The Dissertation Committee for Sheena M. Eagan Chamberlin Certifies that this is the approved version of the following dissertation:

MORAL DILEMMAS IN MILITARY MEDICINE:

A HISTORICO-ETHICAL ANALYSIS OF THE PROBLEM OF DUAL LOYALTIES AND MEDICAL CIVILIAN ASSISTANCE PROGRAMS IN THE U.S. ARMY

Committee:

Jason Glenn, Ph.D
Supervisor

Howard Brody, M.D., Ph.D.

Laura Hermer, J.D., L.L.M.

John Fraser, M.D., J.D., M.P.H.

Sanders Marble, Ph.D

Cary W. Cooper, Ph.D. Dean of Graduate School

MORAL DILEMMAS IN MILITARY MEDICINE:

A HISTORICO-ETHICAL ANALYSIS OF THE PROBLEM OF DUAL LOYALTIES AND MEDICAL CIVILIAN ASSISTANCE PROGRAMS IN THE U.S. ARMY

by

Sheena M. Eagan Chamberlin, B.A., M.P.H

Dissertation

Presented to the Faculty of the Graduate School of

The University of Texas Medical Branch

in Partial Fulfillment

of the Requirements

for the Degree of

Doctorate of Philosophy

The University of Texas Medical Branch

April, 2013

Dedication

To my amazing husband and my wonderful parents whose love and strength has meant the world to me, and inspired me. Your support has carried me through this long journey—this is for you.

Acknowledgements

Throughout my academic studies I have been lucky enough to receive support and encouragement from many people.

Dr. Jason Glenn has been a mentor whose guidance has made my journey a rewarding and thought provoking experience. I would also like to thank my dissertation committee of Dr. Howard Brody, Laura Hermer, Dr. John Fraser and Dr. Sanders Marble for their advice, support and guidance. In addition, I would like to thank Dr. Mark Clark, Dr. Anne Hudson Jones and Donna Vickers, who have answered many questions and provided a great deal of help along the way.

I extend special gratitude to those physician-soldiers who participated in the oral history project that enriched my study of military medicine and provided valuable insight into a unique and complicated profession. Without them this project would lack an important human dimension, and I would lack useful insight into military medicine and the life of a military physician.

My fellow graduate students at the Institute for the Medical Humanities were also an endless source of encouragement. I would like to specifically thank my good friend and colleague Alina Bennett for our many long conversations, her everlasting positivity and her constant support.

Finally, I would like to acknowledge the professor who first inspired my love of ethics, Dr. Brian Cupples. Without him I would never have started down this path and never discovered my true passion. Those first undergraduate classes in ethics sparked an interest that changed everything—Thank you.

MORAL DILEMMAS IN MILITARY MEDICINE:

A HISTORICO-ETHICAL ANALYSIS OF THE PROBLEM OF DUAL LOYALTIES AND MEDICAL CIVILIAN ASSISTANCE PROGRAMS IN THE U.S. ARMY

Publication No. __

Sheena M. Eagan Chamberlin, Ph.D.

The University of Texas Medical Branch, 2013

Supervisor: Jason Glenn

Practicing military medicine is a morally complicated job. While physicians are generally understood as owing moral obligation to the health and well being of their individual patients, military health professionals can face ethical tensions between responsibilities to individual patients and responsibilities to the military institution or mission. The apparently conflicting obligations of the two roles held by the physician-soldier are often referred to as the problem of dual loyalties and have long been a topic of debate. The contemporary intellectual focus on this issue has ignored larger institutional issues that contribute to the problem. The conflict is part of a larger issue: namely, the intersection between the profession of arms and the profession of medicine, as institutionalized by the modern American military. This dissertation seeks to enrich the dual-loyalties debate by grounding it in the philosophical theory of an internal professional morality and exploring an Army program that serves to highlight the problem of dual loyalties at an institutional level. This dissertation examines the embedded case of medical civilian assistance programs, exploring three periods in the history of these programs and analyzing the problem of dual loyalty in each. These programs represent the use of medicine within the military for strategic goals. Thus, a physician is expected to meet his obligation to his role as soldier, while also practicing medicine. These programs involve obligations inherent in both roles of the physician-soldier and thusly they serve as excellent exemplars for the problem of dual loyalties at an institutional level.

TABLE OF CONTENTS

List of Abbreviations

AAR	After Action Report
AMEDD	Army Medical Department
ARVN	Army of the Republic of Vietnam
CA	Civil affairs
CA	Civic action
CAP	Combined Action Program
CDHAM	Center for Disaster and Humanitarian Assistance Medicine
CIA	Central Intelligence Agency
CJTF	Combined Joint Task Force
CMA	Cooperative Medical Assistance
CMOC	Civil Military Operations Center
CORDS	Civil Operations and Revolutionary Development Support
DA	Department of the Army
DENTCAP	Dental Civic Action Program
DHHS	Department of Health and Human Services
DIA	Defense Intelligence Agency
DOD	Department of Defense
FM	Field Manual
GAO	Government Accountability Office
GSBS	Graduate School of Biomedical Science
GVN	Government of Vietnam
HA	Humanitarian assistance
HCA	Humanitarian and civic assistance
HCA	Humanitarian civic action
IED	Improvised Explosive Device
IMM	Internal morality of medicine
JTF- BRAVO	Joint Task Force Bravo
MAAGV	Military Assistance Advisory Group, Vietnam
MACV	Military Assistance Command, Vietnam
MCA	Military civic action
MEDCAP	Medical Civic Action Program
MEDFLAG	Joint military medical exercise
MEDOLIC	Medical operation in low intensity conflict
MEDRETE	Medical Readiness Training Exercise
MILPHAP	Military Provincial Hospital Augmentation Program (later renamed Military Provincial Health Program)
MORE	Medical Rules of Engagement
OEF	Operation Enduring Freedom
OIF	Operation Iraqi Freedom
PA	Physician Assistant
POW	Prisoner of War
ROE	Rules of Engagement

SF	Special Forces
SOUTHCOM	Southern Regional Command
USACAPOC	U.S. Army Civil Affairs and Psychological Operations Command
U.S.	United States
USAID	The United States Agency for International Development
USUHS	Uniformed Services University of the Health Sciences
UTMB	University of Texas Medical Branch
VC	Viet Cong

Introduction

Arms, medicine & medical civilian assistance

Military physicians hold two professional identities as members of both the medical profession and the profession of arms. Self-identifying as both a medical doctor and Army soldier introduces the problem of dual loyalties by establishing obligations to two distinct internal professional moralities. While the internal morality of the military emphasizes service to and security of the state (an aggregate-level client), the internal morality of clinical medicine places emphasis on the health and healing of individual patients.[1] The dual-loyalties conflict is apparent in the differing obligations and clients of these two professions as will be explored in chapters two and three. It may be challenging to balance the prioritization of the individual and aggregate. The contrasting goals of medicine and the military are particularly significant to professionals who hold membership in both professions simultaneously.

[1] This work focuses on the internal morality of medicine as framed by clinical medicine. Although physicians may have other professional obligations to considerations of public health, the state and the maximizing of the distribution of health resources, it is clinical medicine juxtaposed against military medicine that creates the problem of dual loyalties as experienced by physician-soldiers. Beyond that, the internal medical morality as developed by Pellegrino, Miller and Brody is built on clinical medicine, rather than other types of medicine. The clinical encounter, and doctor patient relationship is important to the concept of morality argued in IMM. (See: Franklin G. Miller and Howard Brody, "The Internal Morality of Medicine: An Evolutionary Perspective," *Journal of Medicine and Philosophy* 26, no. 6 (2001); Edmund D Pellegrino, "The Internal Morality of Clinical Medicine: A Paradigm for the Ethics of the Helping and Healing Professions," *Journal of Medicine and Philosophy* 26, no. 6 (2001).

A civilian physician who provides aid during wartime is not necessarily bound to the profession of arms, feeling obligation only to medical morality. Although the civilian physician might choose to consider military factors, she or he has no obligations to the profession of arms. Conversely, the professional physician-soldier must balance the internal moralities of both medicine and the military. Having voluntarily taken up membership in both professions, the physician-soldier is left in a morally complicated space. The military institutionalizes the problem of dual loyalties by combining the professions of arms and medicine, placing both sets of obligation onto to the shoulders of a single moral agent.

There are scholars who argue that the combination of the military and medical professions is impossible. Proponents of this view often contend that physicians should not be involved in warfare.[2] However, physician involvement in war is necessary. Those most often harmed by war are not the ones responsible for its waging. The young men and women who find themselves in the armed forces – often times still adolescents when they sign up for military service - are commonly seeking gainful employment in an environment of limited economic opportunity. Even if one believes that their bravery and service to the state is misguided, this does not mean that they forfeit their right to medical care. Medical treatment is also essential to the morale of soldiers; army soldiers can run towards a battle because they know that they will be taken care of by military physicians if they are injured.

---

[2] Victor W. Sidel and Barry S. Levy, "Physician-Soldier: A Moral Dilemma? " in *Military Medical Ethics*, ed. Thomas E. Beam, Linette R. Sparacino, Edmund D. Pellegrino, Anthony E. Hartle, and, and Edmund G. Howe: TMM Publications, Borden Institute, Walter Reed Army Medical Center, 2003. (Washington, DC: TMM Publications, Borden Institute, Walter Reed Army Medical Center, 2003).

As long as there is suffering, physicians should be there to mitigate it and provide care. Their involvement will be most successful if they are prepared for their duties and understand the unique requirements of the battlefield setting. This knowledge requires military training that may only be possible when medical professionals are an imbedded part of the military. Historically, using a civilian medical force without battlefield training has led to a steep learning curve, resulting in the lost lives of soldiers.[3] Military medicine is an important and vital component of military command. Unfortunately, embedding medical professionals within the military not only ensures the necessary training to provide adequate medical care to soldiers it also confers two sets of obligations on the moral agent as they simultaneously belong to two distinctive professions. Although this twinning of two different professions may be morally problematic, it is necessary in modern warfare and must be addressed.

It is not the medical treatment of military personnel that this dissertation is addressing. Although the health care of soldiers is replete with its own litany of examples of the problem of dual loyalties, the focus of study here is the care of civilians. Although military medicine is an essential component of military command, necessary for maintaining the fighting force and ensuring morale, its usefulness does not end there. Military medicine and other support services have now been recognized as a tool that can be used to achieve military objectives and employed in times of low-intensity conflict (LIC) and military operations other than

[3]Albert E. Cowdrey, *The Medic's War* (Washington, DC: US Government Printing Office, 1987).

war (MOOTW).[4] The use of military medicine as a tool or sometimes termed, "non-lethal" weapon has further blurred the lines between the twin professions of the physician-soldier. The second section of this dissertation will address the institutionalization of the dual-loyalties problem through case-study analysis. The examination of army-medical programs with both military and medical goals and motivations serves to highlight the operational issues and moral dilemmas related to the problem of dual loyalties. Analysis will focus on U.S. Army civilian medical assistance programs. The aim of this analysis is to move beyond the foundations of the dual-loyalty problem by examining the historical manifestations of this institutionalized moral dilemma, and providing information and discussion that will inform the use and development of similar programs in the future.

While humanitarian or altruistic goals are often associated with the medical profession, the strategic intent inherent in medical civilian assistance programs is unique to the military. This dissertation will explore how an understanding of these programs as situated at the intersection between two professions with inherent internal moralities, provides a useful contribution to the dual-loyalties debate by allowing us to understand and explore the issue of dual loyalties on an institutional level. This perspective is currently lacking within the contemporary debate.

MEDICAL CIVILIAN ASSISTANCE

Despite the fact that the Army Medical Department (AMEDD) mission is to "conserve the fighting strength," military physicians do provide care to civilian

[4] Carol Lancaster, "Redesigning Foreign Aid," *Foreign Affairs* 79, no. 5 (2000); Clifford L. Stanley, "Number 6000.16 Military Health Support for Stability Operations," ed. Department of Defense (Washington, DC: Under Secretary of Defense for Personnel and Readiness, 2010).

populations.[5] Historically this has included both domestic and foreign civilian populations during times of peace and conflict. It began as protective public health policy and later shifted towards direct patient care. The original iteration of these programs involved both formal and informal medical care of civilians by the US military only when ground forces were in that area and needed to "pacify" local residents as part of larger strategic operations. Later, the training and strategic value of these programs were recognized, and they were expanded to peace time, short-term training missions.

Due to their programmatic foundation in both humanitarian and strategic goals, medical civilian assistance programs represent an excellent case study of dual loyalties at the institutional level. While humanitarian or altruistic goals are often associated with the medical profession, the strategic component often seeks to promote the military mission. Clear evidence of this dates back to the first civilian medical assistance programs of the Revolutionary War. At that time, Army personnel provided healthcare to civilian populations who lived in proximity to military bases and battlefields. Their intention with these programs was twofold: first they used readily available resources to improve the health and lives of American civilians through military work; second they also bettered the health of soldiers by way of improving hygiene and reducing epidemic disease. A healthier military meant an increased chance of strategic success.

---

[5] The mission of the Army Medical Department has changed slightly throughout history as their mission has formally expanded to include the care of dependants and veterans. That being said, "to conserve the fighting strength" or alternatively "to maintain the fighting strength" are a simplified version of their historically and contemporarily expanded mission still widely recognized and understood throughout the Army Medical Department: Montgomery Hinkson, "Medical Support in Military Operations Other Than War," (Carlisle Barracks, PA: U.S. Army War College, 2001).

The US Army has provided such medical care to civilians both formally and informally under many names throughout its history. It is a long list of acronyms. There is humanitarian assistance (HA); an umbrella term that often has a health component. Humanitarian and civic assistance (HCA), civic action (CA), combined action program (CAP), humanitarian civic action (HCA), military civic action (MCA), medical civic action program (MEDCAP), medical readiness training exercise (MEDRETE), joint military medical exercise (MEDFLAG), military provincial health assistance program (MILPHAP), and medical operation in low intensity conflict (MEDOLIC). The term "medical civilian assistance program" will be used as an umbrella term to cover all programs and missions during which uniformed personnel provided medical care to civilian populations as part of their military duties.

Medical civilian assistance programs warrant examination for many reasons. While the problem of dual loyalty debate has focused on sensationalized topics such as physician complicity with enhanced interrogation, these issues have affected exceedingly few physicians. In contrast, medical civilian assistance programs are a morally complicated situation that has entered the lives of many. Currently, the U.S. military is conducting MEDCAPs around the world. In fact, the Southern Regional Command (SOUTHCOM) has over seventy MEDCAPs that are performed on an annual basis.[6] During the Vietnam War, military medical personnel saw and treated

[6] Robert Franklin Malsby III, "Into Which End Does the Thermometer Go? Application of Military Medicine in Counterinsurgency: Does Direct Patient Care by American Service Members Work?" (U.S. Army Command and General Staff College, 2008).

over 40 million local civilians.[7] Thus, the large number of those affected by the MEDCAP experience warrants further examination. Beyond the numbers, this type of assistance program represents an intriguing example of the medico-military intersection within the U.S. Army. Many Army medical personnel have expressed dissatisfaction with the care provided to civilians, when strategic goals were the driving force of the program.[8] Accepting the argument for an internal professional morality, as will be explored in chapters two and three, medical civilian assistance programs represent a conflict. In fact, medical civilian assistance programs embody the ethical conflict present in the problem of dual loyalties.

The programmatic goals for these missions have been laid out as mainly strategic, aimed at furthering U.S. interests abroad. Robert Wilensky, who has published on the history of MEDCAPs in Vietnam, postulates that there are three motivations for these programs: to win hearts and minds of the population, the acquisition of intelligence, and to occupy the time of the doctors.[9] During the Vietnam War, many senior U.S. government officials identified civilian medical care as an essential tool of foreign policy.[10] The use of medical care as an instrument of policy has been widely criticized as unethical by medical ethicists.

Interestingly, while outsiders have condemned it and participants have expressed dissatisfaction, many military writers have called for greater use of

---

[7] Ibid, 5.
[8] Ibid, 5-11.
[9] Robert J. Wilensky, *Military Medicine to Win Hearts and Minds: Aid to Civilians in the Vietnam War* (Lubbock, TX: Texas Tech University Press, 2004), 5.
[10] Ibid, 11.

medicine as a 'non-lethal weapon.' They see its potential use in strategic planning.[11] This call is being reignited in the contemporary discourse. Security policy has shifted towards stability operations that often prioritize medical operations such as this. Stability operations, including Humanitarian and civic assistance has become an important part of the military mission. National policy has emphasized and prioritized these types of missions within the American armed forces. According to Department of Defense (DOD) Instruction 3000.05 Military stability operations (MSOs) are a "core U.S. military mission," that "shall be given priority comparable to combat operations…"[12] This shift signifies formal recognition of America's role on the international level, and new technique in achieving American military goals. In the post-cold war era, American dominance has left it with a great deal of responsibility.[13] The United States had abandoned its isolationist approach and taken an active role in the development and stabilization of nations around the globe. Now stability operations are as important to national security policy as combat operations as the US recognizes the strategic importance of stability and the value of civic action of military operations other than war (MOOTW). These types of missions and operations include a wide variety of programs, focusing on civic action. Health and medical care have been recognized as a powerful tool for

[11] David E. Womack, "Medical Engagement as National Security Tool a Prescription for Joint Doctrine," (Carlisle Barracks, PA: U.S. Army War College, 1999); John F. Taylor, "Health Care as an Instrument of Foreign Policy (a Proposed Exapnded Role for the Army Medical Department)," (Carlisle Barracks, PA: U.S. Army War College, 1984); William Vanderwagen, "Health Diplomacy: Winning Hearts and Minds through the Use of Health Interventions," *Military Medicine* 171, no. 10 [supplement] (2006); James W. Hendley, *Health Services as an Instrument of United States Foreign Policy toward Lesser Developed Nations* (Boiee, IA: University of Iowa, 1973); William C. Johnson, "Medical Civic Action Programs, U.S. Foreign Policy Tool," (Carlisle Barracks, PA: U.S. Army War College, 1999); John J. Bahm, *Military Assistance: A Tool of National Security and American Diplomacy* (Ann Arbor, MI: University Microfilms, 1967).

[12] Stanley, "Number 6000.16 Military Health Support for Stability Operations."

[13] Lancaster, "Redesigning Foreign Aid."

diplomacy and strategy to bring safety, security and stability to populations and nations that lack medical infrastructure and health care.[14]

In light of this, it is crucial to learn from the history of medical civilian assistance. This history has themes rife for ethical analysis. Physicians were often dissatisfied with the medical care that they were able to provide. MEDCAPs were often short-term; "band-aid" solutions that offered no significant or sustainable help to the health problems of the patients. Many physicians were thus frustrated by their work. This frustration is evident when they describe MEDCAPs as, "the medical discipline being prostituted for a less worthy purpose."[15] Such physicians believed the care they were providing to be negligible, merely "medical show-business."[16]

AMEDD has been used and deployed as a strategic tool in programs similar to medical civilian assistance programs throughout Army history. The primary military goals have been and remain strategic while humanitarian goals are generally only secondary. These programs aim to further international relations, increase the American sphere of influence, further psychological warfare operations, improve troop health and training while only secondarily improving the health of local populations. In this way, military doctrine has been clear; military physicians were soldiers first and doctors second. However, a theme of provider discontent and dissatisfaction is clear throughout the history of many of these programs. Their goals were not aligned with command, often driven by a more medical professional

[14] VADM Richard H. Carmona MD, MPH 10 November 2004 (Caroma cited in Mary V. Krueger, "Medical Diplomacy in the United States Army: A Concept Whose Time Has Come" (General Staff College, 2008).

[15] Robert J. Wilensky, *Military Medicine to Win Hearts and Minds: Aid to Civilians in the Vietnam War* (Lubbock, TX: Texas Tech University Press, 2004), 90.

[16] Ibid, 92

ethic; these physicians expressed dismay with an inability to provide anything but basic medical care. Robert Malsby, a doctor and Major in the United States Army, discusses this feeling of professional impotence in his work recounting, "In Vietnam, this led most providers to feel unable to practice anything but the most shallow and inadequate form of medicine which contradicted their medical oath."[17]

PHYSICIAN EXPERIENCES

Physicians felt stifled by the conditions, constraints and context of their work environment. They often lacked diagnostic equipment; there was generally scarcity of medical supplies and a shortage of time. Often motivated by altruism, they were stymied by the constraints of the mission, medical rules of engagement and supply shortages. MEDCAPs are short-term missions, generally lasting only one day. However, despite the short duration of these visits doctors were confronted with populations suffering from endemic disease and poverty, lack of basic sanitation, potable water, and proper nutrition. They could not begin to address these health problems, leaving providers feeling morally trapped.[18] Military physicians were not equipped to deal with such moral conundrums.

Military medicine institutionalizes the dual-loyalty problem with missions and programs such as military medical assistance. In these programs, the two goals represent the twin roles of the physician-soldier. They are expected to balance these roles without guidance. One commentator notes, "The role of the medical staff is to successfully bridge the gap between the commander's intent and end-state with

[17] Malsby III, "Into Which End Does the Thermometer Go? Application of Military Medicine in Counterinsurgency: Does Direct Patient Care by American Service Members Work?" 24.
[18] Ibid, 24.

solid medical planning and sound medical practices."[19] This recognition seems to ask the military physician to work the system, and simultaneously follow military hierarchy while providing adequate and appropriate medical care. However, military doctors do not receive training for this decision-making.[20] These expectations of military medical professionals are difficult to meet. Army doctors have little training or doctrine upon which to draw for guidance.

Although medical civic action operations have been happening in the American military in some capacity for over two centuries, they have only been formalized since the Vietnam War. Now that they are being emphasized and prioritized at the same level as combat missions, these programs must be studied and analyzed. Military combat has been the subject of a great deal of study, reflection and critical analysis, since it lies at the foundation of military planning. This critical reflection and analysis is key to the formation of institutional knowledge. Although medical stability operations are gaining importance, little analysis of these programs has taken place. In fact, there is little institutional memory and sparse record keeping when it comes to key medical civic assistance programs such as medical civic action programs (MEDCAPs) or Medical Readiness training exercises (MEDRETEs).[21]

---

[19] Shawn Alderman and Igrham Crawford, "Medical Seminars: A New Paradigm for Sof Counterinsurgency Medical Programs," *Journal of Special Operations Medicine* 10, no. 1 (2010), 16.

[20] Jeffrey E. Driftmeyer and Craig H. Llewellyn, "Overview of Overseas Humanitarian Assistance, Humanitarian and Civic Assistance and Excess Propery Programs," in *Measures of Effectiveness* (Bethesda, MD: Center for Disaster and Humanitarian Assistance Medicine, 2002).

[21] Eric J. Reaves, Kenneth W. Schor and Frederick M. Burke, "Implementation of Evidence-Based Humanitarian Programs in Military-Led Mission: Part I. Qualitative Gap Analysis of Current

This dissertation will explore these programs in detail, focusing on the perspective and experience of military physicians. These programs represent a uniquely complicated setting for the military physician. This dissertation will begin by describing in detail this type of conflict, before exploring the foundation of the conflict itself: the internal professional morality of both medicine and the military. The concept of an internal professional morality contributes to the discussion of dual loyalties by grounding the dual loyalty problem's underlying assumption. Specifically, that there is a specific morality inherent in both professions, and that as simultaneous members of both professions military physicians are bound to each. Namely, that the medical professional has an obligation to the health of patients while the military professional has an obligation to the accomplishment of the military mission, which may involve harming or taking lives.

The contemporary intellectual focus on the problem of dual loyalty has been skewed towards the individuals' experience of the dual loyalty conflict and has ignored larger institutional issues that contribute to the problem. The conflict is part of a larger issue: namely, the intersection between the profession of arms and the profession of medicine, as institutionalized by the modern American military. This project will enrich the dual-loyalties debate by grounding it in the philosophical theory of an internal professional morality and exploring an Army program that serves to highlight the problem of dual loyalties at an institutional level. The dissertation will examine medical civilian assistance programs as embedded case studies since these programs represent the use of medicine within the military for

---

Military and International Aid Programs," *Disaster Medicine Public Health Preparedness* 2(2008).

goals that are often both humanitarian and strategic, drawing on both roles of the physician-soldier and thus serving as an excellent exemplar for the problem of dual loyalties at an institutional level.

This dissertation will incorporate the philosophical concepts of professional practice and internal morality, sociological understandings of professional culture as well as historical analysis in order to bring about a greater understanding of the complex dual-loyalties problem, and the importance of fully fleshing out its underlying assumption and greater, institution-wide, implications. However, in focusing on an institutional program it does not seek to devalue the lived experience of individuals who participated in these programs. For that reason, whenever possible, first-hand information and personal reflections will be included. First person information will be garnered from journals, letters, diaries and semi-structured interviews with retired and active-duty members of United States military medical corps.

METHODS

The qualitative methodology employed by this dissertation strives for thorough ethical and historical analysis through case study. The methodology represents an interdisciplinary scholastic endeavor using qualitative methods to investigate questions regarding the dual-loyalties problem and the example of medical civilian assistance in the U.S. Army.

There are several different research designs encompassed within qualitative research methodologies. These include case studies, grounded theory,

phenomenology, and ethnography. This dissertation will use a case study design to examine the dual-loyalties issue on an institutional level. Beverly Hancock argues that a qualitative case study research design offers a breadth and depth of information that is not typically provided with other methods.[22] The case study research design involves the study of a single unit such as a person, an organization or an institution.[23] Importantly, by using a case-study design, this dissertation will offer an in-depth description of the dual-loyalties problem as experienced by military physicians. While this allows for little generalizable power of the study, the work will contribute much to the current literature. The dissertation provides a deeper and broader understanding of the medico-military intersection, where medicine and the military strive, through a single program, for seemingly disparate goals.

This case study makes use of historical research strategies, including the collection and evaluation of source materials, critique, analysis and interpretation. The sources will be drawn from archival work, primary source material, secondary source analysis and a collection of oral histories. Oral histories were collected during semi-structured interviews with veterans, retirees and active duty soldiers who have participated in or been involved with both formal and informal medical civilian assistance programs and civilian medical care as part of their military service.

[22] Beverly Hancock, *An Introduction to Qualitative Research* (Nottingham, UK: Trent Focus Group, 2002).
[23] Ibid, 6.

Much of the primary source material available relating to 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 dissertation. Qualitative research can answer questions not possible through empirical or statistically driven research. The population selected for oral histories was specific and purposeful. The sample selection process for this study was purposeful non-random sampling.[24] This sampling technique was employed so that the researcher can purposefully choose a sample that fits particular and specific criterion.[25] For this dissertation, that population included veterans, retirees, active duty soldiers and civilians involved in medical civilian assistance work in the US military.

The oral histories were collected in a semi-structured interview format. Kvale characterizes semi-structured interviews as a list of questions centralized on a specific topic, offering the participant flexibility in response.[26] The significance of this research style is its plasticity; while the interviews maintain consistency, questions may be added, omitted or changed in order clarify or gain insight. Brief follow-up interviews provided participants with an opportunity to explain and expand on the original interview. It has been suggested that follow-up interviews offer participants time to reflect, clarify and provide a more comprehensive

---

[24] John W. Creswell, *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches*, 3rd ed. (Los Angeles, CA: Sage, 2009), 178-181.

[25] Michael Quinn Patton, *Qualitative Evaluation and Research Methods,* 2nd ed. (Newbury Park, CA: Sage, 1990), 230-246.

[26] Steinar Kvale, *Interviews: An Introduction to Qualitative Research Interviewing* (Thousand Oaks, CA: Sage Publications, 1996), 98-101.

reflection.[27] Follow-up semi-structured interviews also provided the opportunity to select specific participants for a more in-depth, guided conversation.

During all interviews, consenting participants were recorded using the program Audacity. The recorded semi-structured interviews were then transcribed, coded and entered into computer documents. Analysis combined this data with field notes gathered by the researcher. In order to analyze the qualitative data, this dissertation utilized both in-case and cross-case analysis in line with the constant comparison method developed by Glaser and Straus.[28] This methodology allowed the organization of participant responses while analyzing different perspectives on central issues.[29] This provided a systematic approach for comparing significant themes as they emerged from archival work, primary source material, secondary source analysis and collection of oral histories.

This qualitative methodology allowed for rigorous and humanistic study that is ideal for examining the problem of dual loyalties and medical civilian assistance programs. This methodology also allowed for interdisciplinary work that aims to explore and discover new understandings about a given phenomenon. While the history of these programs cannot be fully understood based on published statistical reports alone, primary and secondary source analysis, oral histories and philosophical theory will come together to shed new light on the issues raised by these programs. Examining the problem of dual loyalties through this humanistic

---

[27] Strauss and Corbin, *Basics of Qualitative Research: Grounded Theory Procedures and Techniques*.

[28] Barney G. Glaser, and Anselm L. Strauss, *The Discovery of Grounded Theory; Strategies for Qualitative Research* (Chicago, IL: Aldine Publisher, 1967).

[29] Michael Quinn Patton, *Qualitative Evaluation and Research Methods* (Newbury Park, CA: Sage Publications, 1990), 376.

lens will show that medical humanists, armed with an interdisciplinary education, are well suited to a complex issue such as this.

Although the problem of dual loyalties exists in many fields of medicine, including occupational health and sports medicine, focus will be on the specific dual loyalties of the military physician. Beyond that, the study will be further limited to focus on United States Army medicine. The Army medical institution is the eldest of all the medical institutions within the American military.[30] Its history is rife with examples of the institutionalized provision of civilian aid, both before and after the birth of official Medical Civic Action Plan programs in Vietnam.

OUTLINE:

The first three chapters will introduce the problem of dual loyalties and the concept of an internal professional morality, highlighting the fact that these professional moralities (medicine and arms) create an institutional conflict, which physicians experience as a problem of dual loyalties.

While physicians are normally understood as possessing a type of moral obligation or responsibility to their individual patients, in some situations military health professionals are faced with circumstances and scenarios that make it difficult to uphold this understanding of medical morality. Within the military context, occasions may arise that present ethical tensions between the responsibilities felt towards the individual patient and those to the military mission.

[30] Mary C. Gillett, *The Army Medical Department, 1775-1818* (Washington, DC: Center for Military History, 1981).

The problem of dual loyalties represents an ethical dilemma that is predicated on the assumption that there is morality inherent in the profession of medicine that conflicts with the charge of the military. I will explore this assumption using the concept of an internal medical morality (IMM) and show that IMM provides a rich contribution to the debate surrounding the problem of dual loyalties. The third chapter will argue that this concept is useful in considering the morality incumbent within the second loyalty of the physician-soldiers, namely their moral obligations as military officers. We will then turn to the case study of medical civilian assistance programs, examining three historical periods as follows.

PERIOD 1: HYGIENE, SANITATION, PUBLIC HEALTH & FORCE HEALTH PROTECTION

Medical civic action programs became formalized under that name during the war in Vietnam. However, since its earliest campaigns the U.S. Army has been providing medical care to civilian populations.[31] Clear evidence of this work dates back to the Revolutionary War. At that time, Army personnel provided healthcare to civilian populations who lived in proximity to military bases and battlefields. They used readily available resources to improve the health and lives of American civilians in order to better or maintain the health of soldiers by way of improving hygiene and reducing epidemic disease outbreaks. Initially germ theory had yet to provide the medical knowledge necessary to understand infectious disease they way modern medicine does today. These physicians relied on older models of disease theory and empirical observations.

[31] Malsby III, "Into Which End Does the Thermometer Go? Application of Military Medicine in Counterinsurgency: Does Direct Patient Care by American Service Members Work?" 26-51.

This period involved wars at home, and thus American civilians. This first period was marked by significant reliance on sanitation and hygiene interventions in surrounding civilian populations in order to ensure the health of the soldiers. This was manifest in massive hygiene and health campaigns in port cities during the civil and revolutionary war, where the military instituted quarantines and clean ups in order to prevent seasonal epidemics and maintain troop health. This inevitably had considerable impact on the local civilians, although that was incidental.

The earliest international actions that involved programs resembling later civilian medical assistance programs took place during the Mexican-American War. During this time, Major General Winfield Scott used assistance programs to bolster opposition of General Antonio Lopez de Santa Anna amongst the Mexican population.[32] He issued proclamations pledging to protect Mexican citizens, and operationalized this protection by focusing on public services and sanitation systems.[33] Maj Gen Scott maintained public institutions such as schools, hospitals and clinics. This work continued to grow on the international scene during the Mexican-American and Spanish-American Wars. Larger public health campaigns were launched in Cuba and then later the Panama Canal Zone in order to prevent yellow fever in the troops. These campaigns employed the knowledge gained by Walter Reed's Yellow Fever Board and sought to eradicate the mosquito population. The campaigns were launched and carried out by William C. Gorgas. They involved removing the breeding of mosquitoes' habitat by cleaning up refuse and removing

[32] Wilensky, *Military Medicine to Win Hearts and Minds: Aid to Civilians in the Vietnam War*, 7.
[33] Malsby III, "Into Which End Does the Thermometer Go? Application of Military Medicine in Counterinsurgency: Does Direct Patient Care by American Service Members Work?" 31.

standing water, as well as adding oil to standing water to prevent the larvae from becoming mosquitoes. These campaigns were extremely successful and reduced yellow fever substantially in both the military and civilian populations. However the intent was not to help civilians, rather the intent was force protection: maintaining troop health and readiness.

PERIOD 2: VIETNAM- THE FORMALIZED MEDICAL CIVIC ACTION PROGRAMS (MEDCAP)

The second period focuses on the Vietnam War. During this period, civilian medical assistance became formalized under the name MEDCAP and generally involved basic medical care (not public health but retail medicine) provided by American doctors to foreign populations. Unlike the World Wars, Vietnam did not involve a true front-line, but rather the guerrilla warfare that has gone on to characterize contemporary conflicts. As Wilensky states, "the real battle was for the heart and minds of the civilians," a population that lacked access to any western medical care. These facts point to the usefulness of civilian medical care to military goals. Similarly, the Army Special Forces (SF) emphasized using medical care for improvised gathering of intelligence and information.[34] In fact, the SF considered medical care to be their "most valuable anti-guerrilla asset."[35]

The Vietnam War provides ample evidence and material rife for intellectual analysis, highlighting the increasingly strategic use of medicine by the military. Vietnam represents a problematic trend towards an increasingly strategic programmatic intent, as strategic and medical goals no longer align. This chapter

[34] Robert J. Wilensky, *Military Medicine to Win Hearts and Minds: Aid to Civilians in the Vietnam War*, 32.
[35] Ibid, 33.

will not only examine and analyze the period itself but also serve to compare and contrast it with the first. While domestic and foreign public health interventions had an undeniably strategic motivation, the use of medical care in Vietnam raises a plethora of new ethical issues. In the Vietnam War, medicine becomes increasingly used for military goals. Wilensky states that medical professionals participating in these programs critiqued the level of care provided to civilians as both inadequate and in poor practice.[36] The conflict discussed by these physicians represents an expression of the problem of dual loyalties and is thus useful in furthering understanding of the debate.

PERIOD 3: TRAINING MISSIONS- MEDICAL READINESS TRAINING EXERCISES (MEDRETE)

The third and final period of medical civilian assistance has involved the use of MEDCAP-style programs for training purposes, known as medical readiness training exercises or MEDRETEs. These programs are short-term and generally take place in low-income nations in order to allow military physicians training opportunities that are not possible on the home front. This type of mission differs from those before it. Generally MEDRETEs take place in areas of peace, where there is no active conflict. Thus, medicine is not being used as part of an active military offensive in the same way that it was in the MEDCAPs of Vietnam. That being said these missions maintain a decidedly strategic purpose; aside from larger strategic purposes including the maintenance and development of the American sphere of influence abroad and positive international relations, military personnel are providing medical care to civilians as part of their own medical training program.

[36] Ibid, 88.

Foreign civilians in impoverished nations represent an opportunity for military civilians to "win hearts and minds" while honing their clinical skills. In these environments, physicians are exposed to conditions, traumas and diseases that are rarely, if ever, seen in the continental U.S. These physicians are also able to practice medicine in austere conditions that could not be recreated in a hospital, and are understood to as mirroring the restrictions of a deployed environment.

This chapter will compare and contrast these programs with their predecessors. This program raises the ethical concern of using impoverished and vulnerable populations as clinical material, an important issue in both the history of medicine and medical ethics. While recognizing this ethical dimension to the MEDRETE program, this dissertation will not address this issue- instead focusing on issues related to the problem of dual loyalty. Important ethical issues related to the problem of dual loyalty include the temporary, short-term nature of the MEDRETE. This form of temporary program raises new ethical concerns regarding the exploitation of vulnerable populations and the value of what is termed "parachute medicine." These programs involve American-trained physicians literally dropping into vulnerable foreign populations, who lack medical care and providing services on a temporary basis. The short-term nature of these interventions makes long-term treatment and follow up impossible, begging the question as to whether this peak and trough approach to foreign civilian aid is of any use. According to its internal morality, medicine must have goals geared towards the well being of the patient, which this program does not necessarily prioritize. Rather, the programmatic intent is with the military morality, with politic and strategic aims of furthering

international relations, increasing US military global presence and providing austere and tropical training opportunities for military physicians. This chapter will argue that this period represents yet another chapter in the history of military medical civilian assistance programs, which exemplify the problem of dual loyalties.

A NOTE ON SOURCES:

Army report data, primary source material and secondary source analysis will be combined with oral histories to explore the history of this type of program. It should be noted that primary source materials in the form of After Action Reports (AARs) for these programs are sparse and not easily accessible. Except for DOD I 2205.3, which provides reporting specifications HCAs there are no other formal reporting requirements. The Center for Disaster and Humanitarian Assistance Medicine has highlighted this lack of reporting in their series of reports on these programs.[37] Other authors and commentators have noted a similar lack of reporting.[38] In fact, CDHAM has published a report highlighting a lack of AARs on this topic.[39] With those AARs that do exist, there is no centralized database and thus they are scattered across many commands and difficult to track down. This highlights the necessity for increased documentation and record keeping in reference to these missions and programs.

---

[37] Jeffrey E. Driftmeyer and Craig H. Llewellyn, "Information Management for More Effective Military Humanitarian Assistance Projects & Programs," in *Measures of Effectiveness* (Bethesda, MD: Center for Disaster and Humanitarian Assistance Medicine, 2002).

[38] Erik J. Reaves, Kenneth W. Schor and Frederick M. Burkle, "Implementation of Evidenve-Based Humanitarian Programs in Military-Led Mission: Part 1. Qualitative Gap Analysis of Current Militayr and International Aid Programs," *Disaster Medicine Public Health Preparedness* 2, no. 4 (2008).

[39] Driftmeyer and Llewellyn, "Information Management for More Effective Military Humanitarian Assistance Projects & Programs."

Of those reports that are accessible there are many issues with record keeping. Across these reports there is no standardized reporting, they are often subjective and lack much substantive data. That being said, these reports often placed a high value on statistics and thus qualitative data is sparse. Program evaluations are often limited to the number of immunizations given or total number of patients seen.[40] There is very little narrative space. AARs were used when available and supplemented with other types of primary source documents including, official DOD publications, journal articles, memoirs and oral histories. Secondary source analysis is also employed.

[40] Malsby III, "Into Which End Does the Thermometer Go? Application of Military Medicine in Counterinsurgency: Does Direct Patient Care by American Service Members Work?" 17.

Chapter 1

Describing the Problem of Dual Loyalty

> When physicians were clearly non-combatants in a civilian culture, tending to the sick and wounded of belligerent, armed combatants, regardless of country of origin, protecting and preserving the integrity of the healing arts was less complicated. Today physicians wear the uniforms of their countries, travel imbedded with the fighting forces to intervene and to provide care and treatment to the sick or wounded soldier as quickly as possible with the best expectation of survival.[41]

The military and its operations have become an increasingly important issue in recent years. Recent and enduring conflicts have thrust the problem of dual loyalties into the spotlight, prompting much scholarship. Perhaps the most popular example of this recent attention is that given to those physicians involved in the development and implementation of "harsh" interrogation techniques used against prisoners of war, and the alleged abuses that occurred in the course of their implementation.[42] In the well-known book entitled, *Oath Betrayed: Torture, Medical*

---

[41] Fritz Allhoff, *Physicians at War: The Dual-Loyalties Challenge* (New York, NY: Springer, 2008). 39

[42] Steven H. Miles, *Oath Betrayed: Torture, Medical Complicity, and the War on Terror* (New York, NY: Random House, 2009); Jed Adam and Michael L. Gross, "Caring for and About Enemy Injured [Comment] " *American Journal of Bioethics* 8, no. 2 (2008); Mark A Levine, "Role of Physicians in Wartime Interrogations," *American Medical Association Journal of Ethics* 9, no. 10 (2007); Robert J. Lifton, " Doctors and Torture," *New England Journal of Medicine* 351, no. 5 (2004); Steven H. Miles, "Abu Ghraib: Its Legacy for Military Medicine," *Lancet* 364, no. 9435 (2004); Wendy Orr, "Physician's Duties in Treating Wartime Detainees," *American Medical Association Journal of Ethics* 9, no. 10 (2007); P.R. Lee, M. Conant, A.R. Jonsen and S. Heilig "Participation in Torture and Interrogation: An Inexcusable Breach of Medical Ethics," *Cambridge Quarterly Healthcare Ethics* 15, no. 2 (2006).

Complicity, and the War on Terror, Steven H. Miles explores the problem of medical complicity and involvement in torture and interrogation.[43] The author focuses on three case studies: Afghanistan, Iraq (Abu Ghraib) and Guantanamo Bay, Cuba. While only mentioning the term "dual loyalty" a few times, Miles provides an excellent example of when the twin role of the physician-soldier can lead to ethical conflict.

Miles' book, based on tens of thousands of pages of government documents obtained by the American Civil Liberties Union (ACLU) through a Freedom of Information Act lawsuit, examines how physicians came to be involved in practices that he constructs as contrary to medical morality. According to the author, "health professionals are accountable for the health of their patients, regardless of the fact of imprisonment."[44] Miles grounds this accountability, these medical obligations, within the codes of conduct published and supported by international professional medical associations such as the World Medical Association's Declaration of Tokyo, which states, "the doctor's fundamental role is to alleviate the distress of his or her fellow men, and no motive whether personal, collective or political shall prevail against this higher purpose."[45]

Despite this declaration and the general understanding of physicians' morality as involving obligation to care for individual patients, physicians were intimately linked to the "harsh interrogation" techniques in use in Prisoner of War (POW) camps throughout the Global War on Terror. In fact, medicine was built into

[43] Miles, *Oath Betrayed: Torture, Medical Complicity, and the War on Terror*.
[44] Ibid, 65.
[45] Ibid, 34.

the torture system by way of institutional policy. According to Miles, "In 2002, Defense Department attorney Diane Beaver crafted Guantanamo's request for harsh interrogation, arguing that such techniques were legally permissible 'with appropriate medical monitoring.'"[46] Thus, non-clinicians saw the use of medicine as being a *more humane* approach to the issue of harsh interrogation. Similarly, Secretary of Defense Donald Rumsfeld included physicians in his harsh interrogation plans for Abu Ghraib and Afghanistan.[47]

Physicians played 3 significant roles in the system of harsh interrogation:[48]

1. Vetting patients to ensure that they could withstand torture[49]
2. Monitoring of patients during interrogations
3. Personalizing torture plans according to medical indicators

The third and final role was performed by a group of psychologists and psychiatrists known as Behavioral Science Consultation Teams (BSCTs). These teams were responsible for creating harsh interrogation plans that exploited medical weakness and were informed by psychological knowledge and theory.

The problem of dual loyalty was addressed at an institutional level by positioning the military as the physician's client, rather than the individual patient. According to Defense Department Deputy Assistant Secretary for Health, Dr. David Tomberg, there was "no doctor-patient relationships for interrogatees."[50]

---

[46] Ibid, xiii.
[47] Ibid, 50-51.
[48] Ibid, xiv.
[49] "Torture" is the term used by the author, however there is much debate surrounding whether or not the "enhanced interrogation" technique employed by the U.S. military constitutes torture.
[50] Miles, *Oath Betrayed: Torture, Medical Complicity, and the War on Terror*, xiv.

Thus, the physician is institutionally freed from their medical obligation to the health and welfare of individual patients, by rhetorically redefining the doctor-patient relationship. This line of thought was reinforced by specific policy. "Under Guantanamo's 2002 policy, medical personnel were obliged to give nonmedical personnel, including members of the BSCT, medical information relative to the 'national security mission' upon request."[51]

Interestingly, these policies do little to resolve the problem of dual loyalties in practice because those in power directly contradicted them. While rejecting the allegations that physicians were involved in these harsh interrogation programs, Assistant Secretary of Defense for Health, Dr. William Winkenwerder Jr., stated, "…we always expected a physician to behave ethically in any circumstance."[52] This highlights the military's institutional failure to fully address the problem of dual loyalty, while simultaneously compounding the problem with mixed institutional messages.

These institutional issues surrounding the dual-loyalty problem are what this research seeks to address. Although this work will not focus on the issue of physician complicity with torture and interrogation specifically, the present work will provide a philosophical grounding for the debate surrounding dual loyalties (such as this), and appeal to historical illustrations, such as enhanced interrogation, where military and medical goals conflict. While much has been written on the topic of dual loyalties, little has been done to explore the problem at an institutional level.

[51] Ibid, 54.
[52] Ibid, 63.

Much focus has been placed on the individual medical professional, ignoring the larger institutional issues that play an important part in complicating the moral agency of the physician-soldier (or soldier- physician).

The literature is replete with examples of the problem of dual loyalties at the level of the individual military physician, spanning from issues involving patient confidentiality to the rationing of medical care. In order to establish a background understanding of this issue, these examples of the dual-loyalty problem will be briefly explored. Authors discussing dual loyalties within the military often describe the same or similar individual-level examples of ethical conflict involving doctor-patient confidentiality, treatment aimed at returning the soldier to duty and issues involving triage.

The dual-loyalty problem, sometimes called "mixed-agency," refers to dilemmas that challenge military physicians to prioritize the obligations of one of their professions over the other. These physicians find themselves confronted with situations where military protocol, orders or strategy requires them to behave in a way that is contrary to norms of civilian medical ethics. The military is an ancient profession, with a rich history and long understood social duty. Since the founding of the Army Medical Department in the United States in 1775, military medicine has differed greatly from civilian medicine. Generally these differences were manifested in scale and scope: military physicians, unlike their civilian counterparts, were responsible for the health of large numbers of men, in crowded environments such

as camps and transports.[53] By contrast, private practice physicians were largely unfamiliar with the unique medical issues of large populations in crowded environments.[54] However, scope and scale are not the only differences between these two groups of medical doctors. Beginning during the First World War, just after the bacteriological revolution, military physicians and outside critics alike began to discuss what they saw as an ethical dilemma inherent in physician participation in the military and war.[55] Namely, while private physicians were obligated to serve the individual patient, having sworn the Hippocratic Oath and made a public promise, military physicians had also sworn an oath- making the public promise to serve their country and Constitution. During times of war, this meant preparing men to be deployed into war zones that could result in mass death.[56] Military physicians were also subject to military hierarchy, where they were often outranked by men with no medical training and had to adopt an almost utilitarian framework in order to "maintain the fighting force."[57] Using medical expertise and knowledge to ensure the strength and health of the military as a whole, rather than that of the individual patient, was officially recognized as the mission of military medicine during times of conflict.[58] These conflicting obligations, caused by the twin role of physician-soldier, serve as an excellent example of the problem of dual loyalties.

---

[53] Mary C. Gillett,. *The Army Medical Department, 1775-1818,* (Washington, DC: Center for Military History, 1981), 3.

[54] Ibid, 1-18.

[55] Carol R. Byerly, *Fever of War: The Influenza Epidemic in the U.S. Army During World War I* (New York, NY: New York University Press, 2005).

[56] Ibid.

[57] The official mission of the Army Medical Department (AMEDD).

[58] Byerly, *Fever of War: The Influenza Epidemic in the U.S. Army During World War I*.

TREATING TO RETURN TO DUTY

According to military ethicist, lawyer and psychiatrist Edmund Howe, "mixed agency" is and has been among the most significant issues in military medical ethics.[59] One of the most common examples of the problem of dual loyalty is that of "Treating to return to Duty." At a general level, this refers to the act of returning an injured soldier to battle when he would normally (i.e. in civilian, peace time medical practice) continue to receive treatment. This issue is particularly significant during times of intense combat when soldiers begin to suffer from combat fatigue and post traumatic stress disorder. Combat fatigue is regarded as a psychiatric issue and treated by military physicians, with food and shelter, often referred to as "three hots [hot meals] and a cot [for sleeping]" in military jargon.[60] The ethical question arises in the fact that this treatment is not standard of care for psychiatric stress such as this and places the physician squarely within a situation characteristic of the problem of dual loyalty. Treating and returning to duty goes hand in hand with another well-known and often cited example of the problem of dual loyalties, namely treating to conserve the fighting force. According to Howe, **"**Military physicians' obligation to treat soldiers with the goal of conserving the fighting strength is most clearly seen in three arenas: (1) treating soldiers to return to duty; (2) setting treatment priorities in triage situations; and (3) removing unstable

[59] Edmund Howe, "Mixed Agency in Military Medicine: Ethical Roles in Conflict," in *Military Medical Ethics*, ed. Thomas E. Beam, Linette R. Sparacino, Edmund D. Pellegrino, Anthony E. Hartle and Edmund G. Howe (Washington, DC: TMM Publications, Borden Institute, Walter Reed Army Medical Center, 2003), 333.

[60] Ibid, 336-337.

soldiers from combat."[61] Maintaining an adequate fighting force is an instrumental and undeniable component of military strategy especially in wars of attrition. Conserving the fighting force in this way is a main part of the mission of military medicine.[62]

DOCTOR-PATIENT CONFIDENTIALITY

Another significant issue related to the problem of dual loyalty is the violation of patient confidentiality under military order or in support of the military mission. Generally, these cases exist along a continuum and ethicists such as Howe believe that physicians should violate patients' confidentiality only in some occasions, where the demands of military necessity are stronger.[63] A commonly invoked example involved the "don't ask, don't tell" policy that was recently abolished by President Barack Obama. This policy had banned openly gay citizens from active military duty, and would occasionally place psychiatrists in positions that exemplified the problem of dual loyalty. If a patient were to open up to them about their homosexuality, military psychiatrists had an obligation to report them to their commanding officer, as their sexuality violated regulation. This regulatory obligation was problematic to psychiatrists because they felt that medical ethics called for doctor-patient confidentiality, which was breached by this policy. However, in light of recent policy change this example is no longer relevant. That being said, there may be other occasions in which physicians may be compelled to breach confidentiality—such as reporting diseases and illnesses that affect mission

[61] Ibid, 339.
[62] The official mission of the Army Medical Department (AMEDD).
[63] Howe, "Mixed Agency in Military Medicine: Ethical Roles in Conflict," 345.

readiness or a soldier's ability to fulfill his or her obligations or duties on the job.

THE CASE OF CPT HOWARD LEVY

There is also a body of case studies representative of the problem of dual loyalty. Robert Veatch contributes one such study, entitled "Soldier, Physician and Moral Man," from the larger work *Case Studies in Medical Ethics.* This piece discusses the real-life case of U.S. Army Captain (CPT) Howard Levy, a military physician who felt torn between his twin obligations as a soldier and a physician.[64] CPT Levy's case centers around his refusal to train Green Beret medics with dermatological skills in Vietnam, skills that would be used for strategic goals including the campaign to win the "hearts and minds" of the civilian Vietnamese population. The use of medicine as a strategic tool represents an example of the dual-loyalty problem at an institutional level. This program, and those like it, will be the focus of the second section of this dissertation.

Veatch's case study is useful in helping us to understand the moral reasoning of individual practitioners placed in these dual loyalty situations. CPT Levy based his refusal of orders on two specific arguments, one of which focused on his obligations as a medical professional.

Levy's arguments:[65]

1) The order to train the Special Forces was illegal because to do so would require him to participate in the war crimes of the Special Forces in Vietnam.
2) It forced him, as a physician, to violate medical ethics (supported by the Hippocratic Oath)

[64] Robert Veatch, " Soldier, Physician and Moral Man," in *Case Studies in Medical Ethics* (Cambridge, MA: Harvard University Press, 1977).

[65] Ibid.

Levy understood the work of these programs as "prostituting medicine for political and military purposes."[66] Thus, Levy understood the act of training medics to provide medicine as a strategic tool as in conflict with his professional medical morality. Although he does not use the term "dual loyalty" or "professional medical morality," his sense of violating medical ethics, as justified by the Hippocratic Oath calls to a sense of professional morality, shared by all physicians and grounded in the act of swearing said oath or publicly joining the profession.

CPT Levy's position finds issue with the larger non-medical motivation of the refused work. As a member of the Army Judge Advocate General stated, "We sought to use medicine as a means of approaching the enemy and imposing our will on his."[67] Within the Guerrilla warfare of Vietnam, medicine was seen a necessary and vital component of the military's strategic mission. "The one great 'in' that you have is this medic because people are short on doctors and trained medical personnel in there; that the thing to do is sort of push a medical up there in front and let him get the confidence of these people by treating them…"[68]

This case study is useful in highlighting the perspective and moral reasoning of physicians, which appears to be grounded in a sense of professional medical morality. Similarly, this case emphasizes the differing perspectives present within the institution of the military. Specifically highlighting the differing opinions towards the appropriate use of medicine between non-medical institution-level policy makers and those individual physicians who are supposed to operationalize

[66] Ibid.
[67] Ibid, 63.
[68] Ibid, 63.

their policies.

OTHER PROBLEMS OF DUAL LOYALTY

Analogies are often drawn between those examples just discussed and the conflicting loyalties that occur in the civilian sector. The editors of the Institute of Medicine's published workshop summary entitled *Military Medical Ethics: Issues Regarding Dual Loyalties* acknowledge that this type of dual loyalties problem exists outside of the military sphere, having many civilian analogies:

> In occupational medicine, particularly in small corporations, where the physician or nurse reports directly to corporate executives, an injured employee's desire to return to work in order to obtain full benefits may conflict with corporate productivity goals. In sports medicine, a triad of decision makers—physician, coach, and athlete—typically make a joint decision, based on a full assessment of risks and benefits offered by the physician.[69]

That being said, although this issue is significant for many fields, this dissertation specifically and exclusively focuses on the relationship between the military and medicine, as it represents a uniquely complicated example of dual loyalties. The military physician differs from the above-mentioned professionals in terms of moral obligations and professional status. Howe points out that "the conflicting obligations military physicians face generally are greater in both magnitude and frequency than those faced by their civilian counterparts."[70] According to this argument, the main difference is the fact that the stakes in the military are substantially higher. Military physicians practice medicine in the context of war: a context seen as unparalleled in

---

[69] Neil E. Weisfeld, Victoria D. Weisfeld and Catharyn T. Liverman, ed. *Military Medical Ethics: Issues Regarding Dual Loyalties--Workshop Summary*, edited by Institute of Medicine, (Washington, DC: National Academies Press, 2009), 2.

[70] Howe, "Mixed Agency in Military Medicine: Ethical Roles in Conflict," 334.

civilian medicine. Due to this fact it is possible that medical decisions could lead to the loss of the war, potentially resulting in many millions of deaths and great harm. Occasions such as that may be rare but are nonetheless real. The context of war coupled with the high stakes accompanying such an endeavor differentiates military problems of dual loyalty from those of the civilian sphere. This difference highlights the ethical dilemmas unique to military physicians.

Beyond that, while practitioners of sport and occupational medicine may be placed in situations that challenge their obligation to care for an individual patient, their other allegiances are not to professions in the same sense as medicine and the military. These physicians have not made a public promise as a member of two distinct professions, entering into specific relationships with inherent moral obligations in the same way as a military physician. As one military physician said, "I took a lot of oaths in a single day… one for the military- to uphold the Constitution, and another for medicine-the Hippocratic oath."[71] The act of profession, of publicly promising to become a member of a specific profession, with everything that entails, is a foundational component of professional morality.[72] Practitioners of sports medicine, or occupational medicine have only joined the profession of medicine; they have not taken an oath to the non-medical institution they serve. This oath confers both a moral and a legal obligation to follow orders that support the military mission. Beyond that, their second, non-medical roles generally lack the established professional morality of medicine, making medical

[71] Participant 8, interview by Sheena M. Eagan Chamberlin, January 31, 2013, transcript.

[72] Edmund D. Pellegrino and David C. Thomasma, *A Philosophical Basis of Medical Practice: Toward a Philosophy and Ethic of the Healing Professions* (New York, NY: Oxford University Press, 1981), 81.

obligations easier to prioritize over other, non-medical goals. Although other concerns may enter into their decision-making, including job security and pleasing their employer and patient, the second role of an occupational or sports medicine physician does not carry the same moral and legal obligations as those in the military.

THE PROBLEM OF DUAL LOYALTY & THE MILITARY

In order to gain a more complete understanding of the dual-loyalty debate it is important to move beyond the descriptive accounts. Although these descriptions provide useful insight regarding the realities of military medicine, they do not address the underlying assumptions of the dual loyalty problem. Analytical work that moves beyond descriptions of military-medico practices that challenge physicians provides a richer understanding of the dual-loyalties debate by attempting to understand the conflicting loyalties themselves, rather than the activities or manifestations of this dual-loyalties problem.

Philosopher John Moskop has offered a brief examination of the moral status of military medicine in his 1998 article, "A Moral Analysis of Military Medicine," which sheds light on the morally complicated intersection at which the soldier-physician stands.[73] Here he explains that military physicians assume a set of obligations as physicians (which he characterizes as a fiduciary relationship grounded in the four principles of Beauchamp and Childress) and another as

[73] John C. Moskop, "A Moral Analysis of Military Medicine" *Military Medicine* 163, no. 2 (1998), 76-79.

soldiers (as framed by the institution of the military itself).[74] Moskop acknowledges that these obligations may come into conflict and seeks to highlight the important moral decision a physician faces when joining the military. Standing in contrast to other authors who posit the supremacy of one of the physician-soldiers' twin roles, Moskop recognizes both as having prima facie legitimacy. While acknowledging the moral difficulties of the physician-soldier, Moskop leaves it to the individual to decide his or her own ethical and professional path. According to Moskop, "a physician's decision to enter military service is thus a morally weighty one that bears reflection on the practices of the military service to which one is pledging obedience."[75]

The edited work, *Military Medical Ethics: Issues Regarding Dual Loyalties--Workshop Summary*, published by the Institute of Medicine (IOM) provides substantial analysis of the dual-loyalties issue. The published workshop summary focuses on two case studies, (1) issues related to treating to return to duty, and (2) the treatment of detainees "in ethically charged circumstances, such as a hunger strike."[76] Aside from the descriptive value of this work, its analysis of the dual-loyalties problem is significant because it turns its focus to the military institution. The IOM workshop, "proceeded from the premise that such conflicts are best brought to light and discussed by military and civilian leaders rather than relegated

---

[74] The four principles originally put forth by Beauchamp and Childress are autonomy, beneficence, non-maleficence and justice. Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, (New York, NY: Oxford University Press, 2009).

[75] John C Moskop, "A Moral Analysis of Military Medicine " *Military Medicine* 163, no. 2 (1998).

[76] Neil E. Weisfeld, Victoria D. Weisfeld and Catharyn T. Liverman, ed. *Military Medical Ethics: Issues Regarding Dual Loyalties--Workshop Summary* (Washington, DC: National Academies Press, 2009), 2.

to individuals to cope with them alone in situations of stress."[77] This premise is substantial because it highlights the institutional component of this issue. As previously mentioned, the institutional dynamic is often overlooked by the literature. The editors emphasize the importance of ethics training outside the classroom "in a real-world situation, such as aboard a naval hospital ship on a humanitarian mission, offers teachable moments for addressing ethical dilemmas."[78] This training is important to IOM because it recognizes organizational or institutional values and behaviors as exerting great influence over the actions and decision making of the moral agents working within it. According to the IOM editors, "In the military, the commander sets the tone, as does his or her counterpart in civilian senior management. A just organization exhibits ethical awareness, judgment, and motivation and implements ethical standards."[79] The IOM emphasizes the idea of a just culture or organization that can be used to instill specific ethical values to those moral agents involved.[80] The workshop summary gives plaudits to the military, which has increased its guidance on medical ethics in the last decade to include an extensive "body of literature, policy and standard operating procedures at the operational level."[81]

The introduction of the public health ethics model contributes a new dimension to the dual-loyalty debate by grounding it in a philosophical model very

[77] Ibid, 9.
[78] Ibid, 3.
[79] Ibid, 3.
[80] Ibid, 29.
[81] Ibid, 35.

different from that of traditional patient-centered bioethics.[82] The analogy between the military and public health was prompted by perceived similarities between military and civilian dual-loyalty issues. "If valid analogies can be drawn between dual loyalty in the military context and in civilian life, then it should be possible to develop a conceptually clear and consistent approach to the problem of dual loyalty."[83] The contextual analogy here draws comparison between war and a crisis of public health (such as an epidemic or pandemic). This analogy is useful because both involve a similar paradigm shift in ethical thinking and reasoning. The stakes can be high in both contexts, where the survival of millions may literally hang in the balance and require a shift in mind-set from strong individualism toward communitarianism and utilitarianism.[84] After all, public health ethics have long recognized the fact that during serious threats to public health, individual choices may be subordinated to the greater good.

However, despite these contextual similarities this model fails to analyze a significant difference between public health practitioner and those medical professionals who have joined the military. Namely, while doctors may be confronted with similar situations in a public health emergency, such as a pandemic, they have not joined a public health profession beyond medicine with its own inherent obligations (with the exception of the Public Health Service- a uniformed service). Conversely, military physicians have joined two distinct professions. Thus, though contextually similar, this analogy fails upon closer inspection. Of course, this

[82] Solomon R. Benatar and Ross EG Upshur, "Dual Loyalties of Physicians in the Military and in Civilian Life," *Public Health and the Military* 98, no. 12 (2008).
[83] Ibid, 2163.
[84] Ibid, 2164.

discussion is not meant to dismiss the professional ethics of public health. Public health can be understood as a type of medicine that differs from clinical medicine, which is grounded in obligations to the individual patient. Rather, physicians practicing public health are often understood to abide by a different professional medical morality that while still grounded in ideas of beneficence, looks to population-level, or aggregate concerns. This shift from individual to aggregate is the "paradigm shift in ethical thinking and reasoning" mentioned earlier. Thus, the physician practitioner of public health differs from the practitioner of military medicine. The military remains a unique example of the problem of dual loyalty in which a physician has joined yet another profession, that of arms. The physician-soldier is placed in a uniquely difficult position where the setting is not the only complicating factor in moral decisions. Rather, the main hurdle to moral decision-making is an allegiance to two professional moralities.

Victor Sidel and Barry Levy take an extreme position, namely that there is an ethical conflict that renders the use of physicians by the military objectionable on the grounds of medical morality.[85] These authors believe that it is "morally unacceptable for a physician to serve as both a physician and a soldier in the United States military forces, and probably in other military forces as well."[86] The authors ground their position in the belief that the "overriding ethical principles" of each of these professions are incompatible with the other. Sidel and Levy define the overriding ethical principles of medical practice as "concern for the welfare of the

[85] Sidel, "Physician-Soldier: A Moral Dilemma?"
[86] Ibid.

patient" and "primarily do no harm."[87] The authors understand these principles to be rooted in the ethical codes of professional organization and further codified in the Geneva conventions and similar international documents. On the other hand, the overriding principles of military service are defined as "concern for the effective function of the fighting force" and "obedience to the command structure." These are seen as incompatible because a medical morality is understood as necessitating prioritization of the patient above military concerns. Due to this incompatibility, Sidel and Levy believe that the role of the physician-soldier is an "inherent moral impossibility."[88] They elaborate on their position by way of description of specific ethical dilemmas rather than further analysis of the "overriding principles" they introduced. In this way, their work straddles the line of description and analysis in a familiar way, which fails to address the underlying basis for these medical and military obligations.

As a response to the arguments of Sidel and Levy, other thinkers have gone so far as to posit that there is in fact no problem of dual loyalties for the physician soldier.[89] William Madden and Brian S. Carter have argued that the values are not that different when one explores the essence or *ethos* of the profession's moral world.[90] According to Madden and Carter, the *ethos* of each profession is characterized by the values that define the profession and the professionals,

---

[87] Ibid.
[88] Ibid.
[89] William Madden and Brian S. Carter, "Physician-soldier: a moral profession," in *Military Medical Ethics*, Thomas E. Beam, Linette R. Sparacino, Edmund D. Pellegrino, Anthony E. Hartle, Edmund G. Howe, eds. (Washington, DC: TMM Publications, Borden Institute, Walter Reed Army Medical Center: 2003), 269-291.
[90] Ibid, 269-291.

establishing their collective rights and responsibilities.[91] According to these authors, both professions seek protection of the vulnerable, rendering the dual loyalties inherently compatible.

Madden and Carter ground the ethos of medicine in the professional oaths of medicine (such as the Hippocratic Oath and AMA code of ethics), which have historically existed to prevent medical professionals from becoming "agents of death."[92] Their understanding of professional medical morality is further grounded in social and political policy, which have used "professional, civil, and criminal sanctions to prevent members of the medical profession from becoming involved in activities that led to the deaths of members of their society."[93] This professional medical morality is discussed in conversation with the morality of the profession of arms, which Madden and Carter see as, "tasked with defending members of that society by becoming directly involved in activities that lead to the wounding or death of others."[94]

These authors refute the arguments of Levy and Sidel by appealing to medical necessity and a long history of physician's involvement in war. Physicians have "gone to war" throughout history. Their involvement is necessary because of the very nature and context of war. The unsanitary and overcrowded conditions of war lead to rampant illness and infectious disease, which warrants medical

---

[91] Ibid, 272.

[92] Willian Madden and Brian S. Carter, "Physician-Soldier: A Moral Profession," in *Military Medical Ethics*, Thomas E. Beam, Linette R. Sparacino, Edmund D. Pellegrino, Anthony E. Hartle, Edmund G. Howe, eds. (Washington, DC: TMM Publication, Borden Institute, Walter Reed Army Medical Center, 2003).

[93] Ibid.

[94] Ibid.

attention. Beyond these conditions, the ability to maintain or conserve the fighting force is paramount to military success, necessitating the skills of a medical doctor.

Importantly, Madden and Carter recognize the physician's role in the military system in a way other authors fail to. Madden and Carter acknowledge that physicians have become part of the formal military system, joining in the act of profession by swearing the same oath as non-medical officers and wearing the same uniform. These physicians are not just individuals doctoring in the context of war, they are doctoring within the military profession and that institution. Drawing on the work of Samuel Huntington, which will be discussed in detail in chapter three, Madden and Carter enrich the understanding of the profession of arms as one of the historically recognized professions: namely, divinity, law, medicine, and the military.[95]

Madden and Carter define the goals of medicine as "prevention whenever possible; curative treatment when prevention fails; and healing, the relief of pain and suffering, when specific treatment will not benefit the patient."[96] The goals of the military professional are defined as security. Madden and Carter argue that men and women are "drawn to the profession of arms both by their desire to serve society and by the inherent attraction of the ultimate means of the profession—war."[97] The authors then trace the professional similarities between medicine and the military**.** They argue that medicine aims at aiding individuals in maintaining and

[95] Ibid. It is worth noting that the professional status of law, divinity and medicine has been well developed and explored- but little attention has been paid to the professional status of the military.
[96] Ibid.
[97] Ibid.

restoring health or working to ease the patient's suffering if a cure is not possible. This goal serves society because society benefits from having healthy citizens. The goals of the military also seek to benefit society by protecting it and dissuading others from attacking it. Madden and Carter offer the argument that societies need both of these professions, as they both serve it in preserving its future.

By appealing to the ethos of these professions Madden and Carter appeal to a normative conception of professional morality. In shaping the conception of military morality in this way and understanding the profession of as beneficently protecting society, Madden and Carter are able to frame military morality in a more positive way as compared to Sidel and Levy. This distinction highlights the importance of remembering to maintain both normative theories and descriptive realities in any dialogue of professional morality. The morality of the military profession depends on the morality of the military mission and how that mission is carried out. While some military missions, programs and operations do aim to protect society and uphold constitutional values, there have been historical examples of missions with colonial and imperialistic goals. There are also contemporary cases of military missions charged with protecting corporate interests or on a broader scale protecting markets for the capitalist system. Since the military institution is built on the foundational values of obedience and loyalty, soldiers are trained to uphold the mission and follow orders regardless of whether they agree with the mission.[98]

[98] There are venues for soldiers to appeal or refuse orders and missions that are illegal and immoral—this will be discussed in chapter three. That being said, many feel as though this does not represent a realistic option and could negatively affect their military career.

Similarly, the morality of the medical profession depends on morality of the medical mission. There are many physicians whose goals are to care for and cure their patients. Others act in a way that is contrary to normally understood medical morality, instead motivated by profit (only delivering care to well insured patients) or to mismanage patients for personal gain. Although this dissertation does not attempt to resolve whether each profession's purported morality is actually moral, the disjuncture between normative conceptions of professional morality and descriptive reality warrants mention and will be included throughout the analysis.

This dissertation will expand on the debate put forth by Madden and Carter, introducing the concept of internal professional morality into the debate. Madden and Carter are thus far the only authors who have attempted to explore the foundation of the dual loyalty debate, namely, the underlying morality of each professional loyalty and thus the basis of the moral obligations discussed by many other authors. Their discussion is a much-needed addition to the literature this issue. This dissertation will provide a more in-depth analysis of the moral obligations and responsibilities incumbent on these professionals, by drawing on the concept of internal morality of medicine put forth by Pellegrino, Miller and Brody.

Ultimately, this philosophical concept will be coupled with both historical analysis and the first-hand experience of military physicians, to show that the problem of dual loyalties is real. The underlying assumptions of this debate will be explored to argue that both the professions of medicine and the military have a morality inherent in them that sometimes conflicts. The philosophical concept of an

internal morality of medicine (IMM) and sociological understandings of the military profession will join in conversation with an historical analysis of MEDCAPs to enrich and extend the current dual-loyalties debate.

Chapter 2

The Foundation of Medical Obligation:

Internal Morality of Medicine (IMM)

"The practice of medicine is defined not only by the particular knowledge and skills of physicians but also by a particular morality."[99]

The problem of dual loyalties is rooted in the dual obligations inherent to the twin-roles of the physician-soldier. This military physician is torn between two sets of professional moralities and duties: one to medicine, the other the military. While a great deal has been written on the subject of dual loyalties, few authors have explored the foundation of this problem by focusing on the basis of the moral obligations and duties that shape each of the two professions. Rather, scholarship has focused on both descriptive accounts of this conflict and analysis that falls short of explaining why these dual loyalties exist. The problem of dual loyalties is based on the assumption that there are two distinct moralities encompassed within these professions. While the literature works off this assumption, little scholarly analysis has focused on the assumption itself. Do both the military and medicine have professional moralities? Within the dual-loyalties literature professional medical morality is assumed, and often justified by way of ethical codes published and

---

[99] Jos VM. Welie, "The Relationship between Medicine's Internal Morality and Religion [Medical Anthropology] " *Christian Bioethics* 8, no. 2 (2002), 186.

supported by institutions, organizations, and associations. Professional medical morality is also understood by way of codified laws and regulations. This chapter will introduce the concept of an internal morality of medicine into the dual-loyalties debate.

To begin, it is important to distinguish between professionals and non-professionals. It is the special status of a profession that provides for an internal morality. This special status also confers obligations and, in turn, warrants the public trust and cultural authority granted to members of the medical profession. Samuel Huntington describes three characteristics of professions, which separate them from vocations: corporateness, expertise and responsibility.[100] Corporateness refers to the fact that the medical profession is an organized group, while responsibility refers to a common societal role.[101] Expertise is conferred by way of specialized and restricted education. Expertise is an important part of professional identity. A professional provides his or her client with something understood to be of enormous value to the larger community. The profession of medicine helps members of the community achieve, or restore, health and well being. Health is held as highly valued by most everyone. Professionals, such as physicians, are expected to use this specialized knowledge or expertise to achieve health and well being for their patients. This relationship between professional and client is a foundational part of the medical profession. The etymology of the word *profession* helps us understand what makes a profession different from other types of employment and

[100] Samuel Huntington, *The Solider and the State: The Theory and Politics of Civil-Military Relations* (Cambridge, MA: The Belknap Press of Harvard University Press, 1981).
[101] Ibid.

pastimes. The Latin *professio* comes from the Greek verb *prophaino,* "to declare publicly."[102] Thus, in swearing the Hippocratic oath upon graduation, physicians are understood to be professing their intention to doctor publically. Many believe that it is by publicly taking an oath that a person becomes a professional and acquires specifically professional obligations. The most important feature of a profession is the fact that membership in a profession implies the acceptance of a set of ethical standards of professional practice. Swearing the oath, and thus publically acknowledging one's expert knowledge and acceptance into the medical profession, creates an implicit obligation to treat one's patient and practice medicine while abiding by professional morality.

Understanding the foundation of a physician's obligations as a member of the medical profession requires looking at the morality of the profession itself. This morality is often understood to be manifest in the various ethical codes published and supported by professional medical organizations, such as the American Medical Association (AMA), the American College of Physicians (ACP) or the World Medical Association (WMA). Medical morality is also understood to be laid out by codified documents developed by national and international organizations such as Physicians for Human Rights and the National Institutes of Health, as well both domestic and international law and policy. However, these only lay out codes of conduct for physicians, and do not aim at exploring the reasons behind these obligations. Ethicists and philosophers have proposed that there is something internal to medicine that determines its morality and shapes medical ethics. Ethicist,

[102] David T. Ozar, "Profession and Professional Ethics," in *Encyclopedia of Bioethics*, ed. Stephen G. Post (New York, NY: Macmillan Reference USA, 2004).

Dr. David C. Thomasma, has argued, "The internal morality of the profession emphasizes caring for the common good of patients."[103] He and others argue for a medical morality that is internal to the practice of medicine itself. Though ethical codes, laws and policies may explicitly detail ethical conduct in medicine, these obligations can be understood as stemming from the internal morality of medicine.

Over the last few decades the changing face of medical ethics has inspired discussion among many prominent physicians. Some of these physicians have called for increased discussion of "traditional ethics."[104] These doctors present an understanding of medicine as a practice that should not be shaped or guided by external forces such as economic and political factors; rather, they believe that medical practice should be guided by an ethic or ethos that is *internal* to medicine itself.[105] Jos Welie has argued that this discussion can be best understood as "an attempt to define medicine as a practice that is necessarily ethical in nature, a practice the moral basis of which is internal to that practice."[106] The internalist conception of medical morality is not new. Roman physician-pharmacist Scribonius Largus (14AD-54AD) put forth an internalist conception of medical morality, believing that the true physician should be completely committed to his patients

---

[103] David C. Thomasma, "Healthcare Management and Ethics: In Search of Internal Morality," *Healthcare Executive* 7, no. 6 (1992), 31.

[104] Welie, "The Relationship between Medicine's Internal Morality and Religion [Medical Anthropology]," 175.

[105] Ibid, 176.

[106] Ibid, 175.

and not influenced by personal or financial gain.[107] This chapter will examine the concept of an internal morality of medicine or IMM.[108]

An internal morality of medicine is internal because it is derived from the very nature of medicine itself.[109] This position stands in contrast to other ideas, such as that of Veatch, which postulates that medical morality involves the mere application of pre-existing moral systems to medicine. Edmund Pellegrino, Howard Brody, and Franklin G. Miller have been strong philosophical advocates for this understanding of medical morality. The basis of the IMM model looks to the *telos,* or ends of medicine, and puts forth the argument that medicine is a practice with certain and specific ends.[110]

There are two important conceptions of this theory that will be explored in this chapter. The first put forth by Pellegrino is essentialist in that he sees IMM as unchanging over time; succinctly put: "[O]ne need not look beyond medicine itself to know its morality."[111] The second is an evolutionary model proposed by Miller and Brody, which holds that morality could be reinvented when external social forces push it in new directions.[112] Although this work will not attempt to resolve the differences between these differing understandings of internal morality, this

---

[107] Ibid, 185.

[108] Pellegrino, "The Internal Morality of Clinical Medicine: A Paradigm for the Ethics of the Helping and Healing Professions."; John D Arras, "A Method in Search of a Purpose: The Internal Morality of Medicine," *Journal of Medicine and Philosophy* 26, no. 6 (2001); Tom L Beauchamp, "Internal and External Standards of Medical Morality," *Journal of Medicine and Philosophy* 26, no. 6 (20001); Miller, "The Internal Morality of Medicine: An Evolutionary Perspective."

[109] Pellegrino, "The Internal Morality of Clinical Medicine: A Paradigm for the Ethics of the Helping and Healing Professions." *Journal of Medicine and Philosophy* 26, no.6 (2001), 559-579.

[110] Ibid.

[111] Robert M. Veatch, "The Impossibility of a Morality Internal to Medicine," *Journal of Medicine and Philosophy* 26, no. 6 (2001), 621-642.

[112] Miller, "The Internal Morality of Medicine: An Evolutionary Perspective." *Journal of Medicine and Philosophy* 26, no.6 (2001), 581-599.

chapter will argue the usefulness of this concept to the dual-loyalties debate. This chapter will show that the concept of IMM is useful in understanding the professional morality and obligations that underlie the problem of dual loyalties. By exploring IMM we are able to both validate and understand the obligations felt by physicians in their role as doctors.

THE CONCEPT OF INTERNAL MEDICAL MORALITY:

> *"At the heart of any profession is the notion of role-related moral obligations."*[113]

The contemporary origins of the concept of internal medical morality can be traced back to John Ladd in 1983. Ladd modified Fuller's concept of an internal morality proposed in his philosophy of law and applied it to medical ethics. This internal morality designated a body of norms, which bound physicians together by virtue of their membership in the medical profession. Membership in the profession of medicine is an important part of this internal morality. A physician sees him- or herself not just as a doctor, but also as a member of the medical profession. It is this communal or professional identity that merits the public's trust in these professionals. It is not a matter of individual, but rather professional character that warrants public trust.[114] Each physician is understood as obligated to practice medicine according to standards that apply to *all* members of the profession. Ladd connected the norms of the medical profession to the special features of the physician patient-relationship, distinguishing internal from external norms. Leon

[113] Welie, "The Relationship between Medicine's Internal Morality and Religion [Medical Anthropology]," 191.
[114] Ibid, 191.

Kass then contributed his own analysis, defining the end of medicine as health. Kass' analysis was distinctly Aristotelian and end oriented. He argued that the morality of medicine depended on the advancement of the aims and ends of medicine.

The term "internal morality" has been used in a variety of contexts. It is critical to differentiate between different uses of the term "internal morality." Internal Morality is not a morality defined or authenticated by physicians or the profession of medicine. Namely, in this sense the term "internal" does not refer to the morality as described by professional organizations or representatives of the profession alone. While these professionals definitely deserve a voice in discussions of medical morality, the morality of medicine is inherent in the profession itself. For this reason, we cannot simply look to the codes published and supported by physicians and their professional organizations. Much of the literature on dual loyalties cites these physician-led codes, without reflecting on the internal morality of medicine that informed them. Understanding that the professional morality of medicine is internal to the practice itself, informs the dual-loyalties debate by legitimizing the obligations physicians feel as a member of the medical profession. Something about the practice of medicine itself shapes medical ethics.

Importantly, the proponents of this concept argue that it applies only to clinical medicine and the doctor-patient relationship. Edmund Pellegrino has focused his philosophy of medicine on the clinical encounter. Pellegrino argues that the individual patient encounter is the central defining moral phenomenon of a clinical philosophy of medicine. According to him, this relationship forms the basis for the moral obligations assumed by the physician when he or she offers to "heal,

help, care for, or comfort a sick person."[115] Clinical medicine is the foundational activity, which serves to define physicians *qua* physicians. Clinical medicine also sets doctors apart from other members of the medical community, who may have medical knowledge—making clinical medicine the physician's "*locus ethicus*." Emphasizing the doctor-patient relationship and clinical encounter in this way is consistent with most conceptions of medical ethics. It is also representative of the moral obligations felt by practicing physicians towards their patients.[116]

Military physicians used the term "patient-first" during interviews to characterize their conception of their own professional medical obligations.[117] The clinical encounter represents a crucial space for this "patient-first" mentality. By making the public promise to join the profession of medicine, physicians promise to care for a vulnerable patient population.[118] These sick and diseased patients expect to be cared for and healed by acts of medicine.[119] The clinical encounter is where the physician is able to perform these acts of medicine using diagnostics and treatment. Both physicians and patients understand these expectations as part of their relationship and it is precisely this type of individual patient obligation that serves as the foundation of a dual loyalties conflict. The concept of IMM grounds the military physician's obligation to their patient in the relationship of a physician who offers to heal a vulnerable, ill patient who has sought help.

---

[115] Pellegrino, *A Philosophical Basis of Medical Practice: Toward a Philosophy and Ethic of the Healing Professions*.

[116] Ibid.

[117] Participant 7, interview by Sheena M. Eagan Chamberlin, January 27, 2013, transcript: Participant 10, interview by Sheena M. Eagan Chamberlin, January 30, 2013, interview notes.

[118] Pellegrino, *A Philosophical Basis of Medical Practice: Toward a Philosophy and Ethic of the Healing Professions*, 81.

[119] Ibid, 81.

By locating the central moral phenomenon of medicine as the patient encounter, Pellegrino identifies the good of the patient as the end of medicine. Recognizing medical good as the good of the patient dates back to the Hippocratic oath, "I will follow that system or regimen which according to my ability and judgment I consider for the benefit of my patient and abstain from whatever is deleterious and mischievous."[120] For Pellegrino the good of the patient has four main components. The first is the medical good, which most directly relates to the aim of the art of medicine. This medical good must be in a proper relationship with various levels of good or it may be detrimental. The second component of the patient's good is the patient's perception of the good. This perception includes preferences, choices and values, lifestyle, goals, balance of benefits and burdens. This type of good cannot be defined by anyone but the patient, and Pellegrino recommends that the medical good must be contextualized to this patient's perceived good. The third good is the good for Humans, where the principles are rooted. This good is the same good as that described by Aristotle and Aquinas. The other two goods (the medical good and patient perceived good) must be consistent with the good for human beings as humans. The fourth and final component of the good is the "Spiritual Good." The recognition of this type of good acknowledges an end to life that is beyond material well being, and is established as the highest and ultimate good. The other levels must accommodate the spiritual good.

[120] "The Oath by Hippocrates," MIT, accessed October 10, 2012, http://classics.mit.edu/Hippocrates/hippooath.html.

According to Edmund Pellegrino, an internal morality of medicine is internal because it is derived from the very nature of medicine itself.[121] This position stands in contrast to Veatch's external morality of medicine, which argues that medicine is amoral and an external morality is only applied to it.[122] The basis of Pellegrino's IMM model looks to the *telos* or ends of medicine. He grounds this conception of the internal morality of medicine in the argument that medicine is a practice with certain and specific ends.[123] Pellegrino's notion of practice borrows heavily from the concept put forth by Alisdair MacIntyre in his work *After Virtue*.[124]

According to MacIntyre a *practice* involves, "a coherent and complex form of socially established cooperative human activity through which goods internal to that form of activity are realized in the course of trying to achieve those standards of excellence which are appropriate to, and partially definitive of, that form of activity."[125] As conceived by both MacIntyre and Pellegrino, practices (such as that of medicine) have "goods" or "ends" internal to them that are intrinsic to and constitutive of the behaviors of those who participate in the practice. These are to be distinguished from "external" or extraneous goods. As opposed to internal goods, external goods are in the realm of the individual rather than the practice itself. External goods are also limited, unlike those internal to practice. The limited nature of theses goods is made apparent when MacIntyre states, "the more someone has of

---

[121] _____, "The Internal Morality of Clinical Medicine: A Paradigm for the Ethics of the Helping and Healing Professions."

[122] Veatch, "The Impossibility of a Morality Internal to Medicine."

[123] Pellegrino, "The Internal Morality of Clinical Medicine: A Paradigm for the Ethics of the Helping and Healing Professions."

[124] Alasdair C. MacIntyre, *After Virtue: A Study in Moral Theory* (Notre Dame, IN: University of Notre Dame, 1981).

[125] Ibid, 175.

them, the less there is for other people."[126] This stands in stark contrast to the achievement of internal goods, which represents a good for the whole community of practice participants. Internal goods elevate the practice and improve it. According to MacIntyre, practice is never merely a set of technical skills; he states,

> Conceptions of the relevant goods and ends, which the technical skills serve-- and every practice does require the exercise of technical skills—are transformed and enriched by theses extensions of human powers and by that regard for its own internal goods which are partially definitive of each particular practice or types of practice.[127]

Aristotle and his "division of human undertakings" heavily influenced MacIntyre's work and concepts.[128] Aristotle divided all human activity into three categories: theory, poiesis (production) and praxis (practice).[129] Although Aristotle believed medicine to be merely poiesis, meaning its ends were external to it, McIntyre and others have argued for medicine to be seen as a practice.[130] This distinction is important because poiesis is understood to be value-neutral, while praxis or practice has internal morality. Interestingly, even Plato suggested that medicine did not have external ends. In *The Republic,* Socrates discusses the fact that while it may be necessary to reimburse physicians for their work (especially if they

---

[126] Ibid, 422.
[127] Ibid, 424.
[128] Welie, "The Relationship between Medicine's Internal Morality and Religion [Medical Anthropology]," 175.
[129] Ibid, 175.
[130] MacIntyre, *After Virtue: A Study in Moral Theory*; Welie, "The Relationship between Medicine's Internal Morality and Religion [Medical Anthropology] ".

are not men of independent wealth), a true physician should be concerned solely with the interests of his patient.[131]

The work of MacIntyre has led to conceptualization of medicine as a practice. Many, like Pellegrino, have thus attempted to determine the morality of medicine by asking what the purpose, end or goal of the practice is. Pellegrino's philosophy of medicine draws on the notion that there are three phenomena that are specific to medicine and thereby help to delineate its ends. The first phenomenon he appeals to is "the fact of illness."[132] Stated another way, physicians and medicine exist because humans become ill. The second phenomenon is the "act of profession," referring to the promise or oath taken by physicians who then enter into relationships with vulnerable patients who expect healing.[133] The third and final phenomenon is "the act of medicine," which Pellegrino describes as "right and good healing."[134] According to Pellegrino, health and virtue are fundamental aspirations of human beings. This fact is evident in that enormous effort and resources are devoted to achieving some particular notion of well being. These phenomena lead Pellegrino to define medicine as "a relation of mutual consent to effect individualized well-being by working in, and through the body."[135] The relationship between patient and provider, and the expectations and obligations accompanied by it, are important to Pellegrino as he locates the ends of medicine as "health and healing of the

---

[131] Welie, "The Relationship between Medicine's Internal Morality and Religion [Medical Anthropology]," 181.

[132] Edmund D. Pellegrino, and David C. Thomasma, *For the Patient's Good: The Restoration of Beneficence in Health Care* (New York, NY: Oxford University Press, 1988).

[133] Ibid.

[134] Ibid.

[135] Ibid, 80.

patient."[136] This healing is not reducible to the physical body and is said to include physical, psychological, social and even spiritual dimensions. The ends of medicine are to heal by assisting in making the patient whole again by working through his or her body.[137] Many other philosophers and ethicists have identified health and healing or wholeness as the goals or ends of medicine. As mentioned earlier, Leon Kass has argued for health and healing as the goals of medicine.[138] He understands these concepts broadly to include patient wholeness. Kass argues that physicians must be aware of, and true to, the goals of medicine so that the medical art circumvents becoming a tool used by technicians.[139]

Pellegrino's concept of IMM is essentialist in that he sees IMM as unchanging over time. The *telos* of medicine is completely unaffected by the external; in fact, Pellegrino refuses to see social forces as anything but threatening to the nature of medicine and, therefore, places medicine and society in a continuously contentious relationship. Pellegrino sees no need for considering the external in discussions of medical ethics.[140]

This concept of IMM is thus extremely informative to the debate surrounding the problem of dual loyalties. According to Pellegrino, the problem of dual loyalties is easily solved. The physician-soldier should not consider his or her role as a soldier in medical decisions. Since ethical actions on the part of the physician must be in line with the IMM, the external morality imposed by the military does not enter into

---

[136] Ibid, 35.
[137] Ibid, 35.
[138] Leon R. Kass, "Regarding the End of Medicine and the Pursuit of Health," *Concepts of Health and Disease* (1981).
[139] Ibid.
[140] Veatch, "The Impossibility of a Morality Internal to Medicine."

consideration. Thus, Pellegrino's theories validate the obligations that a military physician feels to the medical profession but dismisses the obligations felt towards his or her role as soldier. Pellegrino's argument could be used to argue against physician involvement in the wartime military, or advocate for a military medical institution that is freed from the obligations of military discipline and command.

Debates on the topic of the dual-loyalties problem in military medicine require further attention and development. The next chapter will argue that the profession of the military has a similarly internal morality, which cannot be simply ignored by physician-soldiers. Their twin-roles and twin memberships in two distinct professions mean that it may be difficult to prioritize one professional morality over the other. If it were simple, there would be no problem of dual loyalties. Throughout the history of formalized military medicine, physicians have been confronted with circumstances that have challenged the typical ease with which they balance their twin roles of physician and soldier. An essentialist appeal to IMM (such as that of Pellegrino) that refuses to deal with external factors also fails to either acknowledge this ethical dilemma. Pellegrino's theories refuse to allow societal needs as factors into discussions of medical ethics. In doing so, Pellegrino fails to recognize the unique position of a physician who is also a soldier. Underlying this debate appears to be the idea that IMM is superior to the morality of other professions. However, those within the military, who are members of both professions, do not all agree to this moral superiority. Many strive to balance the moral obligations and professional moralities of both professions.

Pellegrino's essentialist and static model of IMM has been undermined by the

concept of IMM put forth by other proponents of a morality that is internal to the practice of medicine itself. Other scholars have proposed concepts of IMM that allow for some influence of external morality, acknowledging the fact that the morality of medicine may evolve along with society and thus serve to further enrich the dual-loyalties debate.

Of particular interest to our debate is the theory of an evolutionary IMM proposed by Franklin Miller and Howard Brody.[141] These authors hold that Pellegrino's account of IMM is too essentialist, inherently conservative and predisposed to see all change as negative.[142] Miller and Brody propose an alternative to this essentialist conception, believing instead that morality could be reinvented when external social forces push it in new directions.[143] Miller and Brody agree with Pellegrino that there is an IMM, saying that, "physicians, by virtue of becoming socialized into the medical profession, accept allegiance to a set of moral values which define the core nature of medical practice. These values give rise to at least some of the moral duties. The professional integrity of physicians is constituted by allegiance to this internal morality."[144] However, the concept of IMM put forth by Miller and Brody differs from Pellegrino in that these authors propose a profession of medicine whose morality is determined by both external and internal factors.[145] While Pellegrino sees external and social factors as a threat to medical morality, Miller and Brody do not look upon all external morality with such

[141] Miller and Brody, "The Internal Morality of Medicine: An Evolutionary Perspective."
[142] Ibid.
[143] Ibid.
[144] Ibid.
[145] Ibid.

trepidation. They see external morality as important because medicine is practiced within a social and cultural context.[146]

Miller and Brody hold that an internal morality of medicine can be derived from an understanding of what they call *the goals of medicine and the duties incumbent on physicians in pursuing these goals*.[147] Unlike Pellegrino's essentialist and realist approach to IMM, Miller and Brody hold that medicine also has an external morality that encompasses such principles as "respect for autonomy and distributive justice."[148] The task for medical ethics is to integrate sources of ethical guidance that are internal or *proper* to medicine along with more general norms deriving from "the common morality."[149] Miller and Brody reject the essentialist notion put forth by Pellegrino by conceptualizing the nature of medicine and its internal norms as evolving. In fact, Miller and Brody prefer the term *proper morality* to internal morality because of their acceptance of the role of external factors and the possible evolution of medical goals.[150] This evolution necessarily interacts with the surrounding culture in which medicine exists.

According to this evolutionary model of IMM, there are two distinct ways in which external morality shapes medical ethics.[151] Firstly, external morality may generate its own ethical prescriptions and rules that work in tandem with internal morality but do not become a part of the internal morality itself. Secondly, parts of

---

[146] Ibid.
[147] Ibid.
[148] Ibid.
[149] Ibid.
[150] Ibid.
[151] Ibid.

external morality could gradually become incorporated into IMM as part of what Miller and Brody call the "evolutionary" process. This type of evolution takes place by way of a dialogue with the surrounding culture, allowing medicine to be re-conceptualized as history progresses.

While allowing for evolution, Miller and Brody place high value on tradition, believing it to be extremely important to the practice of medicine. While accepting that external factors can have an effect on and alter IMM, they maintain that careful analysis and dialogue must take place before external factors are allowed to amend or supplement the existing internal morality. Put another way, any external factors believed to effect medical ethics and IMM must prove their value and necessity. Miller and Brody do not advocate a social constructionist view, whereby IMM is constantly changing with every social fad. This conception of IMM serves as a valued and necessary counter to Pellegrino's static notion of internal morality.

CRITIQUES/LIMITATIONS OF IMM:

Robert Veatch is perhaps the most vocal critic of the concept of an internal morality of medicine. His work appeals to an external morality and, in doing so, attacks the entire concept of a morality that is internal to the practice of medicine. Veatch argues that medicine cannot be understood as independent of the society it serves; he bases this on the fact that it exists within a society and cannot be removed from it.[152] This is more a critique of Pellegrino than of Miller and Brody; however, this is a valid critique of Pellegrino's essentialist IMM. There are many

[152] Veatch, "The Impossibility of a Morality Internal to Medicine."

social historians and commentators who have been working to undermine this notion of medicine as divorced from the society it serves. According to R.C. Lewontin, in his work *Biology as Ideology*, medicine specifically, but also the sciences in general, are often seen as something both objective and pure that is untainted by society, composed of facts and truths unshaped by cultural and social ideologies. This understanding has grown from a view of science as an objective quest for pure knowledge, which exists beyond the reach of the political and social structures of human society.[153] According to Lewontin, medicine cannot be divorced from the society that created it.[154] The evolutionary model of Miller and Brody both strongly and adequately addresses the critique of Pellegrino's essentialist conception of IMM. Miller and Brody make room for the external in their evolutionary model, accepting IMM's ability to be changed and modified out of necessity.

While this critique focuses on Pellegrino's model, the main critique launched by Veatch attempts to undermine the entire foundation of IMM by appealing to a morality of medicine that is uniquely external. Moving beyond the critique that Pellegrino's account does not recognize the importance of external morality in informing medical practice, Veatch attempts to undermine the entire notion of morality that is inherently internal to the practice of medicine. According to Veatch, the tangling and intertwining of medicine and society means that, "in order to know what the ends of medicine are, one must first know what the ends of living and

[153] R. C. Lewontin, *Biology as Ideology* (Concord, Canada: Harper Perennial, 1992).
[154] Ibid.

social functioning are and that this, in turn, requires turning outside of any conception of medicine to determine."[155]

Veatch's argument on the impossibility of an internal morality of medicine focuses on three main rationales.[156] These are as follows, "(1) There exist many medical roles and these have different ends or purposes, (2) even within any given medical role, there exists multiple, sometimes conflicting ends, and, most critically, (3) the ends of any practice such as medicine must come from outside the practice, that is, from the basic ends or purposes of human living."[157] I will not attempt to examine all of these critiques but rather focus on the final critique, which represents the thrust of Veatch's arguments. Namely, that the morality of medicine represents the morality of the society it serves. The basis of his argument is that while medical morality may be based on its ends, the proper ends of medicine can only be known by looking outside of medicine. Veatch holds that medicine is nothing but one of many social institutions, whose morality is informed solely by that of the society it serves. This conception of medicine as a social institution might lead one to believe that medicine is morally void, a skill which has some other (apparently societal) morality poured into it. As Veatch says, "that the purpose of medicine is health and healing tells us nothing more than that the purpose of medicine is to solve what is properly perceived to be a problem in the medical realm."[158] This quote is a good summation of Veatch's argument. Here, he states that by conceiving of *health and*

---

[155] Veatch, "The Impossibility of a Morality Internal to Medicine."
[156] Robert Veatch and Frankin Miller, "The Internal Morality of Medicine: An Introduction," *Journal of Medicine and Philosophy* 26, no. 6 (2001).
[157] Ibid, 621.
[158] Ibid.

healing as the purpose or end of medicine we are not drawing on anything internal to the practice of medicine. Rather, medicine is accomplishing the goals placed in its purview by the society it serves. In other words, it is because a society values health and aims to avoid illness and disease that medical professionals are given the role of healer.

According to Veatch there is nothing uniquely inherent to the practice of medicine; it is only an institution designed to provide perceived societal goods. From this idea, Veatch proposes the possibility of many medicines, including Islamic medicine, Catholic medicine, and Military medicine. It is the social goods of each of these communities that determine the morality of each kind of medicine. However, the concept of many culturally relative medicines seems to make the problematic assumption that patients can be easily and systematically divided into single and discrete cultural groups. This concept of medical morality forces patients and physicians to identify with only one of many external moralities; they can be either Catholic or military but not both. This position seems to present a conflict as there appears to be no algorithm for balancing these competing claims. Although Veatch has criticized an internal morality of medicine for its lack of any tool to balance conflict, his proposed external morality falls victim to this same critique. If there are many medicines, which are unrelated and exist independently, where does that leave a patient with multiple subjectivities?

Brody and Miller have also criticized Veatch's many medicines model, calling on the fact that all of these medicines must have underlying similarities that would be grounded in an internal morality of medicine. Perhaps every type of medicine is

still guided by the internal good of *health and healing*, and rather each society helps shape the definition of exactly what that entails. This would seem to be in line with Miller and Brody's evolutionary perspective on the internal morality of medicine. Veatch's critiques are useful in undermining the essentialist approach of Pellegrino but fail to effectively undermine the concept of IMM.

DESCRIPTIVE & NORMATIVE MORALITY

Another possible critique of the internal morality of medicine is that it represents an idealist conception of medical morality that fails to be lived up to in the real world. Experiential and empirical knowledge tells us that this is not the way that all medical professionals behave or even desire to behave. There may be a disjuncture between the narratives of an internal morality of medicine and the descriptive reality of modern medical morality. There are physicians who both act in a way contrary to IMM, and who are not guided by the principles of IMM.[159] Perhaps these physicians are merely failing to live to live up to the ideals of IMM. A more cynical interpretation would be that such an internal professional morality is professed as part of a public relations campaign but not something that individual members always try to embody. Ultimately, this critique blurs the lines between normative and descriptive ethics. To challenge IMM because it represents an idealist conception of medical morality that physicians fail to live up to in real life, is to challenge the way medicine ought to be because it does not represent the way things are. IMM is a normative or prescriptive theory. The difference between

[159] Physicians who are not motivated by the health and healing of their patients; physicians motivated by personal profit, success and other good external to the practice of medicine.

descriptive and normative theories in ethics is a difference of "is" and "ought". Descriptive (or comparative) theories of ethics do exactly what their name implies: they describe.[160] Specifically these theories describe the way things are in the world. They are informed by experience and empirical knowledge. In this case, they describe the way that medicine is practiced and the way that physicians behave. Conversely, normative ethics are a branch of philosophy that deals with how the world should be.[161] Normative theories are often talked about as ethics grounded in the way the world "ought" to be, or the way moral agents "ought" to act. These theories investigate questions beyond the realm of experience and empirical knowledge to focus on more abstract issues.[162] IMM attempts to examine the profession of medicine and understand the way physicians *ought* to act. Leon Kass, an early proponent of IMM, has argued the prescriptive or normative value of IMM. He contends that in being aware of and true to the goals and ends of medicine, physicians can avoid circumventing the medical art, and becoming mere technicians employing the tool of medicine.[163]

That being said, it is crucial to discuss the disjuncture between the normative theory of IMM and descriptive realities of medicine. Later analysis will also focus on the import of similar a disjuncture between prescriptive military morality and descriptive reality. One cannot merely dismiss these critiques as blurring the lines between normative and descriptive ethics, crossing the old is/ought distinction of

---

[160] Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics* (New York, NY: Oxford University Press, 2009), 2.

[161] Ibid, 1.

[162] The well-known ethical theories of deontology, virtue ethics and utilitarianism are all normative theories.

[163] Kass, "Regarding the End of Medicine and the Pursuit of Health."

moral philosophy. Thus far, there have been no descriptive critiques of IMM published within the literature on this topic. Yet, descriptive claims do not need to simply be ignored and dismissed. Philosopher Michael Davis has argued for the role of both the prescriptive and descriptive in professional ethics.

> We do not talk of 'ought' (or 'should'), that is, appeal to a standard, when the conduct in question is inevitable (a matter of physics, biology or the like). We (typically) talk of standards (actual rather than proposed) only when it is true both that violation of the standard is common enough to constitute a problem and that the standards are followed often enough to constitute an ongoing practice against which violations can be assessed.[164]

Thus, although normative and descriptive theories have often dismissed each other, opening a dialogue between these schools of thought provides useful contribution and insight into the debate. Although one cannot directly, or logically derive an 'ought' from an 'is,' these descriptive discussions can be informative and provide both breadth and depth to the normative conceptions and theories. The medical humanities are uniquely suited for this as the dialogical model lies at the foundation of the humanist project.

The embedded case study of this dissertation will contribute a descriptive component to this debate. In the case of medical civilian assistance programs, military medical practice falls short of the ideal presented by IMM. This failure contributes to the problem of dual loyalty, as physicians are unable to embody the values of medical morality and thus feel morally conflicted. However, failing to live up to the idealized conception of professional morality represented by IMM is by no

[164] Michael Davis, "Medicine as Profession: An Overlooked Approach to Medical Ethics," *Philosophy Study* 3, no. 1 (2013), 38.

means unique to military medicine or medical civilian assistance programs. There are many examples in civilian practice whereby physicians fall short of the values that have been discussed in this chapter. Financial, personal and corporate considerations increasingly affect physician decision-making in civilian medicine.

By exploring IMM we are able to both validate and understand the obligation felt by physicians to their role as doctors. It is also instructive in positing the possibility of a morality internal to the profession of arms. If a profession, such as medicine, grounds its morality in the goals or ends of its practice it begs the question of whether this is true of all professions, including the profession of arms. While IMM provides a deeper understanding of the loyalty felt towards medicine, we are still left with little understanding of the obligation physician-soldiers feel towards their role as a member of the military. I believe that the IMM model is instructive in understanding both loyalties, positing the possibility of a similar internal morality of the military profession. The next chapter will draw on the work of Samuel Huntington who proposes a "military ethic" grounded in the goals of the profession of arms.[165] Although he does not use the same terminology as proponents of IMM, he attempts to similarly ground a military ethic as internal to the profession. When the two concepts of IMM (proposed by Pellegrino, Miller and Brody) and the military ethic (proposed by Huntington) are read in concert they shed light on the fundamental assumption underlying the problem of dual loyalties. Namely, they serve to provide the philosophical underpinnings for the moral obligations of both the medical profession and the profession of arms. These

[165] Huntington, *The Solider and the State: The Theory and Politics of Civil-Military Relations*.

concepts are an invaluable contribution to a debate that has thus far failed to explore these foundations. The concepts of IMM (or proper morality) and Huntington's military ethic can be used to better understand and enrich the debate of dual loyalties in military medicine.

Chapter 3

The Foundation of Military Obligation:

Internal Military Morality

I will always place the mission first.
I will never accept defeat.
I will never quit.
I will never leave a fallen comrade.[166]

Practicing medicine as a professional soldier is a morally complicated job. The practitioner of military medicine stands at an intersection between two distinctly different professions. This unique position means that situations may arise where military physicians feel pulled in two different professional directions. The dual loyalties of the physician-soldier are grounded in the dual obligations inherent in their twin-roles. The problem of dual loyalties assumes that there are two separate moralities inherent in the practice of these professions. In chapter two, the concept of an internal medical morality (IMM) was presented. The argument presented in that chapter is that medicine is a profession possessing morality inherent in the practice itself. IMM both validates and enriches an understanding of the professional moral obligations experienced by doctors in the military. The concept of an internal professional morality such as IMM is also useful in

[166] "Warrios Ethos," Department of the Army, accessed January 15, 2013, http://www.army.mil/values/warrior.html.

appreciating the possibility of morality internal to the profession of arms, or the military. If the medical profession possesses internal morality, it must be asked whether other professions possess a similarly internal morality.

Taken together, internal professional morality for both medicine and the military highlights the very foundation of the problem of dual loyalty. These concepts represent a useful contribution to a debate that, while predicated on an understanding of two distinct professional moralities and incumbent obligations, has thus far failed to fully explore these foundations. To date the problem of dual loyalties has relied on invoking examples of military medicine that differ from civilian practice, failing to establish that dual loyalties do in fact exist due to a conflicting professional morality. We can employ the concepts of a professional internal morality to understand the very foundation of the problem of dual loyalties. This chapter will continue to build the argument begun in the last chapter; namely, that the concept of IMM is useful in understanding the professional morality and obligations that underlie the problem of dual loyalties. The exploration of IMM enables both the validation and understanding of the obligations felt by physicians in their role as doctors. However, it does not address their role as a military soldier. This chapter will draw on the work of Samuel Huntington who argues that there is a "military ethic" grounded in the goals of the profession of arms.[167] This chapter will build on this work to argue that the problem of dual loyalties is significant in military medicine because this institution marries the roles of two distinct professions conferring their obligations onto a single moral agent. The physician-

[167] Huntington, *The Solider and the State: The Theory and Politics of Civil-Military Relations*.

soldier holds moral obligations to two different and distinctive professional ends. The discussion will explore the military as a profession similar to medicine, arguing that by virtue of parallels between these professions, the military must also possess an internal professional morality. As in the previous chapter, analysis will also explore the differences between the normative conception of professional morality in official documentation, the internal professional morality and the descriptive reality of military practice and culture.

The term "internal morality" has been used in a variety of contexts. The second chapter noted the importance of a proper understanding of the term "internal," which warrants reiteration here. An internal professional morality is internal because it is based on the inherent aims or goals of the professional practice.[168] It is critical to differentiate this use of the term "internal" from other common invocations of the term. Often "internal morality" is equated with the morality defined or authenticated by professionals or the profession itself. However, for the purposes of this discussion, an internal medical morality does not refer to a specific moral code as formalized by a professional organization or dictated by the professionals alone. It is not internal in the sense that those within the profession itself decide it internally. Rather, it is internal because it is inherent in the ends of the professional practice. That being said, the morality and moral codes discussed and defined within these professional groups are worth examining because they are representations of professional morality offered by the professionals themselves.

---

[168] Pellegrino, "The Internal Morality of Clinical Medicine: A Paradigm for the Ethics of the Helping and Healing Professions." Franklin G. Miller and Howard Brody, "The Internal Morality of Medicine: An Evolutionary Perspective," *Journal of Medicine and Philosophy* 26, no. 6 (2001).

As mentioned earlier, professional medical morality is assumed in the dual-loyalties literature; often justified by way of the ethical codes that have been published and supported by professional institutions, associations and organizations. Since professional medical morality is so often understood by way of codified laws and regulations, it is important to include these codes in a discussion of professional morality. Thus, it is also necessary to briefly examine the ethical codes representative of the profession of arms. We can gain useful insights and understanding of professional morality and identity by examining the moral codes as promulgated by members of the profession, and the institution itself. Beyond that, these codes help us understand how medical professionals understand and choose to represent their own collective morality. For this reason, we will now turn attention to the United States Army.[169]

For as long as men and women have organized themselves for combat codes of conduct have shaped their behaviour. These codes have sought to distinguish honourable actions from dishonourable ones and have historically been based on ideas of chivalry. However, Samuel Huntington rightly points out that the professional soldier of modern warfare varies considerably from the warrior of the past who subscribed to the chivalric code.[170] Interestingly, the U.S. Army does not have a formalized code of ethics. Although many authors have argued the necessity

[169]Although an internal military morality could be argued on a trans-national or global level, the majority of this discussion will focus of the U.S. Army. For the purposes of this project the U.S. is the object of study. Thus, U.S. primary sources and U.S. Army military doctrine dominate the primary source analysis. However that does not negate the validity of this argument for other countries that have a similarly professional military medical corps. This argument could act as a framework for similar arguments, drawing on primary sources from those nations as well as the global community.

[170] Huntington, *The Solider and the State: The Theory and Politics of Civil-Military Relations*.

of codified document that outlines Army ethics, the institution has yet to answer this call with a specific code of ethics.[171]

Despite the lack of any document formalized and titled as a "code of ethics," there are many publications whereby the military attempts to ground the behaviour of its members in a specific morality.[172] This value-driven approach to morality provides soldiers with ethical guidance similar to that provided to physicians by the AMA code of ethics. The "U.S. Army Values" are meant to teach individual Army soldiers how to live and act within the military. Soldiers are taught these values during their Basic Combat Training (BCT) course or Officers training course. All military physicians complete officers training prior to commencing their duties as military medical officers. According to the Army website, these seven core values are supposed to inform soldiers "…every day in everything they do — whether they're on the job or off."[173] The core values of loyalty, duty, respect, selfless service, honour, integrity and personal courage are held up as being what "being a Soldier is all about."[174]

However, the specific morality is not as relevant to this discussion as the existence of the professional morality itself. If we accept morality as internal to medicine, then we can suggest morality internal to the military since the two

---

[171] Arthur J. Dyck, "Ethical Bases of the Military Profession," in *The Parameters If Military Ethics*, ed. Loyd J. and Dale E. Brown Matthews (McLean, VA: Pergamon-Brassey's International Defence, 1989).

[172] United States Army, "Field Manual 1," (Department of the Army, 2005); Department of the Army, "Field Manual 27-10," (United States Army, 1956); "Uniform Code of Military Justice," accessed November 10, 2012, http://www.au.af.mil/au/awc/awcgate/ucmj.htm; "Code of Conduct," accessed January 14, 2013, http://www.au.af.mil/au/awc/awcgate/awc-ethx.htm#codeofconduct.

[173] Army, "Field Manual 1."

[174] Ibid.

professions possess similarly important characteristics, which serve to distinguish them from non-professions, lacking internal morality. By highlighting this fact alongside the concept of IMM, we can gain a more in-depth understanding of the dual-loyalties problem. Internal professional moralities inherent in both the professions of arms and medicine serve to validate the experiences of military physicians and ground the specific obligations tied to each profession within their internal moralities. The remaining discussion will explore the military as a profession similar to medicine.

Chapter two began by distinguishing professionals and from non-professionals. Distinguishing medicine as a profession allowed us to understand the moral nature of professional work. It also exposed the differences between moral-bound professional work and morally neutral occupational work or employment. Chapter two highlighted the fact that it is the special status of a profession that establishes internal morality. The special status of practicing within a profession confers obligations that, in turn, warrant the confidence and power granted professionals.

Army Field Manual 1 (FM1) serves as an official example of formalized military policy and standards of conduct.[175] Although not explicitly titled as such, this publication can, in many ways, be understood as a code of ethics since this field manual addresses the professional status of the military officer. According to FM1, "the purpose of any profession is to serve society by effectively delivering a necessary and useful specialized service. To fulfil those societal needs, professions—

[175] Ibid.

such as, medicine, law, the clergy, and the military—develop and maintain distinct bodies of specialized knowledge and impart expertise through formal, theoretical, and practical education."[176] In this way, the military itself chooses to ally itself with the profession of medicine, one that possesses internal morality (as discussed in chapter two). The understanding of the military as a profession of arms calls for an interrogation into the existence of an internal military morality. The conception of professional identity represented in this field manual, an official army publication, is instructive: clearly the military conceives of its work as being as instrumental to human society as medicine. Medical work is often recognized as possessing a moral component, thus this alliance between the military and medicine draws important analogies and hints at the possible moral dimensions of military work.

The field manual continues by arguing for the profession of arms by detailing features of the military that are similar to those used to argue for an internal medical morality. According to this manual, "each profession establishes a subculture, distinguishing its practitioners from the society they serve."[177] Beyond that, the manual argues that professions establish standards of performance and ethical codes that aim at maintaining their effectiveness in supporting and enhancing society. This standardization is manifest in and made possible by specific vocabularies, research journals, and frequently distinct uniforms or style of dress. The Army understands itself as fulfilling these characteristics of a profession. The military has established a subculture for its members, separate from the general civilian population. Uniforms, clearly identifying members of the military, visually

[176] Ibid, 1-40.
[177] Ibid.

indicate this distinction. The separation is also apparent in the benefits provided to members of the military and their family, including health care and subsidized services and products. Military vocabulary and acronyms reinforce the military subculture, which fosters a close-knit and closed community.

Interestingly, the military also attempts to distinguish itself as unique within the professions, and thus different from medicine. Despite certain similarities between the professions FM1 notes, "the profession of arms is different from other professions, both as an institution and with respect to its individual members."[178] These differences exist on both the individual and institutional level. "Institutionally, the consequences of failure in the profession of arms—for both individual members of the Armed Forces and the Nation—are more dire than those in any other."[179] Beyond that, professional soldiers can be distinguished from civilians in that they "assume unlimited liability in their oaths of office."[180] Significantly, while other professionals might engage in risky or unsafe tasks on a regular basis, "only members of the Armed Forces can be ordered to place their lives in peril anywhere at any time."[181]

The recognition of the possibly dire consequence of military success and failure serves to highlight the moral dimensions of the military's work. When American values and society itself are threatened there are consequences for all citizens, reinforcing the U.S. Constitution as the client served by the professional soldier. This conception of military morality represents the ideal upon which

[178] Ibid.
[179] Ibid, 1-41.
[180] Ibid, 1-42.
[181] Ibid, 1-42.

military action is supposed to be based. Military action is supposed to be guided and motivated by the values of the Constitution. In practice, individual soldiers rarely make decisions that affect the entire U.S. population, and rarely consider the Constitution in those decisions. Generally, while individual soldiers may face decisions of life and death that are far more common in military decision making than other professional settings, their decisions are often shaped by the orders of superiors. These dire consequences form the basis for the key military values and virtues that are expressed in practice. The military prioritizes the mission and values of loyalty and obedience in its members in order to insure a well functioning institution. Without obedience to those in command the military could not function properly, efficiently and effectively. Following orders is a critical component of military conduct because it promotes vertical cohesion and promotes the mission, avoiding the possibly dire consequences understood to be associated with mission failure. It is also undeniable that when the consequences are so significant and failure so ominous, the ethical conduct of the military is necessary to aid in its success.

According to FM1, the American profession of arms includes three dimensions: physical, intellectual, and moral.[182] The profession of arms is necessarily physical because warfare itself is a physical enterprise. The profession is also intellectual due to the body of expertise essential to the success of military operations. Recognition of the moral dimension of military work is significant in clearly establishing one type of "internal" morality. Namely, the institution of the

[182] Ibid, 1-48, 49, 50.

Army itself recognizes a moral component to their work. This recognition highlights the normative representation of professional morality by the military itself. According the FM1, discussions of morality are necessary within the profession of Arms because war is ultimately "fought for ideas."[183] In fact, ideologies serve as prime motivating factors for many combatants. Thus, FM1 acknowledges that military morality must recognize that while force may be necessary to ensure the common good, authority to wield this force brings with it significant moral responsibility.[184] In the U.S., the normative conception of responsibility involves upholding the moral and ethical values of the Constitution and the Declaration of Independence. These are understood as the foundation of the military's professional ideals. The Law of Land Warfare, Uniform Code of Military Justice, and Code of Conduct are also all significant in structuring the moral standards of the military.[185]

As mentioned before, this normative representation forms the idealist foundation for the military's conception of its own morality. In practice, many soldiers do not consider the values of the Constitution in their moral decisions-making process. That being said, these soldiers do place high value on the oath sworn to the Constitution and understand that oath to have conferred moral obligations that bind them to the military mission. Importantly however, their decision-making process is generally shaped by orders from commanding officers, as well as understandings of the overall mission. Ideally the mission itself is informed by the values of the Constitution. If not, these soldiers do have recourse to

[183] Ibid, 1-52.
[184] Ibid.
[185] _____, "Field Manual 27-10."; "Uniform Code of Military Justice."; "Code of Conduct."

disregard and appeal illegal orders—however they often do not feel empowered to do so. Many fear the consequences that such an appeal would have on their career. Still, this recourse does exist and may be used by all members of the military. Ultimately, these practical realities are significant in recognizing the moral environment of the military professional. Although these publications draw heavily on language that connects military morality to the Constitution and the fact that the individual soldier values their Constitutional ties, the moral decision-making of individual soldiers has more to do with orders and the immediate mission than this foundational document. This descriptive reality warrants mention, adding contextual depth to the normative discussion.

While there is no official "code of ethics" for the military in general of Army in particular, there are numerous Army publications that attempt to inform the behavior of the individual soldier. Recognizing that the military places its members in unique environments that may stress everyday morality, the field manual acknowledges, "Doing the right thing for the right reason and with the right intention is always challenging … but this challenge is even more difficult during the fast-moving, ambiguous, and deadly chaos of combat."[186] Arthur Dyck also recognized the uniquely complicated moral environment of war, "military personnel function in the midst of moral and material chaos."[187] In response to the difficult ethical dilemmas its members will face, the Army emphasizes that it is a values-

[186] Army, "Field Manual 1," 1-54.

[187] Faris R. Kirkland, "Honor, Combat Ethics, and Military Culture," in *Military Medical Ethics*, ed. Thomas E. Beam, Linette R. Sparacino, Edmund D. Pellegrino, Anthony E. Hartle, and, and Edmund G. Howe (Washington, DC: TMM Publications, Borden Institute, Walter Reed Army Medical Center, 2003).

based organization. These values involve upholding the principles that are grounded in the Constitution as well as the Army Values, Soldier's Creed, and Warrior Ethos.[188] These attempt to extrapolate the spirit of the Constitution and operationalize its values, translating them into a language that is useful to individual soldier decision-making.

The Army Values (loyalty, duty, respect, self-service, honour, integrity and personal courage) are considered to be the "basic building blocks of a soldier's character" and aim at helping soldiers "judge from right or wrong in any situation."[189] In fact, according the U.S. Army field manual, rooted in the this creed is the Warrior Ethos. The Warrior Ethos is understood to be the heart or "essence" of what it means to be a soldier[190]:

- I will always place the mission first.
- I will never accept defeat.
- I will never quit.
- I will never leave a fallen comrade.

Understanding the basic building blocks of military morality serves to highlight the problem of dual loyalties. While the first tenet of medical morality appears to be "care for the individual patient," the ethos of the military is laid out clearly in this manual, "I will always place the mission first."[191] Thus, we can see that granting military-physicians membership into two distinct professional communities may be

---

[188] "Army Values," Department of the Army, accessed January 13, 2013, http://www.army.mil/values/; "Warrios Ethos."; "Soldier's Creed," Department of the Army, accessed January 11, 2013, http://www.army.mil/values/soldiers.html.

[189] Army, "Field Manual 1," 1-61.

[190] "Warrios Ethos."

[191] Ibid.

morally problematic. While the medical profession has clearly individual moral obligations, military obligations function on an aggregate-level.

According to Arthur Dyck, the traditional approach to professional responsibilities within the military is the understanding of military life as driven by duty, country, and honour.[192] Duty implies an obligation to do military work both conscientiously and abiding by ethically acceptable norms. As a society, we expect military professionals to "protect the innocent, abide by the just war theory, the laws of land warfare, and support the enduring values of American society."[193] The emphasis placed on nation or country highlights the view of American society as the client served by military professionals, mirroring the conception of morality presented by the Army in its own publications. Finally, honour is understood as a call to uphold commitments and values characterized by those who wrote and formalized the Constitution. Army officers are supposed to be characterized by the values of the Constitution since they have professed fidelity to it.[194]

Samuel Huntington's model of the military profession has been recognized as a primary source on the topic.[195] His conception of the profession of arms furthers this chapter's discussion by distinguishing between officers and enlisted personnel and introducing what he terms the "military mind."[196] The concept of the "military mind" is closely analogous to an internal professional morality as seen in the IMM debate discussed in chapter two.

---

[192] Dyck, "Ethical Bases of the Military Profession," 108.
[193] Ibid, 108.
[194] Ibid.
[195] Huntington, *The Solider and the State: The Theory and Politics of Civil-Military Relations*.
[196] Ibid.

The military is a hierarchical institution and within that hierarchy members are divided into different groups. There are reservists (which are part-time members), enlisted personnel and officers. Huntington distinguishes between the military officer and enlisted soldier, a distinction that separates professionals from non-professionals within the military, institutional hierarchy. This division is important to our discussion because military physicians are all officers, and thus professionals within the military institution. According to Huntington, it is the role of the officer to represent the profession of arms. Faris Kirkland makes the same distinction in his chapter of the edited work, *Military Medical Ethics.*[197] This text represents one of the first large scale endeavors by the U.S. Army aimed at discussing the ethics of military medical practice. In this work, Faris argues that while officers are professionals, enlisted personnel are not. According to this author, the difference lies in expertise and responsibility: "enlisted men have neither the intellectual skills nor professional responsibility."[198] Although the Army Field Manual holds all military personnel, whether officers or enlisted, to certain normative conceptions of morality and specific values, this recognizes the fact that an hierarchical institution such as the military does hold those of higher rank (such as officers) to higher standards. Officers are understood to be professionals with expertise in the management of violence. On the other hand, enlisted personnel are described as specialists in the application of violence.[199] This is based on ideas and

[197] Kirkland, "Honor, Combat Ethics, and Military Culture."
[198] Ibid.
[199] Ibid.

concepts surrounding the special status of professionals that remarkably similar to those invoked by Pellegrino and others in establishing medicine as a practice.

Huntington grounds his concept of the military profession on three broad characteristics that he proposes as encompassed in all professions. These constitute a sociological or social approach to professional ethics and are useful to our discussion of internal military morality. The first broad characteristic is expertise, which involves the specific or unique competence in the performance of special tasks and services. Huntington describes the military officer as a "manager of violence" with specialized training and education in combat, peacekeeping, deterrence and knowledge of the politico-military sphere that the non-military professional, and military non-professional lacks.[200] This expertise is imparted to officers through military training and post secondary education. The expert knowledge of the military professional enables the officers to fulfill what Huntington calls "the function of military force, " which is the successful armed combat and security of the nation.[201] The function of the military can be understood as being analogous to the goals or ends of the military profession. The expertise of these professionals enables them to meet the goals and fulfill the functions of the military successfully.

Arthur Dyck also emphasizes the importance of expertise to professional status in his 1989 article.[202] Dyck agrees with Huntington that the expertise unique to the military is "management of violence," including war-related force and

[200] Huntington, *The Solider and the State: The Theory and Politics of Civil-Military Relations*.
[201] Ibid.
[202] Dyck, "Ethical Bases of the Military Profession."

activities, peacekeeping as well as the deterrence of violence.[203] Cogan, a sociologist, also conceives expertise as one of his four characteristics of a profession. According to Cogan, a profession is a "vocation whose practice is founded upon an understanding of the theoretical structure of some department of learning or science and upon the abilities accompanying such understanding."[204] Expertise is also an essential part of the medical profession (obtained by way of medical school and post graduate training) that enables physicians to fulfill the ends of health and healing outlined by the proponents of IMM. Similarly, the expert knowledge that military officers gain in training enables them to fulfill the goals or function of the military; namely, the management of violence for the security of the nation.

The second characteristic of Huntington's concept of a profession is responsibility. Huntington argues that the client of every profession is society, individually or collectively. According to Huntington, "the essential and general character of his service and the monopoly of his skills impose upon the professional man the responsibility to perform the service when required by society. This responsibility distinguishes the professional from other experts."[205] Within the military context, the military officer has a responsibility to the society he serves. In the United States, this relationship is established by way of the act of profession. Military professionals, publicly profess in the form of swearing an oath to the Constitution rather than a specific political leader thereby entering the profession of arms. Their goal is to provide for the security of the nation.

---

[203] Ibid, 106.

[204] Morris Cogan, "Toward a Definition of Profession," *Harvard Educational Review* 23, no. Winter (1953).

[205] Huntington, *The Solider and the State: The Theory and Politics of Civil-Military Relations*.

Army Field Manual 1 accepts that while professionals gain considerable autonomy by way of technical skill, it carries with it responsibility. The manual clearly positions the United States as the body to which soldiers owe obligations. According to section 43 of Field Manual 1, the profession of arms is distinguished by its service to the Constitution, which is intimately linked to the professionalism of officers.[206] The field manual places substantial weight on the professional oath, sworn by members of the American military, to the U.S. Constitution. This oath binds the military professional to support and defend the Constitution rather than a leader, population, government, or territory. As mentioned earlier, this constitutionally based oath serves to ground military conduct in specific normative values. The oath also connects military service to the founding document of the United States. The responsibilities inherent in the role of the professional soldier are not owed to individual American citizens, or military members, but rather to the Constitution and thus American society itself. The Army understands this to imply a specific normative professional ethic.[207] According to this primary source document, "the profession holds common standards and a code of ethics derived from common moral obligations undertaken in its members' oaths of office…by taking an oath to defend the Constitution, Soldiers accept a set of responsibilities that other citizens do not."[208] This concept is reminiscent of a physician's responsibility to his or her patient and ties into ideas surrounding the obligations and expectation incumbent

[206] Army, "Field Manual 1," 1-43.
[207] Ibid.
[208] Ibid, 1-60.

on physicians as established by Miller and Brody.[209] Importantly, the notion of "profession" within medicine is often tied to the act of profession and public promise manifest in the swearing of the Hippocratic oath. In this way, both medicine and the military profess an oath that establishes specific obligations and responsibilities.

As discussed in the previous chapter, the swearing of the Hippocratic oath can be understood as the physicians' public declaration (or profession) of their intention to heal and care for patients. Similarly, in swearing an oath to the Constitution, soldiers profess publicly that they will uphold and protect the nation and its values. Many have argued that the publicly swearing of an oath grants professional status and confers obligations. Swearing the oath publicly, and thus announcing one's military expertise and acceptance into the profession of arms, establishes the obligation to abide by military codes of conduct and strive for military success aimed at security and the protection of American values. The oath and Constitution are thus foundation to the military's normative conception of its own professional morality.

These normative accounts of professional morality represented by the Army embody idealized conceptions of military morality. However, there are many descriptive accounts whereby both individual soldiers and the military institution fall short of this ideal. Similar to IMM, there exists a disjuncture between these normative theories and the descriptive realities. Perhaps these examples represent

[209] Franklin G. Miller and Howard Brody, "The Internal Morality of Medicine: An Evolutionary Perspective," *Journal of Medicine and Philosophy* 26, no. 6 (2001).

a failure on the part of soldiers or the military institution to live up to the ideals of professional morality. However, much like within the IMM discussion, a more cynical argument could be made that there exists ulterior motives; that an internal professional morality is professed as part of a public relations campaign. As a public relations campaign, the military institution could be attempting to increase recruitment or boost its image, instead of seeking to establish a professional morality for its individual members to attempt to embody. Although this chapter focuses on a normative theory of professional military morality, namely an internal professional morality, descriptive claims need not be simply dismissed. As mentioned in the previous chapter (chapter two), although it is impossible to directly, or even logically develop an 'ought' from an 'is,' descriptive discussions are informative and can be quite fruitful, adding depth to normative analysis and theories.

A disjuncture between normative theories and descriptive realities is not uncommon. Ideally since the American military oath is sworn to the Constitution and not the president, soldiers uphold the values of the Constitution and nation, rather than bowing to the desires and whims of a specific leader. However, it is crucial to remember the descriptive reality of the military in this discussion. While the Army's normative conception of professional morality is grounded in the Constitution, the descriptive reality is more complicated when it comes to the moral decision-making of the individual military professional. Although an oath is sworn to the Constitution, the president is still the commander in chief and makes decisions that dictate military policy and actions. Beyond that, the military hierarchy

establishes clear lines of superiority and subordinates to maintain vertical and horizontal cohesion within the force and insure the proper functioning of the institution. Vertical cohesion implies the obedience to one's commanding officer, which is built on trust and creates links between the smaller individual groups, larger units and finally to the military itself and the nation.[210] Thus, although an oath is sworn to the Constitution, the military represents a complex institutional hierarchy with specific leaders, orders and missions that soldiers are supposed to be followed. Importantly, military professionals or officers, as high-ranking members of this hierarchy have the additional responsibilities of the leadership roles they inhabit. Often these officers both follow and issue orders. Issuing orders and leading both enlisted and lower ranking officers is a responsibility that requires specific training and skill.

Cogan also recognizes the responsibilities that accompany the status of the professional. Namely, the understanding that since these expert abilities empower professionals to serve the vital needs of human beings, practitioners have "a first ethical imperative of *altruistic service to clients.*"[211] For the soldier, this is a reminder of their obligations to the state. On the other hand, this highlights a physician's obligation to their individual patient. The juxtaposition of the physician's individual client, with the military's collective client is at the very basis of the dual-loyalties problem.

[210] Kirkland, "Honor, Combat Ethics, and Military Culture," (157-192).
[211] Cogan, "Toward a Definition of Profession."

Arthur Dyck also highlights the moral responsibility of professional soldiers. According to Dyck, a professional-client relationship is a necessary component of professional practice. Professionals enter into a relationship based on "special trust, confidence, understanding and confidentiality."[212] This trust is grounded in responsibilities conferred on professionals as a condition of the expert knowledge they possess. Dyck also outlines the primary motive of a profession as a service; rather than driven by financial gain—as many occupations are, a professional has the "social obligation to use those skills solely for the benefit of society."[213] This service-based or altruistic motive establishes an undeniable moral component to professional practice.

The last characteristic of Huntington's concept of a profession is corporate-ness. The term "corporate" here refers to the communal or collective similarities and unity of the profession, rather than the economic connotations that this term generally carries. This corporate-ness is established by the fact that professionals share a sense "of organic unity and consciousness of themselves as a group apart from laymen."[214] This collective sense has its origin in the lengthy discipline and training necessary for expertise, the common bond of unique work social responsibility (corporateness). In the United States, both the profession of arms and medicine are composed of a group of people dedicated to a specific and common purpose. Both professions wear uniforms that create a symbolic distinction between members and non-members. For the military, uniforms and insignias of rank

[212] Dyck, "Ethical Bases of the Military Profession."
[213] Ibid.
[214] Huntington, *The Solider and the State: The Theory and Politics of Civil-Military Relations*.

publicly symbolize the line between a soldier and the layman or civilian. Within medicine, this symbolic distinction is achieved in the wearing of a white coat. As mentioned earlier, the separation between professionals and laymen is clearly noted and discussed by the Army in Field Manual 1.[215]

Although the characteristics of a profession proposed by Huntington are useful in drawing similarities between the professions of medicine and the military and exposing the moral dimensions of professional practice, it is his construction of a military ethic that is most informative to the dual-loyalties debate. According to Huntington, a military ethic "is deducible from the nature of the military profession."[216] This conception of a military ethic is closely analogous to that of IMM that has been proposed and explored in chapter two. An appeal to the "nature" of the profession is seen in both Huntington's military ethics and the concept of IMM, as outlined by its proponents.[217] Both seek to fulfill a specific goal or function; within the military, that goal is laid out as security, in medicine it is healing. Thus, both concepts refer to normative morality that is similarly inherent in the practice of each profession.

The military ethic discussed by Huntington is based on the concept of what he calls the *military mind* (or *weltanschauung)*.[218] Much like IMM, the military mind consists of values, attitudes and perspectives that are *inherent* in the performance of the professional military function and which are "deducible from the nature of that

---

[215] Army, "Field Manual 1," 1-40.

[216] Huntington, *The Solider and the State: The Theory and Politics of Civil-Military Relations*.

[217] Pellegrino, "The Internal Morality of Clinical Medicine: A Paradigm for the Ethics of the Helping and Healing Professions."; Miller and Brody, "The Internal Morality of Medicine: An Evolutionary Perspective."

[218] Huntington, *The Solider and the State: The Theory and Politics of Civil-Military Relations*.

function."[219] In accordance with the military mind, "a value or attitude is part of the professional military ethics if it is implied by or derived from the peculiar expertise, responsibility and organization of the military profession."[220] In fact, Huntington explicitly states, "any given officer corps will adhere to the ethic only to the extent that it is professional, that is, to the extent that it is shaped by functional rather than societal imperatives."[221] This clearly establishes the military ethic as one that is internal to military practice and not to be shaped by social imperatives or rather, external morality.

Interestingly, Huntington also invokes the same evolutionary ideas as Miller and Brody. Although he characterizes his military ethic as "non-dated" and "non-localized," he does admit that alteration in the nature of the military function could change the military ethic.[222] As did Miller and Brody, Huntington does not allow faddish change to internal morality, stating "so long as there is no basic alteration in the inherent nature of the military function there will be no change in the content of the professional ethic."[223] This statement allows for some evolution but seems to value tradition as highly as Miller and Brody do within their concept of a proper morality of medicine.

This chapter has highlighted the many similarities between the professions of medicine and the military. These similarities were explored in order to show the necessity of recognizing internal morality of both professions, expanding on the

[219] Ibid, 61.
[220] Ibid, 61.
[221] Ibid.
[222] Ibid, 62.
[223] Ibid, 62

one-sided debate that assumes internal morality of medicine. IMM as proposed by Pellegrino, Miller, and Brody works in tandem with the military ethic proposed by Huntington and ideas of morality published in Army Field Manual 1 to shed light on the very foundations of the dual-loyalty problem. By joining two professions with public promising in the form of two separate oaths, the military physician takes on twin-roles, each with its own professional morality.

It is this experience of identifying as both a soldier and a physician that creates the problem of dual loyalties. The internal morality of medicine emphasizes and prioritizes the health and healing of individual patients. Conversely, the internal morality of the military emphasizes service to and security of the state or nation, an aggregate-level client. In practice, the physician holds obligations to the individual patient and their health while the soldier owes obligations to the mission, which is represented as being for the good of the state. As we have discussed, the practical moral decision-making of a military professional is directed by mission concerns and orders dictated by those higher in the hierarchical structure. Since the military values obedience and loyalty, insisting that orders must be followed, and soldiers must act in service to the mission, there is often little space for individual members to make their own individual evaluations as to whether the mission is truly in line with the goals of the profession (in service of the state and representative of the values of the Constitution). This reality highlights a possible disjuncture between normative conceptions of professional morality and descriptive reality that further complicates the problem of dual loyalty. Not only is the normative conception of an internal military morality grounded in aggregate level concerns, but individual

members of this professional are not always able to make their own decisions and shape their own moral actions. Part of the military value system, prizing obedience and loyalty, depends on individual soldiers following the orders of their superiors and commanding officers. Thus, individual moral decision-making is not as independent as it is in the profession of medicine, adding a new layer to the problem of dual loyalty. Physicians make independent decisions and often times give orders in order to fulfill their obligations, conversely soldiers follow orders and act on decisions made for them. This represents another stark and significant difference between the two professional worlds that a physician soldier must straddle.

The military has historically depended on a strict hierarchical system to function effectively and efficiently, relying on soldiers to act on orders without question. The ability to act on orders independent of individual moral evaluation assumes that the mission is founded on the values of the Constitution as outlined by normative conceptions of military morality. Unfortunately, whether or not missions and military actions are actually grounded in constitutional values and representative of what is best for the nation depends on the mission, the order and the moment in history. Of course, when a soldier believes an order or a mission to be unconstitutional there are avenues for appeal. Unfortunately, this complicated process is seen as beyond the reach of many soldiers. Others fear the effect it may have a negative impact on their career.

As discussed in chapter one, the morality of military depends on the morality of the mission. However, the military presents a complicated case because of its institutional values and hierarchy. By way of training and military culture, soldiers

are socialized to believe that they are embodying these normative moral ideals. Since the military is an institution built on loyalty and obedience, soldiers will follow orders and uphold the mission, even if the military mission isn't about providing security and protection—the ethos or function of the profession of arms. This component of practical military morality provides a complicating factor to the problem of dual loyalty as physicians both serve the aggregate level client of the nation-state and do so by following orders, leaving little room for individual moral reflection. The inability to make individual moral decisions creates further difficulties in balancing the twin roles of the physician soldier.

The physician-soldier must serve two masters. Thus, it is easy to imagine situations that could place these two obligations in competition. By combining the professions of medicine and the military and conferring both sets of obligation onto a single moral agent, the Army institutionalizes this ethical conflict. Although peacetime military medicine may pose no problem to medical morality, situations will arise when the two professional moralities conflict. This conflict is inherent in the different clients and obligations of these two professions. Prioritization of the individual and the aggregate are mutually exclusive, making it difficult to fulfill moral obligations to both.

When the two concepts of IMM (proposed by Pellegrino, Miller and Brody) and the military ethic (proposed by Huntington) are read in concert, they serve to shed light on the fundamental assumption underlying the problem of dual loyalties. Namely, they serve to provide the philosophical underpinnings for the moral obligations of both the medical profession and the profession of arms. These

concepts are an invaluable contribution to a debate that has thus far failed to explore these foundations. We can use these concepts of IMM (or proper morality) and Huntington's military ethic to better understand and enrich the debate of dual loyalties in military medicine.

Chapter 4

Hygiene, Sanitation, Public Health & Force Protection

American military medical professionals have been providing medical care to civilian populations since the beginning of formalized Army medicine. In fact, evidence of civilian medical assistance programs date back to the Revolutionary War when the American army first organized.[224] During that time, military medical personnel often provided care to civilians who lived in the vicinity of Army camps and bases. This care was provided out of a motivation to better or maintain the health of soldiers by improving hygiene and reducing epidemic disease, rather than to improve the health of the civilian population. This meant that civilian assistance had a decidedly strategic purpose; improved civilian health meant a reduction in epidemic disease, and thus a healthy and disease-free army, which meant a higher likelihood of mission success. These first civilian medical assistance programs relied heavily on massive hygiene, sanitation and public health campaigns. The forces instituted quarantines and clean ups in order to prevent seasonal epidemics and maintain troop health, which inevitably had undeniable benefit for the local civilian populations.[225] However the intent and motivations behind these programs were

[224] Gillett, *The Army Medical Department, 1775-1818*.

[225] Ibid; Mary C. Gillett, *The Army Medical Department 1818-1865* (Washington, DC: United States Army, 1987); Wilensky, *Military Medicine to Win Hearts and Minds: Aid to Civilians in the Vietnam War*; Malsby III, "Into Which End Does the Thermometer Go? Application of Military Medicine in Counterinsurgency: Does Direct Patient Care by American Service Members Work?";

not humanitarian; it was not simply to help the civilian populations. Instead, the intent was force protection. Interestingly, there are no accounts of physician discontent from these early hygiene, sanitation and public health programs. Of course, a lack of evidence does not mean that discontent was not present. However, as this chapter will show, it can be argued that physician discontent was less significant due to the fact that the care that the medical and military goals of these civilian assistance programs were similar—both aimed to reduce epidemic disease. The medical care that was prvodided as a part of these programs was the standard of care according to the state of medicine at this time, thus physicians did not feel as though they were failing to adequately care for the health of their patients (an issue of significant strife in later civilian interventions-as seen in chapters five and six). This chapter will explore these early medical civilian assistance programs, both at home and abroad. Tracing this early history will enable comparison between these early programs and those that follow as they are later changed and formalized as part of low-intensity conflict, guerilla warfare and stabilization operations within the U.S. Army Medical Department and other branches of the US military.

CIVILIAN CARE:

Throughout times of both peace and conflict, the military physician has provided medical care to American civilians. Mary Gillett's official history of the AMEDD notes several instances in which hospitals list women and children as their

---

Vincent Cirillo, *Bullets and Bacilli: The Spanish-American War and Military Medicine* (New Brunsick, NJ: Rutgers University, 2004).

patients.[226] This patient population is clearly civilian since the military at this time was single-sex, male only. Gillett states that although dependant and civilian care was not required of army surgeons, it was expected of those stationed in remote locations, especially along the frontier.[227] Doctors often moonlighted when off duty and provided care for wives, children and civilians on post.[228] This helped to occupy their downtime, and prevent boredom, while simultaneously serving the community.

While physicians often cared for civilians and dependants in clinics and hospitals while stationed in remote areas and along the frontier, they also provided civilian care throughout times of active conflict. Early American conflicts often involved close proximity with civilian populations. Thus, the state of troop health was directly affected by the civilian health that surrounded them. Military medicine was leading the way in the hygiene movement, and much of their contact with the civilian world was by way of hygiene or sanitation interventions related to infectious and epidemic disease. Thus, a discussion of civilian medical assistance programs should involve an exploration of these interventions that effected civilians, which necessitates an examination of the emergence of public health knowledge in the U.S. Army. Military hygiene and public health knowledge and interventions represent a launching point for the health, hygiene and sanitation movement within larger U.S. society.

---

[226] Gillett, *The Army Medical Department 1818-1865*.
[227] Ibid.
[228] Ibid.

Medicine and medical knowledge in the pre-Vietnam period span two decidedly different eras in the history of medicine. When the American military was beginning to form in the eighteenth century, medical knowledge was based on humors and miasmas, with therapeutics including nursing care and procedures aimed at balancing humors through bleeding and purging. In the late nineteenth century, the bacteriological revolution brought immense change to the field of public health allowing scientists and physicians to understand the cause of disease and illness in a new way. In the early and mid twentieth century, the therapeutic revolution forever changed the treatment of patients with new and improved abilities to cure and care for disease and illness. The state of medicine, medical knowledge and medical education will be discussed throughout the analysis of these civilian medical assistance programs in order to provide historical context and enrich understanding of this embedded case.

REVOLUTIONARY WAR:

The Revolutionary War marks the first time in which Americans fought on behalf of their new nation, and the first time American physicians practiced medicine as part of a national Army. At this point, there were few professional soldiers in the Continental Army, and the United States managed to earn its freedom from the British Crown, with an army of eager volunteers and farmers with little to no formal military training.[229] The Revolutionary War was characterized by shortages of everything, whether it was personnel, ammunitions or medicine.[230]

---

[229] _____, *The Army Medical Department, 1775-1818*.
[230] Ibid.

These wide spread shortages were due to lack of access to finished goods, administrative difficulties and logistics. Locals in the communities surrounding battlefields were often called upon to help provide supplies.[231] Civilian populations were intimately intertwined with military operations during this war. Their proximity to battlefields and camps made them both a source of and drain on the resources of the military; both providing medical supplies when needed and requiring medical care from military clinics, hospitals and surgeons.

At this point, medicine, whether military or civilian consisted of only basic nursing care, and an extremely limited collection of therapeutics treatments that were of dubious value to the sick and the wounded.[232] Although they were able to splint and wrap wounds, the crucial issue confronting this nascent American military was not battlefield trauma but rather disease.[233] Epidemic disease and infection plagued the military, claiming more lives than battle.[234] Unfortunately, the arsenal of a medical man was largely composed of emetics, purges and herbal remedies that rarely provided relief from the diseases of which the Continental soldiers commonly suffered. The main exception to this inability to deal with infectious disease was the widespread use of preventive measures such as hygienic control and inoculation.[235] In this respect, the military was far ahead of their civilian counterparts who remained largely fearful of the practice of inoculating and less informed on matters of hygiene. At this time, the hygiene movement lacked the

---

[231] Ibid.
[232] Ibid.
[233] Ibid.
[234] Ibid; Ira Ruktow, *Bleeding Blue and Gray* (New York, NY: Random House, 2005); Alfred J. Bollet, *Civil War Medicine: Challenges and Triumphs* (Tucson, AZ: Galen Press, 2002).
[235] Gillett, *The Army Medical Department, 1775-1818*.

knowledge of germ theory; their understanding was based on empirical reasoning, observational knowledge and older models of disease theory.

Crowded encampments and large susceptible populations necessitated the need for preventive health measures to be emphasized within military medicine. Largely unable to treat disease effectively once it set in, the military turned to inoculating its troops and enforced strict rules of hygiene in an attempt to avoid widespread epidemics. Without effective and healthy men, the war would surely have been lost. Surgeons that cared for the Continental Army had significant obstacles to contend with, including the lack of a formal rank within the military hierarchy and often the respect to have their ideas enforced within the military chain of command. Still, physicians such as Benjamin Rush called for preventive hygienic measures hoping to curb the rampant epidemics decimating the fighting force.[236] Recognizing the effects of over crowding, Rush criticized the state of encampments, as well as the lack of personal discipline amongst the troops.[237] He believed that there were five main reasons for increased illness amongst the troops: dress, diet, cleanliness, encampments and exercise.[238] Rush sought to address these issues individually, believing that the soldiers should be eating more vegetables (and drinking less rum), cut their hair short and wash their bodies regularly to avoid lice, as well as exercise frequently to avoid idleness. Rush condemned overcrowding in camps and

[236] Henry P. De Forest, "Benjamin Rush's Directions for Preserving the Health of Soldiers," *Military Surgeon* 22(1908).
[237] Ibid.
[238] Ibid.

advocated the use of temporary encampments in order to avoid a build up of human waste and its associated disease.[239]

This call to hygienic prevention was unprecedented in civilian medicine, where personal and public hygiene was seldom an issue in disease control. The small patient pool of the average private physician meant that he rarely encountered this variety or severity of diseases.[240] These diseases were also not as commonplace because the American colonies largely consisted of small communities that did not suffer from significant overcrowding, which predisposed the population to these sorts of health problems. Therefore epidemic disease, hygiene and prevention were not significant concerns for either the patients or physicians of the era.

Beyond that, private physicians did not have the military disciplinary and command structure that enabled enlightened commanders to control the behaviors of their men and establish strict rules of hygiene and discipline. Despite the fact that some physicians called for improved hygiene, this was not universal. Many physicians did not know the value of hygiene in the prevention of devastating infectious diseases.[241] This discrepancy highlights the varying levels of education, training and knowledge possessed by American physicians of the Revolutionary War period. This led to an inconsistent approach in the volunteer military medical community and weakened their collective influence to promote effective change.

---

[239] Ibid.

[240] Military encampments often suffered from epidemics of typhus, lice, smallpox, pneumonia, respiratory infections, dysentery, yellow fever as well as other fevers, and venereal disease. Although private physicians may have encountered some of these diseases in civilian practice, they rarely had experience with all of them, nor with wide spread epidemic control. The large susceptible population of a military encampment meant high infection rate.

[241] De Forest, "Benjamin Rush's Directions for Preserving the Health of Soldiers."; John Pringle, *Observations on the Diseases of the Army*, 4 ed. (London, UK 1753).

CIVIL WAR:

Clinical disagreement became even more deep-seated within the medical community around the time of the Civil War than it had been in the years prior. At this moment in history, long held theories of medicine (such as the humoral and miasmatic theories) had begun to fall away, but the bacteriological revolution in medicine had yet to occur and so physicians were left in a state of uncertainty and equipoise. Benjamin Rush's heroic therapies, which included bleeding (phlebotomy and venesection), as well as blistering and purging, were still used.[242] However, even these longstanding heroic methods were beginning to be openly criticized.

This equipoise was reinforced by a lack of standardization in medical care and education as each physician employed his own version of therapy. Many physicians were still trained by way of apprenticeships; however formal medical education was on the rise. Although not numerous, the best-trained American physicians of the time were those who undertook their medical schooling in Europe.[243] At the start of the Civil War, there were fifty degree-granting medical schools in the US, which varied considerably in quality.[244] Many of the doctorates awarded were for all intents and purposes honourary degrees and did not necessarily serve as an indicator of expertise and competence. In fact, many of the medical schools were proprietary, meaning that one could essentially buy their

[242] Gillett, *The Army Medical Department 1818-1865*.
[243] Ruktow, *Bleeding Blue and Gray*.
[244] Ibid.

degree.[245] These graduates often saw no patients and did not perform any clinical examinations until after graduation.[246]

Civilian and military medicine were inextricably linked. The military had to draw its physicians from the civilian population, and thus the state of civilian medicine was also that of the Army medical department. This lack of accountability and standardization coupled with the diversity in physician training and credentials meant that the Army had to enforce its own quality control measures in an effort to enlist only qualified physicians, ready for the challenges of military medicine. These examinations also served to prevent irregular practitioners from entering the Army.

Despite the work of Benjamin Rush during the Revolutionary War and the comprehensive textbook on military hygiene (*A Treatise on Hygiene)* written by the acclaimed Dr. William A Hammond, many physicians were not well versed in the principles of hygiene.[247] Unfortunately, those who were trained often had trouble implementing the preventive programs they had been taught. Army surgeons were often unable to convince commanders of the need to maintain hygiene until it was too late and disease was well established within the troop population.[248] Doctors complained that their ambiguous rank was ineffective in exerting any type of influence on the chain of command.[249] However, the successful application and employment of sanitation and hygiene programs was also stifled by the lack of evidence to support them. Without germ theory, doctors of this era could not offer

---

[245] Gillett, *The Army Medical Department 1818-1865*.
[246] Ruktow, *Bleeding Blue and Gray*.
[247] Gillett, *The Army Medical Department 1818-1865*; William Alexander Hammond, *A Treatise on Hygiene: With Special Reference to the Military Service* (Philadelphia, PA: J.B. Lippincott, 1863).
[248] Gillett, *The Army Medical Department 1818-1865*.
[249] Ibid.

explanatory models that were backed by the cultural authority that accompanied the science of bacteriological revolution. Without this scientific authority, military commanders were unsure whether or not to take doctors' advice, or how to balance their advice against other priorities. Epidemic disease was rampant, and once again disease casualties far outnumbered those lost in battle.[250] Weakened by malnutrition, men died by the tens of thousands of diarrhea, typhoid, pneumonia, gangrene, and unhealed wounds.[251] Only as the war progressed and commanders began to see the ill effects of disease did they begin to listen and institute sanitary reform. Medical officers emphasized the dangers of overcrowding, overwork and exposure, and the lack of proper supplies such as blankets and food.[252]

As the importance of hygiene was recognized, and the value of sanitation campaigns fully understood, the military began to use medical knowledge to avoid epidemics, improving troop health and readiness and thus increasing the likelihood of mission success. It was also during this period that military hygiene was occasionally applied to neighboring or occupied civilian populations, representing the first iteration of military medical civilian assistance programs. When an Army set up camp in close proximity to a large population, or occupied an urban area, physicians worried about the possibility of troop infection due to seasonal epidemics. Port cities such as Galveston, New Orleans, Boston and Baltimore suffered from annual seasonal epidemic diseases and thus posed serious risks to mission readiness and military success.

---

[250] Ibid.
[251] Bollet, *Civil War Medicine: Challenges and Triumphs*.
[252] Gillett, *The Army Medical Department 1818-1865*.

The Navy carried out some of the first medical civilian assistance programs on record. Obviously these are not the same programs that were later formalized in the 1960s and re-envisioned in the latter part of the twentieth centuries. They do however share similar characteristics to those programs; these programs involved uniformed medical professionals providing medical care to civilians as part of their military duties. Thus, these programs can be understood as the first manifestations of the type of program that this dissertation has been referring to as medical civilian assistance programs.

Prior to the American Civil War, the city of New Orleans had been severely affected by epidemics of yellow fever.[253] Nearly every year, late summer would bring with it a wave of death and disease at the hands of 'yellow jack,' reaching a peak in virulence and intensity in the late 1850's. Between 8,000 and 9,000 people died during the epidemic of 1853.[254] However during the civil war, Union troops implemented various measures that nearly eradicated the disease of yellow fever in the city. In 1861, Union ships established a blockade at the entrance to the Mississippi, which created an effective and protective quarantine.[255] This inadvertent quarantine protected port cities from infected boats, which otherwise would have traveled the waterways, spreading epidemics amongst citizens.

In April 1862, Admiral David Glasgow Farragut and his Union forces entered the city of New Orleans and began occupying the city.[256] Farragut feared that the impending summer months would bring with them epidemic disease and

[253] Bollet, *Civil War Medicine: Challenges and Triumphs*, 298.
[254] Ibid, 298.
[255] Ibid, 298.
[256] Ibid.

decimation of the Union troops. Admiral Farragut's chief surgeon, Dr. Jonathan M. Flotz, sent an urgent letter advising strict quarantine "and positive non-intercourse" with any port that was known to be infected with yellow fever.[257] This Navy medical civilian assistance program then led to Army involvement. Benjamin Franklin Butler, a General in the Union Army, soon ordered additional measures intended to reduce the possibility of a yellow fever epidemic, as well as the spread of other disease. Informed by a miasmatic understanding of contagion, Butler ordered a clean up of all putrefying (or decomposing) organic materials that could spread miasmas, and thus disease. The markets were scrubbed; cleaned and freed of all odors, which were understood to be the source of contagion and disease. All the streets were cleaned and flushed with fresh water to promote hygiene and sanitation. Beyond that, systems of refuse collection were put in place, and sanitary regulations were enforced throughout the city.[258] These interventions markedly reduced the incidence of yellow fever amongst both the occupying military and civilian resident populations of New Orleans. The new found sanitary and hygienic conditions of the city, coupled with the quarantine prevented the usual seasonal epidemic from taking its toll of the citizens.

The military used its resources to engage in programs and interventions that directly affected the health of civilians, establishing one of the first military civilian assistance programs. The aim was strategic; Union forces of both the Army and Navy did not provide this assistance for humanitarian reasons. Rather, the civilian benefit was a necessary byproduct of protecting the military forces themselves. In order to

[257] Ibid, 298.
[258] Ibid, 298-299.

avoid epidemic disease within the troops, disease must be prevented within the neighboring civilian population; especially when living within such close proximity. Occupying an urban environment occasionally warranted city-wide clean-up, quarantine and the establishment of programs, such as refuse collection, in order to prevent conditions that would allow a yellow fever epidemic to take hold, possibly hindering military troop readiness and mission success. Important to our later discussion is the fact that physicians did not express frustration with the strategic goals of these programs. The only frustration was their inability to implement their desired hygiene program due to lack of military status and authority.[259] Military and medical goals during these early programs were aligned, both aimed at the reduction of disease and improvement of health. Unlike the later period where the two sets of goals will drift apart, this first period involved military programs whose strategic goals provided medical care that was the standard of care at the time. These hygiene and sanitation programs dealt with infectious disease in the best way that physicians knew how, according to the state of medicine at the time. Doctors were not left feeling as if they were providing sub-standard medical care to the patients. These early medical civilian assistance programs aimed to reduce disease and improve health according to the contemporary standards of medical care, employing the methods of sanitation and hygiene.

This case is not unique. Military medicine often extended its reach to include large civilian populations during epidemics and epidemic seasons. The best evidence of this fact is the history of the Marine Hospital Service (later renamed the

[259] Gillett, *The Army Medical Department 1818-1865*.

United States Public Health Service or USPHS). The national quarantine act of 1878 empowered the Marine Hospital Service with influence meant to control infectious disease in the U.S.[260] This act effectively established quarantine as a federal function, under the auspices of the Marine Hospital Service and the National Board of Health, rather than the state function it had previously been. Thus, the uniformed service was specifically tasked and authorized to assist local governments in combating specific epidemic diseases (cholera and yellow fever).[261] Thus, medical civic action has its roots at home, in the United States. Before exporting medical civilian assistance to foreign countries, these programs began at home and involved American civilian populations. That being said the intent is critical. The USPHS does not have such a clearly strategic mission. This organization's intent is civilian benefit. The sanitation and hygiene programs such as that in New Orleans had clear strategic intent: to maintain the health of the military by reducing the possibility of an epidemic. Of course, these interventions inevitably had positive outcomes for both civilian and military populations.

Another institution whose history was grounded at the intersection between military and civilian medical care was the Freedman's Bureau. During the American Civil War freedmen, or freed slaves, often gathered around Union Army bases. These men posed a potential threat to the soldiers, as they constituted a potential reservoir of disease. These freedmen often travelled long distances and arrived in poor health; they were the perfect population to act as the site of a disease outbreak.

---

[260] Jerrold M. Michael, "The National Board of Health: 1879-1883," *Public Health Reports* 126, no. 1 (2011).

[261] Wilensky, *Military Medicine to Win Hearts and Minds: Aid to Civilians in the Vietnam War*. 17.

Since the military had to provide care for its own protection, and in order to maintain force readiness they provided medical care to the freedmen. The provision of medical care to this civilian population was not intended to win them over—they already had their support. However, the motivation was still strategic: namely, mission readiness and troop health.[262] Importantly, the motivations were largely strategically driven, just like those described in New Orleans. The Freedman's bureau provided only limited medical services, under the Army. The Freedman's Bureaus went on to establish some of the first medical schools for African Americans.[263]

MEXICAN-AMERICAN WAR

The first international operations involving programs that resembled civilian medical assistance programs took place during the Mexican-American War. This war represented the first conventional war that AMEDD participated in on foreign soil. In Mexico, American troops were plagued with diseases such as dysentery and yellow fever.[264] Of the 100,000 soldiers that fought in Mexico 1,500 died in action, while over 10,000 died of disease.[265] Army doctors recognized that the filth of Mexican streets should be cleaned to prevent disease.[266] Street cleaning first took place in the city of Vera Cruz, at the same time that Surgeon John Porter took over

---

[262] Ibid, 17-18.
[263] Malsby III, "Into Which End Does the Thermometer Go? Application of Military Medicine in Counterinsurgency: Does Direct Patient Care by American Service Members Work?" 31.
[264] Gillett, *The Army Medical Department 1818-1865*, 122.
[265] Ibid, 124.
[266] Ibid, 114.

an old Franciscan convent to serve as a new general hospital.[267] This hospital provided care not only to soldiers, but also to civilian laborers.[268] Similar clean ups also took place in Mexico City. Disease was rampant in the capital city and the cause was understood to be the "character of Mexico City itself."[269] Described as "an exceedingly filthy city," the poor inhabitants of the city often lacked privies, and suffered from infestations of lice and fleas.[270]

Throughout the Mexican-American War Major General Winfield Scott recognized the civilian population as a significant source of possible disease infection for his troops. Initially he dealt with this threat by insisting that troops did not associate with locals and remained in locations with good ventilation.[271] Later, Scott would address civilian health care as part of his larger attempt to win the favor of the locals. Scott understood that he would need the loyalty of local civilians in order to win the war.[272] To gain the favor of the civilian population, Scott used assistance programs to encourage the Mexican people's opposition to General Antonio Lopez de Santa Anna.[273] These assistance programs began with proclamations pledging the protection of Mexican citizens, which included public services and sanitation systems.[274] Maj Gen Scott maintained public institutions such as schools, hospitals and clinics. This work continued to grow on the

---

[267] Ibid, 114.
[268] Ibid, 116.
[269] Ibid, 121.
[270] Robert Newton, "Medical Topography of the City of Mexico," *The New-York Journal of Medicine* November(1848): (302-303)
[271] Gillett, *The Army Medical Department 1818-1865*, 116.
[272] Stephen A. Carney, *The Occupation of Mexico May 1846-July 1848*, The U.S. Army Campaigns of the Mexican War (Washington, DC: Government Printing Office, 2006), 26.
[273] Wilensky, *Military Medicine to Win Hearts and Minds: Aid to Civilians in the Vietnam War*, 7.
[274] Malsby III, "Into Which End Does the Thermometer Go? Application of Military Medicine in Counterinsurgency: Does Direct Patient Care by American Service Members Work?" 31.

international scene during the Spanish-American War, when American soldiers were falling victim to yellow fever in great numbers.

SPANISH AMERICAN WAR:

The bacteriological revolution then brought germ theory to medicine. As the Spanish-American War began, physicians were armed with scientific legitimacy, knowledge and cultural authority that they lacked in the past. Unfortunately, this new knowledge would not be fully implemented, as there was little still therapy to offer sick patients.

The Spanish-American War represented the culmination of a period of worsening international relations between the United States and Spain. Although this war has not been heralded as one of the most influential in American history, it is worth mentioning in this chapter because of the significant medical advances that characterized this period. It represented the first war to be fought after the bacteriological revolution. For the first time, physicians had what the world saw as undeniable scientific legitimacy on their side. The power and expertise that this legitimacy brought with it meant significant reforms in military medicine, specifically in the field of hygiene and sanitation.[275]

As I have shown in my discussion of the Revolutionary and Civil Wars, the status of the medical profession was fairly low during the late eighteenth and early nineteenth century. With few viable therapeutics and great equipoise in the field, physicians had little to offer their patients. Hygiene and preventive medicine was

[275] Cirillo, *Bullets and Bacilli: The Spanish-American War and Military Medicine*.

gaining momentum, but their lack of legitimate influence in the military hierarchy meant that their advice sometimes went unheeded, until disease had already taken its toll. In the military, most commanders and line officers did not place great confidence in the advice of their medical team members. Doctors were allowed only to advise, and often their recommendations were not employed.[276] This ignorance of the importance of hygiene meant tragedy and unnecessary suffering for soldiers in crowded camps.

During the Spanish-American War, physicians were cloaked in greater legitimacy then ever before. The germ theory allowed them to both identify disease and understand contagion in a new way. At this time, medicine still relied heavily on preventive measures. Germ theory provided new understanding of disease spread and causation, which allowed for advancements in public health, hygiene, and sanitation. However, military doctors still lacked influence within the military institutional hierarchy and so the practical application of the germ theory could not be fully implemented. This failure was obvious both in theatre and at home. At the start of the war, training camps of 108,000 volunteers from across the US were gathered in a handful of national encampments located along the Eastern seaboard.[277] Since commanding military officers lacked knowledge of the role of hygiene and sanitation in disease prevention, sanitary facilities quickly became sources of disease and illness.[278] The resulting disease epidemics were met with public outrage.

---

[276] Gillett, *The Army Medical Department 1818-1865*.
[277] Cirillo, *Bullets and Bacilli: The Spanish-American War and Military Medicine*.
[278] Ibid.

In response to this public outcry, the military initiated a series of boards and commissions to investigate infectious diseases such as typhoid and yellow fever.[279] These boards used the knowledge gained during the bacteriological revolution to shed new light on epidemic disease control and provide greater legitimacy to physicians calling for hygienic preventive measures. Although the influence of these boards did not permeate medical consciousness until after this short war, it was the exigencies of war, coupled with rapidly advancing medical knowledge that precipitated their creation.

The most famous was the Yellow Fever Board led by Major Walter Reed along with James Carroll, Jesse W. Lazear, and Aristide Agromonte.[280] Motivated by the high incidence of yellow fever among troops in occupied Cuba, this board sought to and successfully investigated the disease, its aetiology, and mode of transmission.[281] In discovering the disease vector to be mosquitoes, Walter Reed and his team disproved the conventional wisdom. Prior to that time it was believed that the disease was spread by fomites. This discovery helped to pioneer the eradication campaign against the offending mosquito.[282] Major William Gorgas, the chief sanitary officer of Havana, carried out a successful eradication campaign that would later be recreated and reused throughout the southern United States as well as internationally.[283]

---

[279] Ibid.
[280] Mary C Gillett, *The Army Medical Department 1865-1917* (Washington, DC: United States Army, 1995).
[281] Cirillo, *Bullets and Bacilli: The Spanish-American War and Military Medicine*.
[282] Gillett, *The Army Medical Department 1865-1917*.
[283] Ibid.

Gorgas understood that yellow fever could be eradicated if the mosquito population was controlled or exterminated.[284] With this understanding, Gorgas set out a plan to destroy the aedes aegypti mosquito, as well as screen and quarantine the local population to prevent further infection.[285] His plan was first implemented in Havana, Cuba. The population was screened, and the homes of yellow fever victims were fumigated.[286] Gorgas then divided the city into 23 districts, each under the supervision of a sanitary inspector responsible for the inspection of water cisterns, barrels and containers.[287] These inspectors were able to use the paternalistic authority characteristic of medicine at the time.

Physicians and other medical professionals practiced medicine according to a contemporary professional morality that was far more paternalistic than the commonly accepted modern medical morality. Paternalistic public health was especially common in low-income countries and during times of military occupations, and allowed trained western physicians to institute programs using their newfound cultural authority with even greater ease and influence. The inspectors were responsible for the draining of standing puddles and the addition of small amounts of oil to other locations of standing water. Standing water was known to be the breeding ground for mosquitoes and thus the control and inspection of these spaces was instrumental to the eradication of the mosquito and thus the disease. The addition of oil to standing water was a method developed to

---

[284] Franklin Martin, *Major General William Crawford Gorgas M.S., U.S.A.* (Chicago, Illianois: The Board of Directors of the Gorgas Memorial Institute, Date Unknown), 12.
[285] Ibid, 13.
[286] Ibid, 15.
[287] Ibid, 17-18.

suffocate larvae and eggs within the water.[288] Gorgas also appealed to the age-old method of disease control by establishing quarantine on Cuban ports.[289] All ships entering from an infected harbor were restricted.

The results of Gorgas interventions were drastic. Yellow fever had had a continuous presence in Cuba since 1762. In the year 1900, there had been 310 deaths from the disease. After Gorgas had implemented his plan the disease literally disappeared, with the last case of yellow fever reported in September of 1901.[290] These beneficial results were not limited to yellow fever. His eradication campaign also destroyed the breeding and habitat of anopheles mosquito, which is the vector for malaria. This effectively eliminated malaria in Havana, as well.[291] While this disease had also been endemic to the area, with over 300 deaths in 1872, by 1912 there were only four.[292]

The public health interventions of Gorgas represent another early example of military civilian medical assistance programs performed by the US Army. These programs were implemented within the civilian sector, affecting local civilian population in an attempt to prevent epidemic disease. However, both Gorgas' interventions and the Yellow Fever Board were motivated by the disease incidence in US military troops, and its effect on mission readiness and success. Although the beneficial effect on the health of the civilian population is undeniable, these programs did not aim to better the lives of civilians out of humanitarian motivation

[288] Ibid.
[289] Ibid, 19.
[290] Ibid, 19.
[291] Ibid, 20.
[292] Ibid, 20.

or intent. Rather, their health needed to be insured so that the troops could avoid epidemic disease.

The success seen in Cuba inspired Gorgas to bring his program of eradication to the Panama Canal Zone. Here, troops had long suffered similar health problems as those in Cuba.[293] The relentless battle with epidemic disease had affected the French military that reported a 75 percent death rate of newcomers within three months, mostly of malaria, yellow fever or dysentery.[294] In Panama, Gorgas applied the same interventions that had seen such success in Cuba, establishing inspectors, draining or oiling standing water and covering cisterns.[295] He also improved drainage throughout the Panama Canal Zone with a sewage system of drainage ditches and provided mosquito netting to the military and civilian population for further protection.[296] Although he initially met with some opposition from those who did not believe in the mosquito theory, his success spoke for itself. In 1906, disease incidence had reached a peak of 821 per 1,000; however, as the campaign was only in its first phases the infection rate plummeted by almost half, to 424 per 1,000. By 1908, there were only 282 cases per 1,000, and in 1913, the rate was below 100 per 1,000.[297]

The Philippines was also the site of other early examples of military medical civilian assistance programs. After the Treaty of Paris, Spain ceded the islands of Guam and Puerto Rico, surrendered its claim to Cuba, and sold the Philippines to the

---

[293] Gillett, *The Army Medical Department 1865-1917*, 263.
[294] Ibid, 264.
[295] Ibid, 269-270.
[296] Ibid, 273-275.
[297] Ibid, 272.

United States. Suddenly the US was responsible for over seven million Filipinos.[298] The Americans in command drew experience from colonizing American Indians and thus placed a high value on stability operations.[299] Medical support was soon identified as a key component of the pacification program in the Philippines, because of the problems with sanitation, epidemic disease and healthcare infrastructure.[300] The pacification program included preventive medicine and public health campaigns.[301] Many of the actions taken in Manila, mirrored those taken in earlier examples of civilian medical assistance domestically and internationally. Similar to the occupation of Mexico, the health campaigns began with the general cleansing of the city.[302] Borrowing form the successful work of Gorgas, the city was then divided into districts, each with a responsible inspector who examined dwellings, markets, drugstores, slaughterhouses and any other establishment that could affect community health.[303] Drainage was a significant problem in Manila and so Army engineers worked to bring potable water and construct a new sewer system during the occupation of the city.[304]

A smallpox epidemic among Spanish prisoners and American troops in November of 1898 led to the vaccination over 80,000 inhabitants.[305] In fact, throughout the occupation numerous smallpox vaccination campaigns were carried

---

[298] Malsby III, "Into Which End Does the Thermometer Go? Application of Military Medicine in Counterinsurgency: Does Direct Patient Care by American Service Members Work?" 32.
[299] Ibid, 33-34.
[300] John Morgan Gates, *Schoolbooks and Krags; the United States Army in the Philippines, 1898-1902* (Westport, CT: Greenwood, 1973), 57.
[301] Ibid, 58.
[302] Ibid, 60.
[303] Ibid, 58.
[304] Ibid, 59.
[305] Ibid, 58.

out and a special smallpox hospital was operated.[306] As part of the military's larger initiative to prevent epidemic infectious disease a tropical disease board was also established.[307] Similar to the Yellow Fever Board, this board worked with the aim to learn more about the diseases that currently plagued American troops. Another example of these military civilian medical assistance programs is the Board of Health created in the City of Manila. The board consisted of both Filipino and American experts. It was responsible for leper hospitals, public health clinics, venereal disease inspection, vaccination campaigns, and preventive medicine programs such as the restoration of potable water and sanitation.[308]

WORLD WAR I, WORLD WAR II AND THE KOREAN WAR

In the wars that followed, until the Vietnam War, conditions did not permit medicine to be used in this way again. Civilian populations did not possess the same need, thus creating the demand for military health care. As we shall see in the next chapter (chapter six), the move away from public health interventions and toward a more politically motivated type of retail medicine model that would be used in pacification efforts creates an increasingly morally complicated space for military medical professionals. However, the wars that mark the time between the Spanish-American War and the Vietnam War are significant in American military history and warrant brief mention and discussion.

---

306 Ibid, 58.
307 Gillett, *The Army Medical Department 1865-1917*, 287.
308 Gates, *Schoolbooks and Krags; the United States Army in the Philippines, 1898-1902*, 57-60.

Although medicine is rarely used in the same ways that we have been exploring, there are still cases of civilian medical assistance and examples where the exigencies of war cause the line between military and civilian medical care to blur. Still, it is critical to remember that these wars (World War I, World War II and the Korean War) represent conventional warfare, with a frontline and identifiable enemy. In light of these characteristics pacification does not play as significant a role in military strategy, and thus medical civilian assistance programs are not used in the same way that they were in Mexico and the Philippines and will be used in Vietnam. Furthermore, in general the military had far less interaction with civilian populations, thus they were not confronted by the same civilian needs for health care, hygiene, and health infrastructure that are a characteristic component of civilian assistance programs. These programs involve populations who lack access to western medicine and health care infrastructure.

The First World War, or Great War was the first modern war fought by the United States Army, and because of US inexperience in fighting overseas it presented a steep learning curve. During the First World War, medicine was not used as a tool of policy in the same way that it had been in the past. Civilian populations were not in as desperate a need for medical care. Western Europe had a functioning medical system and sanitation program. The only example of blurring at the intersection of civilian and military medical intersection involved the social hygiene movement and venereal disease.

The routine screening of draftees brought an apparent epidemic of VD into the public spotlight as the physical exams administered to recruits suggested that

venereal disease rates were extremely high.[309] People began to fear the possibility of these soldiers infecting their current or future wives and children. However, it was the exigencies of war and the unique leadership of some individuals, notably Thomas Parran that changed the response to the VD epidemic.[310] This epidemic was shown to be taking a huge toll on effectiveness of US Army.[311] In any armed conflict the number of functional, healthy and effective soldiers is paramount to winning the war. Thus, the need to maintain military efficiency forced Americans to face the fact that their country was not as wholesome as they had hoped and resulted in more objective and effective approaches to disease identification and control.[312] Control efforts focused on moral education, regulation of immigration, suppression of prostitution, and quarantine.

The educational campaigns were fear based, and attempted to teach continence and morality to men.[313] However, the need for military efficiency meant that prevention could not be the only approach. Following the gendered notion of sexuality characteristic of the time, which assumed that the male sexual appetite was essentially uncontrollable, the military began to investigate chemical prophylaxis to be administered after exposure to an infected, "fallen woman" or prostitute.[314] These included individual kits containing condoms, as well as the use

[309] Allan M. Brandt, *No Magic Bullet: A Social History of Venereal Disease in the United States since 1880* (New York, NY: Oxford University Press, 1987).
[310] Ibid.
[311] Ibid.
[312] Ibid.
[313] Ibid.
[314] Ibid.

of penile injections of antiseptics.[315] At the same time, the military recognized that a lack of wholesome activities meant that soldiers turned to drinking and visiting red light districts as their sources of entertainment. Thus, social welfare committees and organizations were formed to create opportunities for soldiers to engage in other types of entertainment.[316] These included athletic activities, as well as YMCA tents with films, books and games.[317]

These programs had far-reaching and undeniable affects on the civilian population. The venereal disease campaign of the war had forced a consciousness about sexuality that had been until then unprecedented in the US and caused a sort of sexual revolution. For the first time, the government became heavily involved in venereal disease campaigns that strayed from the social hygiene model that emphasized sexual continence. However, after the war was over people were less willing to talk about and actively control VD. Since the federal government had largely funded these efforts and the war was over, they went unfunded.[318]

In the wake of WWII U.S. military personnel would again provide medical care to civilians. The therapeutic revolution that characterized the Second World War would provide further legitimacy to the field of medicine and arm it with the ability to not only identify, but also treat disease.[319] In particular, the advent of

---

315 Ibid.
316 Ibid.
317 Ibid.
318 Ibid.
319 Albert E. Cowdrey, *Fighting for Life: American Military Medicine in World War Ii* (New York, NY: Free Press, 1994).

antibiotics significantly improved patient outcomes, allowing physicians to finally treat infected battle wounds. WWII also saw improved ability to treat hemorrhagic shock with whole blood products.[320] This period also saw considerable standardization in medical care in both military and civilian medicine.[321] The wealth of knowledge amassed in the wake of the recent medical revolutions served to undermine the equipoise that had previously characterized American medicine. Importantly, the military began to publish the lessons that it had learned throughout its involvement in the world wars. With such a wealth of experience, and large patient population to draw from, the military established guidelines and standards of care for many of the illnesses that affected its ranks. This effectively halted the past problem of lapsed institutional memory that had forced AMEDD to relearn old lessons over and over again, costing many lives.[322] This standardization and reporting of experience can be seen in the many volumes published by the Government Printing Office throughout this period. This medical knowledge and professionalism, combined with official recognition of the physician within the military ranks gave the military doctor new found legitimacy.

The majority of the civilian care provided by military physicians took place in Germany and Japan immediately following the war. In Germany, the U.S. was responsible for getting the local health care system back on its feet.[323] American

---

[320] Ibid.

[321] Ibid.

[322] Gillett, *The Army Medical Department 1818-1865*; ———, *The Army Medical Department 1865-1917*; Mary C. Gillett, *The Army Medical Department 1917-1941* (Washington, DC: United States Army, 2009); Gillett, *The Army Medical Department, 1775-1818*.

[323] Earl F. Ziemke, *The U.S. Army in the Occupation of Germany 1944-1946* (Washington, DC: U.S. Government Printing Office, 1990).

food and medical supplies were instrumental in reestablishing German infrastructure in the post-war period.[324] In Japan, these interventions were part of a larger and expansive civil affairs program that reached almost every host nation citizen.[325] General Douglas MacArthur implemented a comprehensive medical stability and reconstruction program. This program included the establishment of public health centers and preventive medical stations and is credited for establishing goodwill between U.S. military and the local civilians as well as being of significant contribution to the recovery effort.[326] Japanese medical infrastructure had failed, and the U.S. military stepped in to both provide care and help establish a public health system.

The Japanese program marks a departure in strategic intent from the programs that we have examined thus far. The public health and hygiene interventions in the United States and the Spanish-American War were aimed at ensuring force readiness and health for American soldiers, maintaining civilian health was only a means to that end. Conversely, the programs in Japan (just like those that took place in the Philippines) aimed at providing care to civilians for different reasons. They did not aim to better the health of Americans. For the most part, these programs aimed at bettering international relations and winning support. A similar intent is apparent in the programs that were later established in Korea. After World War II, many Korean physicians had left the country and the U.S.

---

[324] Ibid, 360-366.
[325] Wilensky, *Military Medicine to Win Hearts and Minds: Aid to Civilians in the Vietnam War*, 21.
[326] Malsby III, "Into Which End Does the Thermometer Go? Application of Military Medicine in Counterinsurgency: Does Direct Patient Care by American Service Members Work?" 47.

military began medical training campaigns and infrastructure rebuilding. These programs represented attempts to stabilize the "nation's fledgling democracy."[327]

The American military was beginning to recognize the strategic value of medicine. The bacteriological and therapeutic revolution had adorned the medical profession with authority and legitimacy that could be used for specific goals.

> American medicine was envisioned as a means of demonstrating the superiority of American democracy and building the strength of the free world. The idea was that Army medicine would help remove the sources of totalitarianism and thereby make a more secure world. Medicine had assumed a larger importance than ever.[328]

The next two decades would provide time for these ideas to germinate, and grow. Terms such as "medical diplomacy" and medicine as a "non-lethal" weapon would begin to circulate in the medical and military literature. However, for this period civilian medical assistance was limited to disaster relief. The military became very involved in disaster response, providing medical care and security around the globe. However, disaster response is decidedly different from the civilian medical assistance programs that we are focusing on. Disaster response missions are not associated with military engagements or operations, nor are they as overtly strategic in their deployment of resources. Disaster response missions may be strategic, as they can provide excellent opportunities for improving international relations. That being said, it is critical to remember that they are unplanned, acute episodes of emergency response. In contrast, medical civilian assistance programs

[327] Ibid, 48.
[328] Ibid, 49.

plan ahead to use medicine for strategic goals in areas where the military already has some form of presence or purpose. Still, the successes in this arena led President Kennedy to adapt an "activist foreign policy" in the early 1960s that would place medical civic action and similar programs in the spotlight.[329] President Kennedy's plan emphasized using military civic action to contribute to the economic and social development of emerging nations.[330] At this same moment, the State Department created the Agency for International Development (AID), given this new department responsibility for coordinating new priorities and initiatives in this area.[331] The creation of USAID took a great deal of responsibility out the military's hands.

The first medical civilian assistance programs had clear strategic intent. Epidemic disease control served the goals of medicine while simultaneously serving the very important military goal of mission readiness and conserving troop strength. The goals were aligned; they were intertwined and achieved the same way. Public health campaigns, sanitation reform and a concern for hygiene permitted better health and increased military performance. In this setting, military medical professionals cared for both soldiers and civilians. These first medical civilian assistance programs pose few ethical dilemmas for those involved. According the internal professional moralities discussed earlier, the physician acts in line with the obligations incumbent on him according to his twin-roles.

As a physician, he is driven to care for patients and maintain health. The campaigns discussed in New Orleans, Cuba and Panama show clear benefit for

---

[329] Ibid, 49.
[330] Wilensky, *Military Medicine to Win Hearts and Minds: Aid to Civilians in the Vietnam War*, 24.
[331] Malsby III, "Into Which End Does the Thermometer Go? Application of Military Medicine in Counterinsurgency: Does Direct Patient Care by American Service Members Work?" 49.

patient health. The quarantines and clean-ups had an undeniable health benefit for the civilian population involved; fewer fell ill and fewer died because of their care and assistance. At the same time, these programs had military benefit since they promoted troop health and readiness. The medical care that they are providing to civilians is clearly inline with military strategic goals and values, prioritizing the mission. The eradication of disease is both the medical goal and the military goal because improved health status is the result that both goals strive to achieve. In the case of these programs, success is measured the same by both the professional obligations and loyalties of the military physician. In other words, no conflict of dual loyalties exists.

Chapter 5

Vietnam:

The Formalized MEDCAP

Image 1: Vietnam "Villagers from Refugee Camp in Bien Hoa Province Treatment during MEDCAP.[332]

The second period in the history of civilian medical assistance programs marks the moment when these programs became officially formalized by the American military. During this time, medical civilian assistance programs involved the treatment and training of civilians during times of foreign conflict outside of the continental United States. At this point, the programmatic goals were again both

[332] John H. Hay, *Tactical and Material Innovations*, Vietnam Studies (Washington, DC: U.S. Government Printing Office, 1989), 140.

strategic and humanitarian. However, as we shall see, this period differs from the first in that the military and medical goals do not align. In the previous chapter, both medical and military goals aimed to minimize disease and improve health. During this second historical period, the military goals shift away from disease prevention. Here, the term strategic is used to refer to the fact that medicine was used to accomplish military ends such as to foster international relationships, gather intelligence, establish zones of safety (free of enemy troops) and to accomplish the goals of pacification such as "winning the hearts and minds" of the civilian population. Improved health was neither an endpoint nor necessary for a successful operation- it was a secondary byproduct of the mission.

This section will focus on the Vietnam War as it represents both the point in military history when MEDCAPs and other medical civilian assistance programs were formalized under this name and when strategic aims diverge from medical goals, and medicine was increasingly used as a tool or often-termed “non-lethal weapon.” The Vietnam War provides a large volume of evidence rife for intellectual analysis, highlighting the increasingly strategic use of medicine by the military. This chapter will explore the history of MEDCAPs in Vietnam in detail, paying close attention to the official intent of these programs as outlined by the Army and the experiences of those physicians who participated in these programs. This chapter will not only examine and analyze the period itself but also serve to compare and contrast it with the first period, explored in the previous chapter (chapter four). While the first period had an undeniably strategic motivation, the medical and strategic goals were one and the same; both aimed at the reduction of epidemic

disease and improvement of health, by way of hygiene and sanitation. Conversely, the use of medical care as a strategic tool in Vietnam raised a wealth of new ethical issues. Many medical professionals participating in these programs critiqued the level of care provided to civilians as both inadequate and in poor practice. The conflict discussed by these physicians represents an expression of the problem of dual loyalties, and is thus useful in furthering understanding within the debate. In Vietnam, there was a schism of military and medical goals. Beyond that, the exigencies and context of this type of warfare created an environment where the strategic goals were emphasized at the cost of medical ones.

Vietnam was an unconventional warfare, which involved an insurgency or guerilla force. Unlike the World Wars, Vietnam did not involve a front-line in the classic sense, fought for and slowly progressed or retreated. As Wilensky states, "the real battle [in Vietnam] was for the heart and minds of the civilians."[333] Both sides of the conflict were fighting amongst the civilian population and needed their support, a population that lacked access to any western medical care but was in desperate need of it. These facts highlight the usefulness of civilian medical assistance programs to military goals. The military could use their medical resources to fill a gap in the host nation's infrastructure and address a desperate basic need in the civilian population. In fact, the Special Forces considered medical care to be their "most valuable anti-guerilla asset."[334] Thus, the Vietnam War created conditions

[333] Wilensky, *Military Medicine to Win Hearts and Minds: Aid to Civilians in the Vietnam War*, 8.
[334] Ibid, 33.

under which the strategic goals of these programs would come to dominate or be emphasized because of their military value.

Beyond the lack of medical care in Vietnam, its very nature meant that civilians were intimately intertwined in virtually all aspects of the war, as well as being severely affected by its violence. The Viet Cong and the North Vietnamese Army went to considerable lengths to increase the toll of civilians dead and wounded.[335] In fact, during the Tet offensive, over 7,500 civilians in 102 communities were killed.[336] At the same time 16,211 were wounded, 95,000 houses were destroyed with over one million residents left homeless.[337] Estimates for these losses place property damages at over $173,663,000, with the majority of damage taking place in civilian residential areas.[338] When the second wave of attacks centred on Saigon, another 433 civilians were killed in that city alone while over 6,600 were wounded. Another 18,250 homes were destroyed, and nearly 125,000 persons left homeless.[339] Civilian casualties continued in the subsequent campaigns against Saigon as another 515 civilians were killed, almost 4,500 wounded and 176,000 left homeless.[340] The Vietnamese medical system could not handle this burden. Thus, the United States and forty-two other nations contributed medical care to civilians.[341] The United States military contributed an enormous amount of money and manpower to the medical care of civilians throughout the Vietnam War.

---

[335] M. T. Hazzard, "There Are No Non-Combattants in This Stange War," *Viet-nam Bulletin*. (4).
[336] Ibid, 4.
[337] Ibid, 4.
[338] Ibid, 4.
[339] Ibid, 4.
[340] Ibid, 6.
[341] Ibid, 4.

Although this was not the first time that the United States military provided medical care to foreign civilians, Vietnam represented the largest scale of such endeavors to date. It was because of the type of war in Vietnam that we see medical civilian assistance programs become formalized and so widely used. Thus, many medical civilian assistance programs were formalized by the US military during this period: these include the medical civic action program (MEDCAP), the military provincial health assistance program (MILPHAP) and the civilian war casualty program (CWCP).

Their strategic value was also recognized during the Vietnam war as these programs could employ medical treatment projects garnering immediate impact and achievement of specific goals. Civilian Vietnamese populations living in the rural provinces had virtually no access to Western medical care. In fact, prior to American military involvement estimates place the number of Vietnamese physicians at around only 900.[342] Unfortunately, the majority of the western trained Vietnamese physicians were in the Army and not available to civilian population, meaning a patient to physician ratio of 1/93,000.[343] Thus, the US military could use its resources to bring western medicine to this population, winning hearts and minds, fostering positive relationships, expanding their sphere of influence and even using medical treatment and personnel to gather intelligence. The use of medicine as a strategic tool came to dominate the policies and strategies of American medical

[342] David Gilbert and Jerome Greenberg, " Vietnam: Preventive Medicine Orientation," *Military Medicine* 132(1967), 776.
[343]Ibid, 776.

efforts in Vietnam.[344] Since civilians were so intimately intertwined in the war, and this population lacked medical care, yet was suffering from both rampant disease and the effects of war violence, medicine was recognized as an important tool in the "pacification" program of the Vietnamese civilians.

At this point, it is vital to understand what is meant by the term "pacification" within the US military. According to Tran Tho, an author published by the US Army Center of Military History, “Pacification is the military, political, economic, and social process of establishing or reestablishing local government responsive to and involving the participation of the people.”[345] Thus, since the Vietnamese lacked access to established western medicine, the US military saw an opportunity to use medicine to reestablish a U.S.-friendly local government (GVN). American military resources were employed to win the Vietnamese civilian population over to their side. They had identified a void that they could fill, a way to use medicine as a weapon in their war for the people and win the hearts and minds. They would pacify the people with the western gift of modern medicine. Unfortunately, this marriage of military and medicine would mean the subversion of medical goals so that strategic goals could be emphasized. The war needed to be won- that was the priority: it was not the healing of sick civilians, which sometimes (not always) led to medical goals being de-emphasized. This shifting emphasis created a morally complicated space for military physicians who often thought they were participating in medical

[344] E.A. Vastyan, "Warriors in White: Some Questions About the Nature and Mission of Military Medicine," *Tex Rep Biol Med.* 32, no. 1 (1974), 333.

[345] Tran Dinh Tho, *Pacification*, Indochina Monographs (Washington, DC: U.S. Army Center of Military History, 1980), v.

missions and found themselves confronted with the strategic reality of these operations.

CIVILIAN MEDICAL ASSISTANCE PROGRAMS

The United States Armed Forces was involved in various medical programs involving civilian medical care in Vietnam. Although this chapter will focus on medical civic action programs (MEDCAPs), because of American military physicains' direct involvement with civilian care in these programs, there are other programs that were also formalized during the Vietnam War.

CIVILIAN WAR CASUALTY PROGRAM (CWCP)

The civilian war casualty program was meant to address the needs that could not be met by the military provinicial health assistance program (MILPHAP) and medical civic action program (MEDCAP) (to be discussed in detail later). In 1967, an increasing number of civilians became victims of war related violence.[346] Estimates from this time indicated that there were approximately 50,000 civilian casualties of war per year, effectively overwhelming the Vietnamese system.[347] The original intent of CWCP was to seperate those medical installations assigned to this program from others in the US military hospital system.[348] Since Vietnamese civilians were often reluctant to venture far from home, treatment rarely took place

[346] Spurgeon Neel, *Vietnam Studies Medical Support of the U.S. Army in Vietnam 1965-1970* (Washington, DC: Department of the Army, 1991), 166.
[347] Ibid, 166.
[348] Ibid, 166.

in distant hospitals. However, the Tet Offensive in early 1968 led to a an increase in civilian casualties that forced the program to change and officially formalize the medical rules of engagement. This policy change allowed military physicians to care for civilians in all military hospitals if the civilian patient was deemed an emergency, on a "space-available" basis. The types of medical emergencies admited would have varied based on patient load, and resources. Physicians would have treated civilians as patients within a hospital context. That being said, there is little qualitative data regarding physician experiences treating civilians as a part of this program.

MILITARY PROVINCIAL HEALTH ASSISTANCE PROGRAM (MILPHAP)

Another important form of medical civilian assistance was the Military Provincial Health Assistance Program. In the early 1960's USAID initiated this program to supplement and improve Vietnamese provincial health services.[349] The official programmatic goals of the MILPHAP were two-fold: "(1) providing direct medical care and health services to Vietnamese Civilians, and (2) working with Vietnamese medical and health personnel to augment, develop and expand Vietnamese capabilities in clinical health care and public health programs."[350] This program sought an immediate increase in "the government-sponsored health

[349] Ibid, 162.

[350] William Donald and MacDonald Westmoreland, "Joint Directive Number 2-67: Military Provincial Health Assistance Program (Milphap)," ed. United States Agency for International Development (Saigon, Vietnam: Military Assistance Command, 1967); Robert M. Hall, "Briefing on Macv Medical Programs Given to Dr. Louis M. Rousselot, Assistant Secretary of Defense for Health Affairs by Col. Robert M. Hall at Cincpac Hq, 20 March," ed. Department of Defense (Honolulu, HI: United States Pacific Command, 1968).

services available to civilians in the provinces."[351] This was largely achieved by the improvement of medical education and training for Vietnamese physicians, nurses, and medical technicians as well as improved and expanded Vietnamese hospitals and dispensaries.[352]

American physicians and the US military command recognized significant shortcomings with the medical education system in Vietnam.[353] The standards of care in Vietnam varied widely and were vastly different from those in the US. Beyond that, the Vietnamese medical education system was also critically different from the western medical school model. Doctors were trained by way of an apprenticeship program.[354] This apprentice-based model contributed to the lack of standardization and varying levels of knowledge and expertise across the Vietnamese medical professions. The hospitals were also built around a rigid rank system. This hierarchical model often stifled education and forebode questioning of those in higher positions.[355] This training program attempted to shift training towards an American model, which values modern scientific medicine and standardization. Medical care and training attempted to mirror standards in the United States. American military physicians worked to train Vietnamese medical practitioners, in an effort to achieve their goal of developing a self-sufficient and fully independent health service program in Vietnam. Another aim of MILPHAP was

---

[351] Westmoreland, "Joint Directive Number 2-67: Military Provincial Health Assistance Program (Milphap)."
[352] Spurgeon Neel, *Medical Support of the U.S. Army in Vietnam, 1965-1970*, Vietnam Studies (Washington, DC: Government Printing Office, 1973), 162.
[353] Arthur Mason Ahearn, "Problems of Medical Rapport in Vietnam," *Military Medicine* 131, no. 11 (1966).
[354] Ibid, 1402.
[355] Ibid, 1403.

the control of epidemic disease. Malaria was endemic in the area, and it was hoped that these facility and training improvements would lead to the eradication of this disease.

The first MILPHAP teams became operational in November of 1965 and involved aspects of both therapeutic and preventive medicine.[356] MILPHAP teams were composed of three physicians, a medical administrator and a dozen enlisted medical technicians. These teams were assigned to provincial hospitals and under the supervision of a provincial chief of medicine.[357] Within the first year, six MILPHAP teams functioned in provincial hospitals across Vietnam. This program was understood to be successful. It is important to note that success was measured according to the American military mission. Reporting at the time valued quantitative statistices. Success was measured in numbers, the number of patients seen and people trained. The success of these teams led to the decisions to expand the program. The number of teams was increased to eight Army, seven Air Force, and seven Navy over the next two years. By the end of 1970, teams were assigned to over half of the forty-four Vietnamese provinces.[358]

According to the numbers, this program is understood to have been a success by the military—with little critique from the physicians involved. The only critiques expressed by physician participants were related to cultural differences and

---

[356] Neel, *Vietnam Studies Medical Support of the U.S. Army in Vietnam 1965-1970*. (163): Westmoreland, "Joint Directive Number 2-67: Military Provincial Health Assistance Program (Milphap)."
[357] Neel, *Vietnam Studies Medical Support of the U.S. Army in Vietnam 1965-1970*, 163.
[358] Ibid, 163.

difficulties associated with language barriers.[359] The assistance they provided was understood to be sustainable, and the improvements to the health care system were immediately visible.[360] Emphasis was not placed solely on direct-patient care (or retail medicine) but also preventive or public health measures (such as immunization campaigns) and the formalized training of Vietnamese health care providers according to the Western medical model. Beyond that, the numbers were impressive. This program affected the lives of many Vietnamese civilians. MILPHAP teams assisted in the treatment of over 200,000 in-patients during the year 1967.[361] However, it is essential to note the involvement of American physicians in this treatment was not direct.[362] They only *assisted* in the care of these 200,000 civilians, and significantly the term '*assisted'* is never defined. Very little historical, narrative or anecdotal data discusses American military physician experiences providing actual medical care to civilians as part of this program. Vietnamese doctors and nurses provided the majority of the care under the supervision of American medical staff or after being trained by the MILPHAP program.[363] The lack of documentation of direct civilian patient contact marks the distinct difference and distinction between the MILPHAP program and the medical civic action program or MEDCAP.

---

[359] Ahearn, "Problems of Medical Rapport in Vietnam," 1403.

[360] Neel, *Vietnam Studies Medical Support of the U.S. Army in Vietnam 1965-1970*, 163.

[361] Hall, "Briefing on Macv Medical Programs Given to Dr. Louis M. Rousselot, Assistant Secretary of Defense for Health Affairs by Col. Robert M. Hall at Cincpac Hq, 20 March."

[362] Hazzard, "There Are No Non-Combattants in This Stange War."

[363] Hall, "Briefing on Macv Medical Programs Given to Dr. Louis M. Rousselot, Assistant Secretary of Defense for Health Affairs by Col. Robert M. Hall at Cincpac Hq, 20 March."

MEDICAL CIVIC ACTION PROGRAM (MEDCAP)

Many historians and commentators have acknowledged the medical civic action program as the best known of the medical civilian assistance programs in Vietnam. In fact, the MEDCAP was so well known that it made its way into the pop-culture consciousness of America. In a scene in the famous film *Apocalypse Now*, Kurtz discusses his own experiences participating in this program.[364] Kurtz was a highly decorated member of the Army Special Forces, who became a renegade and gained a reputation as a feared man. Interestingly his recollection is one of horror and discontent, presenting an exceptionally dark tale of Viet Cong retaliation to villagers welcoming MEDCAP teams.[365] Although the story presented in this film cannot be verified by historical data, this excerpt is useful in showing the widespread recognition and knowledge of medical civic action programs outside of the military. In part, MEDCAPs were widely known because they were often used as public relations campaigns and photo opportunities for the United States military. Photographs of soldiers caring for sick children were always welcome in hometown newspapers, and unit newsletters. Many in military command recognized this as one of the many strategic benefits to these programs.[366]

---

[364] Francis Ford Coppola, "Apocalypse Now," (USA 1979).

[365] Ibid. Excerpt: "I remember when I was with Special Forces--it seems a thousand centuries ago--we went into a camp to inoculate it. The children. We left the camp after we had inoculated the children for polio, and this old man came running after us, and he was crying. He couldn't see. We went there, and they [VC] had come and hacked off every inoculated arm. There they were in a pile--a pile of little arms." It is important to note that in my research I have no record of this severe a retaliation to MEDCAPs by Viet Cong.

[366] William Foulke, "Macv Army "A" Photo Team Films Medcaps," (The Vietnam Archive, 2004); Tay Ninh, "Medcap and Civic Action a Welcome Break from War," *Tropic Lightning News* 1968.

The American Embassy in Saigon and the US Military Assistance Command in Vietnam (USMACV) developed the Medical Civic Action Program jointly. It has been described in general terms as a "sick call at US military dispensaries... [sometimes involving] major surgical operations requiring extensive hospitalizations."[367] In January 1963, MEDCAP became an operational program under the Department of the Army.[368] Initially, MEDCAPs were the domain of US military advisory teams and Special Forces personnel; however, the program was soon expanded to include regular American military units. Initially, MEDCAP teams traveled to selected hamlets and villages alongside members of the Army of the Republic of Vietnam (ARVN) where they would establish temporary clinics.

This program stood in stark contrast to MILPHAP. While MILPHAP focused on permanent hospitals, the MEDCAP team was a mobile, temporary unit. Also, while MILPHAP focused on inpatient, hospital care, MEDCAPs focused on outpatient care. In fact, the MEDCAP was meant to be understood as a complimentary program, extending the reach of MILPHAP to rural areas, and beyond the walls of the hospital.[369]

In 1965, the buildup of American forces meant the U.S. could expand the use of MEDCAPs.[370] This expansion led to a division in the MEDCAP between MEDCAP I and MEDCAP II. MEDCAP I (the original) involved American military personnel

---

[367] "Command History: Volume Ii 1967," ed. United States Military Assistance Command Vietnam, Promulgation of the USMACV 1967 Command History (Saigon, Vietnam: Military History Branch, 1968), 695.

[368] Neel, *Vietnam Studies Medical Support of the U.S. Army in Vietnam 1965-1970*, 164.

[369] Westmoreland, "Joint Directive Number 2-67: Military Provincial Health Assistance Program (Milphap)."

[370] Neel, *Vietnam Studies Medical Support of the U.S. Army in Vietnam 1965-1970*, 165.

working closely with Army of the Republic of Vietnam (ARVN) physicians and medics. In this original iteration, Americans played only a supervisory and advisory role. However MEDCAP II involved the direct participation of American military medical professionals in patient care, with little or no involvement from the ARVN. MEDCAP II grew to be a large and expansive program. In fact, during the first three months of 1968 approximately 188,441 civilians/month received outpatient treatment from MEDCAP personnel.[371] By 1970, MEDCAP II personnel had been treating 150,000 to 225,000 outpatients per month.[372]

MEDCAP: PROGRAMMATIC INTENT/ GOALS

The general purpose of both iterations of the MEDCAP was the establishment and maintenance of a "spirit of mutual respect and cooperation," while achieving the two-fold main official objectives: (1) "to create a favorable image of the Vietnamese Army and central Vietnamese Government in the eyes of the people and (2) the improvement of hamlet echelon medical care for the civilian populace."[373] The aims of creating a favorable image of the Vietnamese Army/Government, and the US government of "winning the hearts and minds" of the people are understood to fall under the purview of psychological operations (known under the acronym PSYOP). According to Army doctrine, the use of military psychological operations are in practice "Restricted to the political and military goals of the nation that uses it."[374]

---

[371] Ibid, 165.
[372] Ibid, 165.
[373] Gilbert, " Vietnam: Preventive Medicine Orientation."
[374] "Field Manual 33-5: Psychological Operations Techniques and Procedures," ed. Department of the Army (Washington, DC: Department of the Army, 1966), 4.

MEDCAPs were understood to be a key component of psychological warfare operations. This belief continues today. Military command believes that these operations are indispensable because they allow the application "of power without necessarily having to shoot bullets."[375] At this point, it is critical to understand the term "psychological warfare." The mission of Psychological Operations or PSYOP have been understood as influencing "the behavior of foreign target audiences (TAs) to support U.S. national objectives… PSYOP accomplish this by conveying selected information and/or advising on actions that influence the emotions, motives, objective reasoning, and ultimately the behavior of foreign audiences. Behavioral change is at the root of the PSYOP mission." [376]

Importantly, another key programmatic goal was to improve cooperation and increase mutual respect between the military and the civilian population of Vietnam and the United States.[377] MEDCAP II emphasized this third strategic goal, fostering positive perceptions of the American military and American government amongst the Vietnamese civilian population and increasing the American sphere of influence.[378] Other official goals included gathering intelligence, and securing areas by eliminating the enemy from the vicinity.[379]

These goals were both formally written and practically recognized and employed by commanders and units. They have also been recognized and written

---

[375] Colonel Andy Birdy, Commander, 1st Brigade Combat Team, 10th Mountain Division, during Operation UPHOLD DEMOCRACY in Haiti cited in "Fm3-05.30 (Mcrp 3-40.6) Psychological Operations," ed. Department of the Army (Washington, DC: Department of the Army, 2005), 1-1.

[376] Ibid, 1-2.

[377] Neel, *Vietnam Studies Medical Support of the U.S. Army in Vietnam 1965-1970*. 165.

[378] David G. Eisner, "Medical Civic Action Programs (Medcap)," (Military Assistance Command, Vietnam), 27.

[379] Julian J. Ewell and Ira A. Hunt Jr., *Sharpening the Combat Edge: The Use of Analysis to Reinforce Military Judgement*, Vietnam Studies (Washington, DC: Department of the Army, 1974), 158.

about by authors, commentators and historians of this program.[380] Published author and military physician, Spurgeon Neel outlined the MEDCAP objectives as: the relief of immediate health problems among Vietnamese civilian populations and the "maintenance of the favorable image of the central government of Vietnam and the US in the minds of the general population."[381] Neel also recognized a fourth official, and many would argue un-achieved goal of the MEDCAP: "short and long range improvement in medical and health standards and practices in Vietnam through education and precept."[382] This fourth and final goal is more in line with achievements of the MILPHAP (discussed earlier) as the MEDCAP involved little or no training component.[383] This lack of training is especially true of the larger MEDCAP II program. However, putting this fourth, unofficial goal proposed by Neel aside, it is necessary to notice to the programmatic intent of MEDCAP. Although the relief of health problems is listed as the first of the programmatic goals, we shall see that this goal often took a back seat to the other more strategic goals, prioritizing and emphasizing the strategic goals of psychological warfare and employing medicine as the non-lethal weapon by which to achieve these goals.

The emphasis on these strategic, non-medical goals is where we begin to see moral dilemmas arise for the physicians involved. The use of medicine as a tool for these non-medical purposes creates a morally complicated space for military medical professionals. As priest and ethicist Vastyan writes,"medicine is thus no

---

[380] Wilensky, *Military Medicine to Win Hearts and Minds: Aid to Civilians in the Vietnam War*; Malsby III, "Into Which End Does the Thermometer Go? Application of Military Medicine in Counterinsurgency: Does Direct Patient Care by American Service Members Work?".

[381] Neel, *Vietnam Studies Medical Support of the U.S. Army in Vietnam 1965-1970*, 606.

[382] Ibid, 606.

[383] Lowell J. Rubin, "Medcap with the Montagnards," *USARV Medical Bulletin*, May/June (1968): 31.

longer only an instrument serving to preserve the health of a nation's armed forces. Rather, it has become a strategic instrument and a tactical weapon, perhaps the most powerful weapon in the arsenal of psychological warfare."[384] In pursuit of the objectives set out for the MEDCAP program in Vietnam, we see two divergent views develop according to the two sets of goals. According to the programmatic goals, the military was attempting to both use medicine as a psychological and strategic tool to "win the hearts and minds," while also improving the health of people. Thus, two viewpoints emerged: one privileging medical end-points as indicators of success, the other privileging strategic end-points. According to one commentator,

> One view assumed the major goals as winning the confidence and loyalty of the people to the GVN (Government of Vietnam), by using MEDCAP as a psychological tool, and secondarily improving the health of the people. The other viewpoint was that the major effort should do to improve the health and relieve suffering with the winning of the people to the GVN as a possible bonus effect.[385]

Each of these viewpoints employed different operational tactics and used different measures of success. A clear example of this difference of viewpoints is apparent in a Government Accountability Office (GAO) memorandum that was made public for President Johnson's use during the Guam conference with officials from Vietnam. This memorandum, prepared by the US mission in Saigon, in cooperation with the Vietnamese government, stated that limited access to medical care in rural and remote areas, and over-crowding in hospitals was not considered "critical to our

[384] Vastyan, "Warriors in White: Some Questions About the Nature and Mission of Military Medicine," 330.
[385] Ibid, 331.

success in the political-psychological side of the war-effort."[386] This memorandum clearly highlights a difference in values or perhaps a schism between military and medical goals; dismissing medical issues as unimportant and subservient to strategic goals.

This schism was felt by physicians who often ascribed to the viewpoint that prioritized medical endpoints and objectives. These physicians felt challenged to provide medical care in an environment where their commanders often prioritized strategic goals of using the MEDCAP as a psychological tool, rather than a medical one. Sometimes physicians saw these strategic goals as impeding their medical work. One Army physician who participated in a MEDCAP in Vietnam describes his perception of the negative impact of intelligence gathering on medical care,

> We always had intel [intelligence] people with us … and that is very counterproductive … because (you know) we are a bunch of folks who go in and try to do good and winning the hearts and minds, if you will, by being good Samaritans, and if you have folks who are using it for whatever for nefarious means, nefarious purposes, than our means will be viewed as not very positive either.[387]

This physician felt that prioritizing intelligence gathering harmed the trust that patients had in the health care team, and believed that this cast a shadow over the entire MEDCAP operation. The prioritization of strategic goals were problematic because his experience proved "when you are using medical activity" to gather "information that reduces your trust of the population that you are taking care of…

---

[386] Ibid, 333.

[387] Participant 1. Interview by Sheena M. Eagan Chamberlin. Digital Recording. San Antonio, TX, June 7, 2012.

a lot of people didn't even want to bother with you… [the intelligence gatherers] make it very difficult for you to have any credibility at all"[388] Although this physician recognized the military value of intelligence gathering, he expressed discontent at its effect on the physician-patient relationships within the MEDCAP.

Medical issues and goals were further limited by context and environment. Many physicians recounting their experiences participating in these programs have discussed the severe limitations that they experienced attempting to care for patients during MEDCAPs. The same Army physician expressed these limitations as follows,

> And that was the huge issue so that when hospitalization is necessary it is almost non existent…and the ability to provide needed medication on a long term basis was also essentially non existent and not affordable. And that was a huge issue. People cannot afford the care and certainly can't afford the medicines for their care and I've had patients die that I felt responsible for within the last few years in Vietnam who had not been able to afford the antibiotics…[389]

According to one case study, the medical equipment was limited to "what we could carry along with our men in a field ambulance or helicopter. Our medical supplies were drawn from a list of 140 items funded by the Agency for International Development and supplied through the medical depot system."[390] Medications were often limited to adult doses, despite the fact that many of the patients were children. The military is composed solely of adults making their supply of medication solely

---

[388] Ibid.

[389] Ibid.

[390] James E. Anderson, "The Field Experience of a Medical Civic Action Team in South Vietnam," *Military Medicine* 129(1964), 1054.

adult dosage; it does not include pediatric dosing specifications. Diagnostic equipment was sparse or nonexistent, and physicians often lacked translation or interpretive services creating significant issues due to the language barrier. Physicians were also frustrated by a lack of medical facilities, medical knowledge and basic sanitation and hygiene in Vietnamese villages.[391] In fact, lack of hygiene was such a severe issue that many times soap was distributed to the majority of patients in place of any medications, their chief complaint being identified as the result of poor sanitation. One film crew (who was accompanying a MEDCAP for PR purposes) reported that out of fifty patients seen twenty-five bars of soap were distributed, along with instructions on how to use the soap.[392] Another source of frustration was the constant confrontation with preexisting conditions, or those requiring chronic treatment. Chronic care and follow-up was impossible due to the temporary and short-term nature of the MEDCAP program. Generally, a MEDCAP lasted only a few days, and this short window meant that physicians often could identify chronic conditions but do little more than dole out aspirin. Some referral systems were established to the MILPHAP system, however endemic poverty and rural isolation meant that these patients could not access these services.

Yet another source of frustration for physicians was that they were often unable to leave patients with a full course of medication due to strategic concerns. According to the Military Assistance Command in Vietnam (MACV), "To prevent much sought-after drugs from falling into the hands of Viet Cong, only the absolute

[391] James W. Bruce, "Exit Interview: Maj Philip Scozzaro," ed. Department of the Army (Washington, DC: 28th Military History Detachment, 11th Armored Cavalry Regiment, 1969). Foulke, "Macv Army "A" Photo Team Films Medcaps."

[392] Foulke, "Macv Army "A" Photo Team Films Medcaps," 1.

minimum necessary to treat the disease should be given to any individual, and certainly never more than enough to cover the period of time until the next scheduled visit."[393] It was common that once MEDCAPs would leave a village the Viet Cong would enter, taking medications from MEDCAP patients in order to treat their own illness.[394] Thus, physicians were limited to short and sometimes incomplete or inadequate courses of medications. Since MEDCAPs generally did not return to the same village, physicians often wanted to leave chronically ill patients with additional medication, but this was strategically forbidden.

These constraints led to military physicians feeling as if the care that they were providing to MEDCAP patients was "completely futile."[395] They would commonly feel "fed up and resentful at having to take risks to help people who he could only help once and on a very limited level."[396] One MEDCAP participant described this professional impotence as follows: "Then I thought screw these MEDCAPs. This is out there and there's the same diseases and there's the same injuries. There's the same this. Nothing has changed. So what?"[397] These feelings of futility and professional impotence were compounded by the fact that occasionally enemy forces would pose as civilians and receive care within the MEDCAP system. One physician described his main reason for discontinuing participation in

---

[393] Eisner, "Medical Civic Action Programs (Medcap)," 28.

[394] "Oral History: Dr Charles Julienne, Conducted by Laura Calkins," in *Oral Hisotry* (Lubbock, TX: The Vietnam Center and Archive, 2004), 48.

[395] "Oral History: Beth Parks, Conducted by Laura Calkins," in *Oral History* (Lubbock, TX: The Vietnam Center and Archive, 2004).

[396] Ibid.

[397] "Oral History: William Laurie, Conducted by Laura Calkins," in *Oral History* (Lubbock, TX: The Vietnam Center and Archive, 2004), 162.

MEDCAPs as follows, "the people we were helping were coming and bombing the heck out of us."[398]

However, physician discontent was not limited solely to constraints of context and environment. Even civilians participating in humanitarian missions in impoverished nations suffering from endemic disease, lack of sanitation and an inability to access regular medical care feel the same frustrations. They often encounter patient populations with chronic conditions that they cannot help due to scarcity of time and supplies. These critiques are a superficial analysis of a deeper problem; medical concerns were not prioritized in MEDCAPs. Not only did medical goals and military goals vary considerably in Vietnam MEDCAPs, but also medical goals often took a back seat. Physician discontent within Vietnam MEDCAPs is intimately linked to the prioritization of strategic goals over medical goals. Military physicians often expected to be on humanitarian missions and were surprised to discover that MEDCAPs emphasized their roles as tools of psychological warfare and pacification, “winning their hearts and minds,” often to the detriment of medical goals.

The prioritization of strategic aims is perhaps most apparent in a military communication held at the Vietnam archives at Texas Tech University. This communication describes a corpsman's recommendations to maximize psychological warfare efforts. It states, "Since we have two areas in which MEDCAPs are conducted, bring plenty of placebos such as vitamins, etc. to make them think

[398] "Oral History: Beth Parks, Conducted by Laura Calkins."

they are getting something."[399] The statement "to make them think they are getting something"[400] highlights an essential component of the Vietnam MEDCAP that led to much physician discontent: intentional dishonesty and the prioritization of strategic goals to the detriment of medical aims. Vietnamese civilians were led to believe that they were receiving medical care when they were not. Physicians were used for psychological warfare operations while the medical care they were providing was restricted. In this way, these programs were not, in fact medical, but rather as one physician described them "medical show-business."[401] The intent was often not to improve health or eliminate disease but rather purely strategic aims of psychological warfare: winning hearts and minds, expanding the American and GVN sphere of influence and gathering intelligence. Thus, these programs seem to ask military physicians to prioritize their role as soldier, emphasizing aggregate level obligations to the mission grounded in normative conceptions of military professional morality. However, having simultaneously joined two professions, with two sets of moral obligations the military physician is left with an ethical dilemma. These programs did not value the internal morality of medicine that prioritizes the health and healing of the individual patient.

Strategic intent is also made clear in the selection of hamlets where MEDCAP teams were sent. The selection process was not based on medical need or necessity but rather strategic or military goals. MEDCAP teams were sent to those hamlets

---

[399] Thomas Klefhammer, "From: Officer in Charge, Seal Team One Det Golf November Platoon, To : Officer in Charge, Relieving Platcon, Via: Execwtive Officer, Seal Team One, Subj: Dong Tam Seal Detachment; Relief Of," ed. Department of Defense (1971).

[400] Ibid.

[401] Wilensky, *Military Medicine to Win Hearts and Minds: Aid to Civilians in the Vietnam War*, 92.

identified as "key hamlets" by the Governments of Vietnam and the United States.[402] This designation was based on their economic, social and political importance to the provinces in which they were located.[403] MEDCAP teams would use medicine to win over the civilian population, and tactical teams were used to eliminate the enemy in the vicinity, hopefully with the help of intelligence gathered from MEDCAP patients.[404]

The clear strategic intent was also apparent in the information provided to the civilian patients. During MEDCAP operations medication was not dispensed in regular bottles, rather it was dispensed in special envelopes specifically designed by the psychological operation battalion. These envelopes listed not only specific directions for taking the prescribed medication, as well as warning labels, it also included messages meant to win the civilian population over to the side of the Government of Vietnam and the United States. One such envelope was inscribed with the following text: "The Viet Cong kill the people and steal their rice while the GVN looks after the people and provides medicine for them."[405] Another medication envelope included the text; "The Government of Vietnam is looking after the people's health by providing them medical care. The Vietnamese and American Navy Medical teams are constantly striving to help the people."[406] The importance of

---

[402] Ewell, *Sharpening the Combat Edge: The Use of Analysis to Reinforce Military Judgement*.
[403] Ibid, 158.
[404] Ibid.
[405] "Medcap Medicine Envelopes," ed. Department of the Army (San Francisco, CA: 10th Psychological Operations Battalion, 1968). (SEE APPENDIX A for both original and translated document)
[406] "Gvn Provides Medical Care," ed. Department of the Army (10th Psychological Operations Battalion, 1968). (SEE APPENDIX A for both original and translated document).

these documents cannot be dismissed as a single unit reports handed out over two million leaflets over the course of their deployment.[407]

Loudspeaker announcements, gifts and t-shirts that promoted similar messages, specifically crafted by psychological warfare operations units complemented these pamphlets and medication envelopes.[408] All of these propaganda efforts happened in conjunction with MEDCAP operations. Other information pamphlets were handed out to civilians within the Vietnamese hamlets as part of the psychological warfare operations. One such pamphlet was used to explain the presence of the MEDCAP team to the Vietnamese civilian population, and makes the strategic goal clearly apparent. The document is translated as,

Image 2: Member of 8TH PSYOP Battalion broadcast propaganda message. (Photo credit: John H. Hay, *Tactical and Material Innovations*, 144.)

> A medical team has been sent to your village to help you. Come with your family and friends if you are sick or injured. The medical team will help you get well. The Medical team was sent here by the government of South Vietnam because the Republic of Vietnam wants to help your family get rid of sickness and pain. The Medical team must be protected. The Viet Cong want to destroy the medical team because the Viet Cong do not want the government of South Vietnam to help the people. The Soldiers of the ARVN 9th Division are here to protect the medical team so the medical team can help you. Please help

[407] _____, *Sharpening the Combat Edge: The Use of Analysis to Reinforce Military Judgement*.
[408] Ibid.

> us to protect the medical team. Please tell the soldiers where the Viet Cong hide themselves, their weapons and their food.[409]

This explanation highlights several strategic goals of the MEDCAP and poses serious ethical dilemmas, given the narrative knowledge provided by physicians involved in MEDCAPs. The document clearly explains the MEDCAP team as there to benefit the people of Vietnam and aligns their work with the host government, thereby accomplishing their goal of promoting positive conceptions of the GVN and the US government. Problematically, this document emphasizes the idea that medical care and the treatment of disease are a priority, when we know that it was often secondary to the overall mission regarding psychological warfare. This seems to use the goodwill surrounding medical care and practice for strategic ends. The document also informs the civilian population of the need to protect the MEDCAP and requests intelligence from the patients as a means of protecting the medical team and ensuring medical care for the village. The collection of intelligence was a widely recognized benefit of MEDCAP and often a prioritized goal, which physicians found problematic as we saw earlier.

Many operational reports note using MEDCAPs as a means of gathering intelligence.[410] Commanders recognized the special relationship of the provider and patient, and the willingness of those receiving medical care to share information.

---

[409] "Explanation of Us Presence and Medcaps," ed. Department of the Army (San Francisco, CA: 10th Psychological Operations Battalion, 1968). (SEE APPENDIX A for both original and translated document)

[410] "Operational Report of Lessons Learned, Headquarters 1st Brigade, 1st Infantry Division for Period Ending 1 Feb 68- 30 Apr 68, Rcs Csfor-65 (Ri)," ed. Department of the Army (San Francisco, CA: 1st Brigade 1st Infantry Division, 1968); "Pacification Program at Work: Security Comes to Hamlet," (Vietnam Council on Foreign Relations).

Medicine was a good way to build trust with locals who desperately wanted western medicine and placed trust in medical personnel. MEDCAPs were also occasionally used to gather intelligence regarding missing persons.[411]

One author, writing an analysis of his command in Vietnam, described emphasizing psychological operations and intelligence activities in his medical program due to their wide acceptance within the civilian population.[412] According to this author, these programs sought to gain intelligence regarding the infrastructure of the Viet Cong, the current status of security and pacification, as well as to establish rapport with local leaders and officials while gauging the improvement of the American and GVN image. He states, "the Integrated Civic Action Programs paid off with impressive results; some of our most meaningful intelligence was gained in this way."[413]

Interestingly, later studies would show that little valuable intelligence was actually gathered from MEDCAPs.[414] Dr. Robert Wilensky examines the topic of intelligence in his analyses of Vietnam MEDCAPs, concluding that these programs did not contribute any information that was pertinent or affective to decision making at the operational level.[415] Although there are numerous anecdotal accounts of intelligence gathering at the unit level, there are no higher-level intelligence

---

411 Jerry DeBruin, "A Message of Action to Representatives of the United States Government Relative to the Case of Eugene Henry Debruin," ed. U.S. Senate Selet Committee (Toledo, OH1992).
412 Ewell, *Sharpening the Combat Edge: The Use of Analysis to Reinforce Military Judgement*.
413 Ibid, 174.
414 Wilensky, *Military Medicine to Win Hearts and Minds: Aid to Civilians in the Vietnam War*, 121.
415 Ibid, 119-121.

reports indicating information gathered through assistance programs.[416] As Wilensky concludes, operational-level intelligence data was not gathered or it was not recorded and thus under utilized. Either way, the benefits of intelligence gathering as a goal of MEDCAPs are difficult to evaluate.

Records regarding intelligence gathering are not the only data making the success of MEDCAPs difficult to evaluate. Although during the Vietnam War many considered MEDCAP to be a success, later analysis has been highly critical due to the nature of the data and record keeping. In fact, the overall success of medical outcomes of MEDCAPs can be difficult to analyze due to the nature of the records that were kept. Records for these programs evolved, or rather devolved into a quota system, listing basic statistics and numbers. Commentators have speculated that this is due to the fact that medical civic action was "one of the most popular and easily publicized [programs]."[417] Thus, the demand by headquarters for numbers to publicize led to the system of recording simply the number of patients seen, or immunized. There was also a significant amount of competition amongst Colonels to put up big numbers for civic action, which some speculate led numbers to be rounded up.[418] Unfortunately, this means that there is little narrative or qualitative information included in after action reports (AARs) and other official documentation and that even the quantitative data cannot always be trusted.

---

[416] Ibid, 120.

[417] Donald J. Stilles, "Critical Subjective Outline of Problems Encountered in G5/S5 Field in a Tactical Division in Vietnam," ed. Department of Defense (Fort Bragg, NC: United States Army Combat Developments Command Special Operations Agency, 1969), 5.

[418] "92nd Congressional Record ", (Washington, DC: 1971).

The constraints of time and resources led to minimal improvements in health while sometimes simultaneously failing to accomplish strategic goals. In the Vietnam MEDCAP II, some members of the civilian population identified aid solely with the American government, seeing it as a failing on the part of the host-nation government. One peasant said, "Why are the American soldiers so good to us while our own government and soldiers do nothing for us?"[419] Since one of the main strategic objectives was to win the hearts and minds of the civilian population for the cause of the Government of Vietnam, as well as the American government, this statement is indicative of at least some level of programmatic failure. Though the MEDCAP was initially applauded as a great success, further reflection and experience has shown that MEDCAP may have failed to "win the hearts and minds" for both GVN and the US, while also failing to gather much valuable intelligence. Thus, these programs have been argued to have failed in their medical and military goals, despite initially being praised as successful. The provider's goals of bettering civilian health have few success stories. These programs have been largely short-term and infective. Certainly many commentators and historians have levied that charge, and yet, modern MEDCAPs remain based on the Vietnam model.

Physicians participating in the MEDCAPs of the contemporary war in Iraq express similar discontent with the program. One participant, who was deployed with the Marines in the mid 2000s felt as though "nothing medically was done" by

[419] Malsby III, "Into Which End Does the Thermometer Go? Application of Military Medicine in Counterinsurgency: Does Direct Patient Care by American Service Members Work?" 64.

the program.[420] While attempting to win the favor of the civilians, this physician had to deal with the reality of civilian psychological warfare and the limitations of medicine. This provider told the story of a patient who came to a MEDCAP in Iraq, "[a] mother showed up with [her] child, al-Qaida had promised that we could do a surgery and fix her child with cerebral palsy. I had to explain that there was nothing that we could do…she begged us to help and didn't believe."[421] Although this chapter focuses on the MEDCAPs of Vietnam, it is important to note that these issues are still relevant today. Problems noted in the programs of the past can be used to implement changed in contemporary missions and operations. It is also critical to note, that although many reports and archival materials are still classified for recent MEDCAP missions, these programs must be studied and analyzed in future scholarship.

MILITARY DOCTRINE

Some authors have argued that confusion surrounding the mission and lack of instruction and training contributed to mission failure. Within the military institution, military doctrine is fundamental in shaping behaviour and dictating right conduct. Unfortunately, there has historically been very little doctrine that has dealt with military medical civilian assistance programs. More recently there has been a shift in security policy, which has led to an increase in doctrine on this subject. However, this doctrine remains vague and does not guide the behaviour of

[420] Participant 8, interview by Sheena M. Eagan Chamberlin, January 31, 2013, interview notes and transcript.

[421] Participant 8, interview by Sheena M. Eagan Chamberlin, January 31, 2013, interview notes and transcript.

individual soldiers participating in these programs. Rather, new doctrine focuses on clarifying the new emphasis that is to be placed on stabilization and development programs such as medical civilian assistance programs.[422] That being said, pre-2001 there was little official doctrine to aid soldiers in preparing for medical civilian assistance missions.

These types of missions are authorized under Title 10, US Code. Section 401, "Humanitarian and civic and assistance provided in conjunction with military operations," which authorizes the DOD to engage in projects and use funds for humanitarian purposes worldwide, with civilians, in foreign nations. Importantly, these programs focus on non-threatening engagement opportunities with a foreign nation. Humanitarian goals are not mentioned. Beyond that doctrine, little existed during the Vietnam War. According to historians and commentators, there have been clear and fundamental failures on the part of the military that contributed to the moral complexity felt by physicians.[423] In Vietnam, the military has been criticized as being unclear of its goals and objectives with the MEDCAP programs.

Certainly the physicians who participated in these programs found them highly problematic. The prioritization of military goals over medical goals left physicians unable to address the medical issues of their MEDCAP patients. These physicians have expressed confusion and discontent about medicine being used in this way. During the first period of civilian medical assistance, military and medical

---

[422] See "Introduction" for discussion, see also: Stanley, "Number 6000.16 Military Health Support for Stability Operations."

[423] Peter B. Cramblet, "U.S. Medical Imperatives for Low Intensity Conflict." (US Army War College, 1991); Wilensky, *Military Medicine to Win Hearts and Minds: Aid to Civilians in the Vietnam War*; Malsby III, "Into Which End Does the Thermometer Go? Application of Military Medicine in Counterinsurgency: Does Direct Patient Care by American Service Members Work?".

goals aligned. Both aimed to reduce disease. A military physician was not forced to choose between his loyalty to the profession of medicine or the profession of the military. However, in the Vietnam era all of this changed. There was a schism between the military and medical goals. While the medical goals remained constant, the military goals shifted and no longer aligned. This division created a morally complicated space for the physician-soldier as medical goals were sometimes subverted for military goals; they were told to pass out placebo so "they think they [the patients] are getting something."[424]

The internal morality of medicine demands patient-centered consequentialism, driven by beneficence and non-maleficence. Physicians are supposed to act as advocates for their vulnerable patient, to cure when possible and to care always. This normative conception of professional morality existed during the Vietnam War. However, this specific version of the MEDCAP did not allow for that. It sometimes required active deception that did not benefit the patient's health and was thus incompatible with their internal morality. On other occasions, it called for intelligence gathering that physicians believed chipped away at the trust they had with their patients. The internal morality of the military demands the protection of the nation, service to your fellow soldier, and an obligation to a mission first mentality. In Vietnam, the normative conception of military morality emphasized these same values. Yet, the military physician was not taught how to balance on this precarious ledge. The goals of the mission expected them to prioritize their roles as

[424] Klefhammer, "From: Officer in Charge, Seal Team One Det Golf November Platoon, To : Officer in Charge, Relieving Platcon, Via: Execwtive Officer, Seal Team One, Subj: Dong Tam Seal Detachment; Relief Of."

soldiers, while practicing medicine—a morally problematic predicament. They were asked to straddle two professional worlds, practicing medicine that was not meant to serve medical goals, but rather military goals, and therein lay the problem.

As the program shifts towards the third phase, the training MEDCAP, later known as the medical readiness training exercise or MEDRETE, we will see that some of these issues are addressed. Simultaneously, a host of new issues are introduced by the introduction of a medical education component to medical civilian assistance programs. They are not training civilians, but rather using civilians to train themselves. Interestingly though, several significant ethical issues are addressed in this shift; dishonesty begins to be removed, medical personnel become intimately involved in the planning as it is now an issue of medical education, and now medical and military goals begin to realign, relieving the tension between the twin-loyalties.

Chapter 6

Medical Readiness Training Exercises- MEDRETEs

Image 3: Children outside of Bogran Health Clinic in Comayagua, Honduras Photo credit: Bernard L. DeKoning, "Soto Cano Air Force Base, Honduras." Life on the Line: 10.

Medical civilian assistance programs in the post Vietnam era changed significantly from their original form. While MEDCAPs still took place, a new program emerged on the scene in the 1980's and gained popularity, becoming pervasive. This new medical civilian assistance program involved the added dimension of medical education, where military physicians provide medical care to civilians as part of their own medical training. During this third period, medical assistance took the form of short-term training expeditions in poor nations. In these environments, physicians are exposed to pathology, trauma and diseases that are rarely, if ever, seen in the continental United States. No longer do these missions take place during places of active conflict, but rather during places of relative peace. In fact, peacetime engagements have emerged as a significant component of U.S.

national strategic policy during this time.[425] Peacetime engagements refer to "the U.S. remaining actively involved in supporting stability and security..."[426] Within the stability and security operations recognized as an important part of national policy during the third period, medical programs were believed to be a valuable component of these operations.

These medical civilian assistance programs continued to straddle both professional worlds, aimed at both achieving politico-strategic goals as well as humanitarian ones. However, during this period, much like during the first, the military and medical goals more closely align. The introduction of a medical education component meant that an important military goal was the training of military medical personnel, which must also include the provision of appropriate and adequate care to the patient population as a means of proper training. In this way, the treatment and prevention of illness and disease again took priority as both the main medical goal and a key military goal. Other notable military goals carried over from the second period, to include public relations, increasing the sphere of American influence and fostering positive international relations. Foreign civilians in low-income nations represented an opportunity for military physicians to "win hearts and minds" while honing their clinical skills. Thus, the problem of dual loyalties is still present but significantly reduced from those present in Vietnam-style MEDCAPs. Of course, this program does raise new ethical dilemmas related to the use and possible exploitation of disenfranchised and vulnerable populations for

[425] Sue Standage, "A Role for the Army Medical Specialist Corps in Nation Assistance," Carlisle Barracks, PA: U.S. Army War College, 1993.
[426] Ibid, 4.

clinical material in medical education. This ethical issue has been historically significant and is undoubtedly relevant to US medical education in Central and South America. That being said, this dissertation will not deal with that ethical issue. Instead analysis will focus on ethical dilemmas specifically related to the problem of dual loyalty.

This chapter will focus on civilian medical assistance in Central and South America during the 1970s, 80s and 90s. This type of program was not unique to this area. Although these programs have been focused on Central and South America, they have occurred sporadically throughout the developing world in the form of short-term training missions. Peacetime engagements that made use of stability operations, such as MEDCAP-style programs, were understood to be useful in impoverished nations. These types of programs promoted stability and host nation assistance while reversing local violence.[427] This type of temporary program raises new ethical concerns regarding the exploitation of vulnerable populations and the value of what is termed "parachute medicine." These programs involve American-trained physicians literally dropping into vulnerable foreign populations, who lack medical care and providing services on a temporary basis. The short-term nature of these interventions makes long-term treatment and follow up impossible, begging the question as to whether this peak-and-trough approach to foreign civilian aid is truly beneficial to patient health. According to its internal morality, medicine must have goals geared towards the well being of the patient, which this program does not necessarily prioritize. I will argue that this period thus marks a new use of

[427] Ibid.

medicine as a military tool for training, which places physicians in a setting that exemplifies the problem of dual loyalties.

THE POST-VIETNAM ERA POLICY

After the Second World War, the US began to shift away from the isolationist tendencies that had shaped its previous foreign policy.[428] In the period between 1949-1960 US foreign policy began to emphasize assistance to foreign nations that were sympathetic to western democracy and opposed to communism. This period was followed by an era of US policy that shifted toward a balance of military force and humanitarian assistance.[429] In the post-Vietnam era, U.S. national policy took interest in South and Central America. Official history notes that the US recognized a low-intensity threat in Latin America caused by regional violence and destabilization.[430] Journalist Juan Gonzalez has argued that U.S. economic and military interests played a role in destabilizing Latin America, creating a relationship of migration and dependence with the United States.[431] In response to this instability, the U.S. Southern Command (SOUTHCOM) command surgeon's staff developed The Regional Medical Strategy. This strategy sought to use medical initiatives in conjunction with military assets to assist Latin American host governments address the health care needs of their country. The hope was that in assisting the host government augment host nation medical capabilities, the U.S.

---

[428] Taylor, "Health Care as an Instrument of Foreign Policy (a Proposed Exapnded Role for the Army Medical Department)," 15.

[429] Ibid, 16.

[430] Standage, "A Role for the Army Medical Specialist Corps in Nation Assistance," Carlisle Barracks, PA: U.S. Army War College, 1993.

[431] Juan González, *Harvest of Empire: A History of Latinos in America* (New York, NY: Viking, 2000).

would successfully preempt the possibility that the lack of health care would become an insurgent issue.[432] The two countries of specific focus were El Salvador and Honduras.[433]

The development, stabilization, and security assistance missions were in line with both U.S. national policy and DOD directives. DOD directive 5132.3 established military policy for security and civic assistance missions stating, "security assistance is an integral part of the DOD mission."[434] In fact, many senior military officials believed that the Army should be involved with Latin and South American countries, as a partner for development.[435] The U.S. was also interested in increasing its sphere of influence to encompass South America due to the area's rich natural resources, such as oil.[436]

These missions involved the use of non-violent military means, which is generally understood to mean "the provision of training, equipment, personnel or other programs utilizing military resources."[437] Before stabilization and development assistance became a focus of US foreign policy, nonviolent military means referred to the ramping up and scaling back of support forces before and after hostilities. However, as the US became engaged in this type of nation

---

[432] Standage, "A Role for the Army Medical Specialist Corps in Nation Assistance." Carlisle Barracks, PA: U.S. Army War College, 1993.

[433] Ibid, 13.

[434] John F. Taylor, John F. "Health Care as an Instrument of Foreign Policy (a Proposed Expanded Role for the Army Medical Department)." Carlisle Barracks, PA: U.S. Army War College, 1984, 4.

[435] Antonio R. Cobian, "The U.S. Army: A Partner for Development." Carlisle Barracks, PA: U.S. Army War College, 1996.

[436] Taylor, "Health Care as an Instrument of Foreign Policy (a Proposed Exapnded Role for the Army Medical Department)." Carlisle Barracks, PA: U.S. Army War College, 1984, 16.

[437] Ian L. Natkins, "The Role of Health Services in Support of the Theatre Campaign Plan" (US Army War College, 1989), 4.

development and assistance, it recognized that the support forces (including medical) could be used beyond simply augmenting combat power. These support forces could be utilized as a separate and distinct element of power.[438] This recognition was due partly to the perceived success of MEDCAPs and other medical civilian assistance programs in Vietnam. Thus, medical civic action became an prominent component of stabilization and development efforts during the later part of the twentieth century in Latin, Central and South America. The use of medicine in Latin America was recognized as "the least controversial, most cost effective and politically acceptable" means of furthering American military interests.[439] Still, much like the programs of Vietnam that inspired them, published commentators critiqued these programs as small, limited and tending to "concentrate on high impact, short range projects."[440] Similar to the MEDCAPs of Vietnam, the short term and temporary nature of these missions lent themselves to contextual challenges regarding medical goals, such as limited patient care, education and follow-up.

HONDURAS

The Central and Latin American programs began in Honduras, a country that would go on to receive a great deal of medical civilian assistance from all branches of the US military. COL Zajtchuk, part of Joint Task Force Bravo (JTF-Bravo) ammended the MEDCAP model from Vietnam to create the modern MEDRETE. JTF-Bravo represented U.S. Southern Command in Honduras, working with Host-Nation

[438] Ibid, 4.
[439] Lyman C. Gonzalez, "United States Military Medicine's Role in Low-Intensity Conflict in Latin America," (Carlisle Barracks, PA: Army War College, 1988), 12.
[440] Agency for Internal Development, Congressional Presentation, Fiscal Year 1982, 430.

governments in their area of responsibility to organize various comprehensive humanitarian assistance programs, as a part of the stabilization and development missions that were now a priority within US national policy.[441] Zajtchuk held the belief that humanitarian and civic assistance activities or HCAs had "the potential of becoming the greatest promoter of developing positive US policy in Central America."[442] He also believed that these programs would be a good way for him to occupy the time of his staff, improving troop morale and preventing boredom.[443]

One of his largest and most successful programs was the MEDCAP. These MEDCAPs were modeled after those conducted in Vietnam and said to be the "mirror-image of their Vietnam-counterparts."[444] This carbon-copy approach was understandably problematic, given the many issues later recognized in the Vietnam programs and discussed in the previous chapter (chapter 5). However, there were some substantial changes between the MEDCAPs in Vietnam and those being carried out in Honduras. According to Zajtchuk, the intention behind this program was "to take advantage of a unique opportunity and provide US physicians, nurses, administrators, medics and support personnel field training that are unavailable elsewhere."[445] This training component was not a part of the Vietnam MEDCAP.

The focus had clearly changed. In Vietnam, the main focus had been psychological warfare; in Honduras the MEDCAP was now a training mission with

---

[441] Elray Jenkins, "Medical Civic Action Programs (Medcaps) and Medical Readiness Training Exercises (Medretes) as Instruments of Foreign Policy," (Carlisle Barracks, PA: U.S. Army War College, 1988).
[442] Ibid, 17.
[443] Ibid.
[444] Ibid, 21.
[445] Ibid, 17.

the specific purpose of enhancing a military medical professional's ability to practice medicine in austere conditions.[446] As it no longer prioritized the same goals as the MEDCAP, this reorientation led to a change in name. The program began operating under the name Medical Readiness Training Excercise or MEDRETE.[447] The title better reflected the main purpose of the program: the training of military medical personnel in environments that could not be accurately replicated in the US. Low-income nations and the isolated rural populations presented diseases and illness that physicians, nurses and medics rarely saw in the US. Beyond that, the temporary clinical setting of the impoverished rural village was far from the western hospital in which they trained and worked. MEDRETEs provided many training opportunities that the military saw as advantageous for military readiness and mission success.

MEDICAL READINESS TRAINING EXERCISES- MEDRETES

MEDRETEs have involved many different types of medical care and a wide variety of medical specialties. The most common is the general multi-medical specialties MEDRETE. This two-week MEDRETE provides primary care to remote, often rural, locations in low-income nations in conjunction with the host nation's government and ministry of health.[448] Generally, this includes immunizations, basic clinical care and dental activities.[449] Some MEDRETEs also prioritize preventive

---

446 Ibid, 27.
447 Ibid, 27.
448 JTF-B, "Medical Readiness Training Exercises (Medrete)," Joint Task Force Bravo, accessed November 10, 2012, http://www.jtfb.southcom.mil/library/factsheets/factsheet.asp?id=10291.
449 Ibid.

medicine and civilian health education.[450] More specialized MEDRETEs include those involving specialty surgical teams performing cleft lip and palate repair, hand reconstruction, plastic surgery on burn patients, orthopedics and urology.[451] DENTRETEs also represent a popular and common subspecialty of the MEDRETE program, during which dentists perform tooth extractions, tend to dental emergencies, apply fluoride and provide oral hygiene education.[452]

MEDRETE- PROGRAMMATIC INTENT

Although there was little doctrine to inform the behaviour of individual soldiers engaged in these missions, the official intent is clearly documented. Stabilization and development missions, such as the MEDRETE, were understood to fall under the umbrella of military civic action or MCA. According to Field Manual 41-10, MCA projects are:

> … Designed and intended to win support of the local population for government objectives and for the military. Properly planned and executed MCA projects result in popular support. MCA employs predominately indigenous military forces as labor and is planned as short-term projects.[453]

This definition, with a decidedly strategic purpose, serves to distinguish MCA from the civic action done by the *United States Agency for International Development or* USAID, which includes forces of humanitarian assistance such as disaster relief. DOD

---

[450] Ibid.
[451] Ibid.
[452] Ibid.
[453] "Field Manual No 41-10: Civil Affairs Operations," ed. Department of the Army (Washington, DC: Department of the Army, 1985), 10-20.

Instruction 2205.02 provides greater understanding of the military conception of "Humanitarian and Civic Assistance Activities" or HCAs.[454] This DOD instruction directs U.S. Armed Forces personnel to "participate in HCA activities to create strategic, operational, and/or tactical effects that support Combatant Commander objectives in theatre security cooperation or designated contingency plans while concurrently reinforcing skills required for the operational readiness of the forces executing the HCA mission..."[455] This doctrine is reiterated in an earlier instruction, 2205.3: "Implementing Procedures for the Humanitarian and Civic Assistance (HCA) Program," which states "HCA activities shall promote the foreign policy and national security interests of the United States and the Specific operational readiness skills of the U.S. Armed Forces who participate in the activities."[456] The strategic focus of these missions is also apparent in reading the official website of Joint Task Force Bravo, who has been and remains responsible for the majority of Army MEDRETES in Honduras and other SOUTHCOM countries. According to their site,

> There are several mission objectives to MEDRETES, to include providing U.S. military personnel training in delivery of medical care in austere conditions, promoting diplomatic relations between the U.S. and host nations in Central America, and providing humanitarian and civic assistance via a long-term proactive program. These exercises bring together key members of the U.S. and foreign militaries, U.S. Embassy Country Teams, U.S. Non-Governmental Organizations (NGO's), Host Nation (HN)

---

454 "Instruction 2205.02: Humanitarian and Civic Assistance (Hca) Activities," ed. Department of Defense (2008).

455 Ibid.

456 "Instruction 2205.3: Implementing Procedures for the Humanitarian and Civic Assistance (Hca) Program," ed. Department of Defense (1995).

> government agencies and indigenous civilian organizations.[457]

This military doctrine is clearly strategic. The missions are not humanitarian in nature but rather seek to fulfill military goals, and emphasize strategic aims including training and international diplomacy. Medical civic action programs, which were reoriented and renamed medical readiness training exercises during this period, fell under the umbrella of MCA and HCA doctrine. Thus, just like during Vietnam, their primary motivation is military not medical. However, as we shall see, during this third historical period of medical civilian assistance these goals begin to realign.

The strategic purpose of these programs was not lost on participants. In a letter to the editor that was published in the journal *Military Medicine*, one author who had experience developing these programs wrote, "the primary missions of MEDRETES has never been to resolve health problems of the people in the host-nation, but to train our military service elements to be ready for war."[458] Importantly the author also described the many benefits that these programs can have for the host nation civilian populations.

> As training missions, MEDRETES have been invaluable and worth much more in skill learning, time and money than the simulated domestic (US) training of our active and reserve components. As benefits for foreign host-nation recipients, MEDRETEs serve a limited but good, useful

[457] _____, "Medical Readiness Training Exercises (Medrete)."
[458] Leon F. Aller, "Letters to the Editor: Medretes," *Military Medicine* 159, no. 1 (1994), A4.

> service, including some preventive medicine teaching as par of care.[459]

Participants and commentators recognized the potential benefits and the potential pitfalls of these programs, almost from their first implementation in the post-Vietnam era. These programs offered an inexpensive and excellent opportunity for public relations and training.[460] Although they were recognized as a significant and powerful policy tool if they were conducted properly, many believed that irresponsibly conducted medical civilian assistance could be counterproductive.[461] They feared that if the Vietnam MEDCAP style was perpetuated, where strategic concerns subverted medical goals leading to the provision of subpar medical care, the military interests could suffer from the distrust that this could engender.

THE PROMISE & PITFALLS OF MEDRETES

The recognition of both the potential positive benefits and negative consequences of these programs is prominent in the written and interview discussions with participants who reflect on their own experiences on specific missions. Honduras was the recipient of a substantial amount of medical civilian assistance during this time period. The US was motivated to assist the Hondurans in nation building and enhance the image of the US while expanding its sphere of

---

[459] Ibid, A4.

[460] Charles Hardin Hood, "The United States Army Medical Department in Low-Intensity Conflict," *Military Medicine* 158(1991).

[461] Jenkins, "Medical Civic Action Programs (Medcaps) and Medical Readiness Training Exercises (Medretes) as Instruments of Foreign Policy," 7.

influence and providing maximal training experience for its personnel.[462] Programs like MEDCAPs and MEDRETEs were well recieved in Honduras because of the state of medicine there. Although there was an appearance of a local public health system, it had many shortcommings that stymied its success. These included staff shortages, with doctors gathered in large city centers, leaving isolated rural areas without medical care and severe budgetary constraints. Thus, the US military decided to assist Honduras with its medical care and infrastructure problems to ensure stabilization and promote development. HCA in Honduras was approached in a four tiered way: (1) Hospital/clinics; (2) Village outreach programs (transitory MEDRETEs); (3) contingency response; and (4) quarterly visits from maxillo-facial plastic surgery (Operation Smile-cleft lip and palate repair).[463]

The MEDRETEs were usually set up in a village school or church.[464] The majority of their patients were women and children, who are reported to have occasionally created fictionalized complaints simply for the opportunity to see a western doctor.[465] Other patients who were actually ill believed that the mere presence of a western physician could cure them.[466]

These missions involved many types of medical interventions including primary care and preventive medicine, public health lectures delivered in spanish,

---

[462] Charles Hardin Hood, "Humanitarian Civic Action in Honduras, 1988," *Military Medicine* June(1991).
[463] Ibid.
[464] AC Wittich, "The Medical Care System and Medical Readiness Training Exercises (Medretes) in Honduras," *Military Medicine* 154(1989), 21.
[465] Ibid, 21: Bernard L DeKoning, "Soto Cano Air Force Base, Honduras," *Life on the Line*.
[466] Wittich, "The Medical Care System and Medical Readiness Training Exercises (Medretes) in Honduras," 20.

dentistry, surgery and even deworming.[467] Operation Smile is often hailed as an enormous success due to the visual impact of repairing a child's cleft and lip palate.[468] A team of plastic surgeons from William Beaumont Army Medical Center in El Paso TX would travel to Honduras four times a year and select patients for this surgery from pre-determined villages.[469] Much like in Vietnam, the location of MEDRETEs was determined by the US military MEDRETE coordinator in consultation with Honduran military and local civilian officials based on a "particular need."[470] Specific patient populations were also chosen by US and Honduran military, civilian and government officials, leading some physicians to express discontent at the limitations being placed on them in the clinical setting.[471] Rarely did MEDRETE teams revisit the same village.

Many military physicians who had participated in the MEDRETE program expressed critiques reminiscent of those discussed in the Vietnam era MEDCAP. One point of discontent was the constraints placed on medical care by political and strategic requirements and necessity. These critiques often focused on the constraints and limitations placed on them by both the US military and the host nation government. Often the ability of a MEDRETE team to return to a specific

---

[467] Ibid, 21.

[468] Robert G. Claypool, *Military Medicine as an Instrument of Power: An Overview and Assessment* (Carlisle Barracks, VA: U.S. Army War College, 1989), 16.

[469] Ibid, 16.

[470] Wittich, "The Medical Care System and Medical Readiness Training Exercises (Medretes) in Honduras," 21.

[471] Ibid.

village was dictated by the host nation government.[472] Thus, a physician or planner could not choose to return to a specific village to maintain continuity of care, these decisions were dictated by those higher up the chain of command in conversation with the host nation themselves. One participant expressed the concern that he felt that they were making villagers dependent on American military medical care by introducing these people to western medicine, and then never returning to provide follow up care.[473] This presented him with a type of moral dilemma, identifying chronic conditions for which he could do nothing. Other constraints included the fact that the host nation often dictated the patient population that could be seen, the villages that could be visited, as well as what services could be provided and what medications could be distributed.[474]

Other constraints also mirrored those described in Vietnam, dealing with context and environment. These included the lack of support services, language barriers and being unfamiliar with the local culture, endemic diseases, the local health-care system, and standards of care.[475] There were also a large number of patients to see in a short amount of time. Often patients travelled from neighbouring villages for the opportunity to see an American physician.[476] The short-term and temporary nature of MEDRETEs were also a source of constant critique and discontent for the military physician. Often called "parachute medicine" training

---

[472] Charles H. Mitchell IV, "The Medic as an Instrument of National Policy or What in the World Is the Department of Defense Doing in Medical Humanitarian Assistance?," (Carlisle Barracks, PA: U.S. Army War College, 1991).

[473] Participant 5, interview by Sheena M. Eagan Chamberlin, October 11, 2012, transcript.

[474] Participant 2, interview by Sheena M. Eagan Chamberlin, October 1, 2012, interview notes.

[475] JM Crutcher and HJ Beecham, "Short-Team Medical Field Missions in Developing Countries: A Practical Approach," *Military Medicine* 160(1995), 339.

[476] Participant 6, interview by Sheena M. Eagan Chamberlin, October 24, 2012, transcript.

operations because teams dropped in and provided care for a short time and then left, this short-term model prevented long-term and follow up care for patients with chronic conditions.[477] Many participants recognized the need for long-term projects, and re-occurring MEDRETEs.[478]

Interestingly, in this period we see participant discontent expand beyond the physician. While in Vietnam there was no discussion of host nation critiques of the civilian assistance programs, host nation governments were critical of the benefit of early MEDRETEs.[479] The Ministry of Health in Honduras, as well as the Honduran College of Medicine, questioned the utility of the MEDRETEs.[480] Even Army South Command or SOUTHCOM recognized the shortcomings of the MEDRETE program. In a SOUTHCOM memorandum they stated,

> We have done a good job winning the minds and heart of our hemisphere neighbors using these training vehicles. However, despite these efforts we are not able to demonstrate that we have actually done anything to improve the health of those we have treated in the past. The mere provision of a few medicines on a periodic basis can generate a great number of patients seen during a particular visit, but says nothing about the impact of our effort on the health of the population.[481]

Just like in those who participated in Vietnam MEDCAPs, many of the physicians who participated in MEDRETEs shared these critiques. The majority of participants interviewed expressed beliefs that the medical impact of MEDRETEs was

---

[477] Cramblet, "U.S. Medical Imperatives for Low Intensity Conflict.".

[478] Emile P. Lesho, Naseer K. Jawad and Husam M. Hameed, "Towards a Better Approach to Medical Humanitarian Assistance in Iraq and Future Counterinsurgency Operations," *Military Medicine* 176(2011).

[479] Roland J. Weisser, "The Maturing of Medretes," *Military Medicine* 158(1993), 573.

[480] Ibid, 573.

[481] Ibid, 573.

minimal.[482] One participant thought that medically the MEDRETE was, "a disservice to the local population."[483] This same participant was in Honduras from 1999-2000 and explained that prevailing physician sentiment was, "MEDRETEs would be a disservice to the local population and there was a lot of truth to that."[484] Another participant referred to it MEDRETEs as "band-aid medicine."[485] The concept of "band-aid" medicine refers to the idea that little is done for the patients beyond putting on ban-aids and doling out multi-vitamins. For these reasons one physician described MEDRETEs as having, "no impact at all on a medical basis."[486]

POSITIVE PROVIDER EXPERIENCES

However, not all shared these critiques. In stark contrast to the MEDCAPs of Vietnam, many providers felt that the medical care that was provided was of benefit to the MEDRETE patients. These perceived benefits on the part of the participants are where we note a drastic departure from the Vietnam MEDCAP. Clearly, the MEDRETE is not a 'mirror-image' of the Vietnam-style MEDCAP. There were significant changes. Beyond the obvious shift towards training, some physicians were satisfied with their experiences as a part of these programs. One author stated, "The hospital, and the MEDRETES, may not have contributed to the long-term development of a health service, but it made a long-term difference to the

[482] Participant 5, interview by Sheena M. Eagan Chamberlin, October 11, 2012, transcript: Participant 6, interview by Sheena M. Eagan Chamberlin, October 24, 2012, transcript: Participant 9, interview by Sheena M. Eagan Chamberlin, January 27, 2013, transcript.
[483] Participant 5, interview by Sheena M. Eagan Chamberlin, October 11, 2012, transcript.
[484] Participant 5, interview by Sheena M. Eagan Chamberlin, October 11, 2012, transcript.
[485] Participant 6, interview by Sheena M. Eagan Chamberlin, October 24, 2012, transcript.
[486] Participant 9, interview by Sheena M. Eagan Chamberlin, January 27, 2013, transcript.

patients."[487] Another military physician who had the opportunity to participate in both a MEDCAP and a MEDRETE explained that the medical value of the latter was far superior to the former.[488] This opinion was reiterated in the literature as many were beginning to realize that the traditional MEDCAP could be counterproductive and fail in its goal of creating confidence in the local host nation government due to lack of coordination and subpar medical care.[489]

There were specific medical procedures and aspects of medical care that physicians recognized as useful in the MEDRETE setting. Internal medicine physicians were quick to note their limitations in this context. As one participant noted, "internal medicine is the management of chronic disease, there is not much internal medicine can do in a one day clinic at a MEDRETE."[490] However, internists did discover the value of draining and injecting arthritic joints.[491] Surgeons were found to be extremely valuable for cleft lip and palate repairs, amputations, and draining abscesses.[492] Pediatricians felt great satisfaction and saw huge impact with deworming campaigns, and dentists had a significant impact on oral health by way of tooth extraction.[493] Optometrists have also had considerable success distributing perscription glasses. Although medicine was limited in the field, physicians were

---

[487] Mitchell, "The Medic as an Instrument of National Policy or What in the World Is the Department of Defense Doing in Medical Humanitarian Assistance? "

[488] Participant 3, interview by Sheena M. Eagan Chamberlin, October 5, 2012, transcript.

[489] James A. Taylor, "Military Medicine's Expanding Role in Low-Intensity Coflict," *Military Medicine* April(1985).

[490] Participant 10, interview by Sheena M. Eagan Chamberlin, January 30, 2013, interview notes.

[491] Participant 9, interview by Sheena M. Eagan Chamberlin, January 27, 2013, transcript: Participant 10, interview by Sheena M. Eagan Chamberlin, January 30, 2013, interview notes.

[492] Participant 9, interview by Sheena M. Eagan Chamberlin, January 27, 2013, transcript.

[493] Participant 9, interview by Sheena M. Eagan Chamberlin, January 27, 2013, transcript: Participant 10, interview by Sheena M. Eagan Chamberlin, January 30, 2013, interview notes.

able to find avenues by which to make a therapeutic difference. Many MEDRETE participants found their experience rewarding, remembering these benefits and the appreciation of the patients.[494]

A Call for Reform

Although there were many benefits to the MEDRETE and some participants had positive experiences, others still called for increased reform of civilian medical assistance programs. Physician participants and commentators were beginning to call for programs that, unlike the traditional MEDCAP, prioritized medical goals and sustained long-term benefits.[495] Other commentators called for more drastic reform of medical civilian assistance. Regina Gaillard is critical of the historical link between civic action and counterinsurgency, as well as low intensity conflict.[496] She argues that the linkage of a strategic and humanitarian mission has tainted the idealist qualities of the concept causing these programs to be counterproductive in achieving the US military's goals.

Gaillard argues that a reorientation effort should attempt to delink civic action programs and humanitarian and civic assistance activities from counterinsurgency and low intensity conflict (LIC).[497] Gaillard was essentially calling for a prioritization of medical goals over military goals. Contemporary

---

[494] Participant 5, interview by Sheena M. Eagan Chamberlin, October 11, 2012, transcript: Participant 6, interview by Sheena M. Eagan Chamberlin, October 24, 2012, transcript: Participant 9, interview by Sheena M. Eagan Chamberlin, January 27, 2013, transcript: Participant 10, interview by Sheena M. Eagan Chamberlin, January 30, 2013, interview notes.

[495] Taylor, "Military Medicine's Expanding Role in Low-Intensity Coflict."

[496] Regina Gaillard, "Civic Action Versus Counterinsurgency and Low Intensity Conflict in Latin American: The Case for Delinkage" (US Army War College, 1990), 1.

[497] Ibid, 1.

programs show that Gaillard's desired delinking of civic action and counterinsurgency of LIC has not been accomplished. Physician experience tells that MEDCAPs in Afghanistan and Iraq are aligned with the PSYOPs goals of counterinsurgency and LIC.[498] Cramblet has similar critiques and calls for a necessary distinction between war and low-intensity conflict. Programs developed during times of conflict, such as MEDCAPs, cannot simply be transplanted into peacetime or low-intensity conflict operations.[499] Cramblet selects six medical imperatives from cited doctrine that should inform future medical civic action programs in low-intensity conflict. These medical imperatives are as follows: integration, legitimacy, continuity, responsiveness, medical intelligence and simplicity.[500] Importantly, although Cramblet identifies these imperatives as medical, they emphasize and, in fact, prioritize military goals and strategy. The imperative "Integration" is explained as medical commanders both understanding and integrating their efforts with the principles of war and other elements of national power.[501] According to Cramblet, this is important and necessary to ensure the accomplishment of the military mission while ensuring that "well meaning and innovative medical personnel will be making a contribution to the overall effort..."[502] Similar to the MEDCAPs of Vietnam, Cramblet recognizes the importance of gathering medical intelligence through medical civic action in order to protect troops from disease and know the vulnerabilities of both friendly and enemy

---

[498] Participant 8, interview by Sheena M. Eagan Chamberlin, January 31, 2013, interview notes and transcript.
[499] Cramblet, "U.S. Medical Imperatives for Low Intensity Conflict," 1.
[500] Ibid, 4-5.
[501] Ibid.
[502] Ibid, 6.

forces.[503] Cramblet also highlights other noteworthy aspects of a successful MEDRETE such as sustainability, which includes the successful hand off of programs to locals and simplicity necessary for program continuation in devellopping nations.[504]

MILITARY DOCTRINE:

A significant issue for the MEDRETE program, which had also plagued the MEDCAP missions that preceded them, was a lack of military doctrine that specifically instructed participants in how to act in these environments. This lack of military doctrine was recognized by many commentators.[505] As Gonzalez wrote, "At present and in the past, even though medicine has been extensively used, there has never been a doctrine for its proper utilization in Latin America."[506] The lack of doctrine on the topic is problematic because of the foundational role that it plays within the military institution. Military doctrine is essential in shaping the behaviour of soldiers and dictating their proper conduct. Thus, a lack of doctrine leaves participants in these programs without guidance.

These types of missions are authorized under Title 10, US Code. Section 401. Programs established under this statute are intended as opportunities for training. As mentioned in the last chapter, a secondary goal is non-threatening engagement with a foreign nation. It is crucial to note that humanitarian goals are not mentioned.

---

[503] Ibid, 13-14.
[504] Ibid, 15-16.
[505] Taylor, "Health Care as an Instrument of Foreign Policy (a Proposed Exapnded Role for the Army Medical Department)."; Gonzalez, "United States Military Medicine's Role in Low-Intensity Conflict in Latin America."
[506] Gonzalez, "United States Military Medicine's Role in Low-Intensity Conflict in Latin America," 12.

Medical care is not the purpose of these programs; the main purpose is training, while medical care is specifically ancillary. In a way this serves to distinguish military programs from other military, as well as non-military humanitarian programs. Funding has continued for these programs that is specifically earmarked for military training, rather than humanitarian assistance, stabilization, or foreign development. The clear emphasis placed on training can be understood a number of ways. Firstly, it can be understood as protecting the program and rationalizing it within the military budget, allowing physicians to provide at least some care to patients in need. In fact, many physicians believe in the care that MEDRETEs provide, and find it rewarding as both a training and humanitarian mission. Another way to understand the prioritization of training is that the military is being honest about its intentions. As opposed to the Vietnam-era MEDCAPs, which sometimes involved dishonesty and deception, this program presents itself as a training operation with ancillary benefit to host-nation patients.

FM 27-5 addressed public health, sanitation and preventive medicine initiatives but did not address direct patient contact programs such as MEDCAPs or MEDRETEs.[507] FM100-20-, "Military Operations in Low Intensity Conflict," provides vague and uninstructive information regarding these missions, with no mention of the medical mission. At this time, LIC was a catchall term with little distinct doctrine.[508] Joint Publication 3-07.6, "Doctrine for Military Operations Other Than War" (MOOTW), provides additional guidance, stating that the first priority of

[507] "Field Manual 27-5: United States Army and Navy Manual of Civil Affairs Military Government," ed. War Department (Washington, DC: 1947).

[508] "Field Manual 100-20: Military Operation in Low Intensity Conflict," ed. Department of the Army and the Air Force (Washington, DC: 1990).

military medicine is to US troops. However, "when planning for MOOTW, the potential to treat HN [host nation] population of allied military personnel must be considered."[509] Authorized care to foreign civilians should be within resource limitations and should urge continued coordination between the medical and intelligence elements.[510] In fact, this publication recognizes medical operations in MOOTW as a "valuable intelligence source."[511] Joint Publication 4-02, *Doctrine for Health Service Support in Joint Operations,* reiterates that no operation should supplant or compete with the existing local medical infrastructure.[512] This piece of doctrine recognizes the necessity of not creating redundant healthcare systems that simply duplicate local services. History has shown that competing or duplicating local services undermines the local economy, creates hostile relations with the local medical community and thus can be a disservice to the healthcare of the local community and the mission.

Taken together these doctrines provide little in the way of helpful guidance for military physicians participating in these missions. However, the doctrine does clearly establish these missions as of strategic intent: aimed at training and engagement. In this way, the doctrine clearly established a political mission for these humanitarian programs. Thus, the doctrine is straightforward in its use of medicine as a 'non lethal weapon' or tool, employed toward military ends. However,

---

509 "Joint Doctrine for Military Operations Other Than War," ed. Department of Defense (Washington, DC: Joint Chiefs of Staff, 1995), IV-11.

510 Ibid, IV-11.

511 Ibid, IV-11.

512 "Joint Publication 4-02: Doctrine for Health Services Support in Joint Operations," ed. Department of Defense (Washington, DC: Chiefs of Staff, 1995).

beyond the basic programmatic intent and goals of medical civilian assistance, this doctrine provides little guidance for soldiers engaged in this work.

MEDICAL RULES OF ENGAGEMENT- "LIFE, LIMB OR EYESIGHT"

Aside from military directives and instructions there are other rules that could inform, and thus help to shape, the conduct of officers while on medical civilian assistance missions. Many of the participants who shared oral histories identified the medical rules of engagement as the way by which they often balance their twin roles as a physician and a soldier.[513] These rules of engagement represent another form of military doctrine that provide guidance and informs the actions as well as the medical and strategic decision-making of the military physician.

Medical Rules of Engagement (MROE) are used to outline the current military restrictions on whom physicians can and cannot treat, for strategic reasons.[514] The name draws an analogy with the military "Rules of Engagement" (ROE) that determine the limitations and dictate the appropriate situations when soldier can respond with his or her weapon. The restrictions are dictated by command for strategic and political purposes. Similarly, medical rules of engagement are meant to determine when and how medical personnel can respond with their medical skills and technology. For instance, while the Geneva conventions require the treatment of enemy combatant personnel, foreign civilian populations are not always treated within the combat zone due to scarcity of resources or security concerns. That being

[513] Participant 2, interview by Sheena M. Eagan Chamberlin, October 1, 2012, interview notes: Participant 4, interview by Sheena M. Eagan Chamberlin, October 10, 2012, transcript: Participant 7, interview by Sheena M. Eagan Chamberlin, January 27, 2013, transcript.

[514] Gary L. Sadlon, "Army Medical Department Leaders in Military Operations Other Than War," (Carlisle Barracks, PA: U.S. Army War College, 2000).

said, injuries concerning "life, limb or eyesight" are understood to be a deciding and over-riding factor.[515] If a patient presents with an injury that threatens their life, limb or vision, physicians are allowed to treat them, regardless of other factors. Unfortunately, although physicians use MROE as their litmus test for providing civilian care, "life, limb or eyesight" does not make treatment mandatory or expected. Tensions are still reported between physicians and commanding officers over whether or not to treat injured and diseased civilians presenting during times of hostilities and scare resources.[516]

Medical rules of engagement provide another example, and more substantive evidence, to the life of the military physician as simultaneously existing in two professional roles: the soldier-with rules of engagement and the doctor-with patient obligations. The balance necessary for this kind of medical assistance mission is exemplified in the concept of "integration" drawn from doctrine and put forth by LtCOL Peter Cramblet in his US Army War College paper entitled, "U.S. Medical Imperatives for Low Intensity Conflict." Drawing on experiences in Honduras, LtCOL Cramblet holds that

> Medical commanders must understand the first principal of war, objective, and integrate their efforts with other elements of national power to ensure accomplishment… well meaning commanders with sometimes bored, medical staff assume implied medical missions which do not always support LIC objectives.[517]

---

[515] Participant 4, interview by Sheena M. Eagan Chamberlin, October 10, 2012, transcript.
[516] Ibid.
[517] Peter B. Cramblet, "U.S. Medical Imperatives for Low Intensity Conflict," (Carlisle Barracks, PA: U.S. Army War College, 1991), 5.

Cramblet highlights that the balance expected of military physicians is understood by the military to prioritize the mission. Institutional messages are mixed when they are treated like physicians, asked to practice medicine and yet expected to fulfill obligations to their role as a soldier. They are expected to do more than just doctor, and this balance can be delicate to maintain. However, the blame should not fall solely on the shoulders of the physician. Cramblet blamed a lack of clear mission statements in LIC environments. The themes of ambiguous mission statements, lack of doctrine and unclear directives are prevalent throughout the history of these programs.

Beyond the lack of doctrine, participants in these programs also receive little or no training prior to their involvement. A recent study showed that a quarter of the polled participants received no training for their humanitarian assistance missions.[518] Of those that received training, it was primarily on the job and in the field training. There was no formal, pre-deployment training.[519] This lack of training was found to have a negative impact on the effectiveness of the mission.[520] It also may explain why physicians are unaware of the strategic goals of these missions, expecting them to be solely humanitarian missions without strategic intent.

In looking at primary source materials, the goals may seem apparent. However, many oral histories confirm that those involved in these programs were

---

[518] Jeffrey E. Driftmeyer and Craig H. Llewellyn, "U.S. Participants Perspectives on Military Medical Humanitarian Assistance," ed. Special Operations and Low Intensity Conflict Office of the Assistane Secretary of Defence, Measures of Effectiveness (Bethesda, MD: Center for Disaster and Humanitarian Assistance Medicine).

[519] Ibid.

[520] Ibid.

not always aware of the strategic aim of these programs. The ambiguous nature of the programmatic goals, and their lack of dissemination made it difficult for physicians to understand and achieve success. While command sought strategic achievement, physicians aimed for medical and humanitarian triumph. The two goals had different and sometimes conflicting methods and end-points.[521] According to Robert Wilensky, the MEDCAP program was based upon both the "altruistic inclinations of their participants and the policy aims of the U.S. Government." [522] The distinction between the aims and inclinations of those people with "boots on the ground" and those developing the policy resulted in unmet expectations, confusion over roles and responsibilities, successes, end-points and inappropriate policy implementation. This uncertainty and confusion only caused more frustration for the military medical professional.

The strategic intent of the doctrine that dictates these programs is undeniable. That being said the participants' motivations for involvement were often remarkably different. Anecdotal evidence, oral histories and a recent study by the Center for Disaster and Humanitarian Assistance Medicine CDHAM have showed that physicians are motivated by altruism and actively seek out these programs. The study included all branches, active duty and reserves from various duty positions. It showed that nearly half of the physicians surveyed indicated that humanitarian

[521] Malsby III, "Into Which End Does the Thermometer Go? Application of Military Medicine in Counterinsurgency: Does Direct Patient Care by American Service Members Work?" 122.
[522] Wilensky, *Military Medicine to Win Hearts and Minds: Aid to Civilians in the Vietnam War*, 3.

missions were a factor in their decision to join the military.[523] These numbers allow us to understand the values of the physicians participating in medical civilian assistance missions, and understand how physician participants may differ from the command in reference to the goals of the program. These missions appeal to a humanitarian urge rather than a strategic one. Although many military physicians may also agree with larger military goals, this study highlights the crucial role that humanitarian and altruistic values play in shaping the identity and choices of the military physician. Regardless of their views on strategic goals, military physicians place a high value on the possibility of participating in humanitarian missions as part of their military duties. "Many applicants to the USUHS... 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."[524] Their identity as military physicians is thusly shaped by this beneficent drive, to provide medical care in a capacity they thought civilian life could not offer. The significance for the Army is also apparent. These programs are a key contributing factor to physician career planning. These missions also play a vital role in retention and recruitment. The same CDHAM study showed that 60% of respondents reported that humanitarian assistance missions were influential in their decision to stay in the military.[525] Due to the importance of these programs to military providers, their experience within these missions deserves closer attention.

---

[523] Jeffrey E. Driftmeyer and Craig H. Llewellyn, "Humanitarian Service: Recruitment & Retention Effects among Uniformed Services Medical Personnel," in *Measures of Effectiveness* (Bethesda, MD: Center for Disaster and Humanitarian Assistance Medicin, 2002).

[524] Ibid, 3.

[525] Ibid.

The significance of humanitarian missions in physician decision-making provides insight into the morally complicated space of the historical medical civilian assistance model. Medical civilian assistance programs have historically been a well-intentioned, misdirected and frustrating experience for physicians. While they expected a humanitarian operation of beneficent medical care, they were faced with the reality of a military operation with secondary medical goals.

Physician-soldiers are not exempt from the horror and realities of war. While MEDCAPs and MEDRETEs do not involve the trauma of IEDs and mass casualties, one must not discount the psychological impact of providing care in dangerous places, and the disappointment, frustration and impotence felt providing care felt to be inadequate. Within the setting of the MEDCAP or MEDRETE, a physician is the agent of a program with goals that represent his twin-roles. Physicians of contemporary western medicine are used to the comforts of the hospital. They are accustomed to diagnostic tests, support staff, specialist consults, patient follow-up and well-stocked pharmacies. These missions challenge physicians. They are forced to see patients with chronic diseases that would be curable, or at least manageable, stateside but for which a MEDCAP or MEDRETE can do nothing. Instead, providers are confronted with the realities of these missions.

> Although such activities collect large numbers of villagers, the procedure appears to confirm the peasant's belief in magic merely with the statement that Western magic is more powerful than local magic. Such a procedure may win an election, but in the long

> run it is truly dangerous and represents an inexcusable prostitution of medical facilities.[526]

The feeling of provider impotence frustrates them as they dispense multi-vitamins, aspirin, ibuprofen or a few days' course of antibiotics. This frustration is palpable in the way providers joke with each other to alleviate the tension; as one participant shared, his team would often say "All we have done here today is maybe given a couple of people ulcers from taking too much ibuprofen."[527] This type of frustration has led other participants to see this work to be, "of limited value medically, it is an outstanding tool for propaganda."[528] CPT John Irving described one Medical Civic Action Program as a "military maneuver," rather than a humanitarian mission.[529] The moral complexity does not appear to lie with the use of medicine as a strategic tool. Rather, what lies at the heart of provider complaints is the prioritization of strategy above all else. This reality becomes apparent in the fact that when medical goals are emphasized, and medical good is achieved, physicians find these experiences rewarding and positive. However, when these military physicians are morally challenged by an order to provide medical care that they believe to be inadequate they often feel conflicted. This problem is one of dual loyalty.

---

[526] Malsby III, "Into Which End Does the Thermometer Go? Application of Military Medicine in Counterinsurgency: Does Direct Patient Care by American Service Members Work?" 66-67.
[527] Participant 8, interview by Sheena M. Eagan Chamberlin, January 31, 2013, transcript.
[528] Wilensky, *Military Medicine to Win Hearts and Minds: Aid to Civilians in the Vietnam War*, 87.
[529] Ibid, 86.

Conclusions, Solutions & Future Research

A recent 2000 RAND study reported that 59 percent of Americans support international assistance.[530] This percentage represents the highest level of support for international assistance programs since attitudes were first tracked in 1974. At the same time, US policies have been shifting towards the prioritization of international assistance. Stability operations are now understood to be as important as combat operations to American national security policy.[531] As part of these stability operations, humanitarian assistance activities such as medical civic action and civilian assistance programs have been widely recognized as a popular, effective and inexpensive means of furthering military objectives in military operations other than war. However, the use of medicine as a non-lethal weapon creates a morally complicated space for the military physician. The military physician works within two larger professions and institutions, that of the military and medicine. These programs combine the goals of both of these institutions into a single program and ask military doctors to balance their professional moral obligations. As members of two professions with internal moralities, this can be extremely complicated and yet the military provides no training and little doctrine to guide the behaviour of the participating soldier-physician.

This dissertation has traced the history of these programs in order to shed light on the real experiences of physicians who have participated in these programs. Their experiences allow for better understanding of these programs and deeper

---

[530] Judy Mann, "Making the World Better with Us Money," *Washington Post*, April 5 2000.
[531] Stanley, "Number 6000.16 Military Health Support for Stability Operations."

reflection on the morally complicated space that these programs create by institutionalizing the problem of dual loyalty. The dissertation has also explored the true intent of these programs, highlighting their overwhelmingly strategic focus. This discussion underscores the need for training that prepares physicians for the realities of their work since many enter this work with a humanitarian mentality. History also shows us that by prioritizing strategic concerns medical goals can be subverted.[532] The subversion of medical goals often leads to a great deal of discontent on the part of not only the physician but also the host-government and the patients.[533]

Programs such as MEDCAPs represent examples of the problem of dual loyalties on a macro level and help us to understand the ethical dilemmas within a wider context. Currently within the realm of medical ethics and philosophy, this debate needs to be attended to by a broader audience. As this dissertation has shown, the discussion surrounding the problem of dual loyalties in particular and military medical ethics in general can and should be enriched by further interdisciplinary humanistic research.

POSSIBLE SOLUTIONS:

Having identified issues related to the problem of dual loyalties, and the morally complicated experiences of the physician soldier it is crucial to discuss

---

[532] Klefhammer, "From: Officer in Charge, Seal Team One Det Golf November Platoon, To : Officer in Charge, Relieving Platcon, Via: Execwtive Officer, Seal Team One, Subj: Dong Tam Seal Detachment; Relief Of."

[533] Wilensky, *Military Medicine to Win Hearts and Minds: Aid to Civilians in the Vietnam War*; Weisser, "The Maturing of Medretes," 573.

possible solutions and the need for further research. There are shortcomings that if addressed would be of considerable benefit to the military physician.

A lack of military doctrine and training has been noted across historical time periods and medical civilian assistance programs. Despite the fact that doctrine is foundational to shaping the behaviour of military personnel, little has been written to guide the military physician. This population both lacks doctrine that explains how to balance their twin-roles as a physician-soldier and specific doctrine that shapes their behavior on medical civilian assistance missions. The lack of doctrine only contributes to the problem of dual loyalty. While much has been written about the proper conduct of physicians in practice and the obligations inherent to the role of a doctor in specific situations, little has been written about the specific obligations of military medical officers. This paucity of information leaves military physicians with little information on which to base the delicate balancing act of their twin roles. Military physicians and ethicists should be involved in the development of this doctrine to insure that it is adequately and thoughtfully addresses the complications of military medicine.

However, this doctrine must also be coupled with increased training opportunities. This population lacks training that teaches them how to deal with the unique complexities of being a physician soldier. Military physicians also lack specific training for medical missions. Most participants do not receive any formal training prior to their involvement with civilian medical assistance missions. In a recent study, 11/50 participants did not receive any training for their

deployment.[534] While this does appear to indicate that 39/50 participants did receive training, those who did report receiving training characterized it as "on the job training" meaning that no formal training was received by any participants.[535] Importantly, "on the job training" was also never defined. Without proper pre-deployment training, many physician participants do not know what to expect when they deploy as part of these military/medical missions. Thus, the lack of training has only contributed to the problem of dual loyalty and the moral confusion as physicians arrive unprepared for the realities of the mission. Training would allow physicians to understand the mission prior to deployment and give them time to reflect of the moral issues and dilemmas prior to arrival in the field.

One participant engaged in his own version of training.[536] This participant took the time to read journal articles written by other physician participants prior to this own engagement with a MEDRETE.[537] Reading their experiences and reflections allowed him to understand more about his own work and his own mission. He also became aware of the Howard Levy case (discussed earlier), and took the time to think about his own feelings on the use of medicine by the military. This participant felt that by taking the time to think through these issues prior to arrival in Honduras he was better prepared for the experience. He felt more

[534] Driftmeyer, "U.S. Participants Perspectives on Military Medical Humanitarian Assistance."
[535] Ibid.
[536] Participant 3, interview by Sheena M. Eagan Chamberlin, October 1, 2012, transcript.
[537] Ibid.

reflective and was able to see both the shortcomings and the benefits of the work that he was doing.[538]

Training would also provide physicians with an opportunity to be involved with the mission at an earlier stage and voice their concerns and opinions during planning. Historically, the programs that have seen the most success in the eyes of the physician participants have been those that were actively planned by physicians. These programs are often perceived as providing better medical care to the locals, better training for the physicians, as well as opportunities for bonding within the medical team and a superior experience for those involved. Thus, another way that these programs could be improved would be to have more physicians involved at earlier levels of planning. This has already begun with the MEDRETE. As a program geared toward medical education, physicians and physician educators are intimately involved in program development and planning. However, MEDCAPs are still being conducted in conflict zones. The stories from participants of recent MEDCAPs in Iraq and Afghanistan retell the same frustrations as those in Vietnam.[539] They often feel as though little good medicine is being done. The few exceptions are those programs where physicians take the reigns and help to organize the medical care that will be provided. In these cases, physicians focus on the kind of care that can make a difference in a short period of time (de-worming, draining abscesses, treating infectious diseases, public health education and immunizations etc). Allowing

---

[538] Ibid.

[539] Participant 8, interview by Sheena M. Eagan Chamberlin, January 31, 2013, interview notes and transcript.

physicians to be involved in a planning capacity would help to realign the priorities of these programs, permitting medical goals to be emphasized. Ultimately, if medical goals are emphasized this will go a long way in reducing the tension placed on military physicians balancing their dual-roles.

FUTURE RESEARCH

This dissertation has attempted to enrich the dual-loyalties debate in two ways: 1) grounding the debate by introducing the concepts of internal professional morality and 2) providing a program-level example of this issue (the case of medical civilian assistance programs). However, more research needs to be done. Military medicine is becoming more and more complicated, and military physicians are not being given the tools with which to navigate this morally complicated space. Beyond that, medical civilian assistance programs represent a type of military medical engagement that will be increasing in prevalence and effecting an increasing number of physicians. Security policy is shifting towards stability operations, which often prioritizes medical operations making Humanitarian and civic assistance an important part of the military mission. According to Department of Defense (DOD) Instruction 3000.05 Military stability operations (MSOs) are a "core U.S. military mission… given priority comparable to combat operations…"[540] Since national policy has emphasized and prioritized these types of missions within the American armed forces, research and critical analysis of these programs must also be emphasized and prioritized. Health care and western medicine have been identified as a powerful tool for diplomacy and strategy enabling US forces to bring security

[540] Stanley, "Number 6000.16 Military Health Support for Stability Operations."

and stability to populations and nations that currently lack western medical knowledge, medical infrastructure and health care.[541] In light of this, it is imperative to learn from the history of medical civilian assistance and critically reflect on the experience of those who have participated in these programs. Many physicians were frustrated by their work, describing it as, "the medical discipline being prostituted for a less worthy purpose."[542]

Now that these programs are being prioritized at the same level as combat missions, these programs must be studied and analyzed at a similar level. Military study has long focused on combat as key to the formation of institutional knowledge and crucial to increasing military mission success. While medical stability operations are gaining importance, there has been little critical analysis of these programs. Despite its emphasis on these programs, there is little institutional memory and sparse record keeping when it comes to key medical civic assistance programs such as medical civic action programs (MEDCAPs) or Medical Readiness training exercises (MEDRETES) within the U.S. military.[543] This dissertation focused on the perspective and experience of military physicians since these programs represent a uniquely complicated setting for the military doctor. However, further analysis should broaden the scope of analysis to include nurses, medics, corpsman and other participants. Further study should also critically evaluate the successes and failures of these missions, their effect on local populations and on military

---

[541] VADM Richard H. Carmona MD, MPH 10 November 2004 (Caroma cited in Krueger, "Medical Diplomacy in the United States Army: A Concept Whose Time Has Come".

[542] Wilensky, *Military Medicine to Win Hearts and Minds: Aid to Civilians in the Vietnam War*, 90.

[543] Reaves, "Implementation of Evidence-Based Humanitarian Programs in Military-Led Mission: Part I. Qualitative Gap Analysis of Current Military and International Aid Programs."

strategic goals. Some have begun this work. At the Naval Medical Research Center, Unit-6 in Lima Peru, researchers are studying the health benefits of the MEDRETE program.[544] In recent years, CDHAM has also published a number of studies examining military humanitarian missions.[545] That being said, more study is needed. Beyond that, study of these programs cannot be limited to the military sphere. Both civilian and military researchers should endeavour to explore and analyze these issues to insure critical reflection from all possible perspectives and points of view.

[544] Andrés G. Lescano, *Personal Communication with Author* (Lima, Peru 2012).

[545] Driftmeyer, "Overview of Overseas Humanitarian Assistance, Humanitarian and Civic Assistance and Excess Propery Programs."; ———, "Information Management for More Effective Military Humanitarian Assistance Projects & Programs."; ———, "Humanitarian Service: Recruitment & Retention Effects among Uniformed Services Medical Personnel."

Appendix A: Translated Documents- Psychological Operations in Vietnam

DEPARTMENT OF THE ARMY
10TH PSYCHOLOGICAL OPERATIONS BATTALION
APO San Francisco 96215

Leaflet #: 10-363-68
Date: 21 June 68
Title: MEDCAP medicine envelopes
Theme: GVN provides medical care
Target: Population of any hamlet where a MEDCAP is held
Size: 5¼ x 7½
Distribution: Hand
Requested by: Major Van Valkenburg
Number of runs: 50,000
Remarks:

TRANSLATION
(Front)

Name of Medicine_____

Take ___ tablets of this medicine ___ times every day.

1) Drink a lot of water.
2) Prevent children from taking this medicine by mistake.

Go Cong MEDCAP

Down with the Viet Cong's policy to exploit the people and make them poor.

TRANSLATION
(Back contains job #)

The Viet Cong kill the people and steal their rice while the GVN looks after the people and provides medicine for them.

CHÍNH PHỦ VIỆT-NAM CỘNG-HÒA
LUÔN LUÔN SĂN SÓC ĐẾN SỨC KHỎE
ĐỒNG BÀO BẰNG CÔNG TÁC Y-TẾ.

ĐOÀN Y-TẾ HẢI QUÂN VIỆT MỸ LUÔN
LUÔN GIÚP ĐỠ ĐỒNG BÀO KHI BỊ BỊNH

10-007-69

Tên Thuốc _____

Uống thuốc mỗi ngày _____ lần,
mỗi lần _____ viên.

1) UỐNG THUỐC THẬT NHIỀU NƯỚC.
2) ĐỂ PHÒNG ĐỪNG ĐỂ TRẺ EM LẤY THUỐC.

Chương trình Quân-Y-Dân-Sự-Vụ Hải-Quân Việt-Mỹ

CHÍNH PHỦ VIỆT-NAM CỘNG-HÒA
LUÔN LUÔN SĂN SÓC ĐẾN SỨC KHỎE
ĐỒNG BÀO BẰNG CÔNG TÁC Y-TẾ.

ĐOÀN Y-TẾ HẢI QUÂN VIỆT MỸ LUÔN
LUÔN GIÚP ĐỠ ĐỒNG BÀO KHI BỊ BỊNH

10-007-69

Tên Thuốc _____

Uống thuốc mỗi ngày _____ lần,
mỗi lần _____ viên.

1) UỐNG THUỐC THẬT NHIỀU NƯỚC.
2) ĐỂ PHÒNG ĐỪNG ĐỂ TRẺ EM LẤY THUỐC.

Chương trình Quân-Y-Dân-Sự-Vụ Hải-Quân Việt-Mỹ

VIỆT-CỘNG GIẾT HẠI VÀ CƯỚP
ĐOẠT LÚA GẠO CỦA DÂN TRONG
KHI CHÍNH-QUYỀN VIỆT NAM
CỘNG HÒA SĂN SÓC VÀ CUNG
CẤP THUỐC MEN CHO DÂN

10-363-68

Tên Thuốc _____

Uống thuốc mỗi ngày _____ lần,
mỗi lần _____ viên.

1) XIN UỐNG THUỐC THẬT NHIỀU NƯỚC
2) ĐỀ PHÒNG TRẺ EM LẤY NHẦM THUỐC

CHƯƠNG TRÌNH QUÂN Y DÂN VỤ GÒ-CÔNG

Đã đảo chính sách bóc lột, bần cùng hóa nhân dân của Việt.Cộng.

VIỆT-CỘNG GIẾT HẠI VÀ CƯỚP
ĐOẠT LÚA GẠO CỦA DÂN TRONG
KHI CHÍNH-QUYỀN VIỆT NAM
CỘNG HÒA SĂN SÓC VÀ CUNG
CẤP THUỐC MEN CHO DÂN

10-363-68

Tên Thuốc _____

Uống thuốc mỗi ngày _____ lần,
mỗi lần _____ viên.

1) XIN UỐNG THUỐC THẬT NHIỀU NƯỚC
2) ĐỀ PHÒNG TRẺ EM LẤY NHẦM THUỐC

CHƯƠNG TRÌNH QUÂN Y DÂN VỤ GÒ-CÔNG

Đã đảo chính sách bóc lột, bần cùng hóa nhân dân của Việt.Cộng.

DEPARTMENT OF THE ARMY
10TH PSYCHOLOGICAL OPERATIONS BATTALION
APO San Francisco 96215

AVGM-10PDC

Leaflet #: 10-007-69
Date: 8 July 68
Title: GVN Provides Medical Care
Theme: GVN and MEDCAP Help Care for the People
Target: Population of Any Hamlet Where Navy MEDCAP is Held
Size: 5½ x 7½
Distribution: Hand
Requested By: 4th Riverine Area PSYOP Advisor
Number of Runs: 100,000
Remarks:

TRANSLATION
(Front)

NAME OF MEDICINE_____
Take ___ tablets of this medicine ___ times a day.
1) DRINK A LOT OF WATER.
2) PREVENT CHILDREN FROM TAKING THIS MEDICINE BY MISTAKE.

VIETNAMESE AND AMERICAN NAVY MEDCAP

TRANSLATION
(Back contains Job #)

The Government of Vietnam is looking after the people's health by providing them medical care. The Vietnamese and American Navy Medical teams are constantly striving to help the people.

10th PSYOP BN FL6
(20 JUN 68)

TÌNH QUÂN DÂN CÁ NƯỚC BẤT DIỆT

MỘT ĐOÀN Y-TẾ ĐƯỢC BIỆT PHÁI ĐẾN SĂN SÓC SỨC KHỎE CHO ĐỒNG-BÀO, VÀ THÂN BẰNG QUYẾN-THUỘC

ĐOÀN Y-TẾ NÀY VỀ ĐÂY THEO SỰ CHỈ ĐỊNH CỦA CHÁNH-PHỦ VIỆT-NAM CỘNG-HÒA ĐỂ KHÁM BỊNH, PHÁT THUỐC, GIÚP ĐỒNG BÀO THOÁT KHỎI TẬT BỆNH VÀ ĐIỀU TRỊ CÁC NỘI NGOẠI THƯƠNG

TÌNH QUÂN DÂN CÁ NƯỚC BẤT DIỆT

MỘT ĐOÀN Y-TẾ ĐƯỢC BIỆT PHÁI ĐẾN SĂN SÓC SỨC KHỎE CHO ĐỒNG-BÀO, VÀ THÂN BẰNG QUYẾN-THUỘC

ĐOÀN Y-TẾ NÀY VỀ ĐÂY THEO SỰ CHỈ ĐỊNH CỦA CHÁNH-PHỦ VIỆT-NAM CỘNG-HÒA ĐỂ KHÁM BỊNH, PHÁT THUỐC, GIÚP ĐỒNG BÀO THOÁT KHỎI TẬT BỆNH VÀ ĐIỀU TRỊ CÁC NỘI NGOẠI THƯƠNG

ĐOÀN Y-TẾ PHẢI ĐƯỢC BẢO VỆ ĐỂ HỌ PHỤC VỤ ĐỒNG-BÀO MỘT CÁCH HỮU HIỆU. NHƯNG BỌN VIỆT-CỘNG LẠI MUỐN PHÁ HOẠI VÀ TẤN CÔNG ĐOÀN Y-TẾ VÌ BỌN CHÚNG KHÔNG MUỐN HỌ GIÚP ĐỠ ĐỒNG-BÀO. DO ĐÓ, CÁC BÌNH SĨ THUỘC SƯ ĐOÀN 9 BỘ BỊNH VIỆT-NAM ĐƯỢC GỌI ĐẾN ĐÂY ĐỂ BẢO VỆ ĐOÀN Y-TẾ CHỐNG LẠI BỌN VIỆT-CỘNG.

ĐỒNG-BÀO HÃY TÍCH-CỰC GIÚP ĐỠ BÌNH SĨ BẢO VỆ ĐOÀN Y-TẾ BẰNG CÁCH BÁO CHO HỌ BIẾT RÕ NƠI TRÚ ẨN CỦA BỌN VIỆT-CỘNG NẰM VÙNG ĐỊNH PHÁ HOẠI CHƯƠNG TRÌNH CỐ TÌNH CÁCH NHÂN-ĐẠO CỦA CHÍNH-PHỦ VIỆT-NAM CỘNG-HÒA.

10–338–68

ĐOÀN Y-TẾ PHẢI ĐƯỢC BẢO VỆ ĐỂ HỌ PHỤC VỤ ĐỒNG-BÀO MỘT CÁCH HỮU HIỆU. NHƯNG BỌN VIỆT-CỘNG LẠI MUỐN PHÁ HOẠI VÀ TẤN CÔNG ĐOÀN Y-TẾ VÌ BỌN CHÚNG KHÔNG MUỐN HỌ GIÚP ĐỠ ĐỒNG-BÀO. DO ĐÓ, CÁC BÌNH SĨ THUỘC SƯ ĐOÀN 9 BỘ BỊNH VIỆT-NAM ĐƯỢC GỌI ĐẾN ĐÂY ĐỂ BẢO VỆ ĐOÀN Y-TẾ CHỐNG LẠI BỌN VIỆT-CỘNG.

ĐỒNG-BÀO HÃY TÍCH-CỰC GIÚP ĐỠ BÌNH SĨ BẢO VỆ ĐOÀN Y-TẾ BẰNG CÁCH BÁO CHO HỌ BIẾT RÕ NƠI TRÚ ẨN CỦA BỌN VIỆT-CỘNG NẰM VÙNG ĐỊNH PHÁ HOẠI CHƯƠNG TRÌNH CỐ TÌNH CÁCH NHÂN-ĐẠO CỦA CHÍNH-PHỦ VIỆT-NAM CỘNG-HÒA.

10–338–68

DEPARTMENT OF THE ARMY
10th PSYCHOLOGICAL OPERATIONS BATTALION
APO San Francisco 96215

Leaflet #: 10-338-68
Date: 12 June 68
Title: Explanation of US presence and MEDCAPS
Theme: What MEDCAP will do for the people
Target: Patients during MEDCAP, ARVN 9th DIV. Area
Size: 3¾ x 4½
Distribution: Hand
Requested By: Lt. Kaczmarskyj
Number of runs: 25,000
Remarks:

TRANSLATION
(Front)

THE FRIENDSHIP OF PEOPLE AND ARMY FOREVER

Illustration.

A medical team has been sent to your village to help you. Come with your family and friends if you are sick or injured. The medical team will help you get well. The medical team was sent here by the government of South Vietnam because the government of the Republic of Vietnam wants to help your family get rid of sickness and pain.

TRANSLATION
(Back contains Job #)

The medical team must be protected. The Viet Cong want to destroy the medical team because the Viet Cong do not want the government of South Vietnam to help the people. The soldiers of the ARVN 9th Division are here to protect the medical team so the medical team can help you. Please help us to protect the medical team. Please tell the soldiers where the Viet Cong hide themselves, their weapons and their food.

Bibliography

"92nd Congressional Record ". Washington, DC, 1971.

Ahearn, Arthur Mason. "Problems of Medical Rapport in Vietnam." *Military Medicine* 131, no. 11 (1966).

Alderman, Shawn and Igrham Crawford. "Medical Seminars: A New Paradigm for SOF Counterinsurgency Medical Programs." *Journal of Special Operations Medicine* 10, no. 1 (2010): 16-22.

Aller, Leon F. "Letters to the Editor: Medretes." *Military Medicine* 159, no. 1 (1994): A4.

Allhoff, Fritz. *Physicians at War: The Dual-Loyalties Challenge*. New York, NY: Springer, 2008.

Anderson, James E. "The Field Experience of a Medical Civic Action Team in South Vietnam." *Military Medicine* 129 (1964): 1052-1057.

Army, Department of the. "Field Manual 27-10." United States Army, 1956.

Army, United States. "Field Manual 1." Department of the Army, 2005.

"Army Values." Department of the Army, Accessed January 13, 2013. http://www.army.mil/values/.

Arras, John D. "A Method in Search of a Purpose: The Internal Morality of Medicine." *Journal of Medicine and Philosophy* 26, no. 6 (2001): 643-662.

Bahm, John J. *Military Assistance: A Tool of National Security and American Diplomacy*. Ann Arbor, MI: University Microfilms, 1967.

Beauchamp, Tom L. "Internal and External Standards of Medical Morality." *Journal of Medicine and Philosophy* 26, no. 6 (20001): 601-609.

Beauchamp, Tom L. and James F. Childress. *Principles of Biomedical Ethics*. New York, NY: Oxford University Press, 2009.

Benatar, Solomon R. and Ross E.G. Upshur. "Dual Loyalties of Physicians in the Military and in Civilian Life." *Public Health and the Military* 98, no. 12 (2008): 2161-2166.

Bollet, Alfred J. *Civil War Medicine: Challenges and Triumphs*. Tucson, AZ: Galen Press, 2002.

Brandt, Allan M. *No Magic Bullet: A Social History of Venereal Disease in the United States since 1880*. New York, NY: Oxford University Press, 1987.

Bruce, James W. "Exit Interview: Maj Philip Scozzaro." edited by Department of the Army. Washington, DC: 28th Military History Detachment, 11th Armored Cavalry Regiment, 1969.

Byerly, Carol R. *Fever of War: The Influenza Epidemic in the U.S. Army During World War I*. New York, NY: New York University Press, 2005.

Carney, Stephen A. *The Occupation of Mexico May 1846-July 1848*, The U.S. Army Campaigns of the Mexican War. Washington, DC: Government Printing Office, 2006.

Cirillo, Vincent. *Bullets and Bacilli: The Spanish-American War and Military Medicine*. New Brunsick, NJ: Rutgers University, 2004.

Claypool, Robert G. *Military Medicine as an Instrument of Power: An Overview and Assessment*. Carlisle Barracks, VA: U.S. Army War College, 1989.

"Code of Conduct." Accessed January 14, 2013. http://www.au.af.mil/au/awc/awcgate/awc-ethx.htm#codeofconduct.

Cogan, Morris. "Toward a Definition of Profession." *Harvard Educational Review* 23, no. Winter (1953): 48-49.

"Command History: Volume Ii 1967." edited by United States Military Assistance Command Vietnam. Saigon, Vietnam: Military History Branch, 1968.

Coppola, Francis Ford. "Apocalypse Now." 153 mins. USA, 1979.

Cowdrey, Albert E. *Fighting for Life: American Military Medicine in World War Ii*. New York, NY: Free Press, 1994.

———. *The Medic's War*. Washington, DC: US Government Printing Office, 1987.

Cramblet, Peter B. "U.S. Medical Imperatives for Low Intensity Conflict." Carlisle Barracks, PA: U.S. Army War College, 1991.

Cramblet, Peter B. . "U.S. Medical Imperatives for Low Intensity Conflict.", US Army War College, 1991.

Crutcher, J.M. and H.J. Beecham. "Short-Team Medical Field Missions in Developing Countries: A Practical Approach." *Military Medicine* 160 (1995): 339-343.

Davis, Michael. "Medicine as Profession: An Overlooked Approach to Medical Ethics." *Philosophy Study* 3, no. 1 (2013): 36-51.

De Forest, Henry P. "Benjamin Rush's Directions for Preserving the Health of Soldiers." *Military Surgeon* 22 (1908): 182-191.

DeBruin, Jerry. "A Message of Action to Representatives of the United States Government Relative to the Case of Eugene Henry Debruin." edited by U.S. Senate Selet Committee. Toledo, OH, 1992.

DeKoning, Bernard L. "Soto Cano Air Force Base, Honduras." *Life on the Line*: 10-11.

Driftmeyer, Jeffrey E. and Craig H. Llewellyn. "Humanitarian Service: Recruitment & Retention Effects among Uniformed Services Medical Personnel." In *Measures of Effectiveness*. Bethesda, MD: Center for Disaster and Humanitarian Assistance Medicin, 2002.

———. "Information Management for More Effective Military Humanitarian Assistance Projects & Programs." In *Measures of Effectiveness*. Bethesda, MD: Center for Disaster and Humanitarian Assistance Medicine, 2002.

———. "Overview of Overseas Humanitarian Assistance, Humanitarian and Civic Assistance and Excess Propery Programs." In *Measures of Effectiveness*. Bethesda, MD: Center for Disaster and Humanitarian Assistance Medicine, 2002.

———. "U.S. Participants Perspectives on Military Medical Humanitarian Assistance." edited by Special Operations and Low Intensity Conflict Office of the Assistane Secretary of Defence. Bethesda, MD: Center for Disaster and Humanitarian Assistance Medicine.

Dyck, Arthur J. "Ethical Bases of the Military Profession." In *The Parameters If Military Ethics*, edited by Loyd J. and Dale E. Brown Matthews, 103-112. McLean, VA: Pergamon-Brassey's International Defence, 1989.

Eisner, David G. "Medical Civic Action Programs (Medcap)." Military Assistance Command, Vietnam.

Ewell, Julian J. and Ira A. Hunt Jr. *Sharpening the Combat Edge: The Use of Analysis to Reinforce Military Judgement*, Vietnam Studies. Washington, DC: Department of the Army, 1974.

"Explanation of Us Presence and Medcaps." edited by Department of the Army. San Francisco, CA: 10th Psychological Operations Battalion, 1968.

"Field Manual 27-5: United States Army and Navy Manual of Civil Affairs Military Government." edited by War Department. Washington, DC, 1947.

"Field Manual 33-5: Psychological Operations Techniques and Procedures." edited by Department of the Army. Washington, DC: Department of the Army, 1966.

"Field Manual 100-20: Military Operation in Low Intensity Conflict." edited by Department of the Army and the Air Force. Washington, DC, 1990.

"Field Manual No 41-10: Civil Affairs Operations." edited by Department of the Army. Washington, DC: Department of the Army, 1985.

"Field Manual No 3-5.30 (MCRP 3-40.6) Psychological Operations." edited by Department of the Army. Washington, DC: Department of the Army, 2005.

Foulke, William. "MACV Army "A" Photo Team Films Medcaps." The Vietnam Archive, 2004.

Gaillard, Regina. "Civic Action Versus Counterinsurgency and Low Intensity Conflict in Latin American: The Case for Delinkage." US Army War College, 1990.

Gates, John Morgan. *Schoolbooks and Krags; the United States Army in the Philippines, 1898-1902*. Westport, CT: Greenwood, 1973.

Gilbert, David and Jerome Greenberg. " Vietnam: Preventive Medicine Orientation." *Military Medicine* 132 (1967): 769-790.

Gillett, Mary C. *The Army Medical Department 1865-1917*. Washington, DC: United States Army, 1995.

———. *The Army Medical Department, 1775-1818*. Washington, DC: Center for Military History, 1981.

———. *The Army Medical Department 1818-1865*. Washington, DC: United States Army, 1987.

———. *The Army Medical Department 1917-1941*. Washington, DC: United States Army, 2009.

González, Juan. *Harvest of Empire: A History of Latinos in America*. New York, NY: Viking, 2000.

Gonzalez, Lyman C. "United States Military Medicine's Role in Low-Intensity Conflict in Latin America." Carlisle Barracks, PA: Army War College, 1988.

Gross, Jed Adam and Michael L. Gross. "Caring for and About Enemy Injured [Comment] " *American Journal of Bioethics* 8, no. 2 (2008): 3-12.

"Gvn Provides Medical Care." edited by Department of the Army: 10th Psychological Operations Battalion, 1968.

Hall, Robert M. "Briefing on Macv Medical Programs Given to Dr. Louis M. Rousselot, Assistant Secretary of Defense for Health Affairs by Col. Robert M. Hall at

Cincpac Hq, 20 March." edited by Department of Defense. Honolulu, HI: United States Pacific Command, 1968.

Hammond, William Alexander. *A Treatise on Hygiene: With Special Reference to the Military Service*. Philadelphia, PA: J.B. Lippincott, 1863.

Hay, John H. *Tactical and Material Innovations*, Vietnam Studies. Washington, DC: U.S. Government Printing Office, 1989.

Hazzard, M. T. "There Are No Non-Combattants in This Strange War." *Viet-nam Bulletin*.

Hendley, James W. *Health Services as an Instrument of United States Foreign Policy toward Lesser Developed Nations*. Boiee, IA: University of Iowa, 1973.

Hinkson, Montgomery. "Medical Support in Military Operations Other Than War." Carlisle Barracks, PA: U.S. Army War College, 2001.

Hood, Charles Hardin. "Humanitarian Civic Action in Honduras, 1988." *Military Medicine* June (1991): 292-296.

———. "The United States Army Medical Department in Low-Intensity Conflict." *Military Medicine* 158 (1991): 64-67.

Howe, Edmund. "Mixed Agency in Military Medicine: Ethical Roles in Conflict." In *Military Medical Ethics*, edited by Thomas E. Beam, Linette R. Sparacino, Edmund D. Pellegrino, Anthony E. Hartle and Edmund G. Howe Washington, DC: TMM Publications, Borden Institute, Walter Reed Army Medical Center, 2003.

Huntington, Samuel. *The Solider and the State: The Theory and Politics of Civil-Miliatry Relations*. Cambridge, MA: The Belknap Press of Harvard University Press, 1981.

"Instruction 2205.02: Humanitarian and Civic Assistance (Hca) Activities." edited by Department of Defense, 2008.

"Instruction 2205.3: Implementing Procedures for the Humanitarian and Civic Assistance (Hca) Program." edited by Department of Defense, 1995.

Jenkins, Elray. "Medical Civic Action Programs (Medcaps) and Medical Readiness Training Exercises (Medretes) as Instruments of Foreign Policy." Carlisle Barracks, PA: U.S. Army War College, 1988.

Johnson, William C. "Medical Civic Action Programs, U.S. Foreign Policy Tool." Carlisle Barracks, PA: U.S. Army War College, 1999.

"Joint Doctrine for Military Operations Other Than War." edited by Department of Defense. Washington, DC: Joint Chiefs of Staff, 1995.

"Joint Publication 4-02: Doctrine for Health Services Support in Joint Operations." edited by Department of Defense. Washington, DC: Chiefs of Staff, 1995.

JTF-Bravo. "Medical Readiness Training Exercises (Medrete)." Joint Task Force Bravo. Accessed, November 10, 2012. http://www.jtfb.southcom.mil/library/factsheets/factsheet.asp?id=10291.

Kass, Leon R. "Regarding the End of Medicine and the Pursuit of Health." *Concepts of Health and Disease* (1981): 1-30.

Kirkland, Faris R. "Honor, Combat Ethics, and Military Culture." In *Military Medical Ethics*, edited by Thomas E. Beam, Linette R. Sparacino, Edmund D. Pellegrino, Anthony E. Hartle, and, and Edmund G. Howe, 157-197. Washington, DC: TMM Publications, Borden Institute, Walter Reed Army Medical Center, 2003.

Klefhammer, Thomas. "From: Officer in Charge, Seal Team One Det Golf November Platoon, To : Officer in Charge, Relieving Platcon, Via: Execwtive Officer, Seal Team One, Subj: Dong Tam Seal Detachment; Relief Of." edited by Department of Defense, 1971.

Krueger, Mary V. "Medical Diplomacy in the United States Army: A Concept Whose Time Has Come." General Staff College, 2008.

Lancaster, Carol. "Redesigning Foreign Aid." *Foreign Affairs* 79, no. 5 (2000): 74-88.

Lee, P.R., M. Conant, A.R. Jonsen and S. Heilig "Participation in Torture and Interrogation: An Inexcusable Breach of Medical Ethics." *Cambridge Quarterly Healthcare Ethics* 15, no. 2 (2006): 202-203.

Lescano, Andrés G. *Personal Communication with Author*. Lima, Peru 2012.

Lesho, Emile P. and Naseer K. Jawad and Husam M. Hameed. "Towards a Better Approach to Medical Humanitarian Assistance in Iraq and Future Counterinsurgency Operations." *Military Medicine* 176 (2011): 1-3.

Levine, Mark A. "Role of Physicians in Wartime Interrogations." *American Medical Association Journal of Ethics* 9, no. 10 (2007): 709-712.

Lewontin, Richard C. *Biology as Ideology*. Concord, Canada: Harper Perennial, 1992.

Lifton, Robert J. " Doctors and Torture." *New England Journal of Medicine* 351, no. 5 (2004): 415-416.

MacIntyre, Alasdair C. *After Virtue: A Study in Moral Theory*. Notre Dame, IN: University of Notre Dame, 1981.

Madden, Willian and Brian S. Carter. "Physician-Soldier: A Moral Profession." In *Military Medical Ethics*, edited by Thomas E.; Sparacino Beam, Linette R., Pellegrino, Edmund D.; Hartle, Anthony E.; Howe, Edmund G., 269-291. Washington, DC: TMM Publication, Borden Institute, Walter Reed Army Medical Center, 2003.

Malsby III, Robert Franklin. "Into Which End Does the Thermometer Go? Application of Military Medicine in Counterinsurgency: Does Direct Patient Care by American Service Members Work?", U.S. Army Command and General Staff College, 2008.

Mann, Judy. "Making the World Better with Us Money." *Washington Post*, April 5 2000, 15.

Martin, Franklin. *Major General William Crawford Gorgas M.S., U.S.A*. Chicago, Illianois: The Board of Directors of the Gorgas Memorial Institute, Date Unknown.

Matthews, Loyd J. and Dale E. Brown, ed. *The Parameters of Military Ethics*. McLean VA: Pergamon-Brassey's International Defense Publichers Inc, 1989.

"Medcap Medicine Envelopes." edited by Department of the Army. San Francisco, CA: 10th Psychological Operations Battalion, 1968.

Michael, Jerrold M. "The National Board of Health: 1879-1883." *Public Health Reports* 126, no. 1 (2011): 123-129.

Miles, Steven H. "Abu Ghraib: Its Legacy for Military Medicine." *Lancet* 364, no. 9435 (2004): 725-729.

Miles, Steven H. *Oath Betrayed: Torture, Medical Complicity, and the War on Terror*. New York, NY: Random House, 2009.

Miller, Franklin G. and Howard Brody. "The Internal Morality of Medicine: An Evolutionary Perspective." *Journal of Medicine and Philosophy* 26, no. 6 (2001): 581-599.

Mitchell IV, Charles H. "The Medic as an Instrument of National Policy or What in the World Is the Department of Defense Doing in Medical Humanitarian Assistance?" Carlisle Barracks, PA: U.S. Army War College, 1991.

Moskop, John C. "A Moral Analysis of Military Medicine " *Military Medicine* 163, no. 2 (1998): 76-79.

Natkins, Ian L. "The Role of Health Services in Support of the Theatre Campaign Plan." US Army War College, 1989.

Neel, Spurgeon. *Vietnam Studies Medical Support of the U.S. Army in Vietnam 1965-1970*. Washington, DC: Department of the Army, 1991.

Neel, Spurgeon. *Medical Support of the U.S. Army in Vietnam, 1965-1970*, Vietnam Studies. Washington, DC: Government Printing Office, 1973.

Newton, Robert. "Medical Topography of the City of Mexico." *The New-York Journal of Medicine* November (1848): 297-307.

Ninh, Tay. "Medcap and Civic Action a Welcome Break from War." *Tropic Lightning News*, 1968.

"The Oath by Hippocrates." MIT. Accessed October 10, 2012. http://classics.mit.edu/Hippocrates/hippooath.html.

"Operational Report of Lessons Learned, Headquarters 1st Brigade, 1st Infantry Division for Period Ending 1 Feb 68- 30 Apr 68, Rcs Csfor-65 (Ri)." edited by Department of the Army. San Francisco, CA: 1st Brigade 1st Infantry Division, 1968.

"Oral History: Beth Parks, Conducted by Laura Calkins." In *Oral History*. Lubbock, TX: The Vietnam Center and Archive, 2004.

"Oral History: Dr Charles Julienne, Conducted by Laura Calkins." In *Oral Hisotry*. Lubbock, TX: The Vietnam Center and Archive, 2004.

"Oral History: William Laurie, Conducted by Laura Calkins." In *Oral History*. Lubbock, TX: The Vietnam Center and Archive, 2004.

Orr, Wendy. "Physician's Duties in Treating Wartime Detainees." *American Medical Association Journal of Ethics* 9, no. 10 (2007): 676-681.

Ozar, David T. "Profession and Professional Ethics." In *Encyclopedia of Bioethics*, edited by Stephen G. Post. New York, NY: Macmillan Reference USA, 2004.

Pellegrino, Edmund D. "The Internal Morality of Clinical Medicine: A Paradigm for the Ethics of the Helping and Healing Professions." *Journal of Medicine and Philosophy* 26, no. 6 (2001): 559-579.

Pellegrino, Edmund D., and David C. Thomasma. *For the Patient's Good: The Restoration of Beneficence in Health Care* New York, NY: Oxford University Press, 1988.

Pellegrino, Edmund D. and David C. Thomasma. *A Philosophical Basis of Medical Practice: Toward a Philosophy and Ethic of the Healing Professions*. New York, NY: Oxford University Press, 1981.

Pringle, John. *Observations on the Diseases of the Army*. 4 ed. London, UK 1753.

Reaves, Eric J. and Kenneth W. Schor and Frederick M. Burke. "Implementation of Evidence-Based Humanitarian Programs in Military-Led Mission: Part I. Qualitative Gap Analysis of Current Military and International Aid Programs." *Disaster Medicine Public Health Preparedness* 2 (2008): 230-236.

Rubin, Lowell J. "Medcap with the Montagnards." *USARV Medical Bulletin*, May/June (1968): 27-34.

Ruktow, Ira. *Bleeding Blue and Gray*. New York, NY: Random House, 2005.

Sadlon, Gary L. "Army Medical Department Leaders in Military Operations Other Than War." Carlisle Barracks, PA: U.S. Army War College, 2000.

Sidel, Victor W. and Barry S. Levy. "Physician-Soldier: A Moral Dilemma?" In *Military Medical Ethics*, edited by Thomas E. Beam, Linette R. Sparacino, Edmund D. Pellegrino, Anthony E. Hartle, and Edmund G. Howe : TMM Publications, Borden Institute, Walter Reed Army Medical Center, 2003.

"Soldier's Creed." Department of the Army. Accessed January 11, 2013. http://www.army.mil/values/soldiers.html.

Standage, Sue. "A Role for the Army Medical Specialist Corps in Nation Assistance." Carlisle Barracks, PA: U.S. Army War College, 1993.

Stanley, Clifford L. "Number 6000.16 Military Health Support for Stability Operations." edited by Department of Defense. Washington, DC: Under Secretary of Defense for Personnel and Readiness, 2010.

Stilles, Donald J. "Critical Subjective Outline of Problems Encountered in G5/S5 Field in a Tactical Division in Vietnam." edited by Department of Defense. Fort Bragg, NC: United States Army Combat Developments Command Special Operations Agency, 1969.

Taylor, James A. "Military Medicine's Expanding Role in Low-Intensity Coflict." *Military Medicine* April (1985): 26-34.

Taylor, John F. "Health Care as an Instrument of Foreign Policy (a Proposed Exapnded Role for the Army Medical Department)." Carlisle Barracks, PA: U.S. Army War College, 1984.

Tho, Tran Dinh. *Pacification*, Indochina Monographs. Washington, DC: U.S. Army Center of Military History, 1980.

Thomasma, David C. "Healthcare Management and Ethics: In Search of Internal Morality." *Healthcare Executive* 7, no. 6 (1992): 31.

"Uniform Code of Military Justice." Accessed November 10, 2012. http://www.au.af.mil/au/awc/awcgate/ucmj.htm.

Vanderwagen, William. "Health Diplomacy: Winning Hearts and Minds through the Use of Health Interventions." *Military Medicine* 171, no. 10 [supplement] (2006): 3-4.

Vastyan, EA. "Warriors in White: Some Questions About the Nature and Mission of Military Medicine." *Tex Rep Biol Med.* 32, no. 1 (1974): 327-342.

Veatch, Robert. " Soldier, Physician and Moral Man." In *Case Studies in Medical Ethics*. Cambridge, MA: Harvard University Press, 1977.

Veatch, Robert and Frankin G. Miller. "The Internal Morality of Medicine: An Introduction." *Journal of Medicine and Philosophy* 26, no. 6 (2001): 555-557.

Veatch, Robert M. "The Impossibility of a Morality Internal to Medicine." *Journal of Medicine and Philosophy* 26, no. 6 (2001): 621-642.

Vietnam Council on Foreign Relations. "Pacification Program at Work: Security Comes to Hamlet." New York, NY, 1971.

"Warrios Ethos." Department of the Army. Accessed January 15, 2013. http://www.army.mil/values/warrior.html.

Weisfeld, Neil E., Victoria D. Weisfeld and Catharyn T. Liverman, ed. *Military Medical Ethics: Issues Regarding Dual Loyalties--Workshop Summary*. Edited by Institute of Medicine. Washington, DC: National Academies Press, 2009.

Weisser, Roland J. "The Maturing of Medretes." *Military Medicine* 158 (1993): 573-575.

Welie, Jos VM. "The Relationship between Medicine's Internal Morality and Religion [Medical Anthropology] " *Christian Bioethics* 8, no. 2 (2002): 175-198.

Westmoreland, William and Donald MacDonald. "Joint Directive Number 2-67: Military Provincial Health Assistance Program (Milphap)." edited by United States Agency for International Development. Saigon, Vietnam: Military Assistance Command, 1967.

Wilensky, Robert J. *Military Medicine to Win Hearts and Minds: Aid to Civilians in the Vietnam War*. Lubbock, TX: Texas Tech University Press, 2004.

Wittich, Arthur C. "The Medical Care System and Medical Readiness Training Exercises (Medretes) in Honduras." *Military Medicine* 154 (1989): 19-23.

Womack, David E. "Medical Engagement as National Security Tool a Prescription for Joint Doctrine." Carlisle Barracks, PA: U.S. Army War College, 1999.

Ziemke, Earl F. *The U.S. Army in the Occupation of Germany 1944-1946*. Washington, DC: U.S. Government Printing Office, 1990.

Interviews:

Participant 1, interview by Sheena M. Eagan Chamberlin, June 7, 2012, interview notes and transcript.

Participant 2, interview by Sheena M. Eagan Chamberlin, October 1, 2012, interview notes and transcript.

Participant 3, interview by Sheena M. Eagan Chamberlin, October 5, 2012, interview notes and transcript.

Participant 4, interview by Sheena M. Eagan Chamberlin, October 10, 2012, interview notes and transcript.

Participant 5, interview by Sheena M. Eagan Chamberlin, October 11, 2012, interview notes and transcript.

Participant 6, interview by Sheena M. Eagan Chamberlin, October 24, 2012, interview notes and transcript.

Participant 7, interview by Sheena M. Eagan Chamberlin, January 27, 2013, interview notes and transcript notes and transcript.

Participant 8, interview by Sheena M. Eagan Chamberlin, January 31, 2013, interview notes and transcript.

Participant 9, interview by Sheena M. Eagan Chamberlin, January 27, 2013, interview notes and transcript.

Participant 10, interview by Sheena M. Eagan Chamberlin, January 30, 2013, interview notes.

Vita

Sheena M. Eagan Chamberlin was born February 26 1985 in Calgary Alberta Canada, to Paul Eagan and Lynda Beaudoin. Eagan Chamberlin grew up in Canada, completing her undergraduate education at the University of New Brunswick, in Fredericton, New Brunswick. There she received her Bachelor of Arts in philosophy and a minor in history (graduating with first class honours). She then moved to the United States and completed a Masters of Public Health at the Uniformed Services University of the Health Science in Bethesda, Maryland. At the University of Texas Medical Branch her research and studies have focused on medical ethics and the history of medicine, with a specific interest in military medicine. Eagan Chamberlin has worked as a teaching assistant at Georgetown University and the University of Texas Medical Branch. She has also given invited talks, including morning reports and hospital grand rounds at The Center for Clinical Ethics at Georgetown University, Texas A&M University at San Antonio and San Antonio Military Medical Center. Currently, Sheena Eagan Chamberlin holds an adjunct lecturer position in the philosophy department of St Mary's University in San Antonio, Texas. Sheena is married to Michael Chamberlin an internal medicine physician in the US Army.

Publications:

Eagan Chamberlin, Sheena. "Emasculated by Trauma: A Social History of Post-Traumatic Stress Disorder, Stigma and Masculinity." *Journal of American Culture* 35, no. 4 (2012): 358–65.

Eagan Chamberlin, Sheena. "Trauma & Humanism: How the Humanities can contribute to the Treatment of Post-Traumatic Stress Disorder." The International Journal of Critical Cultural Studies. [Forthcoming]

Bennett, A. and **Sheena Eagan Chamberlin**, "Resisting Moral Residue," *Journal of Pastoral Psychology*, 62, Issue 2: pp 151-162

Permanent address: 212 Blue Bonnet Blvd, Alamo Heights, TX 78209

This dissertation was typed by Sheena M. Eagan Chamberlin