MILITARY MEDICINE, 162, 8:533, 1997

A Proposal for the Training of Regional Medical Experts

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Introduction

Each of the U.S. military services recognizes the necessity of a cadre of officers and noncommissioned officers who are not only accomplished in their military skills to service standards, but who also have an appreciable knowledge of the history, culture, language, and geography of a region of the world different from our own. This recognition is demonstrated by the Marine Corps' and Army's Foreign Area Officer (FAO) programs. The 1988 Department of Defense Medical Readiness Strategic Plan noted a requirement for "a cadre of health service foreign area specialists," as well as a "career pattern that provides multiple opportunities for them to work in designated areas of the world."[1] At present, the acquisition of such a cadre of medical personnel with overseas knowledge has not been deemed to be of sufficient value to be worth the cost of the training. It is the position of this paper that in the U.S. military of the 21st century, that policy ought to change. The 1995 Medical Readiness Strategic Plan 2001 prescribes that "a needs assessment to identify training requirements for regional expert training" be conducted.[2] It is the intent of this paper to present the reasons for the need for a corps of regional medical specialists (for the purpose of this discussion called regional medical officers [RMOs]) and to address the major objections to such a program. In addition, it will offer an outline of the training and use of such a force if it were to be developed.

Why We Need Regional Medical Officers

No military officer needs to be told that the world is in a different state than it was just a few years ago: less major power confrontation, more "small wars," less predictability regarding the use of chemical or biological weapons, and a higher terrorist threat. Likewise, domestic concerns over the federal budget and social policies have dimmed the national perception of the United States as an international defender of the status quo against an immediate enemy. Additionally, the U.S. military has transformed itself from a large, draft-based, citizen-soldier, short-service force into a force characterized by a much smaller, career-oriented, volunteer, professional soldiery. The corollary of these national and international sea changes is a transformation of the national military strategy of the United States that stood for 40-plus years after the successful conclusion of World War II. Today's military approach puts much less reliance on substantial forces in place overseas, the so-called "forward deployed." Instead, the national strategy has converted to one of "overseas presence" (i.e., a limited number of full-time personnel stationed overseas supplemented with forces temporarily deployed) and "power projection" (i.e., the ability to put forces from the United States where they are needed, worldwide, on short notice.) Without denying the requirement to be able to fight to win, the national military strategy says that peacetime engagement and conflict prevention are the hallmarks of a world without a great power confrontation.[3] Engagement activities, including military-to-military contacts, humanitarian assistance operations, and operations other than war, put a premium on face-to-face interactions, small-unit activities, and individual competence.

Not all of the potential deployment areas for U.S. forces are tropical or even exotic, but most are subject to health risks peculiar to them and, in all likelihood, unfamiliar to medical personnel trained and based in the continental United States. Malaria, dengue, tuberculosis, plague, and yellow fever are all making comebacks from the disease-control levels the world saw in the 1960s and 1970s. The ranges of exposure to the schistosomiases and trypanosomiases are expanding. Major disease treatment regimens are only rarely simplistic enough to have a "one protocol fits all areas" approach to communicable diseases. Diagnostic techniques are revolutionary, but they have become so detailed that special laboratories or research facilities are necessary for verification.[4] As exemplified in a multi-journal media blitz in 1996, new diseases, mostly confined and local, are emerging almost faster than we can catalog them. In the late 1980s, a prestigious panel of the Institute of Medicine noted that there were fewer than 400 tropical medicine professionals in the United States and that many of them lacked any overseas experience.[5] Fewer still wear uniforms.

Medical care systems vary extensively from region to region and country to country. The strengths and weaknesses of medical education programs differ markedly from one part of the world to another. The level of capabilities of a local physician cannot be judged by his or her title and can only be hinted at by his or her diploma. Likewise, the value of the care offered by a traditional healer cannot be dismissed simply because of the lack of that diploma. The capabilities and roles of medical assistants, nurses, and paraprofessionals are different outside the United States from the expectations raised either by the American medical training system or the American military medical system as exemplified by Wilford Hall, Madigan, or Bethesda medical centers. Medical apparatus manufacture is a worldwide business with similar equipment being produced everywhere and with instruction and maintenance manuals in more languages than are taught in the usual secondary school in the United States.

United States joint force doctrine envisions the conduct of overseas military operations by a joint task force specifically designed to address a particular operational problem. This must be a force capable of responding rapidly either unilaterally or as part of a multinational coalition.[6] The operational terms are "joint," "rapidly," and "multinational."

Very few medical officers in today's military have had the opportunity to work either apart from their home service or in a joint arena. The Goldwater-Nichols Department of Defense Re-

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This manuscript was received for review in December 1996 and was accepted for publication in February 1997.

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organization Act of 1986 dictated that all line officers destined for flag rank have joint experience, so more young officers are forcing that experience into their career patterns. Since medical personnel are waived from that requirement, opportunities for cross-service experience for them have been fewer. However, since "jointly" is the way the national military command authority intends to fight this country's wars, it behooves medical personnel to be knowledgeable about their sister services.

"Rapidly deployable" implies that much of the step-by-step planning for a military operation be done before deployment or that the planning be ad hoc in the face of a crisis. In either case, the planners and the executors have need, on short notice, of people familiar with the peculiarities of the area under consideration. This is no less true for medical and military-medical concerns than for other deployment interests. Under most circumstances, the deployed force will require a joint task force surgeon, usually belatedly appointed, who will have immediate responsibilities that depend on what he or she knows at the time or can learn on short notice. Although the general outlines of a foreign medical care system may be available through intelligence sources, the nuances of the system in place in the area of deployment will not be appreciated unless there is a previous familiarity with the region. Throughout a deployment, but particularly early, the logistics authorities, including medical, will have occasion to be in closer contact with the extant host-nation civilian social systems than the war fighters. Language proficiency is a critical skill in those contacts, and often the jargon of medicine does not translate fluently through a nonmedical interpreter.

Although not surrendering the choice of unilateral action, the U.S. government's preferred position is that of a member of a multinational coalition.[7] The multinational nature of military operations affects the medical service on two critical levels: the care of combatants and intimate engagement with nonbelligerents. It will not be unexpected to have U.S. forces collect, treat, and evacuate allied casualties. Similarly, the choice of the contribution of each country to a coalition is as much, or more, a political decision as a military one. For a variety of reasons, many countries are willing to contribute medical forces but not a combatant force to a multinational engagement. The result of this is that U.S. service members may find themselves receiving care in unfamiliar surroundings. Appropriate responses to each of these scenarios require a U.S. medical presence familiar with, and more importantly, comfortable with non-U.S. personnel and procedures.

Perhaps no issue is more politically sensitive and places military medicine more to the fore than civil affairs. The United States routinely, and correctly, states that "the U.S. is not at war with the. . . people, but with the government (or leader, warfighter, etc.)." Preclusion of collateral casualties, provision of humanitarian civil assistance, refugee and migrant resettlement, and financial and physical support to private volunteer and nongovernmental organizations all point to the interest that the United States maintains in exemplary civil-military relations. The reestablishment of the preexisting medical system or the direct provision of health services for noncombatants is an implied task, at least in the early phases of an operation, of the American military medical system in a war zone.[7] We swore an oath to take care of all of the sick and injured on graduation from medical school; we train for it in medical readiness training exercises; we logistically plan for it; our ambassadors, political leaders, and the American citizenry expect it of us.[8] The care provided should be culturally driven, and the propriety of that care must be appreciated in cultural terms. Later, if security permits, responsibility for such activities can be turned over to United Nations relief organizations, USAID, or nongovernmental organizations, but the capability for the initiation of those activities is a core competency of the military. It will take overwhelming circumstances to preclude American doctors from becoming involved in noncombatant care; therefore, we need personnel who can conduct such operations coherently.[9]

Objections to the Development of a Cadre of Regional Medical Officers

The major objections to the training of medical officers as foreign area experts are money, time, and lack of need.

Money

"Such a program will cost money in an era of fiscal constraint," say the objectors. "Doctors and other medical personnel are paid bonuses specifically to see patients, so the cost of taking these individuals out of direct care is higher than that of an infantry or surface warfare officer."

The expense issue has two aspects: direct costs and opportunity costs. The aggregate cost of training an Army foreign area officer in the full formal program is approximately $10,000 to $25,000 in language training and $10,000 to $30,000 for graduate-level civil schooling (M. Heston, U.S. Army foreign area officer program manager, personal communication, September 9, 1996). Because of additions and deletions from the prescribed course of a FAO (see below), the direct cost of training an RMO can be estimated to be in a similar range of $25,000 to $40,000 per officer. That is less than the sum of the yearly bonuses paid to most medical professionals. The greater costs, which must be accepted by the U.S. military if a credible RMO program is to be developed, will be in the opportunity costs lost to both the individual and the military health care system by taking him or her out of the direct provision of hands-on care for about 1 year to 18 months. Those expenses can be ameliorated by conjoint clinical and training experiences, but the costs are real and must be acknowledged.

Time

The objectors state: "The medical officer's time from approximately 3 to 8 years of service is occupied almost exclusively with individual clinical specialty training and the performance of that specialty in anticipation of national board qualification. He or she cannot be released from clinical duties to undertake an extended training program."

The optimal time for training as a regional medical expert is as early in an officer's career as possible, but it could certainly be deferred until the completion of medical or surgical specialty qualification. Admittedly, the time committed to language and culture studies will be time removed from direct patient care. However, the military medical departments of the 1990s and beyond are not stuck with the 97% turnover rate (every 2 years) that characterized the draft military of the 1960s and 1970s.

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Today, half of the newly commissioned medical officers can be expected to remain on active duty 10 years later (W. York, Medical Corps representative, U.S. Army Medical Department Personnel Proponent Directorate, personal communication, September 19, 1996).

Lack of Need

The objection: "American medicine is at least as good as any other medicine in the world and therefore we do not have to worry about any other system. One American doctor is as good as any other for handling deployment problems."

That is the premise that we have been operating under for the last 40 years, but we can do better. The provision of health care is one of the most intimate and culturally intense areas of human endeavor. The perceptions and expectations of the patient are of critical importance in terms of both the acceptability of the medical care and the therapeutic efficacy of that care. The very concepts of "illness," "doctor," and "healing" are culturally and socially laden with images that are different from region to region.[10] In general, American medicine tries to be sensitive to those variations, but often the differences in level of education and style of upbringing can interfere at this level of intercourse. In this realm, the provider of health care may be as in need of interpretation of the patient's thought processes as he or she is in need of interpretation of the patient's words.[11] A medical officer familiar with the cultural nuances of the society is in a position to aid both the individual patient and his or her colleagues in this area.

How Regional Medical Officers Can Be Trained

The basic obligation of any regional training program must be to meet the Department of Defense requirements for officers possessing foreign area expertise. (This section borrowed heavily from a May 2, 1994, DAMO-SSF Information Paper: "Foreign Area Officer [FAO] Program.") It must provide the individual with the opportunity to develop skills required for the conduct and analysis of military medical activities that have a social, cultural, or psychological impact different from that expected in mainstream American society. The regional medical officer training program must provide regional expertise, language competency, and the sociopolitical awareness of a foreign area as well as ensure the professional medical skills normally expected of a military medical officer.

Three distinctive phases of training are integral to the development of such a qualification: language training, didactic area training, and a period of in-country training. (A section can be waived or modified for prior proficiency. As an example, a native language speaker may not require formal training.) In the FAO program noted above, the three phases are 6 to 12 months, 12 to 18 months, and 12 to 18 months in duration, respectively, with the didactic portion resulting in a university graduate degree.

Language proficiency is a critical skill for a regional medical officer. Language development is a continuous process throughout the training program. Formal language instruction, under the auspices of the Defense Language Institute or a suitable academic alternative, e.g., the American University system, would precede other activities. However, language development would continue during the other phases of the RMO training. RMOs would then be expected to maintain those skills even if they are not serving in a position that requires them. Language courses vary in length from 26 weeks (European Romance languages) to 63 weeks (Arabic and other Oriental languages) in duration. The Defense Language Proficiency Test assesses a score (from 0 to 3) for listening, reading, and speaking. After completing all phases of their training, the RMOs should attain, and maintain, at least a 2/2/2 level proficiency.

Although all FAOs are required to gain a master's degree in an appropriate discipline, the medical professional probably need not. In addition, there are few academic programs as narrowly focused as the needs of a RMO. The goals of the academic phase should be to: (1) acquire the social perspective of the region; (2) understand U.S. policy toward the region and vice versa; (3) acquire familiarity with the health status of the region and the peculiar health problems of the area, both of indigenous personnel and of external visitors; and (4) build on previous language instruction.

The social perspective of the region under consideration is a product of its history, geography, culture, politics, and religion. The RMO should understand this perspective and interpret personal and group activities in light of a world view that might be different from that held by the majority of U.S. citizens. The RMO should understand how foreign policy is derived and how U.S. policy toward the region or country affects relations with neighboring areas. He or she should feel comfortable articulating U.S. policy to foreign nationals and explaining the international policy of the region to Americans. Both goals 1 and 2 could be met by a relatively short, focused program of cultural orientation and training. The special operations command, as well as many academic institutions, offer such programs on a 4- to 8-week basis.

The particular medical concerns of the area should be the prime focus of this phase of training. Tropical medicine, public health, high-altitude medical problems, immersion-injury management, and veterinary or disease-vector peculiarities would be logical avenues of study depending on the geographic area. This program would be individualized to the RMO and the area of specialization. A combination of military and civilian short courses, medical laboratory experiences, and subject matter expert interviews would be most appropriate. Regardless of the service of origin, the RMO should be familiar with the unique capabilities of each of the armed forces of the United States and feel comfortable calling on a necessary capability outside of his or her own branch. Formal instruction in the Atlantic Command's Joint Medical Planner's Course or Joint Task Force Surgeon's Course is appropriate. This entire phase should not be longer than 6 months, but must be comprehensive enough that the graduate can credibly be identified as an authority on the strengths and weaknesses of the regional health care system and the medical hazards peculiar to that area.

Continued development of language proficiency is expected during this period. Examples of opportunities for increased fluency include use of foreign research material as sources, regular examination of foreign language newspapers and journals, and formal and social conversation with regional nationals.

After language training and didactic schooling, the RMO should receive a period of closely monitored in-country training.

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This may also serve as an initial utilization tour. Language fluency is the essential tool of the RMO, and improving proficiency is a principal objective of the in-country training phase. In addition to continued language training, extensive regional travel and immersion in the host culture would be expected. This phase should be at least 12 to 24 months in duration, with the student assigned to an operational billet in the region or to an overseas medical laboratory depending on his or her medical qualifications and specialty. The student would have an assigned supervisor specifically for the RMO training portion of his or her activities within the unit of assignment. Regular reporting must ensure that RMO training is not being diminished in the face of other job priorities. Regional travel would be expected to result in a thorough knowledge of the geography and culture of the host region. Travel can be coordinated with the appropriate U.S. Defense Attaché Offices and U.S. missions abroad to arrange briefings and other regional experiences to provide an introduction to the local community. The development of personal and professional relationships with foreign peers will enhance not only the general interpersonal skills of the student but will also serve the student well if (when) he or she is reassigned to the area in the future.

As proposed, upon completion of RMO training, RMOs would follow dual tracks in their basic specialty and the RMO functional area to maintain the necessary professional and military expertise to perform their duties as military medical officers. After training, they would return to the home service for assignment to continue the career path of their medical specialty. Regardless of unit of assignment, the RMO graduate would have a wartime (or deployment) billet associated with the geographical area of expertise. The RMO may return to the area for a later regular tour if service-specific assignment policies allow. Military readiness training would normally be taken in association with the region, either in-country or as an advisor to others with a deployment mission in the region.

How Regional Medical Officers Can Be Used

Currently, military personnel officers can identify the capabilities and experience level of any individual medical officer. Likewise, they can identify a group by clinical specialty, but they cannot draw up a list of personnel with regional experience or appropriate training without a record-by-record analysis. Graduates of specialized, regionally relevant medical training, such as the Tropical Medicine, Global Deployment, or Cold Weather Medicine courses, are not necessarily retrievable. Language qualification records are not consistently maintained, and there is little incentive for the service member to update either the record or the qualification. As an example, central authorities can identify the fact that Major Sanchez has an undergraduate degree from the University of Quito, that Captain Wagner received an advanced degree in Latin American studies from the University of Arizona, and that Lieutenant Commander Perkins has had two previous tours at the Army hospital in Panama. There is not, however, a systematic way to identify any of these individuals as having specialized expertise regarding Ibero-American medical problems. (This would require a specific addition skill identifier based on the regional expertise, and a proponency office to maintain the data base. I would nominate either the Medical Readiness Division of the Joint Staff or the Joint Medical Readiness Training Center for the database-management portion of this requirement.)

When a U.S. military force is deployed overseas to an unfamiliar area, the RMO would be the first choice for a unit or joint task force surgeon position. In the initial phases of a deployment, when host-nation interactions are most intensive and most sensitive, it would be the RMO who would provide the liaison between the American military and the allied country health care system. An RMO, or a system of RMOs, would be the coordinating elements in a multinational military medical structure assuring coherence between the needs and the capabilities of medical services to the coalition. In campaigns involving refugee affairs, migrant operations, or overseas humanitarian assistance programs, the RMO would provide the lead for interactions with a foreign community structure that may not understand, or be understood by, regular American military units. The medical officer assigned to designated active duty and reserve civil affairs units should be an RMO.

Conclusion

Nothing in the above description of a foreign area specialist is intended to detract from the bedrock of the capable and competent medical officer, trained in a traditional medical or surgical specialty and proficient within the professional references of both the American health care system and the American military establishment. However, in the words of the Medical Readiness Strategic Plan 2001, "the potential for an increased number of military medical missions throughout the world suggests a need for medical personnel with regional expertise."[2] Dual-capable medical officers, comfortable in a range of foreign medical environments as well as that of the United States, can advance national security interests of the United States, help correct a documented national education shortfall, and provide an interesting and rewarding career for a select number of heroes.

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