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Medical Civic Action Program in Vietnam: Success or failure?, The

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Medical services have long been an integral part of the military and warfare. Civilians, however, are also caught up in wars. This article discusses the care of the indigenous civilians by U.S. military medical personnel during the Vietnam War. Civilian medical care is rendered both for altruistic purposes and to satisfy the policy aims of the U.S. government. Evaluation of these two aspects of the programs does not lead to the same conclusions. Doctors doubted the value of the programs, whereas the command structure was enthusiastic. For a program to be of sustained value to the people, it must persist over time and train those who will remain after U.S. forces are withdrawn. This did not occur in Vietnam. Furthermore, I doubt that medical care rendered by U.S. troops in uniform can serve to build up loyalty to another organization, such as the host government.

The United States was medically involved in Vietnam from the time of the Geneva Accords of 1954 until the final withdrawal of U.S. forces in 1973. Dr. Tom Dooley, then a medical officer in the U.S. Navy, participated in Operation Passage to Freedom, the massive evacuation of refugees from the North to the South. He was later decorated by Vietnamese President Ngo Dinh Diem.1 This and later medical care was part of the campaign to win the support of the people, their "hearts and minds," for a Saigon government that never had widespread popular support. The various programs of medical care were contained within what the military termed "civic action."

The Medical Civic Action Program (MEDCAP) during the Vietnam War treated more than 40 million Vietnamese civilians. Between 500 million and 750 million 1960s dollars were expended in the programs. Medicine became part of the civic action program intended to win the hearts and minds of the populace. The Vietnam conflict extensively demonstrated this use of medical care. Many additional civilians were treated in the other programs that provided hospital-based medical care, such as the Military Provincial Health Program (MILPHAP) and the Civilian War Casualty Programs (CWCP), all of them known by their acronyms, which the military truly loves.

The question to be answered is whether or not having all of these physicians running around the countryside to care for the indigenous population was worthwhile in terms of both the

medical care provided and advancing the aims of the government of the United States. This latter aspect bears upon the use of military medical care of civilians as an instrument of policy.2

There were multiple possible motivations for these programs. There was the natural altruism of American physicians, corpsmen, and nurses, doing the only thing they were really well trained to do: caring for the sick and injured. There was the desire of the medical units to be doing something when not otherwise busy, because medical services in a war zone tend to be used on an irregular basis with frequent periods of underuse. This coincided with the desire by command to keep the doctors and nurses occupied. General William Westmoreland considered doctors to be among the worst letter writers in the military. There was the chance to gather intelligence from both civilians and wounded or captured enemy soldiers. Finally, it was part of the overall pacification effort.

According to regulations, military physicians may not be assigned nonmedical duties. This serves to avoid any potential for physicians being in a position to command troops, as might occur if physicians were to serve as officer-of-the-day, for example. It does create another problem for command, however, that of physicians who are under-used and not busy.

The two concepts, that of providing medical care to do good and the provision of medical care as an instrument of policy to advance political/war aims, are not identical. They often coincided and certainly overlapped. I state as an article of faith that a clinical encounter between a qualified Western practitioner and a Vietnamese civilian without previous access to Western medicine benefited that civilian. That is not the same as saying that it advanced the policy interests of either the United States or the government of Vietnam. It may have, or it may have been irrelevant beyond an individual level.

Military physicians have provided medical care to civilians within their area of operation almost since the beginning of the country. Often, the military physician was the only doctor in a remote or newly settled area. During the American Civil War, military medical units provided care for civilians. In that instance, former slaves or freedmen surrounded Union Army camps to be protected by the soldiers. They were lacking any kind of medical care, because their masters had previously provided this. Any army is susceptible to disease in the population around them. Certainly in the Civil War, disease in the camps was as great a threat as was enemy action. It was not until World War I that more soldiers were lost to enemy action than to disease.

Under the Freedmen's Act of March 3, 1865,3 the Union Army was tasked with providing medical services, as well as food and clothing, to former slaves and freedmen. This program

continued through the Reconstruction period, until it was terminated in the time-honored Washington way of cutting off its funding.

The inception of using medical services as a policy tool really began for the U.S. government during and after the SpanishAmerican War in Cuba and continued during the Filipino Insurrection.4 Improvements in sanitation and the provision of immunizations aided both civilians and American soldiers. Lieutenant General Arthur Mac Arthur felt that medical care was significant in winning over the civilian population, depriving the guerrillas of their support base, and securing victory.5 Secretary of War Elihu Root said the policy of benevolence and the humanitarian acts of the Army played a more important role in the pacification campaign than did fear. An essential part of pacification was the development of a public health infrastructure.6

It is difficult, if not impossible, to quantify medical benefit to a civilian population during a conflict. There are rarely initial benchmarks from which to measure, and the programs are so intertwined with other civic action efforts that determining which facet of the effort was significant is virtually impossible. The further one goes from the individual patient who can unquestionably be shown to have benefited toward the national endeavor, the more difficult this determination becomes.

Although most patients treated in Vietnam were cared for under the auspices of MEDCAP, there were multiple other programs in place as well. A brief examination of these programs is necessary to understand fully all aspects of civilian care in Vietnam.

The first is the Volunteer Physicians for Vietnam program. In this short-lived program, which was run in coordination with the American Medical Association, volunteer civilian physicians went to Vietnam for 60, 90, or 120-day tours. Although the caliber of the physicians was high, basically the program could not be sustained. The adventure became less attractive as the war increased in intensity. The number of volunteers was inadequate, creating vacancies. The tours were simply too short to enable the physicians to develop a significant relationship with their Vietnamese counterparts. Although good work was unquestionably done, it had limited effect on the situation in the country.

The next program was MILPHAP. There were actually two different programs that used this same acronym. Originally, it stood for Military Provincial Hospital Program, but it was later changed to mean Military Provincial Health Program. In these programs, U.S. doctors and teams of doctors, nurses, and corpsmen were assigned to the provincial hospitals to aid and train Vietnamese health providers. These programs unquestionably helped improve the quality of medical care that Vietnamese civilians received.

There were some problems with these programs. Initially, the concept was to have teams that would be trained in the United States and rotated into Vietnam intact. This created real problems with both overlaps and gaps in personnel at the hospital. Also, by rotating the entire team at once, there was a loss of institutional memory. Everything about working in that environment had to be relearned rather than passed on. Soon this concept was abandoned for piecemeal replacement.

There were also problems with supplies, in terms of both replacing and safeguarding them. Many hospital supplies appeared on the black market, and many were discovered with captured enemy soldiers. Different in-country organizations were responsible for different aspects of support; for example, vehicles, their drivers, and vehicle maintenance all came from different sources.

In some instances, there were difficulties with Vietnamese physicians accepting the presence of the teams. In part, this depended on the views of the chief medical officer of the province. Some Vietnamese physicians apparently felt that the presence of foreign teams implied greater expertise and ability, resuiting in a loss of face among their own countrymen.

The last hospital-based program was the Civilian War Casualty Program. The question of how civilians were injured was a politically charged one throughout the war. So was providing for their care. General Westmoreland's early tactics of harassment and interdiction fire, in which artillery units would fire at coordinates without specific targets, clearly had the potential to cause many civilian casualties. On the other hand, the less publicized Viet Cong (VC) tactic of firing on U.S. troops from hamlets and then fleeing before the return fire arrived also created casualties from U.S. artillery fire, but one could rationally argue that the VC rather than U.S. troops were responsible for causing them.

It was never possible to accurately determine who caused which casualties or how many were attributable to each side. Certain guidelines were arrived at, such as those caused by bombing were attributable to U.S. actions, whereas those caused by booby-traps were to VC actions. Responsibility or blame for small arms injuries was divided between the two sides. A proposal to build hospitals especially designated to treat these patients was ultimately abandoned, and they were treated in existing U.S. and Vietnamese military facilities on a space-available basis, which was never a real problem.

Perversely, in many ways the hospital-based programs probably accomplished the most good for individual Vietnamese, with less publicity and fanfare than the outpatient MEDCAP. Dramatic results from the repairs of cleft lips and palates, or the case of a boy with congenital club feet who was carried into the hospital by his mother and walked back to the

village on his own a month later, or the elderly man with a large benign tumor on his head (an anatomical site of great significance to the Vietnamese) all showed the impact that modern medicine could have on the lives of ordinary individual Vietnamese. The significance of the care to these individuals is unquestioned. Their lives were markedly improved. However, the ability of the American surgeons to perform these procedures when not otherwise occupied did not fundamentally alter the medical care system. Nor did it necessarily gain support for the government of Vietnam.

The Provincial Health Assistance Program had been a U.S. Agency for International Development program of public health assistance to the Vietnamese Ministry of Health, Social Welfare, and Refugees. It was a multinational program, and the aid was to be administered by Vietnamese nationals. It was designed to be of short-term duration, being phased out of existence as soon as possible. It could not fill the needs of rural areas. A telegram from the State Department to the Military Assistance Advisory Group in April 1962 indicated the need for improved rural medical care in Vietnam.

Understanding the MEDCAP is not easy, because the term was used in multiple ways and for different programs. There were at least three different Medical Civic Action Programs, all known as MEDCAP. In November 1962, approval for instituting the MEDCAP was given, and it was implemented 2 months later on January 27, 1963. It was intended to "establish and maintain a continuing spirit of mutual respect and cooperation between the armed forces of the Republic of Vietnam and the civilian population." The first MEDCAP teams arrived in country in January 1963, without adequate orientation on the environment, language, culture, and medical problems they would face. U.S. medical personnel were assigned to "assist" Vietnamese medical personnel. Initially, the Department of the Army furnished the personnel for the MEDCAP teams, and the 127 members were divided into 29 teams assigned to nine Army of the Republic of Vietnam divisions, regiments, Regional Forces and Popular Forces units, and each corps. Again, it was anticipated that the program would be phased out as the Army of the Republic of Vietnam became capable of carrying out the responsibilities.

As of January 1, 1965, MEDCAP became a program carried out by Vietnamese personnel with U.S. medical personnel to assist them. By mid-1966, 86% of the total teams operating in Vietnam were Vietnamese. Finally, in June 1967, this program officially became the responsibility of the Vietnamese. Thus, the original MEDCAP run by American teams was converted to a program run by the Vietnamese Army.

With the introduction of large numbers of U.S. troops into Vietnam in 1965, many American medical personnel became available to provide care for the indigenous civilians. Military units of the U.S. and Free World Forces assumed this responsibility within their areas of

operation. This program became known as MEDCAP II, with the original program, now run by the Vietnamese Army, being renamed MEDCAP I. As with other military terms, it could be used as a verb (as in "to MEDCAP"), a noun, (as in "going on a MEDCAP"), or an adjective (as in "MEDCAP supplies").

There was supposed to be coordination between the various military units and the Vietnamese civilian health care organizations. This was often absent or deficient. Not infrequently, a medical group from one unit would arrive in a hamlet or at an orphanage to find another medical group working there or having just been there. On one occasion, five different U.S. civic action groups arrived at one hamlet simultaneously. None of them had coordinated their activities through the district or province advisors for "security reasons."

Often, a MEDCAP team would simply show up and set up shop. A schoolroom was frequently the chosen locale (Fig. 1). Mainly elderly women and young children were seen. It was very rare to see a young man of working or military age. Every patient was given something. Most often there was no available X-ray or laboratory backup. If the interpreters were not even slightly medically sophisticated, treatment was based on guessing. Because of security concerns, follow-up visits could not be scheduled on a regular basis. After all, in a war in which ambushes and booby-traps were a major enemy tactic, you simply could not tell people when you would return.

The MEDCAP visit in the village was often somewhat unorganized. The session would last until the medical unit ran out of supplies, all of the patients were seen, or it began to get late in the day and it was necessary to return to the base camp before darkness set in. Generally, supplies gave out before the patients did. A lot of elderly women with cough (chil were seen. They liked the cough syrup that was given out and that had a fairly high alcohol content.

When tumors or other problems that exceeded the capability of the team to treat were seen, the patients were referred to the provincial hospital. In the hamlet, the medical team did not have the capability of removing even a small exophytic growth or tumor (Fig. 2). Referral to the hospital had to be done through the interpreter, and often he or she dealt with the village elder. Whether or not the patient actually went for treatment was generally unknown. There was no follow-up system in the hamlets. There were no medical records.

Often during MEDCAP visits, evidence of nonwestern medicine was seen. Cupping, pinching, and other folk remedies were common. Vietnam has an ancient history and medical influences from India and China. Vietnamese medicine could be Sino-Vietnamese, the medicine of the North (thuoc Bac), or Vietnamese proper, also called the Annamite medicine or the medicine of the South (thu&c Nam).7 In the 1960s, there were about 4,600

practitioners of Chinese traditional medicine (ong Lang) in Vietnam, 600 of whom lived in Saigon.8 Most Vietnamese medical personnel practiced various combinations of Western and Oriental medicine.9

I believe that the care provided in the orphanages was significantly better than in other venues. Even if there was no firm schedule for revisits, if they occurred on a regular basis it was possible to provide a reasonable degree of ongoing care to the children (Fig. 3). Vaccinations could be given, and the nuns (most orphanages were Catholic Church affiliated) could keep some records of which children had received them. Infectious skin disease responded especially well to antibiotics plus proper cleaning with soap and water.

An interesting sidelight is that often a "mock" vaccination of the Vietnamese interpreter would be done before treating the children (Fig. 4). This showed them that it was safe and not too unpleasant. My experience with interpreters also demonstrated another problem inherent in the Vietnamese medical care system. Our interpreter, for example, had fled from the North and was trained for work in a hospital. She earned a great deal more money working as an interpreter for the U.S. Army than she could earn at a hospital. A program to strengthen the medical care system actually removed well-trained people from it.

The orphanages tended to be quite basic structures for housing the children. Meals were prepared for all using only one or two large pots and woks (Fig. 5). It seemed that there were more girls than boys in the orphanages. The children would often serenade the visiting medical team after they had been treated.

Many of the physicians participating in these programs were unhappy regarding the quality of medical care delivered. I agree in principle with a statement of Dr. Tom Dooley. He was accused of delivering 18th century medicine to the people, and he responded that if previously all they had was 15th or 16th century medicine, movement into the 18th century would have been real progress. The lack of even rudimentary laboratory and X-ray capability, absent or very poor follow-up, and inadequate interpreters made American physicians trained in highly sophisticated medical settings quite uncomfortable. The itinerant nature of the programs, with virtual abandonment of hamlets or orphanages when the unit transferred to a different area of operation, violated basic ethical standards for medical care taught at U.S. medical schools.

Command had a totally opposite viewpoint regarding the evaluation of success of the programs. They paid little or no attention to the quality of medical care delivered. If the people were helped medically, it was a bonus. The programs served command needs whether or not that occurred. They kept the doctors and other medical personnel busy,

showed the flag in a positive manner, and engendered good will. It showed the compassion of Americans for the local people. The publicity for the hometown papers, and in fact around the world, was great, not something that occurred very often during the war. Occasionally, some useful intelligence was gathered, another bonus.

As with many aspects of this particular war without a front line, numbers were used by command to evaluate the programs. If more people were being treated, more supplies being expended, and more units participating in the programs, it showed that they were successful. If the programs were successful, then by definition they were contributing to winning the war. There was pressure on the small unit (battalion level) to provide steadily improving numbers to higher levels of authority (group or division)." Each unit commander wanted, in fact needed, to surpass his predecessor in all quantifiable tasks, including villages pacified, missions carried out, and civilians treated by his medical unit, to obtain the best officer efficiency report rating.

There are conceptual problems with the manner in which MEDCAP II was constructed. The entire question of rendering direct medical care by U.S. service members in uniform requires reconsideration. Leaving aside the question of the quality of care rendered, and accepting that some health improvement was achieved, did this advance U.S. aims? There may actually have been a perverse negative effect of the programs. Aiding the civilian population in this manner may have underscored the inability of their own government to provide these basic services. Furthermore, it may have suggested that the foreigners were more anxious to help them than was their own central government. It is critical that such programs be structured so that the credit accrues to the indigenous providers [civilian or military) and not to the U.S. military.

The ultimate goal, as in Vietnam, is for the host government to be able to provide a satisfactory level of preventive and therapeutic medicine. Americans often prefer to deliver direct care, with its more immediate and obvious results and gratification on the part of the care provider, but this is of no benefit developmentally. Standing aside, however, while others attempt to provide health care who are less able and work far slower can be very frustrating. Providing direct care results in only temporary relief of the medical situation and contributes little or nothing to long-term improvement in the health system." The emphasis should be on developing capability, not providing service. This process of education requires a long standing commitment.

Although direct patient care is provided, the real interests served by humanitarian civic action are psychological and political."2 Medical operations in low-intensity conflict situations represent the most cost-effective and least controversial technique for gaining popular

support. 13 The programs aim to reinforce the "Clausewitzian trinity" between the people, the government, and the army. It is critical to constantly reinforce the concept that the trinity is that between the people of the host country, the government of the host country, and the army of the host country. In these conflicts, the aim of the U.S. policy makers is and must be to gain support for the host country, not for itself or for the U.S. forces, which will ultimately leave the scene. A health care delivery system dependent on the presence of U.S. military forces will not survive their departure.

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