

# Medical Treatment for Foreign Nationals: Another COIN of the Realm\*

Captain Robert D. Hodges†

## I. Introduction

While judge advocates practicing administrative law in a deployed environment share many of the processes and problems familiar to their CONUS colleagues, several topics do not have corollaries in garrison. While advising investigating officers and providing miscellaneous legal advice are the bread and butter of a deployed administrative law shop, specific niche legal reviews can significantly facilitate a commander's use of the full spectrum of United States' military power. It can be challenging for judge advocates to keep the "big picture" in mind as the AR 15-6 investigations mount and financial liability investigations of property loss (FLIPLs) are brought in by the bushel, but there are opportunities to directly influence the counterinsurgency (COIN) fight as a non-traditional enabler. This article discusses a little known, but highly important legal review involving medical treatment for foreign nationals.

When the XVIII Airborne Corps assumed duties as Multi-National Corps–Iraq (MNC–I), the brigade combat teams who deployed as part of the "surge" were still in theater.<sup>1</sup> The battle for the future of Iraq was widely seen as a COIN fight.<sup>2</sup> Concisely summarized, the COIN mantra during the Sky Dragons' tenure was "by, with, and through the Iraqis."<sup>3</sup> The partnerships with the Iraqi Security Forces (ISF), and, more importantly, the Iraqi people, helped set the conditions for improvements to the security situation during the XVIII Airborne Corps's tenure as MNC–I. These partnership-style relationships flowed directly from the doctrine contained in Army and Marine Corps

Counterinsurgency Manual.<sup>4</sup> Simply put, the COIN fight is for the populace,<sup>5</sup> this style of conflict requires not only "hard" military skills but also non-traditional implements of military resources to win the populace.<sup>6</sup>

Although it may not be perfectly intuitive, the logistical and medical expertise of the U.S. Armed Forces often plays a significant role in the COIN fight. One of the more visible examples where rules and regulations complicate the use of non-traditional combat multipliers occurs in U.S. military medical care for foreign nationals. The use of these organic capabilities has tremendous leverage for U.S. forces given lack of access to comparable medical care from the Iraqi Government or the Iraqi economy.<sup>7</sup> While some may say "damn the regulations" and press forward unflinchingly, this article explains how legal advisors can provide commanders maximum flexibility with COIN medical treatment in Iraq within the limitations of applicable policies. The numerous regulatory restrictions addressing medical care exist as a virtual minefield for the incautious with "shipping lanes" for obtaining a waiver to policy even less evident. After briefly discussing the underlying fiscal background for the regulations, this article charts a course for the best practices concerning foreign national medical waivers in COIN environment.

## II. Fiscal Background

As a member of the Executive Branch, the Armed Forces are obliged to work within the funds allocated by Congress.<sup>8</sup> Generally speaking, Congress has appropriated funds for the use of members of the Armed Forces in furtherance of U.S. policy interests. While the treatment of foreign nationals may well advance U.S. policy, the use of appropriated funds to accomplish such care risks violation of the Anti-Deficiency Act<sup>9</sup> and Purpose Statute.<sup>10</sup>

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\* This article is the fifth and last in a series of articles written by members of the XVIII Airborne Corps Office of the Staff Judge Advocate following their deployment as the Multi-National Corps–Iraq, Headquarters, 2008–2009. Each article in the series discusses one significant legal issue that arose in each of the Corps's functional legal areas during the deployment. Articles in the series cover issues that arose in Administrative Law, Rule of Law, Contract and Fiscal Law, Operational Law, Criminal Law, and Foreign Claims.

† Judge Advocate, U.S. Army. Currently assigned as the Brigade Judge Advocate, 525th Battlefield Surveillance Brigade, Fort Bragg, North Carolina.

<sup>1</sup> See, e.g., Michael O'Hanlon, *Lloyd Austin: A U.S. Military Hero You Should Know*, USA TODAY, Apr. 23, 2009, at A11, available at [www.brookings.edu/opinions/2009/0423\\_lloyd\\_austin\\_ohanlon.aspx](http://www.brookings.edu/opinions/2009/0423_lloyd_austin_ohanlon.aspx) (describing the situation when XVIII Airborne Corps assumed the role of Multi-National Corps–Iraq).

<sup>2</sup> See, e.g., Stephen Myers et al., *Marking Five Years Bush Insists We Must Win in Iraq*, NY TIMES, Mar. 20, 2008, at A1 (exploring the continued insurgency and the appropriate response).

<sup>3</sup> "Sky Dragons" is the name for the XVIII Airborne Corps. This mantra was repeated at nearly every nearly meeting, Battle Update Assessment, or speech during the XVIII Airborne Corps's deployment.

<sup>4</sup> U.S. DEP'T OF ARMY, FIELD MANUAL 3-24, COUNTERINSURGENCY 2-6 (15 Dec. 2006) [hereinafter FM 3-24] (representing a joint endeavor of the U.S. Army and U.S. Marine Corps).

<sup>5</sup> *Id.*

<sup>6</sup> *Id.* at 1-153.

<sup>7</sup> See, e.g., Michael Kamber, *Wounded Iraqi Forces Say They've Been Abandoned*, N.Y. TIMES, July 1, 2008 at A1 (describing the devastated state of Iraqi hospitals).

<sup>8</sup> U.S. CONST. art. I § 8.

<sup>9</sup> 31 U.S.C. §§ 1341–1350, 1517–1519 (2006). There is no specific appropriation to fund foreign national medical treatment or foreign national flight.

<sup>10</sup> *Id.* §1301(a) (stating "[a]ppropriations shall be applied only to the objects for which the appropriations were made except as otherwise provided by law.").

Furthermore, Army regulations indirectly prevent the use of taxpayer-purchased items for the benefit of a foreign national.<sup>11</sup> The language in the Army's property accountability regulation, "government property will not be sold, given as a gift, loaned, exchanged, or otherwise disposed of unless specifically authorized by law,"<sup>12</sup> seemingly precludes the "gift" of medical treatment or supplies to foreign nationals.<sup>13</sup> These regulatory constraints limit the commander's ability to act, even when there is sufficient medical capacity at a local medical treatment facility.

One potential policy solution to this sticky situation is asking Congress for a separate appropriation regarding COIN medical treatment of foreign nationals. The request for funding of medical treatment could be viewed in humanitarian terms as a corollary to existing funded infrastructure projects.<sup>14</sup> Although advancing the ability to wage an effective COIN fight, the allocation of funds for the direct benefit of individual foreign nationals has political implications at home and within the Armed Forces.<sup>15</sup> Another possible avenue of funding for COIN-associated medical treatment is through non-military U.S. governmental agencies that are currently working in the rebuilding of Iraq.<sup>16</sup> While foreign aid from agencies such as the State Department could theoretically be used to fund foreign national medical treatment,<sup>17</sup> this has yet to occur in the care of individual Iraqis. The Army fights not with the appropriations it desires, but with allotted appropriations. Thus, judge advocates must work through the current fiscal constructs.

Within the military system, there exist authorized methods to enable the care and transport of foreign nationals on a reimbursable basis. Congress has recognized the need for military cooperation and specifically permitted for cross-servicing agreements with foreign armed forces.<sup>18</sup> These agreements, which are usually bilateral and labeled as Acquisition and Cross-Servicing Agreements (ACSAs), allow the United States to recoup the resources expended for the benefit of foreign armed forces.<sup>19</sup> An ASCA is a methodology for military-to-military reimbursement authorized by Congress.<sup>20</sup> Coalition Forces from a country with an ASCA are eligible for treatment by U.S. military medical professionals with costs that are fully reimbursable under the terms of the ASCA. Despite these advantages, Iraq lacks an ASCA at this time. Given the lack of an ASCA and the statutory guidance provided by Congress, the use of funding for the benefit of Iraqis is limited to extremely narrow exceptions. Utilizing these exceptions is the key to getting to "yes" for a commander contemplating a medical approach to the COIN fight.

The fiscal law underpinnings of the regulations are not the only obstacles in providing medical treatment and travel to foreign nationals. Other policy-level and technical concerns exist in applicable regulatory guidance. The specific language and interpretation utilized by the XVIII Airborne Corps provide supplemental assistance to future practitioners facing similar issues.

### III. Foreign National Medical Treatment

While insurgents may be able to supply weapons and intimidation to the population, few insurgents can provide medical expertise. The U.S. Armed Forces, on the other hand, can provide some of the highest quality medical care in the world.<sup>21</sup> These services can be used as a tool to calcify popular support for a counterinsurgency campaign.<sup>22</sup> Regulatory implications, however, generally prevent U.S. medical professionals from treating local nationals absent

<sup>11</sup> U.S. DEP'T OF ARMY, REG. 735-5, POLICIES AND PROCEDURES FOR PROPERTY ACCOUNTABILITY para. 2-1(f) (28 Feb. 2005) [hereinafter AR 735-5].

<sup>12</sup> *Id.*

<sup>13</sup> The other way to give property to Iraqis was to term the property "excess" and move the property through the Foreign Excess Property or Defense Reutilization and Marketing Service channels. Each of these processes has limited authorities and impacts. In reality, there were few alternatives to the waiver process.

<sup>14</sup> The U.S. Government has spent millions of dollars on creating infrastructure projects and other programs designed to put military-aged males to work. Employment helps prevent the insurgency. An allocation for saving these same military-aged males' sick children would seem to be money well spent, ultimately answering the question, "Who do you like better the doctor who saves your son, or your boss?"

<sup>15</sup> Stephen Biddle, Funding the U.S. Counterinsurgency Wars, Jun. 19, 2009, available at [http://www.cfr.org/publication/19666/funding\\_us\\_count\\_erin insurgency.html?breadcrumb=%2F](http://www.cfr.org/publication/19666/funding_us_count_erin insurgency.html?breadcrumb=%2F) (discussing the interplay between tactics, politics, and funding). This is especially true given the Department of State's role as the lead agency in the foreign assistance arena.

<sup>16</sup> See 22 U.S.C. § 2151-2220 (2006) (describing Foreign Assistance Programs administered by the U.S. Department of State, with the statutes existing as codifications of the Foreign Assistance Act of 1961).

<sup>17</sup> *Id.*

<sup>18</sup> 10 U.S.C. §§ 2341-2350 (2006). This congressional authorization trumps the language in AR 735-5.

<sup>19</sup> *Id.*

<sup>20</sup> *Id.*

<sup>21</sup> See generally U.S. DEP'T OF THE ARMY, WAR SURGERY IN AFGHANISTAN AND IRAQ: A SERIES OF CASES: 2003-2007 (Nessen et al. eds., 2008) [hereinafter WAR SURGERY CASEBOOK] (showing the quality of military trauma care).

<sup>22</sup> See, e.g., Erica Goode, *Toddler Returns to Iraq After Life-Saving Surgery*, N.Y. TIMES, Mar. 10, 2008, at A8 (observing the clear public benefit of medical treatment, even though, in this case, it was provided outside of the waiver process)). One successful tactic in COIN operations is separate the insurgents from the population, which causes the insurgency to wither on the vine. FM 3-24, *supra* note 6, at 1-29. It also improves the quality of life, demonstrating the prevention of human suffering as another effective COIN tactic. *Id.*

exigent circumstances,<sup>23</sup> as Department of Defense (DoD) guidance customarily reserves medical treatment for the benefit of DoD personnel.<sup>24</sup> The challenge of navigating the regulatory framework falls squarely on the shoulders of the judge advocate, whose primary function is determining the propriety of a foreign national medical waiver for non-emergency treatment.

The quality of organic medical care provided to the members of the U.S. military is quite strong.<sup>25</sup> This competence, while not only providing confidence to U.S. personnel, can be used as a combat multiplier in the battle for the hearts and minds of the local populace.<sup>26</sup> Though Iraq does have a strong medical tradition, the infrastructure, training, supplies, and equipment are not always to the standard normally associated with the U.S. military.<sup>27</sup> Providing medical care to the local populace, when available, proves the friendship portion of the “no better friend, no worse enemy” slogan popularized by the U.S. Marine Corps in Al Anbar province.<sup>28</sup> While the public relations benefit of providing treatment appears to be clear,<sup>29</sup> the more fundamental question is whether and when the regulatory scheme permits such treatment.

This article approaches the issue of medical treatment much like the peeling of an onion, working from general to specific. Additionally, as the application of the guidance necessarily varies for categories of prospective patients, it is necessary to explore how the restrictions apply to each subset of foreign nationals. Illustrations and examples will round out the discussion for evidence of the practical aspects of medical treatment and medical waivers.

#### A. The Regulatory Environment

The current DoD policy regarding military medical treatment and medical force protection is outlined in DoD

Instruction (DoDI) 6200.04.<sup>30</sup> Included in this document is the mandate for the Armed Forces medical community to provide treatment for contractors and civilians accompanying the force.<sup>31</sup> Non-emergent civilian medical care in a COIN fight could seemingly be an extension of the current policy.<sup>32</sup> Despite the policy arguments and current mandate for treatment of non-Service members, DoDI 6200.04 is silent on the treatment of foreign nationals.<sup>33</sup> This silence should not be inferred as acquiescence to non-emergent treatment of foreign nationals. In fact, generic foreign nationals likely do not “accompany the force,” which prevents any affirmative grant of routine treatment.<sup>34</sup> Other than the broad precedent of situations where non-emergent medical treatment of civilians is appropriate, DoDI 6200.04 provides little substantive guidance.<sup>35</sup>

The sparse direction that does exist on this topic can be found in chapter IV of Joint Publication 4-02,<sup>36</sup> particularly subsection 9(d) is on point in regards to contractor medical care available.

(1) During contingency operations in austere and nonpermissive environments, contingency contractor personnel may not have access to emergency medical support established by their employer. MTFs within the theater of operations should provide resuscitative care, limited hospitalization for stabilization and short-term medical treatment, with an emphasis on return to duty or placement in the PM [patient movement] system; and assist with PM to a selected civilian facility, in emergencies where loss of life, limb, or eyesight could occur.

(2) Contingency contractor personnel are afforded resuscitative and medical care, when life, limb, or eyesight is jeopardized,

<sup>23</sup> See *supra* notes 7–12 and accompanying text.

<sup>24</sup> See generally JOINT CHIEFS OF STAFF, JOINT PUB. 4-02, HEALTH SERVICE SUPPORT, at IV-19 (31 Oct. 2006) [hereinafter JOINT PUB. 4-02] (cautioning healthcare providers to be aware of the limits of providing non-DoD beneficiaries medical treatment).

<sup>25</sup> See generally WAR SURGERY CASEBOOK, *supra* note 23 (showing how military trauma treatment has evolved).

<sup>26</sup> Goode, *supra* note 24.

<sup>27</sup> Erica Goode et al., *For a Hundred Iraqi Doctors, A Return to Normal*, N.Y. TIMES, Apr. 30, 2008, at A10.

<sup>28</sup> See, e.g., Samantha Power, *Our War on Terror*, N.Y. TIMES, July 29, 2007, at 7-1 (speaking of Lieutenant General James Mattis’s famous motto for the Marines in Al-Anbar province).

<sup>29</sup> This impact can occur both within the populace engaged by the COIN fight and among the larger public population. Maintaining domestic public support for the lengthy process of defeating an insurgency is also a significant objective.

<sup>30</sup> U.S. DEP’T OF DEFENSE, INSTR. 6200.04, FORCE HEALTH PROTECTION § 4 (9 Oct. 2004) [hereinafter DoDI 6200.04].

<sup>31</sup> *Id.* § 4.3.4.

<sup>32</sup> The argument that DoDI 6200.04 provides a basis for non-emergent treatment of civilians was not used as the authority for treatment for during the XVIII Airborne Corps’s rotation as Multi-National Corps–Iraq, Headquarters, 2008–2009. Furthermore, there was no evidence in the files of MNC–I which indicated previous reliance.

<sup>33</sup> DoDI 6200.04, *supra* note 32.

<sup>34</sup> *Id.* There may, however, be additional interpretations if indigenous people have picked up and followed the Armed Forces to work as translators, laborers, or in other supportive positions. These personnel pose a possible exception to the general rule prohibiting medical treatment for foreign nationals as a fair reading would appear imply these individuals are “accompanying the force.”

<sup>35</sup> The plain language of the source appears to be a probable and very general delegation of authority. Further guidance serves to provide a more substantive and concrete authority.

<sup>36</sup> JOINT PUB. 4-02, *supra* note 26, at IV-29.

and emergency medical and dental care while supporting contingency operations. Emergency medical and dental care include, but are not limited to: refills of prescription or life-dependent drugs (Note: contractor personnel are required to deploy with 180 days of required medication and cannot be assured that their specific medication will be included on the theater pharmaceutical formulary), broken bones, lacerations, broken teeth, or lost fillings.<sup>37</sup>

The above provisions express the general rule that the military community can provide care if the life, limb, or eyesight of the patient is in jeopardy.<sup>38</sup> This general rule provides the baseline for treatment for both contracting personnel and foreign nationals.<sup>39</sup>

The harder question to answer in practice is what constitutes a danger to life, limb, or eyesight. For instance, if an infection in a normally-functioning hand goes unchecked, the patient may lose the arm given the level of care available at the local Iraqi hospital. Applicable regulations simply did not treat this situation (and similar situations) to qualify as an actual emergency. Thus, care is not available under the exigent circumstances analysis because the infection is more of a gradual process and less immediate of an injury.<sup>40</sup> Progressive diseases such as cancer, although very deadly, likewise do not meet the definition of emergencies within the prevailing regulatory framework. A contrary interpretation would allow nearly any injury or illness to be boot-strapped into the emergency exception and effectively eviscerate the applicable policy limitations.

If medical care is provided under the emergency/resuscitative provisions, the care should be limited to stabilization of the patient until the emergency ends.<sup>41</sup> In fact, Joint Publication 4-02 states the patient should be returned to a local facility “as soon as medically

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<sup>37</sup> *Id.*

<sup>38</sup> *Id.* at IV-6, IV-18 (limiting urgent medical care only to civilians, refugees, and internally displaced persons when otherwise unavailable). The limits of this urgent care are arguable given the guidance. If care is limited to urgent medical care, the waiver process may not be required. Additionally, if routine medical care is available through contract, the waiver process is also equally unnecessary. The trend appears to be moving away from language providing this routine care in the contracting process.

<sup>39</sup> This article’s treatment of contractors is discussed only as it impacts the foreign national medical treatment analysis.

<sup>40</sup> Reasonable minds can differ on where to draw the line on exigent circumstances. Consultation with medical professionals is critical to gain an understanding of the exact medical condition and accept input on the best course of action. In line with the noted anonymous adage, “A pig gets fat, but a hog gets slaughtered.” A friendly interpretation of exigent circumstances may be allowable, but can quickly become dubious.

<sup>41</sup> JOINT PUB. 4-02, *supra* note 26, at A-8 to A-13 (discussing stabilization, evacuation, short-term hospitalization policies).

feasible.”<sup>42</sup> This language is rather ambiguous and open to significant legal and medical interpretation, especially when advanced treatment simply is not available in the local medical community.<sup>43</sup> It may be impractical to move a patient under all circumstances, with necessary stabilization legitimately lasting days at a time. After this flexible “grace” period, a policy waiver generally becomes necessary for additional medical care. In other words, medical authorities must be able to articulate a fixed point when the emergency situation has terminated, thereby permitting relocation of the patient to Iraqi facilities. Despite this relatively flexible emergency standard, logical and practical considerations still limit the “wiggle room” provided by most emergency treatment provisions. Medical personnel should therefore undertake continued medical treatment in good faith, supported by well-reasoned medical and legal underpinnings.

On a practical note, coordination should occur during the transition period between a possible medical waiver and any return to the Iraqi system. The best solution is often to have the “emergency” care provided by the U.S. forces get the patient on the road to recovery in the first hours, and then transfer the patient to an Iraqi facility for follow-on care. Coordination between the Iraqi and U.S. medical personnel can leverage this initial emergent treatment to the greatest extent possible. Education of the medical professionals regarding the legal constraints for foreign national follow-on care is helpful to ensure resources are best utilized. If the medical treatment cannot be considered emergency treatment, the legal analysis does not necessarily end. The final method to facilitate U.S. military medical care is through a foreign national medical waiver request. Guidance for the Iraq Theater of Operations (ITO) is outlined in Multi-National Force–Iraq (MNF–I) Policy Memorandum 11-1.<sup>44</sup> This document reflected not only the broad intent of regulatory compliance, but also the COIN value of providing medical care to foreign nationals in limited circumstances.<sup>45</sup> Under this policy, the ITO was given a strict process for controlling non-emergency medical care of foreign nationals as reflected in DoD policy.<sup>46</sup> The approval authority for medical waivers generally rests with the Chief of Staff of MNF–I in concurrence with the MNF–I Surgeon.<sup>47</sup> The waiver requests, however, were routed through operational channels including the Multi-National

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<sup>42</sup> *Id.* at IV-30.

<sup>43</sup> When there is no comparable level of care available in local facilities, the term “medically feasible” has limited meaning. Arguably, a return to local care is never feasible when comparable care is unavailable.

<sup>44</sup> See generally Policy Letter 11-1, Multi-National Force–Iraq, subject: Chapter 14 Medical Services (2 Dec. 2007) [hereinafter MNF–I Policy 11-1].

<sup>45</sup> *Id.*

<sup>46</sup> See MNF–I Policy 11-1, *supra* note 46, at 14-50 to 14-57.

<sup>47</sup> *Id.* at 14-53.

Corps–Iraq (MNC–I) Chief of Staff and Surgeon.<sup>48</sup> Thus, the MNC–I legal reviews focused on advising the MNC–I Chief of Staff and providing the first legal look at the proposed grounds for medical treatment of a foreign national.

Each waiver request was analyzed on an individual basis given the potential patient’s medical diagnosis, demographic, and location. The outcomes were based upon the confluence of these factors, but were fundamentally a function of the patient’s demographic. An examination by demographic appears to be most instructive, as this was the largest factor in the ability U.S. forces to treat foreign nationals in non-emergency situations.

## B. Civilians on the Battlefield

Although the COIN fight is recognized to be for the people,<sup>49</sup> medical policies have not been updated to reflect this crucial strategic objective. Iraqi civilians are not generally entitled to medical care with American assets absent exigent circumstances and should seek treatment at local Iraqi facilities.<sup>50</sup> This policy reinforces the historical thinking regarding wounded civilians on the battlefield.<sup>51</sup> Third-country civilians, absent an unusual relationship with the U.S. Government, should be treated in much the same way as local civilians.<sup>52</sup> This generic analysis, however, can be impacted by the individual circumstances of the civilian, the mechanism of injury, and any “special” status the civilian may hold. In short, a medical waiver is the usual and customary route for civilian treatment of non-emergency illness.

The ITO is flush with contractors serving various aspects of the military apparatus.<sup>53</sup> The ability to provide medical care for contractors is impacted by their location of hire, contract position, and contract language. Foreign nationals may gain additional avenues of medical treatment

if they are contractors working in direct support of military operations.<sup>54</sup> Locally-hired theater support contractors, however, have no entitlement to medical care, except when injured on the job at a U.S. military facility.<sup>55</sup> For other contractors, routine medical care by the military was included in their individual contract.<sup>56</sup> A foreign national medical waiver is not needed if the U.S. Government has a contractual relationship with the injured foreign national to provide for non-emergent care. Experience has shown that few foreign nationals were able to secure this medical language in their contracts, although contractual medical requirements were more wide-spread among American citizens. Any suggestion that a medical waiver is unnecessary due to contractual relationship necessarily requires the reading and review of the individual contract in question.

The idea that non-emergency care is in the best interest of the United States can also provide the grounds for a medical waiver under the applicable policy.<sup>57</sup> Normally a “best interest” scenario occurs when U.S. forces unintentionally injure Iraqi citizens. In fact, if the injuries to a civilian occur as a direct result of U.S. action, the wounded civilians may be evacuated and treated by U.S. medical personnel.<sup>58</sup> Despite the general preference to treat Iraqi civilians in Iraqi facilities, continued treatment is in the best interest of the U.S. Government when it has caused such injury. Medical care of foreign civilians who were simply bystanders injured in combat was the most widely used foreign national waiver during the XVIII Airborne Corps’s rotation as MNC–I.

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<sup>48</sup> *Id.*

<sup>49</sup> FM 3-24, *supra* note 6, at 2-6.

<sup>50</sup> *Id.*

<sup>51</sup> Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in the Armed Forces in the Field art. 12, Aug. 12, 1949, 6 U.S.T. 3114, 75 U.N.T.S. 31 [hereinafter 1949 Geneva Convention] (explaining that civilian medical care remains the primary responsibility of civilian authorities).

<sup>52</sup> See MNF–I Policy 11-1, *supra* note 46, at 14-53. (depicting a table treating non-governmental organization workers the same as Iraqi civilians and briefly discussing existing relevant agreements). Detainees, Federal civilian employees, and United Nations personnel, however, generally had access to the full-spectrum of U.S. military medical care based upon this policy and the underlying agreements. Planning for treatment of U.S. Government employees, detainees, and others is specifically addressed in JOINT PUB 4-02, *supra* note 24, at IV-4.

<sup>53</sup> See, e.g., John Broder & David Rohde, *State Dept. Use of Contractors Leaps in 4 Years*, N.Y. TIMES, Oct. 24, 2007, at A1.

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<sup>54</sup> JOINT PUB 4-02, *supra* note 26, at IV-30 (generally prohibiting host nation and locally-hired, third-country-national personnel from receiving medical treatment, but recognizing the requirement to support contractors who operate in direct support of combat operations).

<sup>55</sup> *Id.* The United States often provides theater support contractors as a non-skilled labor force to augment numerous logistical and construction requirements in deployed settings. An example of a theater support task would be to employ local nationals to help with the emplacement of earthen berms, barriers, or structures for installation protection.

<sup>56</sup> *Id.* at IV-27. These provisions typically were found with U.S. citizen contractors employed by the DoD. Iraqi Nationals who had routine healthcare in their employment contracts appear to be few and far between as the MNC–I administrative law section only read one contract with routine care provisions during OIF 2008–2009 for an Iraqi National. Contractor care, however, is generally based on a system of reimbursement. Thus, many fiscal problems associated with the use of medical resources are solved by the reimbursement requirement. Although this process requires deliberate tracking of expenses, the regulatory concerns are mollified by the reimbursement clauses. Furthermore, many contractors were former members of the U.S. Armed Forces. Armed Forces retirees have the ability to obtain routine care at most military treatment facilities on account of their retirement status. These retirement benefits may circumvent the need for additional analysis on treatment eligibility.

<sup>57</sup> MNF–I Policy 11-1, *supra* note 46, at 14-53 to 14-54.

<sup>58</sup> JOINT PUB 4-02, *supra* note 26, at IV-29 to IV-30.

The best interest exception was not limited to bystanders. Iraqi officials could also receive American medical treatment based on the nature of their job or stature under the “best interest of the United States” exception.<sup>59</sup> The prospective patient’s position should make treatment specifically advantageous in the COIN environment. The request for treatment under the “best interest” rationale must come from at least a major general or the U.S. Ambassador to Iraq.<sup>60</sup> Top officials in the Iraqi Government may be granted medical care in consultation with the Department of State and the MNF–I surgeon.<sup>61</sup> These upper-level officials’ requests are evaluated on a case-by-case basis and coordinated through the Department of State Health Attaché for maximum results.<sup>62</sup>

Additionally, treatment may be provided if the prospective patient is a high value individual or security risk.<sup>63</sup> The most applicable use of this exception occurred when the prospective patient had recognized authority outside of the official Government of Iraq and was, thus, a “high value individual.”<sup>64</sup> There is an inherent political weighing process applicable to every waiver request, as each waiver packet must be authorized in writing before treatment can begin.<sup>65</sup> Practically speaking, important sheiks and other local powerbrokers had a better chance of obtaining a foreign national medical waiver given their ability to impact the political and security environment. In fact, engaging key leaders is an important aspect of the COIN fight.<sup>66</sup> Medical treatment can build stronger relationships and serve as a source of leverage in these engagements. Iraqi leaders who were targeted by insurgents because of their cooperation with U.S. forces were also often the beneficiary of medical waivers. Although the exceptions might be interpreted as preferential treatment to the politically well-connected, this is not the case. In order for the waiver to be effectively used in a COIN environment, judicious use of medical resources must be exercised only on those whose treatment can improve conditions on the ground in some concrete way. A little wiggle room is inherent in the broad “in the best interests” or “high value” language, but articulable benefits

must be present for a medical waiver to comply with the regulatory structure.<sup>67</sup>

If the United States did not cause the injury, the civilian has no ties to the U.S. Government, and the best interest or high value exceptions are unavailable; treatment in a U. S. facility is generally precluded. While the unavailability of military medical care for these civilians is unfortunate, the fact remains the regulatory constraints simply prevent the U.S. military from serving the entirety of the civilian population on the battlefield. Even though most civilians are not eligible for medical care, there are also other populations which may avail themselves of U.S. military medicine given the appropriate conditions.

### C. Security Forces

Although the mantra of “by, with, and through” the Iraqis is still applicable, the medical treatment of Iraqi Security Forces (ISF) is not mandated by this partnership.<sup>68</sup> The Iraqi forces are properly categorized as “host nation forces” under the applicable guidelines.<sup>69</sup> Given this status, the standard answer to the question of medical treatment is that host nation forces will be treated using host nation facilities. In most respects the legal analysis for ISF mirrors the analysis for Iraqi civilians.<sup>70</sup> In fact, MNF–I policy explicitly states “MNF–I has no legal obligation to evacuate the ISF, however, MNF–I units may do so if called upon by specific reasons.”<sup>71</sup> When applying this policy, MNC–I interpreted the “specific reasons” to include the preservation of life, limb, or eyesight as listed in Joint Publication 4-02.<sup>72</sup> The non-emergent treatment of members of the ISF posed challenges where they were not injured by the Coalition or during Coalition operations.<sup>73</sup> The waivers submitted for members of the ISF were often generically based upon moral underpinnings, because the level of care provided in the Iraqi system simply was not commensurate with what the United States could provide.<sup>74</sup> While these cases may have

<sup>59</sup> *Id.*

<sup>60</sup> MNF–I Policy 11-1, *supra* note 46, at 14-54.

<sup>61</sup> *Id.* at 14-53.

<sup>62</sup> *Id.* at 14-53 to 14-54.

<sup>63</sup> *Id.* at 14-54.

<sup>64</sup> As the COIN environment matured, tribal and religious leaders played an increasingly important role coordinating with the U.S. military. Although an Iraqi national could be both a “high value individual” and a “high value target,” these terms are not synonymous. A “high value” individual in the context of medical waivers was typically a political or tribal leader.

<sup>65</sup> MNF–I Policy 11-1, *supra* note 46, at 14-54.

<sup>66</sup> FM 3-24, *supra* note 6, at 2–9 (cautioning readers to consider the impact of key leaders).

<sup>67</sup> MNF–I Policy 11-1, *supra* note 46, at 14-53 to 14-54.

<sup>68</sup> *Id.* at 14-50.

<sup>69</sup> See generally JOINT PUB 4-02, *supra* note 26 (differentiating between allied personnel and host-nation personnel).

<sup>70</sup> See generally MNF–I Policy 11-1, *supra* note 46.

<sup>71</sup> MNF–I Policy 11-1, *supra* note 46, at 14-50.

<sup>72</sup> See JOINT PUB 4-02, *supra* note 26, at IV-29.

<sup>73</sup> See discussion, *supra*, regarding Iraqi civilians obtaining medical waivers.

<sup>74</sup> Part of the security gains were attributable to tribal rejection of and resistance to extremist influence. These tribal and local militias—especially ones located in Al Anbar—would become known as the Sons of Iraq. While these men did provide security (and may have even been promised integration into the ISF), a waiver request for a Sons of Iraq was typically processed through in much the same way a request for treatment of an Iraqi civilian.

been opportunities to strengthen the partnership between the two nations, successful non-emergent waivers for standard ISF members were few and far between.

#### IV. Conclusion

At times, despite humanitarian sentiments, it is simply outside the regulatory guidelines to provide medical care for foreign nationals. While the regulations are more conducive to a garrison and cold war paradigm, judge advocates and commanders can only change behavior, not rules. Effective

COIN operations during a contingent environment require nimble commanders and all the resources of the U.S. Government. The medical waiver process can be an important component of this battle when the regulations would normally preclude the utilization of such a weapon. In coordination with the medical community, the deployed judge advocate can further focus all the resources of the U.S. military on winning the COIN fight.