

USAWC STRATEGY RESEARCH PROJECT

**911 FOR THE WORLD: A CASE FOR GREATER
U.S. MILITARY INVOLVEMENT IN HUMANITARIAN OPERATIONS**

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ABSTRACT

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The United States is in a precarious situation. Although her position as the only remaining global superpower is indisputable, she has been subjected to increasing violence by non-state belligerents and come under increasing criticism by the world community in general. The American Military is the most capable in the world, and has conducted numerous extremely successful operations over the past fifteen years. However, it is also a highly effective humanitarian tool, and its employment in response to unmet humanitarian needs, particularly medical, may serve to improve America's reputation in the world and thus deprive her attackers and critics of both motive and support.

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911 FOR THE WORLD: A CASE FOR GREATER U.S. MILITARY INVOLVEMENT IN HUMANITARIAN OPERATIONS

The plain fact is that our country has, with all our mistakes and blunders, always been and always will be the greatest beacon of freedom, charity, opportunity and affection in history. If you need proof, open all the borders on Earth and see what happens.

— GEN (ret.) Richard Hawley, USAF

As the only remaining global superpower, the United States has a unique opportunity, and in fact an obligation, to facilitate the evolution of a world order that is stable, peaceful, prosperous and tolerant. The U.S. must bring to bear all of the elements of her power to achieve this, and the military will continue to play a leading role in the implementation of U.S. policy and the pursuit of American interests. However, not all of the application of military power should be kinetic. The American Armed Forces are the most effective humanitarian tool in the world, and there is significant untapped potential residing within which can be used to provide humanitarian support to other nations, improve public health in underserved areas, and train and educate foreign health care providers, to the end that the U.S. image will be enhanced in the eyes of the world. This increased participation in humanitarian operations, both planned and contingency, will enhance the application of the diplomatic and informational elements of national power. In addition, regular participation in these operations will improve the readiness, knowledge and skills of military health care providers, thus enabling them to deliver even more effective care to American soldiers wounded or taken ill in combat.

An increased humanitarian operational tempo is not without cost and risk. These efforts will require personnel, materiel and transportation resources from a military already fully involved in dozens of operations around the world. Engagement in humanitarian support operations has a huge potential for “mission creep” and must be managed carefully, as must the actual physical risk to U.S. personnel. To ensure that the U.S. derives the political benefits of these efforts, diplomatic and informational assets will play a crucial role in the ultimate success or failure of such a strategy.

The U.S. is at a pivotal point in her history. How she manages her foreign affairs over the next decade could very well spell the difference between relative global harmony and global chaos. Although increased involvement in humanitarian operations is but one small part of foreign policy, it is potentially a very important one. Properly managed, these efforts are almost sure to reap good will, trust and cooperation by appealing to the “hearts and minds” of people in need of

assistance. This, in turn, will facilitate the pursuit of America's numerous security, economic and diplomatic interests throughout the world. It is noble pursuit, worthy of America's traditions, and no country in the world is better able to bring to bear the resources which can truly make a difference in the lives of so many people.

BACKGROUND

The United States currently occupies what is arguably the most unique position of any major nation in the history of the world. No other great power has ever commanded the wealth, the global reach, the military dominance and the influence of the United States, and despite some missteps along the way, the U.S. has generally applied these elements of power with beneficence, restraint and generosity. Nonetheless, a rising tide of anti-American sentiment is prevalent in many parts of the world, and manifesting itself in increasingly violent attacks on American interests and those of her allies.¹

The reasons for this are complex and still perhaps a bit unclear. Surely, there is resentment of American success and prosperity in some quarters, but this hardly seems a reason for the acts of terror which have marred the last decade. There is clearly hatred on the part of some radical groups of the entire American way of life, her friendship with Israel, and her ongoing military, diplomatic and commercial presence in some parts of the world. There is also an abiding fear on the part of some nations that America will use her almost infinite resources to become a latter-day Roman Empire, with a view toward dominance of the entire world with associated imposition of American values, Western religious thought, and republican government. It is the latter attitude which is probably the most incomprehensible to most Americans, given their tendency to view their nation as decidedly, although not exclusively, benevolent in thought, word and deed.

Upon further reflection, however, the latter sentiment is certainly more understandable given American military actions since the terrorist attacks of September 11, 2001. While few nations, other than her most intransigent critics, objected to America's invasion of Afghanistan, the pursuit of al Qaeda, and the toppling of the repressive, intolerant Taliban regime, almost the reverse was true of the opinions of the invasion of Iraq. As America failed to clearly articulate the complex reason for this pre-emptive campaign, the nation found herself no longer the recipient of empathy and respect, but the subject of increasing resentment, fear and loathing.²

That America has been generous in her extension of assistance to other nations in the form of economic aid, humanitarian assistance, security guarantees, and myriad other avenues, public and private, really cannot be argued. Since the end of the Second World War, the U.S.

has invested hundreds of millions of dollars in aid to friends and foes alike. And although America has clearly benefited in many indirect ways from these programs, she has asked little in the way of material reimbursement or compensation over the decades. Despite this apparent huge “balance of beneficence” in America’s favor, however, there remains the nagging question that perhaps more should be done to reverse the perception on the part of many that America is becoming increasingly ruthless, autocratic and insensitive. Ironically, the vehicle for this increased engagement may be the highly lethal and feared Armed Forces of the United States.

The American armed services are really microcosms of everyday American life. Despite their unique and basic mission to fight and win America’s wars, their global reach and their organic ability to sustain operations almost indefinitely actually makes them a uniquely capable and potentially very responsive humanitarian tool. A forward-deployed American military base is really just an American city in miniature, with its own shelters, transportation, water purification capability, electricity generation, communications, civil engineering, civil affairs expertise, and medical and public health assets.

It may be in the last area that the U.S. Armed Forces have the most to offer in terms of humanitarian assistance. Lack of access to health care is pervasive in many parts of the world, largely due to shortages of health care providers. Although “how much is enough” is subject to some debate, the American managed care model generally calls for one primary care physician per about 1500 patients, which is a rate of seventy-five physicians per 100,000 people(). According to the World Health Organization’s 1998 estimates (the most recent available), sixty-eight nations have fewer than seventy-five physicians per 100,000 population, and thirty-nine have fewer than twenty per 100,000³. Again, the 1:1500 is just the “suggested” ratio for primary care physicians, and does not take into account the mix of required specialists. Frankly, in many countries that is almost a moot point, because access to specialty care, particularly surgical care, is almost non-existent. According to the American Association of Neurological Surgeons, there are at least ten countries with populations greater than three million people, primarily in sub-Saharan Africa, with no neurosurgeons at all.() Many other countries have as few as one or two, and similar shortages of general and orthopedic surgeons exist, again primarily in Africa.

Nursing shortages are also a significant problem in many countries. The same WHO estimates give a ratio of 972 nurses per 100,000 population in the United States, a nation said to be suffering from a nursing shortage. Although that in itself is a complex subject outside of the scope of this paper, it at least allows a reference point, since WHO estimates that sixty-three nations in the world have fewer than 100 nurses per 100,000 population (roughly one-tenth the American ratio).⁴ Again, adequacy of healthcare manpower is a complex topic, but the above

figures are illustrative of the fact that many dozens of nations in the world struggle to meet routine day to day health care needs of their populations. In the face of a catastrophe, such as an earthquake, a tropical storm or major outbreak of disease, one can easily see that these marginal medical capabilities would be quickly overwhelmed with potentially catastrophic results.

In fact, large-scale disasters can even overwhelm countries with fairly advanced and robust medical delivery systems. After the devastating November 2003 earthquake in northwestern Turkey, the staff of the hospital in Izmit found it impossible to adequately care for the hundreds of casualties in the immediate area.⁵ Ultimately, almost 10,000 people died and tens of thousands of others were injured. In an earthquake earlier in the year, all three hospitals in Bingol suffered such severe structural damage as to be unsafe and thus unavailable for the delivery of patient care.⁶

Lack of good relations need not be a barrier to U.S. assistance. Assuming the absence of open hostilities, and the request for (or acceptance of) assistance, even nations like Iran should be candidates for American relief efforts. 50,000 people died and tens of thousands more were injured in the devastating earthquake that struck Bam in late 2003. This resulted in a huge influx of aid from all over the globe, including the U.S., despite Iran's status as one of the members of the "Axis of Evil," and the fact that no diplomatic relations exist between the two nations. Although most of the American aid was provided by civilian organizations, the U.S. Air Force provided aircraft to deliver people and supplies, the first time American planes had entered Iranian airspace legally in over twenty-five years. That such efforts may lead to increased good will, and possibly a thaw in chilly relations, is obvious. In fact, in *Newsweek* magazine, a man (referring to the dogs employed by an American civilian rescue team) was quoted as saying, "We've said 'Death to America' for 25 years, and now they're helping us when we need them. They came here with their (search) dogs, which (the Iranian government) says is a dirty animal. But write that I love Americans and I love their dogs."⁷

Support of humanitarian operations is by no means anything new to the U.S. military, which has conducted hundreds of such missions over the years. Most are carefully planned in advance, such as those which have involved the deployment of plastic surgery teams to Central America to perform elective reconstructive surgery on patients with cosmetic birth defects and burn scars. Others, however, have been contingency operations conducted in response to a disaster, such as the relief efforts for the victims of Hurricane Mitch in 1999 and the response to the blast at the American Embassy in Dar Es Salaam, Tanzania, in the same year.

The medical services of the American Armed Forces are probably the most robust, flexible and capable in the world. Possessing a broad spectrum of professional expertise, from medicine and nursing to medical logistics and medical operations, the medical departments offer a virtual full-service capability. In addition, field medical shelters and equipment are durable, proven and for the most part relatively easy to transport by air or ground. This combination of expertise and equipment makes the American military's deployable medical assets uniquely suited to respond to contingencies.

Based on the situation at hand, a medical package is easily custom-made to suit the requirements of the contingency. For instance, an earthquake or explosion generally results in surgical patients, and would thus require corresponding capabilities on the part of the responders. On the other hand, a disease outbreak which overwhelms local resources would require more of an emphasis on internal medicine and preventive medicine. All of these capabilities are readily available, and can be quickly assembled to facilitate a prompt response to the emergency. The Army's Forward Surgical Teams, the Navy's equivalents (which provide combat casualty care to the Marine Corps), and the Air Force Expeditionary Medical Support units are all highly capable and easily transportable. Starting with the personnel and equipment of these basic units, one could readily assemble a package which would suit almost any need.

TYPES AND METHODOLOGY OF ENGAGEMENT

This U.S. military's self-awareness of this rapid-response medical capability already exists. In an article published in *Airpower* in 2001, former Air Force Surgeon General LTG P. K. Carlton makes a strong argument for a medical expeditionary mindset and capability. In the article, he cites the very flexibility and modularity which already exists, although he focuses naturally on capabilities within the U.S. Air Force.⁸ Although the other services have similar medical capabilities, clearly a rapid response will require the lift assets of the Air Force.

The existence of the newly-created Air Expeditionary Wings provides a ready-made mechanism for rapid lift response. These units are intended to be "wheels" up within six hours of notification, and can easily handle the personnel and materiel of the medical response team. Whether the team is co-located with the air assets or not is of fairly minor importance, as they can easily be picked up en route to the disaster area. The key is readiness to go at a moment's notice, and that is not something the Armed Forces have accomplished to this point.

In these days of very high operational tempo, any new mission naturally raises concerns of over-commitment. To minimize the impact of this on any given service, the first-response duty, similar to the Army's Division Ready Brigade and the Air Force's Medical Expeditionary

Wing, could be rotated between the three services, depending on the geographic area of responsibility and the assets organic to it. This team should have pre-packaged equipment and supplies in modules suitable for different scenarios (e.g. surgical vs. medical), and have the appropriate personnel on two-hour recall. Arrangements should be made for rapid procurement of perishable supplies, such as blood products and medication, through the medical logistics system at the home installation. Adequate ground transportation must be readily available for movement of personnel, supplies and equipment to the airhead, whether the originating base of the airlift, or that co-located with the medical unit, should they be different. The latter would be a common occurrence, particularly with the Army and the Navy participating in this effort, but again should not result in significant delay or a significant increase in complexity of the operation.

The key, again, is systematizing this effort. Everything described above has been done before, and could be done again, but unless a specific unit is identified and the above arrangements made for rapid availability of personnel and materiel, it would simply take too long to be of benefit in an emergency; just as in the case of combat troops or aircraft, there can be no question who is "on call" to respond to a crisis.

Earthquakes, for example, often result in hundreds or thousands of casualties suffering long-bone fractures, head injuries, partial amputations and body cavity injuries. Delay of definitive surgical treatment in many of these cases will result in death or morbidity which might otherwise be avoided. To be meaningful, any deployed medical unit should be at least partially functional within forty-eight hours of the incident. There is thus no time for bureaucratic wrangling or head-scratching.

Another key to the success of an initiative of this type is the actual processing of the request for assistance. A well-understood process must be established which allows a foreign government to make a request for assistance, ideally through the American embassy or consulate. The request must be vetted for appropriateness, and the actual requirement determined. Again, this must be done rapidly, because for the sick and injured the clock starts ticking at the time of the disaster, not at the time of embarkation of the medical package. Ideally, this would be a joint effort of the Department of State and the Air Force operations cell. Service permission to deploy the medical unit should not be required, as this would be a standing arrangement that all services have subscribed to. It would simply be a matter of the State Department approving the request and notifying the Department of Defense. A reasonable approximation of the appropriate make-up of the medical force package can be made as a result of what is known of the nature of the incident, and does not have to be done with great

precision, as there is great commonality in basic medical supplies, equipment and personnel, regardless of the injuries or illnesses requiring treatment. Little time would thus need to be spent puzzling over who and what should go.

The Combatant Commander whose area of responsibility includes the nation requesting assistance should engage in this process very early. In fact, response packages should ideally be located in those Combatant Command areas of responsibility which have existing medical facilities (such as the European Command and the Pacific Command). This allows relative geographic proximity to most areas of the world, and thus a more expeditious response. Naturally, units located in the continental United States would respond to crises in the Americas.

Issues such as security, communications and enhanced logistical support (such as water purification capability) may also be paramount, depending on the situation, and may best be addressed and resourced by the Combatant Commander. Depending on the situation, in fact, the responding medical unit will often be part of a larger relief package, which could include, for example, field kitchens, water purification personnel and equipment, and engineers. Again, much of this equipment, unlike heavy armored vehicles, can be transported by air fairly readily, with a correspondingly rapid response capability.

In addition to the ability to rapidly respond to medical contingencies, the medical departments of the U.S. Armed Forces have many, many other services which the government could extend to other nations as part of our engagement with other governments and peoples. These sorts of services are such that one has the luxury of deliberate planning, enabling the use of both active and reserve component personnel on a planned, predictable basis, thus minimizing the impact on any given service, component or command.

Instructors of virtually every training program sanctioned by civilian professional organizations exist in the Army, Navy and Air Force. These programs include Advanced Trauma Life Support, Advanced Cardiac Life Support, Emergency Nursing Pediatric Course, Trauma Nursing Core Course and Pediatric Advanced Life Support, to name but a few. Many, many nations, particularly those with poorly-developed health care infrastructure, would stand to benefit from the sharing of this knowledge and these skills. Just a handful of instructors, with some basic, lightweight training aids, can train dozens and dozens of health care workers over a period of just a few days. This will not only serve to improve relations, but to allow these nations to become more medically self-sufficient, ultimately potentially decreasing the need for actual U.S. assistance in the future.

Preventable disease is a major cause of morbidity and mortality on nearly every continent, even in the 21st century. The World Health Organization estimates that eleven million children

under the age of five die each year of preventable diseases such as measles, malaria and dysentery (almost always contracted through contaminated water sources).⁹ In a very recent article, the New York Times reported an outbreak of cholera in a town in Zimbabwe. The hospital had no intravenous fluids available, the generator was broken, and chemicals to purify water were in short supply.¹⁰ That this is not an isolated phenomenon is clearly illustrated by the horrific death rates noted above.

The Military Health System has some of the finest public health and preventive medicine capability in the world, as the nature of the expeditionary experience naturally requires exhaustive attention to disease prevention through immunizations and vector control. Preventive medicine teams, commanded by environmental science officers and staffed with soldiers specially trained in field sanitation, currently exist in the inventory. Much like the forward surgical teams, these small, highly deployable packages are potentially of great value to nations with poorly developed public health systems.

As the administration of immunizations is a virtually universal skill of nurses and medics, “shot teams” can be quickly cobbled together to deploy in support of humanitarian assistance operations. Whether on a scheduled basis or in response to a contingency (such as a flood or tropical storm, with the concomitant risk of a cholera outbreak), such a team can immunize thousands of people over a period of just a few days, minimizing the prevalence of disease which would just further overwhelm the host nation’s medical capabilities.

There is more to be gained from an aggressive policy of medical engagement than just good will, however. It is ironic but well known that military medical personnel often have much less exposure to the management of trauma than their civilian colleagues on a day to day basis, because most military hospitals do not care for large numbers of trauma patients. Although a recent program that allows forward surgical teams to work together for a month in selected civilian trauma centers partially addresses this, the opportunities for a given team to participate in this training are few and far between. In addition, medical soldiers in field units often get little hands-on patient experience, with their days occupied more by vehicle maintenance, miscellaneous installation details and field training with simulated casualties. Finally, physicians and nurses assigned to field units spend the vast majority of their time providing patient care in fixed facilities, and often have little opportunity to use the supplies and equipment that the field unit takes to war. Thus, deployment in support of humanitarian medical missions provides a terrific opportunity for training and team building, which can only enhance the readiness of the unit to care for American soldiers should it be deployed in support of a combat operation.

In addition, military health professionals will benefit from exposure to patients with exotic diseases, such as leishmaniasis, hemorrhagic fever, typhus, dengue and malaria. The ability to rapidly diagnose and effectively treat these illnesses is a crucial skill, because despite aggressive immunization and prophylaxis programs, American soldiers deployed around the world are still susceptible to these maladies. An active duty Medical Corps General Officer, with an M.D. and a PhD., amusedly recalls an incident during rounds at a major Army medical center in which a patient with leishmaniasis was being presented. The medical students, having seen several cases of this in soldiers re-deployed from Southwest Asia, knew right away what the soldier's problem was, but the General (then an attending physician) didn't have a clue. The knowing eye sees.

A recent review of humanitarian medical operations in fact cited numerous positive comments from participants as to the training benefits of such experiences¹¹. The authors make the point, though, that the quality of the experience and the value of the services rendered to the beneficiaries would be enhanced by more deliberate efforts at training prior to the actual mission. This is just another argument for the U.S. military to further invest in a deliberate effort to train and deploy medical forces for support of humanitarian operation

POTENTIAL ISSUES

Despite the many advantages cited above, a greater degree of involvement in humanitarian operations is not without its share of risks. In addition to the obvious consumption of human and materiel resources in a military already stretched almost to the breaking point, many other issues must be considered and carefully managed if such a strategy is to ultimately be successful.

As discussed in the Rand report on military medical support of humanitarian operations published in 1995, there is unavoidable "mission creep" once one gets into the business of caring for non-U.S. patients.¹² Questions will arise about how to manage situations in which U.S. medical personnel have begun treatment of an ill or injured person, only to determine that further care will be required which is beyond the capabilities of either the deployed medical unit or the host nation. Examples of this include renal dialysis, the management of extensive burns, and the long-term management and rehabilitation of brain and spinal cord injuries. It is a virtual certainty that there will be occasions when patients are transferred to U.S. medical facility, with the attendant diplomatic, fiscal and social issues. There is certainly precedent for this, and although some prior planning for these eventualities will be necessary, the fact is that they will

all be unique situations, and a certain amount of individual case management “on the fly” will be required.

Deployed U.S. medical units will require some inpatient capability, since in most situations lack of this will be part of the problem encountered by the host nation to begin with. The issues of patient disposition then become important, as these missions will of necessity be of limited duration. A good plan for transfer of patients to host nation hospitals or other relief organization facilities is thus an absolute necessity, not only to ensure expedient re-deployment once the crisis is past, but to avoid “cluttering up” the U.S. facility with convalescent patients to the detriment of its ability to treat those acutely ill or injured.

As discussed earlier, security of the medical unit will often be an issue, particularly if deployed to a region which is either politically unstable or just not on good terms with the U.S. American soldiers have a tendency to be terrorist magnets, and despite the good intentions of a humanitarian mission, there are many who seek to inflict harm on the U.S. no matter what the situation. Medical units have very limited self-defense capability, restricted to personal weapons, and, of course, if the medical soldiers are devoting most of their effort to ensuring their security they will have little time to provide medical care. Thus, in many situations a security “tail” will be necessary, the nature of which will, of course, vary depending on the threat environment.

Perhaps the biggest threat to the success of an aggressive humanitarian engagement strategy is the potential for the gesture to “backfire” politically. After the Bam, Iran earthquake, the U.S. and Great Britain came under sharp criticism from the left-wing media, which lost no time in impugning the two nations’ motives for providing assistance. Although justly critical of the slow response time (it took the U.S. five days to get assistance in, although in fairness this may have been a result of official Iranian foot-dragging), the World Socialist Web Site claimed cynical self-promotion as the principle reason for the willingness to provide assistance.¹³ Although some groups will probably always seek to twist facts and denigrate American actions, no matter how altruistic or selfless, most media organs, governments and societies will probably see these efforts for the truly humanitarian actions that they are if properly presented to the audience of public opinion.

There is thus no guarantee that U.S. efforts will be appreciated, and a policy like this will have to be very carefully “marketed” if the benefits of good will are to be reaped. The State Department and the Department of Defense will need to carefully coordinate their efforts, particularly when it comes to interacting with the media. Spokespersons will need to make it very clear that this is not military adventurism, that the mission is very short-term, and that American motives are purely altruistic. Properly handled, not only will the U.S. efforts be

appreciated by the beneficiaries (such as the Iranian man quoted in Newsweek), but they will be seen by the world audience as generous, unselfish and genuine.

CONCLUSION

The Armed Forces of the United States are the most capable in the world, having proven themselves time and again in combat and peacekeeping operations. However, their value as a humanitarian tool, while recognized, is probably underestimated. In particular, the medical departments of the armed services possess unique capabilities to provide comprehensive care in austere and even hostile environments. This, coupled with the robust air transportation assets of the U.S. Air Force, makes Army, Navy and Air Force medical units highly capable and highly responsive assets in support of humanitarian missions, both planned and emergent.

In a time in which America's international motives are increasingly suspect in the eyes of many people, increased engagement in humanitarian relief operations is a small but important part of a foreign policy that seeks to ensure the preservation of American interests while also preserving America's credibility. In particular, the use of uniformed relief workers may go a long way to demonstrating America's willingness to use all instruments of her national power for purely altruistic, and not just selfish, reasons.

There are risks to such a strategy. The U.S. military is already severely taxed by many global obligations, and is likely to be so for the foreseeable future. Physical risk always accompanies military deployments, and depending on the individual relief operation may approximate that encountered in a combat zone. In addition, many observers are so jaded, or have such rigid agendas, that there is no guarantee America's increased humanitarian engagement will be seen by all as truly altruistic. However, properly managed, such a strategy will probably contribute to a thawing of relations with many nations and groups, easing of global tensions, and growth in trust.

In his book, *Rogue Nation*, Richard Prestowitz expresses concern about the unilateralist trend of U.S. foreign policy. Although he would probably agree with GEN (ret.) Hawley's view quoted at the beginning of this paper, he justifiably bothered by America's "my way or the highway" mentality. At the end of the book, he summarizes his feelings and his hopes:

"Part of the shock of September 11 was the shattering of the myth that bad things happen only to other people. It was the shock of joining the world. It doesn't mean that we should be fatalistic, but in an age of globalization we need to recognize that others' problems are our problems too and that we don't have all the answers. . . . An America that stressed its tolerance rather than its might, its tradition of open inquiry rather than its way of life, and that asked for God's blessing on all the world's people and not just its own, would be the America the

world desperately wants. It would be something else, too. I'll never forget my first glimpse of the Italian town of Assisi, home of St. Francis. As I turned a curve in the road just before sunset, there it was, white and shimmering on the hill."¹⁴

WORD COUNT= 5099

ENDNOTES

¹ Paul Richter, "The World; 7 of 8 Islamic Nations in Poll Fear U.S. Attack," *Los Angeles Times*, 4 June, 2003, sec. A, p. 3; available from ProQuest; accessed 24 November 2003.

² Karim Raslan, "A View from Southeast Asia," *Foreign Policy* 137 (Jul/Aug 2003): 38; available from ProQuest; accessed 24 November 2003.

³ World Health Organization; available from www3.who.int/whosis/health_personnel.cfm?path+wh...; Internet; accessed 24 November 2003

⁴ Ibid.

⁵ Stephanie Kriner, "Inside Turkey, Hope Fades for Survivors," 23 Aug 1999; available from www.disasterrelief.org/Disasters/990819Turkey5/; Internet; accessed 19 November 2003.

⁶ Enrico L. Frontini, M.D., "First Situation Report, Bingol Earthquake 1 May 2003," available from www.reliefweb.int/w/rwb.nsf/j0/; Internet; accessed 19 November 2003.

⁷ Maziar Bahari, "Iranians: After the Quake, Signs of a Changing Reality," *Newsweek* (12 January 2004): 9.

⁸ Paul K. Carlton Jr, "New Millennium, New Mind-Set: The Air Force Medical Service in the Air Expeditionary Era," *Aerospace Power Journal Online* December 2001; available from www.airpower.maxwell.af.mil/airchronicles/apj01/win01/carlton.html; Internet; accessed 17 October 2003.

⁹ Katherine Stapp, "Health: Preventable Disease Claim 11 Million Children Each Year," 5 July 2003; available from www.proquest.umi.com/pgdweb?index+1&did; Internet; accessed 3 February 2004.

¹⁰ Michael Wines, "With Health System in Tatters, Zimbabwe Stands Defenseless," *New York Times*, 5 February 2004, sec. A, p. 1.

¹¹ Jeff Drifmeyer, "Military Training and Humanitarian and Civic Assistance," *Military Medicine* (January 2004): 23 – 29.

¹² Lois M. Davis, et al., *Army Medical Support for Peace Operations and Humanitarian Assistance* (Washington, D.C.: Rand 1996), 86.

¹³ Jean Shaoul, "On the British and U.S. Response to the Bam Earthquake," 22 January 2004; available from www.wsws.org/articles/2004/jan2004/bam-j22.shtml; Internet; accessed 16 February 2004.

¹⁴ Clyde Prestowitz, *Rogue Nation* (New York: Basic Books, 2003), 284

BIBLIOGRAPHY

- Bahari, Maziar. "Iranians: After the Quake, Signs of a Changing Reality." *Newsweek*. (29 January 2004).
- Carlton, Paul, "New Millennium, New Mind-Set: The Air Force Medical Service in the Air Expeditionary Era," *Aerospace Power Journal Online*, Winter, 2001; available from www.airpower.maxwell.af.mil/airchronicles/apj/apj01/win01/carlton.html. Internet. Accessed 27 October 2003.
- Davis, Lois, Susan D. Hosek, Michael G. Tate, Mark Perry, Gerard Hepler, and Paul S. Steinberg. *Army Medical Support for Peace Operations and Humanitarian Assistance*. Washington, D.C.: Rand, 1996.
- Drifmeyer, Jeff and Craig Llewellyn. "Military Training and Humanitarian and Civic Assistance." *Military Medicine*. (January 2004).
- Frontini, Enrico. "First Situation Report, Bingol Earthquake 1 May 2003." 1 May 2003. Available from www.reliefweb.int/w/rwb/nsf/0/. Internet. Accessed 19 November 2003.
- Kriner, Stephanie. "Inside Turkey, Hope Fades for Survivors." 23 August 1999; available from www.disasterrelief.org/Disasters.990819Turkey5/. Internet. Accessed 19 November 2003.
- Prestowitz, Clyde. *Rogue Nation*. New York: Basic Books, 2003.
- Raslan, Karim. "A View from Southeast Asia." *Foreign Policy* (July/August 2003): 38.
- Richeter, Paul. "The World; 7 of 8 Islamic Nations in Poll Fear U.S. Attack." *Los Angeles Times*, 4 June 2003, sec. A, p. 3 (795 words); available from ProQuest. Accessed 24 November 2003.
- Shaoul, Jean. "On the British and U.S. response to the Bam Earthquake." 22 January 2004. Available from www.wsws.org/articles/2004/jan2004/bam-j22.shtml. Accessed 16 February 2004.
- Stapp, Katherine. "Health: Preventable Diseases Claim 11 Million Children Each Year." 5 July 2003. *Global Information Network*. Available from ProQuest. Accessed 3 February 2004.
- Wines, Michael. "With Health System in Tatters, Zimbabwe Stands Defenseless." *New York Times*. 5 February 2004. Sec A, p. 1.
- World Health Organization. Available from www3.who.int/whosis/health_personnel.cfm?path=who. Accessed 24 November 2003.

