



# AIMING AT A FALSE TARGET: MEDICAL READINESS WARGAMES REVEAL GOODHART'S LAW

Goodhart's Law: Once a metric is used as a target, it loses its value as a reliable indicator.

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## ABSTRACT

The Army National Guard (ARNG) Chief Surgeon's Office (CSG) hosted medical readiness wargames during the 2025 ARNG Medical Team Conference and the most recent iteration of the ARNG State Surgeon / Deputy State Surgeon course. These games were designed around real-world data from the ARNG Medical Readiness System Availability Model, a data system that analyzes changes within the Medical Protection System (MEDPROS) data over time (Annis, 2019a & Annis, 2019b). These games represented the first opportunity to enhance the peer-learning of state-level senior medical leaders through high-fidelity simulation training. Unlike previous tabletop exercises, these wargames responded to the participants' operational plans based on real-life data. For example, the notional soldiers in the scenario failed to report to their periodic health assessments in the same ratio as this had occurred in the previous year for the real-world sample of soldiers selected to build the simulations. As small teams navigated the wargames, their actions were scrutinized to identify which tactics worked best for improving medical readiness. However, in both wargames, the team that raised its Medical Readiness Classification Go (MRCGo) status the highest had the least understanding of its risk. Interestingly, the reverse was also true. The team that had the lowest MRCGo had the best understanding of the medical readiness deficiencies in its formation. Unintentionally, CSG wargames revealed the impact of Goodhart's Law. This led to a greater conversation about the true purpose and meaning of metrics used to assess medical readiness. It may be time for the Army AMEDD community to reflect on the true purpose of measures of medical readiness and how the risks of medically unready soldiers might be best communicated to commanders.

## CONFLICTING OPERATIONAL PHILOSOPHIES

The wargame presented a fictional state that had interrupted medical readiness operations over the previous three months. The mission was to preserve and improve, to the best degree possible, the medical readiness of the state with the fiscal and time resources provided. Two operational philosophies emerged in both wargames. The first philosophy, referred to as "continuous monitoring," totally reset the medical readiness of units. The second philosophy, referred to as "defect-focused concentrated medical readiness activities on those who were or would become medical readiness deficient during

the next quarter. The small teams operating under the continuous monitoring philosophy inspected more troops and found more medical readiness deficiencies (MRC3–Not Medically Ready soldiers). This approach lowered the overall percentage of MRCGo soldiers. Meanwhile, the teams operating under the defect-focused philosophy sought to correct only known deficiencies and, as a result, examined fewer soldiers overall. While those who used the defect-focused philosophy did in fact gain greater levels of MRCGo, they did so at the cost of having an unknown risk of soldiers not being medically ready if activated for a mission. This recurring pattern raised several questions. Were the teams' interpretations of the mission

flawed? What were the Commanders actually seeking when they asked to improve medical readiness? Was it simply a positive change in the MRCGo metrics that was provided by the defect-focused philosophy, or were they asking for a genuine reduction in the risk of medically non-available soldiers through continuous monitoring?

### GOODHART'S LAW MEETS MEDICAL READINESS

Economist Charles Goodhart observed that when a metric becomes a goal, its effectiveness as a performance measure diminishes. Without a goal, a metric simply reports what “is.” When a target goal is applied to a metric, a value judgement of being “good” (within standards) or “bad” (outside of standards) is created. This may simply be a function of the law of unintended consequences. Organizations or individuals often change or manipulate their actions to artificially raise or maintain a desired performance measure, without actually addressing the underlying issue.

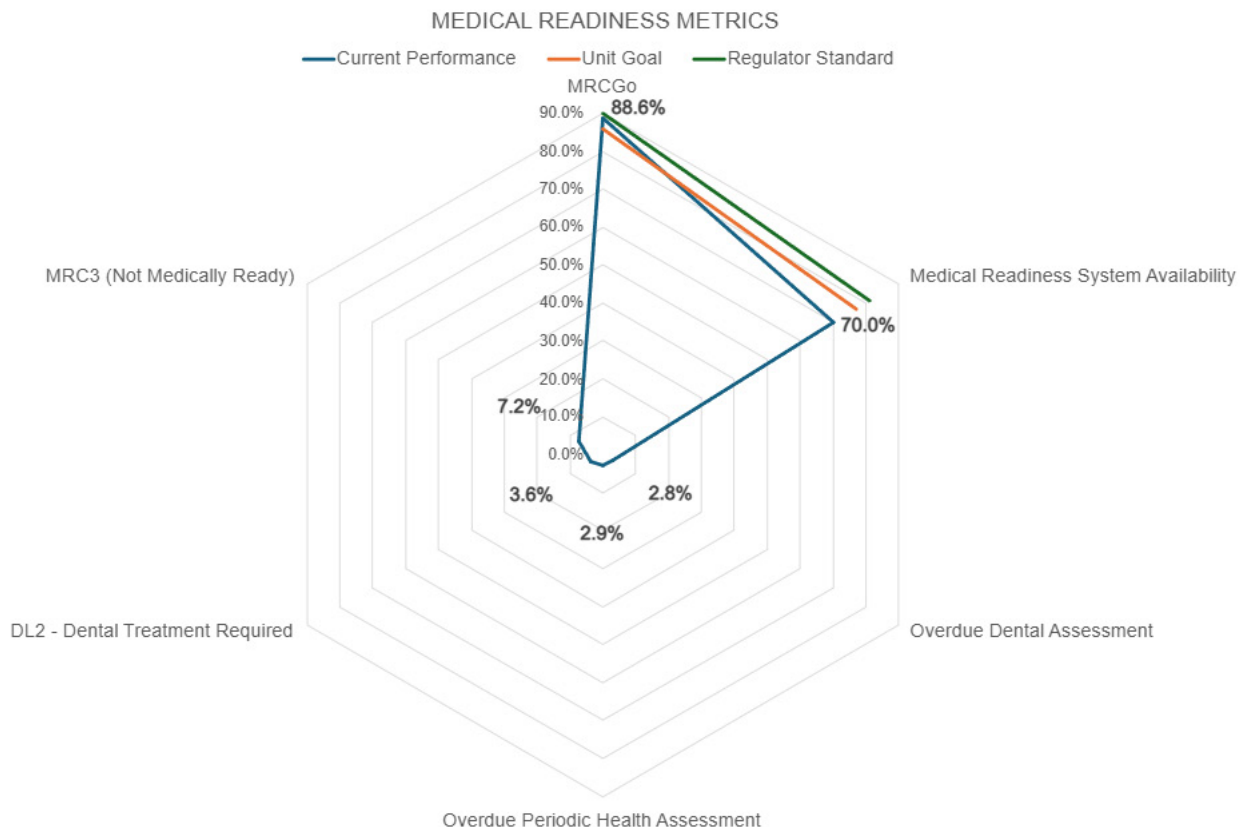
After Army Regulation 40-502 set 90 percent as the medical readiness goal, it created an incentive for soldiers to game the system. While units can legitimately reach 90 percent by improving medical readiness operations, policies, and support systems, some may find it easier to manipulate the data to hit the target. Gaming can be relatively harmless, such as focusing only on fixing readiness deficiencies, or more serious, such as providers avoiding necessary profiles to preserve the appearance of medical readiness. Over time, this can lead to surrogation, where the metric becomes the focus instead of the purpose behind it. Those who used the

defect-focused philosophy in the ARNG Medical Readiness wargames appeared to fall into this trap, losing sight of the true intent of medical readiness monitoring.

### AVOIDING/MINIMIZING THE IMPACT OF GOODHART'S LAW

The AMEDD community can take several steps to minimize the problems associated with Goodhart's law. The first is understanding a unit's mission and communicating medical readiness in relation to the mission instead of the arbitrary standard of AR 40-502. The second is to communicate medical readiness through more than a single metric. The third is to clearly articulate the areas where the commander can be most influential on medical readiness. The fourth is to shape any medical readiness award systems through the above suggestions. Commanders need a clear understanding of the intent behind these steps. Ultimately, the purpose of a more complex medical readiness reporting system is to ensure more accurate, and potentially less corruptible, assessments of medical readiness.

Units in garrison could display MRCGo to provide the current level of medical readiness along with the MRC4 (Medically Indeterminate soldiers) percentage, an area where commanders can immediately influence. A deployed unit might display its MRCGo rate, showing the percentage of soldiers who are immediately medically ready for missions, along with the Medical Readiness System Availability rating, which predicts the percentage of soldiers expected to be medically ready on any given day one year into the future. This would allow commanders to source



troops for immediate missions and anticipate how medically ready their formations might be for future missions.

## IMPROVED VISUALIZATION OF DATA

Improving medical readiness reporting will require a change in how we visualize data. Shifting from the single-metric “stoplight” chart (Green / Amber / Red) to a multi-variable radar chart will mitigate some of the negative effects of Goodhart’s Law. Instead of using arbitrary medical readiness goals, units should shape their own specific, measurable, achievable, relevant, and time-bound (SMART) goals for the needs of their assigned missions and resources.

Most importantly, the AMEDD community must exercise courage and remember their mission to conserve the fighting strength. It is imperative that no effort be made to disguise any problems with medical readiness. The commander needs to be informed about any medical readiness metrics that show unusual patterns even when the overall MRCGo rating is at or above the regulatory 90 percent. In this way, either medical information systems can correct data issues and commanders are given maximum time to address medical threats to fighting strength. Let us not confuse our focus. Excellence is not a MRCGo percentage; it is the ability to keep soldiers in combat formations.

## MAINTAINING FIGHTING STRENGTH

As the ARNG medical readiness wargames showed, Goodhart’s Law was on full display, demonstrating that once a metric becomes the focus, it becomes a less accurate measure of genuine success.

The contrasting operational philosophies—one aiming for comprehensive resets and the other for targeted interventions—showed the potential danger of valuing metric improvements over actual preparedness. Teams that maximized their Medical Readiness Classification Go (MRCGo) scores often did so at the expense of understanding underlying risks, while those with lower scores had a deeper grasp of their units’ deficiencies. This accentuates the threat of surrogation, where the metric becomes more important than the mission it was designed to reflect. For AMEDD to overcome these difficulties, it needs to implement a more detailed, mission-specific method for readiness reporting, moving away from single-metric evaluations. Incorporating multiple metrics, aligning goals with unit missions, and fostering transparency will help ensure commanders receive an accurate picture of medical readiness. Ultimately, excellence should not be defined by achieving a specific MRCGo percentage, but by the ability to maintain a force that is truly prepared for deployment. By embracing these lessons, the AMEDD community can better safeguard the fighting strength and integrity of its formations.

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