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UNITED STATES MILITARY MEDICINE'S ROLE IN  
LOW-INTENSITY CONFLICT IN LATIN AMERICA

BY

COLONEL WILLIAM GONZALEZ

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USAWC MILITARY STUDIES PROGRAM PAPER

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UNITED STATES MILITARY MEDICINE'S ROLE IN  
LOW-INTENSITY CONFLICT IN LATIN AMERICA

AN INDIVIDUAL STUDY PROJECT

BY

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ABSTRACT

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TABLE OF CONTENTS

	Page No.
ABSTRACT . . . . .	.11
CHAPTER I. WHAT - LOW INTENSITY CONFLICT . . . . .	1
CHAPTER II. WHERE - SITUATION IN LATIN AMERICA. . . . .	7
CHAPTER III. HOW - ROLE OF MILITARY MEDICINE IN A LOW-INTENSITY CONFLICT ENVIRONMENT . . . . .	.10
Introduction. . . . .	.10
FID . . . . .	.14
Mao's Phase I . . . . .	.22
Phase II. . . . .	.23
Phase III . . . . .	.25
Other Low-Intensity Conflict Military Operations. . . . .	.26
Introduction . . . . .	.26
Combatting Terrorism. . . . .	.28
Proinsurgency . . . . .	.30
Peacetime Contingency Operations. . . . .	.32
Anti-Drug Operations. . . . .	.33
Peacekeeping Operations . . . . .	.37
Conclusion . . . . .	.37
CHAPTER IV. RECOMMENDATIONS . . . . .	.38
ENDNOTES . . . . .	.41
BIBLIOGRAPHY . . . . .	.44

UNITED STATES MILITARY MEDICINE'S ROLE IN LOW-INTENSITY  
CONFLICT IN LATIN AMERICA

CHAPTER I

WHAT - LOW INTENSITY CONFLICT

Twenty-five years ago the United States Military developed an approach to insurgencies with the doctrine of "counterinsurgency". Today a new concept, with an evolving definition, is developing to assist us in our military response in a "Low-Intensity Conflict" or "LIC" environment.<sup>1</sup>

The term low-intensity conflict reflects an American perspective and is indeed a misnomer. To the people more directly affected, the threat is immediate and vital. To us it represents military involvement in the ambiguous environment between peace and conventional war. In LIC, the contribution of military force to the achievement of the strategic aim is usually indirect; that is, military operations support non-military actions which establish the conditions under which the strategic aim can be realized. What makes these military operations distinct is the inclusion of not only the armed conflict, but also the series of diverse civil-military activities conducted.<sup>2</sup> The conflict in a low-intensity environment is by its nature considered a limited struggle, usually confined to a definite geographic area and usually has political, social, economic, or psychological objectives. Its constraints include weaponry, tactics, and level of violence utilized.<sup>3</sup> Predictions are that this is the most likely type of conflict that the United States will be involved in for the rest of this century.<sup>4</sup>

At this level of conflict, in the spectrum between peace and war, insurgencies play a big role and the environment in which they occur is a predominant feature. Most of our leaders have recognized this and it can partially be illustrated by the recent statement made by the Secretary of the Army, John Marsh, in which he stated that "The roots of insurgencies are not military in origin, nor will they be completely military in resolution, therefore, emphasis must be in non-traditional forms of coercion--economic, diplomatic, psychological and paramilitary."<sup>5</sup>

To best prepare for the military operations in a low-intensity conflict we must first try to understand something of what is involved. The all inclusive currently accepted military definition is: "Low-intensity conflict is a politico-military confrontation between contending states or groups below conventional war and above the routine competition among states. It frequently involves protracted struggles of competing principals and ideologies. Low intensity conflict ranges from subversion to the use of armed force up to and including fighting between conventionally organized and armed forces. It is waged by a combination of means, employing political, economic, psycho-sociological, and military elements. Low-intensity conflicts are often localized, generally in the Third World, but contain regional and global security implications."<sup>6</sup> The use of conventional forces does not necessarily change an insurgency into a conventional war, it merely adds another element into the equation.

Current United States policy recognizes that indirect--rather than direct--applications of U.S. military power are the most appropriate and



cost-effective ways to achieve national goals in a LIC environment. The principal U.S. military instrument in LIC is security assistance and when friends or allies are threatened this security assistance is intended to help in ensuring that their military institutions are able to provide security to their citizens and government. It is also accepted that the United States may also engage in combat operations when it cannot protect its vital interests by other means.<sup>7</sup> When this type of a U.S. response is called for, it must be in accordance with the principles of international and domestic law, usually based on the inherent right of self-defense against armed attack.<sup>8</sup>

There are many dynamic forces that contribute to LIC, chief of which are change, discontent, violence and instability. These can often interact to create an environment conducive to LIC. But, usually the factors which lead to an insurgency are complex and, in many cases, cannot be resolved by short-term actions. Success in this environment is dependent upon the effective application of all elements of national power with clearly defined goals and objectives. Political objectives usually establish the limits and constraints for military operations, and are influenced by social, political and economic conditions.

In the direct military aspects, the difference between operations in low intensity, counterinsurgency conflict, and in conventional war, as found in mid- and high-intensity levels, lies in the measure of military success. In both conventional and unconventional war the measure of success is in the achievement of political objectives which protect national interests. In the conventional, it is usually necessary to win battles and campaigning to achieve these objectives, while in the

unconventional we attempt to achieve success without the protracted commitment of U.S. regular forces in a combat role. 9

Any conflict situation can involve elements of peaceful competition, LIC, and war. Low-intensity conflict does not inevitably escalate into war, neither does war inevitably resolve all aspects of conflict and can evolve into some form of LIC.<sup>10</sup>

Similarly, while the concepts of direct and indirect operations differ, they are not mutually exclusive and it is possible to secure policy objectives by indirect, direct or both types of operations.

In comparison to the relative simplistic approach taken in the 60's of categorizing military operations into conventional or unconventional (counterinsurgency), contemporary writers have taken a different approach by subdividing LIC into 4-6 major military operational categories.<sup>11</sup>

Some authors describe six while our FM100-20 combines insurgency and counterinsurgency (FID) and does not recognize antidrug operations as a major category while some civilian authors do. I will use six since operational medicine plays a different and important role in each.

These categories are:

1. Foreign Internal Defense: Counterinsurgency, encompassing those activities taken by the United States to assist friendly governments resisting insurgency threats.

2. Proinsurgency: The sponsorship and support of insurgencies against hostile governments in the Third World.

3. Peacetime Contingency Operations: Short-term military activities--rescue missions, show-of-force operations, punitive strikes--taken in support of U.S. foreign policy.

4. Combatting Terrorism: The efforts of the United States armed forces to counter the threat of terrorism.

5. Anti-Drug Operations: The use of military resources to attack and destroy overseas sources of illegal narcotics, and to curb the flow of drugs into the United States.

6. Peacekeeping Operations: The use of American forces (usually under international auspices) to police cease-fire agreements or to establish a buffer between hostile armies.<sup>12</sup>

Historically, low-intensity conflict, guerrilla warfare, and counterinsurgency are not new. Throughout history, groups have sought to achieve their goals through the aggressive use of various elements of power, including limited military actions. Embargoes, blockades, demonstrations of military capabilities, mutiny, supporting insurgents, harrassment at borders, incursions, and intimidations have long been a part of international affairs.<sup>13</sup>

The description of level of participation and the activities that take place in the low-intensity conflict spectrum have changed somewhat since the days of pure "counterinsurgency" of the early 1960's, but the common denominator, even though at times it appears obscure, still rests with the importance of the population in this environment. In Mao Tse-Tung's classic concept of a "Peoples war," he described insurgency in phases. Phase I being the grass-roots organizational effort, Phase II was armed action building up to guerrilla war of attrition, and Phase

III was a rising tempo of guerrilla attacks culminating in a final offensive of a conventional military character.<sup>14</sup> Many variations and modifications to his doctrine have been described, but his most famous dictum<sup>is</sup> that "guerrillas are fish, and the people are the water in which they swim. If the temperature is right, the fish will thrive and multiply" is as relevant today as it was when he wrote it.<sup>15</sup>

To this concept, I would add one more phase which is possibly the most important. It would be a Pre-Phase I state: where the conditions are ripe for an insurrection, but the organizational movement has not yet developed. Based on the experience of the last 25 years, if we are not successful at this stage, I doubt that we can reverse the situation without an extremely protracted costly effort that might even necessitate employment of U.S. combat forces. Insurgencies feed on themselves and once people become desperate enough to make the final plunge into an all or nothing situation, it is very difficult to satisfy their real or perceived needs. In my opinion a typical developing Third World nation involved in this stage is easily recognized. Usually it is one whose government cannot fulfill its peoples' desire for basic dignity, stability, security, employment, shelter, food, health, education or hope for a better future for their children.

Poverty alone is not a major factor in creating insurgencies, nor does material wealth prevent them, but the overall situation of poverty with its attendant ills, exacerbated by unequal distribution of wealth is still considered by most to be the fundamental problem that causes people to resort to violence. Rapidly growing populations coupled with stagnant, indebted economies complicate the problems with decreasing per

capita goods and services. If you are poor, perceive injustice in your present society, and there is no hope of peaceful improvement, certainly one of your alternatives is to resort to an attempt at violent change.

## CHAPTER II

### WHERE - SITUATION IN LATIN AMERICA

The contemporary world environment has several aspects which make it necessary to study and consider closely the potential of U.S. military involvement in LIC. Specifically the problems associated with emerging nations that experience uncontrollable internal strife, semi-developed nations where terrorism and other forms of political violence are commonly used to influence national will, and the East-West confrontation dividing nations into two camps are all special aspects that potentially can get us involved.

The Soviet Union and its surrogates, up to the present, have demonstrated a policy to use extensive means to attain their objective of world domination and, particularly, in Latin America, of neutralization of U.S. influence and control. Developing societies have also become increasingly vulnerable because of the greatly improved techniques, organizations, and sophisticated technological advances that have given insurgents such an advantage. With improved barrier defenses, easily available light-weight radios, high powered weapons, light compact explosives and shoulder held rockets, their potential for communications, organized attacks and ability to inflict significant damage has greatly improved. Latin America, where all these conditions

exist, being so relatively close to us and vital to our interests is the most likely place of our future involvement.

No discussion of U.S. involvement can be presented without a review of the present situation in Latin America and the reasons why it is the most likely area of turmoil. The region is of great concern to the United States and, as such, must be considered as a critical area of potential military operations.<sup>16</sup> In size, the region dwarfs the United States. Brazil alone is larger than the continental United States, without Alaska. The remainder of the Latin American nations combine to equal an area more than twice that of the U.S.

Latin America is projected to have a population of more than half a billion by the year 2000.<sup>17</sup> There are few signs of downturn in population growth rates and at a growth rate of about 3% per annum, the population should double in the next 25 years in Latin America.

There is a rate of unemployment which, in some Latin American countries, is already at 46 percent. The region as a whole has an external debt approaching \$400 billion, or nearly 45 percent of all the global debt. There exists a tremendous feeling of hopelessness in the economic situation. Interest alone will double the debt in the next ten years.<sup>18</sup> Several Latin American nations now measure annual inflation rates in terms of hundreds of percent and many have postponed payment of huge national loans.<sup>19</sup>

Despite depressed economies, Latin America remains a major trading partner. Annual U.S. exports to the region (\$31 billion) are approximately 50 percent of those to Europe and larger than U.S. exports

to Japan. The U.S. also imports approximately \$45 billion a year from Latin America.<sup>20</sup>

The region is a leading source of important raw materials, and regional oil fields and refineries provide more than half of U.S. imported petroleum. Even more critical, however, is the ability to move crude oil through Panama and the Caribbean enroute to Europe and NATO. Sixty percent of NATO resupplies pass through the Caribbean sea lanes.<sup>21</sup>

There are wars going on in El Salvador and Nicaragua, and at least ten other countries have active insurgencies. Twenty percent of the world's ten million refugees are in or are from Central America; add to this a \$156 billion per year drug trafficking business with some of the profits thought to be bankrolling leftist insurgent groups for protection.<sup>22</sup>

The Soviet Union's single largest external foreign-assistance investment goes to Cuba--in the amount of almost \$13 million per day. Due to that sponsorship, the Cubans now represent both a conventional and an insurgent threat in the Americas, making that militant little island the Soviet proxy of most immediate concern to the United States.<sup>23</sup> It also currently has the ability to close off shipping in both the Caribbean and the Panama canal.

Cuba is the dominant military power in the Caribbean and exports a virulent form of insurgency throughout Latin America. Cuban/Soviet support of Nicaragua has established a conventional force of more than 40,000. This is by far the largest military in Central America. Since 1980, the Soviet bloc has delivered more than \$1.25 billion in weapons

and military equipment to Nicaragua. In 1986 alone, they sent war supplies totaling \$600 million.

The Cubans now offer a catalog of 50 different guerrilla and terrorist courses that boast 10,000 graduates, most of whom have returned to their homelands in Central and South America. The instability of the region cannot be blamed solely on the Soviets and Cubans, but the environment lends itself very well to their sponsorship of terror and insurgency.<sup>24</sup>

### CHAPTER III

#### HOW - ROLE OF MILITARY MEDICINE IN A LIC ENVIRONMENT

The role of the United States military in Latin America is fairly clear. United States strategy is based on U.S. interests in the region. These interests, some real and others political, have determined U.S. objectives which are the promotion of democracy, defense, diplomacy, and development throughout the Americas. The military component of the overall strategy can be greatly influential in the accomplishment of these objectives.

The U.S. military's participation in supporting the strategy is represented at two distinct levels: at the regional level which is "aimed at maintaining a stable U.S. southern flank" and at the local country level which involves input into 17 distinctly different country plans or strategies that have to be coordinated with each individual ambassador.

We are involved throughout the region, but three areas are presently of great concern to us. These are the disturbing situations



in Panama, Nicaragua and El Salvador. We still have an obligation to protect and defend the Panama Canal. We do this by attempting to assure regional stability and providing local defense with the approximately 10,000 U.S. troops stationed there.<sup>25</sup> In Nicaragua we deter the "Sandinista" regime by maintaining a continuous force presence in the region, mainly in Panama and Honduras; and sponsoring a counter-revolutionary movement within Nicaragua in the form of the "Contras." Our stated intent has been to prevent the Nicaraguan government from taking action against its neighbors, while moving towards democratic pluralism and accommodation with the peaceful goals of its neighbors.<sup>26</sup>

In El Salvador the U.S. military is involved in assisting with intensive counterinsurgency projects. We participate in training, teaching, advice and providing for USSOUTHCOM's largest security assistance program in the region.<sup>27</sup>

Situations vary from country-to-country, but U.S. military strategies never stand alone. They must be carried out under the direction and with approval of each ambassador. Some overall generalizations can be made for the whole region. One of these is that the majority of our efforts are designed to achieve expanded military-to-military contacts. In so doing, we are given the opportunity to assist the host nations' military institutions in participating in democratic development and national stability.<sup>28</sup> Some general forms in which we participate in the development of country strategies or plans include security assistance, combined exercises, mobile training teams, personnel exchange programs, small unit exchanges, conferences, workshops, visits and a variety of other

initiatives. The average USARSO deployments throughout 112 Latin American nations is 250 per year.

A large portion of USSOUTHCOM's strategy for the region involves the use of civic action projects which include, to a great extent, the use of medical personnel and programs. Historically, and in actual practice, the use of medicine in the LIC situations of Latin America has been the least controversial, most cost effective and politically acceptable means of furthering our interests.

In the future it is contemplated that U.S. military medicine, both active duty and reserve component, will play an ever increasing role. Hopefully this will not only be in its traditional service support function, but also in a more operational sense. As its use increases it is essential to develop a doctrine for the utilization of this military instrument. 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.

In the development of this doctrine many factors will have to be considered. The Army Medical Department (AMEDD) will have to develop greater flexibility in fulfilling the two major roles of conventional and unconventional employment. This is especially critical because of the great variety of missions involved. This will call for not only medical coverage for strictly military activities, but also the country building, counterinsurgency, civic action and humanitarian functions.<sup>29</sup>

To properly accomplish the traditional role it will be crucial that commanders and planners be indoctrinated to the fact that AMEDD personnel must be included in the initial overall planning effort.

Without this participation, as has frequently happened in the past, adequate support, evacuation routes, host country coordination and medical care will not be optimized. Ideally, every mission, both in the conventional and counterinsurgency fields, will have a medical annex prepared by the supporting surgeon. It is his responsibility to see to it that the mission is covered by the right mix of personnel. This is not only in the professional sense, but also by personnel that have been properly indoctrinated, trained, and equipped for these special missions.

In the non-traditional, unconventional role-equipping and training will be important, but indoctrination of the medical personnel into the role of being humanitarian representatives of our government in a sensitive military-political environment will have to be concentrated on. Special language and area studies should also be included. These individuals must be well founded in the basic concepts of military medicine plus the art of medical political diplomacy.

It is essential that we select and develop physically fit, mentally stable, intelligent practitioners that have the capacity to be flexible and use common sense. They must be well-trained in state-of-the-art field medical equipment, class VIII logistics, and military medical procedures while still being able to exhibit kindness, caring and compassion in dealing with the host population. They have to know that the dictum of "first do no harm" must be explicitly followed.

Throughout Mao's phases of insurrection, with preferred employment in Pre-Phase I, operational use of medicine can be of great benefit in assisting the host government in altering the "temperature of the water." Within our currently defined operational areas of low-intensity

conflict, the best utilization of military medicine would be in the category of Foreign Internal Defense or (FID).

### Foreign Internal Defense

FID is defined by the JCS as the "participation by civilian and military agencies of a government in any of the action programs taken by another government to free and protect its society from subversion, lawlessness and insurgency." These programs can be proactive, designed to protect the society before an insurgency develops, or they can be reactive once an insurgency has begun.<sup>30</sup>

On the proactive side, support is usually provided by the ambassador and his staff in the form of developmental and security assistance, but all too often, it is mostly reactive. In general, security assistance provides mobile training teams, sells military equipment under the foreign military sales program, trains students, and mans many security assistance offices throughout Latin America.<sup>31</sup>

In the reactive aspect of FID, U.S. security assistance continues, now supporting the host country's counterinsurgency program. This support can extend from training and advisory assistance to the use of U.S. combat forces.<sup>32</sup> This extreme would naturally have to be requested by the host country and be approved by the National Command Authority (NCA).

In FID, U.S. military medicine and the Army Medical Department can participate in three ways in the support of our troops and providing assistance to the host country. The first way is in the strictly traditional role of combat service support to deployed U.S. troops and

their allies. The second way is in the assessment of host country medical institutions and participation in educational programs. The third is in the development of combined operational programs to be conducted at the grass-roots level.

In general, most of the medical programs we would participate in would be combined projects between the U.S. forces and the host nation. These projects are usually developed either through the host nation's military Surgeon General, the Minister of Health, or a combination of both. The relationship between the local military medical authorities and the Ministry of Health does vary extensively from country to country, but in most countries, the military usually plans for and uses Ministry of Health facilities to a great degree in its operations. This is especially so in rural areas.

Coordination with the Minister of Health is done through the United States Agency for International Development (AID) director of the embassy who usually serves as the medical project director for the ambassador. Military to military we negotiate directly with the Surgeon General or his representatives. Overall, approval for projects comes from the level of the Surgeon General/Minister of Health, but the execution and development of projects is usually done with our counterparts at a local level.

The important subject of formulation of long-term country sanitation and medical development objectives and determining funding for these objectives is coordinated between the AID director and the Minister of Health. These are usually long-term projects in which, in the past, U.S. military medical personnel have had difficulty in

participating. There are two main reasons for this. The first is that, since these are usually long-term projects, the military, because of the frequent rotation of its personnel and their unpredictable availability, has not been included. The second includes the tremendous lack of knowledge of our civil servants as to military medicine's potential and capabilities. In my opinion there is a definite role that military medicine can perform in these long-term sanitation developmental projects. In particular, we can furnish readily available expertise for preventive medicine and participate in short-term endeavors that support the accomplishment of AID's long-term objectives.

In most Latin American countries there does not appear to be a coordinated effort in the execution of military medical and civilian sanitation country-building projects. There especially appears to be a lack of knowledge of understanding of individual capabilities between U.S. agencies. One of the exceptions is Honduras where AID, the embassy and the U.S. Military Clinic at Palmerola are working very closely with the host government's Ministry of Health medical personnel in the execution of their outreach projects. This cooperation and coordination took a long time to develop. It has been my experience that both the U.S. military and other U.S. agencies, to include embassy personnel, are not being protective of their own areas of responsibility but rather they just do not know much about each other or each other's capabilities. The relations between U.S. agencies must be developed. There is a great need for mutual understanding, support and cooperation if all U.S. resources are going to be used to the maximum degree.

In Foreign Internal Defense, the host country's medical institutions are going to do most of the work. We should assist in country-plan development, funding, advising, teaching and occasionally in-field project participation. Our primary interest should be to develop an excellent military-to-military relationship. This, we hope, will lead to combined projects that will advance their capabilities to fulfill the needs of their nation, army and population.

In these combined military projects, U.S. medical personnel can offer extensive assistance to host nation medical departments. Since in the majority of Latin countries the military uses the public health system extensively for support, we may generalize and include both the host nation military and Ministry of Health together. Combined studies and assessments of the medical infrastructures, preventive medicine programs, development of means and routes for patient transportation, introduction of modern technology, surveys of medical facilities, medical maintenance, dental and veterinary services would all be fields in which the AMEDD could be extremely helpful in the formulation of combined nation building projects.

There are certain general deficiencies noted in most Latin military medical departments. My recent experience has been that the greatest need in developing a responsive host country military medical department has been in the process of developing an attitude of "professionalism." This not only in the medical personnel, but also in the attitude of the rest of the armies toward their medical departments. To a great extent the problem has been with the medical professionals who are only part-time in the Army and the rest of the time in private practice.

This automatically makes them relatively static and non-deployable. Other problems are the attitude toward the enlisted medical personnel who, as a whole, do not have the respect to foster confidence and professionalism, the doctor's attitude toward the nurses who are still considered greatly subservient and not equal professionals, and the problem of the almost non-existent medical administrative officer corp. Where they do exist their job has usually been delegated to officers that, for one reason or another, cannot serve with line units and, therefore, are treated automatically as secondary citizens.

The medical departments are usually loose organizations that do not have the respect, interest or attention of the rest of the military. It is very difficult to be aggressively responsive to counterinsurgency or the other civic action projects if the organization as a whole is greatly deficient. Any support we can give to correct some of these deficiencies would be greatly beneficial to our combined endeavors.

The second general deficiency noted in most Latin American military medical departments is the matter of medical logistics. In most countries, there is a foundation of procurement and distribution, but it usually functions very erratically and in very few is it a dependable system. In many countries the practitioners are available, but the medicines are not. There are multiple stories of soldiers not receiving care unless they, or their officers, go to the closest civilian drug store and purchase the medicine out of their own pocket. This situation is not found in all countries, but occurs so frequently that we can generalize and state that, as a whole, the medical logistical systems need much attention. Most of the time it is a matter of funding, but



the U.S. AMEDD can certainly be of assistance in teaching and developing the basics of purchasing, storing and distributing medical products. There are still many in our army that have experience prior to the age of computerization who could act as advisors. Needless to say, it will be very difficult to get soldiers to function aggressively, unless they are healthy and for this they must have the medicines necessary for their care.

The third situation that I have observed is the almost universal lack of medical maintenance. Unless the military hospital is located in a fairly large city where services are available from commercial sources, there is no internal capability to fix and maintain medical equipment. This does not necessarily mean very complicated equipment, but includes the simplest of laboratory, refrigeration, electrical and x-ray equipment. There is no system to develop military medical personnel who will carry out preventive routine maintenance or first and second echelon repair for any breakdowns. In the same vein, knowing that they lack this capability, we have to be very careful as to what equipment we advise to be introduced in our security assistance programs. There are situations where small hospitals and clinics cannot provide services either because the equipment is broken or they cannot afford the expense of running it. This is very frequently seen in the cost of diesel fuel for generators, lab reagents, or structures with inadequate electrical systems that cannot support the equipment. U.S. Medical Maintenance personnel have been and continue to be in great demand for hospital surveys, repair of host country medical equipment,

training, and educational projects. I see a growing demand, but no initiatives to train their own military medical maintenance personnel.

The fourth general deficiency that I have noted, and possibly the most important, is the lack in most Latin American armies of well-trained and well-equipped field medical units. A lot of this, I am sure, is also because of funding, but the lack of professional leadership and the lack of concern or interest by the rest of the military also play a big part. In most places the training of the line medics is rudimentary. The leadership of officers and NCO's is usually deficient. The expectations by the soldiers and rest of military is usually low. The project carried out in El Salvador by a few advisors in developing a medical battalion is a fine example of what can be done with proper orientation, training, accountability and equipment.

In further analyzing the need, in general, of Latin American military medical departments and the ministries of health, there is also a noted tremendous hunger for post-graduate educational support. Assistance in this field is more in the vein of helping develop a higher standard of care in the host country's military while creating a core of potential U.S. sympathizers who might be extremely helpful in the future. The formation of educational relationships is usually welcomed and can be of great mutual benefit.

We are considered particularly rich in medical education, both civilian and military, and in sharing this we can expect rewards both in the development of a more responsive host country medical professional and in furthering beneficial mutual professional relationships. Exchange programs, both in the form of professional seminars and

hands-on professional visits, medical and nursing school affiliations, development of administrative and auxiliary personnel and scholarships to professional schools at all levels are examples of this type of assistance.

All of this is certainly not a one-way street. Latin America is fertile ground for our students to be exposed to in practicing in a different language with people of different cultures. This is usually in an austere environment where conditions and disease are common that would be difficult to duplicate in the U.S. Our professors and medical students, especially from our military medical school, could rotate throughout these countries. This would give us a rich reserve of experienced medical practitioners for future potential employment in Latin America.

## PHASE I

In Mao's Phase I, which is the grass-roots organizational stage of insurgency, the situation might be irreversible, but operational medicine can play a very important role in the attempt to prevent the spread. At this stage the focus must be on winning the "hearts and minds" of the population. The issue must now be forced and we should assist the host government in the rural areas. The noted generalized deficiencies of the host country military medical departments should be corrected and all the rest of the FID projects still managed, but now, in this phase, the center of effort must be shifted. The area specific field-oriented operational medical programs have to take priority over the generalized, central, long-term sanitation initiatives. Civic action, development of medical field units and outreach programs will have to be given special emphasis.

Our medical personnel will have to be better prepared for all combat operations which will include proper planning for conventional and unconventional casualty producing situations. While fulfilling our traditional role as service support, we should still be able to actively participate in civic action and humanitarian activities. The host government and its military, that we believe in and support, must be presented in a favorable light to its population.

In this phase combined outreach programs will have to be developed for both hostile areas and areas where hostilities have not yet developed in the hope of preventing them. The principle of follow-on and repetitive visits should be well indoctrinated in the planning

sequence to avoid the potential of doing more harm than good by raising expectations that cannot be fulfilled. These types of missions require no special training, but must have a guiding philosophy on how to be able to practice the art of medicine under a host country's flag and rules.

We can never forget that our primary purpose is to present the government we support in an acceptable manner to its population. Of course, the people will also know that they have a good friend in the United States.

At this stage, all the medical projects should fit into the overall country plan, and must be coordinated with the host country, AID, country team, mil-group and the supporting CINC through his surgeon.

The participating U.S. medical personnel will have to be special kinds of individuals to be able to accomplish these missions. They must not only be medically and politically astute, but must exhibit tremendous flexibility. Their character should include the basics in the practice of the art of medicine which include caring, compassion and empathy. The population will immediately notice if these basic ingredients are missing.

## PHASE II

In Phase II, Guerrilla Warfare, operational medicine continues with the previously described programs, but the military mission coverage and outreach programs must be greatly intensified. There must be more attention paid to intelligence and security. Projects should be

developed in an attempt to reach areas prior to the insurgent forces to assist in consolidating and attracting the will of the people.

By necessity, this being a phase of active insurgent activity, conventional military service support will predominate, and all activities must be closely coordinated with the local field commanders. At this stage is where medical personnel must be insistent that they be included in the mission planning so that full utilization of medical activities and support can be assured. The tendency by field commanders to concentrate on the strictly military aspects of counterinsurgency and forget the civic action, humanitarian projects will have to be guarded against.

In the service support role patient evacuation routes, host country hospitals, transportation, class VIII logistics, preventive medicine, and contingency plans for all eventualities must be developed and coordinated with supporting U.S. units, facilities, and the host country.

For Pre Phase I and Phase I, I see great use for the Reserve Component Medical Units, but from Phase II on, for political reasons, only active duty medical units should be employed. Since a great number of our teaching professors are in the reserve component, I would use them individually in central, relatively secure areas throughout all the phases.

In this phase we can start to receive predictable casualties and since counterinsurgencies, once they reach this stage, will usually lead to greatly protracted situations we should not only attempt to win the "hearts and minds" of the host nation's population, but should also be

very attentive to the will of our people. All medical activities and the great general good that they do should be widely publicized.

### PHASE III

Phase III represents intensified guerrilla activity leading to a final conventional push. Here operational medicine's role becomes much more of a warfighting service support one. Civic action, humanitarian, and counterinsurgency soft activities become a secondary role. The primary military missions must be medically covered while we are still attempting to reach the people. This can be accomplished as missions of opportunity while supporting conventional forces or as planned pacification projects in areas where consolidation of government control is necessary or needs intensification.

At this phase, care of refugees has to also be taken into consideration. Adequate medical care, sanitary support and preventive medicine projects will have to be developed for them. Care of refugees will be necessary from Phase I on, but by the time we reach Phase III, well established procedures for adequate medical care, sanitation support, and preventive medicine projects should have been worked out. This also includes coordination with international relief organizations.

This phase is also the stage where heavier medical units, fixed facilities, increased dedicated evacuation transports, enhanced logistical support, and conventional medical regulating will play a part. Experience, especially in El Salvador, has taught us that rehabilitative means and facilities for the host country wounded

personnel need to be taken into consideration and we should assist in their development.

In dealing with our host country counterparts we have to insist on delineating the priorities for operational medicine. At this stage there is also the tendency to concentrate on the military activities and completely forget the civic action, humanitarian projects. It is still essential to insist on the dictum of winning the "hearts and minds." The host country field commanders must also be indoctrinated so that they will allow their medical units to function in such a manner that it will assist in their counterinsurgency mission.

#### OTHER LOW INTENSITY CONFLICT MILITARY OPERATIONS

In the other contemporarily described military operations of Low-Intensity Conflict which include combatting terrorism, proinsurgency, peacetime contingency operations, anti-drug operations, and peacekeeping operations, operational medicine plays a very important role. In all the categories the traditional service support role is essential, but in most participation in civic action and humanitarian projects is also very important.

The service support portion is well delineated in our manuals, but there are certain unwritten rules in the performance of medical civic action projects in Latin America which should be discussed.

Operational medicine's major objective in the performance of the civic action and humanitarian projects should be to assist the host government in taking care of its population, but there are also other benefits which can be realized. In most missions where U.S. troops are



involved, medicine can make the environment in which they operate much more "wholesome." By this we do not mean only in the sanitary sense, but also in the political benefits that can be derived from helping the surrounding population, allied troops (host nation), and local officials.

Participating medical personnel must use common sense and be careful not to violate certain medical-political principals. To practice medicine on a host nation's population, we must first have permission from the local authorities. Host country professionals can be very sensitive about this. The authority can be given by the local Ministry of Health. Often this sensitivity can also be accommodated if we act in a combined manner with local practitioners and practice under their authority. These can be military, Ministry of Health personnel, or civilians.

Some of the unwritten rules that we must follow include: we must not compete with the host country medical establishment, especially at the local level; we have to have real or implied permission to practice medicine by the authorities; we must not antagonize the local village elders or chiefs; we have to treat the people with the utmost of empathy and dignity; we have to be careful with the improper and obtrusive use of the camera; we have to practice safe medicine and not over extend ourselves; and, above all, we must "first do no harm."

These rules imply a complicated business for us to function, but it is really not. In my experience, I have found that if we use common sense and are concerned about professional and political sensitivities of the host nation and its population we will have very little trouble.

The proper courtesies must be followed and we should always remember that it is not our land we are practicing medicine in.

It is conceivable that at times our forces will be so isolated that it really does not matter what we do as long as we accomplish our mission.

#### COMBATTING TERRORISM

Combatting terrorism--which includes the efforts of the United States Armed Forces to counter the threat of terrorism--is particularly important in Latin America.

In the medical world we must plan for both reactive and proactive activities. In the reactive we have to be prepared to respond to a terrorist attack, and in the proactive we have to be prepared to support all activities taken by our forces in countering or preventing terrorist activities.

In planning for terrorists' attacks all areas of potential targets must have contingency plans. Management of mass casualties, hospitalization, medical specialty teams, patient evacuation procedures and host country coordination must all be delineated in these plans. There must be regional plans and supporting annexes for the different geographical areas. The region can be divided by sections, such as Central America, Caribbean, northern South America, western South America (Pacific) and eastern South America (Atlantic). It can also be done country-by-country, but either way, all plans for medical response to a terrorist attack should be coordinated with the embassies. We have to assure that the military plans are coordinated with the embassies'

contingency plans and that they do not work at cross-purposes to each other. They must be mutually supportive.

Regional medical intelligence will have to play a large role in the development of these plans to accomplish the mission properly. The medical capabilities of each area must be well-documented and, if possible, surveyed. Local facilities, in particular, must be analyzed to see what their capabilities are. Lists of available specialties and specialists, with some idea of their credentials, must be known. The availability of in-country evacuation means and potential distance to be covered should be included. All this is necessary because frequently the decision has to be made, in case of terrorist attack or mass casualty situation, to treat the patients locally, treat locally and evacuate, or evacuate immediately. All this depends on the local capabilities to manage medical emergencies. Most of this information is available from the U.S. embassies.

The responsibility to develop, coordinate, and exercise these plans lies with the surgeon's office of the supporting CINC. In Latin America it would be USSOUTHCOM in Panama.

In the proactive medical activities of combatting terrorism the missions are quite varied, so the medical aspects have to be tailored to each situation. The role is mainly of service support, but since it potentially includes activities by our specialized troops, such as quick strikes, the medical care should be coordinated and developed by the medical personnel and components attached to these strike units. It will be their responsibility to see that all the proper medical coordination takes place to assure the best care possible in case of

casualties to our troops. They must pay special attention to the availability of medical intelligence on their regions of deployment, and maximize the accessibility of all medical capabilities that are potentially available. It has been my experience that often these missions are so highly classified that the medical personnel do not take full advantage of all available information and support because of the constraints placed on them by the intelligence restrictions. This can be solved partially by close coordination between the deploying strike forces of the Special Operations Forces (SOF) and the surgeon of the supporting CINC.

#### PROINSURGENCY

The area of "proinsurgency" is where operational medicine can potentially have its greatest immediate impact in the development and accomplishment of its LIC mission.

The sponsorship and support of guerillas against a hostile government in the Third World, lies on the flip side of the counterinsurgency coin: while foreign internal defense is intended to prevent hostile guerrilla movements from seizing control of the Third World countries, proinsurgency is intended to topple any government that we might want to remove.<sup>33</sup> The tactics employed in these two missions may vary, but the environment in which they exist is essentially identical.<sup>34</sup>

Unconventional operations of this type fall within the traditional provenance of the Army's Special Forces in their role of "providing support and advice to the indigenous resistance forces in order to

exploit military, political, economic and psychological vulnerabilities of an enemy."35

The Special Forces medics under their surgeons play a very important role. They have been specially trained for this type of mission. They play the dual role of conventionally providing for the medical care of the U.S. and insurgent troops and also the unconventional role of winning the "hearts and minds" of the people.

In this type of operation, since it is most likely that they will be greatly isolated in a hostile environment, greater attention will have to be paid to class VIII logistics, intelligence, security, and patient evacuation. Overall, the medical mission is much more defined and simpler in its execution than in counterinsurgency. It is much easier to pick the place and time to do good with the practice of medicine and not have to worry about the entanglements of the medical-political world that the counterinsurgent, government sponsored, forces have to work with. As an insurgent, if militarily secure, there are really no significant political restrictions on the accomplishment of simple medical programs.

In Special Forces activities throughout the world, medicine has always been found to be a universally acceptable means to reach a population. It is an easy, cost efficient and readily acceptable means to raise the sympathies of the population toward the insurgents' cause. If it does not win the people over it, at least, neutralizes them while at the same time being an excellent source of intelligence.

If secure, it does not take much of a load, nor heavy equipment to hold sick-call in villages. The number of projects that can be

developed are only limited by the military aspects, logistics, and the imagination of our excellent Special Forces medics and doctors.

#### PEACETIME CONTINGENCY OPERATIONS

Another important Low-Intensity conflict military operation is that of "peacetime contingency operations." This is generally defined as the early use of force to immediately correct an unacceptable situation and encompasses intelligence gathering missions, strike operations, rescue and recovery, demonstrations/shows of force, unconventional warfare and counterterrorism.<sup>36</sup> Such operations are normally sudden, violent, and short in duration and are conducted either unilaterally or with allied nations.<sup>37</sup> Such activities are usually confined to Third World areas after diplomatic initiatives have not resolved the problem. The potential of this happening in Latin America is high.

Military medical personnel, in an operational mode, can potentially play a very significant role. This is both with traditional service support and in situations that require specialized medical efforts. As we have mentioned before, in intelligence gathering they can be very useful when deployed in an unconventional environment. In strike operations the operational plan must have its medical annex which should cover all contingencies for medical care and patient evacuation of participating troops. In rescue and recovery operations the same medical coverage must be planned for, but preparations must be made to treat and evacuate rescued hostages. This often takes the form of developing special teams to provide a spectrum of care, from resuscitative life saving measures to psychological rehabilitation. In

demonstrations of force the normal service support element must be present, but must also have contingency plans that provide for care in case the situation suddenly deteriorates and becomes violent. It is essential that the medical department prepare and train for the worst eventualities whenever troops are deployed for any reason. To us show of force should mean to plan for the use of the force and its predictable casualties.

#### ANTIDRUG OPERATIONS

Antidrug operations to combat the flow of illegal drugs into the United States, using military resources, are going to increase in the years ahead. While such activities have heretofore received only scant attention from the military, they have become a high priority for members of congress and for administration officials who seek a more vigorous drive against narcotics trafficking.<sup>38</sup>

At this point, primary responsibility for halting the drug traffic still remains with civilian agencies--notably the Justice Department and its Drug Enforcement Administration (DEA), the Coast Guard, and the Customs Service. However, as a result of recent legislative and presidential decisions, the armed services are assuming an ever expanding role in antidrug operations.<sup>39</sup>

The first major initiative in this area was undertaken in 1981, when the armed services were authorized by Congress to share with law-enforcement officials any intelligence on narcotics-trafficking obtained during the course of military operations. The authority to make certain facilities and equipment available to these officials was

also granted. Military personnel were also authorized, in a support capacity, to be employed in antidrug operations conducted by civilian law-enforcement agencies.<sup>40</sup>

The Defense Department conducted its most elaborate antidrug operation to date in the summer and fall of 1986: a prolonged search-and-destroy mission in the coca-growing Chapase region of Bolivia. U.S. Army Black Hawk helicopters ferried DEA agents and Bolivian police units to the site of suspected cocaine processing facilities.<sup>41</sup> This operation was known as "Blast Furnace." It was credited with temporarily halting the processing of cocaine in Bolivia and was considered by our officials as the potential model for future Joint operations.

The medical section of the helicopter unit that supported "Blast Furnace", and I, as U.S. Army South Surgeon, were responsible for all the medical initiatives in this operation. Since it could potentially serve as a future model of operations, I will go into the medical coverage in some detail so that we can profit by the lessons learned.

The deploying unit had its own flight surgeon whose main responsibility was to see to the welfare of the helicopter crews, but his mission was greatly expanded once on the ground in Bolivia. Various problems were encountered. The first was that, because of the unpredictable length of deployment, no arrangements had been made for rotation of the medical personnel. This was done as we went along since the duration of the operation was uncertain. We were first informed that this would be a short mission with no rotations necessary--it did not work out that way.



The medical coverage for the forward and base camps became the responsibility of the flight surgeon on the ground. He, his medics, and his Physician Assistant became responsible for the health and mission medical contingency planning for all the U.S. personnel deployed plus the attached Bolivian police. The host country police, working with our DEA, had absolutely no medical support, which is not uncommon in Latin America for paramilitary forces. Sanitation and preventive medicine projects at the main base became a big problem which took a lot of the flight surgeon's time. He also had arranged for medical care in a local hospital by local specialists for those patients that could not be evacuated to Gorgas Army Hospital in Panama.

The second major problem was the arrangement for payment of the local specialists and hospital for services rendered to our soldiers. By the system we had previously established, our payments were so slow that the practitioners and hospital, in frustration, were forced to demand cash only or they would not treat our troops. This was smoothed over, and we eventually developed a better system where the bills would be paid with local approval instead of having to go all the way back to Panama for approval authority. The bills we were charged in a couple of cases could be considered way over the expected, but there was little we could do. Here was an example where the local town was eager to have us there, but only if it improved their business, otherwise, at best, they were neutral toward us or our mission. This was a very obvious example that not all countries or their populations are very sympathetic in our antidrug endeavors. Especially if we do not offer an alternate means of revenue.

In his secondary role of counterinsurgency or making the environment more "wholesome" for U.S. forces to operate in, the flight surgeon, being a mature, aggressive Spanish-speaking physician also assumed the duties of interpreter for the aviation and task force commander. He also served as the primary liaison between the U.S. troops and the leaders of the local town, the hospital, the physicians and the local military authorities.

As the operation drew to a close our medical personnel were in the process of arranging, with local medical and military assistance, a combined civic action, humanitarian project in the areas around our forward camps. The only reasons it had not been done before were the difficulty with the legal requirements and the always present question of funding for the medicines to be used.

As we left, the relations with the people, officials, military authorities and medical establishment were very good. A lot of this was due to the interaction of the medical personnel. We considered it an excellent example of what can potentially be accomplished with the proper selection of the deploying personnel.

In summary in the mission category of antidrug operations, operational medicine can best serve in its traditional service support role, but must be prepared for all contingencies as with any other LIC mission. The potential for sudden violent action and casualties is great.

## PEACEKEEPING OPERATIONS

Peacekeeping operations are defined as the use of American forces to police cease-fire agreements or to establish a buffer between hostile armies.

By its very nature, these operations take place in potentially very hostile or explosive areas. The role of our military medicine is mainly one of service-support, but here again, great care must be taken to assure that proper planning for all contingencies is covered. Logistics, hospitalization, evacuation routes, medical specialty teams, and potential care for allies must all be outlined prior to deployment. Our experience has been that sanitation and preventive medicine projects for our camps will be necessary and should have priority.

There is usually no civic action or humanitarian role involved in this type of mission, with the possible exception of special areas where we are allowed to furnish health care to the local population and so contribute to the legitimacy of U.S. force presence.

## CONCLUSION

In conclusion, it must be remembered that when we hear or read of Mao Tse-Tung, Ernesto (Che) Guevara or Carlos Marighella (Brazilian author of the Mini-Manual of the Urban Guerrilla) calling guerrilla warfare or insurgency a "peoples war", it is not an oversimplification or mistranslation. Insurgencies are just that. They are wars that are ultimately fought, not for territory, but for the support of people. The sole target for such wars, for both the government and the

insurgents, is the loyalty and support of the general population. The people have relative basic concerns--that they be able to raise their families, till their land in peace, and have a hope of prospering with their nation. Whoever best answers these needs will win their support.<sup>42</sup>

It is obvious that the Army Medical Department cannot only serve in its traditional role of service support, but can be a tremendous operational instrument in assisting host governments, and participating in a counterinsurgency role in the LIC environment of Latin America.

Operational medicine in this role is cost effective, readily acceptable, highly influential at all levels, and potentially an excellent conduit to assist, not only in "winning the hearts and minds," but also in the development of better relationships with the host nation political and military authorities. The investment is relatively small while the benefits can be great.

#### CHAPTER IV

#### RECOMMENDATIONS

The role of operational medicine in the LIC environment of Latin America, in my opinion, can be greatly enhanced by the following:

1. MEDCOM - A medical command should be established in Panama on the order of that found in Europe and Korea. All medical assets in the CINC's area of responsibility should come under the direct command or technical guidance of this Medcom. The SOUTHCOM surgeon should be the commander with three deputies. Those would be the hospital commander, the USARSO surgeon, and the commander of medical element JTF Bravo.

Very close liaison would be maintained with the commander of the Air Force and Navy medical elements. The SOUTHCOM surgeon would be the father for all his deputies and have input into the Air Force and Navy medical element commanders. The regional medical logistics, the Reserve Component element, and the air ambulance section would also come under the Medcom.

All this would greatly facilitate command and control, budgeting, planning, policy, coordination, educational projects, emergency response, and accountability. In particular, the coordination within the U.S. military, host nation's medical institutions, our civilian counterparts in our embassies, and other agencies would be greatly facilitated.

2. MEDSOM - At present the regional medical logistics responsibility lies with the Meddac Panama's logistical section and, even though they perform extremely well, more of a regional emphasis must be provided. Therefore, the formation of a regional logistical section would greatly enhance our capabilities, especially if it was augmented with personnel, an increased budget, transportation, and communications to assist in the performance of regional missions.

3. DOCTRINE AND POLICY - Clear National, DOD, and AMEDD doctrine and policy on military medical care, humanitarian action programs, and the medical role in LIC environments must be formulated.<sup>43</sup>

4. EDUCATIONAL PROJECTS - Funds and resources should be allocated for training of foreign personnel in the United States, either at civilian or military educational facilities. Government sponsored scholarships should be expanded significantly to bring Latin American

students to the United States. This includes training for such career fields as physicians, nurses, administrators, technicians, and medical maintenance. All foreigners should return to their native countries upon completion of the training.<sup>44</sup>

5. TRAINING - Qualified medical personnel should be identified and trained to deal with the LIC environment. These individuals should acquire skills and expertise necessary for interaction with host nation medical systems, U.S. government agencies, and international organizations. Special training programs should be developed for this purpose which would include regional orientation and language training.<sup>45</sup>

6. COORDINATION - If the AMEDD's mission in Latin America is going to be optimized, it is essential that the proper coordination be accomplished. All programs must be coordinated. This does not only include within our own military, but also with key U.S. agencies, international organizations, and host government military and civilian medical institutions. In particular, very close coordination should be accomplished with AID and our State Department.

7. AWARENESS PROGRAM - Campaign to increase the awareness of the U.S. military establishment, our politicians, and the public in general as to the LIC situations in Latin America. In particular, the awareness of our commanders as to the benefits of the use of operational medicine should also be enhanced. It will be almost impossible to accomplish anything in this theater if there is no interest or awareness of the necessity to stabilize our southern flank.

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