CLIC PAPERS

ARMY MEDICAL DEPARTMENT ROLES AND FUNCTIONS IN LOW INTENSITY CONFLICT

Army - Air Force Center for Low Intensity Conflict

Langley Air Force Base, Virginia

UNCLASSIFIED
SECURITY CLASSIFICATION OF THIS PAGE

REPORT DOCUMENTATION PAGE

Form Approved
OMB No 0704-0188
Exp. Date: Jun 30, 1986

1a. REPORT SECURITY CLASSIFICATION: Unclassified	1b. RESTRICTIVE MARKINGS: N/A
2a. SECURITY CLASSIFICATION AUTHORITY: N/A	3. DISTRIBUTION / AVAILABILITY OF REPORT: The paper has been reviewed by security and policy review authorities and is cleared for public release
2b. DECLASSIFICATION / DOWNGRADING SCHEDULE: N/A	
4. PERFORMING ORGANIZATION REPORT NUMBER(S): N/A	5. MONITORING ORGANIZATION REPORT NUMBER(S)
6a. NAME OF PERFORMING ORGANIZATION: Army-Air Force Center for Low Intensity Conflict	6b. OFFICE SYMBOL (If applicable): CLIC
6c. ADDRESS (City, State, and ZIP Code): Langley AFB, VA 23665-5000	7a. NAME OF MONITORING ORGANIZATION
8a. NAME OF FUNDING / SPONSORING ORGANIZATION	8b. OFFICE SYMBOL (If applicable)
8c. ADDRESS (City, State, and ZIP Code)	9. PROCUREMENT INSTRUMENT IDENTIFICATION NUMBER
	10. SOURCE OF FUNDING NUMBERS: N/A
	PROGRAM ELEMENT NO. / PROJECT NO. / TASK NO. / WORK UNIT ACCESSION NO
	7b. ADDRESS (City, State, and ZIP Code)

11. TITLE (Include Security Classification)
Army Medical Department Roles and Functions in Low Intensity Conflict (Unclassified)

12. PERSONAL AUTHOR(S)
Maj (P) William H. Thornton, USA

13a. TYPE OF REPORT	13b. TIME COVERED	14. DATE OF REPORT (Year, Month, Day)	15. PAGE COUNT
Final	FROM N/A TO	1987, August	15

16. SUPPLEMENTARY NOTATION
N/A

17. COSATI CODES		
FIELD	GROUP	SUB-GROUP

18. SUBJECT TERMS (Continue on reverse if necessary and identify by block number)
Low Intensity Conflict (LIC), Insurgency, Counter-insurgency, Combatting Terrorism, Peacekeeping Operations (PKO), Peacetime Contingency Operations (CONT).

19. ABSTRACT (Continue on reverse if necessary and identify by block number)

Low intensity conflict (LIC) has increasingly played a conspicuous role in the strategic planning programs of the Armed Forces and the Army in particular. This paper looks at LIC from the standpoint of its functional areas and the roles which the Army Medical Department (AMEDD) is expected to fulfill in each. Emphasis is placed on the AMEDD's expanding role in the insurgency/counter-insurgency arena. The author concludes that the AMEDD must be ready to support US strategic policy in two ways: the traditional health service support role to deployed American forces, and the new LIC operational mode addressing the root causes of instability. In this new model, the AMEDD may act to prevent war, not just to treat the casualties of conflict.

20. DISTRIBUTION / AVAILABILITY OF ABSTRACT	21. ABSTRACT SECURITY CLASSIFICATION
☐ UNCLASSIFIED/UNLIMITED ☒ SAME AS RPT. ☐ DTIC USERS	Unclassified
22a. NAME OF RESPONSIBLE INDIVIDUAL: Ronald L. Zelms, Capt, USAF	22b. TELEPHONE (Include Area Code): (804) 764-2630 / 22c. OFFICE SYMBOL: CLIC

DD FORM 1473, 84 MAR — 83 APR edition may be used until exhausted. All other editions are obsolete.

SECURITY CLASSIFICATION OF THIS PAGE
UNCLASSIFIED

ITEM 18 (CONT): (PCO), Mobile Training Team (MTT), Medical Civic Action Program (MEDCAP), Medical Readiness Training Exercise (MEDRETE), Medical Support Mission, Army Medical Department (AMEDD), Regional Medical Expert (RME), Health Service Support.

ARMY MEDICAL DEPARTMENT

ROLES AND FUNCTIONS IN LOW INTENSITY CONFLICT

by

MAJ(P) WILLIAM H. THORNTON, USA

Army-Air Force Center for Low Intensity Conflict
Langley Air Force Base, Virginia 23665-5000

August 1987

DISCLAIMER

This paper represents the views of the author and does not necessarily reflect the official opinion of the Army-Air Force Center for Low Intensity Conflict, the Department of the Army, or the Department of the Air Force. The paper has been reviewed by security and policy review authorities and is cleared for public release.

CLIC PAPERS

CLIC PAPERS is an informal, occasional publication sponsored by the Army-Air Force Center for Low Intensity Conflict. They are dedicated to the advancement of the art and science of the application of the military instrument of national power in the low intensity conflict environment. All military members and civilian Defense Department employees are invited to contribute original, unclassified manuscripts for publication as CLIC PAPERS. Topics can include any aspect of military involvement in low intensity conflict to include history, doctrine, strategy, or operations. Papers should be as brief and concise as possible. Interested authors should submit double-spaced typed manuscripts along with a brief, one-page abstract of the paper to Army-Air Force Center for Low Intensity Conflict, Langley AFB, VA 23665.

Previous CLIC PAPERS include:

Operational Considerations for Military Involvement in LIC

Logistical Considerations in LIC

Security Assistance and LIC: A Challenge to Excellence

The Role of Reserve Forces in LIC

Compilation of References and Bibliography, Volume I: An Annotated Bibliography on LIC Taken from the Joint Low Intensity Conflict Project Final Report of 1 August 1986

PREFACE

Low intensity conflict (LIC) has increasingly played a conspicuous role in the strategic planning programs of the Armed Forces and the Army in particular. This paper looks at LIC from the standpoint of its functional areas and the roles which the Army Medical Department (AMEDD) is expected to fulfill in each. Emphasis is placed on the AMEDD's expanding role in the insurgency and counterinsurgency arena.

The author gratefully acknowledges the assistance of many Army Medical Department personnel who had a hand in the development of this paper, including: Colonel Edwin Carns, the SOUTHCOM Surgeon; Colonel Richard Proctor, the TRADOC Surgeon; and most particularly, Colonel Robert Elliott, Mission Chief, El Salvadorian Humanitarian Medical Mobile Training Team, for his assistance over the years and in many countries.

ARMY MEDICAL DEPARTMENT
ROLES AND FUNCTIONS IN LOW INTENSITY CONFLICT

The Low Intensity Conflict Environment

Low intensity conflict (LIC) has become a threat to the United States alliance structure and a major challenge to US military planners. How best to balance national socio-economic inequities within foreign political systems under stress in the face of declining US military force structure and budget outlays poses the single most critical problem in addressing the national military needs for the remainder of this century. These constraints make the prevention of regional instabilities a priority goal for the Department of Defense (DoD) as well as the Department of State (DoS). This preventive effort will require maximum participation by those agencies most involved in the non-combatant and developmental skills areas, to include the health sciences. The growing role of the Army Medical Department (AMEDD) in the LIC arena will be examined in this paper, along with proposals for possible future changes in concepts, doctrine, and force structure necessary to enable the assumption of a more active role in the formation and execution of national strategy.

First, what is LIC? The Organization of the Joint Chiefs of Staff (OJCS) defines it as:

> A limited politico-military struggle to achieve political, social, economic or psychological objectives. It is often protracted and ranges from diplomatic, economic and psychosocial pressures through terrorism and insurgency. Low Intensity Conflict is generally confined to a geographic area and is often characterized by constraints on weaponry, tactics and the level of violence.(1)

In addition to the OJCS definition, there is another that deserves merit because it suggests important strategic aspects of LIC and places the military role in proper context. Expressed by President Ronald Reagan in The National Strategy of the United States, the definition states:

> Low Intensity Conflicts . . . take place at levels below conventional war but above the routine peaceful competition among states . . . . They often involve a protracted struggle of competing principles and ideologies. [LICs] may be waged by a combination of means, including the use of political, economic, informational and military instruments.(2)

From this definition, then, it is clear that LIC refers to a condition of warfare that does not involve a traditional conflict of opposing armed forces; it is also clear that the US must develop a long term interagency approach to formulate and execute a precisely crafted policy to address the LIC threat to the US and its allies. The DoD controlled military might of the US constitutes one of the entities heavily involved in the LIC arena, but it is, by no means, the sole (or even the primary) operator. As in all matters concerning the conduct of foreign relations, the President and the Department of State comprise the primary operators in LIC.

These definitions are necessarily broad and consequently they are difficult to interpret operationally. To facilitate understanding and discussion, the Army-Air Force Center for Low Intensity Conflict (A-AF CLIC) at Langley Air Force Base, Virginia, has divided LIC into four components: insurgency and counterinsurgency (IN/COIN); combatting terrorism (CT); peacetime contingency operations (PCO); and peacekeeping operations (PKO). Established Army doctrine makes the same distinctions; however, it labels the categories somewhat differently. Generally speaking, LIC incorporates all those situations involving the use of force, or its threatened use, short of direct, sustained combat between conventional forces.

The major operational differences between LIC and conventional combat operations (vice Airland Battle) lie in the often protracted and highly politicized nature of the conflict, the generally reduced level of forces employed, and the more narrowly defined missions for military forces. Low intensity conflict has no single "first key day of battle" to be won, rather, each day is key to an interagency/internationalized effort to secure the peace. The very term "low intensity conflict" also connotes a special consideration. The LIC environment poses no immediate threat to the national survival of the US as it does for the nations who may be locked in direct struggles for continued national existence.

Low intensity conflict is often characterized as "war in the shadows," or as strictly a Third World phenomenon. Yet, superpower competition at levels short of war may be the dynamic factor engendering externally-supported insurgencies, state-supported terrorism, radical nationalism, and other manifestations of LIC. Hence, the potential for US involvement in LIC is much greater than is the risk of large scale US participation in either conventional or strategic nuclear war.

Under these conditions, the use, or threatened use, of US military combat power may prove to be either counterproductive to overall US strategic interests or inappropriate to the level of the threat. However, the DoD, in coordination with other agencies of the government, may still utilize its vast resources to support the overall strategic policy actively through the

Security Assistance Program and/or through its assets present in the skills of non-combatant personnel. Such DoD participation may be especially appropriate for those situations in which developmental assistance rather than strictly military aid is the proper form of assistance.

Traditional Health Service Support Focus

Since the earliest days of the US, there have traditionally been three health service support missions for the Army Medical Department. These three missions are:

- o Health Service Support to US Forces
- o Health Service Support to Allied Forces
- o Health Service Support to local civilians as time and situation permit

These missions have been the cornerstone of the Medical Department's motto "To Conserve the Fighting Strength," and they reflect the primacy of treatment and evacuation of military personnel both historically in the records of the department and legally under national law. Current legislation does not allow the unlimited use of military medical personnel to treat civilians either in the US, or in other countries, without specific authorization and guidance.

Medical Support to LIC Operations

Each of the LIC mission areas is unique in character and aims at the achievement of specific goals upon execution. The military units and personnel normally taking part in such missions are likewise unique and usually come from either the Army Special Operations Force (SOF) or the 18th Airborne Corps.

In the case of peacekeeping operations and peacetime contingency operations, current health service support concepts of operation and the emerging Health Service Support Airland Battle (HSSALB) doctrine are adequate to meet needs. Specific forces participate in these missions according to their training and operational readiness status. Organic modular medical units and medical support units provide appropriate levels of care and evacuation necessary to maintain the health of the force.

Health service support to combatting terrorism operations is provided by specially trained, quick reaction teams. These teams are able to respond rapidly to incidents and are equipped primarily to deal with trauma injuries such as those that result from a terrorist bombing in a non-combat environment. Medical teams can train to meet the exigencies of such incidents through

the medium of the mass casualty training exercise, a currently existing military medical training program.

These three health service support mission areas focus mainly on the treatment and evacuation of US military personnel or, in some instances, limited numbers of allied and civilian casualties. These missions also share the characteristic of normally being of limited duration. Within the LIC arena, these areas are the most traditionally oriented in terms of the target population and expectations as to the roles of medical personnel. The general medical community and planning staffs understand them well, because they stem from known, quantitative factors: population to be supported, evacuation policy in effect, and established medical planning and programming guidance.

It is the area of insurgency/counterinsurgency (IN/COIN) that most challenges the medical planner. It is here that traditional medical support functions heavily clash with emerging roles and developing doctrine. The emphasis of military medicine in the IN/COIN environment is not on health service support to US forces but rather is on such nebulous areas as "Nation Building" and "Rural Development." These areas laden with political and socio-economic overtones. Most of the recent debate on the so-called "Emerging Role of Military Medicine in LIC" has in reality been solely concerned with the IN/COIN area.

The necessary overall solution to the systemic problem of instability that spawns IN/COIN lies in the achievement of key political goals over a protracted period of time. Since the root problems of insurgency are usually political, social, and economic, assisting the host country to combat the military threat is but one element in a comprehensive strategy that must address the conflict's multiple dimensions. The US strategy is not so much to help these nations win battles as it is to assist their military to gain the time necessary for needed reforms to take root and flourish.(3) It must be emphasized that the military role in this environment, and a key one, is that of support to the national political effort For this reason, overall direction of the resultant programs is the purview of the US Ambassador, the United States Agency for International Development (USAID, for such development programs such as those in medical and engineering areas) and at the operative level, the US Country Team.

It is in this context that the Army Medical Department can both make the most effective use of its personnel assets and, in a proactive manner, play an active role in the elimination of the root causes of war. It is important to stress that this mission will in all reality take a long-term dedicated effort, an effort which should be expressly contingent upon the counterpart involvement of the host government. Otherwise, exclusive US participation will eventually create a level of unfulfilled medical expectations by the indigenous population, particularly

those in rural areas. Such unfulfilled expectations will only fuel the already existing dissatisfactions and work in a manner counterproductive to the US regional strategic objectives.(4)

Military medical personnel may perform functions in the IN/COIN environment beyond those of rendering advise and assistance to host nation military personnel. These include:

- Public Health: US medical personnel can assist in the development of a comprehensive public health program designed to educate and train the people in long term skills necessary to improve their quality of life. For example, education campaigns for basic sanitation, water procurement/purification and vector control, combined with mass inoculations for major endemic diseases are efforts of lasting benefit. Veterinary medicine may also comprise a major effort in the Third World because quite often the status of the population's livestock is both the sign of wealth within the community and their major means of support.

- Civil Affairs/PSYOP: US and host country military medical personnel can be an exceptionally effective tool in gaining popular support for the host government. Providing even the most basic health care to people who have little or no exposure to modern medicine is a very positive step. If incorporated into a well-coordinated national health program, it can greatly assist the government in regaining or retaining the loyalty of the people -- a key political objective. However, this program must be seen by the people as a program to which their government is totally committed and exercising direct control. It must flow from the government's interest in their well-being and future, not merely as a salve to the US conscience.

- Humanitarian Activities: Active involvement of US military medical personnel in both unilateral and multilateral humanitarian rescue and relief efforts serves as an exceptionally effective measure in the IN/COIN environment. Humanitarian assistance provided to a host nation people, particularly during an ongoing insurgency, without regard to their political stance, does more to display US resolve to help the nation than any effort of a centrally planned program. The recent El Salvadorian earthquake relief effort is an excellent example of such US humanitarian assistance to a nation at war.

It is essential to remember that US military medical personnel should function primarily as trainers in the Third World. Working together, US and host nation medical personnel can develop a legacy of capabilities and expertise in the host country which can eventually meet the domestic requirements and popular expectations.(5)

Training Instrumentalities in Insurgency/Counterinsurgency

There are several effective military medical training programs currently in use to assist nations involved in insurgencies. It bears re-emphasis at this point to note that such programs require close coordination with the civilian health care agencies of the host nation and the USAID prior to implementation.

- Mobile Training Teams (MTTs): The MTTs provide the single most comprehensive mechanism available to the DoD to address a host nation's capability shortfalls. The MTTs are a part of the security assistance effort managed by the Country Team, an interagency forum working for the ambassador, whenever the existing in-country US training capability is not able to meet the host nation requirements.

The purpose of the MTT is to provide the host nation a self-training capability in a particular skill area. This is accomplished by training selected host nation personnel who will then constitute an instructional base for continuing the training. As such, the MTT is a key element in US "nation building" efforts.

The MTTs are programmed for less than 6-month periods and tailored to provide the specific capabilities required for their missions. Under most circumstances the MTT will operate directly under the control of an in-country Security Assistance Organization (SAO). The MTT may include command and control elements when the mission requires. The MTTs may become involved in a continuously changing effort as the program and the host nation capabilities improve. The US Army Humanitarian Medical MTT, El Salvador, is an example of such an ongoing MTT. Currently, this MTT is entering its 9th iteration. The focus of the program began with basic field medical support and evacuation and has progressed through surgical and rehabilitation phases.

- Medical Civic Action Programs (MEDCAPs): Military medical personnel conduct MEDCAPs as a part of the overall military civic action program. The major purpose of such missions is to enhance the popular perception of the US military involvement in a nation and of the host nation government itself. As such, there must be a highly coordinated effort between military and civilian health care agencies with a sizable representation of host nation medical authorities on each mission. The US effort must neither undermine nor compete with the established health services of the nation. Rather, it must extend the host government's public health capabilities into remote or contested areas.

The short-term nature of MEDCAPS requires that only simple medical problems be addressed; primary emphasis should be placed on education for basic sanitation and hygiene (personal and

oral). Veterinary services (if available) should be included in MEDCAP missions. Any indigenous personnel requiring hospitalization should be evacuated to host country medical facilities.

- Medical Readiness Training Exercises (MEDRETEs): These are OCONUS training exercises to enhance our personnel's ability to deliver health service support under austere conditions. They are a means by which medical personnel gain experience in diagnosing and treating diseases not normally found in the US. These exercises also provide a mechanism for the testing of new equipment.

The MEDRETEs do not aim specifically at assisting or training host nation medical personnel. Any benefit that may accrue the host nation military or civilian populace is considered as "incidental" to the training of the US medical personnel involved. However, by closely coordinating exercise scheduling with USAID and host nation public health officials, MEDRETEs can be a useful educational tool for both the US and host nation.

In tabular form, LIC mission areas and the type of medical missions to conduct in their support are:

LIC MEDICAL MISSIONS

MISSION AREAS	MEDICAL SUPPORT MISSIONS
Peacekeeping Operations	Conventional HSS from assigned or attached medical personnel
Contingency Operations	Conventional HSS from assigned or attached medical personnel
Terrorism Counteraction	Specialty teams/reaction forces
Insurgency/ Counterinsurgency	MTTs, Civic Action and MEDRETEs

NOTE: HUMANITARIAN ASSISTANCE MISSIONS MAY OCCUR IN ANY LIC MISSION AREA.

Future Trends and Requirements

The President and Congress have recognized the growing LIC threat to the national security interests of the US. Recent changes resulting from this recognition include the establishment of a new Assistant Secretary of Defense for Special Operations and Low Intensity Conflict, and a new Unified Command -- United States Special Operations Command (USSOC). These developments are indicative of the seriousness of the Department of Defense's perception of the threat.

At this time, Army doctrine is under development to support the expanding military missions involved in LIC. An Army-Air Force manual (FM 100-20/AFM 2-XY) for LIC is nearing draft stage, as is a supporting Army Medical Department coordinating draft from the Academy of Health Sciences.

Some degree of change may be necessary within the AMEDD to meet the expanding requirements of the LIC environment fully, particularly those new missions which pertain mainly to the insurgency/counterinsurgency arena. These changes reflect not so much a shortfall in current medical support capabilities as they do a new focus in the operational use of medical assets and personnel in an active versus reactive treatment mode.

The AMEDD needs to avoid the temptation to include all LIC medical support considerations and planning under the emerging Health Service Support to AirLand Battle (HSSALB) doctrine. This emerging doctrinal force structure design emphasizes support to conventional operations from the mid to high intensity levels. As this is the basis for the force design, many of the modular units under development are equipment and personnel heavy when considering their use in the much more tailored environment of LIC, particularly when a prime consideration for LIC planning is keeping the American presence to an absolute minimum.

Consideration must be given to the design of units for employment only in the LIC environment; units designed with the realities of the bare-based health care systems of the Third World in mind. Such units must be adaptable to the technology of the host nation, since their primary role will be that of teacher, not the prime "doer." Those medical specialties critical to LIC treatment and training requirements, which are currently diffused throughout our medical force structure, need reorganization. They should centralized into a specialty team or unit for use in the LIC arena.

A crucial proposal which has emerged to enhance the AMEDD capability for future employment in the LIC environment is that for the development of a new, intensively trained cadre of qualified medical personnel. These individuals would serve in selected assignments requiring the special skills and training

needed to interact effectively both with the host nation medical planners and administrators and the full range of US government agencies.(6) Such a career program, variously referred to as a Regional Medical Expert Program (RME) or Regional Medical Consultant Program (RMC), would fill designated key Command Surgeon and Medical Planning Officer billets within Unified Commands, the Department of the Army, and the Department of Defense.

The medical commanders and planners on the staffs of the Unified Commanders (CINCs) faced with addressing the requirements of the LIC milieu must not solely be proficient in their medical areas of expertise. They also must be knowledgeable in the regional and cultural dynamics of their CINC's Area of Responsibility. Specific regional language and area studies are essential skills to enable their full support for the CINC's mission. However, a more fully developed program to identify, train, and utilize military health service personnel in this non-traditional operational mode is necessary. A time-tested and successful model exists for the military medical community to emulate in establishing this program. This model is the Army's Foreign Area Officer Program (MOS 48 series of regional specialists).

Selection, training and utilization of these officers must be a closely monitored program in order for it to be effective. Repetitive assignments within the same regional area, combined with adequate opportunity for both professional and advanced civilian schooling, could make such a program attractive to many members of the AMEDD community.

Summary

As a form of warfare, LIC is neither new, nor is it likely to disappear in the near future. Given the realities of today's nation state rivalries in a nuclear world, LIC is an attractive strategy. It is a means of international competition with roots in contemporary ideology and at acceptable levels of violence. Low intensity conflict therefore is an enduring reality with which policy and decision makers will have to be prepared to cope.

The Army Medical Department must be ready to support US strategic policy in two ways: the traditional health service support role to deployed American forces and the new operational mode addressing the root causes of instability. In this new model, the Army Medical Department may act to prevent war not just to treat the casualties of conflict.

ENDNOTES

1. "Memorandum for the Director, Joint Staff (SM-793-85)," The Joint Chiefs of Staff, 21 November 1985. The definition is to be published in the next edition of JCS Publication 1, Department of Defense Dictionary of Military and Associated Terms, 1 January 1986, US Government Printing Office, Washington DC.

2. National Security Strategy of the United States, The White House, Washington DC, January 1987, p. 32.

3. CLIC PAPERS, Operational Considerations for Military Involvement in Low Intensity Conflict, Army-Air Force Center for Low Intensity Conflict, Langley AFB, VA, June, 1987, p. 10.

4. "Memorandum for Chief, Army Reserve," Subject: Provisional TDA "Rural Medical Treatment Team," Colonel Robert F. Elliott, Office of the Chief, Army Reserve, Washington DC, 13 April 1987.

5. "Memorandum for Chief, Army Reserve."

6. Draft, "Memorandum for Secretaries of the Military Departments, Chairman, Joint Chiefs of Staff, Subject: Medical Readiness Strategic Plan, Assistant Secretary of Defense for Health Affairs, Washington DC, 9 April 1987, p. 9.