Turning Good Deeds Into Policy

by James Peake

Military Medicine to Win Hearts and Minds: Aid to Civilians in the Vietnam War
by Robert J. Wilensky
(Lubbock: Texas Tech University Press, 2005), 192 pp., $29.95

Robert Wilensky has provided a valuable retrospective of the U.S. humanitarian military medical experience in Vietnam from the first engagement in 1954 to the departure of U.S. forces in 1973. It was an effort that in many ways was a twenty-year experience, but one year at a time over and over, reminiscent of the Bill Murray movie *Groundhog Day.* Each year was characterized by differing circumstances shaping it and new people (one-year rotation policy) to plan and execute it. Wilensky's slice of that experience was in 1967–68 as a battalion medical officer, which both personalizes and colors this extensively documented work throughout. Perhaps in the same way, my year in Vietnam as an infantry officer during the same time period and my subsequent thirty-six years in Army medicine personalize and color this review.

I confess (unapologetically) to running ad hoc medical assistance missions in essentially every encounter we had with the Vietnamese community. Invariably, my medics, within the limited extent of their supplies and capabilities, treated a child, a mom, or an elderly family member—there were no young men in those villages—each time. Each encounter put the face of humanity (real, not contrived) on our soldiers. It was not a part of a grand medical scheme, but more along the adage of "try to help someone else every day." Although not documented, this was counter to the picture of U.S. soldiers as ogres that our enemy disseminated to these same people.

This same sense of "tactical" value was related to me recently in Afghanistan, where a forward surgical team in a remote site supporting special operations forces provided treatment to the local villagers. Parents of the patients reported enemy rocket positions and enemy weapons caches. These are local tactical successes apart from the grand strategy.

I do agree that well-designed and -executed medical programs by the military can complement an overarching strategy to create an environment supporting the desired end state. Often in a war zone it is only the military medical system that, integrated as it is in the security operations of the combat commander, can support local civil efforts while filling the replaceable gaps in those efforts. The overarching strategy must take into account the cultural norms, the human resources, and the other agencies'/nongovernmental organizations' (NGOs') resources that will be brought together in the longer term to create the enduring health system.

The principles that Wilensky suggests for planning and executing military medical operations in support of the host-nation populace are the right principles and have been codified in the Army's doctrinal *Field Manual 8-42: Combat Health Support in Stability Operations and Support Operations*, under the chapter on "Nation Assistance." This Army doctrine stresses the importance of planning with the country and with the external influencers of health care such as the World Health Organization (WHO):

> It should be emphasized that the medical infrastructure, which evolves through assistance from U.S. forces, must pervade throughout the country and be broad based. It cannot only be

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> concerned with urbanized areas, but must make primary health care available to rural areas also. This often requires convincing the HN [host nation] government that the expense of hiring and training additional medical and public health personnel for providing rural area services will be justified by the amount of support for the government it quickly generates (p. 3-10).

The excellent appendices in the field manual provide more detailed guidance on areas of assessment and on building the plan as well as a section on the legal considerations in military engagement in medical humanitarian activities .

Military Medicine has 531 separate citations supporting the whole spectrum of opinion, from the good that medical programs did for the people individually; to the personal sense of contribution by the care providers; to the variety of motivations for supporting the program, ranging from altruism to influencing popular opinion and to the desire to keep doctors busy with medicine and not with writing letters to their congressmen. These references are by and large opinions and lack the metrics and measurables that Wilensky calls for. Such metrics are hard to come by, and even in the humanitarian agency world, process metrics are surrogates for the outcome measures that are often difficult to collect and that are the result of the combination of programs that affect the health of a population. It is an area that should be studied prospectively with both medical and nonmedical outcomes to know that the surrogate measures are meaningful.

Wilensky makes the distinction between a war of insurrection and a war to repel an invader. I believe that these distinctions are strategically irrelevant when it comes to the importance of the opinion of the population. Even if the distinction were relevant, the battlefield that we foresee (and are experiencing) is complex and often shifting, with humanitarian and peacekeeping operations in one sector and combat operations against organized elements in another or simultaneously within a sector where they can be done. Conflict is always on the backdrop of a population (and its future leaders) that is forming opinions about the combatants, and it is always in our interest to let them know our people, our values, and our value of them as fellow human beings.

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These issues are being played out in Iraq today. One of the first government sectors to stand up was the Ministry of Health. The Coalition Provisional Authority (CPA) was augmented by military medical personnel, and the first meeting of an Iraqi Medical Society was instigated by the military. In each divisional sector, division surgeons and brigade surgeons helped Iraqi medical clinics and hospitals get back on their feet. The military medical leadership understands the importance of the principles of coordinated action and high-level interface with the minister of health to ensure that the principles are followed. Yet the position of medical attaché in the U.S. Embassy has remained vacant for nearly a year.

Wilensky's excellent study of the U.S. experience in Vietnam is well timed to remind all of us of these principles, which have become so relevant to every conflict. The interest of public and private institutions in the importance of global health issues is high. Those issues that can affect the world, independent of borders, demand a health system in every country linked to the global community. It is time for the U.S. secretary of state to have a dedicated "surgeon" at the special staff or undersecretary level to advise on and oversee our coordinated international medical engagement policy and to ensure that each country team is supported with the expertise necessary to achieve these strategic goals. Then the military will have a rightful partner with whom to apply the principles that Wilensky has extracted from the Vietnam experience.