Medicine as a Non-Lethal Weapon: The Ethics of "Winning Hearts and Minds"

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by Sheena M. Eagan Chamberlin

For decades, military medicine has been formally used as a tool of strategy, sometimes called a 'non-lethal weapon' aimed at "winning hearts and minds." These missions often operate under larger programs that fall under the categories of humanitarian assistance or civic action. Medically oriented humanitarian assistance missions have become a significant component of contemporary deployments for militaries around the world. In contrast to their civilian analogies (such as Médecins Sans Frontières or International Red Cross and Red Crescent), these military programs are not uniquely medical in their intent and purpose. Rather, military humanitarian assistance missions have clear strategic goals behind their provision of medicine. These missions have been increasingly emphasized within the United States Department of Defense (US DoD) and expanding throughout the militaries of other nations; however, this expansion has occurred with little reflection or critical analysis.

This paper brings together a variety of resources and research strategies in an attempt to examine the ethical issues of these missions. Sources are drawn from archival work, primary source material (including official reports, doctrine, and published personal accounts), secondary source analysis, and a collection of oral histories gathered by the author. This paper prioritizes a descriptive approach to ethics: identifying and analyzing the ethical issues and moral dilemmas found in civilian medical assistance missions, and offering concrete solutions. This research specifically aims at recounting the moral realities and complexities of these missions as experienced by participants in an attempt to improve the moral experience of the physician-soldier. Larger normative questions regarding the moral permissibility of instrumentalizing medicine for political purposes, or instrumentalizing medicine in general, are beyond the scope of this paper, and addressed in other research.

The history of medical civilian assistance missions

Military medical professionals have been providing medical care to civilian populations since the beginning of formalized Army medicine in the United States. The types of missions discussed in this paper have been and are known under many names, depending on the specific program, historical period, national military, or branch of service. However, at a basic level all of these missions, regardless of their specific goals or title, share certain fundamental similarities: these missions involve the deployment of uniformed military medical personnel to provide medical care to civilian populations as part of an official military mission or program. For the purpose of clarity, the term 'medical civilian assistance' will be used as an umbrella term throughout this paper, as it has been used in my other work.[1] This term is inclusive of all programs that meet the above description, whether formal, informal, or ad hoc, and independent of their official title. Beyond that, avoiding the use of the term "humanitarian" sidesteps any confusion with other non-military, civilian, and nongovernmental organization (NGO) programs.

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The first formalized medical civilian assistance missions were operated under the large-scale and far-reaching Medical Civic Action Program (MEDCAP). This program began in the Vietnam War where military medical personnel saw and treated over 40 million local civilians as part of MEDCAP missions. In 1968, approximately 188,440 civilians per month received outpatient treatment from MEDCAP personnel, increasing to 225,000 outpatients per month in 1970. At the time of the Vietnam War, Vietnamese civilians had extremely limited access to medical care with a physician to patient ratio of only 1/93,000.[2] The US military had the resources to provide medical care to a population that lacked access and understood that the provision of this care had major strategic value. In light of this recognition, the provision of care was decidedly strategic in nature – The MEDCAP's main objective was to create "a favorable image of the [...] Government in the eyes of the people" with the improvement of patient or population health understood as a secondary goal or ancillary benefit. Other strategic goals of MEDCAP included larger psychological operations (PSYOP) and strategic objectives to include intelligence gathering.[2]

After the Vietnam War, MEDCAP was hailed as a great success due to the large numbers of patients seen, and the inferred large number of hearts and minds won. It was exported and has since expanded its reach around the globe to include: Central and South America, Africa, Eastern and Western Europe, Asia, and the Middle East. Due to the apparent success of MEDCAPs during the Vietnam War, military writers, commanders, and students at military command colleges have argued for the increased use of medicine to achieve military goals, including the increased emphasis on civilian medical assistance programs. Its perceived value as a military asset that accomplishes strategic goals without the deployment of force and violence is appealing to many within the military institution. Its ability to achieve military goals without the use of force has led students at military command colleges, and others within the military institution, to make use of the term "non-lethal weapon" when discussing and arguing for the validity of medical civilian assistance programs. Commanders see its potential use in future and current low-intensity conflicts (LIC), military operations other than war (MOOTW), and unconventional warfare.

Policy and practice have mirrored this line of thinking, as security policy has shifted towards stability operations that prioritize civic action and humanitarian assistance. Within the US, Department of Defense (DOD) Instruction 3000.05 states that military stability operations (MSOs) are a "core US military mission," that "shall be given priority comparable to combat operations ..." Similarly, the International Security Assistance Force (ISAF) has emphasized MEDCAP-style programs as a major form of deployment in contemporary engagements, and an increasing number of militaries are adopting these types of missions, instrumentalizing medicine for the military goals of "winning hearts and minds." Importantly, contemporary civilian medical assistance programs have not been altered since the model first adopted in Vietnam. While technology and locale may have changed, the program itself has not. The guiding doctrine, strategic goals, and priorities remain constant.

However, while policy has emphasized these programs and commanders have provided plaudits and legitimacy, others have been critical. Philosophers, ethicists, civilian physicians, and even the participants themselves have expressed disapproval and dissatisfaction. Despite the numerous negative experiences reported by participants, the expansion of these programs has occurred with little reflection or analysis. In fact, the ethical issues

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and critiques raised by program participants have more or less fallen on deaf ears.

The remainder of this paper will examine the ethical issues raised by medical civilian assistance programs. The ethical analysis will draw on historical research (doctrine, reports, and secondary source materials) and oral history data as a way of examining the moral realities of these missions. The stories shared by these physician-soldiers provide experiential knowledge with regard to medical civilian assistance missions and the unique ethical dilemmas that they present to those involved.

Physician-soldier experience: oral histories

Much of the primary source material available on these programs exists in the form of military reports. Unfortunately these documents do not speak to the ethical dilemmas that are the focus of this research. For this reason, oral history data is introduced and serves as the foundation for many of the conclusions drawn in this paper. Oral histories were collected through semi-structured interviews done by the author, under an IRB- approved research protocol. The population selected for these interviews was necessarily specific, employing purposeful non-random sampling. For this research, that population included veterans, retirees, and active-duty service members involved in medical civilian assistance work as part of their military service. All participants were physician-soldiers; however, ranks, ages, and years of service varied widely. Moreover, their participation in medical civilian assistance programs was diverse, ranging from involvement in Medical Civic Action Programs (MEDCAP) in Vietnam, Kuwait, Iraq, and Afghanistan to Medical Readiness Training Exercises (MEDRETE) in Honduras and Bolivia, among other ad hoc and informal civilian care work. Years of participation in these missions ranged from the 1960s to 2012. All participants were made anonymous from the outset to ensure confidentiality.

During all interviews, consenting participants were recorded. The recorded interviews were transcribed, coded, and analyzed along with field notes. Both in-case and cross-case analyses were utilized in line with the constant comparison method developed by Glaser and Straus. This methodology allowed for the organization of participant responses while analyzing different perspectives on central themes, ethical issues, and common dilemmas. This provided a systematic approach for comparing significant themes as they emerged from archival work, primary source material, as well as secondary source analysis and oral history data. Ultimately, these interviews provided oral histories and narratives of physician-soldier experiences that had not before been told, providing valuable insights into the moral realities of these missions and the ethical dilemmas felt by those directly involved.

Ethical issues

Across medical civilian assistance missions, physician-soldier participants have felt constrained by the conditions, limitations, and context of their environment. The ethical issue of providing “sub-par” medical care is often raised in relation to these missions. Within the context of medical civilian assistance missions, there are many restrictions. Locations are pre-determined for safety, as well as strategic value. For instance in Vietnam, Hamlets were selected for their political influence, instead of the medical needs of the population; this continues today in both MEDCAPs and MEDRETEs. Medication and equipment are often limited, and time is always in short supply. Medication is drawn from the medical depot system within the military supply chain and is thus commonly limited to adult doses, despite the fact that many of the patients

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continue to be children. Diagnostic equipment is sparse or nonexistent, and physicians often lack translation or interpreting services, creating significant issues due to the language barrier. Chronic care and follow-up are nonexistent, as missions involve only a one-day clinic in a specific location, meaning that they can often do little but identify health problems and distribute multivitamins and ibuprofen or aspirin. Physician-soldiers have also reported accounts of patient populations being restricted due to military or host-nation requirements. Often motivated by altruism, physician-soldiers have reported being hindered by the constraints of the mission, medical rules of engagement, and supply shortages.

These critiques are not just about working in a traveling clinic, developing nation, or conflict zone – frustrations that may be shared by their civilian counterparts working with MSF or a similar organization – this understanding represents only a cursory analysis of a deeper problem formalized within these programs. The frustration of providing what has been perceived as "sub-par medical care" is an expression of a complex programmatic and ethical issue; namely, that medical concerns are not prioritized within these military missions. Unlike in the context of civilian missions, where physicians may feel frustrated with their inability to provide care due to limited resources and environmental constraints, physician-soldier discontent and disapproval of these programs is intimately linked to the prioritization of strategic goals over medical goals. Military physicians often find it morally challenging that these programs emphasize their roles as soldiers and, specifically, as tools of pacification – "winning hearts and minds" – to the detriment of or distraction from medical goals. Participants saw the prioritization of military goals clearly, describing these programs to be "of limited value medically," but rather "an outstanding tool for propaganda."[3]

In the famous case of U.S. Army physician CPT Howard Levy, Dr. Levy refused to train Green Beret medics in dermatological skills in Vietnam. These medics were to use the dermatological skills to accomplish the strategic goals of the MEDCAP. Levy understood the work of these programs as "prostituting medicine for political and military purposes." During the trial of this case, a member of the Army Judge Advocate General explained the motivation behind MEDCAPs succinctly:

> *"We sought to use medicine as a means of approaching the enemy and imposing our will on his [...] The one great 'in' that you have is the medic because people are short on doctors and trained medical personnel in there; that the thing to do is sort of push a medic up there in front and let him get the confidence of these people by treating them [...]."*[4]

Howard Levy disapproved of this instrumentalization of medicine and specifically worried that the health of patients was not a main concern. The Levy case and other physician-soldier narratives are useful in highlighting the perspectives and moral reasoning of physician-soldiers. In fact, throughout oral histories, letters, and other forms of personal narratives, physician-soldier participants have recognized that military medicine has been used and sometimes abused in this way, alongside clear expressions of disapproval and discontent when its use is perceived as exploitation. The main reason underlying their disapproval of these programs, and the larger ethical condemnation of instrumentalizing medicine for political purposes, is based on the effect that the abuse and exploitation of medicine can have on patient care. The difference between instrumentalizing medicine and exploiting medicine is morally relevant and important to participants.

During the Vietnam War, MEDCAP operations were intimately intertwined with psycholog-

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ical operation battalions (PSYOP). This meant that MEDCAPs were aligned with forms of pacification propaganda that included specifically designed medication envelopes, loudspeaker announcements, gifts and T-shirts that promoted explicit messages.[1] During these medical civilian assistance missions, medicine was also instrumentalized, or perhaps exploited, as a means of gathering intelligence. Commanders exploited the trust of the patient–provider relationship to gather information, focusing on tactical intelligence. With the goals of pacification and intelligence gathering, medicine took a backseat.[1] Physician-soldiers have expressed in the course of oral history interviews that prioritizing intelligence gathering significantly harmed the trust that patients had in the healthcare team, and cast a shadow over the entire MEDCAP operation: "when you are using medical activity [to gather] information that reduces the trust of the population that you are taking care of." This confluence of priorities and policies contributed to the inability of physician-soldiers to provide adequate care, and their perception that medicine was exploited. Since the goals were strategic, the improvement of medical care was not the driving force; instead it was a sidenote to the achievement of the primarily strategic goals.

Physician-soldiers have reacted in different ways to their negative experiences as participants in these missions. Medical officers are often "voluntold" to participate or (less commonly) to organize these missions. Many are initially excited to participate, expecting a typical humanitarian assistance mission, unencumbered by military strategy. When the reality of the mission becomes apparent, many face the ethical dilemmas and conflicts discussed above, grappling with the instrumentalization/exploitation of medicine, the inability to adequately care for patients, the provision of sub-par medical care, and their morally complicated roles as physician-soldiers. Their lack of knowledge regarding the realities of these missions stems from several factors: physician-soldiers are often deployed with limited information regarding the mission, locale, or population and receive no pre-mission training. They are also rarely involved in the pre-mission or pre-deployment planning stages.

A particularly telling trend is that some participants have been so distraught and found these programs so ethically and medically problematic that they have refused to participate. There has been an increasing number of anecdotal reports of this – either physicians officially voicing opposition or unofficially refusing participation through tactful evasion. This refusal to participate in current programs highlights the moral realities and real-life ethical conflicts felt by the medical personnel involved in these missions. The intensity of their reactions also points to a need for change if these missions are to continue.

Written narratives, oral histories, and a recent study conducted by the Center for Disaster and Humanitarian Assistance Medicine (CDHAM) provide evidence that physicians are motivated by altruism to participate in these programs. The CDHAM study reported that nearly half of all physicians surveyed indicated that humanitarian missions were a factor in their decision to join the military.[5] In fact, "Many applicants to the USUHS [Uniformed Services University of the Health Sciences] expressed positive feelings about the potential to go overseas [...] humanitarian missions are one of the key factors that led them to apply to USUHS and to prefer a career as a military physician."[5] The survey results provide valuable insights concerning the motivation of physician-soldiers participating in medical civilian assistance missions. Their identity as military physicians is at least partly shaped by this humanitarian drive to provide medical

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care in a capacity they thought civilian life could not offer. The same CDHAM study showed that 60% of respondents reported that humanitarian assistance missions were influential in their decision to stay in the military.[5] Thus, the significance for the military is notable. These programs are key to retention and recruitment, serving as a significant factor in physician-soldier career planning. Due to the importance of these programs to military providers, their experience within these missions deserves closer attention. Medical civilian assistance programs have historically been a well-intentioned, misdirected, and frustrating experience for physician-soldiers. While they expected a humanitarian operation of beneficent medical care, they were faced with the reality of a military operation with only secondary medical goals.

Successful programs & other solutions

Importantly, physician-soldiers do not hold issue with every incarnation of this type of program. There are successful iterations of medical civilian assistance programs that have minimized ethical issues and moral dilemmas for participants. MEDRETE, a training-oriented reinvention of MEDCAP, is met with far less critique. Since medical education is a primary goal of this program, medical goals take on a guiding role. Physicians who have participated in both MEDCAPs and MEDRETEs report that the medical care provided in the latter is far superior. There are also successful versions of the MEDCAP that should be emphasized and recreated. These examples of success are programs that re-emphasize medical goals, avoiding the exploitation of medicine and instead accomplishing both medical and military goals. Internal medicine physicians have provided valuable contributions in the form of draining and injecting arthritic joints as well as draining abscesses. Surgeons have found success both medically (and with PSYOP strategic goals) with cleft lip/palate repairs and amputations. Pediatricians have seen a huge impact with deworming campaigns, and dentists had a significant impact on oral health by way of tooth extraction. Optometrists have also had considerable success distributing prescription glasses. Other missions focused on public health and preventive medicine to include vaccination and public health lectures in the native language. Although medical interventions are limited in this setting, physicians have been able to find avenues by which to make a therapeutic difference. Importantly, these missions involve physician-soldiers focusing on the kind of care that can be instituted over a short period of time while achieving a sustainable positive health benefit.

In contrast to missions where strategic goals were emphasized, and medical goals ignored, the missions mentioned above were planned and organized with the involvement of medical personnel. Historically, since MEDCAPs had a primarily military (or strategic) mission they were planned by non-medical commanders and officers, prioritizing strategy. Involvement in planning and organization is recommended – after all, as the only successful programs are those that were actively planned by medical officers to balance military and medical goals. Programs planned in this way are often perceived as providing better medical care to the locals, better training for the physicians, opportunities for bonding within the medical team, and superior overall experience for those involved, minimizing the ethical dilemmas encountered. Allowing physicians early involvement in the planning stages would help to realign the priorities of these programs, permitting medical goals to be emphasized and balanced. The realignment of these priorities addresses many of the ethical issues discussed in this paper, avoiding the exploitation of medicine, the provision of sub-par medical care and minimizing the frus-

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trations felt in the field by physician-soldier participants.

Despite the growing literature on military medical ethics, the ethical issues and moral dilemmas incumbent in civilian medical assistance missions remains a neglected area of study. The negative moral experiences and ethical dilemmas faced by those involved continue to go undiscussed. These programs have expanded their reach, and increasingly become the focus of military medical deployments and engagements with no change in structure or doctrine. Moreover, the narratives of physician-soldiers' have rarely been examined as "lessoned-learned."

The lack of discussion, doctrine, education, and training on the issues related to civilian medical assistance missions are noteworthy. The paucity of reflexivity, education, and discussion only contributes to and confounds the moral issues. Physician-soldiers are ill prepared for this instrumentalization of medicine and untrained in the delicate balancing act of their roles as both physician and soldier. Thus, military physicians and ethicists must contribute to the development of doctrine and educational materials. This population lacks training that teaches them how to deal with the unique complexities of being a physician-soldier.

There are many ethical dilemmas related to providing medical care in the context of the programs and missions discussed in this paper. These missions challenge physician-soldiers to be agents of a program with goals that may not prioritize medicine and medical care. The dilemmas surrounding the provision of inadequate care to accomplish strategic goals challenge deeply held norms of professional medical ethics. The moral frustration of merely distributing multivitamins, aspirin, or ibuprofen is clear in the coping mechanisms used to alleviate tension such as the often-told quip "All we have done here today is maybe given a couple of people ulcers from taking too much ibuprofen." The moral reality is that these participants are rarely troubled by the use of medicine as a strategic tool, or "non-lethal weapon"; instead, the core of their disapproval and basis for their dilemmas is the prioritization of strategy above all, and thus the exploitation of medicine; a balance is needed. This reality becomes evident in the fact that when medical goals are emphasized, and medical benefit is achieved, physicians find these experiences rewarding, positive, and unproblematic. However, when these military physicians are morally challenged by an order to provide medical care that they believe to be grossly inadequate they often feel conflicted.

Very few militaries are currently examining these issues, and only one is beginning to offer training and opportunities for moral reflection to medical professionals specifically dealing with medical civilian assistance. The moral complexities of these programs must be analyzed and discussed. More education, training, and policy are needed to address these issues. Ideally this moral education would involve both military medical professionals and their non-medical commanders so that ethical tensions can be eased, and medicine can be used appropriately, without being exploited.

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