and objective resourced analysis of their outcomes are difficult if not absent altogether.

Intelligence

The various programs used intelligence of a medical nature, which is the study of local and prevalent health conditions to gain a picture of the general health of enemy forces. MEDCAPs offered an avenue for this study. For example, there were historical summaries of combat units capturing medical supplies in tunnel complexes. This provided the ability to catalog enemy medical facilities and their capabilities.³³⁸

Though informally lauded as a reason for conducting MEDCAPs, non-medical intelligence gathering was not useful except in limited success at the tactical level. This included examples of the local population volunteering the location of enemy mines, booby traps or pending attacks as noted earlier. The greatest requirement for this success, however, was having

³³⁶ Wilensky, *Military Medicine to Win Hearts and Minds*, p. 79.

³³⁷ Peter B. Cramblet, “U.S. Medical Imperatives for Low Intensity Conflict,” MHIA, Student Paper AD–A 236 817 (5 April 1991), p. 8.

³³⁸ Wilensky, *Military Medicine to Win Hearts and Minds*, pp. 119–20.

these units remain in one location for a significant time.³³⁹ Unfortunately, there was little permanence, so successes like this were limited. Historically, any non-medical intelligence collected dealt with locations and movements of small local Viet Cong units, potential ambushes, or booby traps. No significant strategic or operational intelligence has come to light.

Unfortunately, these medical civic activities decreased as enemy activity increased. For instance, during the Tet Offensive beginning in January 1968, all MEDCAP activities stopped with most units offering no assistance to the civilian population during or immediately after the offensive.³⁴⁰ So when intelligence gathering seemed the most critical, the American means of collection stopped. It seems, in retrospect that intelligence was not a critical reason for these programs and played little significant role in the counterinsurgency.

Ethics

There were some benefits evident from these programs, from a general ethical standpoint. Altruistically, they treated and cured patients with infections. They created educational programs for corrective and life saving surgeries, via the MILPHAP. Villages and Hamlets received life extending immunizations and sanitation improved for thousands. Some of these programs and the lessons that they taught may have persisted after U.S. withdrawal, but this is unknown.³⁴¹ Unfortunately, the occasional MEDCAP did not contribute to any of this. If curing malnutrition, malaria, or combating poor sanitation was the goal, then direct patient care programs, like MEDCAPs, fell far short of accomplishing this objective.

Most providers eventually felt unable to treat adequately anything but the most superficial medical problems. This became obvious to all parties with both patients and providers feeling unsatisfied. Medical moral energy did not accompany a clear idea of the “bigger picture” and proved detrimental. Jonathan Moore’s “theme of constraint” was not addressed and these programs, especially MEDCAP II went too far and too fast for the local population. Thus

³³⁹ Wilensky, *Military Medicine to Win Hearts and Minds*, pp. 118–20.

³⁴⁰ *Ibid.*, pp. 80–1.

³⁴¹ *Ibid.*, p. 99.

interventions did more harm than good.³⁴²

Conclusion

By 1969, planning began for the eventual withdrawal of American medical personnel and the turnover of their functions to the Vietnamese. MEDCAP activities declined and were discontinued by 1972 with the cessation of funding. The war was over and this tremendous medical assistance effort made little-to-no influence on the outcome. Many people received medical care that otherwise would not have been available. Some programs trained many Vietnamese medical personnel. These gains were small and inadequate to the bigger picture and retrospectively it would appear that the program did not work in Vietnam.

Some disagree, however, with the idea that this effort failed. Colonel ElRay Jenkins argued that it worked quite well. He said that the problem was that Vietnam was not a counterinsurgency after 1964, and most insurgency operations ceased after the Tet Offensive of 1968. In order for these programs to work, they must be directed within the counterinsurgency spectrum when the government can protect the population. To win the hearts and minds of the people, MEDCAP actions had to be implemented before the conflict expanded into a major confrontation with the insurgents controlling large segments of the country.³⁴³

In the end, if the fundamental battle for Vietnam was the “hearts and minds” of the people, then the basic guiding principle was flawed. The nationalistic banner had been unfurled when the French were removed from the country. This appealed to the highest aspirations of the Vietnamese people. The line had been drawn for people to choose, either French colonialism or Vietminh. To many, the South Vietnamese leadership were French sympathizers and wealthy landowners; in a country where the majority was rural, poor, and underserved. The South Vietnamese government started in a weak position and focused little attention to the peasant population. The U.S. government was attempting to prop up a minority landowner class among

³⁴² Jonathan Moore, *Hard Choices* (Rowman & Littlefield Publisher, 1998), pp. 6–7.

³⁴³ Jenkins, “Medical Civic Action Programs,” pp. 11–12. Excerpts also taken from James Taylor’s lecture “The Emerging Role of Military Medicine in Low Intensity Conflict,” St. Louis University Medical Center. St. Louis. Mo.

rural peasants. The populace appreciated American medical assistance, but never identified it as coming from the Republic of Vietnam.³⁴⁴ Regardless of the Vietnam outcome, most of present-day U.S. concepts on utilization of medical forces in a counterinsurgency unfortunately come directly from this conflict.³⁴⁵

Afghanistan

Thirty years later, with this issue of counterinsurgency medical doctrine to guide AMEDD officers ignored, America again applied medical support to a counterinsurgency. The question of “weaponizing” medicine has not been answered. Medical readiness and training exercises provided humanitarian assistance to many countries in Latin American and Africa over the preceding decades; building relationships with developing countries of similar interests. The U.S. Navy and Army Special Forces employed such activities for “Operations Short of War” with the flexibility and mobility to offer support to countries across the globe.³⁴⁶ This was common practice during the 1980s and 1990s with pictures of the USS *Mercy* and *Comfort* anchored off the shores of developing allies. Like the disaster relief operations of the 1950s and early 1960s, end-states were set with host nation participation and limitations understood. None of these operations were counterinsurgencies though. These concepts, as with Vietnam, were applied to the counterinsurgency in Afghanistan with little actual guidance or evidence of efficacy. So examining MEDCAP support with the same principles of legitimacy, continuity, unity of effort, doctrine, resourcing, intelligence and ethics, helps determine their effectiveness.

Legitimacy

The success of counterinsurgency in Afghanistan depends on the ability to build and maintain legitimacy of the host nation government in the eyes of the populace. That social trust must be created in the government. This trust will come only when the government is capable of

³⁴⁴ Wilensky, *Military Medicine to Win Hearts and Minds*, pp. 128–129.

³⁴⁵ Jenkins, “Medical Civic Action Programs,” pp. 11–12.

³⁴⁶ Milan N. Vego, “On Naval Power,” *Joint Forces Quarterly* 50 (2008): pp. 11–14.

providing vital services, like healthcare.³⁴⁷ This cannot be done by American uniformed personnel conducting direct patient care to the local population, although it may be started by them. Paramount to this is security.

Until security is integrated into all activities of stabilization and reconstruction, any program is doomed to fail.³⁴⁸ Indeed, this is the foundation on which all counterinsurgencies must be founded. Likewise, it is the backbone of all medical assistance programs. American forces understood this in previous stability operations. Immediately after the fall of the Japanese empire the U.S. projected the need for a force of approximately 685,000 soldiers. By the end of 1945 this force was reduced to 354,675 but still represented a considerable commitment of military manpower which was dedicated to security. This was in a country that is less than two-thirds the size of Afghanistan, which is roughly the size of Texas. This number is even more significant when compared to the non-violent capitulation of the Japanese people.³⁴⁹ Currently there are approximately 72,000 coalition forces in Afghanistan, of whom 34,000 are U.S. personnel.³⁵⁰

Security is such an integral part of medicine within a counterinsurgency that CJTF-82 placed this at the foundation for their Public Health Pyramid and Healthcare guidance structure.³⁵¹

³⁴⁷ David P. Cavaleri, *Easier Said than Done: Making the Transition Between Combat Operations and Stability Operations* (Fort Leavenworth, Kansas: Combat Studies Institute Press, 2007), p. 64. Henceforth Cavaleri, *Easier Said than Done*.

³⁴⁸ Thompson, "The Role of Medical Diplomacy in Stabilizing Afghanistan," p. 1.

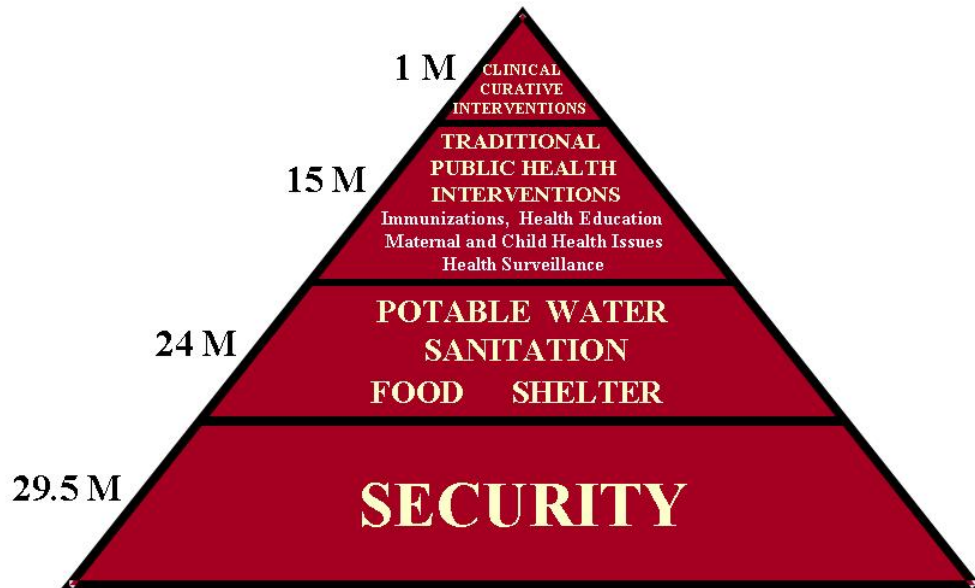
³⁴⁹ Cavaleri, *Easier Said than Done*, p. 64.

³⁵⁰ Michael Gisick, "Afghanistan: U.S. Training Units Endorse Single-Command Strategy," *Stars and Stripes Newspaper*, 18 August 2008.

³⁵¹ Figure reprinted with permission of COL Dalton Diamond, Cooperative Medical Assistance director, CJTF-82, 2006-2007. In this figure the numbers to the left represent the total number of the population positively affected by each intervention.



Public Health Pyramid in Afghanistan



Public Health Pyramid in Afghanistan

Source: Cooperative Medical Assistance, CJTF-82, 2006-2007.

Continuity

Continuity, and indirectly, legitimacy, is now beginning to show with MEDCAPs only utilized by PRTs in areas that are void of healthcare facilities. These outreach missions have also decreased as the number of clinics and locally trained medical providers continue to climb. The PRTs have directly contributed to this. For example, one PRT has seen its province's health network increase from twelve sub-standard clinics six years ago to now twenty-four suitable facilities. This includes one provincial hospital, nine comprehensive health clinics, fourteen basic health clinics and an additional 242 basic health posts.³⁵² Unfortunately, most medical PRT elements are understaffed and receive inadequate training prior to deployment. Interviews and

³⁵² Lieutenant Neil Myers, USN, "Konar Provincial Reconstruction Team medical staff supports reconstruction of Afghan health system," *CJTF-101*, Bagram, Afghanistan, 20 July 2008, pp. 1-2. Henceforth Myers, "Konar PRT."

after action reports from medical PRT members described having to learn on-the-job, and more through trial-and-error than through a unified training curriculum.

The traditional MEDCAP mission did not contribute to any of these successes. MEDCAPs as a whole provided some education and had potential for positive change. Projects such as pediatric de-worming could have had an influence, but only with frequent follow ups. The CMA element could have addressed immunizations if allowed to integrate with the World Health Organization and the Ministry of Public Health's immunization program. Unfortunately, like its MEDCAP predecessors in Vietnam, this program did not produce a positive effect on the health of the nation. This was complicated by force protection requirements and the fear of attacks with follow up missions. Such fears prevented any long-term presence and merely re-emphasize the core problem, security.³⁵³

Unity of Effort

With this in mind, any medical support needs unity of effort with synchronized guidance. General (Retired) Barry R. McCaffrey stated this well in his after action report from Afghanistan, "we can't win with a war of attrition. The economic and political support from the international community is inadequate."³⁵⁴ He went further to state plainly that there is no such unity of effort in Afghanistan. The total U.S. expenditures in Afghanistan for 2008 will be in excess of \$34 billion, \$2.8 billion per month. Unfortunately, there is no such corresponding effort from the international community.³⁵⁵ Unity of command is also nonexistent; with a splintered command structure, there is no single military command, while most NATO and international coalition forces respond to different national operational restrictions and caveats.³⁵⁶ International actions are piecemealed without a unified approach. Analysis from the Bonn Conference in December of

³⁵³ Diamond Interview, 2008. CMA and MEDCAP participation in immunization programs were discouraged by the World Health Organization due to fears of such actions being associated with the military. Most non-military organizations felt that they were a target if associated with military security efforts. These organizations took a reversal view of security.

³⁵⁴ McCaffrey AAR.

³⁵⁵ Ibid.

³⁵⁶ Ibid.

2001 estimated funding needs to be between \$22 and \$45 billion. U.S. estimates put this need at around \$55 billion. Unfortunately, as of 2007, coalition donors have only pledged \$4.5 billion. Even this amount has been slow to materialize.³⁵⁷

With lessons learned from Vietnam, some proponents have advocated a complete withdrawal of such humanitarian measures and a return to a more coercive counterinsurgency method. But coercion has proven largely ineffective, in Afghanistan especially, throughout history. All one has to do is look at the massive Soviet firepower used against Afghanistan insurgents during their occupation. This only generated global sympathy and attracted more insurgents to the cause of jihad. Not to mention this approach, unlike the Soviet Union, seems vastly unsuited to twenty-first century counterinsurgency actions conducted by Western democracies like the U.S.³⁵⁸

This attitude was echoed by Secretary of Defense, Robert M. Gates. He stated in his November 2007 speech to Kansas State University, “We cannot kill or capture our way to victory.” He went further, stating, “It will take the patient accumulation of quiet successes over time to discredit and defeat extremist movements and their ideology.”³⁵⁹ This is similar to the “benevolent assimilation” from counterinsurgency campaigns of the earlier 1900s in Southeast Asia and Latin America. Gates went further to warn of “creeping militarization” into stability operations. Terms like “mission creep” and the “slippery slope” come to mind with the U.S. military becoming more involved in missions once handled by civilian agencies.³⁶⁰ Such issues are topics for another debate, but what is pertinent to this work is how these activities are given to an organization, like the AMEDD, which is unprepared and untrained for such tasks. Gates has even taken the radical step of speaking out on behalf of the underfunded and understaffed State

³⁵⁷ Cavaleri, *Easier Said than Done*, pp. 70–71.

³⁵⁸ Colin H. Kahl, *Foreign Affairs: COIN of the Realm*, Center for a New American Security, December, 2007, <http://www.cnas.org/en/art/?259>. Colin H. Kahl is an Assistant Professor in the Security Studies Program at Georgetown University and a Fellow at the Center for a New American Security.

³⁵⁹ Robert M. Gates, Secretary of Defense in his lecture at Kansas State University, Manhattan, Kansas, 26 November 2007.

³⁶⁰ Ann Scott Tyson, “Gates Warns of Militarized Policy,” *Los Angeles Times*, July 16, 2008.

Department. He concluded that the U.S. military should not be mistaken for “the Peace Corps with guns.”³⁶¹

Improvement is beginning to show, although progress is exceedingly slow. The CMA Cell has been restructured and associated MEDCAPs were discontinued at the CJTF level. More resources are now directed toward the PRTs with medical representation. PRTs are now working with non-governmental organizations and the local Ministry of Public Health. Places like the Konar Province are showing success. Working with the Aide Medicale International, a humanitarian French organization, this PRT has built fifteen new healthcare facilities which are staffed by professionals training by these non-governmental organizations. Supplies are provided by the Ministry of Public Health and supporting non-governmental organizations.³⁶²

Doctrine

If the AMEDD is to continue such tasks, there is a critical need for an education and training system that prepares providers and medical planners to conduct such missions. Unfortunately, when altruistically minded individuals are put in this position with little to no training, or supporting doctrine for such an operation, they will naturally revert back to their basic principle, which is to treat the patient in front of them. It is equally important that commanders understand these deficiency in medical support. Commanders have a tendency to take their “tool box” and utilize all of their combat power, not understanding how to use each of those tools, especially the medical one. So this educational process needs to extend past the AMEDD officer and to the maneuver commander.³⁶³

Entry-level training for AMEDD officers and healthcare providers needs to focus on medical infrastructure development and its support for counterinsurgency operations.³⁶⁴ This

³⁶¹ Lolita C. Baldo, “Gates Warns of Militarization of US Foreign Policy,” *Associated Press*, July 15, 2008.

³⁶² Myers, “Konar PRT.” pp. 1–2.

³⁶³ Diamond Interview, 2008.

³⁶⁴ Thompson, “The Role of Medical Diplomacy in Stabilizing Afghanistan,” p. 7.

infrastructure becomes the “arms and legs” to the strategy of winning “hearts and minds.”³⁶⁵

Unfortunately, this training is inadequate with no supporting medical doctrine. As of the writing of this study, the Captain’s Career Course at the U.S. AMEDD Center and School, includes only three days of counterinsurgency “familiarization.” Included in this is one day of “cultural awareness” and one practical exercise. With no established doctrine, this curriculum is not only very limited, but was not implemented until 2007.³⁶⁶ What doctrine is available, to support this training, addresses humanitarian assistance as a generality and primarily in support of disaster relief. There is no dedicated doctrine to guide AMEDD officers in support of a counterinsurgency.³⁶⁷ This must change.

Resourcing

Despite slow changes in the more secure provinces, infrastructure development, which is characteristic of a modernized state, remains absent. As stated previously in chapter four, Afghanistan still relies on international compassion to provide basic healthcare services to its rural population. After seven years of U.S. and ISAF stability operations, the per capita income averages between \$150 and \$180 dollars. International per capita donations since 2002 have amounted to a dismal \$150 dollars. This is barely adequate to maintain a country at even a poverty level, let alone stimulate growth. Compared to this is the \$80 billion dollar a year illegal opium crop that is twenty six times the GNP.³⁶⁸

U.S. appropriations are outdated and designed to support short-term humanitarian assistance missions. These funding avenues are restricted to humanitarian assistance and are not authorized for nation building. This has made bureaucracies like OHDACA useless as a funding

³⁶⁵ Merriam Mashatt, Daniel Long, and James Crum, *Conflict-sensitive Approach to Infrastructure Development*, Special Report 197 (Washington, DC: United States Institute of Peace, January 2008), p. 3. Accessed at www.usip.org/pubs/specialreports/sr197.pdf.

³⁶⁶ Colonel (retired) Robert C. Leeds, DMD, Instructional Operations Officer for the Captain’s Career Course Leader Training Center, AMEDD Center and School, San Antonio, Texas. Interviewed by the author September, 2008.

³⁶⁷ As stated in Chapter Four, publications that do address medical support for humanitarian assistance include *Department of Defense Directive 3000.05* (November, 2005), *Joint Publication 4-02, Health Service Support* (October, 2006) and *Joint Publication 3-57, Civil Military Operations* (July, 2008).

³⁶⁸ Cavaleri, *Easier Said than Done*, pp. 72-73.

mechanism.³⁶⁹ CERP was an attempt to circumvent this. Congress appropriated \$180 million to fund CERP projects as part of an Emergency Supplemental Appropriations Act on 30 September 2003. This permitted the purchasing of goods and services to support a wide array of projects that address humanitarian needs, including: sanitation infrastructure, and healthcare. Though this program gained national media attention and popularity with commanders, these funds were unavailable for long-term nation building, and so, became perfect funding avenues for limited missions like MEDCAPs.³⁷⁰

Intelligence

History has not demonstrated a clear instance where medical support actions, especially MEDCAPs, have proven of any significant value toward a successful counterinsurgency.³⁷¹ This was neither as a legitimate agent for infrastructure development nor a passive source for actionable intelligence. This is not to say that intelligence collected during medical missions did not further public health issues and force protection, but the deliberate gathering of passive operational intelligence, which many lauded as a reason for such missions, did not justify these missions alone.

Ethics

The difference between the U.S. life expectancy of over seventy eight years and the forty three years in Afghanistan is not a result of cardio-bypass surgery or cancer therapy. It is access to potable water, nutritional food, waste management and window screens for vector control; it has nothing to do with managing hypertension or treating chronic back pain; it has everything to do with immunizing children, hand washing and sterile delivery techniques for mid-wives. None of this is possible with a single-day visit from an American provider.³⁷²

³⁶⁹ Thompson, "The Role of Medical Diplomacy in Stabilizing Afghanistan," pp. 3–4.

³⁷⁰ CLAMO, pp. 168–171.

³⁷¹ Smith & Llewellyn, "Humanitarian Medical Assistance In U.S. Foreign Policy," p. 73.

³⁷² Information Paper, *Cooperative Medical Assistance (CMA) Planning Considerations in Afghanistan*, (Combined Joint Task Force–82, Bagram, Afghanistan: March 2007) p. 2. Ethical issues are addressed during this study though there are other legal implications which are raised briefly in chapter three. This includes the use of non-combatant personnel as a tool for combat operations. Such a legal topic is outside the scope of this study but warrants further research.

Vietnam marked a revolution in military medicine. This was the first concerted effort to use direct patient care to aid combat operations against an insurgency. The factors that shaped this were: the U.S. losing focus on prior counterinsurgency missions and the principles that had shown success; lack of knowledge to the limits of humanitarian assistance missions; and medical training outpacing the mission.

As with Vietnam, there is no applicable doctrine available for counterinsurgency medical support for Afghanistan, and what doctrine is available is limited to humanitarian assistance and pertinent only to disaster relief. While humanitarian assistance missions are similar in structure, they do not have the same purpose as a counterinsurgency. Army operational principles and doctrine mention medical care as an issue, but this is not synchronized with counterinsurgency doctrine and is American-centric in its wording. Currently, there is only minimal counterinsurgency training for AMEDD officers, although counterinsurgency is the most common conflict confronted by American forces.

One could argue that this is a Civil Affairs issue and should be left to them for training and doctrine development. Unfortunately, as seen in Afghanistan and earlier in Vietnam, the training of civil medical personnel is inadequate. It would also stand to reason that any medical mission planned by Civil Affairs will most likely be supported by the AMEDD.

Such training is critical because medical education and technology are outpacing these missions. Previously medical corps officers during the Philippine Insurrection and small wars of the early 1900s focused on sanitation, hygiene programs and infrastructure engineering. This is all that was available at the time. Modalities like antibiotics, advanced palliative care and reconstructive surgery were still in their infancy.

By the 1960s American medical training had progressed and now focused on pharmaceutical therapies for developed countries. The “magic bullet” is now at the core of the American treatment mindset. Basic preventive services are an afterthought in most medical

institutions of training. Altruism is paramount, and doctors are taught that the most important person is the patient sitting in front of them. Such providers then become the subject matter experts for commanders in the field as they are assigned as division, brigade and battalion surgeons. In the absence of any doctrinal training, naturally these professionals fall back to their basic core training; “treat the patient in front of you.” They instinctively ask the question, “What kind of technology can I bring to bear to solve this clinical problem?” There is none in a counterinsurgency.

Direct patient care programs demonstrated no positive outcomes, despite hundreds of millions of dollars expended, this means of non-lethal combat power persisted with as much vigor during the first five years of OEF as during the MEDCAP programs of Vietnam. U.S. planners attempted no significant change in this program and the same amount of money was wasted proportioned to the times. One must ask. Is medicine the right weapon? Like any targeting one needs the right weapon for the right effect.

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