EDITORIAL

MEDCAPS - DO THEY WORK?

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Abstract

The objectives of this paper are to lay out for wider discussion the potential advantages and disadvantages of active military units providing medical care for the local population through *ad hoc* clinics (MEDCAPS). The literature on this subject has been reviewed and the personal experience of MEDCAPS by the author and other doctors in Helmand Province 2007/8 is presented. Although in the published literature, MEDCAPS are almost universally regarded as being good for relations between the military and civilians, the reality on the ground is that they potentially risk the lives of both staff and patients. and may actually contribute little in terms of relieving suffering, or improving relations between military and civilians. The conclusion of this paper is that MEDCAPs at best have a very limited and specific role, but that there will remain a strong desire from staff on the ground to initiate them.

Introduction

MEDCAP (Medical Civic Action Programme) is a term that has been used to describe all types of interaction between the military and civilian population where health care or advice is given. They probably started in their modern form with British Special Forces in Oman [1] where they were regarded as a key to the success of that campaign. Since then there have been many positive reports about their value especially from US forces from all over the world. However, questions about their value are not new [2] and there is no evidence as to their actual efficacy in any objective terms. MEDCAPS are not without risks and have the potential to do harm as well as good. This paper tries to review the pros and cons of MEDCAPS based on the author's experience in Helmand Province, Afghanistan in 2007/8. It then makes some recommendations about their use. For a comprehensive overview of the strategic and logistical problems faced by those tasked with planning and by medical staff in this area at the time, the reader is referred to the trio of papers by Col Bricknell [3-5].

Definition

For the purposes of this paper a MEDCAP is defined as an *ad hoc* clinic set up and staffed by the military to provide medical advice and assistance to the local population.

Why do MEDCAPS happen?

Any well-equipped military force should have adequate medical support to cover most eventualities. This will inevitably mean that in all but the most 'kinetic' situations there will be spare capacity to take on other perceived needs, such as providing medical care to the local population. The sight of the illness and poverty in a third world country makes all military personnel (both medics and non-medics) eager to do something to help.

After military action there is often a greatly increased need for medical care in the local population as a result of societal disruption. People may be displaced, water and electricity supplies disrupted, and there may be casualties from the conflict itself. Food supplies or their distribution may be inadequate, and as a result of damage to roads, patients may find it even more difficult than usual to reach medical care facilities. The aftermath of military action is also a high risk time for the outbreak of an epidemic disease such as measles. In most third world countries, medical services cannot come near to coping with demand even under ideal circumstances. If their ability to function is compromised by military activity and at the same time the demand for care from the local population is also increased, there is potential for complete collapse of health care. It is in these situations that MEDCAPS should be considered.

There is also a desire for our forces to be seen as an agent for good, and to win over the 'Hearts and Minds' of the local population. This should assist a smooth transition from a strategy of military control into one of stabilisation and reconstruction. A MEDCAP may be seen as one way of starting this process [1].

The Current situation

In Afghanistan the policy on MEDCAPS has fluctuated from active encouragement by central command through to strong discouragement. There is no reason to believe that in future (as the command rotates between countries) that these fluctuations will not continue. On the ground, there remains a strong desire to 'do something' whenever military activity slackens. Allied forces (ISAF) have tried to organise MEDCAPS at very short notice so that there is no time for enemy forces to prepare an attack on them. There has also been strong resistance to arranging routine or follow-up clinics because this sets the pattern of behaviour that the enemy can use to plan attacks. The result is that notice of a clinic may be so short that only patients very close to the site of the MEDCAP can attend, and no continuity of care is possible. When clinics are organised they are usually held outside, but close to, a Forward Operating Base as it is not felt wise to allow local population without security clearance into a militarily sensitive area. This means that the medical staff, who are running the MEDCAP need a cordon of protection against conventional enemy attack, and suicide bombers. This is a heavy drain on personnel. Equally it is not possible to put the MEDCAP too far from the Base as this makes security more difficult. The clinics are therefore potentially not positioned where there is greatest need.

MEDCAPs set up on an *'ad hoc'* basis cannot have adequate facilities (medicines, equipment etc) to diagnose, or manage, most conditions properly. It was difficult to provide proper facilities,

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The aim of this editorial is to stimulate debate on a controversial issue. The opinions expressed herein are solely those of the author and are not intended to represent any official view of the Army, Minister of Defence or any other organisation.

which gave patients adequate privacy. It was also impossible to provide any investigations such as blood tests, ECG or Chest X-Rays. The inadequacy of the environment is especially problematical when seeing female patients, who, with children, are those most in need of care. The local culture strictly limits their contact with men, and even with female medical staff, if they are foreign. Intimate examinations are not feasible, and even examination of the chest and abdomen is difficult. Language problems can be overcome using translators, but cultural issues such as the way in which people in different societies describe symptoms present a much more difficult barrier to understanding. This is especially true in psychiatric illness, a common condition in war-torn areas [6].

The medical staff deploying to Afghanistan receive only limited prior training in the prevalence, presentation, diagnosis and treatment of medical problems likely to be encountered amongst the local Afghan population which is often insufficient when faced with many problems on the ground. Diseases such as cutaneous Leishmaniasis, malaria, tuberculosis and nutritional deficiency are not easy to diagnose, and require proper training if they are to be diagnosed properly. The clinics also do not have the drugs needed to treat these conditions. Most of the conditions seen are also chronic and are either not easily treated (Leishmaniasis) or require long-term monitoring if treatment is to be successful (tuberculosis). They cannot be managed using MEDCAPS.

In the small towns in Helmand province there is a public health service and a thriving private medical service provided through pharmacies run by 'doctors'. The state system is managed by a charity 'Ibn Sina' which provides appropriate training for all their staff. The pharmacist doctors are also technically and culturally knowledgeable. Both groups of health worker can provide continuity of care. In the two towns where we actually performed a survey (each with a population of less than 10,000 people), we found that each had over 20 pharmacies operating on top of the state health provision. These pharmacies were well stocked with cheap generic copies of all the commonly needed drugs (antibiotics, antimalarials etc.).

Our experience in the MEDCAPS was that it was not possible to make a reliable diagnosis of a treatable condition in the vast majority of cases.

There was a temptation, when unsure of the diagnosis, to give a panacea/placebo such as aspirin or vitamin tablets. Leaving aside the ethics of such behaviour, we found that the local population in Helmand province is quite sophisticated medically and will not tolerate being patronised in this way.

We also inevitably saw cases, which could have been treated if the patient was referred in to the main military hospital such as burns, but which the eligibility criteria forbid, as the military hospital is needed to treat military personnel. The MEDCAP staff are left knowing that treatment could have been provided but was denied for operational reasons. This may damage the morale of the staff and does nothing for the health of the patient.

During our time in Helmand Province there was a major drive to eradicate polio, which was then still active in only four countries in the world. The logistics of getting vaccine out to remote vaccination centres was an obvious opportunity for the military to provide humanitarian assistance. Despite this, we were specifically asked not to become involved because any suggestion that the programme was associated with the political and military ends of ISAF might make all the local staff involved in the programme legitimate military targets to the Taliban.

Discussion

There is a strong and legitimate desire for military staff to set up clinics to provide health care to the local population. It is therefore unlikely that any order from the centre however definitive will prevent military teams on the ground from starting up some form of help. Instead it may be perceived that those who issued the command do not understand the 'real situation'. Similarly 'Eligibility criteria' which prohibit the treatment of local nationals may be seen as unhelpful and inhuman by those troops on the ground tasked with building trust and rapport with the local population. However, there are considerable problems with MEDCAPS which may result in them doing more harm than good such as single treatments stimulating drug resistance. It may be tempting to justify running the clinics despite this on the grounds that 'anything' is better than 'nothing'. That will not be true if, as a result, incorrect treatment is given

There is no simple answer to what is an emotional argument pitched against a logical one, but one solution may be for military staff to be given time to reflect on, and discuss, the kind of dilemmas which they will face in the field before they are confronted by the reality. This could be arranged during pre-deployment training, when rational decisions are less likely to be swamped by raw emotional need. Staff also need to be trained in the local culture and the conditions which they are likely to encounter.

Where possible MEDCAPS should only be undertaken with the agreement and support of the local health care services, as otherwise the clinic may only serve to damage local infra-structure and antagonise local practitioners. It is most likely that MEDCAPS will be of value where they are treating a single condition which cannot be managed by the local health care services such as cataracts or dentistry. In Helmand, as in many parts of the world, cataracts are a common problem which cannot be managed by local services. If there is a one-off treatment available, as there is in the case of cataract surgery, then it might be valuable to provide and resource a team specifically geared to perform this one task [7]. There is good evidence for the value of such work [8], however an even better solution would be to train and equip local staff to do this work for their own people. This would then be a sustainable development.

This is likely to mean creating MEDCAP teams specifically set-up to deal with a local problem, and will require central planning. This planning should also include a properly constructed plan to evaluate the MEDCAPS value to the local population.

Conclusion

The pros and cons of MEDCAPS and the ethical issues which arise from them need to be discussed properly with staff before they deploy, so that their desire to help is recognised, but the dangers and problems of MEDCAPS are also appreciated. Health care provision would be more sustainable if local staff were trained and equipped to deal with local problems rather than special teams imported to treat specific medical problem.

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