STRATEGY RESEARCH PROJECT

ARMY MEDICAL DEPARTMENT LEADERS IN MILITARY OPERATIONS OTHER THAN WAR

BY

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The views expressed in this academic research paper are those of the
author and do not necessarily reflect the official policy or position of the
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ABSTRACT

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As the Army expands the way it responds to a full spectrum of conflicts identified in Joint Vision 2010, leaders must be trained to operate in new and challenging environments. Likewise, the Army Medical Department (AMEDD) must insure its leaders, specifically those selected to deploy world-wide, have a more diverse skill set that enables them to fully operate within the full spectrum of scenarios. Most recently, Army missions have involved deploying into Military Operations Other Than War (MOOTW) such as Somalia, Haiti, Bosnia, Hurricane Mitch, and Kosovo. According to military analysts, for at least the next 10-20 years, the US will be involved in more of these actions.

AMEDD leaders involved with MOOTW have found the environment much different than trained for in the past. Just as combat soldiers find themselves as peacekeepers, rescuers, and humanitarians, medical leaders find themselves serving in expanded health service support missions. These missions create new leadership challenges quite different from traditional health services support (HSS) to a major theater war.

This strategic research project looks at the MOOTW missions and the type of leadership needed to successfully operate in this unique medical environment. If the challenges of operating in MOOTW require different leadership skills, then it is possible that the AMEDD must change the way it trains and develops its leaders.

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ARMY MEDICAL DEPARTMENT LEADERS IN MILITARY OPERATIONS OTHER THAN WAR

The nature of Military Operations Other Than War (MOOTW) has tremendous medical implications for an Army Medical Department (AMEDD) leader. The medical aspects of these operations create new leadership challenges for medical leaders that are different than those planned for or trained for during the Cold War era. In MOOTW, AMEDD leaders are providing health service support in an environment of multinational forces, Non-Governmental Organizations (NGOs) and International Organizations (IOs), contractors, other US agencies, regional governments, local health officials, and local populations.[1]

US Army leaders involved with Military Operations Other Than War (MOOTW) have also found this new environment much different than the one they trained for in the past. Recent deployments into Kosovo, Bosnia, Somalia, Haiti, and Central America have placed new demands on military leadership operating on the ground.[2] Rick Atkinson, related some of these examples of leadership challenges in a 1996 Washington Post article.

> "When U.S. Army Col. John R.S. Batiste showed up at the Panorama Hotel here last month for a Saturday afternoon meeting with Bosnian Serb officers, he unexpectedly found himself in the middle of a rollicking wedding reception.
>
> As the tipsy guests snaked through an adjacent banquet hall in a kind of Serb conga line – to the electrified blare of a keyboard and an accordion – Batiste quickly reminded the Serb officers of their obligation to remove land mines and to pull back their heavy artillery. He and several staff officers from the 1st Armored Division's 2nd brigade then scraped together nearly $100 from their own pockets as a goodwill gift for the happy couple.
>
> To cheers and applause, Batiste handed the cash to the bride and kissed her proffered cheeks – once, twice, three times, Serb – style. Then, to the colonel's clear chagrin, the groom pushed forward for a reciprocal smooch of gratitude.
>
> "This is a strange mission," Batiste muttered, after escaping with an awkward brushing of cheeks. "They didn't train me for this."
>
> Similar assessments can be heard from U.S. officers throughout northeast Bosnia. Long schooled in the traditional art of fighting war, American commanders now find themselves grappling with political, diplomatic and military demands that go far beyond the martial skills they were taught.
>
> Batiste goes on to explain "It's so different. Here we're dealing with mayors and police chiefs. Even dealing with the factions on military matters is something we never learned to do."[3]

Medical support in the MOOTW is quite different from traditional health service support (HSS) to a major theatre war (MTW). Instead of defining unit responsibilities by linear boundaries that designate patient/service beneficiary populations, MOOTW requires asymmetrical medical support characterized by different populations, confusing borders, natural and man created disasters, vague mission statements with minimal senior level guidance or established policies.[4] Atkinson's same article highlights the

challenges for leaders. "Gen. William L. Nash, commander of U.S. forces in Bosnia explains, "I've trained for 30 years to read a battlefield. Now, you're asking me to read a peace field. It doesn't come easy. It ain't natural; it ain't intuitive. They don't teach this stuff at Fort Leavenworth.... It's an inner ear problem. No one feels comp (sic) balanced."[5]

The article goes on to explain that commanders traditionally have distinguished between the tactical decisions an officer makes affecting the immediate battlefield, the operational decisions a senior general makes affecting the larger battlefield and the strategic decisions affecting the military theatre or the entire mission. In the words of one senior staff officer in Tuzla , "But in an operation like this, those lines blur because something you do at a tactical level may have strategic implications." Likewise, medical leaders in MOOTW are finding themselves doing work in tactical units but requiring operational and strategic leadership.[6]

A reason for this "blurring" of leadership levels stems from the nature of MOOTW as well as the way the US has employed its military for these deployments. Since the end of the Cold War and the era of bipolar superpower support to the countries throughout the world, there has been an increased number of smaller scale conflicts. Newly independent countries struggle with the simultaneous problems of transitioning to both a democratic government and a market economy. The uncertainties of this transition often fuel fear and conflict. The resulting disruption of commerce, agriculture, and industry, combined with the loss of control by the central governments, and interventions by neighboring states, contribute to high loss of life and a vast number of refugees. Analysts predict an increase in regional crises because of extreme poverty, uncertainty, and the failure of existing social and economic systems. Meeting the needs of these large displaced civilian populations require world involvement of civilian humanitarian relief organizations and other government militaries.[7]

The recurring theme of most recent MOOTW has involved deployments to places with little or no health care, vast numbers of refugees, lack of food and water, and marginal living conditions. These conditions combined with the numerous response agencies, governments, and other relief organizations create a very complex medical environment. These health-related issues require a strong response and effective leadership when the US Government assumes a central leadership role in MOOTW.[8]

Current AMEDD leadership training and development follows the established Army Leadership Framework. This model, as described by the Army War College, involves a progression of leadership levels as one gains experience, responsibility, and rank.[9] According to FM 22-100, Army Leadership, the factors that determine a person's leadership skill level include the position's span of control, its headquarters level, and the extent of the influence that the leader holds.[10] This research paper looks at the MOOTW missions and the type of leadership needed to successfully operate in this unique medical environment. Since the MOOTW medical mission is different than traditional health service support in a major theatre war, then it's possible that the AMEDD must change the way it trains and develops its leaders.

THE ARMY LEADERSHIP FRAMEWORK

The Army Leadership Framework consists of three leadership levels: direct, organizational, and strategic as depicted in figure 1. Leader development begins at the direct level of leadership. At this level, junior leaders spend most of their time on planned tasks, completed through direct interpersonal contact with subordinates. The leader uses individual or small group collective leadership skills to exercise direct control over those who complete a task. The leader uses individual or small group collective leadership skills. These skills are taught and learned in early stages of one's career.

The Three Levels of Leadership

Strategic Leadership

Organizational Leadership

Direct Leadership

FIGURE 1 ARMY LEADERSHIP FRAMEWORK
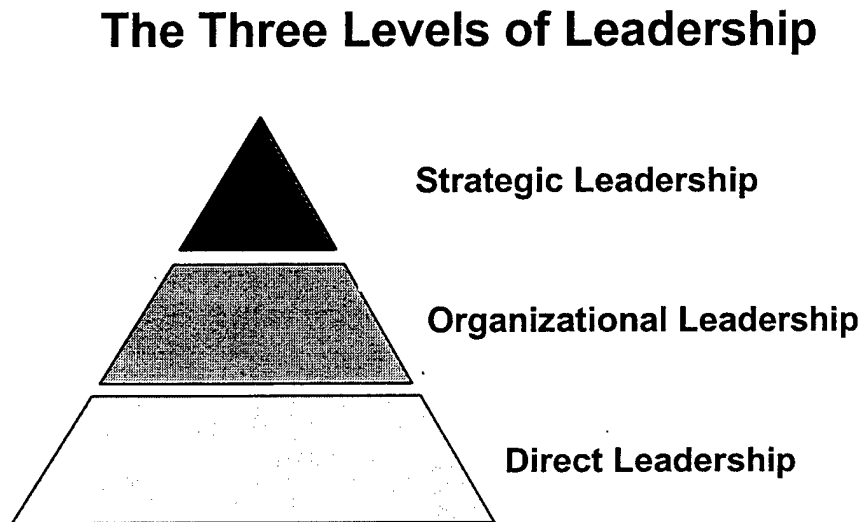
Leaders operating at the organizational level of leadership are experienced at the direct level of leadership and now spend the majority of their time working through a hierarchy of subordinates to achieve task completion. This indirect type of leadership style emphasizes staff processes and resolving systemic type of issues. Authority relationships are usually clearly defined. This level of leadership is characterized by missions that are inward oriented and tasks focused on the organization's missions.

The Army Leadership Framework describes strategic leadership as a level that primarily practiced by senior leaders. Strategic level thought processes deal with US national objectives and strategies. Instead of resolving issues that are definable and systematic in nature, strategic leaders must deal with ambiguous problems, where there are no clear-cut solutions. Every solution involves degrees of risk and strategic leaders have to choose the most acceptable consequences. Daily strategic leadership focuses outward toward the environment instead of internal organizational operations.[11]

MOOTW LEADERSHIP AND HEALTH SERVICE SUPPORT MISSIONS

In the MOOTW environment, a medical force provides direct health service support (HSS) to a population of US military personnel, contractors, civil service employees, and other multinational forces.[12] The direct HSS mission consists of health related services called medical battlefield operating systems (BOS). Medical BOS includes medical treatment, hospitalization, evacuation, dental, veterinary, logistics, blood management, preventive medicine, mental health, and clinical support services.[13] In the direct HSS mission, leader efforts are focused inward on integrating these services into a comprehensive health care system for the deployed force.[14] Organizational leaders use subordinates and staffs to accomplish

the direct health care mission. The Army Leadership Framework categorizes these tasks as organizational leader tasks.[15]

Organizational leaders have authority over organizational processes to make decisions that solve problems and issues.[16] In a MOOTW, since AMEDD leaders control the direct health service support system, leaders have the authority to solve issues. The 396th Combat Support Hospital leaders in Bosnia provide an example of organizational leadership by being able to solve MOOTW unique health care problems. The issue for hospital leaders was trying to identify who was eligible to receive treatment in their hospital. In Bosnia, the deployed force consisted of US and multinational military forces, contractors, an international police task force, and others from US agencies. Hospital leaders and lawyers had to review every contractor agreement, multinational agreement, and other deployment documents in order to determine medical eligible personnel. Once an eligibility list was identified, 396th CSH leaders had to develop a scope of medical practice to care for this diverse population that now included people of all ages, some with chronic or gender specific medical problems. To accomplish their mission, the 396th CSH had to develop new internal policies, procedures, and make organizational changes in areas like equipment, clinical training, and pharmacy items. Although the MOOTW environment changed the scope of medical care provided by the 396th CSH, issues were resolved because hospital leaders had control over the organizational processes and decisions. This example shows how AMEDD leaders who manage direct health service support in MOOTW operate as organizational leaders.[17]

Peculiar to the MOOTW medical environment, in addition to AMEDD leaders having a direct health service support mission, there is also an externally oriented mission. This mission involves health care assistance to a region's population and repair to a country's damaged medical infrastructure. US Army Field Manual FM 8-42 describes this external mission as indirect health service support.[18]

An example of a unit that had both a direct and indirect medical mission was the 524th Veterinary Detachment in Bosnia. The 524th had to inspect food sources for US dining facilities throughout Bosnia, Croatia and Hungary as well as provided animal care for military working dogs. Similar to the 396th CSH, this internal oriented mission required organizational leadership skills in order to support deployed forces. However, the Commander of US Task Force in Bosnia ordered the 524th Veterinary (Vet) Detachment to inspect, provide information, and help reestablish local food production facilities in Bosnia. This was not a near-term mission of veterinary services but involved long-term problems of safe food production in Bosnia. This indirect health service support mission was politically sensitive and required the ability to deal with a multitude of local mayors, NGOs, military civil affairs personnel, other US agencies, and the World Health Organization. The Detachment OIC did not have authority over those he had to deal with in order to accomplish this mission.[19] Successful accomplishment of this mission required the Detachment OIC to use higher-level leadership skills that the Army Leadership Framework describes as strategic leader competencies.[20]

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MOOTW AND STRATEGIC LEADER COMPETENCIES

The Army War College instructs strategic leadership to senior military and other governmental leaders. The Army War College publication, Strategic Leadership Primer, describes strategic leadership as "the process used by a leader to affect the achievement of a desirable and clearly understood vision by influencing the organizational culture, allocating resources, directing through policy and directive, and building consensus with a volatile, uncertain, complex, and ambiguous global environment which is marked by opportunities and threats."[21] Strategic leaders deal with complex and ambiguous tasks; often these are problems with no clear-cut answers. The strategic leader spends the majority of time influencing the organizational culture, and building consensus between subordinates. Individuals who operate at this level work mostly with other players, outside of the leader's organizational control, in order to manage problems.[22]

Strategic Leaders requires significantly different techniques in both scope and skill from direct and organizational leadership. In an environment of extreme uncertainty, complexity, ambiguity, and volatility, strategic leaders think in multiple time domains and operate flexibly to manage change. Moreover, strategic leaders often interact with other leaders over whom they have minimal authority.[23]

While direct and organizational leaders have a short- term focus, strategic leaders have a "future focus." With this perspective, strategic leaders deal with initiatives that may take years to come to fruition. Instead of solving individual issues, strategic leaders deal with families of related problems, which must be managed toward a long-term desired end state.[24]

The Strategic Leadership Primer lists three major leader competencies when describing thought processes of the strategic level of leadership. These major leader competencies are conceptual, technical, and interpersonal. The Strategic Leadership Primer explains that some of these competencies are often the same skills required at direct and organizational levels of leadership, but applied at higher levels while other strategic competencies are qualitatively different and new, and incorporate dealing with vague and complex issues. The strategic level competencies require higher thought processes in order to understand and deal with the complex and ambiguous strategic world.[25] Strategic leader competencies described in the Strategic Leadership Primer are depicted in table 1.

Conceptual	Technical	Interpersonal
Frame of Reference Development	Systems Understanding	Consensus-Building
Problem Management	Joint and Combined Relationships	Negotiations
Envisioning the Future	Political and Social Competence	Communications

TABLE 1 - STRATEGIC LEADERSHIP - MAJOR LEADER COMPETETENCIES

The lessons learned from recent MOOTW deployments reveal a recurring theme about the medical challenges that leaders face. There are many medical players such as NGOs, coalition forces, other US

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agencies, and local health officials. Since the military mission includes stabilizing the country/region and rebuilding the medical infrastructure, there is frequent interaction between military and civilian health care leaders. Guidance from senior leaders about the medical missions is often vague and ambiguous. Often local populations have immediate health related problems that have no short-term resolution.[26] All of these challenges are extremely complex and require leaders to use strategic level leadership competencies.

Recent operations in Kosovo provide an example of a problem requiring a seemingly simple solution, but actually was so complex, it entailed strategic level leadership competencies. BG Kussman, senior US military medical officer Europe explained the problem, "the extent of aid the Army is giving Kosovo civilians is life, limb and eyesight. However, the task force commander has agreed to allow US military medics to aid refugees with the care they need immediately, as long as it doesn't jeopardize our care of US forces. But, it's the right thing to do, and the Brits and Germans are also treating refugee casualties."[27] In his statement, BG Kussman identified the differences of medical mission practices between members of the multinational force. It pointed out the need for AMEDD leaders to work with other coalition members to achieve a unity of medical effort. But this issue had other implications, which were the second- and third- order effects of showing partiality to Albanians refugees over the Serbs. This could potentially result in various factions within the country either favoring or disliking one contingent of the force more than another. Another consequence could be the dependency of local populations on external medical care only to lose it when the military departs the area. The Strategic Leadership Primer explains that the strategic leader must understand the second- and third- order effects of the way a problem is managed; actions that appear reasonable in the short run may be detrimental in the long run.[28]

Besides understanding the second- and third- order effects of actions, this example demonstrates another strategic leader competency. Strategic leadership involves managing problems rather than decision making. When managing problems, courses of action are not clear-cut or without a degree of risk. Therefore, problems are managed over a long term, and adjustments are made to deal with the changing environment.[29] In the situation that BG Kussman discussed, simple and direct alternative courses of action that solved the problem did not exist. But, after assessing the risks of alienating the Kosovo Serbs and chancing that Kosovo Albanians would become dependent on US military health care, considering all the variables in the environment (the practices of the other contingents), the problem was managed. In this case, the decision of the US Task Force Commander was to reissue a policy providing medical support for refugee casualties.[30]

The Strategic Leader Primer states that strategic leaders face competing issues that have no clear-cut solutions.[31] In Kosovo, AMEDD leaders are deployed in a humanitarian mission, but are precluded by US law from providing direct humanitarian medical care to the civilian population. Yet Army physicians frequently come in contact with Kosovars who require medical treatment. In every MOOTW, AMEDD leaders are routinely faced with this situation and in every case, the complexity of circumstances change

the way the problem is managed.[32] The ability to deal with problems such as this one requires higher-level leadership skills.

Instead of establishing a military end state, military missions in MOOTW are focused on the country's or region's political, economic, or infrastructure end state. In order to support these missions, leaders are provided broad guidance that requires an understanding of US national intent for regional stability.[33] For example, Colonel Lester Martinez-Lopez was selected to plan US medical support for Hurricane Mitch relief efforts in Central America in 1998. His guidance from the Army Chief of Staff, General Reimer, focused on broad and open-ended national goals for the region. In order to conduct a mission analysis and planning for US medical support for the region, Colonel Martinez-Lopez had to focus on the desired long- term end-state for the region. He then had to envision the region's future medical end state while considering the abundance of immediate health related issues and the uncertainty of the situation. Colonel Martinez-Lopez analyzed these problems as they applied to US national goals and US Southern Command (SOUTHCOM) operational objectives.[34] As a result, his HSS plan provided the ends, ways, and means that supported US objectives for the region. Colonel Martinez-Lopez effort resembles the process that FM 22-100 describes as strategic leadership because it involved understanding and applying National Military Strategy, US security interests, and the US SOUTHCOM Commander's regional strategy.[35]

During a MOOTW, if AMEDD leaders do not apply strategic leadership skills, then efforts to achieve national aims will not occur. This was demonstrated during the initial US military deployment into Bosnia in 1995 following the approval of the Dayton Peace Accords. Medical leaders concentrated on developing a health service support plan that only provided services to deployed US military personnel. However, the Dayton Peace Accords provided additional guidance and strategic objectives for the deployed force that included tasks to rebuild the medical infrastructure of the country.[36] The CINC of the US European Command (EUCOM) also addressed these areas in his Civil Affairs Campaign Plan by tasking commanders to conduct medical training, repair medical equipment and health care facilities, assist in disease prevention, and initiate programs medical programs that allowed cross zone of separation (ZOS) exchanges. For various reasons, including disagreements between the senior military commander and the senior State Department official, AMEDD leaders did not focus their efforts on this indirect HSS mission. As a result the medical tasks supporting the strategic aims of the Dayton Peace Accords and the CINC's Civil Affairs Campaign Plan were not accomplished. Without specific guidance from the AMEDD leadership, US medical units in Bosnia were unsure of their role in humanitarian relief efforts and the repair of the Bosnian medical infrastructure. Cooperative efforts with NGOs and other members of the multinational force were awkward and nonproductive. While some medical units took it upon themselves to assist in medical infrastructure repair efforts, others did not.[37] Medical leaders, who developed medical plans for the initial deployment into Bosnia, failed to apply the necessary strategic level leadership competencies that would have incorporated national and international goals into the

medical missions. Instead, by focusing inward on the direct medical care to the deployed force, they only operated at the direct and operational levels of leadership.

The MOOTW environment is unique because less experienced leaders are often placed in situations that require strategic level leadership skills. For example, the World Health Organization (WHO) insisted that the Federation of Bosnia-Herzegovina and Republic of Serpska Ministries of Health adopt a family practice system of health care or risk the loss of funding. AMEDD leaders of deployed medical units, understood the long-term consequences of this action, worked with Bosnian health officials to rebuild the medical infrastructure in the country to comply with WHO guidelines. Family practice physicians from the US and Norway, designed a family practice residency program and served as residency instructors/consultants. Their intent was to help develop a Bosnia family practice residency program to train local physicians to work at outlying Bosnian clinics. They realized that this was necessary for continued WHO medical funding for Bosnia. Until they took action, the concept of family practice health care did not exist in Bosnia was and the war-torn health clinics were not staffed with physicians. These leaders understood that the development of a suitable health care infrastructure was necessary for the stabilization of the country and that training family practice physicians was a big step toward this end state.[38] This scenario is typical of the type of situations junior medical leaders find themselves placed in by MOOTW. In example above, junior leaders envisioned an end state and developed a long-term program to achieve it. They demonstrated strategic leadership skills by understanding and applying US and international intent (a strategic-level conceptual competency), envisioning the future of health care in Bosnia (strategic conceptual competency), and operating in a multicultural environment (strategic technical competency).

MOOTW provides situations, which require leaders to use strategic leadership skills in managing a problem. The Dayton Peace Accords stipulated that the former warring factions would allow people freedom of movement and initiate open trade practices throughout Bosnia Herzegovina, but this was frequently ignored. Frustrated by local police checkpoints, roadblocks, and harassment of travelers, BG Anthony Jones, the Assistant Division Commander for Support for the 1st Armored Division, in conjunction with multinational medical leaders, used the medical MOOTW environment to manage the problem. BG Jones and others held tri-entity physician continuing education meetings that brought together Serb, Bosnian, and Croatian physicians to attend US and Norwegian medical lectures. Although the subject material was important to the Bosnian physicians, the real intent of these meetings was to foster free travel between areas and to encourage dialogue and discussions between the Serb, Croat, and Muslim health officials. Eventually, the three groups of physicians began working on regional health related issues as well as sharing medical equipment and supplies. From the strategic level, this program supported the Dayton Peace Accords and the European Commander's intent of conducting cross-zone of separation (ZOS) programs and allowing freedom of travel and dialog between the factions.[39] These leaders' actions again demonstrate the need for strategic leader competencies in MOOTW. They anticipated the second- and third- order effects of their meetings and used them to

achieve the CINC's goal of allowing freedom of movement across the ZOS without creating further animosity.

STRATEGIC LEADERSHIP AND OTHER MOOTW PLAYERS

Whenever the United States commits its armed forces to a MOOTW, other elements of the US government are energized to develop policies and guidance for the theater or operational commander of those forces. These situations give other US government agencies, especially the State Department, a mission as important as the military one.[40] Since US law charges the State Department with overarching authority for all interactions with foreign government and citizens, the US Agency for International Development (USAID) and its subsidiary the Office of Foreign Disaster Assistance (OFDA) are the lead agents in the humanitarian effort. Therefore, in many MOOTW deployments, the military medical mission involves supporting these agencies. Consequently, the military must first receive direction and authority from these organizations to coordinate and execute indirect health service support missions.[41]

The Strategic Leadership Primer states that strategic leaders have several reporting and coordinating relationships outside the organization and must understand the interrelationships and boundaries of these roles. It also states that effective participation in the interdepartmental process requires strategic leadership skills.[42] The interagency process involves planning and operating with all elements of power, not only the military.[43] The Strategic Leadership Primer categorizes the ability to operate in the interagency process as a fundamental component of strategic technical competencies. These competencies go beyond demonstrating technical skills of a particular role or position. Strategic technical competencies encompass the skills to build and facilitate relationships inside and outside the leader's organization and to use the political and social systems in which the organization operates to effectively participate.[44]

On MOOTW deployments, especially those involving humanitarian operations, indirect military medical efforts fall under the authority of the either US State Department leaders or United Nations (UN) leaders. For example, in Haiti, the 44th Medical Brigade Commander, although working for a military chain of command, had numerous reporting and coordinating relationships with US Department of State, United Nations, Haitian health care system.[45] In this case, the brigade commander and his subordinate leaders had to understand the political and social aspects associated with each of these organizations to participate effectively in the interdepartmental process. Success in this environment required these AMEDD leaders to demonstrate technical competencies associated with the strategic leader level.

During domestic MOOTW, an AMEDD leader is placed in situations that require strategic level political and social competence. Mr. Dale Shipley, Region 5 Federal Emergency Management Agency (FEMA) Director, discussed a weapons of mass destruction (WMD) planning exercise in Columbus, Ohio. Military medical leaders were called upon to develop policy and participate in planning for a coordinated response from state, federal, local, and private agencies. These particular leaders did not understand that military assistance to civilian authorities (MACA) involves complex relationships between the military,

other US agencies, local governments, and civilian health care institutions. As a result, military assistance was not properly planned and coordinated. These AMEDD leaders did not understand the political and social aspects of the interagency process. Mr. Shipley stated that military medical leaders did not effectively work with state (State Coordinating Officer), federal (Department of Health and Human Resources), and other military (Military Coordinating Officer) to achieve a unity of effort. He stated that military medical leaders did not desire to become part of the planning and coordination team, but rather, wanted specific medical missions under a military command structure. AMEDD leaders supporting domestic MOOTW must be able to work with other federal agencies, state and local governments, no-federalized National Guard units, and civilian hospitals.[46] The leadership skills needed to effectively participate in this environment encompass strategic-level technical competencies.[47]

During operations in Haiti, AMEDD leaders were tasked to assist USAID and OFDA in repairing damaged medical equipment and rebuilding medical facilities destroyed in Haiti's civil war. Military and the State Department officials made an agreement that the AMEDD medical facility architects would supervise the rebuilding of medical treatment facilities by local contractors, while USAID and OFDA, would provide funding and oversee construction efforts. This interagency cooperation insured proper and prudent use of construction efforts and resources. Success in this mission required use of numerous reporting and coordinating channels by AMEDD leaders.[48] Again, the understanding of the complex social and political interrelationships between the military and other US agencies demonstrated by AMEDD leaders in Haiti is a component of the technical competencies required at the strategic leadership level.

As the United States rarely finds itself acting unilaterally in a MOOTW, AMEDD leaders are often finding themselves dealing with an international system of health service support.[49] In Bosnia, there were 112 nations supporting the Dayton Peace Accord Stabilization Forces (SFOR). Senior military leaders specifically designed military operations so that multinational integrated units would operate checkpoints, patrol in the same vehicles, and respond to contingency situations together. In the same manner, AMEDD leaders have to bring multinational medical assets together in order to provide comprehensive health services to this diverse force.[50] The Strategic Leadership Primer states that leaders who operate in a multicultural environment need strategic-leader technical competency.[51]

In 1996, AMEDD leaders developed a six-nation medical support agreement for Bosnia, called the Stuttgart Agreement. It stated that the US military would provide hospitalization and air evacuation for personnel from all nations. The Norwegian military would lease and pay for the land and the buildings where the medical task force would operate. Norway, Sweden, Finland, Denmark, and Poland would conduct ground evacuation and provide clinical personnel to the medical task force.[52] The AMEDD leaders, who developed and worked under the terms of this agreement, demonstrated all three major categories of strategic level leadership competencies (conceptual, technical, and interpersonal). Developing the Stuttgart Agreement required an appreciation for the second- and third-order effects of

issues associated with a multicultural medical care system. Leaders had to manage multicultural problems such as different standards of medical care, professional credentials, and equipment differences. These problems had no clear-cut solutions and required leaders to manage risks.

Later during the operation, medical leaders had to facilitate multinational medical cooperation and dialogue in order to make the Stuttgart Agreement work. MAJ Paul Rotmil, Chief Surgeon of the Norwegian Medical Company (NORMEDCOY), identified significant issues concerning multinational differences in medical practices, professional credentials, equipment, training, and medical operating procedures. To overcome these differences and to seek unity of effort, MAJ Rotmil conducted medical education meetings between medical leaders of the multinational force. He fostered social as well as medical dialogue. The meetings opened channels of communication between the various military medical organizations concerning standards of care, patient evacuation, and treatment protocols. Subsequently, his ability to leverage the multinational clinical capabilities saved the lives of two head trauma patients. Two patients (a US and Swedish soldiers injured while patrolling together) were rescued by a US medical evacuation helicopter t whose crew included a Norwegian physician and Swedish anesthesiologist. The physician, who because of the meetings, was now aware of the capabilities of the international medical care system, redirected the aircraft to a German hospital staffed with a credentialled neurosurgeon, who performed the life-saving treatment. In this example, MAJ Rotmil demonstrated a strategic level leadership competency by developing a workable multicultural network of international health service support for SFOR.[53] His leadership went beyond the direct and organizational levels of leadership.

The MOOTW medical environment involves cooperating and orchestrating military and NGO missions, even though NGOs are outside a leader's authority limits. The unique nature of MOOTW creates conditions that link the military and non-governmental organizations closer than ever before. Since both military medical and NGO missions involve medical care to relieve human suffering, AMEDD leaders and NGOs find themselves working together. While they are usually not relevant in MTW scenarios, NGOs have evolved to serve as an essential planning and operational arm in resolving humanitarian challenges in MOOTW.[54]

Achieving unity of effort with NGOs requires medical leaders to build consensus. This is not easy to do because the political and social aspects of MOOTW often create tension and differences between NGOs and military efforts. Even though military leaders agree that NGOs occupy an essential role in MOOTW, and are included in military operations orders, the fundamental differences in operating procedures and priorities frequently hamper good relations between the two. For a myriad of reasons, most NGOs purposefully isolate and insulate themselves from international and local militaries. NGOs view themselves as independent entities solely focused on their clients' needs. In order to operate with them, AMEDD leaders must understand the internal political and social systems of the NGOs. As the role and integration of NGOs increase, medical leaders will have to bridge differences (philosophic,

organizational, and cultural) and capitalize on similarities to achieve desired end states.[55] For these reasons, working with NGOs requires strategic level interpersonal skills.

In the same manner, differences between the military and the NGOs in areas such as values, missions, and operating procedures, require the medical leaders to be skillful negotiators to manage problems and produce effective actions. Medical leaders will find that NGOs have agendas much different than military ones. As peers, AMEDD leaders do not have authority over NGOs.[56] For example, NGOs, such as Doctors Without Borders, work on short-term humanitarian problems to alleviate suffering. Military medical units, although equipped and staffed to provide health care, are often prohibited by US law from treating the local population. As a result, Doctors Without Borders and perceive the military medical leaders as unwilling to contribute toward their cause and resent the fact that the US Military won't use its the equipment and personnel to help treat local populations.[57] AMEDD leaders will have to manage this issue of competing interests through skillful consensus building and negotiating other types of support such as providing supplies, transportation, and force protection. Successful cooperation with NGOs to attain the desired end state requires strategic leader interpersonal competencies.

CONCLUSION

Every article, lesson-learned, and personal interview in my research reveals three major recurring themes about the MOOTW. First, there is a broad range of institutions engaged in these operations. They include the United Nations and its operating agencies, international and non-governmental organizations, national governments and their military forces, corporations, individuals, and the media. Second, their military missions have no end states, but instead, focus on the long-range political, economic, and medical infrastructure objectives for the region or country. Third, they involve two military medical missions. There is a direct HSS mission to the deployed force and another indirect one that involves providing some type of health related service to local populations.

The interaction of these themes presents a medical environment that is complex, volatile, uncertain, and ambiguous. The complexity and uncertainty of MOOTW comes from the broad range of institutions engaged in the operation and the different agendas and cultures they represent and these organizations fall outside the authority limits of military leaders to control. Indirect HSS missions are volatile because their end states are difficult to determine as medical problems can take years to overcome. The local population's health is volatile and unstable, capable of turning worse at any moment. Finally, the medical environment is ambiguous because of the competing issues and interests between the institutions supporting the MOOTW, the local population, and the military.

The ability for AMEDD leaders to operate successfully in this type of environment requires what Strategic Leadership Primer categorizes as strategic leadership skills. It states, " The environment at this level (strategic) is characterized by the highest degrees of uncertainty, complexity, and ambiguity, as well as tremendous volatility (VUCA) due to the compression of time in which the leader must act. Strategic leaders find themselves enmeshed in intricate networks of competing constituencies and cooperative

endeavors that extend beyond their own organization."[58] It also states, "the leader at this level (strategic) must interact with a number of actors over which they have minimal influence." And, "Whereas leaders at lower levels of the organization remain focused on the short term, strategic leaders must have a "future focus."[59] Using this, the Army's definition of the strategic environment, it is logical to conclude that AMEDD leaders need strategic leadership skills to deal with the unique environment of MOOTW.

FM 22-100, Army Leadership, limits its definition to strategic leadership to "the Army's highest-level thinkers, warfighters, and political-military experts."[60] This FM goes on to explain that, "these leaders deal in an environment of extreme uncertainty, complexity, ambiguity, and volatility. Moreover, they interact with other leaders over whom they have minimal authority."[61] Based on my research, the same type of environment exists in MOOTW. To successfully deal with the MOOTW environment, AMEDD leaders must have strategic leadership skills."

RECOMMENDATIONS

Successful MOOTW medical operations require the AMEDD to train its leaders in a wide range of topics such as the interagency process, NGO structure and culture, United Nation missions, FEMA response to domestic disasters, and multinational operations. However, training in these areas alone is only a partial solution in preparing leaders to operate in the MOOTW medical environment. Leaders must also have the requisite leadership skills and higher level thought processes to engage in these areas successfully. These leadership skills go beyond direct and organizational levels of leadership. The skills necessary to lead medical efforts in MOOTW require strategic leader competency training. For example, leaders should be knowledgeable of Presidential Decision Directive 56 (PDD-56), which promotes interagency unity of effort in complex contingency operations. They should understand the framework of interagency coordination and planning tools.[62] However, this knowledge alone will not insure the successful implementation of PDD 56 in the MOOTW environment. Leaders must also demonstrate the requisite strategic leader competencies to effectively apply PDD-56. MOOTW demands certain strategic leadership skills from all leaders for success in this unique and complex environment.

Lastly, the recommendations listed above should occur early in the careers of AMEDD leaders. Junior leaders play a large role in US Military medical efforts in MOOTW and they need training in these the areas that help them be successful.

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