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Projection or Diplomatic Debacle Waiting to Happen?

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Introduction

Navy Medicine has conducted multiple humanitarian assistance (HA) missions such as the Tsunami Relief in 2004, advising of Afghani and Iraqi authorities in the development of their health care systems, and utilizing naval hospital ships to provide health care in developing nations. Some of the most positive results of the hospital ships were seen in the summer of 2006 on the MERCY. Relations were fostered with foreign military medical personnel from Canada, Australia, Singapore, India and Malaysia and 11 Non-governmental organizations who embarked aboard the ship. This crew's accomplishments include 60,081 patients seen, 131,511 total services provided; 1,083 surgeries; 19,375 Immunizations; 9,373 Dental Extractions. In an August 2006 public opinion survey, conducted by Terror Free Tomorrow, 85% Indonesia aware of MERCY's visit had a favorable opinion, and in Bangladesh this figure was 95%.¹

Focusing in the latter two types of missions Navy Medicine is taking on more than their current capability allows. Similar to Rwanda in 1996 where a UN force of 2,500 was overwhelmed; Belgian Peace keepers were murdered by Hutu backed military for assisting opposition factions.² Operating in Asian and South American countries known to have instability, far from an embassy limits civil and cultural liaisons recognized the local government and Non Governmental Organization (NGO) to

provide guidance on culture; navy medicine may inadvertently agitate opposition factions to strike at our medical personnel as in the case of Belgian peace keepers. To mitigate negative outcomes Navy Medicine should adopt contemporary business organizational models that include decentralized cross-functional teams and training concepts to enhance humanitarian assistance operations (HAO).

Back Ground

The military brings security and logistics in support of HAO. In accordance with National Security Strategy, the military is called to intervene in hostile and chaotic environments where NGOs are having difficulty disseminating aid; examples of this are Operation Restore Hope in Somalia, OIF, OEF and Tsunami Relief. The goal of the national strategy is to promote democratic efforts, encourage human rights, alleviate human suffering, help establish democratic regimes and pursue economic development.³

Navy Medicine's assets, being expeditionary in nature, are increasingly utilized for humanitarian assistance missions. The hospital ship USHS MERCY's multiple port calls in predominantly Islamic countries, individual augmentees (IA) in Afghanistan, Djibouti and Iraq are operating independently with long-term health care missions, opposed to a traditional role as a

component of a task force responding to a crisis. The IA's deployment, which most often lasts six months, conflicts with the time-intensive mission. As a result, any knowledge of culture gained by experience leading to situational awareness (SA) and effective application is short lived.⁴

In defense of Navy Medicine, the current application of its assets are dictated by national policy. The hospital ships specifically have done wonders to develop positive relations as part of the post Tsunami relief task force in Asia.⁵ The task force in five months conducting biomedical equipment repairs, trained 254 people; restored 59 major and 177 minor medical systems to 100% operational capacity; and, 6,201 host nation students trained. Eighty seven percent of those polled in Bangladesh stated that MERCY's activities made their overall view of the United States more positive.⁶

Yet, the short duration of medical assets in an area requiring HA operations events can go wrong due to lack of understanding on the part of medical personnel of politics and culture within the country.⁷ As an example of what can go wrong when people are not culturally aware a Marine/Navy task force that quickly steamed to Sri Lanka after the 2005 tsunami and began to off-load relief supplies to people on the beaches failed to realize they were giving the supplies to the Tamil

Tigers (a rebel insurgency group) and Sri Lanka's government objected.⁸

Training Limitations

In a Military Medicine study it was found that 50% of Army internists who had completed residency had been involved in humanitarian assistance.⁹ According to the study, "Their training lacked an internal medicine residency-training curriculum to address tropical disease management, sanitation, and interactions with civilian humanitarian workers and military civil affairs officials. The most prepared internists were those who graduated from the Uniform Service University (USU) medical school, but those graduates still felt unprepared for the administrative roles (e.g., interacting with NGOs and military civil affairs units) of humanitarian assistance medicine."¹⁰

An argument can be made that the impact of individuals lacking training on medical units can be mitigated during HA missions by supplementing their intelligence and staffs with that of NGOs, who could also be designated as the lead agency. In HA operations such as Restore Hope, Tsunami relief, and hospital ship cruises, NGOs have been in the AOR long before the military deployed to the area. The presence of NGOs in country is reinforced by Col. Rutherford at the Army War College by his statement that, "Many humanitarian NGOs have a commitment to

long term projects in support of economic and social development. NGOs can sometimes identify the status of a conflict early, provide warning indicators and make reports available to governments, the United Nations and the media."¹¹ They have achieved situational awareness through the relationships built amongst the people and governments. When the military exits and hands over operations to the host government; it is the NGO who sustains operations; hence, it is in their best interest to have optimal relations.¹²

The success of NGOs such as CARE, UNICEF, and International Medical Corps can be attributed to recruitment of qualified and motivated staff with experience abroad.¹³ This has allowed NGOs to have a great deal of accumulated experience.

Diplomatic Pitfalls

The USHS MERCY operating independent of a task force in 2006, treated up to 60,000 patients over five months during HAOs in Philippines, Bangladesh, Indonesia, and East Timor.¹⁴ Five hundred out of thousand medical crew (doctors, nurses, medical planners and corpsmen) lacked essential HA training (applying the percentage from the Military Medicine study¹⁵); potentially handicapping any operational and tactical planning process.

A large component of planning entails coordination with NGOs to gain situational awareness of political dynamics,

culture, cultural taboos and sociology of those being treated¹⁶. The lack of situational awareness can lead to manipulation by political factions; naively lead to treatment of one faction over an adversarial faction validating its political agenda over the other and potentially introducing a destabilizing factor within the country.¹⁷ As in a case mentioned earlier when a Marine/Navy task force that quickly steamed to Sri Lanka after the 2005 tsunami and began to off-load relief supplies to people on the beaches failed to realize they were giving the supplies to the Tamil Tigers (a rebel insurgency group) and Sri Lanka's government objected.¹⁸

Cross-functional Teams

Navy medicine's versatile missions require updated delegation of authority and placement of human capital rather than its current rigid processes. To mitigate negative outcomes Navy Medicine should adopt decentralized cross-functional teams. Dr. Weiner, Professor at Haifa University states, "New team based organizational forms should be developed. Their design should be functional, project oriented, and short-lived, with team composition that may change over the life of the project. Those that have been successful have been non-hierarchical in nature, flexible, and interdependent. In addition these organizations have an ability to solve problems be responsive to a situation utilizing free information flow made possible by

advanced technology and authority grounded in knowledge, not position.”¹⁹ NGOs are successful for they operate in cross-functional and decentralized groups.²⁰ Human capital can be organized as *Virtual Teams, Cross Functional, Product Development Teams, and Self-directed teams.*²¹

Conversely, Navy Medicine accepting the new concepts in a vacuum is of no good. A process not synchronized with military counterparts within Navy Medicine and outside would only increase friction and uncertainty. However in lieu of the deficit in HA trained medical staff, Navy Medicine should utilize Medical Service Corps Officers (MSC), specifically Medical Planners (MP) with operational experience in Patient Administration (PAD), Plans Operations and Medical Intelligence (POMI), and graduates of Expeditionary Warfare School (EWS) to be a part of *Cross functional teams* with the implementation and management functionalities of a *self directed team*.

The MP, as a *Cross-functional and product development team member*, would be the medical functional expert amongst various departments, and organizations. This group, through meetings and multi-media, would develop, adapt and resolve dilemmas.²² A self directed team member one would be part of the implementation and management of the mission similar to the role of 5th MEB in Relief Activities Coordination and Monitoring Cell (RACMC) in OPERATION SEA ANGEL. Here the Joint Task Force J-3,

the Embassy, NGO coordination cell and host nation government met to track information and to gather requests. The cell kept track of all relief efforts and served as a liaison to the decision making body of the RACMC.²³

Another application would be similar to having a Patient Evacuation Team (PET) within the DASC to coordinate inter-theater patient movement analogous to having a Medical Planner as a cross functional team member with NGO, and or indigenous governmental organizations coordinating the planning and utilization of the hospital ships. This would allow for advance party in the form of a liaison from medical to be factored in during the initial planning process resolving any communication and process concerns in advance.

Training Concepts

To mitigate negative outcomes, Navy Medicine should adopt planning and training to enhance humanitarian assistance operations. Providers (doctors and nurses), similar to junior/ mid-level infantry officers who operate at the tactical level are at the forefront of incurring dynamic issues with indigenous peoples / patients during HA port calls. Until HA training on the medical staff can become part of their training pipeline utilization of experienced medical planners while developing DUINS and cultural exchange opportunities could be an answer.

DUIINS internships with NGOs similar to the FEMA LNO internship would develop experience. Currently the IMC has internships with Uniformed Services Health Sciences University for medical physicians.²⁴ This internship should be a model to develop similar arrangements with other NGOs, allowing junior medical officers an alternative venue for experience.

The reality is that Navy Medicine in HA ops is acting as a diplomatic vehicle to influence foreign perception of the U.S. It would be wise to ensure medical staffs are culturally sensitive. An option would be to open the overseas experience and immersion that the Olmstead Foundation provides to line officers. Its mission:

"To provide... military leaders an unsurpassed opportunity to achieve fluency in a foreign language, pursue graduate study at an overseas university, and acquire an in depth understanding of foreign cultures, thereby further equipping them to serve in positions of great responsibility as senior leaders in the United States Armed Forces" ²⁵

In many cases where Navy Medicine is operating alone and unafraid, decisions made by medical staff officers in sole billets overseas could greatly benefit from the cultural experiences gleaned from the types of exchange and training opportunities.

Conclusion

The lack of training has been identified as the Achilles Heel for medical staff to avoid the cultural pitfalls of a diplomatic incident during HA. Contemporary business organizational models of Cross-functional product development and decentralized Direct teams to develop strategy and implementation will allow for increased efficacy of communication and skills to augment the lack of training. Alternative sources as Medical Planners, DUINs opportunities with NGOs and cultural immersion opportunities with the Olmstead foundation will increase exposure to a foreign culture and awareness which will enhance capabilities of Naval Medical Officers during humanitarian assistance operations.

¹Statement of Admiral Michael G. Mullen Chief of Naval Operations Before the Senate Armed Services Committee, 29 MAR 2007, http://www.jag.navy.mil/documents/testSASC_CNO_FY08_Posture_Hearing_final.pdf, Accessed 19 Feb 2008, 13.

²Guimond, Marie-France, Noah S. Philip, Usman Sheikh, "Health concerns of peacekeeping: a survey of the current situation", McGill University, 2001, www.jha.ac/articles/a067.htm, Accessed 19 Feb 2008, 2.

³ Chaplain Donald L. Rutherford, (COL) (USAR), "The Strategic Implementation and Employment of Non-Governmental Organizations in Contingency Operations", U.S. Army War College, Carlisle Barracks PA, 2000, 1.

⁴ Department of the Navy, BUMEDINST 644.5C, Health Service Augmentation Program (HSAP), 24 JAN 2007, http://www.nme.mar.med.navy.mil/POMI-Docs/BUMEDINST-6440_5C_Health-Services-Augmentation-Program.pdf, Accessed 18 Dec 2007, 4-1.

⁵ The White House, Ask The White House, Karen Hughes, 24 AUG 2007, <http://www.whitehouse.gov/ask/20070824.html>.

⁶ Statement of Admiral Mullen, 1.

⁷ Jeff Drifmeyer, Craig Llewellyn, "Toward More Effective Humanitarian Assistance", *Military Medicine*, Mar 2004, http://findarticles.com/p/articles/mi_qa3912/is_200403/ai_n9397915/pg_1, 1.

⁸ Fisher-Thompson, Jim, "Study of Culture Increasingly Important to the Military", America.gov, 23 April 2007, <http://www.america.gov/st/washfile-english/2007/April/200704231042231EJrehsiF0.7528803.html>, 1.

⁹ DeZee, 1.

¹⁰ DeZee, 5.

¹¹ Rutherford, 2

¹² Ibid.

¹³ Ibid.

¹⁴ Department of the Navy, Naval Attaché NewsLetter, U.S. NAVY FOREIGN LIAISON OFFICE, 2000 NAVY PENTAGON, WASHINGTON, DC 20350 Captain John T. Segura, Director, OPNAV N2L, <http://www.navalattaches.com/NAN061005.doc>

¹⁵ DeZee, 5.

¹⁶ DeZee 1.

¹⁷ Christopher Seiple, The U.S. Military/NGO Relationship in Humanitarian Interventions, Peace Keeping Institute, Center for Strategic Leadership, U.S. Army War College, 1996, 68.

¹⁸ Fisher-Thompson, Jim, "Study of Culture Increasingly Important to the Military", America.gov, 23 April 2007, <http://www.america.gov/st/washfile-english/2007/April/200704231042231EJrehsiF0.7528803.html>, 1.

¹⁹ Eugene Weiner, The Handbook of Interethnic Coexistence, Antonia Handler, Chayes Handler and Abram Chayes, " International Organizations and Conflict Preventions: Lessons from Business", The Continuum Publishing Company, New York, NY, 1998, 281.

²⁰ Seiple, 81.

²¹ Weiner, 281.

²² Weiner, 281.

²³ Seiple, 77.

²⁴ Rahib Torbay, CMO Luncheon, 28 November 2007.

²⁵ <http://www.olmstedfoundation.org/olmsted/web/index.cfm>, The George and Carol Olmstead Foundation, the Olmstead Scholar program.

The White House, Ask The White House, Karen Hughes, 24 AUG 2007, <http://www.whitehouse.gov/ask/20070824.html>.

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