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Leadership challenges in multinational medical peacekeeping operations: Lessons from UNIFIL Hospital

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ABSTRACT

Commanding a military multinational and multilingual healthcare facility can be a formidable task with very little margin for error. The authors were in leadership positions of UNIFIL Hospital, unique in its diversity of both staff and clientele. Experience about the challenges faced and methods adopted to overcome them will be shared. Troops from diverse backgrounds differ in their competency, and also in their attitudinal approach to situations. It is imperative for the medical commanders to identify these differences, and work towards harnessing individual strengths to form a cohesive unit. Frequent rotation of team members and thereby difficulty in adapting to new environment makes the tasks more challenging. Challenges can be broadly categorized in those dealing with functional roles (providing medical support) and command and control issues. Linguistic challenges especially in situations where professionals have to work as a coordinated unit remains a major challenge. The threat of medical errors arising out of misunderstandings is very real. Gender sensitization is essential to avoid potential unpleasant situations. Interpersonal conflict can easily go out of hand. The leadership has to be more direct and deliberate relying less on hierarchy and more on direct communication. A strict enforcement of UN standards for equipment and competence, frequent joint medical drills help to overcome interoperability issues and develop mutual confidence. Leadership in multinational UN hospitals is a demanding task with its peculiar set of challenges. A systematic and deliberate approach focused on mutual respect, flexibility and direct leadership can help medical commanders in such situations.

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Introduction

The Medical Support Manual for UN Field Missions states that the purpose of medical support for peace operations is to secure the health and well-being of members of United Nations peacekeeping operations in a timely and efficient manner.¹ This medical support is of paramount importance and greatly impacts the success of a mission. It not only contributes to the morale of the troops but also may present a humanitarian face and lends credibility amongst the local population. The multinational and multilingual nature of these deployments brings together people from diverse cultures, religions and backgrounds on to a common platform. This brings with it an opportunity to cooperate and learn from the others. However, this very multinational nature of the medical missions poses some unique challenges to the effective delivery of healthcare in the field. There is little scope of error in medical care and the slightest possibility of mismanagement and miscommunication can pose a major challenge. Though similar issues of multi-culturalism may be faced by various multi-national corporates and hospitals, the problems it may pose in the context of mixed military medical units needs further deliberation.

The authors were deployed in the UNIFIL Hospital, which is a UN owned and equipped (UNOE) Level II healthcare facility in the United National Interim Force in Lebanon (UNIFIL) in leadership positions from Apr 2011 to May 2012. This hospital is unique in that it has healthcare professionals from more than 4-5 countries working under one roof catering to the medical needs of troops from more than 20 countries. The diversity being dealt with in the hospital is extraordinary and the leadership needs to fully understand the complex interplay between personnel from different backgrounds working towards a common goal. The aim of the present article is to highlight the leadership challenges which exist when commanding a multinational hospital in a peacekeeping mission. Some possible approaches to overcome these challenges will also be discussed.

Background

Resources for medical support in UN missions are classified into various levels of healthcare facilities based on the capability.² Though field hospitals in UN peacekeeping operations are the responsibility of Troop Contributing Countries (TCCs), the UN itself has a few of its own hospitals. The UNIFIL Hospital in Lebanon is one such hospital which provides Level I medical support to the Force HQ and Level II support to the force. This is a unique model in which the hospital is managed with military medical personnel from multiple TCCs but with UN owned equipment and infrastructure. The senior most Medical Officer from the largest medical team takes over the command and control function. Other than the military medical personnel, there is a local civilian component too in the form of doctors, nurses, pharmacists and ambulance drivers.

As a leader of such a diverse setup, it is important to understand the dynamics of troops under command. Military

field hospitals have been described as complex dynamic organizations with an unique conflict between a military hierarchical culture and process oriented clinical culture.³ An added dimension of multiculturalism to this organization certainly makes it more complex. The challenge for the command then, is not only to ensure optimal medical support to those dependent on the hospital but also maintain an amicable and harmonious work environment with a reasonable level of understanding between team members from different nations.

Challenges can broadly be categorized into those dealing with provision of medical support (professional) and those dealing with command and control. Both types of challenges are further discussed.

Professional challenges

Standards of care are a core pillar of modern healthcare management and the current medical support manual specifies certain standards for health care providers and expected level of proficiency.¹ The challenge the commander faces however, is in translating this standard of care given the diverse competency and skill levels of the healthcare personnel. This is primarily an outcome of different background training of the personnel and not reflective of their motivation/ability. For instance, the training of a physiotherapist may vary from country to country and a situation may arise when a particular type of therapy is not available due to the difference

Fig. 1 – Air ambulance based CASEVAC drills between hospital staff, aircrew and aeromedical evacuation teams, all from different countries.

Fig. 2 – Equipment familiarization drill to increase interoperability.

in training of the new paramedic. Standardization of competencies is a desirable goal but difficult to set and even more hard to follow.⁴ New inductees must undergo pre induction and in-mission training especially in trauma and life support. This requires a consistent effort on part of the commander of the medical mission.

Unfamiliar CASEVAC and MEDEVAC procedures. With varying levels of skills of doctors and paramedics pooled in from different countries, CASEVAC and MEDEVAC, with its exhaustive set of protocols, becomes a challenge for the commanding officer of the hospital. Getting a diverse medical team to work with clock-like precision and make split second decisions to deliver optimal care, can become a daunting and uphill task. Throw in the different languages into this boiling cauldron of diversity and you have the perfect recipe for disaster!! Interoperability is the key here and one of the way to overcome this is intensive “in-mission” training and active participation in exercises to know CASEVAC drills and procedures (Fig. 1).

Unfamiliar equipment and drugs formulations. Being a UN owned facility, both the equipment and drugs in UNIFIL Hospital are supplied by the mission. This may lead to the medical team-members from TCCs being unfamiliar to the already installed technical equipment and drug formulations. Efforts at short training sessions to enable the person to become familiar to the equipment and some degree of standardization are essential. Critical care staff should especially be made to undergo intense familiarization drills so as to avoid any mishaps (Fig. 2).

Attitudinal differences. Troops from diverse backgrounds are not only different in their knowledge, skill and competency, but also in their attitudinal approach to situations. As they differ in cultures, it is not surprising to see differences they have towards professional work, emergencies, complaints, waiting times and communication skills. For example, a patient from country 'A' about to undergo an exploratory

laparotomy may want to discuss every possible cause of his ailment and also speak to his family immediately before and after the surgery whereas a patient from country 'B' might be less inquisitive and might not even want to disclose his illness to his family. Even the role and responsibility of the paramedics varies. For example, in certain situations, the nurse might be expected to counsel a patient about diet for diabetes which is not expected in their parent country. The leadership at all levels needs to understand this difference and avoid benchmarking. It would be a better approach to make efforts to elicit the positives from an individual by understanding their background and fully optimizing their services.

Inter-personnel communication. Multinational hospital staff have to interact not only with patients of other countries but also each other as colleagues. Professional teamwork and interdependence is an essential component of providing quality medical care and an inadequate understanding between the doctors, nurse, pharmacists and other technical staff can very easily jeopardize the same.⁵ This becomes especially important during the frequent patient handovers which occur in such missions (Fig. 3). Even in critical care areas like the ICU and OTs, there are many times when care is being proved by a hybrid team of surgeons, anesthesiologists, nurses and paramedics. A case in point is an example where a French soldier diagnosed as acute appendicitis and being operated by an Indian surgeon based on an ultrasound done by an Italian radiologist along-with the Anaesthesia team consisting of an anesthesiologists of Belarus and India and OT nurse from Indonesia and a multinational post-operative nursing staff! In such a cauldron, efficient and smooth communication between the team members becomes a key result area of the leadership. The role of joint training and practicing drills is paramount to develop this interpersonal skill. Close teamwork is essential in such situations and a mutual trust needs to develop for optimal functioning (Fig. 4).

Fig. 3 – Patient handover between Belgium and Indian peacekeepers.

Fig. 4 – Mass casualty drill being filmed to observe intra-force coordination skills.

The role of a common language (English) is important and helps to overcome the linguistic barrier to some extent. However, many times it is not possible to have every member of the team to be fluent in English speech and comprehension. Medical situations demand clear communication lines between people with little margin of error. Soldiers of various nationalities may further be able to express their symptoms in their native tongues only leading to difficulties.⁶ The availability of medical staff speaking that language/from the same country is then invaluable and efforts are always made to use the services of doctors located with contingents. The services of online translators like Google translate, can help in understanding a patient's symptoms albeit not very accurate.⁷ An attempt should be made by commanders to reinforce the need for clear unambiguous communication between the staff using multiple means (verbal, nonverbal, email, etc.) in a slow and deliberate manner. It should also be embedded in every team member's mind that communication is key and they should not get annoyed at what might seem a simple expression for one but a complex puzzle for another. Pre

induction screening of critical staff like OT team for assessing proficiency in speaking and understanding a common language like English, and in mission availing the facility of language classes would go a long way in addressing this problem.

Command and control challenges

Command and control structure. The leadership of multinational troops with an ever changing staff is a formidable task to say the least. Militarily, as in any unit, there must be a clear, well-structured and unambiguous chain of command to optimize the functioning and smooth execution of tasks. This necessitates that the commander exercises full command and control over the troops placed under his charge. This expectation of full command and control however comes with riders and commanders are not given disciplinary powers in such multinational setups. Their appraisal by the commander too is limited and country specific. This makes the challenge even

more demanding and commanders need to exercise leadership skills to the maximum with neither a carrot nor a stick!! A potential for breakdown of the command and control always exists and commanders need to be extra careful and judicious in their approach.

Frequent rotation. Since members of the team rotate on a regular basis with short tenures (8 weeks to 6 months), there is not much time for the commander and the members of the team to familiarize themselves with each other to understand the tasks at hand and adapt to the unfamiliar working styles of different people. This calls for a high degree of flexibility to adapt to rapidly changing situations from all sides. Again the short rotation cycle time would mean frequent training modules focused on practical deliverable competency. A suggested way out is to have a period of at least 6 months made mandatory for the military medical team.

Diverse socio economic and cultural background. Leadership in a multicultural setup is a challenging task with many suggested leadership styles.⁸ Troops come from backgrounds which have very diverse cultures, social systems, religious beliefs and value systems. This automatically places them in mental compartments with a barrier between others with dissimilar backgrounds. The commander must act proactively to help break down these barriers and facilitate the positive interaction between troops. Encouraging the expression of individual culture and beliefs helps to reduce the invisible mental barriers and accepting the differences. Celebrations of festivals, birthdays, national days and social interactions assist in forming and maintaining the team.

Language plays a barrier to some extent and at times even if people understand English, the interpretations are very different. Similarly, expression of thoughts in a non-native tongue may lead to misunderstanding of what is being conveyed. It is advisable at times to clarify by means of repetition and alternate ways to avoid confusion. A quick feedback taken from the individual about what he/she has understood can help avoid misunderstandings. The use of language interpreters and language training can help reduce these misunderstandings.

Gender sensitization. Another sensitive matter which needs to be directly addressed is the interaction between troops and the opposite gender. Professional and social interactions are acceptable but background differences in social systems and values can easily be forgotten leading to gender abuse and rarely cases of sexual misconduct. To address this issue it is important to embark on a gender sensitization drive so that the team from varied social systems learn to accept these differences. A zero-tolerance policy towards sexual mis-conduct needs to be followed and apart from the induction training about the UN code of conduct, the commander needs to keep an open door policy for any such complaints. Early timely intervention and warning by the commander can save a huge embarrassment not only for the individual and unit but also the country and peacekeeping mission at large.

Interpersonal conflict is a reality in any organization and the military is no exception. Troops differ in their personality types and small arguments can easily go out of hand if not addressed quickly. Sometimes an inadequate understanding of perspectives of individuals of other nations may catalyze

this conflict. The commander needs to avoid this at all costs and treat individuals without biases and stereotypes. A mistake often made by commanders may be to take sides or downplay the matter as trivial. A feeling of mutual respect needs to be developed amongst the troops with a spirit to adjust and accommodate.

Innovative leadership styles. As brought out earlier, commanders in a multinational military hospital have limited authority over the troops due to very nature of its existence. This means using innovative leadership styles to carry the team along. This includes participative decision making and taking opinions from others. This can also help in ensuring active involvement of the members and giving the collective ownership of tasks assigned. Opportunities of praising positive deeds by members, direct feedback, involvement of members in decision making and empowerment of others helps to positively reinforce the trust between the commander and troops and reduce communication barriers. Despite all this, the commander needs to remember that he/she is 'in charge' of the situation and responsible for the outcomes. An overtly democratic style of functioning should therefore be avoided. Transparency and participative nature of decision making should not become a loss of authority.

Treatment of civilians and local population. Though there is no official obligation of UN to provide or take responsibility for medical services of the local population, situations do arise when local medical aid is provided.⁹ The medical team may face difficult ethical issues while treating local population and the problem is compounded when you have a team belonging to diverse cultures and practices.¹⁰ The local population may occasionally be hostile and the team must have an understanding of the popular beliefs and cultures to manage them effectively. Also human rights issue must be kept in mind and it is the commanding officers job to keep his team updated on the UN stance on these issues and regularly sensitize them to prevent and unpleasant or untoward mishaps.

Conclusion

To conclude, the challenges faced in leadership of a multinational UN hospital are unique and intriguing. Though the present commentary is not a scientific study and not in a position to make recommendations, probably the lessons learnt can be used gainfully by other commanders in similar situations. To successfully overcome these challenges, medical commanders need to develop a multicultural mindset themselves and create an atmosphere of mutual respect and co-operation in the hospital. Potentially serious medical errors can be prevented by improving the communication between hospital staff from various backgrounds. The role of pre-induction training and joint group activities is critical. Leading the team with a participative mindset and flexible approach is important. The leader him/herself has to take initiatives to reduce the communication chain and adopt a horizontal approach rather than a top-down approach. Notwithstanding the challenges it poses, the command of such a multi-national body of troops engaged in a common medical support goal is a rewarding and enriching once in a lifetime experience.

Conflicts of interest

The authors have none to declare.

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