like it! But man's predeliction for destructive courses of action must end, logically, in self-destruction. Perhaps only a deep awareness of this fact will save us. Thus, Marcuse's hope and despair derive neither from the categories he extrapolates from a hoary system of metaphysics nor from his pessimistic assessment of what our problems are (as many of his critics allege). The truth, I believe, is more nearly that both are grounded in the nature of our problematic selves.

other voices

CIVILIAN WAR CASUALTIES AND MEDICAL CARE IN SOUTH VIETNAM

E. A. Vastyan of the Department of Humanities, Pennsylvania State University College of Medicine, is interested in the civilian casualty "numbers game." His concern with statistics is that they correctly reflect the problem of providing adequate medical care for the people of South Vietnam. Perhaps most startlingly illustrated below is the lack *of adequate data on the number of war-injured civilians. Nevertheless, estimates can be made, as Mr. Vastyan shows, and these indicate that the numbers are large indeed. If such estimates are dismissed as "mere speculation," we can ask if there is any chance for proper assessment of the real needs of the Vietnamese populace.*

Only a portion of Mr. Vastyan's study is reprinted here, and readers might wish to consult his original article which first appeared in the April issue of the Annals of Internal Medicine.

The plight of civilians who are casualties of the war in Vietnam stands in blunt contrast to the remarkable medical care available to injured American troops, who are receiving what is clearly the best such care in military history. Among combatant casualties who reach medical aid, the death rate has fallen from 4.8% in World War II and 2.5% in Korea to but 1% in Vietnam. One survey of a major American combat hospital unit showed that patients arrived on an average of forty minutes after wounding; some were under expert medical care within five minutes.

Accounts of the medical facilities and care available to noncombatant casualties, on the other hand, use such descriptions as shocking, appalling, and frightful. Casualty statistics were not kept or apparently even attempted during the first three years of intensified hostilities; only estimates of the magnitude of war damage to civilians are available. Yet even the most moderate of these reveals massive suffering and a major tragedy.

> Between 1967-1969, the number of civilians killed or wounded each year has been between 100,000 to 300,000, according to authoritative estimates [*New York Times,* December 3, 1969; United States Senate, Committee on the Judiciary, Subcommittee to Investigate Problems Connected with Refugees and Escapees: Civilian casualty and refugee problems in South Vietnam: findings and recommendations, U.S. Government Printing Office, 1968]. Of these, an estimated 25% have been killed outright or have died seeking medical care or abandoned without any care [Subcommittee findings and recommendations, *op.-cit.; New York Times,* December 12, 1967]; and this figure has been sharply challenged as being far too low [*New York Times,* December 13, 1967]. One knowledgeable estimate placed the civilian casualty toll as 1,000,000, with an estimated 300,000 killed, during a decade of war [Edward M. Kennedy: Civilian war casualties in Vietnam, *Congressional Record—Senate, Dec. 22, 1969*]. . . .

Civilian war casualties have been incurred by the South Vietnamese throughout the more than twenty years of a war that had already ravaged the country, but the magnitude of the problem burgeoned with the escalation of hostilities. After the first landing of U.S. Marines on March 8, 1965, United States troop levels had reached more than 175,000 by the end of August, and major military engagements and casualties became routine. Widespread civilian casualties became routine as well.

No reliable statistics regarding noncombatant injuries or deaths in South Vietnam exist for periods before 1967. According to the United States Agency for International Development of the U.S. Department of State (USAID), such data were identified in the medical records of neither the Vietnamese nor United States hospitals concerned. In response to increasing public pressure, the first authoritative estimates were made in April, 1967 and later clarified before executive sessions of a Senate Subcommittee. These indicated that each month approximately 1,200 civilian war casualties were being admitted to the Ministry of Health (M.O.H.) hospital in 1965; these casualties increased to between 1,500 to 2,000 in 1966 and jumped sharply to 4,000 per month for 1967. Half the casualties that were actually occurring, it was

judged, never reached provincial hospitals, nor were figures then available as to those treated as outpatients. Since 1967 an attempt has been made to collate statistics regarding hospitalized civilian war casualties, but reporting by Vietnamese provincial hospitals has been incomplete and erratic. The total number of civilian war casualties and the basis and methods for compiling whatever figures are cited remain an issue of sharp political contention.

Expanded hostilities also produced a flood of refugees who began "to wash down from the north to the dubious security of Saigon as if the whole country had been tilted up to drain." From an estimated total of 40,000 at the end of 1964, the refugee population grew by an officially admitted cumulative total of 1,679,000 during the next two years. It had reached a cumulative total of 2,114,200 by the end of 1967, with unofficial estimates insisting the actual figure was between 2 to 3 million more. One-third of the population has been made homeless during the course of hostilities. . . .

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With the appointment of Major General James W. Humphreys, Jr., as Assistant Director of Public Health of the USAID, a redirection was mounted in American efforts [in the area of medical aid to Vietnam]. Operational concepts were based on the explicit assumption that the war situation would become more intense through 1968 and that the steadily increasing number of injured persons would overwhelm the current capabilities of health resources in Vietnam. A key policy principle enunciated at that time stipulated "the philosophy of *working within the framework of the Government of Vietnam will remain valid* and only in those instances where they wholly lack, or a critical shortage of technical skill exists, will any direct action be taken and then only with the approval of/or in conjunction with the Vietnamese authorities." Assessing the Vietnamese Ministry of Health's "budgetary limitations and depleted health infrastructure" as rendering it incapable of coping with massive aid, USAID planned "an orderly, phased, and planned build-up of foreign technical assistance under strict control." . . .

Thus the USAID, charged with directing all American medical assistance to South Vietnam, clarified its policy principles just as hostilities increased the medical burdens sharply, both in scope and intensity. Enunciated clearly and explicitly, these two standards were to dominate both policies and procedures throughout the subsequent years: aid was to be directed toward the sharpest psychological impact upon the population's loyalty to the Government of Vietnam; aid would be provided only with, through, and dependent upon the Vietnamese government, under the Minister of Health. Both principles were cast within a projection of sharply increased civilian casualties.

Within such constraints, United States medical assistance to South Vietnam increased markedly during the next two years. And by mid-1969 certain substantial accomplishments could justifiably be claimed in providing care for civilian war casualties. . . .

Despite such accomplishments, criticism of United States efforts in behalf of injured civilians has recurred sporadically in the public press. Some of this has been directly related to political dissent over the nation's role in the Vietnamese war, but informed criticism has come from physicians and other voluntary agency personnel who have worked in Vietnam. The most persistent, concerned, and informed scrutiny of the plight of civilian war casualties has been directed by Senator Edward M. Kennedy, through his role as Chairman of the Subcommittee to Investigate Problems Connected with Refugees and Escapees of the Senate Committee on the Judiciary. Kennedy's public involvement predates American military escalation and was expressed for the first time in a Subcommittee report dated February, 1965.

With its first concern directed toward the fate of the mounting numbers of civilians made homeless by hostilities, the Subcommittee urged adequate assistance to refugees as an integral part of any effort in Vietnam. Failing to gain satisfactory response from the Administration, the Subcommittee opened executive sessions in July, 1965, to question representatives of the State Department and USAID. . . .

The Subcommittee's attention to refugees inevitably involved it in the problems of war-injured civilians and the critical shortage of medical care available to them. Little factual information was available. In addition to launching a staff investigation of both problems, Subcommittee members made personal tours of South Vietnamese refugee and health facilities in October. Although budget levels were subsequently increased somewhat, USAID made few changes in its basic policy of a phased increase in medical assistance channeled entirely through the Ministry of Health. . . .

Apparently in response to criticism and to the Subcommittee's persistent prodding, the medical care problem was placed on the agenda of the March, 1967, Guam Conference between American and South Vietnamese Presidents. Shortly after the meeting, President Johnson dispatched Dr. Howard A. Rusk on an investigation tour of Vietnamese hospitals, and by April USAID announced that three new hospitals would be built and manned by Department of Defense personnel that would be devoted exclusively to the care of civilians. As announced, they would provide up to 1,000 beds, and helicopter ambulances would be provided to USAID for civilian use for the first time. In a *New York Times* column three days later, Dr. Rusk hailed the announcement as "a truly historic milestone." But funding for the hospitals was constantly postponed, and monies were not provided until after Senator Kennedy's personal appeal to De-

partment of Defense Secretary McNamara. None of the hospitals opened until July, 1968, and then they were reserved for wounded American servicemen and opened to civilians only on a "space available" basis. One has since been closed. Helicopters were never provided for full-time use for civilian evacuation. . . .

. . . What came to be called the "numbers game" had begun in 1965 with Kennedy's charges of a lack of realism in appraising the magnitude of an exploding refugee population and a lack of urgency in coping with it. After USAID had discounted his allegation, he had launched the first G.A.O. [General Accounting Office] investigation, which reported "serious deficiencies in the attitudes and actions of both the South Vietnamese and American government agencies involved," leading to USAID's admission that "we were caught short . . . the health problem is so enormous that everything we have done to date is not much more than a drop in the bucket" [W. S. Gaud, in testimony before the Subcommittee, 1968].

In the public press, civilian casualty statistics had been reported to be secret until the Subcommittee released an estimate of 100,000 casualties for 1967. USAID countered with an immediate rejoinder insisting casualties would not exceed 50,000, but the Agency's own medical director in Vietnam, Col. William Moncrief, in the first official estimate made in December, corroborated 100,000 as the projected rate. He further estimated that, of these, 24,000 would either have been killed outright or have died seeking medical aid.

Health budgets were reported to be totally inadequate by Dr. John H. Knowles of the Medical Appraisal Team [sent by President Johnson to Vietnam in 1967 for a one-month tour of health facilities]. USAID's total medical budget for fiscal year 1967 was roughtly ¼ of 1% of the total U.S. expenditures in South Vietnam, "an allocation for an entire year equal to one-half day's war effort." . . .

An absence of urgency was repeatedly charged. Although the G.A.O. reported that USAID claimed the civilian casualty problem as the single most important aspect of the public health program, it held in contrast a briefing document prepared by USAID for President Johnson's use at the Guam Conference. That memo said in part:

> Neither the U.S. Mission in Saigon nor the GVN [Government of Vietnam] advocate a radical acceleration in the presently planned steady expansion of the civilian medical assistance effort. They do not consider the present overcrowding of hospitals or limited access to medical treatment in remote areas critical to our success in the political-psychological side of the war effort.

Shortly after the open hearings were concluded, the Subcommittee again toured refugee and health facilities in Vietnam just before the Tet hostilities multiplied the numbers of both refugees and casualties. Already overburdened medical facilities were overwhelmed, many were destroyed, and the medical school at Hué succumbed entirely. . . .

Commissioned by the Subcommittee, a new field study was conducted during the summer [of 1970] and reported familiar findings of devastation and despair. In Laos 253,261 refugees were officially recognized by USAID in a July report, with 60% of the number generated since February; serious food shortages, inadequate health and housing facilities, and minimal resources were described. Of an estimated 1960 population of 400,000 Meo tribesmen, 40% to 50% of the men had been killed, and 25% of the women and children had fallen as casualties of war by 1970. From the outset of American involvement in Laos, the report charges, USAID has acted as a paramilitary organization—"simply a euphemism to cover American assistance to persons, mostly hill tribesmen, who agreed to take up arms and support efforts against the Pathet Lao."

In Cambodia, tides of refugees—both ethnic Vietnamese and Khmers—were described as sweeping rootless through the country. In less than six months of war it was estimated that more than 400,000 Vietnamese ethnics and 1,000,000 Khmer were made refugees; by early August the population of Phnom Penh had more than doubled, from 700,000 to 1,500,000, and provincial capitals throughout the country were described as bulging with new arrivals. "Although U.S. officials were obviously aware of the widespread displacement of people, there was little evidence to suggest they were much concerned about the situation, its tragic potential if the war in Cambodia continued, or the impact of U.S. military activities on the civilian population."

In Vietnam the problems of civilians were found to be as overwhelming as they had ever been in the past. The rate of casualty admissions to G.V.N. and U.S. hospitals was found to be little changed from previous years, although higher in certain sections, and still not reflective of the larger number of casualties who die or are treated elsewhere or not at all. Although 500,000 refugees remain on official counts (with thousands more being generated each month), the report states that at least 3,000,000 remain in camps and urban slums as "statistically resettled," classified out of existence while remaining in unalleviated conditions. A threatened 25% budget cut in the USAID medical support program was disclosed. "Under the banner of 'Vietnamization,' a plethora of new terms and slogans have been created in Saigon to describe, and hide, old problems and unchanged programs," the report charges.

Turning again to the General Accounting Office, the fiscal "watchdog" of the Congress, the Subcommittee requested a new investigation into the use of American expenditures for civilian health programs in Vietnam. In a report published in December, 1970,

the G.A.O. found that USAID had still established no specific priority designation for the treatment of war-related casualties. A new USAID recommendation had been made, however, "that the project associated with civilian war-related casualties be placed in the lowest category, and that top priority be accorded longer term assistance projects."

Continuing inadequacies in counting civilian war casualties were again reported, with USAID estimates still based solely on admissions to Ministry of Health and U.S. military hospitals. Although such admissions show no significant decrease from previous years, G.A.O. found cut-backs in resources allocated for the care of civilian war casualties. . . .

Yet little public or professional attention, apart from the Senate Subcommittee, has been paid to the obvious inadequacies of government actions and policy in the medical sector. Although USAID has responded with reluctance to public scrutiny, numerous investigations and hearings have revealed severely censurious data regarding both its activities and policies. . . .

Over the past two decades, disaster research has provided fairly reliable methods for disaster planning. Yet USAID has apparently undertaken no such efforts regarding civilian war casualties; on the contrary, it has repeatedly discounted all casualty estimates as "mere speculation." The attempts by the Senate Subcommittee to determine a reliable casualty projection and a base for rational action are dismissed as "having no valid basis or methodology." Paradoxically, USAID continues to publicize detailed statistics regarding Viet Cong terrorism, without reservations about their accuracy, although such figures are collated from "incidents reported daily to the National Police of South Vietnam, who record assassinations, abductions and wounded." . . .

United States medical assistance efforts were minimal until a National Security Council directive of 1962 urged increased aid as part of the counterinsurgency program of our foreign policy in Indochina. From that time onward, there are repeated exhortations to "the other war," to "winning the hearts and minds of the people." According to USAID's consequent policy principles as described by Humphreys, medical aid would be delivered through the Ministry of Health except in rare instances, and priority would be given to such aid as created the sharpest impact upon the people to win their loyalty. Thus the ethics of medical relief were delivered as hostages to bureaucratic protocol, on one hand, and to psychological strategy aimed at winning support for a specific regime, on the other.

Other military physicians corroborate and defend such policies without questioning the contradictions involved, hailing medical care as the universal language of altruism and, at the same time, as a powerful psychological tool for military purposes. . . . Clearly enunciated, such a policy of ideological triage has permeated official medical assistance programs; it has also engendered an accepted and officially acceptable policy of neglect. . . .

The agony of Vietnam is the agony of innocents—of noncombatant civilians, mostly women and children. Whether or not we choose to acknowledge such suffering, it is the agony of the American people as well.

correspondence

STILL MORE ON "RHETORIC"

Washington, D.C.

Dear Sir: Ernest Lefever's analysis of "Reckless Rhetoric and Foreign Policy" (*worldview*, November, 1970) may yet stimulate a meaningful dialogue on the serious issues he raised, but the responses of Richard Neuhaus and James Smylie in the February issue can only be regarded as disappointing. Both accuse Dr. Lefever of employing the type of rhetoric he claims to deplore and suggest he help us all to begin by reforming himself. It takes no particular perspicacity to note that they did not heed their own advice, when Mr. Neuhaus speaks of hoping to rescue "something of Mr. Lefever's reputation as a man of integrity" and Professor Smylie discusses "Lefever's Joe McCarthyism." . . .

In defending Martin Luther King's Riverside Church speech of April, 1967, which Dr. Lefever had singled out for detailed analysis, Mr. Neuhaus lays down several specific challenges to Dr. Lefever. He says that Dr. Lefever is wrong, first of all, in calling it "little-remarked" and suggests, in retrospect, that it was probably one of Dr. King's "three most-remarked speeches." I searched *Time* and *US News and World Report* for that period and found no singular mention of the speech. Both did report on Dr. King's anti-Vietnam policy proclamations at the Chicago rally of 25 March and on his presence at the mass demonstration in New York on 15 April and his sharing the anti-Administration platform with Stokely Carmichael. The Executive Director of the Society for Religion in Higher Education distributed King's speech to members of the Society in May of 1967 partly "because it did not receive adequate press coverage". . . .

. . . I was the author of a paper at the CRIA consultation to which Mr. Neuhaus and Dr. Lefever both refer in presenting their assessments of that speech. . . . I pressed my point of view with Mr. Neuhaus following break up of the formal discussion. We were joined by Dr. Lefever, and a discussion of the origin as well as the factual basis of Dr. King's speech ensued. In his letter, Mr. Neuhaus challenged Dr. Lefever "to produce any evidence of his slurring remark" to the effect that the Riverside speech was ghost written. I doubt that it is very important to analysis of the content or even the intent of Dr. King's speech, but it was in that particular encounter that both Dr. Lefever and I first learned from Mr. Neuhaus that he was among the principal authors of