

# FIELD HOSPITAL SUPPORT for Civilians in COUNTERINSURGENCY OPERATIONS

Colonel Albert R. Bryan, U.S. Army Reserve, Retired



**I**F AN IRAQI MAN believes that your hospital has saved the life of his child, sister, or parent, will he shoot at you? Most will not. He may even tell you where insurgents and criminals are hiding, which furthers the counterinsurgency (COIN) mission and decreases U.S. casualties.

This point may seem obvious, but it bears repeating. Medical support of civilians in an area of operations can be a tool for winning support for the counterinsurgency. Unfortunately this realization is dawning much too slowly, as doctrinal changes are always slow. For instance, while one combat support hospital (CSH) could note that 60 percent of its patients at times were Iraqis, and another could note that it routinely sees civilians injured by “collateral damage,” it still remains the enunciated policy of Medical Command (MEDCOM) that you do not treat civilians if you can possibly avoid it. It was this way in Desert Storm and persists in the current operating environments.

Instances of providing care, including the transportation of injured children by a Marine unit in Ramadi to Baghdad for treatment, are spur-of-the-moment targets of opportunity, or random acts of kindness. They are not part of the commander’s visualization and design for operations. They are not part of the execution of plans. Campaign design does not include deployment of field hospitals in support of civilians. If the evacuation of the Ramadi children in September 2007 was, in fact, a proactive part of information operations employed to favorably influence the populace’s perception of all coalition actions while simultaneously discrediting the insurgents, this reporter was unaware of it.

## Bucking Doctrine

What field hospitals can contribute in COIN remains largely unexplored, and the reasons why they have not been deployed for civilian support appear merely doctrinal. The capacity of a deployed U.S. field hospital to do good (and to look good doing it) presents an awesome but underappreciated “force multiplier” to senior commanders. During Desert Storm, the 13th Evacuation (EVAC) Hospital from Wisconsin and another EVAC from North Carolina were colocated on Pipeline Road. In six weeks, they saw 17,000 patients, had admitted 500 patients, and performed 200 surgeries. After Desert Storm the 912th Mobile Army Surgical Hospital (MASH), Tennessee, was deployed to support Shi’ite refugees at Safwan, Iraq. The refugees were effusively

*Colonel Albert R. Bryan, U.S. Army Reserve, retired, spent four years on active duty in Germany where he served as a flight surgeon and an internist. He deployed with the 13th Evacuation Hospital in Saudi Arabia and with the 912th MASH in Iraq during Operation Desert Storm. COL Bryan has served on temporary duty as a consulting physician in medical clinics outside of the United States. He received a B.A. from the University of Wisconsin, and earned his M.D. at McGill University.*

PHOTO: An Iraqi man presents a child to a U.S. Navy Hospital corpsman for medical care in a town in Ninewa province, Iraq, 16 December 2008. (U.S. Marine Corps, SGT Jason W. Fudge)

***What field hospitals can contribute in COIN remains largely unexplored, and the reasons why they have not been deployed for civilian support appear merely doctrinal.***

grateful for routine obstetrical, medical, pediatric, and surgical attention. In Pakistan, the 212th MASH, Landstuhl, treated 20,000 casualties of the 2005 earthquake in four months. These treatments included 500 hospitalizations and 425 operations. The 212th was deployed also in Bosnia and Croatia along with the 48th Air Transportable Hospital and Navy Fleet Hospital 6. The latter two treated civilian refugees routinely to great effect; the 212th adhered to MEDCOM doctrinal limitations.

A field hospital's capabilities come from a complex interaction of the clinical sections: emergency room, laboratory, pre- and post-operative care, anesthesiology, surgery, internal medicine, intensive care unit, pediatrics, obstetrics-gynecology, nurses, and corpsman. The level of nursing care in U.S. field hospitals is at least an order of magnitude better than what I have observed as a physician in six of the best hospitals in Frankfurt, Germany, and in Moscow, Russia. Most line officers have little knowledge of this scientific expertise that military hospitals bring to the field. Only one commanding general, General Frederick Franks, Jr., experienced the modern field hospital as a patient. He had to have his leg amputated in Vietnam. Twenty years later, as commander of VII Corps in 1991, when faced with a serious refugee problem in Iraq, he deployed three MASH units to provide civilian refugees with standard medical care. He ignored MEDCOM doctrine.

Shortly after Desert Storm, MEDCOM told me "Doctor, we're here to preserve the fighting strength,

***...[In 1991] when faced with a serious refugee problem in Iraq, [General Franks] deployed three MASH units to provide civilian refugees with standard medical care. He ignored MEDCOM doctrine.***

period, end of story. If we take on care of civilians, then the Red Cross/Red Crescent, the UN, Merlin, and MSF (Doctors Without Borders) will all back off and we'll be stuck with them." There is clearly a doctrinal influence in such an aversion to imaginative use of medical assets. Complex mission needs, as in COIN, demand a flexible, imaginative approach not trammled by rigid doctrinal assumptions.

Medical support is a doctrinal combat service support function associated with corps-level logistics, a G4 mission. Medical support may be occasionally referred to in the morning report by G1, but rarely if ever, as a logical line of operation (LLO) in G3 planning. It is not a doctrinal form of engagement. Nor is it a doctrinal form of information operations. Yet, in a COIN environment, targeted medical support of civilians as a tool for peace and stability could and should be used.

Two important means of measuring success in COIN operations are improvement in intelligence voluntarily given by the population and a decrease in insurgent recruitment. Within days, smiling faces replaced sullen expressions on both patients and their families treated at the 912th MASH in Iraq—just as they had done after a six-month anticommunist campaign in Malaya and Vietnam in 1966. If we think past the limitations of doctrine, imagining a COIN role for field hospitals is obvious. In COIN operations they are force multipliers, non-kinetic "weapons systems." They save peoples' lives, which affects not only the families involved, but also the milieu of an insurgency.

## **Soft Power and Economy of Force**

Field hospital support for civilians produces several positive effects in COIN. A modern treatment center will epitomize the "soft power" or persuasive side of U.S. foreign policy. Word of medical successes spreads rapidly throughout a country and is remembered when memories of abuses fade. Police and citizens groups have a vested interest in protecting a medical facility that combines host nation and U.S. military care in which their family and neighbors are being treated. The police themselves might be the next patients. Women are accorded regard that they can never expect from Al-Qaeda and Sharia insurgents. Civilian patients frequently are treated in the same hospital where U.S. soldiers are treated. A higher regard cannot be accorded or communicated.



**U.S. Air Force Technical Sergeants Daniel Wilson, right, and Julie Zygulski wrap a bandage around an Iraqi man's leg during a physical therapy session at the Air Force Theater Hospital at Joint Base Balad, Iraq, 22 July 2008.**

In addition, civilians can see that the hospital's doctors recognize the contributions of medicine from the Golden Age of Islamic civilization and demonstrate respect for the work of physicians from Arab countries. We should capitalize in showing this appreciation and demonstrate that the military can do more for them than drop bombs and kick in doors. For the majority of civilians, especially when sick or injured, medicine transcends ideology.

As insurgents and criminals retreat before a successful clearing phase, fully intending to return when our attention is diverted, they leave open a window of opportunity for activities of the "hold" and "build" phases to win hearts and minds of the population with hospital care and other services. Even the most intractable areas can be won over by the "soft power" of medical care.

As "soft power," medical care is a highly efficient economy-of-force measure. The two components of

***Word of medical successes spreads rapidly throughout a country and is remembered when memories of abuses fade.***

the combat support hospital can be supported for approximately \$12 million per unit per year, plus transportation. In contrast, a smart bomb costs \$1.27 million, and each F-22 Raptor aircraft costs \$135 million. If we can afford smart bombs to help win a war, can we not also afford to use field hospitals as a "weapon" to help secure the peace?

Field hospitals in the COIN environment can provide treatment, advice, training, material support, and security for medical providers during a transition period between phases and the assumption of responsibilities by nongovernmental organizations (NGOs) and by the host nation. Nongovernmental organizations cannot bring with them secu-

urity or evacuation assets. One hears from senior MEDCOM officers that the military fears it will be stuck with the care of civilians. Of course, this must never happen even for a short time under any circumstances. This refrain reveals more doctrinal rigidity than truth. With a modicum of financial encouragement from the U.S. Agency for International Development, and spearheaded by the Army Medical Corps, NGO participation could and should take root and blossom during the "build" phase of COIN and irregular warfare operations.

## **Obstacles**

The major problems with deployment of hospitals for civilian support are not security or recruitment. Regional host nation/U.S. hospitals, complete with secure housing for providers and families, have been in the planning stage for over two years, but none is open as yet. Reluctance on the part of the MEDCOM staff to face the complexity and risk involved in integrating medical assets into LLOs for COIN operations is the main obstacle. They do not want to buck the doctrine.

A significant problem involves the level of authority to decide whom to treat at the CSH. The officers in charge of the emergency medical team, operating room, and admissions office have

to seek permission through the required channels. Thus when a Marine battalion commander reports that he has an important sheik in his area who is hard of hearing and asks the hospital to help the sheik, he is put off. The hospital answers that it will submit a request through channels rather than arrange forthwith for an audiologist. Time is lost, as are opportunities to undermine the insurgency.

Another obstacle is the interpretation or obstruction of the commander's intent. For instance, the Multinational Force-Iraq commander may direct that medical assistance be provided to the population in the short term—that we conduct medical visits, mentor HN doctors and nurses, and provide medical assistance to civilian facilities. In fact, this happened when I was in Iraq. The surgeon may then specify that up to 10 percent of medical assets be utilized for nation-building activities. The medical brigade commander may then rewrite the mission statement to include site visits as patient loads permit. He then may issue 18 pages of algorithms and eligibility restrictions on who may be treated. This filtering also occurred. For doctors and nurses, this bureaucratic appendix insulted their judgment and humanity. Few can read through such an appendix without feeling that it is antithetical to the job they came to do. The CSH commander may then reinterpret that part of his mission to read something like, “The hospital will support cooperative engagements . . . as directed” (i.e., only if specifically directed). He may then order CSH personnel not go beyond the wire and that indigenous medical personnel will not be trained at the CSH because “It's not our mission.” This layering of bureaucracy also occurred.

Lack of knowledge of the big picture is also a problem. Only rarely does a Reserve Component hospital commander have an understanding of civil affairs or how medical care can contribute to COIN operations. Although their professional credentials, and those of the nurse and doctor providers, meet the highest civilian standards, they do not participate in medical staffing of LLOs in campaign design and planning. Hospital commanders should be oriented to civil affairs, to FM 3-24, *Counterinsurgency*, and to FM 8-42, *Combat Health Support in Stability Operations and Support Operations*. A field hospital that is 80 percent underutilized in the middle of Iraq is obviously missing opportunities

***A field hospital that is 80 percent underutilized in the middle of Iraq is obviously missing opportunities to win hearts and minds.***

to win hearts and minds. However, according to the doctrinaire, it is better that the staff watch movies, run in the gym, read a book, and hold cookouts rather than examine a civilian or help an old sheik with his hearing.

### **Exploiting Strength**

Al-Qaeda never stops recruiting among the disaffected, but its cannot provide medical care. Opportunities knock for U.S. “soft power” as long as we are in Iraq and Afghanistan and as long as people become ill and get hurt.

Contacts work. Iraqi casualties often receive treatment at U.S. military facilities, and wounded detainees have said things to me like, “I can't believe you Americans are so nice to me.” A dramatic case happened in late 2007. The wife of a sheik suffered an amniotic fluid embolus during childbirth in a local hospital. Her complicating coagulation deficit is usually fatal in the U.S., uniformly so elsewhere. At the CSH, by dint of heroic efforts of the intensive care unit physician and the blood banking system, she survived. She and her child are alive and well at home. Her community is grateful. Such acts have far-ranging ripple effects.

An overarching policy change is needed to authorize hospital providers to expedite medical, not tactical, decisions at the local level. We need to unravel top-down rigidity which frustrates more than it facilitates. The cost of a \$3,000 hearing aid is insignificant compared with that of a smart bomb or a Soldier's leg. Yet its effects can have tremendous and lasting value that could save the bomb and the leg. Doing what can be done in a timely manner wins hearts and minds. Appearing not to do what one could do alienates people. We do both. The relative impact is hard to quantify, except in terms of winning or losing hearts and minds. **MR**