

USAWC STRATEGY RESEARCH PROJECT

DENTAL CONSIDERATIONS IN A UNIFIED MEDICAL COMMAND

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ABSTRACT

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Volumes have been written touting the benefits of a Unified Medical Command, but none have discussed the Army, Navy, and Air Force Dental Corps' role in this command. The pace of military medicine's transformation is increasing, and in order to ensure eligible beneficiaries continue to get world class dental care, a study of dentistry's potential role must be conducted. Whether a Unified Medical Command is established or not, there are several joint dental initiatives that should be undertaken to achieve unity of effort between the services in both peacetime and war. To meaningfully contribute to a Joint Medical structure, the Dental Corps must start now to ensure young officers receive joint exposure to understand each service's dental capabilities and how to employ them.

DENTAL CONSIDERATIONS IN A UNIFIED MEDICAL COMMAND

While improving the quality of leadership is an important initiative, it should not, however, be seen as a substitute for necessary organizational reform. Although good people can, to a certain extent, overcome a deficient organizational structure, a well-designed structure will support a higher level of sustained effectiveness.

—Dr. James R. Schlesinger

In support of the Department of Defense's (DOD) ongoing transformation initiatives, the concept of a Joint/Unified Medical Command (UMC) is again making headlines.¹ Many new structures have been proposed over the years in an effort to quell the unsustainable growth in the cost of providing health care to DOD beneficiaries. New ideas are emerging as a result of Program Budget Decision (PBD) (#753) which was signed by the Deputy Secretary of Defense in December 2004. Great efforts have been put forth to study the most efficacious medical structure; however, none have addressed the role the Army, Navy, and Air Force Dental Corps would play in the command.

The Army and Navy have embraced the issue of a UMC, while the Air Force's strong resistance is credited with the rejection of the latest plan.² Strategic leaders in the Army Dental Corps continue to struggle with many issues affecting the current climate and effectiveness of Army Dentistry, but the possibility of a Unified Dental Command (UDC) and its ramifications on traditional service specific core beliefs has the potential to destroy decades of tremendous success. That is the perception; however, a proactive approach to this problem may in fact have the opposite effect. With a well thought out plan, devoid of both corps and service parochialism, the military dental health system can soar to new levels of success.

Whether a Unified Medical Command is established or not, there are several joint dental initiatives that should be undertaken to achieve unity of effort between the services in both peacetime and war. This paper will review issues that will form the foundation for any future UMC or new medical governance structure.

A brief history of UMC concepts will be examined, along with a review of recent proposals. The history of the Army Dental Corps is important to understand the reasoning behind the current Army Medical Command/Dental Command (MEDCOM/DENCOM) relationship. A detailed structural diagram of the UMC structure is not within the scope of this paper, but several recommendations for possible inclusion in a UMC structure will be made. An Army War College Student Research Paper written in 1992 began with "Military medicine and the Military Health Services System (MHSS) are in the midst of change and turbulence. Decreasing

defense budgets, reductions in the active duty and civilian work force, and escalating costs of medical care make it increasingly difficult for the MHSS to accomplish its patient care and medical readiness missions. Today, the most frequently prescribed remedy for these problems is to increase the amount of “jointness,” the amount of centralization and consolidation of military medicine.”³ Fourteen years later, the same can be said with the exception of decreasing defense budgets.

Is a UMC inevitable, or should we step back and reevaluate the need after taking some initial steps to streamline the Defense Health Program (DHP)? The UMC is a contentious concept and the topic of great debate between the services Surgeon Generals.⁴ Does the UMC proposed most recently by the Assistant Secretary of Defense for Health Affairs, Dr. Winkenwerder, go far enough in ensuring the different service medical assets are “interoperable, interchangeable, or even interdependent,”⁵ as Vice Admiral Donald C. Arthur notes are obvious problems when operating in war zones such as Iraq or Afghanistan? A look at historical proposals along with experience gained in Operation Iraqi Freedom may expose weaknesses in the proposal and suggest areas to improve.

The streamlining of Military Health Services has been studied by the Department of Defense at least 16 times,⁶ and all but three previous DOD studies have recommended the creation of a unified service or at least adding to central authority to improve coordination between services.⁷ Despite all the efforts put forth in these projects, all studies have been rejected to date. Efforts to consolidate the military health care systems began after World War II, when then Chief of Staff, General Dwight D. Eisenhower “advocated both unification of the armed services and unification of the military medical departments.”⁸ Most recently, the 2001 P&R RAND Study, Defense Business Board FY06-5 Report, and 2006 OSD (HA)/Office of Transformation all advocated a “Unified Joint Command.”⁹ None of the studies mentioned dentistry, but all exposed areas where the service Dental Corps could work together to achieve better interoperability.

The Defense Business Board formed a civilian led task group at the request of the Deputy Secretary of Defense to consider which course of action had the best potential to improve the military health system performance and “balance the needs of the war fighters with DoD beneficiaries.”¹⁰ This study again concluded that level I and II care should remain service specific, and that a joint command would reduce costs through eliminating redundant processes and consolidating personnel.¹¹ While this study did not mention dentistry specifically, it did advocate adopting best industry practices such as combining like shared services. Common equipment, education and training, research and development, testing and evaluation, logistics,

information management, and information technology were some that apply to both medicine and dentistry.

The Bureau of Medicine and Surgery (BUMED) requested the Center for Naval Analysis (CNA) conduct a study on cost implications of various UMC configurations.¹² In this 2006 study, they analyzed cost savings in relation to forming a single medical command, a medical command and a healthcare command, and a single medical service. While the study did not recommend one over the other, the detailed background on the formation of SOCOM and its successes supports an argument that a single medical service is the structure of choice.¹³ Economies of scale, administrative consolidations, elimination of underused inpatient capacity, and elimination of duplicative services are listed as the expected results of a unified medical command. Savings in healthcare operations were studied based on the assumption that clinical operations would not change, but changes on the command and administrative structure would lead to savings.¹⁴ The history of command relationships within the AMEDD must be understood in order to maintain the successes the Dental Corps has been enjoying.

The Army health care system is composed of two distinctly separate elements. The medical and dental care systems are “self-standing in that the professional components of each are not interchangeable, nor is one element dependent upon the other for the delivery of professional services. Yet, throughout the history of the Army Dental Corps, the Dental Care System has been primarily controlled by the medical element of the health system.”¹⁵ Policy decisions in the form of Army Regulations specified the command and control of dental units for the initial 35 years after establishment of the Dental Corps. During this time, dental units were subordinate to medical units. After WWII, regulations were revised, authorizing dental units at each Army post to be established and commanded by the senior dental officer assigned. The dental commander reported to the installation commander, rather than the senior medical officer as had previously been the case.

In 1967, regulations were again revised, giving senior Medical Corps officers command over all health-related resources, including dentistry.¹⁶ Two years later the regulation was changed, assigning the senior Medical Corps officer on each installation as commander of all health services, denying dental officers access to the installation commanders.¹⁷ Morale and efficiency plummeted as a result, and by 1974 the Dental Corps had the lowest retention rate of junior officers in the entire Army.¹⁸ Productivity by 1975 had fallen by 17%, and 63% of dental clinics were still in temporary structures due to the dental facilities construction program being ignored.¹⁹ With fenced dental funds, personnel being diverted, and MC officers receiving four times as many continuing education experiences as DC officers, something had to be done.

The Army Surgeon General formed an ad hoc committee of General Officers to study the organization for dental services. The committee concluded that “decreasing dental productivity and low retention rates for Dental Corps officers were problem areas, and that the existing organization for dental services might be a contributing factor.”²⁰ As a result of the committee’s findings, CONUS dentists were given control of their dental resources and placed in a parallel relationship with medical commanders with regards to installation commanders. The change brought about tremendous improvements in productivity, and eventually led to the Vice Chief of Staff of the Army calling for further study of the Army Dental Care System. This study led to worldwide implementation of the above command relationship and changes in regulation which severed the command line between dentists and physicians on installations.

Due to the tenuous nature of policy directed changes, the American Dental Association (ADA), in conjunction with the Department of the Army, supported the passing of House Resolution H.R. 6038 which solidified the Army Dental Corps organization which had proven so effective. The ADA position, as stated by Dr. Joseph Salcetti during congressional testimony, was that the legislation was “to provide Army and Air Force dental officers with the proper command authority over their own professional operations. These proposed changes in administration and structure would, in our view, ensure an effective and efficient dental care delivery system within those two military services (Army and Navy).”²¹ The culmination was President Carter signing the Dental Corps Reform Bill into law 20 October 1978. The law provided that: “1. Dental clinics worldwide will be commanded by dentists. These dental commanders will have their own funds and personnel. 2. All enlisted personnel working with the dental care system will be under the control of dental officers. 3. Dental commanders will be responsible to post commanders and not to physicians on the post. 4. All matters relating to dentistry at the Army level will be brought to the Chief of the Dental Corps.”²² As a result of the reform, productivity increased 153% from 1975 to 1989, and junior officer retention increased six-fold.²³

Legislation in 1946 authorized a Dental Corps within the Navy, thus “assuring that responsibility for dental professional matters would be vested in those naval officers who are qualified by virtue of training and experience.”²⁴ The Army is authorized a dental command by statute. The Navy has similar legislative language for a Dental Corps Chief, but not for a dental command. Due to this loophole, Title 10 did not have to be changed in order for the Navy Surgeon General to make sweeping changes in the current organization of Navy dental care operations.²⁵ The Navy medical/dental relationship has recently changed making Navy dental operations subordinate to medical control, taking the Navy Dental Corps back to its pre-1946

status. The ADA, through major policies adopted to date, opposes such relationships. The UMC provides many opportunities for interoperability and sharing of resources, but history must not repeat itself with the subordination of installation dental units to medical units.

The current Army Dental Corps structure is an outcome of the Army Medical Department reorganization which was based on the results of Task Force Aesculapius 1993-1995.²⁶ Many new commands were formed, to include the Army Dental Command (DENCOM), as a result of the study's goal of separating operational work from staff work along product lines. The Army Veterinary Command (VETCOM) and Army Center for Health Promotion and Preventive Medicine (CHPPM) were also created during this time because the "products and services delivered by each of these new commands were considered separate and distinct product lines."²⁷ Positive comments on the support being rendered by each product line were important in the decision to establish stand-alone commands, and should be considered in the structure of a UMC or DHA.

Current patient satisfaction data is readily available today due to the DOD patient survey organization easily queried on the internet. In a trending report for all Army, Navy, and Air Force patient encounters from October 2001 through June 2006, 96.9% of the patients were satisfied with their dental visit.²⁸ This extremely high satisfaction rating must be considered in the placement of dental command and control in the UMC or DHA hierarchy. After a careful review of the Dental Corps history, Sculley wrote that the DC reorganization should proceed "cautiously with an eye to retaining those aspects of the current structure which have fostered the "golden age" of Army Dentistry."²⁹ These words remain true today as we consider dentistry's involvement in the UMC and how the evolution of our current structure relates.

PBD 753 directed the Under Secretary of Defense for Personnel and Readiness to "develop an implementation plan for a Joint Medical Command by the FY 2008 – FY 2013 Program/Budget Review."³⁰ Dr. Winkenwerder sent a new Joint/Unified Medical Command (J/UMC) proposal to Gordon England, Deputy Defense Secretary, on 27 November 2006, only to have it ultimately rejected due to opposition from the Air Force.³¹ Dr. Winkenwerder's plan was to create a Joint/Unified structure to improve the management and efficiency of the MHS. While the wire diagram included in the draft organizational chart failed to include a UMC Commander, it did identify many areas to consolidate common services while maintaining service unique culture for each of the services' medical components. From this proposal, a "new governance plan" for the health care system was conceived to establish joint oversight over for "key functional areas."³² The four target areas are medical research, medical education

and training, health care delivery in major military markets, and shared support services. Each of the four target areas will now be reviewed as it pertains to the Dental Corps.

Medical research is one area where joint efforts can be very effective and have profound joint implications on the practice of military dentistry. The Naval Institute for Dental and Biomedical Research in Great Lakes, Illinois, was established in 1947. Early efforts at establishing a joint research center were made by the 1996 move of the Army Dental and Trauma Research Detachment and the 2000 move of the U.S. Air Force Dental Evaluation and Consultation Service (Formerly known as the Dental Investigative Service) to Great Lakes. According to their website, "Great Lakes is now the single site for DoD combat dentistry research and is optimally positioned to facilitate triservice collaboration."³³ Triservice collaboration is far different than a joint command. While the opportunity for collaboration exists, investigation into the functioning of the research elements at Great Lakes revealed three separate command elements, logistics systems, scientific departments, and funding streams along service lines.³⁴ Great Lakes is scheduled to close due to the Base Realignment and Closing (BRAC), and the units will fall under the future Institute of Surgical Research at Fort Sam Houston with the Army as the executive agent.

Dental research is extremely important to support military dentistry, and has great impacts on both clinical and field dentistry. Scientific investigations, biometric and public health dentistry, dental support of forward deployed troops, and environmental issues are all areas of interest to the research units and have made an impact on not only military field and clinical dentistry, but also on civilian practices. Research on equipment must continue to meet the challenges faced by deployed dentists, and can and should be carried out jointly. Army, Navy, and Air Force dentists are all forward deployed in Iraq and work under similar conditions often with the same equipment. Lessons learned by all three services are being captured, and should be capitalized upon through joint efforts in future projects. While the focus of research efforts may vary slightly between the services, having separate commands inhibit true collaboration of efforts. Until the funding for the research detachment comes from one source, the efforts will be aligned with the money trail and person who holds the pen to sign the authorization.³⁵

The conceptual framework for Winkenwerder's "New Governance Plan" leaves three organizational possibilities: an existing command structure, a current or new defense agency or field activity, or one of the military departments as an executive agency.³⁶ The move to San Antonio is a perfect opportunity to improve the efficiency of dental research by combining all units under one command and logistics structure while maintaining the joint assignments and functions of each services efforts. A joint Dental Research Command under the Joint Research

and Development Command being proposed by Winkenwerder should be pursued with the director chosen through a best qualified board with candidates from each service. Just as medical research has joint implications, medical education and training should be the focus of early joint efforts.

The Joint Medical Education and Training Command with the Army as the executive agent will be the single source for medical education and training. Enlisted training is already conducted in a joint environment in Texas, but the training for dental officers is along service lines with some efforts at sharing resources being made. The benefits of Graduate Dental Education (GDE) are common among all three service Dental Corps: increased skills and retention of dental officers who would otherwise leave the military after their initial service obligation. The current system for dental officer education can be divided into two entities: graduate dental education (Advanced Education in General Dentistry- 1yr and residency programs) and continuing education required to maintain licensure. All three services have developed robust training programs which provide top quality educations, while contributing to the dental readiness of their respective populations. The Orthodontic program at Wilford Hall is an example of a joint training venture, with Army, Navy, and Air Force dental officers training together under a memorandum of understanding (MOU) between the services. Resources are also shared in the Washington DC area between the Oral and Maxillofacial Surgery residents of Walter Reed and Bethesda. A Tri-service education meeting is conducted each year, and one outcome is the sharing of vacancies in programs between services.

The dual mission of the Army Dental Corps is to provide care for Soldiers before they deploy and to provide care for deployed forces. The AEGD-1yr program is instrumental in both missions. According to Atchison, program directors reported dental school graduates were coming to their programs inadequately prepared in such critical areas as oral diagnosis, treatment planning, oral surgery, and endodontics.³⁷ Military dentists must be trained to a high level of proficiency in these areas in order to provide forward deployed care in austere environments, and the AEGD- 1yr provides that training. In deciding on locations for GDE sites, two factors must be considered: The capacity of existing facilities to support GDE faculty and residents, and the patient population to provide the experience for residents while contributing to the wellness and readiness of our fighting forces. Efforts to create efficiencies in GDE led to a study of existing graduate dental training.

The Uniformed Services University consists of the School of Medicine and School of Graduate Nursing. In July 2005 the Federal Services Integrated Postgraduate Dental Education Committee (FSIPDEC) provided a report to the Service Chiefs titled "A Joint Postgraduate

Dental Education System May Maximize Throughput, Decrease Excess Capacity, and Reduce Infrastructure.”³⁸ This report was conducted to study the effectiveness and efficiency of Federal Services postgraduate dental education and explore the potential for joint opportunities. The committee performed a comprehensive review of how each service resources and delivers Postgraduate Dental Education (PDE), identified areas of overlap, and came up with options on how the Federal Services can be more efficient in the future. One service acting as the executive agent could reduce the infrastructure, but would not be as effective as a joint entity to oversee all Federal Services graduate dental education.

While a common curriculum would appear to be ideal for military dentistry, the different missions for specialties such as comprehensive dentists in each service necessitates slightly different skills being trained. As with research, a joint dental education director under the Joint Medical and Training Command being proposed by Winkenwerder should be pursued with the director chosen through a best qualified board with candidates from each service. An effort to provide continuing education opportunities in geographic regions shared amongst different services is another area where a joint education director could affect positive efficiencies. The third functional area, health care delivery in major military markets, is not a new concept.

In 1986, ASD(HA) Mayer directed the Army and Air Force to establish a Joint Military Medical Center in San Antonio, joining Brooke Army Medical Center and Wilford Hall Air Force Medical Center.³⁹ Many lessons can be learned from this in order to effectively carry out plans for the National Capital Region and San Antonio Region joint projects as currently proposed. In the 1986 San Antonio JMMC, the Air Force was the executive agent, thus had an Air Force General Officer in command. In many respects, both hospitals continued to operate independently. Joint academic departments were not successfully formed and when Operation Desert Storm and Desert Shield required medical providers, the system did not provide for deployments.⁴⁰ This plan, forced upon the services despite objection of the Surgeons General, eventually was ended in 1991.⁴¹ The National Capital Region (NCR) and San Antonio areas are slated to become joint markets. Consolidation of clinics in areas where two existing facilities are in close proximity must be carefully studied to ensure the closure of one clinic does not overwhelm the capacity of the remaining clinic. Basis of Allocation varies among the services, and until agreement on a single number is reached, true joint efforts will be impossible to plan. Consolidating shared support services will likely provide the most beneficial near term savings and improvements in efficiency, and will now be reviewed.

Dentistry requires the use of a dental laboratory to fabricate many different prostheses. Some clinics maintain a small laboratory to support the specialists practice, but most rely on a

central laboratory. The Army, Air Force, and Navy all maintain Area Dental Laboratories to support their providers. While some sharing of resources exists due to the capabilities of each lab, the case loads performed are predominately service specific. The dental labs have a dual mission of supporting the referring dentists and training military dental technicians. The Joint Dental Labs should fall under a Joint Dental Command, but be linked to the Joint Dental Education and Training curriculum for sustainment training of military dental laboratory technicians. The support provided by each laboratory should not be tied to any one service, and funding should be based on the dentists being supported in the catchment area, regardless of service.

Support and Logistics, especially as it relates to the TOE environment, is an area overdue for joint review. Requisitioning dental supplies is difficult for deployed medical logistics units initially due to the fact that they do not provide this service in peacetime. The TOE dental Unit Assembly Listings (UAL) includes a tremendous amount of dental specific items not ordered in large quantities, and delays in procuring essential equipment can have serious effects on mission accomplishment. Standardizing supply lists among Army dentists increased the efficiency of ordering dental supplies during Operation Iraqi Freedom 04-06, but joint efforts warrant further review. Building uniform sets, kits, and outfits for dental providers would appear to be a method to reduce costs, but the Tactics, Techniques, and Procedures (TTPs) used to support each services warfighters mandate different equipment and acquisition practices. Current field dental equipment was not designed for prolonged deployments, and a joint dental research and development command would be ideally suited to identify equipment suitable for tri-service use in all phases of operations. Differences in IM/IT capabilities and the lack of standardization of medical forms also pose multiple problems.

The Army Dental Command (DENCOM) led development of the Corporate Dental Application (CDA) which tracks patient workload, schedules patients, maintains a database of patient radiographs (X-rays), and is evolving into an early electronic record for deployed Soldiers. The Navy and Air Force use completely separate systems. Due to the large number of widely dispersed Forward Operating Bases (FOBs) still present in the Iraqi Theater of Operations, each FOB does not have an organic dentist. Dentists are distributed using Basis of Allocation (BOA) values determined by dated research. New studies need to be conducted reviewing the number of deployed dentists, the frequency of dental emergencies per supported troops, the condition Soldiers deploy in, and the condition they redeploy in at a minimum. Current data is needed to establish accurate staffing requirements for both TDA and TOE clinics. Efforts have been made to standardize the IM/IT capabilities of each service, and

AHLTA is anticipated to bring the services together. A joint command would certainly streamline the process of development, and would hopefully provide the funding needed to move the program forward.

Recruiting is another area that should be considered a shared support service in the evolution to a Unified Medical Command. Army Dental Corps recruiting missions have not been met for over 20 years,⁴² with 2006 being miserably short of the goal. Fiscal Year 2006 ended with only 87 dental officers being accessed, despite a goal of 145. All three services use the Armed Forces Health Professional Scholarship Program (HPSP) as their main recruiting tool, and for the last two years the Army has not been able to find enough qualified applicants to fill all the available scholarships. With 115 scholarships available, only 80 went filled in FY06, and only 83 of the 93 went filled in FY05. Many factors can be cited for this, but the risk of deployment has been heard most often.⁴³ This factor may not be able to be changed, but recruiting efforts need to be enhanced to reverse the trend, and joint initiatives may assist the military mission as a whole. The Navy has also faced difficulty recruiting; however the Air Force has not fared as poorly.⁴⁴ The current system has each service in competition for the same students interested in military service. A joint process for recruiting and processing applicants warrants consideration and study. One possibility exists for students to utilize a standard application for military service, prioritizing their service choices. If one service meets their goal, then the students not selected would have the opportunity for entry into one of the services that didn't.⁴⁵ This would not be possible without joint oversight and direction, but success is critical to ensure the military force structure is maintained.

Army, Navy, and Air Force dentists are dual professionals serving not only as dentists, but also as military officers. A foundation for maintaining uniformed dentists rests with the understanding that military dentistry is a profession within itself. Don Snider uses Abbotts System of Professions to frame his works on the Army as a profession, and states "an occupation's identification as a profession and its standing within society are outcomes of social competition within a system of professions for control over expert knowledge as applied to particular situations."⁴⁶ Is there expert knowledge held by a military dentist that is applied to provision of dental care both in peacetime and at war? The answer is unequivocally yes, and at the tactical level each service must maintain their ability to support the fight.

A common misconception of a Joint Medical Command is that the three services will combine to form a "purple suit" military health care system. As long as we still have an Army, Navy, and Air Force, we need dentists to be trained for their service specific missions and in their parent service's culture. While the dentists' understanding of the mission and subsequent

acceptance by those he serves is an immeasurable yet important factor, the training necessary to integrate into each service's fighting force is not. A dentist entering a combat zone or deploying in stability operations cannot be expected to read an article and understand the internal jurisdictions which must be developed over time while working and training within their service. It is the expert knowledge that makes the dentist a military professional with military-technical understanding.⁴⁷ A framework may now be proposed to design the dental role in a Unified Medical Command that ensures each service continues to provide world-class dental care in the TOE and TDA environments.

When thinking about the formation of a Unified Medical Command, several guiding principles with which to approach defense reformation were proposed by Murdock and Weitz.⁴⁸ Key principles that apply to the formation of a UMC are: 1. Civilian control over the military must be preserved, 2. Institutional vitality of the military services must be maintained, 3. Extending jointness in some areas will produce superior operations, and 4. Defense resources should continue to be organized, managed, and budgeted along service lines.⁴⁹ These principles warrant careful consideration as applied to Military Health Service (MHS) reform.

Civilian control is preserved in all models by the retention of the Assistant Secretary of Defense (Health Affairs) (ASD(HA)) who is the leader of the Military Health System (MHS). He is responsible for overall supervision of the health and medical affairs of the Department of Defense (DOD), and serves as the principal adviser to the Secretary of Defense for all DOD health policies, programs, and activities, and exercises oversight of all DOD health resources. The mission of the MHS is "to ensure the nation has available at all times a healthy fighting force supported by a combat ready healthcare system; and it is to provide a cost effective, quality health benefit to active duty members, retirees, survivors, and their families. The MHS provides medical care for 9.2 million beneficiaries through a \$39 billion dollar healthcare system consisting of a worldwide network of 70 military hospitals, over 500 military health clinics, and the Department's extensive private sector health care partners,"⁵⁰ in addition to operating the Uniformed Services University. With the preservation of civilian control, it is next important to ensure the institutional vitality of each of the services is maintained. Two of the functional commands provide insight into how this can be accomplished.

USSOCOM, one of the nine Combatant Commands, is often mentioned as the model for a Unified Medical Command. The Unified commands are made up of 5 Geographic Commands (GCC): NORTHCOM, CENTCOM, EUCOM, PACOM, and SOUTHCOM, and 4 Functional Commands: SOCOM, JFCOM, STRATCOM, and TRANSCOM. The addition of MEDCOM as an additional functional command has been proposed, along with joint Component Commands

under each GCC. A Joint Medical Component Command (JMCC) could provide the Geographic Combatant Commander a single source for all aspects of medical support to the region, and allow centralized coordination, development, and enforcement of policies.⁵¹ The JMCC would be able to form task forces for major operations in as many Theaters of Operation as necessary in a Theater of War. A dentist should be assigned to each JMCC in order to oversee operations. All dental forces in each GCC unless service unique or theater-assigned would be under the operational command (OPCON) of the JMCC; however, funding would still flow from each service. This model is currently working with the Air Force dental structure. Air Force dental assets belong to the supported Wing, however, funds still flow through TMA to execute the medical missions.

The establishment of the Transportation Command (TRANSCOM) in 1987 provides useful corollaries to the establishment of a UMC. Formed to coordinate and ensure adequate wartime transportation support, three service commands were placed under the combatant command (COCOM) of TRANSCOM: the Army's Military Traffic Management Command, the Air Force's Military Airlift Command, and the Navy's Military Sealift command. The operational control (OPCON) of each organization was redelegated to each component commander.⁵² The sphere of logistical influence in each theater of operations is maintained by the Deployment and Distribution Operations Center (DDOC) who works for the Theater Support Commander (TSC). Much like the DDOC, the JMCC would ensure each service medical component is utilized in a manner that is most effective and efficient. Aligning the JMCC's with GCC regions may require realignment of current Tricare and medical regions, but would ensure unity of effort and facilitate coordinating resources.

The Army and Navy were the principle advocates for the new command, and just as the UMC faced stiff opposition throughout the years, many studies were conducted and ignored prior to the President directing the TRANSCOM formation in 1987. The new command's roles were contingency planning, systems automation and enhancement, and support of exercises. The routine support operations of the military continued to be individual service responsibilities, and a phased approach to the commands growth was undertaken.⁵³ TRANSCOM's authority was initially limited to wartime, but eventually grew to include peacetime as well.

The inclusion of a dentist in each JMCC would ensure efficiencies are achieved and dental assets are properly utilized and resourced. Institutional vitality of each service must be maintained in a UMC in order to train and equip forces for deployment in support of each service and maintain clinics geographically to support each service's forces. Level II unit assigned care would remain organic to each service, along with clinics regionally positioned in

support of each service. Each service uses slightly different basis of allocation numbers which are a function of the way in which they prepare and deploy forces. Level III care could be explored by the JMCC dental officer, and where efficiencies could be achieved, recommendations for consolidation could be made. The flow of funding would remain service specific, but would be allocated based upon the forces supported by each clinic. Joint doctrine now calls for a joint surgeon's staff section for each GCC and for a Joint Task Force (JTF) Surgeons office to be established as needed when JTF headquarters are stood up.

The inclusion of a dentist in a JTF would greatly enhance the planning and execution of deployed dental health care, and would result in the superior operations that Murdock and Weitz reported could come from expanding jointness in some areas. The current Joint doctrine falls short of this goal, and the effects were seen by the author in Operation Iraqi Freedom 04-06 while serving as the Task Force 44th MEDCOM Theater Dental Surgeon.

The current joint doctrine has the combatant commanders responsible for the HSS and FHP for the forces assigned or attached to their commands, and the joint force surgeon (JFS) is a member of the commander's personal staff.⁵⁴ Joint Pub 4-02 was recently updated in October of 2006 and covers Health Service Support (HSS) in the joint environment. Dental service as one of the functional categories of HSS is recognized as playing "a significant role in FHP for the joint force. Dental services must be included in the early stages of planning."⁵⁵ As stated in JP 4-02, the "appointed joint force surgeon (JFS) for each combatant command, subunified command, and joint task force (JTF) is a member of the joint force commander's (JFC's) personal staff, and reports directly to the JFC."⁵⁶

The JTF Surgeons cell as described in JP 4-02 is void of a dental officer on the staff, which limits the effective coordination and utilization of dental assets. Operation Iraqi Freedom 04-06 provided the author first hand experience in this matter, as there was not a dentist overseeing CENTCOM dental assets deployed to both Afghanistan and Iraq. The distribution of dental assets in Afghanistan was inappropriate for the workload being seen, and solutions for better allocating resources were difficult to affect. Dental services must be added as a functional area in the organization of the Joint Task Force Surgeon's Office and included as a Functional Area as shown in Figure II-2 of JP 4-02.⁵⁷

A dental officer should be included in the JTF Surgeons cell and carry out the following functions:

1. Prepare the concept of dental operations to the FHP portion of Annex Q to JTF OPLANs/OPORDS.

2. Provide the JTFS with recommendations on dental operations to include policies, force structure, and priorities for use of dental resources.
3. Plan, monitor, and supervise dental operations, to include level II and III care being provided in theater, and provide the JTFS with advice and procedural recommendations for the evacuation of patients with needs which can't be met in theater.
4. Maintain liaison with dentists of higher headquarters, those of US, multinational, and foreign government agencies, the JTF J-4 medical liaison, and the JTF J-4 contracting officer.
5. Provide the JTFS with recommendations on policies and capabilities regarding dental humanitarian assistance missions.
6. Ensure workload and Dental Population Health Metrics (DPHM) are being properly captured and ensure appropriate Information Technology/Information Management (IM/IT) support is available.
7. Provide health risk assessment information to redeploying units and their health care providers.
8. Assist the JTF Force Health Protection officer with establishing procedures for reporting Disease and Non-Battle Injury (DNBI) and incorporating DPHM in reports.
9. Assist JTF J-4 with conducting HN/allied liaison to assess dental capabilities availability and assist in nation building as necessary.
10. Assist JTFS and JTF J-4 with types of dental supplies needed, supply procedures to be followed, stock levels to be maintained, and medical maintenance procedures.
11. Ensure standardization of dental supplies being ordered and monitor requests for non-standard equipment/supplies.
12. Coordinate with JTF J-4 medical liaison for dental material from foreign sources and support provided by HN and coalition partners as required.
13. Maintain thorough knowledge and understanding of JTF OPLANs, OPORDs, and component and supporting forces concepts of operations/support.
14. Monitor the status and location of dental assets as they move into, within, and out of the Joint Operational Area.
15. Conduct staff visits and inspections of JTF component dental facilities.
16. Serve as a member of the Joint Medical Operations Center (JMOC).

The dental officer must understand the concepts of deployed dental support for each of the services and be able to ensure seamless care is offered to all beneficiaries. On today's

battlefield, the dentist will see patients of all services and through proper utilization of available technology, continuity of care will be maintained. As the length of deployments remains at 12 months for Army Soldiers, and increases for Marines, Airmen, and Sailors, prevention must be given new emphasis in theater. Maintaining good DPHM will be critical to studying the effectiveness of pre-deployment, deployment, and post-deployment dental health and formulating strategies to maintain caries risk at acceptable levels. Ensuring a dentist is on the joint surgeon's staff and in command of dental assets in the peacetime dental health system will allow the dental product line to continue providing the care necessary to support the joint war fighting effort.

The Joint/Unified Medical Command proposed by Winkenwerder maintained care along service lines with the Army Regional Medical Commands reporting to each service Surgeon General. In this scenario, each service should retain their Dental Corps Chief, along with the DENCOM and regional dental commands. To subordinate the RDCs under RMC's would be a mistake supported by historical examples, although studies into sharing support services may improve efficiencies between medical and dental commands, and between services. In order for effective unity of effort to be achieved, one dental officer must be the final authority for approving and instituting joint initiatives. The officer must be higher in rank than each service corps chief and have joint experience. Very few dental officers have joint experience now, and this must begin to change. Assigning several officers from each corps in the sister services will begin to foster a joint understanding. Training, operational research, and clinical assignments need to be shared in order to develop officers with a thorough knowledge of each services capabilities. To effectively function as a JMCC or JTF dental officer, these experiences will be critical.

The lessons learned by reviewing the evolution of the Dental Corps must be applied when considering how the service Dental Corp's fit into an UMC. Outcomes from the earlier works of MG Bhaskar, Dr. Salcetti, and then COL Sculley must be followed in planning a joint dental organization within a UMC and include: 1. Dental TDA commanders must be held responsible to the garrison commanders for the care delivered, 2. Enlisted personnel working with the dental care system should belong to the dental command, 3. Dental clinics should be commanded by dental officers with funds coming from TMA through a higher Dental Command, and 4. There needs to be a Dental Corps Chief to whom all matters relating to dentistry are brought.

The risk of increasing the size of the bureaucracy is great with the formation of any new organization, and we must ensure service parochialism does not enter into the doctrine eventually developed. While chipping away at the periphery of a Unified Medical Command was

not envisioned as the path to take, it may very well lead to a better design. Lessons learned by the establishment of joint medical markets in the National Capital Areas and in San Antonio will serve as beacons into future concepts to be incorporated into a UMC. Joint opportunities in TDA patient care, training, research, and operational assignments must be given to our junior officers now to ensure the joint culture is instilled in our future leaders.

With the rejection of Winkenwerder's most recent proposal the future of the UMC is unknown; however, many lessons learned have been gained from the study of possible structures. Whether or not a Unified Medical Command, Defense Health Agency, or some other yet undefined organization is designed to increase the efficiency and effectiveness of Military health care delivery, several joint initiatives will be undertaken and serve as a study in service interoperability.

In the evolution of a joint command, one fact is certain: unless the funding stems from a single source, an entity such as a joint dental research and development office will not be truly joint. Tremendous efficiencies can be gained by focusing on the target areas discussed to improve service, enhance efficiency, and support mission effectiveness. While some efficiency can be gained through tri-service collaboration and cooperation, more will come with the assignment of a Unified Medical Commander, and subsequent Dental Commander who can ensure the proper funding is routed to each service and each joint activity. Once this happens, it may be possible for medicine to enjoy the "synergistic application of the unique capabilities of each service so that the net result is a capability that is greater than the sum of the parts."⁵⁸

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