MEDICAL DIPLOMACY in Full-Spectrum Operations

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AMERICAN MEDICINE is a powerful "weapon of freedom" in our Nation's arsenal against terrorists and the forces of oppression.[1] However, tailgate medicine, as commonly practiced by many well-meaning medical civil-assistance programs (MEDCAPs), is not an effective tool for commanders conducting counterinsurgency (COIN) operations in the Iraqi theater of operations. To legitimize the Iraqi Government, we must build capability in local institutions, not replace essential services like medicine with direct medical care by occupying forces.

The major fault of MEDCAPs in Iraq is strategic. MEDCAPs undermine local medical services sanctioned by the Iraqi Ministry of Health and provincial medical directors, thus decreasing support for Iraq's national and provincial governments. The insurgency in Iraq will be defeated when Iraqis reject it through their acceptance of and dependence on the legitimate Iraqi Government. Instead of helping to achieve this end state, MEDCAPs, no matter how well intentioned, planned, or executed, weaken Iraqi Government services and, therefore, are counterproductive to U.S. strategic aims.

Military medicine can be an effective operational tool if we apply it thoughtfully. Many have noted that it contributed to social, economic, and political stability in past conflicts.[2] Tommy Thompson, the former U.S. secretary of Health and Human Services, has called for increased "medical diplomacy" in America's foreign and defense policy, declaring it "the best chance to win the war on terror and defeat the terrorists."[3] The 2005 *National Strategy for Victory in Iraq* cited the value of building and rehabilitating health care facilities.[4] More recently, *The Iraq Study Group Report* stated that "building the capacity of the Iraqi Government should be at the heart of U.S. reconstruction efforts."[5] However, turning observations, strategic guidance, and situational understanding into effective operational missions presents a challenge for leaders on today's battlefield. This article examines the U.S. military's experiences with medical civil-military operations (MCMO); discusses current policy, doctrine, and practice; and describes the experiences of the 3d Armored Cavalry Regiment (3d ACR) in Tal Afar, Iraq, in 2005 as an example of successful brigade-level operations that support, build, and promote local medical institutions.

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PHOTO: A sign, in Arabic and Turkman, at the entrance to Tal Afar's general hospital.

(All photos courtesy of the author)

Historical Perspective

We have used medicine as a tool for winning hearts and minds in previous COIN campaigns. For example, an essential part of the pacification campaign

in the Philippines Insurrection was establishing public health measures, along with organizing municipal governments and public schools. General E.S. Otis and General Arthur MacArthur's pacification policies were the foundation for the colonial civilian government that President William Howard Taft later established. The medical component of the program helped achieve a relative peace that lasted for nearly four decades.[6]

During the Vietnam War, the U.S. military invested between $500 million and $750 million in the Medical Civic Action Program (MEDCAP) and treated more than 40 million Vietnamese civilians.[7] MEDCAP was designed to provide aid to villages and communities by using Vietnamese military medical personnel assisted by U.S. medical personnel, but with the introduction of large numbers of U.S. troops into Vietnam in 1965, U.S. military medical teams assumed responsibility for medical care to civilians in their respective areas of operation (AOs).

A 2001 *Military Medicine* article described the Vietnam MEDCAPs:

> Often, a MEDCAP team would simply show up and set up shop. A schoolroom was frequently the chosen locale. Mainly elderly women and children were seen. It was very rare to see a young man of working or military age. Every patient was given something. Most often, there was no available X-ray or laboratory backup. If the interpreters were not even slightly medically sophisticated, treatment was based on guessing. Because of security concerns, follow-up visits could not be scheduled on a regular basis. The session would last until the medical unit ran out of supplies, all of the patients were seen, or it began to get late in the day and it was necessary to return to the base camp before darkness set in. Generally, supplies gave out before the patients did.
>
> There was supposed to be coordination between the various US military units and the Vietnamese civilian health care organizations. This was often absent or deficient. Not infrequently, a medical group from one unit would arrive in a hamlet or at an orphanage to find another medical group working there or having just been there. On one occasion, five different US civic action groups arrived at one hamlet simultaneously. None of them had coordinated their activities through the district or province advisors because of security reasons.[8]

There were other medical programs in Vietnam as well. The Volunteer Physicians for Vietnam program (coordinated with the American Medical Association) rotated volunteer civilian physicians into Vietnam for 60-, 90-, or 120-day tours. However, the number of volunteers was inadequate and the tours were too short to enable physicians to develop significant relationships with their Vietnamese counterparts; thus, the program was not sustained.

The Military Provincial Health Program (MILPHAP) was a team of U.S. doctors, nurses, and medics assigned to provincial hospitals to aid and train Vietnamese health providers. Initially, the MILPHAP teams provided medical care and health services directly to Vietnamese civilians while training hospital staff workers and improving Vietnamese physicians' surgical skills. By 1971, MILPHAP personnel were training Vietnamese medical personnel in preventive medicine and public health. These programs were thought to have improved the quality of medical care given Vietnamese civilians. However, there were problems: program administrators intervened before finding out what the Vietnamese wanted or were able to support; no long-range health plan existed; frequent rotations of personnel resulted in a lack of institutional memory; missing medical supplies often appeared later on the black market or in the hands of enemy soldiers; and some Vietnamese physicians believed that they lost face in their community because the presence of foreign teams implied that the foreign doctors had greater skills.[9]

In his book *Military Medicine To Win Hearts and Minds: Aid to Civilians in the Vietnam War,* Dr. Robert Wilensky concluded, "The medical assistance effort had little impact on the outcome of the conflict."[10] Although the locals appreciated individual benefits, these various medical programs did nothing to build support for the Republic of Vietnam, because its citizens did not identify U.S. military medical actions with the Vietnamese Government.

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Although MCMO in low-intensity conflict may be a cost-effective and uncontroversial way to gain popular support, medical programs, in the words of Wilensky, "should aim the best light possible on the host government, not on the United States. The emphasis should be on developing capability, not providing service."[11]

Current Events

In Iraq, medical and combat arms officers alike often see MCMO as a drive-by operation for supporting pacification, gathering local intelligence, or rewarding locals for their cooperation. We can only practice "band-aid medicine" at MEDCAPs: we provide no enduring medical care. As in Vietnam, a MEDCAPs-like operation in Iraq often consists of a temporary "clinic" staffed by a physician or physician's assistant and supported by several medics. We advertise the clinic for a short time in the local community, rush as many patients through as can be seen in a couple of hours, and then hastily decamp. We distribute over-the-counter medications to patients and then discover the medicine we dispensed is being sold on the black market.

In addition, MEDCAPs can create tactical and operational problems. Due to the perception that U.S. medicine is superior, huge crowds commonly gather at a temporary clinic, creating a target of opportunity for the would-be suicide bomber or for the enemy's indirect fire.

Another problem is that theater medical rules of eligibility constrain medical care and prohibit referrals to higher levels of U.S. care; we refer patients with serious medical conditions back to Iraqi hospitals or clinics. All too often, the local citizens' unmet expectations lead to their dissatisfaction and distrust of U.S. forces. Thus, whether due to a catastrophic attack or to inadequate medical care, the secondary and tertiary effects of tailgate MEDCAPs overshadow any goodwill that may have developed.

Many Arab leaders are physicians, including Ibrahim al-Jaafari and Ayad Allawi, the first two Iraqi prime ministers after Saddam's deposal. In the cities and villages of Iraq, physicians are commonly the most educated members of their communities, and their influence is substantial. Courting their cooperation could result in greater community support. In this endeavor, American military physicians may take a leading role by virtue of their common training and experience. However, like the programs in Vietnam with Vietnamese physicians, poorly planned MCMO may cause Iraqi physicians to lose face and feel that their honor is compromised. U.S. and coalition forces lose a prestigious and respected ally in the community when this occurs.

The enemy recognizes the powerful value of medicine as well. As part of their terrorism campaign, insurgents target Iraqi physicians because of their financial status and social prestige.[12] In other fronts of the War on Terrorism, terrorist organizations such as Hezbollah have established shadow medical systems to develop local support for their operations.

In his article "Winning the Peace: The Requirement for Full-Spectrum Operations," Lieutenant General Peter Chiarelli, a former commander of Multi-National Corps-Iraq, noted, "Full spectrum operations are the continuation of combat operations by other means."[13] In Iraq, these tactics include improving infrastructure, training security forces, and creating jobs. Instituting MCMO is another unconventional tactic that would contribute immensely to successful operations.[14]

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On the battlefield, our ground forces are constantly using innovative solutions to adapt to current tactical and operational realities, and the Army is developing new doctrine on full-spectrum operations. Army Medical Department leaders recognize American medicine's potential for combating terrorism, and they also see the need to adapt medical doctrine to incorporate medical civil-military operations. The new *Joint Task Force Senior Medical Leader Operations Guide* states that "the focus of Health Support Services initiatives during MCMO is to improve Host Nation capacity to provide public health and medical services to its population, thereby enhancing legitimacy of the Host Nation, enhancing force protection, and accomplishing the Combined Joint Task Force's political-military objectives."[15] In September 2005, the commanding general of the 44th Medical Command (MEDCOM)

recommended that the Army Medical Department Center and School develop a program of instruction for use in its basic and advanced officer courses for "the employment of medical forces in civil-military operations as well as for the development of strategic medical engagement strategy."[16] In particular, the 44th MEDCOM after action review noted that there are not enough public health teams in Iraq to support the medical engagement strategy adequately.[17]

Optimizing the use of the combat units' organic medical personnel and resources could help achieve strategic objectives. Lessons learned from operational and tactical successes in MCMO could be used to help develop doctrine for medical diplomacy on the battlefield, to include an MCMO toolset for combat commanders.

3d ACR's Experience

The 3d Armored Cavalry Regiment's experience in Tal Afar, Iraq, demonstrates how brigade-level medical units can successfully contribute to full-spectrum operations and help win the peace. When the 3d ACR arrived in Tal Afar in April 2005, Al-Qaeda had infiltrated the only hospital in the city, and the hospital director was reportedly an insurgent sympathizer. Violent crimes were committed at the hospital, including the murder of Shi'ite Iraqi police officers and the detonation of explosives attached to a Shi'ite youth's booby-trapped corpse, a depredation that killed the youth's father when he sought to retrieve his son's body.

In May 2005, a platoon from 3d ACR's Sabre Squadron took up an overwatch position near the hospital. However, the hospital soon became a target for attacks, and the public's confidence in the hospital plummeted to new lows. Visits decreased to a nadir of less than 10 outpatients a day, and no patients would remain overnight because of the security situation. But the hospital was suddenly inhospitable to the enemy as well: injured insurgents were detained and medical support for the insurgency was denied. Third ACR forces continued to guard the hospital until August 2005, when an Iraqi Army unit assumed full-time responsibility. In the fall of 2005, a police station was established nearby, and the Iraqi Army stopped providing security for the hospital.

In September 2005, Operation Restoring Rights (ORR) succeeded in restoring security to the city, which optimized conditions for successful MCMO. Before ORR, an international medical nongovernmental organization (NGO) and the 3d ACR civil affairs officer planned and coordinated medical services to meet the needs of Tal Afar's citizens. Third ACR obtained a World Health Organization kit and pre-positioned medical goods in refugee camps. Three large-scale suicide attacks between the end of ORR Phase III and the nationwide constitutional referendum in October provided 3d ACR an opportunity to demonstrate its commitment to the hospital and Tal Afar. U.S. medical personnel cared for scores of civilian casualties during these emergencies.

Guidance to the 3d ACR from higher headquarters regarding MCMO was "no MEDCAPs", but no alternative doctrine existed, either formal or informal. Public health teams, which are a civil affairs asset, were not available after the conclusion of Phase III of ORR. To remedy the shortfall, 3d ACR initiated a novel plan, which it called Medical Clinic Action Teams (MCATs), to exploit the strength of its organic medical assets (see Table 1). The regiment conducted substantial planning and rehearsals and coordinated security before the mission. The MCATs delivered trauma supplies and textbooks, and the four teams split apart with accompanying security and collected over 100 findings of potential hospital needs.[18]

The MCATs did more than just hospital assessments: they created the opportunity for increased engagement with the region's medical facilities and staffs. The regimental surgeon subsequently conducted bimonthly visits with Tal Afar hospital and clinic directors over the next three months. The MCAT assessments provided a starting point to negotiate aid activities. In many cases, consultation was all that was required to address identified needs, such as providing a packing list for a pediatric emergency crash kit. Table 2 below shows a variety of actions that were accomplished because of continued efforts after the MCATs' missions.

Third ACR also actively sought to cooperate with local NGOs. Representatives from international medical NGOs frequently attended meetings with the Tal Afar medical leaders and pursued additional health-related aid projects (Table 3). The Ninewa director general of health sent a representative to Tal Afar to coordinate and synchronize priorities

Group Focus	Group Members	Assessment Tasks
Administration	• Medical troop commander • Support operations officer • Regimental surgeon • Civil affairs officer	• Administration of hospital • Communications
Clinical	• Field surgeon • Regimental nurse • Support operations officer (supply and services) • THT(-) • Interpreter	• Obstetrics (infant mortality) • Pediatrics • Emergency room • Operating room • Nursing procedures • CL VIII supply procedures • HUMINT
Physical plant and maintenance	• Seabee engineer • Medical platoon leader • Medical maintenance • Technician • Interpreter	• Structural integrity of facility • Medical maintenance (identify non-mission capable equipment) • Medical maintenance procedures (identify services and repair part resupply) • Equipment serviceability (identify technology level)
Ancillary Services	• Medical platoon sergeant • Ambulance platoon NCO • Lab and x-ray technician • Interpreter	• Laboratory assessment (identify capabilities and hazardous material procedures) • X-ray (Identify capabilities and training) • Ambulance/emergency vehicle fleet assessment (identify non-mission capable vehicles and trauma capabilities) • Ambulance utilization (identify dispatching procedures and partnership with other municipal agencies i.e. Iraqi Police, fire department, etc.)

Table 1. Medical consulting action team groups.

Project	Donation/Labor Source
Ambulance repair prior to December elections	Commander's Emergency Response Program funds
Warehouse replacement with donation of two	Regimental S4 donation, coordination with support
Wheelchair donations coordinated	International non-governmental organization (NGO)
Donation of medicines	Corps donation
Donation of body bags	2/3 ACR medical platoon
Packing list for pediatric crash cart	Regimental support squadron medical troop
Ambulance load plan	Regimental support squadron medical troop
Intervention re: Shia complaints	Regimental surgeon (RSURG), 2/3 ACR Squadron
New water pipes in parking lot	Regimental engineer
Emergency telephone number flyers	Psychological operations (PSYOPS)
Preventive medicine teaching slides	RSURG
Preventive medicine flyers for community distribution	RSURG, PSYOPS
First aid kits for schools	2/3 ACR medical platoon
Project sharing with medical international NGO	RSURG

Table 2. 3d ACR MCMO activities following MCAT.

1. Established 8 water points with 10,000 liter capacity and rented water trucks to supply daily potable water to 8 districts.
2. Repaired broken pipes on main water line and supplied water office with manual tools, welding machine, uniforms, boots.
3. Constructed 12 garbage pits within neighborhoods.
4. Planned to supply Al-Salam public health clinic with furniture and medical equipment.
5. Initiated construction of birthing unit in Al-Amal public health clinic.

Table 3. Selected medical international NGO activities in Tal Afar.

and efforts. Interactive crosstalk with all interested parties created synergy and avoided duplication of effort.

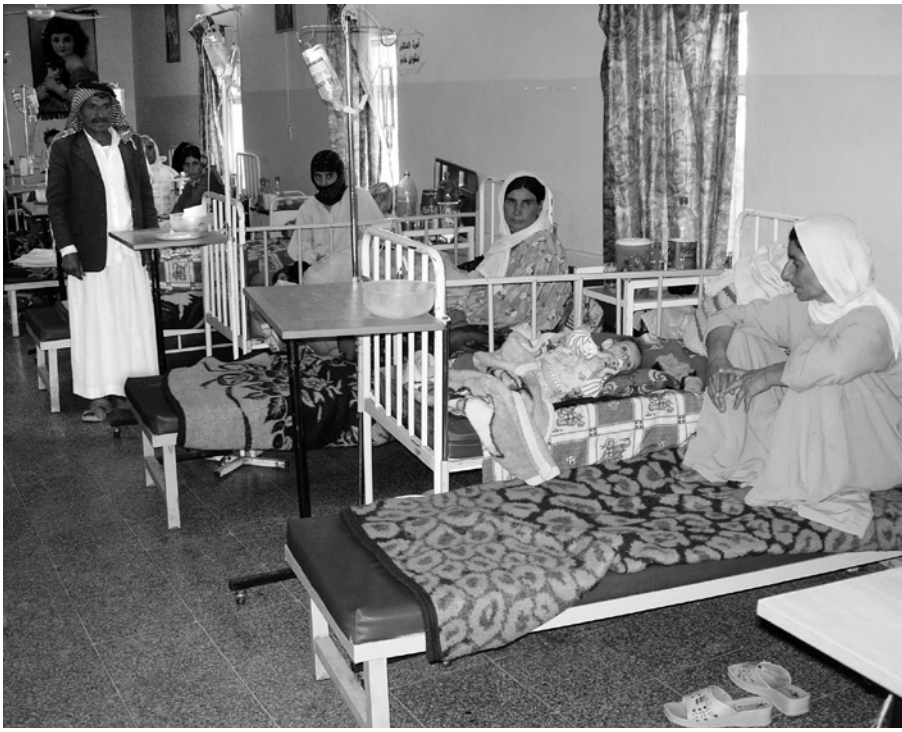
The permanent presence of Iraqi Security Forces (ISF) at the hospital facilitated a relationship of mutual benefit among the Iraqi hospital administrators, Iraqi medical personnel, and ISF. Initial doubt gave way to cooperation, and familiarity and trust developed. Medical care for Iraqi soldiers and police officers improved when the 3d Iraqi Army Division received a surgeon in December. The Tal Afar hospital director agreed to begin training ISF soldiers to become combat lifesavers, using a model already successfully implemented in the neighboring city of Sinjar.

In January 2006, the ACR capitalized on relationships that had developed in a few months of vigorous activity to organize a regional medical society. The newly arrived Iraqi Army surgeon at the Iraqi Army base near Tal Afar hosted the Western Ninewa Medical Conference (WNMC), inviting regional hospital and clinic directors as well as the Ninewa directorate governor of health. The intent was to organize the region's medical leaders, give them experience in the exercise of free assembly, and help them become a self-sustaining professional organization. The conference conferred additional legitimacy on the Iraqi Army surgeon as a valuable partner with the local physicians to improve regional medical capabilities.

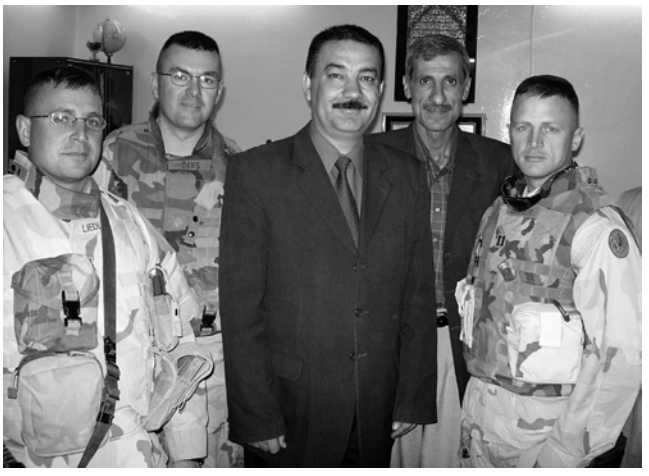
Third ACR's primary MCMO goal was to strengthen and rebuild Tal Afar's medical system to increase the local population's trust in and reliance on Iraqi Government institutions. Second Squadron commander Lieutenant Colonel Chris Hickey stated,

> I used to believe in MEDCAPs, but I saw that we achieved greater, more long-lasting, enduring effects when we focused on improving their medical system. I could sense the level of fear and intimidation of the population by going to visit the hospital. During the summer of 2005, this level was very high. By the fall, I could sense people's confidence and faith in security and their government had drastically improved. One indicator was when the female doctors came back to work and the hospital started seeing women and babies again.[19]

By February 2006, the hospital was seeing over 800 patients a day, a huge jump from the 10 per day in summer 2005.[20] In my last meeting with the Tal Afar hospital director, in February 2006, he told



Iraqi patients in the Tal Afar hospital in January 2006 after security had been reestablished and medical civil-military operations were underway.



The day of the MCAT: (left to right) CPT Dan Liedl, med troop commander; MAJ Hugh Davis, support officer; Dr. Salih, Tal Afar hospital director; Dr. Said, Tal Afar clinics director; and the author.

me, "I see peace in the faces of the people for the first time in two years."

Summary

In "Winning the Peace," Lieutenant General Chiarelli cited President John F. Kennedy's remark that "few of the important problems of our time have, in the final analysis, been solved by military power alone."[21] In a similar vein, Lieutenant Colonel Hickey stated, "restoring the community's faith in the hospital was one of the keys to our strategy of restoring confidence in the Iraqi government. The other keys were restoring confidence in the city government, getting the judicial system operating, improving the schools, getting markets reopened and people to work, improving the food distribution system, improving power and water services, and restoring trust in the Iraqi security forces."[22]

The U.S. Army Medical Department is a powerful force that can contribute to operational success on today's battlefield by exercising medical diplomacy. Army doctrine should leverage the full capabilities of Army physicians, physician's assistants, medics, and other medical personnel, and these capabilities should be tested during unit-level training exercises. Combat commanders will gain a valuable tool in COIN operations by directing their units' organic medical assets to conduct appropriate capacity-building MCMO.

The principles of successful MCMO are *secure, engage,* and *build*. First, establishing security for local hospitals and clinics should be paramount. Second, to ensure they understand the needs and wants of Iraqis in their AOs, units should engage regularly with local Iraqi medical leaders, who are likely to be influential members in their communities. This should include frequent assessments to maintain situational awareness. Finally, after assessing the community's needs and their own priorities and capabilities, units should build medical capacity in the AO. They must take corrective action to avoid self-defeating actions, and should eschew any Vietnam-era kind of medical program.

As Iraqis begin to trust and embrace their national and provincial governments and rely on essential government services such as medical care, they will reject the insurgency. Building Iraqi medical capabilities instead of providing direct medical care will assist in that effort and increase Iraqi self-sufficiency. The combined acts, improving security using combat forces, engaging local health professionals and institutions using brigade-level medical assets, and employing MCMO-building activities will help achieve the combat commander's objectives on the battlefield and America's strategic objectives in the region. ***MR***

NOTES

1. The former secretary of Health and Human Services, Tommy G. Thompson, taught a course on "medical diplomacy" at Harvard's Kennedy School of Government in the fall of 2005. He described this vision in an op-ed article, "The cure for tyranny," *The Boston Globe,* 24 October 2005, <www.boston.com/yourlife/health/other/articles/2005/10/24/the_cure_for_tyranny/>.

2. Robert J. Wilensky, *Military Medicine to Win Hearts and Minds: Aid to Civilians in the Vietnam War* (Lubbock, Texas: Texas Tech University Press, 2004), 38. Wilensky's book is an exhaustive research of MCMO in Vietnam with hundreds of references.

3. Thompson.

4. *National Strategy for Victory in Iraq*, by George W. Bush (Washington, DC: The White House, 30 November 2005), <www.whitehouse.gov/infocus/iraq/iraq_strategy_nov2005.html>.

5. James A. Baker, Lee H. Hamilton, et al., *The Iraq Study Group Report* (New York: Vintage Books, 2006), 86.

6. John M. Gates, "The U.S. Army and Irregular Warfare, Chapter Three: The Pacification of the Philippines," November 2002, < www.wooster.edu/History/jgates/book-ch3.html>.

7. Robert J. Wilensky, "The Medical Civic Action Program in Vietnam: Success or Failure?" *Military Medicine 166, no. 9* (September 2001): 815-19.

8. Ibid.

9. Ibid.

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

11. Ibid, 126.

12. "Iraq: Insurgents and criminals target doctors," *IRINnews.org: UN Office for the Coordination of Humanitarian Affairs,* 10 May 2005, <www.irinnews.org/report.asp?ReportID=47039&SelectRegion=Middle_East&SelectCountry=IRA>.

13. MG Peter W. Chiarelli and MAJ Patrick R. Michaelis, "The Requirement for Full Spectrum Operations," *Military Review* (July-August 2005): 4-17.

14. Brigadier Nigel Aylwin-Foster, "Changing the Army for Counterinsurgency Operations," *Military Review* (November-December 2005): 2-15.

15. U.S. Joint Forces Command: Office of the Command Surgeon, "Annex J: Medical Civil-Military Operations", *Joint Task Force (JTF) Senior Medical Leader Operations Guide* (Norfolk, VA: 6 March 2006), 131-33.

16. LTC Wendy Harter, TF44 MEDCOM G5, for BG Elder Granger, "Point Paper: Developing Medical Civil-Military Operations Leadership Capabilities," 14 September 2005.

17. "TF 44th MEDCOM AAR/Lessons Learned Brief," <https://secure-ll.amedd.army.mil/reports/oif/OIF3-44-MEDCOM-V3.ppt>.

18. CPT Jay Baker and CPT Dan Liedl, "Medical Consulting Action Team (MCAT): A New Tool for Commanders to Replace MEDCAPs," PowerPoint presentation, May 2006.

19. LTC Chris Hickey, personal communication by email, 7 December 2006.

20. Ibid.

21. Chiarelli, 4.

22. Hickey.