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MILITARY STUDY PROJECT

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"ARMY MEDICAL DEPARTMENT AVIATION AND
ITS RELATIONSHIP TO THE NEW ARMY AVIATION BRANCH"

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ABSTRACT

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Introduction

The decision to form a separate Aviation Branch was very controversial throughout the Army. There are still some officers and even generals today that question the validity of the decision. The Army Surgeon General supported the branch formation issue, but at the same time posed a very persuasive argument that the Medical Service Corps aviators and the medical air ambulance units remain a part of the Medical Department.

The rationale for not including the medical assets in the new branch was accepted by General "Shy" Meyer, Army Chief of Staff, and in 1983 the decision was made to implement the Aviation Branch, less the Medical Department assets.

This essay describes some of the background leading to that decision and some personal thoughts as to its validity. I will attempt to discuss some of the training and doctrine challenges and some of the proposed and ongoing "fixes" necessary for the Army Medical Department to keep pace with the aviation community.

Background

In the mid-1970's the U.S. Army began to complete various analysis as to how well it performed its combat role in the Vietnam War. One aspect of that performance that shined brightly in every assessment was the tremendous contribution of Army aviation. Truly, the helicopter, as an instrument of military combat, came of age during the 1960's in a remote place in the world known as Vietnam.

Army aviation grew almost out of control from 1964 to 1970 and the population of aviators in the army tripled in the decade of the 1960's. Aviation was no longer just a supporter of the Army in the field, it was now a

major combat power. It is hard to think of the Army fighting without aviation as an integral part of the effort.

During the late 1970's, many of the Army's senior aviation proponents began to discuss the desirability of a separate aviation branch. The fragmented career development of commissioned aviators gave credence to such a proposal, for in the 1970's, company grade aviators found it difficult to remain branch qualified compared to their non-aviator comrades.

The proper management of aviators as a sub-force within the Army became such a problem that in 1974 Congress mandated an aviation career act that placed stringent requirements and a specific protocol for the future management of aviators in the Army.

The idea of an Aviation Branch with a proponent school and a corps chief could solve many of the personnel management problems--but it was still just a dream.

Finally, in the fall of 1981 a major event occurred, when, while attending the first Aviation Mission Area Analysis General Officer Review at Fort Rucker, Alabama, the Chief of Staff of the Army advised the Commander of the Aviation Center, to proceed with the development of an Aviation Branch proposal.

In 1982, the U.S. Army Training and Doctrine Command (TRADOC), took the lead in developing a concept for the proposal, and on 27 January 1983 the Army Chief of Staff approved the TRADOC proposal to centralize aviation proponent responsibility and establish aviation as a basic branch of the Army. The DCSPER was tasked to determine the branch composition and to provide the Chief of Staff of the Army with a recommendation.

The train was moving so fast that before the staff work for the composition was completed, the Secretary of the Army, on 12 April 1983, approved the establishment of an Aviation Branch in the United States Army. Thirty-six years after the inactivation of the Army Air Corps, once again our nation's land force had a formal aviation arm wearing the green uniform.

During the first week in April 1983 the DCSPER met with the Army Staff, TRADOC, and MILPERCEN in an effort to prepare a recommendation to the CSA as to the make-up of the Aviation Branch.

A very significant event occurred on 7 April 1983, during a meeting chaired by the DCSPER, with representatives from DCSOPS, DCSLOG, TSG, ACSI, TRADOC, and MILPERCEN. The purpose of the meeting was to finalize the Aviation Branch composition. All parties concurred with the TRADOC plan for inclusion of Warrant Officers MOS 100, 150, and 160; and enlisted personnel in the career fields of CMF 67 and CMF 64--MOS 71P, 93E, 93H, and 93S only.

The Surgeon General nonconcurred with the inclusion of the Medical Service Corps (MSC) aviator (MOS 67J) as a part of the Aviation Branch. He proposed that the MSC aviator remain a part of the Army Medical Department (AMEDD).

On 13 April 1983, the DCSPER forwarded a memorandum to the Army Chief of Staff, recommending that the Aviation Branch be composed of all aviation personnel as stated in the TRADOC Plan, with the exception of the MSC commissioned officer aviators.

On 25 April 1983, thirteen days after the Secretary of the Army approved the Aviation Branch, the Chief of Staff (General Meyer) approved the personnel composition of the Branch and excluded the Medical Service Corps aviators.

7

In the remaining pages of this essay I will attempt to explain why this decision was a prudent one. While my arguments and positions will undoubtedly be similar to those of the past Surgeon General (Lieutenant General Mittenmeyer), I have not discussed this paper with him, and thus my thesis is personal and does not necessarily reflect the official position of the Office of the Army Surgeon General.

The inventor of the helicopter as we know it today was Egor Sikorsky, a Russian immigrant to this country who tried and failed at helicopter flight three different times over a span of 20 years. He finally succeeded in 1914 and when asked later in life why he persisted so in an effort to make the helicopter work, his reply was: "I was continuously obsessed by the thought that such an aviation machine would be a tremendous savior of human lives, I was determined to make it work."

Indeed, that dream has come to pass; for the statistitions of the American Helicopter Society now believe that sometime in the late months of 1982--the one millionth human life was saved by a helicopter somewhere in the world.

The United States Army is the world's largest operator of medical helicopters, in fact, it is the only Army in the world that has a dedicated helicopter medical evacuation service as a part of its land forces. The historical evidence demonstrating the effectiveness of such a system is abundant. The first recorded use of aviation to evacuate patients by the U.S. Army was in the African Campaign during World War II. However, it was the Korean War experience that demonstrated for the U.S. Army the tremendous potential in reduced mortality by the use of an aerial platform for evacuating the wounded.

Since the Korean War, a dedicated fleet of air and ground evacuation vehicles under medical command and control, have repeatedly proven to be the most effective, responsive, and reliable method for transporting wounded and injured soldiers to treatment facilities. Rapid medical evacuation significantly increases the opportunity for soldiers to survive their wounds. The need for a dedicated air ambulance on the modern battlefield, given the large geographical area, dispersion of units, and increased mobility, is critical to conserving the fighting strength and maintaining a responsive, comprehensive medical support system. Our experience in Vietnam proved beyond a doubt that the medical helicopter is the cornerstone to the Army's combat health care system.

It is precisely this irreplaceable support and synergistic effect that the air ambulance provides to the health care system that, in my opinion, is the reason the Surgeon General fought so hard to retain the aeromedical evacuation capability within the medical system vice the aviation system.

Let us examine more closely why the aeromedical helicopter makes a greater contribution as a member of the medical system rather than the aviation system.

Aeromedical evacuation is not a "taxi ride," but an integrated health care delivery system in flight. The aircraft is equipped with trauma life support gear, and the crew is specifically trained to deal with life support decisions and treatment. Within the Army, the AMEDD is charged with the responsibility for all medical evacuation, whether by surface or aerial means. In order to ensure selectivity of evacuation and timeliness of treatment, the appropriate medical command must retain control over the evacuation means to include as a minimum, the designation of patients to be moved, selection of

destination hospitals, and the provision of medical attendants and life support equipment. A tactical doctrine which deemphasizes rapid evacuation of casualties on the battlefield is counterproductive to the conservation of human combat resources. A dedicated, responsive, aeromedical evacuation system is perceived by the combat soldier as an investment by the Army in his behalf and contributes to maintenance of his morale and willingness to fight.

The American soldier is very much aware that if he is seriously wounded, the medical helicopters, known as "DUSTOFF," will get him to a hospital and fast!

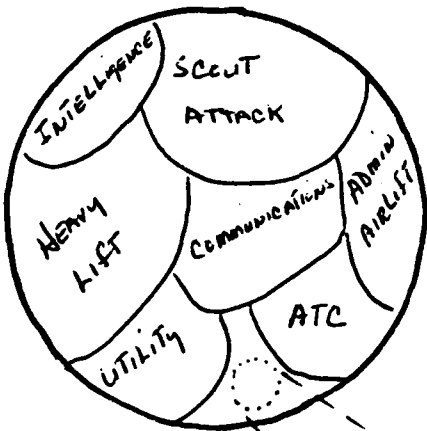
I don't know how much this means to the infantry platoon leader who orders his men to assault an enemy position--but I submit to you that in the human dimension of combat the unspoken confidence that rapid medical evacuation is always available may lesson the fear of combat more than any of us ever care to admit.

A Systems Perspective

Since the Korean War days, the aeromedical evacuation team, under the leadership of the Medical Service Corps aviator has evolved into an effective and efficient element of the health care system, and has contributed significantly to improved survival rates in both peace and war. As stated earlier, the success of this current system was keenly evident in Vietnam.

To those who would argue that the Aviation Branch should be comprised of all aviation assets--regardless of function--I submit that consideration be given to the following systems portrayal.

AVIATION SYSTEM



MEDICAL SYSTEM

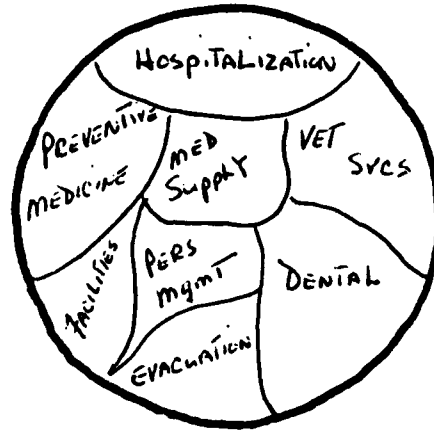


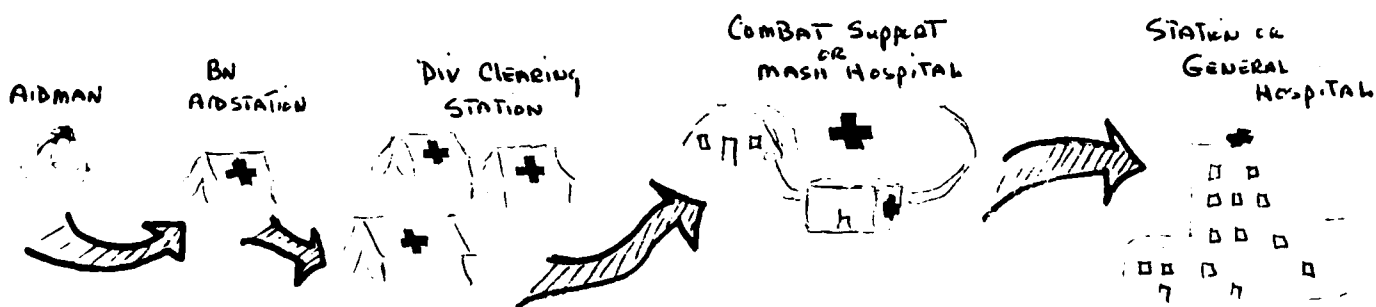
Figure 1

It would not be difficult to list reasons why the air ambulance service of the Army, could be positioned within the Aviation System. Its hardware is aviation oriented, it uses aviation resources such as POL and aircraft maintenance and parts and it performs its mission under the auspices of aviation rules, requirements and limitations. Under this concept the customer would be the Medics, and its modus operandi would be as simple as "You Call--and we Haul."

With its hundreds of complicated helicopter machines and a very expensive and sophisticated logistical tail--why then would the Surgeon General want so strongly to keep "DUSTOFF" within the Medical System?

7

The transportation of the sick and wounded is a vital function of health care. The Army treats its sick and wounded via a protocol of echelonment, or the progressive movement from a level of lower to higher capability. The aidman has a certain capability and if the injured soldier can be repaired or treated at his level then he returns to duty. If not, the soldier is referred to the next higher level of capability, i.e., the Battalion Aid Station, and so on until he reaches the point in echelonment that his injury can be definitively treated. (See Figure 2.)



CHAIN OF EVACUATION
Figure 2

The movement from a lower to higher level is called evacuation, and the treatment requirements make it more than just transportation. Evacuation, both ground and air modes, often require en route treatment. The flow of evacuation is key to the treatment process, and the ability to orchestrate this flow between air and ground assets is necessary to optimize the regulation of the treatment resources. Air and ground modes of evacuation compliment each other. There are times when one is more appropriate than the other, and just as often there are times when there is no option and only one mode is available or capable. Should the air assets not be an integral part of the field medical command, but instead come from the general aviation

resources, and thus have to compete with other essential combat requirements in the heat of battle, the assurance of optimum availability with the necessary medical crew is likely to be compromised.

The air ambulance, carrying the appropriate medical equipment and staffed with a medically trained crew, both officer and enlisted, is not just an instrument of transport to be called upon by the Medical personnel, but is truly an integral part of the evacuation function of the total Medical System.

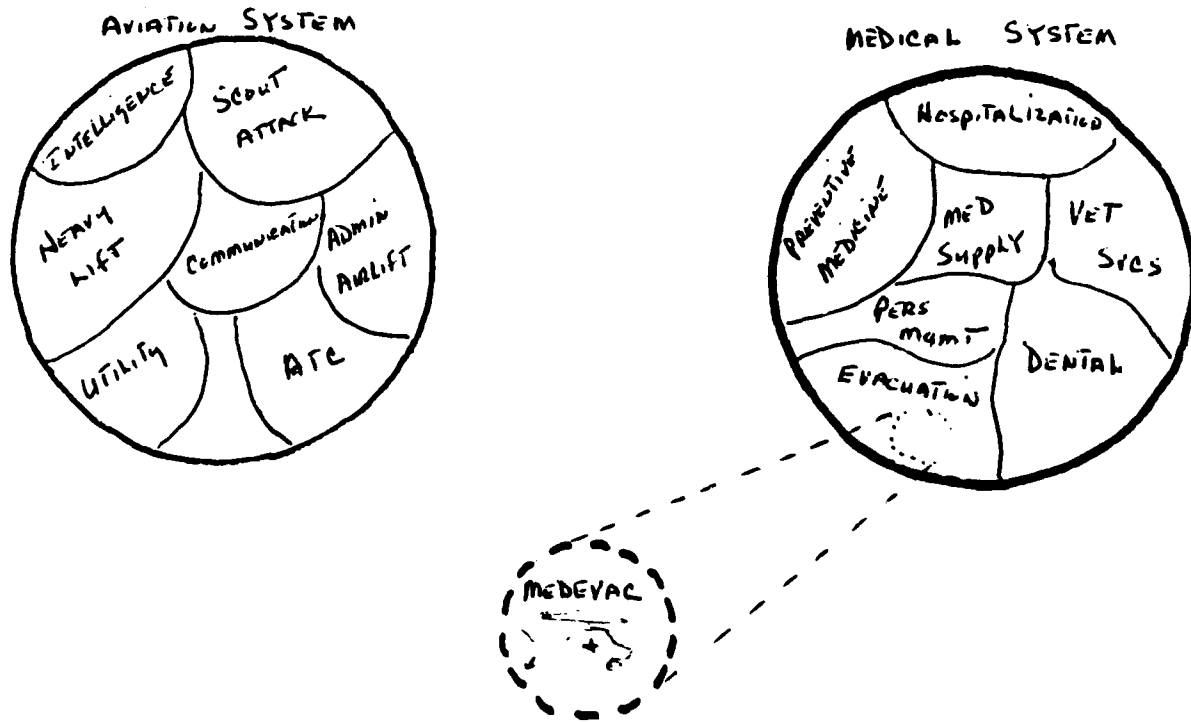


Figure 3

It would be a mistake to separate the air ambulance function from the medical mission. Evacuation, both ground and air, of the sick and wounded, is an integral part of the total medical treatment system. It cannot be conducted in an adjunct manner without degrading patient care. To separate

7

the air/ground evacuation function between two managers and then eliminate one of these resources from the medical system entirely, will adversely affect the optimum management of already scarce medical resources.

Clearly, aeromedical evacuation of the sick and wounded is a medical mission--not a combat arms mission!

To place the air ambulance mission and the Medical Service Corps aviator in the Aviation Branch has the following disadvantages:

- It could place the welfare of the soldier secondary to other logistical and tactical considerations and may result in misutilization of medically designated aircraft.
- It reduces medical control over patients, which reduces selectivity.
- It could create delays in the treatment of the patient and lead to over evacuation.

To use the same helicopter as a logistics/troop transporter part of the time and an air ambulance the rest of the time sounds good in theory and is always advocated by the "bean counter" resource economists, but the dual mission is frequently competitive. One only has to look at the United States Marine Corps experience in Vietnam to understand this problem. Over 50 percent of the Marine emergency aeromedical evacuations in Vietnam were completed by dedicated Army "DUSTOFF" medical evacuation assets because the Marine helicopters, having multiple missions, were not responsive.

Future Training and Career Development of the AMEDD Aviator

To this point, all I have discussed in this paper concerning the exclusion of the AMEDD Aviator (SC 67J) from the Aviation Branch formation can easily be labeled emotional and even parochial. But whether or not you

believe that the AMEDD aviator belongs in the Aviation System or the Medical System, for now, that issue is academic--the decision has been made.

What is now important, is how to proceed with the training and career development of the AMEDD aviator to insure that his knowledge and capability parallels and keeps equal pace with his Aviation Branch comrade.

The Aviation Branch Implementation Plan (ABIP), approved on 6 June 1983, by Headquarters Department of the Army, included a very comprehensive plan for professional development of the aviation commissioned officer. The Aviation Officers Advanced Course and the Aviation Officers Basic Course have been developed by the U.S. Army Aviation Center (USAAVNC) and both the lieutenants and captains courses were initiated last summer.

The Surgeon General had argued that the AMEDD aviator should remain a part of the Medical Department and concurrently the training of that officer was his responsibility.

What was being developed at Fort Rucker during 1983 and 1984 was a very impressive aviation career training program for the Aviation Branch officer (SC 15). The first real test of the Aviation Branch composition issue now set squarely on the Surgeon General's desk. How to keep the 67J, MSC pilot equivalent from an aviation development standpoint with his/her Aviation Branch running mate and simultaneously develop his/her AMEDD potential.

The Commandant of the Academy of Health Sciences was given this mission, and on 16 August 1983 the first meeting was convened to discuss options and develop a plan.

It was readily apparent that the career development program available to the MSC officer, i.e., the AMEDD Basic Officers Course and the AMEDD Officers Advanced Course was inadequate from an aviation perspective. It was also apparent that the Academy of Health Sciences could not and should not

7

duplicate aviation specific training which had been developed at Fort Rucker by the Aviation Center.

An Individual Training Plan Proposal (ITPP) was developed for TRADOC consideration identifying the shortcomings and recommended solutions for AMEDD training issues. The U.S. Army Aviation Center (USAAVNS) at Fort Rucker made available to the AMEDD the opportunity to send the Medical Service Corps officer to any of the newly developed Aviation Branch courses.

The ITPP was tentatively approved by all concerned and is presently undergoing refinement by the Academy of Health Sciences and the U.S. Army Aviation Center. The following decision highlights the key elements of that program.

Aviation training for the AMEDD aviator (SC 675) should parallel the aviation training for his MILPERCEN counterpart (SC 15), Army aviator. At present, officer accessions for Medical Service Corps aviators (SV 675) is derived from two sources: (1) newly commissioned and (2) current active duty MSC officers with less than 40 months total federal officer service. According to the Surgeon General's Office, initial aviator training quotas for the MSC Branch will be established at thirty-four (34) for Fiscal Year 1986 and 1987. This number is sufficient to maintain force structure authorizations but does not provide for any structure growth.

The newly accessed MSC officer should attend the AMEDD Officer Basic Course and serve in a troop leadership assignment in a Field Medical unit before flight training. This field assignment should not exceed 18 months prior to initial flight training and is intended to develop initial military and leadership skills.

Following Initial Entry Rotary Wing (IERW) training, the MSC officer should also receive the Essential Medical Training Course for AMEDD Aviators

at the Academy of Health Sciences before his or her initial assignment to a Medical Air Ambulance unit. (See Figure 4.)

Between the Medical Service Corps officer's fourth and seventh year, the officer will be programmed to attend the Aviation Advance Course at Fort Rucker, followed by the AMEDD Aviator Advanced Course at the Academy of Health Sciences (AHS).

This AMEDD Aviator Advanced Course is new and is presently under development by the AHS staff. It is expected to be six weeks in duration.

The next professional development step for the MSC aviator should be attendance at the Combined Arms Service and Staff School (CAS³).

This new advanced course strategy, which includes a full 20-week Officer Advanced Course at Fort Rucker followed by a 6-week AMEDD Course at the Academy of Health Sciences, will ensure a solid coupling of aviation and medical career skills.

The Future

One final comment about some things on the horizon.

Recently the Army Vice Chief of Staff was briefed on a comprehensive Medical Systems Program Review (MSPR) and approved development of several new medical organizations. Most significant of these new changes is the future realignment of both ground and air evacuation units into a new Evacuation Battalion. The Evacuation Battalion will include a mix of ground ambulance companies/detachments and a new 15 aircraft, 125-man, Air Ambulance Company.

The nucleus of the first of these Evacuation Battalions has already been approved for implementation in Korea. The first FORSCOM Evacuation Battalion will probably be organized at Fort Bragg from assets within the 44th Medical

Brigade. An Evacuation Battalion proposal is being staffed in U.S. Army Europe at this time.

The Evacuation Battalion will be commanded by a Medical Service Corps aviator (SC 67J); and thus the future command and aviation opportunities for the MSC aviator is brighter than ever before.

The combining of all evacuation assets into one Medical Battalion is a proper move for the Army Medical Department. This most recent decision only serves to reinforce the Chief of Staff decision to retain the AMEDD aviator assets under the Surgeon General. Evacuation is a medical mission--and all means to that endeavor belong within that system.

Conclusion

Army aviation is in a state of transition, preparing itself for its new role on the next battlefield. That preparation is well underway and it is truly an exciting time to be a member of the Army Aviation team. The Medical Services Corps aviator and the Air Ambulance units are proudly a part of that team. The AMEDD assets are not a formal constituent of the Aviation Branch, but I know they are anxious to be a full team player. I urge all members of the aviation community to consider some of the reasons outlined in this paper as to why the AMEDD aviation assets are more properly aligned in the Medical System. Both branches must work harmoniously together to insure optimum mission accomplishment. It is my hope that the members of each branch, both Aviation and Medical Service Corps, perceive a need for each other and a time for sharing and "wholeness" of the aviation team.

If AMEDD aviation is not accepted for what it is and what it can do by the "line" aviation community, then it will surely die. We must never let that happen, for to loose "DUSTOFF" as we know it today over some future

resource fight for hardware or people would be a great mistake and an
unconceivable loss to the combat soldier. The motto of Army Aviation is
"ABOVE THE BEST," and the motto of the Army Medical Department is "TO CONSERVE
THE RIGHTING STRENGTH." The tradition of "DUSTOFF" is ready, willing, and
able to do both!

7

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