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STRATEGY RESEARCH PROJECT

A UNIFIED MEDICAL COMMAND: THE NEXT STEP IN JOINT WARFARE DEVELOPMENT

BY

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ABSTRACT

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American Military Medicine's early organizational roots came from a British model. During the Civil War military medical services reorganized to support large land forces in heavy combat. The pattern developed during that period remains, with minor adjustments for improved technology, the organizational model for today's medical force. This pattern is based on service specific, separate medical departments with limited interoperability. A transformation is underway that is converting much of the force structure into an interoperable joint force. As they are currently organized, the military medical services cannot efficiently support a joint force. To solve this problem, all three service medical departments should be reorganized under a single Unified Medical Command that retains the individual service medical departments as subordinate component medical commands. Such a structure will maximize efficiency, eliminate unnecessary redundancy, conserve limited resources and respond to the needs of a joint force better than the current structure.

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A UNIFIED MEDICAL COMMAND: THE NEXT STEP IN JOINT WARFARE DEVELOPMENT

This study addresses a need, and proposed patterns, for reorganization of military medicine. The solutions offered establish a datum on a continuum of possible responses ranging from no change to potentially radical change. This paper is intended to stimulate discussion and analysis of a problem in our medical organization.

A "Revolution in Military Affairs" (RMA) is a shift in concept, policy, procedures, tactics, and or technology of such a profound nature as to change permanently the way we organize and fight.[1] In some way, they change the fundamental nature of the organization forever. Organizational RMAs, whether company or corps level, are complemented by technological changes such as the advent of mechanization, development of aviation and invention of nuclear weapons. Major changes are occurring in every facet of modern military organization. Elements of our military organization that cannot, or do not change, may become marginalized. Military medical services are faced with such a threat. Addressing this threat may require changes on the order of an RMA; a new way of seeing the role of medicine on the battlefield, a new approach as radical as elimination of horse cavalry was thought to be in the early 20th century. Military medical services should address this threat by adopting a new organizational design, that of a single Unified Medical Command, encompassing the full range of health service support activities.

Changes of the magnitude discussed here have to come from a deep-seated need. Why change, and if so, to what? Medical support is an integral component at every level of military force structure, from the smallest to the largest and most complex. Military medical services, as currently organized, may be in danger of falling behind the needs of their customers. Across all service branches, medical organizations are under pressure. Fixed facility hospitals are struggling to implement managed care programs while combat health service support wrestles with old technology, progressively limited training opportunities, skills sustainment shortfalls and personnel shortages. An oft-heard comment is that the medics are needed but they are too big, too heavy, and too slow responding.

The 1997 Quadrennial Defense Review (QDR) took an especially hard look at the current status of military medicine. Dividing our requirements into those capabilities absolutely critical for operational forces and those more focused on fixed facility, installation missions, the QDR recommended an expanded role for outsourcing. It defined provisions to expand outsourcing for some types of patient care, selected types of medical training, and installation

fixed facility health care support.[2] These recommendations are clear signals that major changes in military health care are coming, if not from within, then most assuredly from outside.

HISTORICAL OVERVIEW: REVOLUTIONARY WAR TO THE CIVIL WAR

Plotting a course into the future requires a sound understanding of the historical path that brought us to our present position. American military medicine had its origins in our Revolutionary War.[3] Prior to then, local militias relied upon folk medicine, civilian physicians and, occasionally, British military surgeons supporting forces comprised of mixed militia and regulars. Medical care for the sick and wounded soldier was seldom a high priority and was often neglected completely. Wounded soldiers were usually cared for by fellow soldiers, local civilians, and occasionally, by overworked community physicians. In many cases, if care existed at all, it was provided from the purse of the commander. Early surgeons were seldom considered part of the unit organization. Most land forces of the period considered them ancillary personnel permitted to travel with and service the force. Surgeons often received little or no pay, no medical supplies and no ancillary staff. Only occasionally was a medical service included in the force mix.[4]

Armies of Europe started including standing medical services in their organizations by the early to mid 1700s.[5] One of the first documented examples of organized battlefield medical care occurred at Fontenoy in 1745. The British army medical services, the best organized of the day, treated soldiers on the field, evacuated them to what we today call an ambulance collection point, and then moved them behind the lines to field surgeons prior to follow-on movement to hospitals in nearby towns. This first truly organized system, along with that of the Royal Navy, was the model for the fledgling American medical service. Such organized patterns were the exceptions, especially for land forces.[6]

By the outset of the American Revolution, a rudimentary medical service already existed in the force structure. Massachusetts created a medical commissioner to find, purchase, and issue medical supplies to the militias. When hostilities started, the Continental Congress organized a Committee of Safety chartered to purchase medical and surgical chests with central funds for use by regiments of the Continental Army. By mid -1775, largely under the authority of the Committee of Safety, commanders had rented buildings in the Boston area and organized in them rudimentary hospitals with separate facilities for smallpox and mental illness.[7] On 27 July 1775, the Continental Congress formally established a "Hospital Department" and appointed Dr. Benjamin Church as "Director General and Chief Physician."[8] This heralded the beginning

of a formalized medical structure that would later become the Army Medical Department. At the time, the newly formed Continental Army numbered only about 20,000 men.

During the Revolution, scores of physicians and ancillary medical personnel joined the Continental Army in capacities ranging from surgeon to apothecary.[9] This system was largely the British Army model with many of its weaknesses, especially in ancillary support sectors such as nursing and logistics. Following the British surrender at Yorktown, the Continental Army's fledgling medical department shrank. By 1784, it consisted of a single surgeon and four surgeon's mates.[10] From 1784 through 1789, there was no formal military medical department. Each state was responsible for healthcare of the soldiers and militia garrisoned within its borders.

U.S. Naval medical tradition began in 1775 with the official commissioning of the American Fleet. Acts of the Continental Congress formally establishing the Continental Navy did not call for, nor recognize, a distinct medical organization. Beyond those posted directly on ships of the line, there were few Naval surgeons. The Navy medical service focused almost entirely on shipboard care, relying on civilian, and in some cases, Continental Army treatment facilities once the sailors were on shore.[11] The few medical facilities ashore were seldom more than shacks for sick sailors located near naval yards. This system of reliance on civilian or the other service's medical departments for support when not at sea could be viewed as an early example of joint operations. From the end of the American Revolution until nearly the middle of the next century, the history of Naval medicine was largely that of the exploits of individuals and not of a formal organization.[12] The first substantive proposal for a separate Naval Medical Department came in a paper prepared by Dr. Edward Cutbush in 1808. In his "Observations on the Means of Preserving the Health of Sailors and Soldiers, with Remarks on Hospitals and their Internal Administration," Dr. Cutbush described a scheme for organizing a Naval Medical Department.[13] The "Bureau of Medicine and Surgery" was established within the Department of the Navy nearly 34 years later.

Between the Revolutionary and Civil Wars, both the Army and Navy made organizational improvements leading toward fully accepted and integrated medical services. Medical officers were given rank and authority commensurate with position; medical services received increased funding and infrastructure improvements in the form of a growing hospital system. Perhaps most important of all, medical officers achieved a growing respect among their civilian peers.[14]

CIVIL WAR TO WORLD WAR II: THE PERIOD OF GROWTH

By the outbreak of the Civil War, both the Army and Navy had distinctly organized medical services with clearly delineated hierarchical structures. Each had a "Surgeon General" with dedicated staff and administrative divisions supporting a loose structure of hospitals, clinics and pharmacies. In 1862, Congressional Act 12 Statute 379 reorganized the Army Medical Department. Under this act, the Surgeon General became a general officer, the Medical Department staff expanded, and the role of the Medical Department within the War Department increased. These actions marked the real acceptance of medical services within the military.[15]

Existing medical systems could not cope with the Civil War's vast numbers of sick and wounded. Concepts of medical evacuation from the battlefield, first used by European armies nearly a century earlier, reemerged and improved.[16] New organizational concepts for hospitalization greatly expanded the number of soldiers who could be treated in a given period. Logistics programs expanded so medical supplies could get to the front faster. The concept of providing lifesaving care near the battlefield became standard.[17] Scientific breakthroughs quickly found their way into the hands of surgeons and physicians. This period represents the first real RMA for American military medicine. Changes made then profoundly affected everything we do in some way today.

The American Civil War was the first grand experiment for modern military medicine. Previously, military medicine had been an afterthought, a detractor from the task at hand. After the Civil War, military medicine was an integral part of the military art and science. At the beginning of the 19th century, not a single major military power had a well-developed distinct medical service. By the end of the 19th century, every major power had organized medical departments within their militaries.[18] However, service-specific medical departments were the norm, with little cross branch activity.

Between 1901 and 1916 major additions to the medical armamentarium improved the range of support available and started a reversal of casualty statistics still in progress today. In World War I (WWI) modern scientific medicine and destructive, technology-dominated warfare came together both synergistically and cataclysmically. Greater patient numbers and greater technological capability marked every aspect of military medical practice.

During WWI, the Army Medical Department expanded to a maximum strength of 344,000, including 31,000 physicians and over 21,000 nurses.[19] For the first time in American military history, deaths due to disease were brought down to levels comparable to those caused by battle.[20] Military medicine's technical contribution to the fight was now evident in the hard

numbers. Following the war, improvements to organizational design and force structure integration heralded a pattern of change that continues to this day.[21]

The medical departments of the Army, Navy, and Air Force are organized to provide health services to the force in both peace and war. However, the skill sets required to provide health care in a peacetime garrison environment (clinical or tactical) are not identical to those needed to provide care on the battlefield. Although there is some clinical overlap, there are significant differences not readily appreciated nor commonly considered by garrison-oriented medical departments. These differences contributed to a need for, and influenced the patterns of, organizational changes proposed later.

By the beginning of the 20th century, the Army and Navy each had its own medical department, headed by a Surgeon General, with staff and infrastructure covering every area from clinical care and field operations to logistics and research. These service medical systems had much in common, clinically and tactically. Their key differences related to service roles and missions, not to unique technical requirements. Armies fight on land, therefore requiring a shore-based clinical delivery system. Sea services fight, for the most part, on the water and thus require delivery systems for that environment. Under it all, however, the medical departments are charged with one simple task, the repair and maintenance of a single identical system, the individual soldier and sailor (and later, airman). Herein lies the seed of opportunity. With today's increased emphasis on joint and combined operations, the commonalities of our medical roles and missions far out number the dissimilarities. This old reality was seen time and again, in a thousand places and a hundred battles, throughout the twentieth century. Joint operations in military medicine became increasingly common.

WORLD WAR II FORWARD: THE EMERGENCE OF JOINTNESS

Joint operations are far from a recent idea. MacDonough's naval operations on Lake Chaplain during the War of 1812 contributed greatly to the overall ground campaign. During the Civil War, Grant and Porter coordinated operations at Vicksburg in one of the most successful joint endeavors of the war.[22] Medical support also contributed to these successes.

A major factor limiting feasibility of joint and combined operations before 1900 was technological. Efficient joint operations rely upon fast, responsive communications, which did not exist then. Medical support was also limited and service specific, with almost no opportunity for interservice or joint activity. With limited schemes of combined and or joint operations feasible, there was no plan for systematic cooperation between the medical services. The

system remained captive to a primitive technological environment where jointness was neither suitable, nor feasible. America was principally a local power during the 19th century, with few excursions beyond the hemisphere. The demand for interoperability had not developed.

With the Spanish-American War, the United States made her debut as a world power. She found herself in control of territory in both hemispheres. This came during a period of tremendous technological advances. The accelerating scientific revolution was changing the way we saw the world and our place in it.[23] Advances in medicine transformed what had been largely an art, with some scientific underpinnings, into a science with an artistic character. Earlier technological limitations to cooperation and coordination between organizations were falling to new solutions. Our growing international involvement demanded greater cooperation and coordination between the military departments. The increasingly cooperative atmosphere between the services opened new opportunities for medical departments to interact and coordinate support for the force as a whole. Coordination could make capabilities unique to one service available to another simply and quickly. Increasingly, commonalities in requirements and capabilities were more noticeable than differences.

Several abortive attempts at coordinated joint operations occurred during the Spanish-American War and triggered a decision to form a board to develop joint plans in 1903.[24] The "Joint Army and Navy Board" was composed of the heads of both services and their respective chief planners. Their initial mandate was broad but vague: plan for joint operations and resolve any problems arising from dissimilar approaches between the services. This was the first real attempt to coordinate for joint operations at the service chief level.[25] Concepts for plans came from the service secretaries; it was the job of the board to develop plans from this guidance. The board existed right up to World War I but had little impact on the concepts for the War Plans. Medical planning received little consideration.

After World War I, the "Joint Army and Navy Board" reactivated, at the direction of the Service Secretaries. Its expanded membership included the Chief of the War Plans Division of the Army and the Director of Plans for the Navy. Even more significant was the creation of a separate staff called the "Joint Planning Committee." Made up of members from both services' planning divisions, this was the first codified joint staff in the United States military structure. However, this second version of the Joint Army and Navy Board was no more effective than the first, a condition that lasted right up to 1947 when it was finally disbanded.[26]

During World War II, the United States military's concept of joint and unified operations came alive. The global conflict demanded new strategies, new tactics, and new procedures employed far faster and in more remote settings than ever before. Because of the vast

distances and the geography involved, no single service had the capability to carry the fight to the enemy and win.[27] Unified effort had to be employed across the force to assure victory. The Army would depend upon the Navy, the Navy upon the Army, and the Air Corps on both and neither at the same time. Out of necessity, the services cooperated and coordinated as never before. Cooperation and coordination extended throughout the force, to include the medical departments.

Our modern structure of Geographic and Functional Unified Commands came from recognition of the value of the unity of effort concept during World War II. Modern technologically driven warfare become too complex for simple cooperative agreements between services. Unified commands would be the organization design for the future.

The major difficulties in implementing a unifying plan lay in two areas. First, how could such a plan be developed in a politically charged atmosphere where each service is ultimately focused inward toward protecting and preserving its own organization, roles and functions? Second, how could such a radical evolution in military organization be implemented? Could it be done solely within the military departments or would it require outside political pressure? The answer was a combination of political and internal pressure.[28]

Disputes around roles and missions usually pitted those favoring geographically based areas of responsibilities against those supporting functionally based organizational designs.[29] Initially, the impetus for reorganization came solely from within the War Department. Before war's end, the Joint Chiefs had already decided to keep some form of the unified command concept in peacetime.[30] Friction between the Navy and Army in the Pacific theater during the war provided the drive to make this change as soon as possible afterward. In 1946, after much debate and discussion revolving around functional verses geographic structures, a compromise agreement established a global system of unified commands under the direct control of the Joint Chiefs of Staff. This "Outline Command Plan" was the first true "Unified Command Plan" and resulted in creation of the first geographic unified commands.[31] The National Security Act of 1947 codified in statute the unified command concept and laid the foundation for today's joint movement. Over the next five decades, the unified command concept continued to evolve, improving and changing through departmental and legislative adjustments. The first unified commands were geographic. Functional unified commands, grouping like capabilities with common roles and requirements under a single headquarters, were established later. All of these actions improved efficiency and increased operational flexibility across the whole defense organization. Today there are five geographic and four functional unified commands. The four

functional unified commands represent a model upon which military medicine could be reorganized.

DRIVERS OF CHANGE

Throughout the last half of the twentieth century, our military force structure, and its command and control organization, focused on fighting and defeating the Soviet Union on a linear battlefield in central Europe. It countered the Soviet threat at every turn during the Cold War. The collapse of the Soviet Union left the United States as the only remaining superpower. The resulting power imbalance, along with the responsibilities of a sole surviving superpower, is driving change within our military. Change is taking shape in various ways along both service and functional lines. Across all branches the central theme is a revolutionary "transformation" of the way we are organized, equipped, and fight. The process is pervasive and affects every aspect of our military culture to such an extent that it qualifies as a Revolution in Military Affairs. The common threads linking all transformation activity are multi-service cooperation and jointness spanning service boundaries.

The Chairman of the Joint Chiefs of Staff, General Henry Shelton, stated in January 2001 that "our biggest challenge is to create a truly joint force," a military in which every branch is an integrated part of a larger team.[32] Joint Vision 2020 is built around this construct; a military with core competencies built upon a joint force that integrates capabilities seamlessly across all battle operating systems.[33] Creating such a joint force will require simultaneous joint and service transformations. A trans-culture, trans-service, trans-battle operating system, change of this dimension will affect not only combat arms but also the accompanying combat support and combat service support structures. This movement could be the most profound change in the history of the military profession.

The transformation movement is not really new. It has been ongoing, at increasing tempo and depth, for the last two decades. The creation of the United States Special Operations Command (USSOCOM), as a result of the 1987 Goldwater-Nichols DOD reorganization Act and the accompanying Nunn-Cohen Amendment to the Defense Appropriations Bill, is a superb example of this movement: a major legislatively mandated, transformational change simultaneously affecting all three branches of the military.

Change at all levels has to occur regardless of the ultimate design implemented. The final design will, however, be a joint organization. The Chairman recently said, "Creating a truly joint force will require a joint transformation."[34] A geographic Commander in Chief (CINC) reinforced this when he said that we must break down the seams between forces to achieve the

enhanced joint capability needed in this new century. Such a design already exists in the form of a Joint Special Operations Task Force (JSOTF).[35] A JSOTF is an organization specifically designed and trained to conduct missions with forces from all branches of the Armed Forces, in a seamless manner with maximum efficiency. It incorporates the best capabilities of all the force into a single structure, which is greater than the sum of its parts. Military medicine needs just such an overarching structure that includes all elements of the profession, across all service branches.

PROPOSALS AND ANALYSIS

"There have been other occasions in military history when one puzzle was supplanted by another; when," as the Greek rhetorician Gorgias said," the choosing is most difficult."[36] Such times, often driven by technological developments, are with us again. All of the elements of national power are affected to some degree. New technologies are driving policy adjustments and forcing strategy changes that require new types of organizations to execute. Today's military medical services are feeling the affects of just such a situation. Conditions and requirements are changing. Military health service support, at the strategic and operational levels, is not matching the changing needs of its customers. New ideas must be entrained to fix this growing schism.

Any valid proposal must improve efficiency and maximize flexibility at all levels of the organization. It must add value to the whole joint concept. An acceptable proposal for wholesale reorganization of military medicine must address both the garrison (Table of Distribution and Authorization, or TDA) and combat (Table of Organization and Equipment, or TO&E) pillars of the medical house. Change of great magnitude is not free of cost, political, cultural, or fiscal. A good solution must retain the positive attributes of each component, separately and in combination, while minimizing transition chaos. It must give us full integration across the force while maintaining individual service identities. The four discussed options each have benefits and disadvantages but only one fulfills all the requirements of a valid solution.

A: The first option is leave military medicine organized as it is today with branch autonomy and chains of command through respective Surgeons General and Chiefs of Service. The major weakness in this system is not with support at the installation and fixed facility level (TDA) but with support for deployed and maneuver forces (TO&E). This is the system we have been operating under for the last century. It is hierarchical, branch focused, and not compatible

with joint medical support. It has given us a chain of fixed base hospitals and major medical centers with their supporting network of training and research programs.

This system is designed and organized to support a global, multi-theater war with simultaneous engagement of all the elements of national power. It separates deployable combat medical forces from community-focused garrison medical forces, placing them in completely different commands. It is a system reliant upon large, forward deployed fixed capability with few resource constraints. It is not designed for seamless support to a power projection joint force. In addition, this system is not focused on health care for combat but on peacetime community-based care. It relinquishes responsibility for deployable medical support to non-medical major commands, thus creating two different medical communities.

This garrison-focused organization has little visibility on, and minimal influence in, maneuver medical support. It is community healthcare-focused and does not respond to the direct support needs of combatant commanders in a joint organization. Under this pattern, fixed facility community-focused support will continue to thrive at the expense of a stagnating operational medical community.

B: The second option keeps the current organization and addresses some of the needs of the operational medical community. Only the doctrine changes, not the organizational design. Individual service focused organizations for both installation (TDA) and operational (TO&E) medicine remain but with augmented doctrine directing operational joint training. Training focus aims at ensuring interoperability for the deployable medical force. This proposal requires cooperation and coordination between the services to develop joint doctrine and design programs that maximize capabilities while eliminating unnecessary redundancy and duplication. DOD, through the joint staff, will have to be directly involved in coordinating and monitoring the joint elements of such a program.

The Office of the Assistant Secretary of Defense for Health Affairs and the Joint Staff Medical Readiness Division will have to provide coordinating guidance and oversight to make inter-service cooperation a reality. The office of the Command Surgeon for Joint Forces Command (JFCOM) could be given the mission, directive authority and infrastructure to plan, coordinate, and execute all joint training programs and requirements for the service medical commands. Without this authority and the required budget, there will be interservice friction and squabbling over primacy. This option can be planned and executed as an internal DOD reorganization, with limited additional legislation.

Under this proposal there is little disruption of the current individual service focused medical departments. Installation and fixed facility managed care programs continue under the

TRICARE model. Service unique medical capabilities and budgetary authority remain unchanged. What does change is the emphasis on joint interoperability and operational medicine. Open support is emphasized through policy and guidance from the Secretary of Defense down. This proposal maintains a balance between installation and operational medical requirements.

C: The third option lets each branch of the military decide on its own if reorganization of its medical services, either alone or in coordination with other branches, is needed to support future joint interoperability and, if so, what pattern it should follow. This option relies completely on the individual services to see a need, initiate a process, and develop the required programs for a DOD-wide medical system capable of supporting joint interoperability. Considering service parochialism and institutional inertia, it is highly unlikely that the service medical departments will broaden their focus enough to see and accept change affecting their cultural preconceptions.

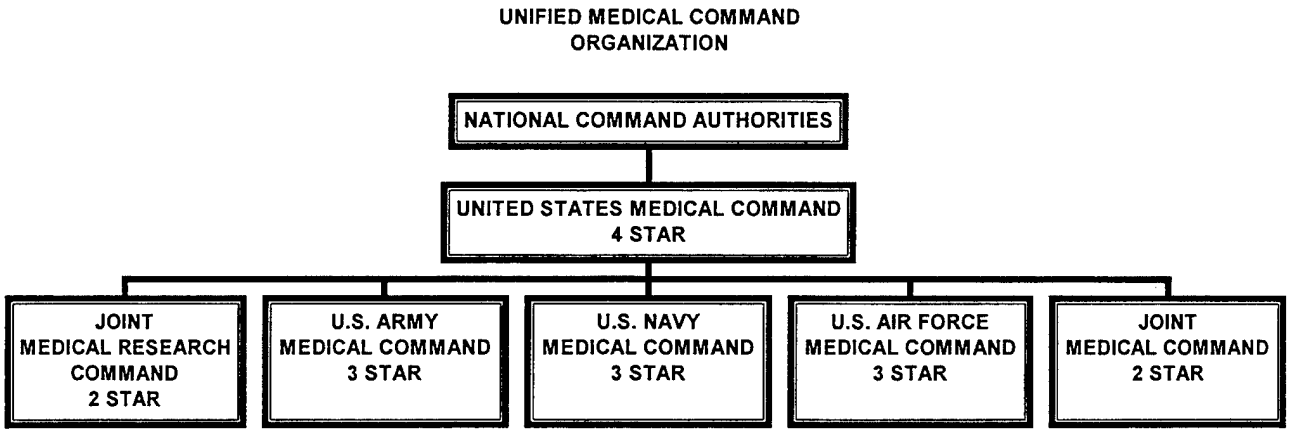

FIGURE 1.

D: The final proposal contains sweeping and revolutionary changes for our military medical system. As depicted in Figure 1, it is a complete reorganization of all service medical departments similar to that suggested in the report from the Joint Medical Wargame 2000.[37] Under this proposal, all three service medical departments will be suborned to a single Unified Medical Command with responsibility for planning, training, and executing military medical support across the Department of Defense, in both operational and installation environments.

The organization design is similar to that of existing Functional Unified Commands. The pattern draws its provenance from the Unified Command Plans and the Goldwater-Nichols Department of Defense Reorganization Act of 1986.[38] This seminal piece of legislation clearly

established the concept of unified and joint operations as the model under which our military will organize, train, and fight in the future.

A functional unified United States Medical Command (USMEDCOM), with broad responsibility and authority for medical support across service lines, will bring all medical requirements and capabilities into a single synchronized package. The United States Special Operations Command (USSOCOM) provides an organizational model.[39]

Similar to USSOCOM, USMEDCOM preserves individual service roles by making the service medical departments component medical commands under the unified command. Army, Navy, and Air Force Medical Departments become subordinate component medical commands with respective Surgeons General as the commanders. The Commander In Chief (CINC) of the USMEDCOM is a four-star level medical officer drawn from the ranks of component medical commands. Four-star rank is needed, not only because of the size of the organization but to ensure command parity with other Unified Commands. Medical Component Commanders, with simultaneous roles as service Surgeons General, remain at the three-star general officer level. To organize, coordinate, and execute all operational medical missions, a Joint Medical Command, equal in stature to the component commands, is included. This command helps develop and execute the CINC's Health Service Support plan including joint medical training. The Joint Medical Command will be commanded by a two-star medical corps general officer with a one-star general officer deputy.

The CINCUSMEDCOM, as a nominative four-star position under the Unified Command Plan, provides the command parity, credibility, and command and control needed for such an expansive organization. This position should be restricted, by legislation if necessary, to Medical Corps officers because of the unique perspective and special knowledge needed as the senior physician in the military. The Deputy Commander in Chief (DCINC) is a three-star Medical Service Corps general officer. The Joint Medical Command commander is a dual-slotted as a second DCINC if needed. The Medical Service Corps DCINC provides a balanced focus between clinical and operational issues at the policy generation level. The deputy commander position at the JMC adds flexibility to cover multiple theater support missions simultaneously. This position should be open to officers from any medical department branch with appropriate experience in operational medicine. All staffs, above the component level, will follow a typical Unified Command staff pattern with the appropriate special sections needed to oversee a multi-service medical support organization.

The service medical departments move from service chains of command to that of CINCUSMEDCOM as subordinate component major medical commands. Their previous

designation as Medical Departments is dropped. Responsibility for service unique installation health care activities, equipping and training medical personnel, and operations of healthcare facilities remains the domain of the component medical commands. They serve as force providers for the joint operational medical support mission. The Surgeons General maintain their traditional roles as medical advisors to their respective service chiefs.

Under a unified command design, authority, policy, and guidance for military medical programs and operations come directly from the National Command Authorities, to the Commander in Chief of the United States Medical Command for execution. Combatant commander support requirements likewise go directly to CINCUSMEDCOM, thus streamlining the process while adding flexibility. Fiscal support and authority, like that for USSOCOM, come from a dedicated appropriation. Responsibility for recruiting, training, and equipping medical forces remains with service component medical commands. Joint and advanced operational medical training falls under the Joint Medical Command. All operational field medical forces at and above Level III (Echelon above Division in Army doctrine) or equivalent are assigned to the Joint Medical Command, which develops joint doctrine, equipment and training for field and fleet missions.

Installation medical support, including all Department of Defense managed care programs, falls under CINCUSMEDCOM for planning, guidance, and management oversight. Execution and direct management remain with the respective Surgeons General. A separate staff section at CINCUSMEDCOM monitors all managed care programs and contracts to insure efficiency and coordination, replacing the current TRICARE Management Activity. This design provides total vertical and horizontal program visibility within the DOD.

Medical research and materiel programs, because of the degree of commonality, are part of a separate two-star command under the direct oversight and supervision of the Commander in Chief of the United States Medical Command. This "Joint Medical Research and Materiel Command" ensures efficient response to service unique and operational requirements.

DISCUSSION AND RECOMMENDATION

Any plan to reorganize a military element is influenced, and to some degree constrained, by issues of readiness, quality and affordability. This applies whether we are talking about a squad, a corps, or the whole DOD. Even though important, they cannot be considered barriers to progressive thought when considering a reorganization of the magnitude needed. We must divorce ourselves of the preconceived and consider the possibilities.

Of the four options presented, the last (Plan D) is the most sweeping and the most complete. It affects every aspect of military medicine in every branch of service. If implemented, it will change the cultural identity of the medical services. Operational medical support will separate from existing logistics categories and assume an identity all its own. The proposal is not without precedent. A comparable successful design already exists as the United States Special Operations Command.

There is both opposition and support related to a sweeping medical reorganization. During the Joint Medical Wargame 2000 held at the United States Army War College, panel members offered several points in favor of some form of "Joint Medical Command."[40] A joint command could:

- Streamline medical support
- Ensure unity of command
- Increase responsiveness to operational requirements
- Add flexibility in tailoring medical units to the task
- Enhance our ability to cross-level capability[41]

Option D, with its DOD wide vertical and horizontal integration, capitalizes on these enhancements to a streamlined design from foxhole and fantail to the highest levels. This plan will achieve the goal of efficient, flexible joint medical support regardless of how we organize our forces in the future.

SUMMATION

Historically, military medical services focused on caring for warriors of the line so they could return to duty. When medical care was available, soldiers were much more likely to show bravery in combat.[42] In the twentieth century, military medicine evolved in two directions, one focused on fixed facility/installation care and the other on combat care. Today the schism is both physical and philosophical, even in the minds of medical policy makers. The reorganization plan recommended here solves some of the issues brought about by this schism and forces both communities to adopt a DOD wide "big picture" strategic vision.

The question of which plan is the best is irrelevant unless we accept the premise that change is needed in the first place. Each demands surrender of some of our most preciously held notions of what is, or is not, the right way to do things. Buy-in, especially by the policy makers and senior program executors, is absolutely essential. Weak support at the top will undermine enthusiasm in the middle and sabotage acceptance at the bottom. Because of

institutional inertia, it is doubtful that such broad sweeping reorganization efforts can be initiated internally. This movement will have to have a political constituency at the national level. Only legislative action can force movement of this dimension, as it did with the creation of the United States Special Operations Command in the 1980s.

Change comes slowly when trying to overcome decades of entrenched ideas. Anthony Cordesman, senior military analyst with the Center for Strategic and International Studies said, in response to a question about Army transformation, "To field something light and cheap, you have to get the details right."[43] When considering a change of the magnitude proposed here, the little details will be cited as reasons for maintaining the status quo. Cordesman also said the Army has proven itself a very slow innovator: "It took them until the Gulf War to learn the lessons of Vietnam."[44] It is not so much that the Army is a slow learner, but its bureaucracy, the maintainers of institutional inertia, react slowly to course changes. This problem will slow positive reaction to the ideas presented in this study.

Fear of a long protracted effort must not dissuade us from attempting to change the organization for the better. Only the validity of the goal need be considered. Our military system is undergoing an upheaval and rebirth. We are on the edge of a new cycle of change on the order of a revolution in military affairs. Military medical services can choose to embrace change aggressively in the form of more relevant organizational designs, roles, and missions, or they can resist and either be increasingly marginalized or have outside forces dictate a course not of their liking.

Regardless of the final pattern adopted, much of the high-level policy superstructure already exists. Patterns for unit design are available. The need for change is articulated. The logic for doing so is transparent. All that is needed is the will to start. "When torrential water tosses boulders, it is because of its momentum."[45] The waters of another Revolution in Military Affairs are starting to flow; military medical services must move with the current or be tossed asunder by the momentum.

WORD COUNT = 6018

ENDNOTES

[1] Theodore Davis, "Discussions on Military History and Tactics," Lecture Series, Fort Leavenworth, KS, U.S. Army Command and General Staff College, October 1996. Class Notes.

[2] Office of the Secretary of Defense, Report of the Quadrennial Defense Review (Washington, D.C.: Department of Defense, May 1997), 55.

[3] Mary C. Gillet, The Army Medical Department: 1775-1818 (Washington D.C.: Center of Military History, 1990), 178.

[4] Richard V.N. Ginn, The History of the U.S. Army Medical Service Corps, (Washington D.C.: Office of the Surgeon General and Center of Military History, 1997), 3-6.

[5] Francis R. Packard, History of Medicine in the United States, Vol. I (New York and London: Hafner Publishing Company, 1963), 339-380.

[6] Richard A. Gabriel and Karen S. Metz, A History of Military Medicine, Volume II (New York: Greenwood Press, 1992), 131-136.

[7] Ibid, 131.

[8] Rose C. Engleman and Robert J.T. Joy, Two Hundred Years of Military Medicine (Fort Detrick, MD: The Historical Unit, U.S. Army Medical Department, 1975), 1.

[9] Ginn, 3.

[10] Engleman and Joy, 2.

[11] Packard, 659.

[12] Ibid., 665-705.

[13] Ibid., 670.

[14] Engleman and Joy, 2-7.

[15] Ibid., 6.

[16] Ginn, 14.

[17] Ibid., 5-8.

[18] Gabriel and Metz, 204.

[19] Association of the United States Army Institute of Land Warfare, Special Report. The Army Medical Department, Caring for the Troops in War and Peace (Arlington, VA: Association of the United States Army, 1989), 5.

[20] Ibid., 5, 8.

[21] Ibid., 5.

[22] Armed Forces Staff College, Publication 1: The Joint Officer's Guide, 1997, (Norfolk, VA: National Defense University, 1997), 2-7.

[23] Ibid., 7.

[24] Ibid., 2-3.

[25] Ibid.

[26] Ibid., 2-8.

[27] Ibid., 2-8,9.

[28] Ronald H. Cole et al. The History of the Unified Command Plan, 1946-1993 (Washington, D.C.: Joint History Office, Chairman of the Joint Chiefs of Staff, Februrary 1995), 1.

[29] Ibid.

[30] Armed Forces Staff College, 9.

[31] Cole et al., The History of the Unified Command Plan, 1946-1993, 11.

[32] Henry H. Shelton, "The National Military Strategy and Joint Vision 2020," Army, vol. 51, no. 1 (January 2001), 8.

[33] Ibid.

[34] Ibid.

[35] The ideas expressed in this paragraph are based on, and supported by, remarks made by a speaker participating in the Commandant's Lecture Series.

[36] Office of the Secretary of Defense, Report of the Quadrennial Defense Review (Washington, D.C.: Department of Defense, May 1997), 55.

[37] United States Army Medical Department. AMEDD After Next, Joint Medical Wargame 2000. Final Report. [CDROM] Joint Panel (Fort Sam Houston, TX: U.S. Army Medical Department, 23 August 2000), Panel 2.

[38] Cole et al., 11.

[39] Armed Forces Staff College, 2-38.

[40] United States Army Medical Department, Panel 2.

[41] Ibid.

[42] Gabriel and Metz, 107.

[43] Anthony H. Cordesman, "Compensating for Smaller Forces: Adjusting Ways and Means Through Technology," Lecture Notes, Carlisle Barracks, PA, U.S. Army War College, 1992.

[44] Ibid.

[45] Sun Tzu, The Art of War, trans. Samuel B. Griffith (New York.: Oxford University Press, 1963), 92.

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