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**A Joint Medical Command --- Is It Needed to Enhance Medical
Interoperability in the Modern Warfight ???**

by

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**A paper submitted to the Faculty of the Naval War College in partial satisfaction of the
requirements of the Department of Joint Military Operations.**

**The contents of this paper reflect my own personal views and are not necessarily
endorsed by the Naval War College or the Department of the Army.**

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Abstract

A Joint Medical Command --- Is It Needed to Enhance Medical Interoperability in the Modern Warfight ???

As the entire Department of Defense continues to transform in the midst of a global war on terrorism, all of the Services continue to promulgate ways and means to become more expeditionary and modular in their approach to warfighting. In order to maintain relevancy, so must the service Medical Departments also find ways to enhance their benefit to the Joint Force Commander. In an era of budgetary constraints, it is apparent that the time has come to look at just how significant the formulation of a "Joint Medical Command" would be to the operational aspect of warfare. There have been many recent episodes of jointness in medical support on the battlefield, but nothing in doctrine supports the premise, and current service parochialisms often stand in the way of furthering this concept. This paper will look at advantages and disadvantages of joint medical support using key operational functions and the six joint health service support principles as a framework for analysis and conclusion. Many have written about benefits to peacetime healthcare, yet little exists in ways of analyzing this concept with respect to the warfighter from a joint support perspective.

This paper will look at formulation of a Unified Joint Medical Command from two different courses of action, and also look at remaining with current Service medical structure. These will be analyzed against several key operational functions and the six joint health service support principles. Advantages (Arguments For) and disadvantages (Arguments Against) will be offered for further consideration.

In the endstate of this paper, creation of a Joint Medical Command that will enhance medical support to the JFC will be recommended for further study. This is predicated on increased unity of effort, better flexibility and adaptability of support to the warfight, and significant gains in synchronization of effort and joint interoperability.

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Definition of Key Terms:

Operational Functions --- Defined from the source Operational Warfare, written by Milan N. Vego, JMO Professor at the Naval War College.

1. Operational Command and Control: Operational command and control is perhaps the most critical and at the same time all-encompassing of all operational functions. It is the principal means by which the operational commander sequences and synchronizes the actions and activities of both military and non-military sources of national power in a given theater. Sound theater wide C2 should be simple and flexible enough to allow for the full application of the principle of centralized control and decentralized execution.
2. Operational Logistics: Logistics is one of the most important operational functions in support of a major operation or campaign. Its ultimate purpose is to extend operational reach for one's forces or to prevent the adversary from extending operational reach for his own forces. Operational commanders are solely responsible for the smooth and effective functioning of logistics in the theater. They must have full authority over logistics for their subordinate forces; otherwise it is difficult to synchronize various logistical functions with operations during major campaigns or operations.
3. Operational Protection: Operational protection is inherently a joint responsibility. It is organized, planned, and conducted by the respective theater commander. This in turn, requires an operational rather than tactical perspective on the part of the operational commander and staff.
4. Operational Movement/Maneuver: Operational maneuver is the movement of all operational forces within a theater or AO, in joint and combined, for the purpose of achieving the strategic or operational military objectives of the operational commander's campaign or major operation. Operational movement is the function of deployment or regroupment.

Joint Health Service Support Principles --- Defined from the Joint Pub 4-02, Doctrine for Health Service Support in Joint Operations, 30 July 2001.

5. Conformity: Integrate and comply with the Commander's plan.
6. Responsiveness: Provide timely access to health service support through proximity or evacuation.
7. Flexibility: Shift health service support resources to meet changing requirements.

8. Mobility: Anticipate the need for rapid movement of health service support resources to support combat forces during operations.
9. Continuity: Provide optimum, uninterrupted care and treatment.
10. Coordination: Ensure that health service support resources are efficiently employed and used effectively to support the planned operation.

“The nature of modern warfare demands that we fight as a Joint Team. This was important yesterday, it is essential today, and it will be even more important tomorrow.”¹

--- GEN John Shalikashvili

Introduction:

Born out of crisis, bloodshed, and battle hardened combat health care spanning many wars throughout our nation’s history, today’s joint health service support construct did not come easily, yet with all major facets of military structure today, the time is upon us to look at better ways of supporting our Soldiers, Sailors, Airmen, and Marines. Military health support as it exists now is the product of vision, innovation, and the passion of saving lives on today’s battlefields, and most combat commanders will attest to its relevancy and accolades. However, in today’s military posture of increased “jointness”, the time is here to explore new and better possibilities of providing this critical facet of support.

In this era of unprecedented force transformation, the Department of Defense (DoD) is considering a major revamping of the health service support construct by creating a Joint Medical Command (JMC) that will serve to enhance current operational support. Though this facet has been mainly viewed from a peacetime healthcare perspective to date, this paper will analyze the impacts to the true operational aspects of war fighting and just how this will effect the support provided to the Joint Force Commander. The essence of what really needs to be answered in this context is the thesis of this paper --- Does current joint structure and doctrine allow for proper management and employment of joint force health service support?

As the DoD looks for new and innovative ways to execute its business, the establishment of a Joint Medical Command appears to be a viable concept, as it appears outwardly that this plan will serve to enhance health service support and allow for considerable gains in medical interoperability across all services. As outlined in Chapter IX of *The National Security Strategy*

of the United States of America (March 2006), “we must indeed transform America’s national security institutions to meet the challenges and opportunities of the 21st century.”² Clearly the DoD transformation is essential to our current administration’s NSS success and future building of the military force construct, and consequently, this proposal for a Joint Medical Command will support this desired endstate. Becoming more efficient in our execution of healthcare will allow the military to become more lethal in its combat capabilities and be able to sustain its transformation initiatives due to the gains that this concept will place back into the system. However, in order to validate its true merit, it must enhance the support to the operational commander.

When Secretary of Defense Donald Rumsfeld talks about transforming the DoD, he is asking leaders to reshape our military capabilities for this century, and that means changing our business practices, processes, organizations, and our culture for a sustained advantage in the future.³ Transformation for the medical arm of the DoD will most certainly mean looking at the new environment in which the military health system operates and taking a responsive action in order to implement change for the greater good of the DoD.⁴ Transformation will radically alter the way we fight and the speed at which we can engage in significant combat which results in casualties, thus requiring the capability to provide combat casualty care more quickly than in the past. Care for early casualties becomes a key component of the success of the operation and, as such, a center of gravity.⁵ The uncertainty of war drives redundancy and capability far beyond efficiency, and this is the very reason that the medical support construct must be carefully re-evaluated. Despite our vast improvements in medicine and our ability to save lives in combat, the uncertainty and friction of war that Clausewitz emphasized have not been abolished.⁶

The underlying principles for Defense Reform are to focus the endstate goal on a unifying vision, commit the leadership to change, focus on core competencies, streamline organizations for agility, invest in people, exploit information technology, and break down barriers between organizations.⁷ In order to remain relevant in this new century, the military medical services need to adopt the DoD focus and make a major paradigm shift in current structure and support. The changes we will discuss in this paper must come from a requirement that will serve to benefit the overall organization, and it is my belief that this paper will serve to provide a sound analysis in to that very premise, because even though “transformation” is the very sexy buzz word of today, the bottom line is that it must make sense to give support to the troops on the ground.

Historical Perspective / Analysis:

The concept of exploring a “Joint Medical Command” is definitely not a new initiative. General Dwight D. Eisenhower wrote after World War II:

“..... after giving careful consideration to the problem of providing medical service for the Armed Forces, I have reached a conclusion that there is but one real solution, the establishment of one single, integrated medical service to my mind it is absolutely silly to have individual service medical systems”.⁸

Since the end of World War II, the issue of whether to reorganize and create a Joint Medical Command has arisen repeatedly. Some observers suggest that a joint organization could lead to reduced costs, better integrated healthcare delivery, a more efficient administrative process, and improved readiness.⁹ There were numerous studies conducted over time to validate this concept and look at some sort of “medical unification”, and these included the 1948 Hawley Board; the 1948 Joint Chiefs of Staff Review; 1st and 2nd Hoover Commissions; DoD OMB Study; the “Doc Cooke” Study/Review of the DoD Healthcare Organization in 1991; and the recent DoD “733”

study. The majority of these reports recommend a complete overhaul of medical structure within DoD into a single “joint” medical service. However, the “Doc Cooke” study was the first and most pointed one to address the political controversy that encompasses such an endeavor. This has been the key underlying reason associated with this initiative to date --- politics, and a perception of a “loss of power” by the individual Services. Thus the concept never took hold, and service parochialism won out over the years. However, it is time to look pragmatically at just how this initiative will support the operational aspect of warfare, and see if it truly makes sense from this standpoint.

One might ask, does a joint medical command concept make sense? In putting all Service politics aside, and looking at the future, the answer will become evident. It was the Goldwater-Nichols Act in 1986 that spearheaded the essence of jointness that we work with in the DoD today. After the establishment of Regional Unified Commands, there was joint gains made in the areas of Special Operations and Transportation with the standup of United States Special Operations Command (USSOCOM), and United States Transportation Command (USTRANSCOM). Based on the success of these organizations, the time is here for the medical community to study the same model (see Appendix 1) and get over the Service centric issues and look to enhancing interoperability across the spectrum of future conflict. (This appendix 1 shows a potential Joint Medical Command as a Unified Command, like our other major 4-star headquarters today).

Current Joint Vision / Joint Health Service Support:

“The complexity of future operations also requires that, in addition to operating jointly, our forces have the capability to participate effectively as one element of a unified national effort.”¹⁰

Clearly this portion of the current Joint Vision 2020 lays out an operational framework in which our forces of today must operate from as we continue to transform. This becomes seemingly more critical as we continue to place increased emphasis on Joint Task Force (JTF) operations. More recently, Geographical Combatant Commanders are establishing JTF's to accomplish specific, limited objectives that require the significant and closely integrated efforts of forces from two or more services.¹¹ As this appears to be the current future of warfare across the operational continuum, there is a definite need for change amongst the Joint Health Service Support (JHSS) aspect, specifically when it comes down to controlling assets and overall synchronization of efforts.

According to joint doctrine, the primary objective of Health Service Support is to conserve the fighting strength of the forces.¹² As explained in this doctrine, the objective is most effectively achieved through optimum use and integration of all available HSS assets.¹³ Though a common framework for attaining this goal would seemingly be to effect more joint operations medically, there does appear to still be many arguments against such a venture. The majority of the arguments against this initiative seem to stem from Service uniqueness in mission and support structure. There is some validity to this argument, based on the fact that each of the Services does have very different ways of executing their wartime roles and missions. However, the commonality in providing Joint HSS maintains a common theme of saving lives, and though there are differences, the time is here to properly evaluate the CONOPS for a Joint Medical Command structure against support to the joint force.

In recognition of the need for continued improvement in joint operations, the JCS developed a white paper that addresses key elements and capabilities for the future of joint warfare. This perspective suggests that, within the operational environment, successful future military

operations will continue to require highly qualified people trained and focused on a joint force context.¹⁴ There is no doubt that creation of a joint medical command will globally optimize the employment of medical forces through appropriate posture of Service capability packages. This will allow the Joint Force Commander to tap the resources and capabilities of a single military medical service, rather than dealing in a convoluted system that exists today, however it is essential that we look across several criterion to ensure that this decision is the best mechanism to ensure timely and succinct medical support for the warfight today and in the future. Medical support in a joint environment must ensure that quality medical care is continuous, proximal, flexible, and mobile. It must balance the optimum employment of evacuation with medical treatment and surgery platforms in order to address the realities of the battlespace (mission, enemy, time, terrain, etc). Careful planning and integration of tailored medical capabilities such as medical treatment, evacuation, Class VIII (med logistics) requirements, theater patient movement control, theater medical information networks, medical surveillance, and pre-emptive intervention are all functions of medical battle command and the medical common operating picture that must be integrated more “jointly” in order to ensure future success on the battlefields of tomorrow.¹⁵

Analysis of the Problem/Thesis:

As there have been numerous studies and panels conducted to look at the feasibility of a Joint Medical Command entity, it has clearly been a case of doctrinal bias and service parochialism that has stagnated the type of innovative thinking that is really required to evaluate this concept. True transformation requires us to have the requisite vision and boldness required to pursue needed changes or to have the intestinal fortitude to remain with current systems in the face of

change in our military. The reason for looking at the current JMC concept is to enhance medical support for the full range of military operations (ROMO) and sustain the health of those entrusted to its care. The primary task for the JMC should be to serve as the joint medical force provider, responsible for providing agile, interoperable joint force health protection across the ROMO, in support of combatant commanders. If this proposal is feasible, it should also it should provide command and control of the overall joint medical force, with the exception of organic and/or assigned medical assets. In order to evaluate the true merit of this concept, this paper will look at the aspect of three operational functions and the six tenets of JHHS, thus providing a framework to evaluate potential courses of action against in formulating whether or not this is a sound decision.

Operational Functions Perspective:

The first function that we will discuss is that of **Operational Command and Control**. In this regard we are concerned with the fact that this function is key to the operational commander's success, as it is the principle means by which sequencing and synchronization of actions takes place.¹⁶ Effective C2 in its best application should allow for unity of effort through unity of command, thus ensuring a viable plan of execution is ready to be implemented.¹⁷ In the current architecture of health service support, there appears to be a concerted deficiency, in that there is no real jointness in current C2 arrangements of medical support units, and when forced to execute in wartime, there are issues that detract from proper support. This is based on the fact that this general lack of joint medical C2 can hamper effective planning and execution. We have the parochial service stovepipe organizations and medical plans for going to war, and they oftentimes have very little resemblance to one another, so we lose synchronization. Each of our services medical assets tend to plan support in a vacuum, and they lack the requisite joint

experience to gain unity of effort. In our current medical architecture within DoD, we have no effective mechanism for coordinating service operations in wartime, nor an ability to effectively resolve key issues concerning deployment and overall operational effectiveness for the force. Too much is done “on the fly”, when there are better ways to get this completed. Achieving unity of effort and enhanced operational C2 requires the seamless integration of all medical capabilities and assets with DoD that can support the warfight.

Next we will look at **operational logistics**, and it is here that we are concerned with ensuring we have a system of support that will maximize the Commander’s operational reach ability. In the realm of medical support this is paramount to success, in that class VIII (medical supplies) must be flowed in the same manner as all other major classes of supply, however, this one can mean the difference in life or death if it fails. The current medical logistics system amongst services has received mixed ratings in after action reviews. The current issue at hand is that medical logistics in a major operation is conducted through use of a single item line manager (SIMLIM), which is set up to be led by the Army. However, as noted in OIF lessons learned, the system was inadequate.¹⁸ Much of this was due to the fact that the med log planning was not properly nested, and the Service components were planning in a vacuum regarding this area, thus there were dangerously low levels of class VIII reported during initial operations.¹⁹ This issue can be solved, as it is clear that the service construct is an inhibitor to success. Increased joint application will ensure synchronized planning efforts, and increased asset visibility on medical supplies for the overall joint force.

The next area we will consider is **operational movement / maneuver**, in this context we are focused on positioning combat forces in order to gain an advantage over opposing forces that is essential for success at tactical and operational levels in war.²⁰ The success of major operations

is often based on sound planning and execution of this critical elemental. In the aspect of health service support, we are more concerned with the movement and maneuver branch of rapid and precise response capability of support. This imperative is critical in that it provides the ability to the joint force commander to meet constantly changing needs and ensures that medical support is readily available at all times. Any lack of medical support to the operational commander, regardless of reason, undermines readiness and can increase mission risk. The current medical support architecture is sufficient in this area, yet it could be improved from an increased joint mindset and perspective that would enhance operational readiness. During Opn Desert Storm, medical units were tasked by Services, and their abilities to provide care and movement to support the warfight were substantially different across the board.²¹ Army and Marine medical units, due to their doctrine and structure were best postured, however, the Navy and Air Force units had a very hard time adapting to this realm of movement in order to support, and this caused issues. Also, these units did not communicate well in planning for all potential scenarios that ODS could have brought, and the end results could have been dramatically different if the enemy at that time had inflicted greater casualties on the U.S/Coalition forces. In order to mitigate any shortfall in the future in supporting the JFC, there has to be changes in construct and design across the board for medical assets. This will ensure that units, regardless of Service, have the ability to support the intended plans of the warfighter, and ensure that medical capability is equal across the service spectrum.

Joint Health Service Support Tenet Perspective:

The principles of health service support were defined in the key terms and definitions earlier in this paper. However, it is important to maintain the focus that proper planning in adequate HSS to the joint force commander requires an in-depth analysis of all these factors in order to

ensure interoperability with the campaign or operational plan. The structure of the HSS system is determined largely by the JFC's mission and the overall threat.²² Each JFC and JTF should maintain the ability to have a viable health service support continuum that encompasses all aspect of healthcare. This can only be maximized in a truly joint arena, by where the effective distribution of component medical assets can be maneuvered in a joint effort to sustain the JFC's fight. In a truly synchronized and coordinated effort, joint health service support can provide prompt, effective, and unified health services to enhance the combat fighting ability of the overall joint force entity.²³

Case Study Analysis: (OIF)

The first case reviewed will be that of Operation Iraqi Freedom from a medical lessons learned perspective regarding overall health service support to the warfight. One of the key lessons learned was that in the area of medical command and control. Areas of friction were caused by the lack of any concerted medical command structure at the operational, and this led to a lack in unity of effort. Much of this was due to the fact that we have staff personnel who attempt to dictate command policy, and this often leads to confusion. One of the solutions recommended to alleviate this from being a future issue was to dual hat the medical brigade commander and the command surgeon for Multinational Corps – Iraq (MNC-I). I disagree with this synopsis, as it will further damage the issue. Command and Staff entities must be separate and distinct in times of war in order to gain synchronization and true unity of effort. This is a perfect example of where a joint medical command structure would benefit the JFC on the ground at MNC-I, and be able to effect total JHSS visibility, flexibility, and coordination that will result in more effective support to the forces.

Another issue that has been a concern for medical support in OIF is transformation. The current operations are now joint in nature, with Air Force, Navy, and Army all having medical elements in theater caring for a mix of patients. Each service has a very different structure and operational scheme, and this has caused some issues with interoperability and force apportionment of medical assets. Not everything has been negative, as there have been some very positive results of joint medical interaction, i.e., the 31st Combat Support Hospital in Baghdad and Balad, conducted a battle handover with an Air Force Hospital, and it was a very successful initiative. However, there have been numerous issues that have caused commanders at various levels to look harder at the joint construct. Many of these stem from incompatibility of medical systems, varying capabilities and degrees in medical units, and cumbersome deployment flows due to weight and cube of patients and equipment.

Also, in OIF there have been many problems with services due to organizational differences in medical type units. It has been validated that requests for units of joint forces must be done for capabilities rather than for specific units. For example, an Air Force preventive medicine (PM) detachment has markedly different capabilities and support requirements than an Army PM unit.²⁴ The biggest difference in this realm centered on level III hospitals across the services. The AF and Navy hospitals are custom built in modules according to capabilities requested, unlike the Army that is centered on one large unit. Thus, the differences in structure, capability, and focus often cause issues to the JFC when dealing in the current service system.

The need to transform to a joint mindset requires critical examination of areas of joint medical integration and interoperability. Some of these challenges will include changing the ability of current service systems in order to maintain like sorts of data, information, materiel, and services

that will enable them to operate more effectively and to enhance the JFC's ability to better medically support his efforts.²⁵

Case Study Analysis: (Opn Restore Hope/TF Ranger in Somalia)

Somalia was a definite case of the service medical departments doing its combat mission in operations other than war (OOTW) context. The nature of the medical mission was in terms of peaks and valleys in that the demand for medical support overall was relatively low and primarily for routine care, yet this mission was heightened by periods of combat.²⁶ Planning for succinct and coordinated support for such operations can be a very difficult challenge, as commanders need to be able to respond to the worst-case scenario and yet make the best use of their medical assets.²⁷

Initially the Army had lead on overall medical support in this theater of ops, thus it was relatively easy to effect coordinated actions and overall synchronization of efforts. In fact the Army remained the lead service for all level III (hospitalization) and Corps level medical assets in theater. They maintained a sound medical C2 architecture that was able to plan in conjunction with the JFC and his staff. They also did well in planning support with other services on the ground and with coalition partners that were a part of this task force operation. In fact, some would say that this is a very good example of service specific capabilities providing the right asset at the right time.

Initially, the medical assets brought into theater were robust in nature due to the intensive staffing of providers and specialties amongst the hospitals on the ground. However, as time went on, the medical assets transitioned to a lower posture in staffing, and went from a true medical brigade asset to placing a field hospital commander in position as both the Medical TF and hospital C2 for the overall theater. This led to issues that could have been catastrophic in nature.

At the time of the TF Ranger firefight, the number of providers in theater was at its lowest level, and the medical sustainment outcome though successful, could have been worse. At its best, the combat support hospital on the ground was stretched very thin on that 3 October day based on the intense casualty count, yet, there were some very key and essential SOF medical assets in theater that were able to augment and assist in a critical way.

This operation was a clear example of an OOTW that was characterized by low intensity conflict with a distinct potential for combat. This truly illustrated just how difficult it is to plan medical support in this environment. In such a situation, commanders need to be able to react to events as they unfold, and at the same time, a commander must be able to make the best use of his medical assets. These types of operations are successful when flexibility in planning remains unchanged, and the in-theater medical commander must be able to maintain this flexibility to tailor or modify medical support in order to meet the needs of the day to day missions. This was not the case in Somalia, as we lost the medical C2 asset after rotation one, and failed to properly plan for unexpected contingencies that could arise medically. Also, the lack of overall joint HSS was evident and did not enhance the true medical support architecture on the ground.

How Do We Solve the Problem ???:

In order to solve the problem defined in this paper, we need to look at three potential courses of action (COA) in evaluating the merits of a joint medical command entity. COA 1 is remaining with the status quo and leaving service medical departments in place to support as we have been for many years. COA 2 would be to create a JMC that is a unified command that would encompass all medical assets (both fixed facility healthcare and TOE assets at the corps level and above) under one four star headquarters (see Appendix 2). COA 3 would be to create

the four star JMC, but have sub-unified medical JTF's under each geographical combatant command in order to effect enhanced battlefield healthcare (see Appendix 3).

These three COA's will provide a solid framework to look at arguments in favor of (advantages) and arguments against (disadvantages) as the best solution to this problem is recommended in the end. It must be remembered that JHHS exists to give the JFC the freedom of action to meet mission objectives. It delivers this effect by integrating all medical capabilities within the operational space, and thus it must maximize the ability to change if there are better ways to support the joint force. The following discussion of advantages and disadvantages will look at the specifics of the JMC entity. Appendix 4 attached (JMC Decision Matrix), lays out the three COA's discussed, and analyzes against the criteria that was outlined earlier in this paper.

Advantages (Arguments For): Creating the JMC will pose significant advantages to the joint force it supports. First of all it will enhance operational C2, as it will streamline overall medical control of assets and stop the service stovepipes that have had negative impacts to date. This is a major advantage in either COA 2 or COA 3, however, COA 3 lends itself to being the better option due to closer alignment with the GCC it must support. Another key advantage that the JMC offers is better operational logistics from a CL VIII standpoint. The benefit derived in this realm will stop the current disparity that is evident in service medical logistics infrastructures. A better and streamlined system will be able to take effect with this JMC construct in place, and that will serve to enhance support to the warfight, and this area has been extremely problematic in many of our past major operations.

In reviewing the JHSS principles as a measure, it is evident that the creation of a JMC offers significant increases in almost all areas, and this is largely due to having a unified effort and

increased synchronization. The most critical advantage to this course of action being adopted is that it enhances joint interoperability and increases military effectiveness across all services, thus enabling better support to the joint force. Another key advantage is that this concept would increase medical support surge flexibility, thus allowing for better preparation for stability operations, global war on terror, homeland security, and the overall range of military operations.

Another very significant area of benefit to the JMC concept is theater hospitalization. Current shortcomings in level III hospitals have become increasingly apparent as combat operations continue in the current war on terrorism fight.²⁸ After action reviews from OIF and OEF from both the line side and medical expertise, point to severe deficiencies in modularity and scalability of hospital support.²⁹ A truly joint effort in medical command and control will assist in alleviating this disparity, as we will be able to construct enhanced unit assemblages that are now capable of rapid force projection and increased mobility. This in turn will enhance continuity of support to maneuver units by allowing for increased tailored medical assets that can adapt to changing conditions.

Disadvantages (Arguments Against): As important as the benefits to a joint medical command creation are to the force, one must also look at the disadvantages in order to be cognizant of major issues that could make this a bridge too far. One of the key arguments against this concept would be of JMC would be loss of individual service identity for the current medical departments. This may be a key political pet rock that could cause service Chiefs to opt toward maintaining the status quo.³⁰ Though many might argue against this premise, it does have merit, in that there does need to be service specific medical doctrine that supports each entity, and losing the medical oversight at the Department level is a cause for concern.

Another argument against the formation of a JMC is that this entity would be too large and complex to manage. As outlined in Appendix 2 and Appendix 3 schematics, the JMC will encompass a significant wealth of resources that mixes both peacetime and wartime support requirements, thus making this a very expansive. Again, it must remain paramount that any new organization be an enhancing construct to support the JFC, and not be a hindrance. In order to attain this facet, the JMC concept requires detailed flushing out of the overall staffing.

Maintaining the current status quo will also enable JFC's to maintain support that is doctrinal to their component structure. Though they fight as a joint entity, the aspect of medical support may be better left to component staffing under and ad hoc JTF Surgeon for overall C2. This would maintain strength in the JHHS principles of conformity and continuity, and allow the system to maintain a steady state.

Recommendations:

Based on the analysis of the three basic COA's outlined, and contrasting their merit against set criteria, it is recommended that establishing a Joint Medical Command that maintains sub-unified medical JTF's in each GCC should be adopted for further consideration. It is clear in analysis that a unified JMC construct would enable operational JHSS to have the depth, flexibility, and agility to support the joint force commander in a way that has not yet been attained.

Conclusion:

Transformation of any system must begin with a clear and definable vision. It would be easier to continue on our current path and accept incremental change to the current design of our joint medical system, particularly given our successes in Operation Iraqi Freedom and operation Enduring Freedom. True JHHS transformation will and should invite controversy, as it is only

through critical analysis that we will forge ahead to achieve the best healthcare system that will enhance the warfighter's support.

The employment of medical capabilities in the joint warfighting concepts of joint force protection, battle command, battlespace awareness, and focused logistics is a complex art and science. The Joint Medical Command will ensure that the provision of JHSS is synchronized with non-medical enablers such as communications networks, movement and maneuver control, logistics, and overall joint force commander's intent. This will give the warfighter's a better capability to sustain casualties and enforce the tenets of JHHS. The bottom line is that the medical force must be fully capable of supporting joint operational concepts across the range of military operations. This JHSS must be agile and aligned with current joint force concepts, to provide optimum combat service support to the Joint Force and maintain the capability to rapidly respond to new theater and operational requirements dictated by the changing national security environment. The Joint Medical Command will significantly enhance the overall support to our Soldiers, Sailors, Airmen and Marines, given that this entity will focus support efforts unlike we have ever been capable of doing, and this model will adhere to the principles of unity of command, unity of effort, and economy of force. Thus the JFC will be able to maximize better medical support that is relevant and reliable to the force it supports.

ENDNOTES

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