

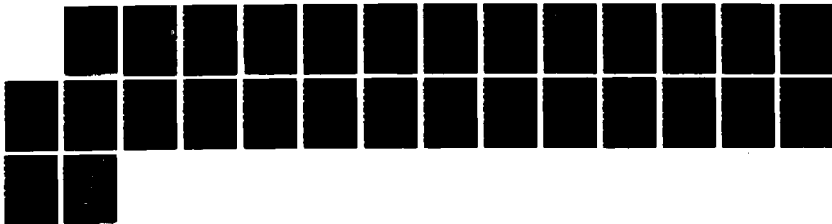
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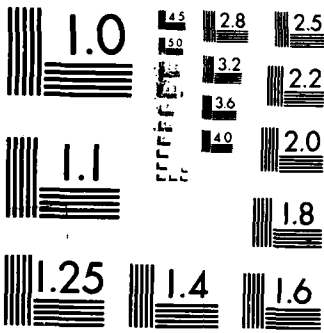
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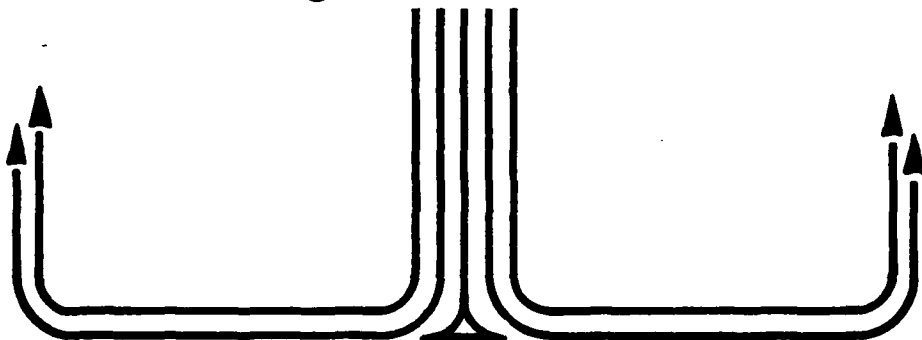
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STUDENT REPORT

CIVILIANIZATION WITHIN THE USAF  
DENTAL CORPS - A THREAT TO  
MEDICAL READINESS

MAJOR DANIEL R. BOWMAN 88-0340

"insights into tomorrow"



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**REPORT NUMBER** 88-0340

**TITLE** CIVILIANIZATION WITHIN THE USAF DENTAL CORPS  
- A THREAT TO MEDICAL READINESS

**AUTHOR(S)** MAJOR DANIEL R. BOWMAN, USAF

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Submitted to the faculty in partial fulfillment of  
requirements for graduation.

**AIR COMMAND AND STAFF COLLEGE  
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## PREFACE

The mission of the US armed services is to defend our country in time of conflict and to train and maintain its forces in a high state of readiness in peacetime. This paper concerns the war readiness posture of the Medical Service and the specific contribution of the USAF Dental Corps.

Reorganization of medical manpower and a recent defense budget initiative have resulted in the replacement of many active duty dental officers by contract civilian dentists. How this "civilianization" within the Dental Corps will effect the readiness posture of the Dental Corps and the Medical Service is the subject of this paper. Hopefully, this study will provide the reader some insight into the wartime mission and capabilities of the Dental Corps and how it is actively pursuing its wartime role through readiness training programs.

I would like to thank Col Isadore Neurock, Col Edward Herbold, and Lt Col Dave Dasher for their valuable assistance in providing much of the information used in this paper. Opinions expressed throughout this paper do not necessarily represent those of the USAF Medical Service or Dental Corps. They do, however, reflect eight years of experience in the Air Force Dental Corps and associated medical readiness programs.

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## ABOUT THE AUTHOR

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Dr. Daniel Bowman is a native of Nebraska but spent the greater part of his school years in Phoenix, Arizona. Dr. Bowman did his undergraduate work at Northern Arizona University from 1970-1974 and graduated magna cum laude with dual Bachelor of Science degrees in chemistry and zoology. He also attained a secondary school teaching certificate. Dr. Bowman attended the University of Iowa Dental School in 1975 and attained his DDS in 1979.

Dr. Bowman joined the Air Force in 1979 and enjoyed his first four year tour at Ellsworth AFB, South Dakota where he completed Air Command and Staff College by seminar. The next four years brought an equally enjoyable tour at Elmendorf AFB, Alaska. In addition to his duties on the dental staff, Dr. Bowman served as Base Oral Health Officer and assisted in providing dental care to Elmendorf's remote sites at Galena, King Salmon and Shemya, Alaska.

Dr. Bowman and his wife Connie have two daughters, Hannah (2 yrs) and Sarah (9 months).

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## EXECUTIVE SUMMARY



Part of our College mission is distribution of the students' problem solving products to DOD sponsors and other interested agencies to enhance insight into contemporary, defense related issues. While the College has accepted this product as meeting academic requirements for graduation, the views and opinions expressed or implied are solely those of the author and should not be construed as carrying official sanction.

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**REPORT NUMBER** 88-0340

**AUTHOR(S)** MAJOR DANIEL R. BOWMAN, USAF

**TITLE** CIVILIANIZATION WITHIN THE USAF DENTAL CORPS  
- A THREAT TO MEDICAL READINESS

I. Problem: Reorganization of USAF Medical Service resources has resulted in the replacement of 98 active duty dental officers by contract civilian dentists.

II. Objective: To show that the use of contract civilian dentists within the USAF Dental Corps will reduce dental wartime mission capabilities and readiness posture of the USAF Medical Service.

III. Discussion of Analysis: The use of contract civilian dentists to replace 98 active duty dental officers stemmed from a reorganization of medical manpower in response to readiness needs and defense budgetary constraints. The decision to implement contract civilian dentists assumed that the current number of active duty dental officers was in excess of those needed to satisfy probable wartime dental requirements. At the time of this decision, however, wartime dental requirements were still being determined while the scope of dental wartime capabilities was increasing through advances in readiness training programs. Currently, dental readiness requirements are still being debated and a well-trained and ready Dental Corps is being reduced.

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## CONTINUED

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IV. Conclusion: It is impractical to reduce the Dental Corps' wartime potential and jeopardize overall medical readiness through civilianization when medical wartime requirements are still being determined.

V. Recommendation: Civilianization within the USAF Dental Corps should be discontinued while dental wartime requirements are determined and evaluated in light of current dental readiness training initiatives. Steps should then be taken to reestablish a totally active duty Dental Corps.

## Chapter One

### INTRODUCTION

The greatest misfortune of war, the human casualty, finds its origin on history's first battlefield and still remains one of war's inescapable consequences. Casualties of past wars provide an awful appraisal of victories and defeats and have molded nations' past and present policies and attitudes. The devastation experienced by the Soviets in WWII with the loss of 23 million Russian soldiers, for example, helped form the foundation of their militaristic society, their attitude of xenophobia, and strong ties to its bordering Warsaw Pact countries. As for the US, the Viet Nam war memorial acts as a grim reminder of what a low level protracted conflict on foreign soil costs in terms of lives and continues to impact society's attitudes vis-a-vis our continued involvement in Nicaragua and apprehension about our presence in the Persian gulf.

The effect and management of battle casualties, therefore, is of vital importance to military planners. As a result, the medical services in peacetime have a responsibility to attain and maintain a high level of proficiency in preparation for wartime mass casualty management--in short, that they have a sound medical readiness program.

All medical personnel in the USAF Medical Service have specific wartime duties. But the wartime role of one group of specialists, the dental officers, is often misunderstood and/or underestimated. Many Air Force dental officer positions within the continental United States are currently being replaced by contract civilians as a result of a defense budget initiative and remodeling of manpower within the Medical Service.

The purpose of this paper is to demonstrate that "civilianization" of a large part of the USAF Dental Corps is founded in misunderstanding and an underestimation of wartime dental requirements and the wartime potential of dental officers. The readiness role of the Air Force dental officer will be discussed as well as that of the contract civilian dentist. Comparison of the two will then illustrate the negative impact civilianization will have on the readiness posture of the USAF Medical service and help to determine what should be done to maintain a strong medical readiness program.

## Chapter Two

### ROLE OF THE USAF DENTAL CORPS IN MEDICAL READINESS

The USAF Dental Corps has two main military functions as stated in Air Force Regulation 162-1:

**Mission of the Air Force Dental Service:** Maintain the oral health of Air Force personnel and other uniformed service members to insure their maximum wartime readiness and combat capability. Train to insure competency in tasks required to support the overall medical mission in time of war or other contingency situations. Provide, to the greater extent possible, a peacetime oral health service for all eligible beneficiaries.

The peacetime mission of the Dental Corps is not merely to attend to acute dental problems of the active duty and, where possible, eligible beneficiaries. Rather, on a much broader scale, it is to help provide for a healthy active duty force which, unhampered by oral disease, is prepared to mobilize and defend our country. Another vital peacetime role of the corps is to prepare to assume its place with the remainder of the medical service to render emergency dental treatment and assist in caring for mass casualties in time of war or disaster -- its mission in medical readiness.

The wartime role of the Dental Corps has traditionally been to render emergency dental care and assist the medical staff in casualty care. In the World Wars I and II, for example, the Army Dental Corps was furnished trucks equipped as mobile operating units. The Director of the Dental Division in Europe stated: "Success of the mobile operating units in several theaters, especially in Italy, warrants the conclusion that such units are essential to modern warfare" (9:193-195). The corps' alternative medical mission in World War II found dental officers working in shock wards, triaging casualties returned from overseas, and engineering prostheses such as artificial eyes, hearing aid adapters and tantalum plates for the repair of skull defects (8:710; 9:235-238; 10:261). Dental officers in Viet Nam identified remains of the dead, assisted in triage in mass casualty situations at all medical levels and served as

augmentation to anesthesiologists (7:588).

The Dental Corps' wartime mission of today was summarized by Lt General Murphy A. Chesney, The Surgeon General, United States Air Force in his 4 March 1986 presentation to the House Appropriations Committee Subcommittee on Defense:

In time of war, every Air Force medical member will have a role. For example, the Dental Corps will support the overall Air Force medical mission by providing care necessary to reduce loss of life or limb, prevent undue suffering and conserve the military strength by aiding in returning casualties to duty as rapidly as possible. In the theater of operations, the Dental Corps will treat mission threatening dental disease, dental emergencies and maxillofacial surgical tasks as directed by the medical unit commander.

Dental officers, as alluded to above, will have a multi-purpose dental mission as well as an adjunctive medical care mission in wartime. It is assumed this multi-purpose dental mission for dental officers will include the following duties:

- A. Treatment of dental emergencies.
- B. Treatment of maxillofacial injuries.
- C. To provide sustaining, maintaining and comprehensive care.
- D. To perform administrative, staff and command functions.
- E. To perform forensic dental identifications.

The adjunctive medical care mission, on the other hand, will call upon the dental officer to:

- A. Perform life sustaining procedures.
- B. Perform as surgical assistants.
- C. Perform field medical triage.
- D. Monitor general anesthesia patients.
- E. Assist in battle stress management.
- F. Treat minor wounds.
- G. Perform command functions (4:--)

Whereas the dental aspect of the wartime mission requires those skills practiced in peacetime, the adjunctive medical care mission demands special skills for which the dental officer must be trained. A large part of medical readiness training is the peacetime cultivation of these special skills.

Regarding medical readiness training for dental officers, Lt Gen Chesney stated in his March 1986 address to the House Appropriations Committee Subcommittee on Defense:

Medical readiness training will enable dental officers to serve as surgical assistants and to monitor patients under general anesthesia when necessary. There is an ongoing training program to make the readiness training for dental officers responsive to the needs of the Air Force.

The ongoing training program to which Lt Gen Chesney referred has been quite active since 1986. Many courses that teach medical skills have been opened to or designed for dental officers in addition to those of surgical assisting and monitoring general anesthesia. Four such courses are Basic Life Support, Advanced Cardiac Life Support (ACLS), Basic Anesthesia and Surgical Skills Training Course for Dental Officers, and the Combat Casualty Care Course (C4).

The Basic Life Support course is an annual mandatory one-day session for all medical personnel and deals primarily with on-the-scene life saving techniques in such emergency situations as myocardial infarction (heart attack), sudden death, electrocution, and choking. Proficiency in academic and practical skills must be demonstrated prior to passing this course and receiving certification by the American Heart Association.

Whereas Basic Life Support is first-on-the-scene emergency care, Advanced Cardiac Life Support (ACLS) entails care afforded once medical help has arrived. This rigorous two-day course is given primarily to physicians but is offered to dental officers as well. Simplified for this discussion, the academic requirements involve a knowledge of adult and newborn cardiac drug therapy, the heart's electrical conduction mechanism and cardiac monitoring (electrocardiogram, intraarterial and intravenous), invasive resuscitation techniques (intracardiac injection and emergency cardiac pacing), and post-resuscitation supportive medical care (management in the special care unit). The practical aspect of this course involves demonstrating proficiency in airway control and ventilation, intravenous techniques, cardiac defibrillation and interpretation of cardiac monitor output, and the integration of academic and practical skills in management of an emergency scenario. This course must be taken every two years for the practitioner to remain current in ACLS (1:--).

A course designed specifically for enhancing readiness skills of physicians and dentists related to casualty management in a battlefield environment is the Combat Care Casualty Course, or C4 held at Camp Bullis, Texas. C4 is a rigorous eight day course that enables physicians and dental officers to develop hands-on battlefield casualty management skills in the field under simulated combat conditions. The comprehensive curriculum, stressing maximum student participation, is divided

into the two major areas of Advanced Trauma Life Support (ATLS) and Combat Medical Operations (6:--).

The two and one-half-day ATLS portion of the curriculum involves lectures, demonstrations, skill stations and a surgical lab. "Lectures cover initial assessment; upper airway management; shock; thoracic, abdominal, head, spinal and extremity trauma; burns; and stabilization and transfer of patients" (6:--). The ATLS course concludes with a multiple choice test and a practical examination requiring proper management of multiple live simulated trauma patients (6:--).

The Combat Medical Operations segment orients students to the duties and skills of combat medical personnel. In practical field exercises, students find themselves members of a tactical patrol led by U.S. Marine Corps personnel and participate in such activities as field site selection, tent erection, map and compass reading, air-ground evacuation and triage. Students also spend one day at the USAF School of Aerospace Medicine receiving instruction on nuclear/biological/chemical warfare defense (6:--). Although it would be desirable for all dental officers (especially those destined for overseas assignments) to participate in C4, this is not yet possible due to present constraints in class size (3:--).

A readiness training course specifically for dental officers is the Basic Anesthesia and Surgical Skills Training Course conducted at the USAF School of Aerospace Medicine at Brooks AFB, Texas. "The objective of this course is to provide the dental officer with initial or refresher training in emergency medical procedures which will help him to be a valuable team member in war, contingency and/or disaster situations" (5:1-3). In addition to attending lecture sessions on anesthesia and surgical skills, dental officers obtain hands-on training utilizing animal models under direction of the professional and technical staff from the Veterinary Sciences Division at Brooks AFB. Skills learned range from emergency airway management and intravenous techniques to venous cutdown and insertion of chest tubes (1:--). The Basic Anesthesia and Surgical Skills Training Course, as well as the Combat Care Casualty Course, offer dental officers invaluable hands-on practical emergency medical experience. All dental officers sent on temporary duty to San Antonio, Texas to participate in continuing dental education courses (that do not already involve surgical training) are required to participate in this course (3:--).

In addition to these comprehensive readiness training programs, Air Force dental officers gain trauma and surgical experience during hospital emergency room duty. Responsibilities here include evaluation of the patient's health history, diagnosis and alleviation of dental pain, care of intraoral and lip lacerations, preliminary diagnosis of

mandibular/maxillary fractures, and in more involved cases, working in concert with oral surgeons in treating complex facial trauma.

Dental officers also participate in hospital general surgery rotations where they gain experience in operating room procedure, sterile technique, surgical assisting, general and intravenous sedation, and airway management. Individual Air Force bases also conduct readiness training programs and exercises. Two such programs consist of annual didactic training in Medical Chemical Defense and Unit Disaster Training (the role of medical facilities in local disasters and wartime contingencies).

Base disaster exercises and recalls are initiated anytime, day or night, where medical personnel participate in mass casualty scenarios ranging from tornados and floods to terrorist bombings and aircraft accidents. Often these exercises are conducted with cooperation of local civilian hospitals. It is also an annual requirement for all Air Force bases to conduct a Medical Red Flag II exercise. This readiness field exercise deploys medical personnel to a nearby simulated battlefield for 2 to 3 days where they set up perimeter defenses and participate in academic as well as practical readiness education. Subjects covered range from field sanitation to casualty care resulting from nuclear/biological/chemical warfare. This readiness session then culminates in a simulated battlefield mass casualty exercise (3:--). As part of the medical mission, each dental officer is assigned to one of the following disaster teams: triage, minimal care, immediate care, delayed care or expectant. The academic programs and practical readiness exercises mentioned above allow dental officers to develop and cultivate adjunct medical and command skills necessary to be a valuable disaster team member.

These and forthcoming comprehensive readiness training programs and exercises illustrate continuing achievements of the USAF Dental Corps in pursuing the medical aspect of its overall mission.

## Chapter Three

### CIVILIANIZATION OF THE USAF DENTAL CORPS

Readiness of the medical service depends not only on the wartime/emergency skills of its members but on the size of the medical service staff as well. And the size of the staff, ideally, should be based on what the Department of Defense perceives to be wartime medical needs. Unfortunately, the size of the medical service staff is influenced not only by readiness needs but by the country's ability to afford such a staff as reflected in the Federal Defense Budget. The attempt to balance medical manpower requirements with budgetary constraints has led to staff reorganization within the Medical Service. In 1985, for example, a budget initiative resulted whereby the Assistant Secretary of Defense for Health Affairs was charged by Secretary Weinberger to "redirect resources and change the composition of the medical force to ensure medical readiness as the top priority" (15:--). As a result, beginning on October 1, 1987, the Dental Corps relinquished 98 active duty dental officer authorizations to favor the Nurse Corps. To compensate for the lost active duty dental slots, 98 civilian contract dental slots were made available and located at Air Force bases throughout the Continental United States or CONUS (12:--). Whereas the Nurse Corps needs the additional manpower to enhance its current wartime readiness capabilities (15:--), compromising the overall wartime response of another, dissimilar medical component does not necessarily contribute to a state of increased overall medical readiness. In December 1985, this proposed use of contract civilian dentists was, in fact, directly opposed by the Assistant Secretary of the Air Force for Manpower, Reserve Affairs and Installations in a letter to the Assistant Secretary of Defense for Health Affairs (16:--). In determining how this civilianization will affect USAF medical readiness, it is important to consider the distribution and functions of the contract civilian dentist in the Dental Corps.

The 98 civilian contract dental slots are in the form of "full time equivalents" or FTEs. An FTE represents a time slot allotted to a dental facility to be occupied by a full time civilian contract dentist. Up to two contract dentists (working interchangeably) may occupy each FTE. This precludes vacancies in the contract dentist's work schedule due to illness or unforeseen emergencies. Therefore, a facility awarded three FTEs

may employ a maximum of six contract civilian dentists (14:5). Of the Air Force dental facilities to receive contract civilians, the FTEs awarded range from one to three depending on the size and mission of the facility. In total, 71 Air Force dental facilities throughout CONUS will be awarded 98 FTEs to begin 1 October 1987 (12:--).

The services the contract civilian dentist is expected to provide closely parallel those clinical functions of the active duty dental officer. Basically, he/she is expected to provide quality clinical dentistry on a full time basis. The contract civilian dentist's job differs from that of the active duty dental officer in that he/she is not expected to participate in military readiness training or exercises, military continuing medical/dental education, provide after-hours emergency services for the base or conduct ancillary extra-duty programs within the base clinic (14:--). Readiness training of these contract civilians would not be practical since their contracts are up for renewal annually, two contract dentists working alternately may occupy each FTE allotted, and they will not mobilize in response to disaster or conflict. It is this lack of readiness education and responsibility which sets the civilian contract dentist apart from the military dental team.

## Chapter Four

### IMPACT OF CIVILIANIZATION ON READINESS

• Although civilianization of the Dental Corps as designed may not reduce the corps' clinical capability to produce adequate dental services to maintain the peacetime military, the lack of readiness education and training on the part of the civilian contract dentists will, in fact, reduce the Dental Corps' overall readiness capability. The absence of 98 dental officers schooled, practiced, and dedicated to the military readiness mission may be realized in peacetime today as well as in a possible future overseas wartime scenario.

Dental officers may be called upon to rely on readiness skills in peacetime, assisting in medical mass casualty management in response to such conditions as natural disasters (floods, tornados, earthquakes, etc) and military/nonmilitary accidents involving multiple victims. Acts of terrorism also present a threat, especially in the military environment, to which dental officers as part of a base disaster team might be expected to respond. In the terrorist bombing of a government building in Ramstein AFB on 31 August 1981, dental officers were first to respond to the disaster scene. Their readiness skills enabled them to take command of the situation, maintain order, triage and stabilize the injured until more definitive medical help could arrive (11:--).

The United States should not be complacent with regards to the possibility of international terrorism within its borders. Threats of terrorism have been openly levied against the United States, for example, by Iranian militants in late 1987 in response to our peacekeeping efforts in the Persian Gulf. Military medical responses to possible peacetime disaster situations, therefore, may call for the aid of an efficient dental staff; one that is proficient in readiness skills and prepared to work in harmony with the remainder of the medical service. In such disaster situations, contract civilian dentists would not be expected to respond. And even if they did respond, because of their lack of readiness education and skills, their contributions would be of questionable value when compared with those that could have been rendered by the active duty officers they replaced. It is in this regard that civilianization of the Dental Corps would serve to compromise

the peacetime readiness posture of the medical service.

The negative impact that civilianization of the Dental Corps would have on the war readiness posture of the Medical Service would be realized should medical or dental war requirements demand extensive mobilization of dental officers from CONUS to an overseas theater. An increase in these medical/dental requirements could be expected if the magnitude of the conflict warranted mobilization of various reserve component forces, draftees and recalled/retiree personnel (4:--). The number of dental officers available to mobilize would then possibly have to be restricted, as civilian contract dentists would not leave CONUS, resulting in a shortage of skilled dental officers in the battle theater. In other words, "Increasing the number of civilian practitioners adversely affects ...the availability of those [active duty dental] officers to be sent where needed and when needed to provide assistance in surgery to fulfill their alternate wartime role" (16:--).

Civilianization of 98 active duty dental officer positions assumes that the Dental Corps has sufficient manpower to meet wartime needs. This is a matter of continued debate. The Assistant Secretary of Defense for Health Affairs maintained in Jan 86 when the civilianization concept was being developed that "...all of the theater and CONUS wartime requirements for dental officers, ...can be met with projected inventories of uniformed dental officers" (15:--). The Assistant Secretary of the Air Force for Manpower, Reserve Affairs and Installations, however, felt the following with regard to civilianization: "This [civilianization] is evidently based on a perceived lack of dental officer wartime requirements. I feel there is a need to retain all Air Force dentists on duty now to fulfill our wartime requirements" (16:--). Central to this debate are the medical wartime requirements upon which dental requirements are partially based. These are related to the nature of the most probable future conflict scenarios and ensuing casualties. Predicting the most probable conflict involving US forces, however, would seem a difficult if not impossible task for two reasons. First, future conflicts may range anywhere from low intensity conflict to conventional war on the European continent; from one of tactical nuclear weapons to an escalated nuclear exchange involving land, sea and space forces. Secondly, since the American Civil War, the nature of the battlefield has changed to such an extent that each war has been more technologically advanced and devastating than its predecessor. The technology that influenced WWI by the machine gun and WWII through the advent of air power has grown to produce guided "smart" weapons, CBN (chemical-biological-nuclear) warfare capability, and sophisticated space systems that characterize today's battlefield.

Unfortunately, commensurate with the changing nature of the

battlefield is an increase in its lethality. One theory as to the next conflict, for example, concerns a conventional war in Europe and maintains that there will be:

...approximately 20,000 casualties per day in a nonnuclear war on the European continent and that this conflict will last about ten days. It is estimated that there will be 55,317 patients with abdominal wounds; 6,880 burns; 3,084 cerebral injuries; 5,841 crush injuries; and 72,542 minimally wounded soldiers. These figures are only for military casualties and do not include information on civilian casualties (5:2-7).

Estimated casualties if tactical or strategic nuclear weapons were incorporated in the above scenario would challenge the imagination.

Compounding the threat to medical readiness of the changing nature and lethality of the battlefield is the fact that world tensions are on the increase. Both superpowers are currently involved in low intensity conflicts throughout the world. The United States, for example, through security assistance, influences conflicts in Nicaragua, Israel and the Persian Gulf as does the Soviet Union and its proxies in Afghanistan, Africa and South America. By a direct superpower confrontation stemming from an inadvertent escalation of one of these conflicts, we could quickly find ourselves in a conventional or nuclear combat scenario.

Suffice it to say that our government must be perceptive in determining medical wartime requirements in the current light of today's battlefield and weapons technology, increasing world tensions, and our current 1 1/2 wars concept. Whereas it would seem prudent to seek means of increasing or at least maintaining our overall medical readiness posture, civilianization of the Dental Corps represents an active step in reducing the readiness potential of one important component of the medical service by 98 trained officers. Unfortunately, the extent to which the overall medical war readiness will suffer as a result of civilianization will be a measure of the underestimation and uncertainty of future combat scenarios upon which it is based.

Finally, civilianization also poses a long term threat to medical readiness as it represents a possible source of instability in CONUS dental manpower. In the short term, civilianization may not change the net Air Force peacetime clinical capability. It does, however, represent a portion of the total CONUS manpower which can change annually through contract renewal or disapproval (14:--). As one aspect of the Dental Corps' wartime mission is to "provide treatment in any mobilization prior to a conflict ...by providing the maximum amount of care possible for patients in preparation for their

movement to the theater of operations" (16:--), any possible decrease in the established contract civilian dentist base would endanger this portion of the readiness mission. The ease with which the government will be able to regulate civilian contract positions increases the vulnerability of this portion of the CONUS mission capability to annual defense budget decreases (as proposed in the Gramm-Rudman-Hollings bill) and perceived fluctuations in future war readiness requirements.

## Chapter Five

### RECOMMENDATIONS

As discussed previously, the likelihood of sources of future conflicts involving the United States and the possible magnitude of such conflicts is increasing. An ongoing program of medical readiness must be developed that is reflective of current and future world threats. Such a program calls for constant reevaluation of our medical readiness posture in response to changing world events and the quality of readiness forces and must be able to respond accordingly. The need for such a program was demonstrated only a decade ago during "Nifty Nugget", the October 1978 full-scale simulated mobilization exercise designed to reinforce US combat units in Europe. A DOD report noted that:

A lack of adequate intratheater medical treatment forced the evacuation of many casualties who should have received all of their care there...For every three evacuation missions to CONUS, one aircraft was required to return aeromedical kits to Europe. After all available kits had been used, many patients were evacuated in aircraft configured for inflight medical care but lacking galleys, latrines, and airline seats (2:--).

Current and future civilianization of the Dental Corps must be stopped as it is not compatible with such a program. It does not consider the ongoing advances in dental readiness training that reflect, in part, the quality of medical readiness forces. Late in 1985, for example, as civilianization was being developed, advances were being made in dental readiness training. The Assistant Secretary of the Air Force for Manpower, Reserve Affairs and Installations stated:

We [the Dental Corps] are presently in the process of giving specific wartime assignments to each dentist. This is based on readiness training that has been ongoing for the past five years. I request you consider a delay of civilianization for one year until ...[a] standardization of dental wartime requirements is completed... (16:--).

Since that time, the Basic Anesthesia and Surgical Skills Training Course was developed, annual Medical Red Flag II exercises have become mandatory at all Air Force bases, and an increasing number of dentists are encouraged to take Advanced Cardiac Life Support and the Combat Casualty Care Course.

The Defense Department, therefore, must conduct further studies on the impact of civilianization on medical readiness and reconsider perceived dental wartime requirements in the light of ongoing strides in comprehensive readiness education and increasing readiness demands. Once this is achieved the Assistant Secretary for Health Affairs should reevaluate dental manpower within the Planning, Programming and Budgeting System (PPBS) and move toward reestablishing a totally active duty Dental Corps (15:--). The Defense Department, then, can help assure a quality and responsive medical readiness force by ending the dental civilianization initiative and investing in and maintaining a total active duty dental staff of adequate size to respond to potential medical wartime demands.

## Chapter Six

### CONCLUSION

In summary, with regards to medical readiness, civilianization is a budget initiative that carries with it near and long term consequences. Engaging civilian contract dentists in order to supplement the Nurse Corps with 98 additional active duty positions will enhance overall medical readiness on one hand but compromise it on the other. The fact that civilians are being hired indicates current Air Force CONUS dental needs are sufficient to support previously established manpower levels. Why, then, diminish the active duty Dental Corps only to reconstitute it with an element lacking in readiness potential? The answer lies in the degree of medical war readiness that our nation is willing to afford.

In the near term, purchasing the services of contract civilian dentists in favor of investing in active duty officers would appear to yield the benefit of serving CONUS dental care requirements at a reduced cost. However, "...If we allow ourselves to focus only on analytic tools, such as cost-benefit ratios, for planning health care functions, medical readiness will not be achieved" (13:--). For the cost of a civilian contract dentist, for example, we expect full time clinical dentistry, relief from the financial obligations of retirement and benefits afforded active duty troops, and the ability to terminate his/her services on an annual basis as dictated by perceived Air Force needs and/or the defense budget. What we actually receive, however, is a member of the CONUS dental staff unable to support all aspects of the Air Force dental mission as called for in Air Force Regulation 1-1; who cannot be expected to assist the remainder of the Medical Service in CONUS mass casualty situations; who will not mobilize in time of conflict; and who may serve the corps' needs one year and be gone the next.

In contrast, investment in an active duty dental officer yields leadership, skill, and the total commitment to duty required to benefit the Medical Service and Air Force on a 24-hour, 365 days a year basis, in the CONUS and overseas; those characteristics vital to a responsive, mobile, and enduring medical readiness force. After all, the consequences of choosing the less costly alternative of civilian contract

dentistry may in fact never be realized. But, when considering the results of what an underdeveloped wartime medical potential could entail, the question becomes whether or not we are really prepared to take that risk.

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