

The Dilemma Over Medical Command and Control

**A Monograph
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AY 2008

REPORT DOCUMENTATION PAGE			<i>Form Approved</i> <i>OMB No. 0704-0188</i>		
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1. REPORT DATE (DD-MM-YYYY) 13-06-2008		2. REPORT TYPE Master's Thesis		3. DATES COVERED (From - To) AUG 2007 – JUN 2008	
4. TITLE AND SUBTITLE The Dilema Over Medical Command and Control			5a. CONTRACT NUMBER		
			5b. GRANT NUMBER		
			5c. PROGRAM ELEMENT NUMBER		
6. AUTHOR(S) Major Jason R. Sepanic, United States Army			5d. PROJECT NUMBER		
			5e. TASK NUMBER		
			5f. WORK UNIT NUMBER		
7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES) U.S. Army Command and General Staff College ATTN: ATZL-SWD-GD Fort Leavenworth, KS 66027-2301			8. PERFORMING ORG REPORT NUMBER		
9. SPONSORING / MONITORING AGENCY NAME(S) AND ADDRESS(ES)			10. SPONSOR/MONITOR'S ACRONYM(S)		
			11. SPONSOR/MONITOR'S REPORT NUMBER(S)		
12. DISTRIBUTION / AVAILABILITY STATEMENT Approved for Public Release; Distribution is Unlimited					
13. SUPPLEMENTARY NOTES					
14. ABSTRACT The command surgeon presents a dilemma to the line and staff model in that the command surgeon actually performs line and staff functions. An attempt to solve this dilemma is playing out in Army Transformation as the Army and the Army Medical Department (AMEDD) leadership struggle with how to flatten medical command and control structures. The AMEDD maintains that it needs four regionally focused medical commands, in the form of a Medical Command (Deployment Support) [MEDCOM(DS)], at the Army Service Component Command (ASCC) level. At this same level, each regionally focused ASCC commander has a command surgeon with a staff section that appears to serve the same function as the medical command. The question that needs to be answered is, is there a difference between the ASCC Command Surgeon's Division and the MEDCOM(DS)?					
15. SUBJECT TERMS Command Surgeon, Medical Command and Control, Medical Command (Deployment Support), Army Service Component Command					
16. SECURITY CLASSIFICATION OF:			17. LIMITATION OF ABSTRACT	18. NUMBER OF PAGES	19a. NAME OF RESPONSIBLE PERSON
a. REPORT	b. ABSTRACT	c. THIS PAGE			19b. PHONE NUMBER (include area code)
(U)	(U)	(U)	(U)	55	

Standard Form 298 (Rev. 8-98)
Prescribed by ANSI Std. Z39.18

SCHOOL OF ADVANCED MILITARY STUDIES

MONOGRAPH APPROVAL

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Abstract

The Dilemma Over Medical Command and Control, by MAJ Jason R. Sepanic, US Army, 55 pages.

If asked what the command surgeon does, most Army officers would respond, “Advises the commander on the health of the command.” When asked what a medical unit commander does, the response will be, “Directs the execution of healthcare.” These answers typify the line and staff organizational model, where the “line” is directly involved in the execution of a task and the “staff” advises and assists the line. However, the command surgeon presents a dilemma to this model in that the command surgeon actually performs line and staff functions. An attempt to solve this dilemma is playing out in Army Transformation as the Army and the Army Medical Department (AMEDD) leadership struggle with how to flatten medical command and control structures. The AMEDD maintains that it needs four regionally focused medical commands, in the form of a Medical Command (Deployment Support) [MEDCOM(DS)], at the Army Service Component Command (ASCC) level. At this same level, each regionally focused ASCC commander has a command surgeon with a staff section that appears to serve the same function as the medical command. The question that needs to be answered is, is there a difference between the ASCC Command Surgeon’s Division and the MEDCOM(DS)?

Applying the line and staff model to the command surgeon shows what makes this staff position “special” and grants the command surgeon an informal authority that is just short of “command” authority. A review of medical doctrine shows that the misunderstanding of the command surgeon’s informal authority has led to the creation of a theater level medical headquarters that mirrors the ASCC Command Surgeon’s Division. However, the “command” authority of this medical headquarters comes into conflict with the ASCC command surgeon’s responsibility to provide technical supervision over medical assets and the informal authority given to him by the ASCC commander. As seen in the evolution of medical command and control during Vietnam, having two different organizations with similar responsibilities and authorities confuses lines of command and control.

Understanding of the differences between personal staff and line command functions exposes the problem associated with the assignment of authority to the ASCC Command Surgeon’s Division and the MEDCOM(DS). Knowing that this problem exists and understanding the effect the problem of authority had on medical command and control structure in Vietnam reveals two things. First, as they are currently employed, the MEDCOM(DS) is a redundant organization of the ASCC Command Surgeon’s Division. Second, because the Command Surgeon’s Division uses authority of the ASCC commander to direct medical services, the MEDCOM(DS) is unnecessary.

TABLE OF CONTENTS

Introduction	1
The Command Surgeon: Line or Staff?.....	5
Medical Doctrine and Organization Review	10
Medical Doctrine	10
Organization of Medical Command and Control Structures	14
Evolution of Medical Command and Control in Vietnam.....	19
Theory versus the reality of the Current Operating Environment	35
Conclusion.....	41
APPENDIX A	45
Command Surgeon's Duties and Responsibilities.....	45
APPENDIX B.....	49
Comparison of MEDCOM(DS) and ASCC Surgeon Section Officer Authorizations and Requirements.....	49
BIBLIOGRAPHY	51
Articles and Books	51
Briefing.....	51
Military Manuals and Authorization Documents	51
Operational Reports and Memoranda.....	53

LIST OF ILLUSTRATIONS

Figure 1 - MEDCOM Headquarters and ASCC Command Surgeon's Division Leadership	14
Figure 2 - Comparison of Personnel Management Sections.	15
Figure 3 - Comparison of Theater Patient Movement Centers.....	16
Figure 4 - Comparison of Plans and Operations.....	17
Figure 5 - Comparison of Consultant requirements.	18
Figure 6 - Medical command and control in Vietnam, July 1966.	26
Figure 7 - USARV medical command and control structure, 10 August 1967.	30
Figure 8 - Individuals working on both USARV Surgeon's and 44th Medical Brigade's staffs. ..	31
Figure 9 - Possible medical command and control in the current operational environment.	39

Introduction

If asked what the command surgeon does, most Army officers would respond, “Advises the commander on the health of the command.” When asked what a medical unit commander does, the response will be, “Directs the execution of healthcare.” These answers typify the line and staff organizational model, where the “line” is directly involved in the execution of a task and the “staff” advises and assists the line.¹ The staff and line relationship however, is not so clear-cut, as there are often times when the staff must do line functions, and the line must do staff functions so the organization can succeed. Due to the nature of this relationship, a dilemma arises in determining the amount of authority the staff has in dictating the line’s actions. This dilemma is playing out in Army Transformation as the Army and the Army Medical Department (AMEDD) leadership struggle with how to flatten medical command and control structures. The AMEDD maintains that it needs four regionally focused medical commands at the Army Service Component Command (ASCC) level.² At this same level, each regionally focused ASCC commander has a command surgeon with a staff section that appears to serve the same function as the medical command. The question that needs to be answered is, is there a difference between the ASCC Command Surgeon’s Division and the Medical Command (Deployment Support) [MEDCOM(DS)]? Knowing if there is a difference between the ASCC Command Surgeon’s Division and the MEDCOM(DS) is important because this information will validate the need for both organizations and ensure that both organizations have clearly defined roles and responsibilities.

To find out if there is a difference between the ASCC Command Surgeon’s Division and the MEDCOM(DS), it is important to understand the difference between personal staff and line

¹ Robert McLaren, *Organizational Dilemmas* (London: John Wiley and Sons, 1982), 24.

² Headquarters, Department of the Army, *The Modular Force, FMI 3-0.1* (Washington, DC: U.S. Government Printing Office, January 2008), 3-17.

command. As a special staff officer, the command surgeon has a unique relationship with the commander. This relationship is unique in that the Surgeon is often the commander's personal physician and has staff responsibility for advising the commander on the health of the entire command. Due to the unique nature of Health Service Support (HSS) and Force Health Protection (FHP), the command surgeon serves as a functional "directed telescope"³ for the commander. Having the command surgeon as a functional directed telescope frees the commander from having to learn and manage the intricacies of HSS and FHP, allowing him to spend more time on other warfighting functions.

The command surgeon's roles and responsibilities change however, at the various levels of command on the battlefield. At the battalion level, the command surgeon spends the majority of his time practicing medicine and maintaining the health of the command. Through his day-to-day activities of providing healthcare to the unit's soldiers, the battalion surgeon is able to step into the staff realm as needed to advise the battalion commander on the health of the command. Transitioning to higher levels of command, the command surgeon spends less time providing healthcare and more time doing the staff functions necessary to advise the commander. As the scope of the command expands, the command surgeon uses an appropriately sized staff to assist him in his advisory and planning responsibilities. At the ASCC level, the relationship between line and staff functions of the command surgeon is inversely proportional to that at the battalion level. However, the line and staff functions of the command surgeon blurs at the senior levels when the command surgeon serves simultaneously as a medical unit commander. This is particularly true when the ASCC command surgeon serves as the commander of the MEDCOM(DS). Because the articulation of the differences between line functions and staff

³ As defined by FM 6-0, a directed telescope is "a dedicated information collector—a trusted and like minded subordinate—to observe selected events or units and report directly to the commander."

functions are not clear at the senior levels of medical command and control architecture, medical doctrine and structure have developed duplicate organizations.

The Army's "keystone doctrine" for HSS and FHS, FM 4-02 (8-10), *Force Health Protection in a Global Environment*, states specifically that the command surgeon is "charged with planning for and monitoring the execution of the HSS mission."⁴ A list of thirty-seven duties and responsibilities for the command surgeon establishes the command surgeon's role as a staff officer. Thus, at the theater level, the ASCC command surgeon has the role and responsibility for monitoring the health of the command and through the ASCC commander can affect all Army units on the battlefield. Although much of the field manual dwells on the staff functions of the command surgeon, the manual does not clarify the line functions of a medical unit commander. In search of clarity, one must turn to FM 4-02.12, *Health Service Support in Corps and Echelons Above Corps*. FM 4-02.12 reiterates the command surgeon's roles and responsibilities and recognizes the possibility that the command surgeon may also be assigned as the medical unit commander. Although the ASCC command surgeon has a robust staff, the manual does not describe it. Rather, the field manual uses the command surgeon's staff functions to describe the line functions of the MEDCOM(DS). It is unknown whether the mixing of the command surgeon's staff functions and the MEDCOM(DS) commander's line functions reflects an assumption that one officer is assigned to both positions. However, using staff functions to describe line functions causes confusion, as experienced during the Vietnam War.

Medical command and staff functions were confused during the Vietnam War because the clear delineation of US Army Vietnam (USARV) command surgeon's staff functions and the line functions of the 44th Medical Brigade commander were missing. Having one individual serve as both the command surgeon and medical commander with two distinct staffs exacerbated

⁴ Headquarters, Department of the Army, *Force Health Protection in a Global Environment, FM 4-02 (FM 8-10)*. (Washington, DC: U.S. Government Printing Office, 2003), 3-3.

confusion between commands, resulting in poor staff coordination. As the medical command and control structure evolved in Vietnam, the USARV command surgeon, who also served as the 44th Medical Brigade commander, realized that the Medical Brigade and the USARV Command Surgeon's Office were redundant. That realization led to the 44th Medical Brigade merging with the USARV Command Surgeon's Office to form the US Army Medical Command, Vietnam (MEDCOMV) on 1 March 1970.⁵ The formation of the MEDCOMV eliminated the line and staff tensions between the USARV Command Surgeon's Office and 44th Medical Brigade, thereby creating an efficient and responsive organization. The design of the new modularized AMEDD command and control structure appears to ignore the lessons behind the formation of the MEDCOMV.

Under modularization, the MEDCOM(DS) does not have any assigned subordinate units. Only when a medical unit fills a request for forces will the MEDCOM(DS) have a subordinate unit assigned. In all likelihood, these units will be attached to or under the operational control (OPCON) of a non-medical unit that is outside the MEDCOM(DS) Commander's ability to exercise control. As a headquarters element, the MEDCOM(DS) has the capability to provide all of the administrative functions necessary to support its subordinate units. However, to perform its medical functions the MEDCOM(DS) is staffed by an organization that is almost identical to that of the ASCC Command Surgeon's Division, creating a redundant structure. As noted earlier, both the ASCC Command Surgeon's Division and the MEDCOM(DS) have the same doctrinal duty to provide technical supervision over HSS and FHP assets. However, only the ASCC command surgeon, through the command authority of the ASCC commander, can truly supervise and exercise command and control of all HSS and FHP assets in theater as well as implement policies

⁵ Spurgeon Neel, *Vietnam Studies: Medical Support of the U.S. Army in Vietnam 1965-1970* (Washington, DC: United States Government Printing Office, 1973), 27-28.

that will affect all Army units in theater. This modular structure is similar to that of the medical command and control structure in Vietnam that led to the formation of the MEDCOMV.

By understanding the difference between personal staff and line command functions it is possible to see that these differences are not recognized by the doctrine when the doctrine describes the roles and responsibilities of the ASCC Command Surgeon's Division and the MEDCOM(DS). Describing these differences exposes the problem associated with the assignment of authority to the ASCC command surgeon on and the MEDCOM(DS) commander. Knowing that this problem exists and understanding the effect the problem of authority had on medical command and control structure in Vietnam reveals two things. First, as they are currently employed the MEDCOM(DS) is a redundant of the ASCC Command Surgeon's Division. Secondly, because the command surgeon uses authority of the ASCC commander to direct medical services, the MEDCOM(DS) is unnecessary.

The Command Surgeon: Line or Staff?

Within organizational design theory, the two terms used to describe functional components of an organization as well as delineate who has authority within an organization are "line" and "staff". The term "line" describes those individuals that are directly involved in the execution of a task or the output of an organization.⁶ Within a hierarchical organization, those line individuals that are not at the base of the organization typically possess the authority to make decisions that affect the organization's output. Within the military, the line consists of soldiers serving as the base level of a hierarchical organization with a commander serving at the apex of the organization. Soldiers complete tasks and provide some sort of output but have no decision-making authority. Whereas commanders direct the employment of soldiers and have "command"

⁶ Writings by Henri Fayol, Lyndall Urwick, and Fredrick Taylor, among others have led to the line and staff model. The definitions for line and staff here are influenced by Robert McLaren, *Organizational Dilemmas* (London: John Wiley and Sons, 1982), 24; and Henry Mintzberg, *Structure in Fives: Designing Effective Organizations* (Englewood Cliffs: Prentice-Hall, Inc., 1983), 9-19.

authority to make decisions that affect the organization to include distributing rewards and punishment. “Staff” describes those who advise or assist the line in making decisions and who standardize processes within the organization.⁷ As advisors, the staff does not have the authority to make decisions. Appropriately, the military uses the word “staff” to describe those that assist the commander in making decisions. Thus, the labeling of the command surgeon as a “staff” officer gives the impression that the command surgeon only advises the commander. However, the command surgeon’s specialization in medicine makes him a “special” staff officer, more than just an advisor.

As useful as the terms “line” and “staff” are in differentiating two components of an organization, the terms are limited. The limitation occurs because one person can perform both line and staff functions. The command surgeon exemplifies the limitations of the line and staff definitions. When viewing line and staff as functions rather than positions, the command surgeon performs both line and staff functions. Within the realm of the line, the command surgeon provides direct healthcare to soldiers within the organization. As a licensed physician, the command surgeon has the authority to dictate the treatment a soldier receives. Within the realm of staff functions, the command surgeon advises the commander on the health of the organization, recommends measures to maintain or improve the health of the organization, and establishes healthcare standards. Because the command surgeon is acting in the staff realm, only the commander has the authority to decide whether to implement the recommended measures.

The level of command in which the command surgeon works dictates how much time he spends in each function. At the battalion level, the command surgeon’s primary responsibility is that of a physician and not as a special staff officer.⁸ Therefore, the battalion surgeon’s day-to-day activities consist primarily of providing soldiers’ healthcare and training the unit’s medics.

⁷ Ibid.

⁸ The battalion level is the lowest of command authorized a command surgeon.

The battalion surgeon's day-to-day activities allow him to collect and analyze data about the health of the command. Using this information, the battalion surgeon is able to step into his staff role and advise the battalion commander on the health of the command. At each higher level of command, the command surgeon's activities progressively shift from providing primarily healthcare to almost entirely providing advice to the commander. At the Army Service Component Command (ASCC) level, staff actions dominate the ASCC command surgeon's day-to-day activities. To perform these staff activities the command surgeon has a small staff of his own to assist him. As the scope of command and breadth of the HSS and FHP systems increase, so does the size of the command surgeon's staff. The command surgeon's staff gives him a greater ability to shift between line and staff functions. The ability to shift from line to staff functions and the amount of time spent doing each function is not the only unique characteristic of a Command Surgeon within the line and staff model.

Although, by definition, the staff only advises and does not have the authority to make decisions, this is not entirely the case with the command surgeon. Organizational design literature recognizes the tension over decision-making authority within the line and staff relationship. The tension concerns the need to allow specialized staffs to make decisions without the line relinquishing authority, sometimes called horizontal decentralization.⁹ One way to solve this dilemma in a hierarchical military organization is through informal authority. The command surgeon gains informal authority by being a "directed telescope".

In the Army, there are responsibilities that come with the decision-making authority of command. Two of the responsibilities are maintaining the health and welfare of assigned

⁹ Robert I. McLaren, *Organizational Dilemmas* (London: John Wiley and Sons, 1982), 25; and Henry Mintzberg, *Structure in Fives: Designing Effective Organizations* (Englewood Cliffs: Prentice-Hall, Inc., 1983), 105-114.

personnel.¹⁰ Every commander is charged with maintaining the health and welfare of assigned personnel through the functions of Health Service Support (HSS) and Force Health Protection (FHP).¹¹ However, because HSS and FHP are specialized functions, the ASCC commander does not have the time to learn all the facets necessary to manage the two functions at the theater level. Therefore, the commander must rely on a “directed telescope” or trusted subordinate dedicated to collecting HSS and FHP data to inform his decision-making.¹² In this case, the command surgeon serves as the ASCC commander’s directed telescope for the functions of HSS and FHP. By placing this trust in the command surgeon, the commander relinquishes some of his control over the decision-making process.

Decision-making related to HSS and FHP has become decentralized¹³ because the ASCC commander, lacking the technical medical knowledge, must choose between the options presented to him by the command surgeon. He only retains the authority to make the choice. By controlling the information gathering on HSS and FHP functions, the command surgeon assumes informal power. The strength of this informal power increases with the command surgeon’s ability to understand the data and make recommendations. Therefore, due to the command surgeon’s specialized knowledge and the technical nature of the decisions made in reference to HSS and FHP, the command surgeon controls the entire decision-making process. Although he retains the final decision-making authority, the ASCC commander must trust the ASCC

¹⁰ Department of Defense, *Doctrine for the Armed Forces of the United States, JP 1* (Washington, D.C.: Government Printing Office, 2 May 2007, Incorporating Change 1, 20 March 2009), GL-5.

¹¹ FM 3-0, dated 27 February 2008, states that Health Service Support is a sub-function of the war fighting function of Sustainment and “consists of all support and services performed, provided, and arranged by the Army Medical Department. It promotes, improves, conserves, or restores the mental and physical well-being of Soldiers.” Force Health Protection is a sub-function of Protection and “includes all measures to promote, improve, or conserve the mental and physical well-being of Soldiers.”

¹² Headquarters, Department of the Army, *Mission Command: Command and Control of Army Forces, FM 6-0* (Washington, DC: U.S. Government Printing Office, August, 2003), 3-23.

¹³ Henry Mintzberg, *Structure in Fives: Designing Effective Organizations* (Englewood Cliffs: Prentice-Hall, Inc., 1983), 101-109. When a decision maker only retains the authority to make the choice the decision making process is the most decentralized.

command surgeon to provide only recommendations that will maintain the health of the command.

The command surgeon's ability to manipulate the decision-making process leads to another problem with the line and staff model that involves the term "manager". Within organizational design theory, managers operate within the line realm. According to the "classical school" of management, managers plan, organize, staff, direct, coordinate, report, and budget.¹⁴ As the next section will show, medical doctrine directs the ASCC command surgeon to manage HSS and FHP to assist the ASCC commander in maintaining the health of the command. Although he acts as a staff officer, the command surgeon's management responsibilities increases the informal authority that the command surgeon possesses.

Overall, the command surgeon does not neatly fit into the line and staff model. Although the label of special staff elicits connotations of only being an advisor to the ASCC commander, the ASCC command surgeon is much more. The ASCC command surgeon's specialization in HSS and FHP and the responsibility to manage those two functions gives him a great amount of informal authority within his organization. In the military hierarchy, the commander always retains decision-making authority, but the significant amount of informal authority that the command surgeon wields allows him to manipulate the choices made by the commander. The command surgeon's ability to manipulate the choices of the commander, leads to the need to understand the differences in roles and responsibilities of the command surgeon and a medical unit commander when managing HSS and FHP.

¹⁴ Henry Mintzberg, *The Nature of Managerial Work* (New York, N.Y., Harper & Row Publishers, 1973), 9.

Medical Doctrine and Organization Review

Medical Doctrine

Three references describe the elements of medical command and control at the theater level.

Army Regulation (AR) 40-1, *Composition, Mission, and Function of the Army Medical Department*, and Field Manual (FM) 4-02 (8-10), *Force Health Protection in a Global Environment*, establish the position and roles of the Command Surgeon. FM 4-02.12, *Health Service Support in Corps and Echelons Above Corps*, provides defines the roles and responsibilities of the Command Surgeon at the Army Service Component Command (ASCC) level and provides details on medical headquarters that are not provided in FM 4-02. All levels of command from battalion to army have a command surgeon authorized. According to AR 40-1, the Command Surgeon is the senior Medical Corps officer in the headquarters and exercises “complete technical control within a command over medical units in the maintenance of health, and in the care of the sick and wounded.” As the “keystone” to all Army medical doctrine, FM 4-02 expounds on AR 40-1 and establishes the doctrinal role of the Command Surgeon by stating that the command surgeon is “a special staff officer charged with planning for and monitoring the execution of the HSS mission.”¹⁵ The term Health Service Support (HSS) has gone through an evolution since FM 4-02’s publication. All medical functions once fell under the umbrella of HSS but now medical functions fall under HSS and the inter-related function Force Health Protection (FHP).¹⁶ Because of this recent change, not all doctrinal manuals have been updated to note that the Command Surgeon is now responsible for the planning and monitoring the execution of the HSS and FHP missions.

¹⁵ Headquarters, Department of the Army, *Force Health Protection in a Global Environment, FM 4-02 (FM 8-10)*. (Washington, DC: U.S. Government Printing Office, 2003), vi.

¹⁶ Headquarters, Department of the Army, *Operations, FM 3-0* (Washington, DC: U.S. Government Printing Office, 2008), 4-5 – 4-8.

In addition to the establishing the doctrinal role of planning and monitoring the execution of the HSS and FHP missions, FM 4-02 assigns thirty-seven duties and responsibilities to the command surgeon (Appendix A). The manual acknowledges that the list of duties is not complete. The list applies to command surgeons at all levels from the battalion surgeon to the ASCC command surgeon. Although this list, by using words such as “advising” and “recommending”, presents itself as a list of staff functions, it must be remembered that duties under the auspices of the managerial duties to plan and coordinate the execution of HSS and FHP missions. In describing the roles and responsibilities of the command surgeon, FM 4-02 states that the command surgeon “may be dual-hatted as a HSS unit commander.” However, there is no further description of what the line responsibilities are for a HSS unit commander. It is reasonable to expect there to be some explanation here differentiating between the Command Surgeon’s “complete technical control” of HSS and FHP assets and the medical unit commander’s control of HSS and FHP assets. To find a differentiation between the theater level medical commander and the ASCC command surgeon, it is necessary to examine FM 4-02.12.

Expanding on FM 4-02, FM 4-02.12 “establishes command, control, communications, computers, and intelligence (C4I) doctrine for the provision of health service support (HSS) in corps and echelons above corps (EAC)”. Additionally the manual is “designed for use by HSS commanders and their staffs involved in planning and execution of HSS operations in corps and EAC.”¹⁷ It is important to note that there is not a separate field manual for use by the corps or theater command surgeon and their staffs. In other words, at the corps and theater levels, medical doctrine combines line and staff functions into one manual. Whereas, at the division level and below, there are separate field manuals for providing guidance to division and brigade surgeons and their staffs as well as commanders of HSS units. Although there are some slight differences

¹⁷ Headquarters, Department of the Army, *Health Service Support in Corps and Echelons Above Corps, FM 4-02.12* (Washington, DC: U.S. Government Printing Office, 2004), vi.

between FM 4-02 and FM 4-02.12, the latter reiterates the general roles and responsibilities of the command surgeon. FM 4-02.12 goes further to give specific detail on the roles and responsibilities of the ASCC command surgeon and the Medical Command (MEDCOM) commander.¹⁸ FM 4-02.12 explicitly states that “Health service support for the Army component in a TO (theater of operations) is the responsibility of the ASCC. The command surgeon is on the commander’s special staff.” The manual goes on further to state that “**normally** (emphasis added), the medical command (MEDCOM) commander or the senior medical commander in the COMMZ (communications zone) functions as the ASCC command surgeon.” The manual then lists eight explicit responsibilities for the ASCC command surgeon, including “has staff responsibility for all HSS provided in theater.”¹⁹ Although included in the list of thirty-seven command surgeon responsibilities, these eight emphasize theater level planning, coordination, and development of theater-wide HSS policies, as well as assisting in the management of priority assignments for AMEDD personnel in the command.

Conversely, the MEDCOM commander is only responsible for ensuring “adequate HSS is provided throughout the COMMZ,” and providing command, control, communications, computers, and intelligence (C4I) for all attached and assigned units.²⁰ When the MEDCOM commander is the same individual as the ASCC command surgeon, and only then, do the MEDCOM commander’s responsibilities cover the entire battlefield. The doctrine is clear, only

¹⁸ To eliminate confusion, MEDCOM will be the term used throughout this section for the theater level medical command. The terminology for the organization at this level of medical command has changed several times since the publication of FM 4-02.12 in 2004. This published version of FM 4-02.12 refers to the senior Army medical organization in theater as an Echelons Above Corps Medical Command (EAC MEDCOM). The Initial Draft of the next version of FM 4-02, AMEDD briefing documents, and FMI 3-0.1, *The Modular Force*, refer to this level of command as a Medical Command (Deployment Support) [MEDCOM(DS)]. To create further confusion, this level of command was for a short time referred to as a Medical Deployment Support Command (MDSC). MDSC is the term utilized on current Modified Tables of Organization and Equipment (MTO&E) documents.

¹⁹ Headquarters, Department of the Army, *Force Health Protection in a Global Environment: Health Service Support in Corps and Echelons Above Corps, FM 4-02.12* (Washington, DC: U.S. Government Printing Office, 2004), 1-14.

²⁰ *Ibid*, 1-15.

the command surgeon's responsibilities cover the entire scope of the theater. When not serving as both the command surgeon and commander, the MEDCOM commander is only responsible for and can only affect HSS and FHP at the echelons above brigade. Assigning the ASCC command surgeon responsibility for the whole battlefield while limiting the MEDCOM Commander's responsibility for only a portion of the battlefield is consistent in medical doctrine as far back as the March 1951 version of FM 8-10, *Medical Service, Theater of Operations*.

The theater level medical command is described briefly outside the family of medical field manuals in FMI 3-0.1, *The Modular Force*. The FMI clearly states, "the theater surgeon provides policy and technical guidance to the medical command (deployment support) and all Army medical units in theater." However, three sentences later, the distinction between the roles and responsibilities of the ASCC Command Surgeon's Division and MEDCOM become confused. The statement, "The medical command (deployment support) develops plans, procedures, and programs for medical support in the theater army." This sentence is strikingly similar to FM 4-02.12's statement that the ASCC command surgeon "has staff responsibility for planning, coordinating, and developing policies for the HSS of Army Forces." Because this sentence is not precise, the phrase "in the theater army" can be understood to mean those forces at the theater level (in the COMMZ) or all Army forces in the theater army (ASCC). From the fact that the MEDCOM's roles and responsibilities in FMI 3-0.1 are ambiguous it can be inferred the doctrine does not recognize the control over HSS and FHP assets that the ASCC command surgeon derives from either the informal authority entrusted in him by the ASCC commander or the technical authority granted to him by Army Regulation. This lack of recognition leads to the MEDCOM being given redundant roles and responsibilities.

Returning to FM 4-02.12, the doctrine's failure to appreciate the command surgeon's informal and technical authority is more evident. The manual states that the command surgeon has a staff to assist him in his staff responsibilities, but there is no description of the organization or capabilities of the ASCC Command Surgeon's Division. The manual, however, does specify

the staff organization and capabilities of the MEDCOM staff. Hence, it is not possible to compare the organizations simply by comparing doctrine. To compare the ASCC Command Surgeon's Division with the MEDCOM(DS) staff it is necessary to refer to the authorization documents.

Organization of Medical Command and Control Structures

A review of the Modified Tables of Organization and Equipment for the ASCC Command Surgeon's Division shows that it requires thirty-eight personnel but is only authorized twenty-six.²¹ The key individual that is required, but not authorized, is the ASCC command surgeon! (Figure 1) This position is assigned the grade of brigadier general. By default, the deputy surgeon, in the grade of colonel, becomes the surgeon. The failure to authorize assignment of a brigadier general can be explained by noting frequent references in doctrine to the ASCC command surgeon and MEDCOM commander being the same individual. Since the MEDCOM is a separate, complete headquarters, there cannot be an equal one-to-one comparison with the ASCC Command Surgeon's Division. However, there are functions in both that can be compared, specifically those areas dealing with the management of medical personnel, patient movement and tracking, medical planning and operations, and clinical consultants.

MEDCOM						ASCC Command Surgeon's Office					
Title	Grade	AOC	Branch	REQ	AUTH	Title	Grade	AOC	Branch	REQ	AUTH
Commander	MG	00B	GO	1	0	Surgeon	BG	00B	GO	1	0
Deputy Commander	BG	00B	GO	1	1	Deputy Surgeon	O6	60A	MC	1	1
Chief of Staff	O6	67A	MS	1	1						

Figure 1 - Leadership comparison of MEDCOM Headquarters and ASCC Command Surgeon's Division²²

As their title suggests, the primary function of the Health Service Personnel Management Officers on the ASCC command surgeon's staff is to assist the command surgeon with his

²¹ Headquarters, Department of the Army, MTOE UIC (WJN2AA) - ARCENT, Edate 16 OCT 08." *FMSWeb*. <https://webtaads.belvoir.army.mil/> (accessed September 16, 2008).

²² Compiled from MTOEs UIC (WJN2AA) – Operational Command Post, HQ, Army, Edate 16 OCT 08; UIC (WATGAA) – Main Command Post, HQ, Army, Edate 16 OCT 08; and UIC (WNF5AA) – 0030 MD HHC MED DEPLOY, Edate 16 OCT 08. *FMSweb*: <https://webtaads.belvoir.army.mil/> (accessed September 16, 2008).

responsibility for monitoring the availability of and recommend “the assignment, reassignment, and utilization of AMEDD personnel within his AO.”²³ This is particularly important in the management of PROFIS (professional filler system) medical providers who may be rotating in and out of theater as often as every 90 days. The number of officers within a specific medical specialty in the Army, the critical need for that specialty in theater, and the service component, Active or Reserve, dictates the length of time a provider may be in theater. The Deputy Chief of Staff for Personnel of the MEDCOM has a larger staff to handle all additional personnel actions within the command. Although the MEDCOM has a larger staff, both the ASCC Command Surgeon’s Division and the MEDCOM G-1 have the same officer authorizations and requirements for the management of medical personnel. (Figure 2). The officers in the ASCC Command Surgeon’s Division are in a better position to manage all AMEDD personnel in theater because through the ASCC G-1, they can effect AMEDD personnel movements down into the Brigade Combat Teams. The MEDCOM G-1 can only effect the movement of AMEDD personnel in units assigned or attached to the MEDCOM. Because of the similarities in these two sections, there is potential for assignments and reassignments of medical personnel to be impeded by redundant organizations.

MEDCOM					
DCS, Personnel					
DCS Personnel	O6	70F	MS	1	1
Health Service Personnel Off	O5	70F	MS	1	1
Personnel Management Officer	O4	42H	AG	1	1
Personnel Staff Officer	O4	70F	MS	1	1

ASCC Command Surgeon's Office					
Medical Personnel Management					
Health Service Personnel Mgt	O5	70F	MS	1	1
Health Service Personnel Mgt	O4	70F	MS	1	1

Figure 2 - Comparison of Personnel Management Sections.²⁴

²³ Headquarters, Department of the Army, *Health Service Support in Corps and Echelons Above Corps, FM 4-02.12* (Washington, DC: U.S. Government Printing Office, 2004), 1-7.

²⁴ Compiled from MTOEs UIC (WJN2AA) – Operational Command Post, HQ, Army, Edate 16 OCT 08; UIC (WATGAA) – Main Command Post, HQ, Army, Edate 16 OCT 08; and UIC (WNF5AA) – 0030 MD HHC MED DEPLOY, Edate 16 OCT 08. FMSweb. <https://webtaads.belvoir.army.mil/> (accessed September 16, 2008).

In the category of patient movement and tracking, also called medical regulating, both the ASCC Command Surgeon’s and MEDCOM’s Theater Patient Movement Centers have identical staffing models (Figure 3). However, the Patient Administration Officers in the ASCC Command Surgeon’s Division are authorized personnel one grade higher than both positions in the MEDCOM. According to FM 4-02.12, the Medical Regulating Office in the MEDCOM is responsible for “medical regulating of all patients in theater, and preparation of patient statistical reports,” as well as, “providing advice and consultation on the maintenance and disposition of medical records.”²⁵ The ASCC command surgeon’s responsibilities are slightly different in terms of medical regulating. The ASCC command surgeon is only responsible for monitoring, rather than conducting medical regulating and patient tracking operations. However, when it comes to medical records, the ASCC command surgeon is responsible for “ensuring field medical records are maintained on each soldier at the primary care MTF (Medical Treatment Facility) in accordance with AR 40-66 and FM 4-02.4.”²⁶ There are slight differences between the MEDCOM’s and Surgeon’s responsibilities but because the staffing model is so similar, it appears redundant.

MEDCOM					
Theater Patient Movement Ctr	Grade	AOC	Branch	REQ	AUTH
Aeromedical Evac Officer	O4	67J	MS	1	1
Patient Admin Officer	O4	70E	MS	1	1
Patient Admin Officer	O3	70E	MS	1	1

ASCC Command Surgeon's Office					
Theater Patient Movement Ctr	Grade	AOC	Branch	REQ	AUTH
Patient Admin Officer	O5	70E	MS	1	1
Aeromed Evac Officer	O4	67J	MS	1	1
Patient Admin Officer	O4	70E	MS	1	1

Figure 3 - Comparison of Theater Patient Movement Centers.²⁷

In the category of medical plans and operations, both the MEDCOM’s and ASCC command surgeon’s Operations and Plans Sections are again almost identical in officer staffing

²⁵ Ibid., 2-8.

²⁶ Ibid, 1-8.

²⁷ Compiled from MTOEs UIC (WJN2AA) – Operational Command Post, HQ, Army, Edate 16 OCT 08; UIC (WATGAA) – Main Command Post, HQ, Army, Edate 16 OCT 08; and UIC (WNF5AA) – 0030 MD HHC MED DEPLOY, Edate 16 OCT 08. FMSweb: <https://webtaads.belvoir.army.mil/> (accessed September 16, 2008).

(Figure 4). In theory, the ASCC command surgeon’s Medical Planners are doing long range planning and monitoring medical operations across the entire theater. The MEDCOM Medical Plans and Operations Sections are planning and monitoring the day-to-day operations of the Echelon Above Brigade (EAB) medical units. The ASCC command surgeon has the responsibility to ensure that all medical “functional areas are considered and included in OPLANS and OPORDs” to support the ASCC commander.²⁸ Due to the similarity of these two sections and the overlapping scope of their planning responsibilities, there is potential for both organizations to plan in separate directions if there is not close coordination.

MEDCOM					
DCS, Security, Plans, Operations	Grade	AOC	Branch	REQ	AUTH
DCS, Security, Plans, Operations	O6	70H	MS	1	1
Curr Ops Branch					
Medical Operations Officer	O5	70H	MS	1	1
Medical Operations Officer	O4	70H	MS	2	1
Medical Operations Officer	O4	70H	MS	1	1
Plans Branch					
Medical Operations Officer	O5	70H	MS	1	1
Medical Plans Officer	O4	70H	MS	1	1
Medical Operations Officer	O4	70H	MS	1	1
Intel/Ops Br, G2/3					
Medical Operations Officer	O5	70H	MS	1	1
Intelligence Officer	O4	70H	MS	1	1
Medical Operations Officer	O3	70H	MS	1	1

ASCC Command Surgeon's Office					
Medical Operations	Grade	AOC	Branch	REQ	AUTH
Medical Operations Officer	O6	70H	MS	1	1
Current Ops					
Medical Operations Officer	O5	70H	MS	1	1
Medical Operations Officer	O4	70H	MS	1	1
Med Ops Officer	O3	70H	MS	1	1
Med Ops Officer	O3	70H	MS	2	2
Medical Plans					
Medical Plans Officer	O5	70H	MS	1	1
Medical Plans Officer	O4	70H	MS	1	1
Plans Officer	O3	70H	MS	1	1

Figure 4 - Comparison of Plans and Operations.²⁹

Finally, there is the professional services division that contains all of the consultants. By MTOE, the MEDCOM requires a few more consultants than the ASCC Command Surgeon’s Division (Figure 5). Many of the consultants are not authorized because those duties are likely in addition to service as a commander of a specialty medical unit or serving within a subordinate medical unit. Because the ASCC command surgeon is responsible for all medical care in theater and for advising the ASCC commander, it can be inferred that he too will be calling on the

²⁸ Headquarters, Department of the Army, *Force Health Protection in a Global Environment, FM 4-02 (FM 8-10)* (Washington, DC: U.S. Government Printing Office, 2003), 3-3.

²⁹ Compiled from MTOEs UIC (WJN2AA) – Operational Command Post, HQ, Army, Edate 16 OCT 08; UIC (WATGAA) – Main Command Post, HQ, Army, Edate 16 OCT 08; and UIC (WNF5AA) – 0030 MD HHC MED DEPLOY, Edate 16 OCT 08. FMSweb: <https://webtaads.belvoir.army.mil/> (accessed September 16, 2008).

consultants within the MEDCOM to ensure that he is providing the best possible information to the ASCC commander. The overlapping organization results in a situation in which a consultant is serving multiple bosses in the same functional role as a technical expert. As will be seen in the next section, consultants working for multiple bosses can lead to confusion between technical supervision channels and appropriate command channels when the consultant does not keep the appropriate commands informed of his recommendations.

MEDCOM						ASCC Command Surgeon's Office					
Clinical Services	Grade	AOC	Branch	REQ	AUTH	Consultants	Grade	AOC	Branch	REQ	AUTH
Deputy CDR, Professional Serv	BG	00B	GO	1	1	Chief Medical Services	O6	61F	MC	1	0
Medical Consultant	O6	61F	MC	1	1	Trauma Coordinator	O6	61J	MC	1	0
Surgical Consultant	O6	61J	MC	1	0	Chief Nursing Services	O6	66N	NC	1	0
Nursing Consultant	O6	66N	NC	1	1	Dental Surgeon	O6	63R	DC	1	0
Dental Surgeon	O6	63R	DC	1	1	Vet Prev Medicine	O6	64B	VC	1	0
Senior Veterinarian	O6	64Z	VC	1	0						
Psychiatrist	O6	60W	MC	1	0						
Pharmacy Officers	O6	67E	MS	1	0						
Optometry	O5	67F	MS	1	0						
Nuclear Medical Science Off	O5	72A	MS	1	0						
Social Worker	O5	73A	MS	1	1						
Public Health Dentist	O5	63H	DC	1	0						
Dietetic Consultant	O6	65C	SP	1	0						

Figure 5 - Comparison of Consultant requirements.³⁰

The comparison of the ASCC Command Surgeon's Division and the MEDCOM staff shows that the special staff officer's staff and a line command's staff are very similar. At the surface, the difference between the two is only the MEDCOM commander's "command authority". However, recalling the informal authority that the ASCC command surgeon has due to his expertise, his control over HSS and FHP information gathering, his doctrinal responsibility to manage the theater's HSS and FHP missions, and his technical authority granted by regulation, the ASCC command surgeon has as much control over HSS and FHP assets as the MEDCOM commander. This leads to the question, is there a need for two different organizations when a

³⁰ Compiled from MTOEs UIC (WJN2AA) – Operational Command Post, HQ, Army, Edate 16 OCT 08; UIC (WATGAA) – Main Command Post, HQ, Army, Edate 16 OCT 08; and UIC (WNF5AA) – 0030 MD HHC MED DEPLOY, Edate 16 OCT 08. FMSweb: <https://webtaads.belvoir.army.mil/> (accessed September 16, 2008).

special staff officer and a line commander with like staffs have the same amount of control over HSS and FHP missions?

Because doctrine and organizational structure are a reflection of experience, a historical reference can show whether similar doctrine and structure have worked in the past. The organizational or doctrinal history may reveal incidents that caused change in doctrine and structure. Unfortunately, there is very little recent literature published on the evolution of medical command and control structures. Most references focus on the actual practice of medicine and medical trends giving only a cursory mention, if at all, to the operational aspects of medicine. An Army War College briefing on the redesign of the Medical Deployment Support Command (MDSC) [now designated as a MEDCOM (DS)] pointed to lessons learned in Vietnam as justification for the current command structure.³¹ It might have been possible to confirm how the Vietnam experience was used in shaping the redesign, but the AMEDD does not release internal decision papers. Alternatively, a review of The Surgeon General's 1971 annual report points to a lesson learned on medical command relationships in Vietnam. The 1971 report concludes that corps level medical assets not be subordinated to logistical support elements.³²

Evolution of Medical Command and Control in Vietnam

The medical command and control structure that was present at the end of the Vietnam War did not resemble the structure that was in place when United States combat troops arrived in 1965. As the United States' involvement in Vietnam evolved, so did the Army's medical command and control structure. When military advisors were committed to Vietnam, the coordination of medical support was the responsibility of the U.S. Army, Ryukyu Islands (USARYIS) command surgeon. On 24 February 1962, the medical section of the USARYIS

³¹ John A. Bonin, "Medical Deployment Support Command (MDSC) Redesign", 2008.

³² The Historical Unit, U.S. Army Medical Department, *Annual Report, The Surgeon General United States Army: Fiscal Year 1971* (Washington, D.C., Office of the Surgeon General, 1974), 113.

Support Group (Provisional) was authorized. It consisted of one medical plans and operations officer and a clerk.³³ The medical section's primary role was to assess the needs and capabilities of the units arriving in Vietnam and to recommend medical force requirements. At that time, there were only a few medical detachments in Vietnam providing dispensary support on an area support basis.

On 1 April 1962, the USARYIS Support Group (Provisional) was designated the U.S. Army Support Group, Vietnam (USASGV) and placed under the command of the commander, U.S. Military Assistance Command, Vietnam (USMACV). Upon USASGV's activation, the medical section's mission became "to advise the USASGV commander and his staff on matters pertaining to the medical, dental, and veterinary services of the command, and to supervise all technical aspects of those services."³⁴ Upon the arrival of the 8th Field Hospital on 18 April 1962, its commander, Lieutenant Colonel Carl A. Fischer, Medical Corps, became the USASGV command surgeon. With the assumption of the USASGV command surgeon's duties, he became responsible for all Army medical activities in Vietnam. As the USASGV command surgeon, LTC Fischer's staff consisted of one officer and one clerk. Utilizing the senior medical commander as the command surgeon was in line with the medical doctrine of the time.³⁵ However, assigning the senior medical commander in theater the position of the theater command surgeon immediately made it difficult for LTC Fischer to command the 8th Field Hospital because the USASGV Headquarters was in Saigon and the 8th Field Hospital was located 200 miles away in Nha Trang. Not only was distance a factor, but the headquarters staff of the hospital was not prepared or organized to provide the administrative support and control of its eight attached medical units.

³³ Spurgeon Neel, *Vietnam Studies: Medical Support of the U.S. Army in Vietnam 1965-1970* (Washington, DC: United States Government Printing Office, 1973), 4.

³⁴ *Ibid*, 5.

³⁵ Headquarters, Department of the Army, *Medical Service, Theater of Operations FM 8-10* (Washington, DC: United States Government Printing Office, 1959), 5-7.

LTC Fischer requested a change to the authorization documents to permit the assignment of a permanent surgeon, but this request went unheeded.³⁶

In 1963, the USASGV became the U.S. Army Support Command, Vietnam (USASCV) and was assigned as a subordinate command to USMACV. There were no structural changes made to the USASCV Surgeon's Section until the addition of a dental surgeon, preventive medicine officer, veterinarian, and an additional clerk in 1964. Unfortunately, the addition of the three officers had little effect because they were also commanders of specialty medical detachments, two of which were located in Nha Trang. At the request of the Commander, USMACV, and the outcome of COSTAR II, 1st Logistical Command was activated on 1 April 1965. As the field army support command, 1st Logistical Command had responsibility for providing service and support to all Army units and for distributing supply items common to all military services in theater. As a result, the 8th Field Hospital was subordinated to the 1st Logistical Command and the hospital commander gained a third duty, 1st Logistical Command Surgeon. These three duty positions were too much for one individual to handle and it did not take long to remedy the 8th Field Hospital commander's situation.³⁷

A physician was quickly brought in as interim 1st Logistical Command Surgeon to buy time for the arrival of the 58th Medical Battalion on 29 May 1965. The 58th Medical Battalion assumed command and control over all non-divisional medical units in theater and its commander assumed the duties of the 1st Logistical Command surgeon. That June, the Army answered the requests for a full-time surgeon with the assignment of a physician to USASCV. With the designation of USASCV as U.S. Army, Vietnam (USARV) that July, there was a full-time

³⁶ Spurgeon Neel, *Vietnam Studies: Medical Support of the U.S. Army in Vietnam 1965-1970*. (Washington, DC: United States Government Printing Office, 1973), 5.

³⁷ *Ibid*, 8.

command surgeon at the Army Service Component Command level and no equivalent medical command. The USARV Surgeon was responsible for the

planning of **all** (emphasis added) USARV medical service, to be correlated at USARV headquarters with the troop concentrations, logistical support areas, and the concept of tactical operations. Additional duties included preparing and coordinating broad medical policies, recommending assignments for medical personnel within USARV, maintaining medical records and statistics, and furnishing medical consultants to the command.³⁸

These duties and responsibilities were specified in the 1965 doctrine and are the same duties and responsibilities in today's doctrine. Whereas the USARV command surgeon was responsible for all Army medical structure in Vietnam, the 1st Logistical Command surgeon was only responsible for non-divisional medical units. As the buildup in Vietnam continued and more medical units flowed into theater, the 43rd Medical Group was activated. The 43rd Medical Group was commanded by a Colonel and was created to provide command and control of non-divisional medical units. As the senior Army medical unit, the 43rd Medical Group's commander now had the additional duty of the 1st Logistical Command surgeon.³⁹

In December of 1965, the leadership in Vietnam and Washington, DC decided the number of non-divisional medical units in Vietnam had grown to the point it was necessary to send a medical brigade to Vietnam to provide command and control. Upon the decision to activate a medical brigade, the USMACV command surgeon, Army Colonel Spurgeon Neel, and the USARPAC command surgeon, Brigadier General Byron Steger, began politicking to place the medical brigade under the direct command and control of USARV and the supervision of the USARV Surgeon rather than 1st Logistics Command. COL Neel's argument was that "optimal medical service could only be achieved if directed solely by professional medical personnel."⁴⁰ This argument did not persuade the commander of 1st Logistics Command because the argument

³⁸ Ibid, 12.

³⁹ Ibid.

⁴⁰ Ibid, 13.

ran counter to the COSTAR II concept in which medical service was a logistical function that belonged to the field army support command (FASCOM). It is also important to note that this request was counter to FM 8-16, *Medical Service, Field Army*, which had been published only six months earlier in June of 1965 and had superseded portions of the 1959 version of FM 8-10, *Medical Service, Theater of Operations*. FM 8-16 clearly stated, “the FASCOM includes a medical brigade which operates the field-army-wide medical service system,” and furthermore, that the “commander of the medical brigade also functions as the staff surgeon for the FASCOM commander.” Placing medical services under the command of a support commander was not a radical change from previous doctrine. The 1959 version of FM 8-10 has an entire chapter dedicated to medical service in the communications zone and the role of the theater army logistical command surgeon.⁴¹ That version of FM 8-10 provides a much broader description of the medical units that may appear in the Theater Army Logistical Command without specifying a medical brigade as the senior medical unit in theater. Because no senior medical unit is identified and given the role of providing medical command and control throughout the communications zone, it appears that the informal authority that the surgeon has is still realized within doctrine.

In March of 1966, Colonel Wier, the incoming commander for the 44th Medical Brigade, met with the deputy commanding general, USARV, and the commander of 1st Logistics Command. During the meeting, Colonel Wier made one last attempt to place the 44th directly under USARV. Colonel Wier was unsuccessful, but all agreed that the USARV command surgeon should be the senior Army medical officer in theater and not the medical brigade

⁴¹ Chapter 14 of the 1959 version of FM 8-10 is titled, “Medical Service in the Communications Zone: General Considerations.” After a general introduction the chapter is dedicated to the roles, responsibilities, and relationships of the theater army logistical command surgeon.

commander. Upon the arrival of the Headquarters, 44th Medical Brigade, Colonel Wier was assigned as both the brigade commander and the 1st Logistics Command surgeon.⁴²

According to Neel, as the operational capability of the Headquarters, 44th Medical Brigade increased, the duties of the 1st Logistics Command surgeon were shifted to the 44th Medical Brigade. The shift in duties in turn led to the reduction of the 1st Logistics Command surgeon's staff to a liaison officer and clerk. However, according to a 44th Medical Brigade's Operational Report there was a different reason for the shift in duties and the movement of personnel. The report states the 1st Logistics Surgeon Section was primarily responsible for medical planning and there was difficulty in transitioning the plans to the operations officers in the Medical Brigade's S-3 section.⁴³ Therefore, the medical planners were moved from the 1st Logistics Command Headquarters to the 44th Medical Brigade Headquarters so the Brigade S-3 could provide better supervision over the planners in hope that better coordination between the plans and operations officers would occur. The report also noted a staffing shortfall in the Brigade 3 section that led to the submission of a request to change the MTOE for additional officers.⁴⁴ The consolidation of the 1st Logistics Surgeon Section into the Brigade S-3 section actually served the purposes of filling a staffing shortfall and unifying planning and operations efforts. Therefore, the Operational Report shows that the shift in planning duties and personnel from the 1st Logistics Surgeon's Section to the 44th Medical Brigade was done to increase the 44th Medical Brigade's operational capabilities, not because the 44th Medical Brigade had increased capability. The Operational Report sheds light on a lesson that for the 44th Medical Brigade to have effective

⁴² Spurgeon Neel, *Vietnam Studies: Medical Support of the U.S. Army in Vietnam 1965-1970* (Washington, DC: United States Government Printing Office, 1973), 13.

⁴³ Headquarters, 44th Medical Brigade, "Operational Report for the Period Ending 31 October 1966." 15 November 1966. (Combined Arms Library, Ft. Leavenworth, KS), 3.

⁴⁴ Ibid.

operational capabilities, the medical planning and current operations sections needed to be in the same headquarters. A lesson that was not captured in Neel's justification for the shift in duties.

Although there was now a Medical Brigade headquarters present, the medical groups assigned to the Medical Brigade were still under the operational control (OPCON) of the area support commands in the Corps Tactical Zones (CTZs) (Figure 6). To further confuse the line of command and staff relationships, commanders of medical groups served as command surgeons to the area support group commanders and may have served as consultants in the Clinical Services Division of the USARV Command Surgeon's Office. Neel's account of medical command and control problems in Vietnam only briefly touches on the issue of consultants serving in multiple positions. Neel observed, "the existence of an intermediate, nonmedical headquarters between medical practitioners in the field and consultants in the USARV surgeon's office, created duplicative, overlapping, and confusing channels of communication."⁴⁵

Because there are many medical specialties, the command surgeon, particularly at higher levels, relies on consultants to advise him on their specialty and efforts to standardize care across the theater. A consultant is typically the senior officer in a particular medical specialty in theater and may have other primary duties. Specialty unit commanders (i.e. dental, veterinarian, and preventive medicine) often served as staff officers on the 44th Medical Brigade staff and as consultants to the USARV command surgeon. Consultants standardized medical care through battlefield circulation and the inspection of medical facilities.⁴⁶ As the consultants completed their inspections, tension developed between the medical commands. Although the consultants were serving both the 44th Medical Brigade/1st Logistics Command surgeon and the USARV

⁴⁵ Spurgeon Neel, *Vietnam Studies: Medical Support of the U.S. Army in Vietnam 1965-1970* (Washington, DC: United States Government Printing Office, 1973), 18.

⁴⁶ Andre J. Ognibine, "Full-Scale Operations," in *Internal Medicine in Vietnam: General Medicine and Infectious Diseases, Vol II*, by United States Army Medical Department, edited by Andre J. Ognibene and Jr., O'Neill Barrett (Washington, DC: United States Government Printing Office, 1982), 39-44.

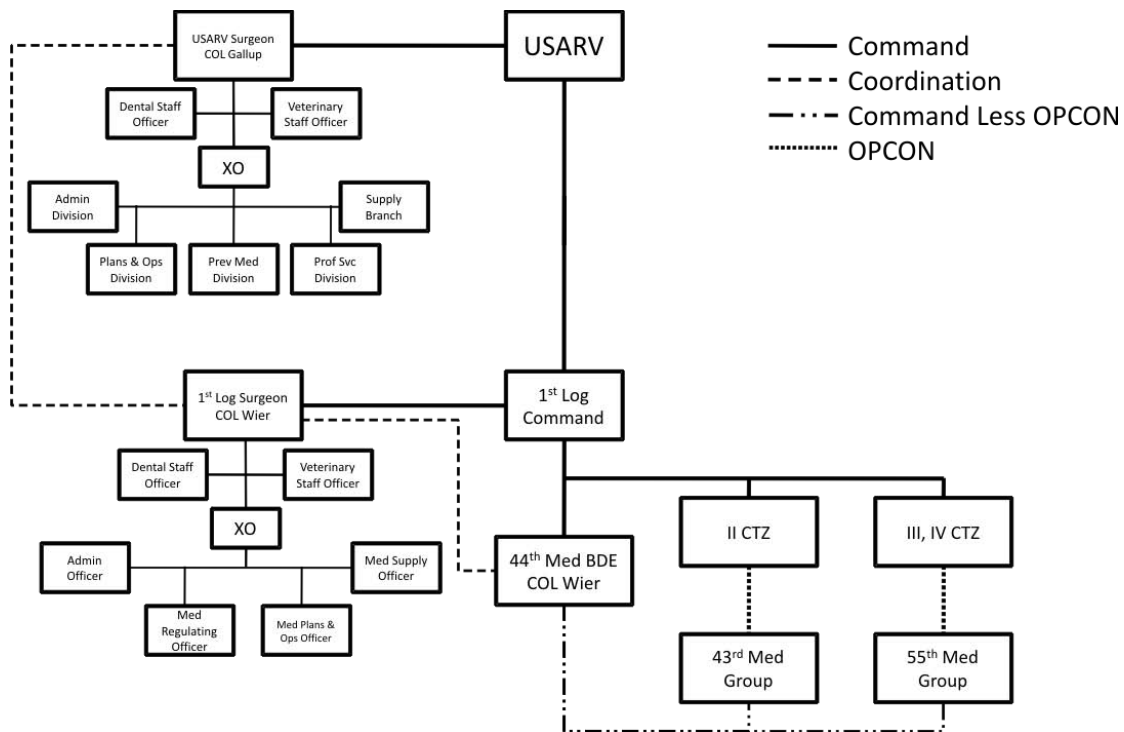


Figure 6 - Medical command and control upon arrival of the 44th Medical Brigade in Vietnam.⁴⁷

command surgeon, they made their recommendations for personnel moves only to the USARV command surgeon. The USARV Surgeon was then making personnel decisions involving lower units without coordinating with the losing unit before the transfers occurred.⁴⁸ The inability to do proper staff coordination led to much frustration because hospital and medical group commanders were unable to explain to their supported Area Commanders why they were losing a medical specialist. Although the USARV Surgeon was exercising his rightful technical authorities, there is still a need to properly staff actions that cross command boundaries.

⁴⁷ CPT Darrell G. McPherson, "Army Medical Service Activities Report (RCS MED-41 R4) CY 1966." (The Office of Medical History, Falls Church, VA), 3-7; Spurgeon Neel, *Vietnam Studies: Medical Support of the U.S. Army in Vietnam 1965-1970*. (Washington, DC: United States Office, 1973 Government Printing), 20.

⁴⁸ Spurgeon Neel, *Vietnam Studies: Medical Support of the U.S. Army in Vietnam 1965-1970*. (Washington, DC: United States Office, 1973 Government Printing), 18-19; and Andre J. Ognibene, "Full-Scale Operations," in *Internal Medicine in Vietnam: General Medicine and Infectious Diseases, Vol II*, by United States Army Medical Department, edited by Andre J. Ognibene and Jr., O'Neill Barrett (Washington, DC: United States Government Printing Office, 1982), 39-40.

Neel attributed the command problem to a medical command and control structure that was not vertically integrated. Hence, there were multiple, overlapping, and confusing channels of communications and command. He went further to state that the confusion “could have been eliminated through a concise delineation of the responsibilities of Headquarters, 44th Medical Brigade, vis-à-vis the USARV surgeon’s office.”⁴⁹ Neel’s account then refers to the theory mentioned earlier that the USARV (ASCC) Surgeon’s Office is responsible for long-range plans and operations and the 44th Medical Brigade (MEDCOM) is responsible for day-to-day operations of all non-divisional medical services.⁵⁰ Although Neel and Ognibene both note the difficulties of managing officers with medical specialties, the 44th Medical Brigade’s Operational Reports capture the problem in a slightly different context. The first of the Commander’s Observations and Recommendations for the quarterly report ending 31 January 1967 is on personnel service support for medical units. The report discusses the loss of control over medical personnel upon their attachment to other commanders for administrative purposes. The 1st Logistical Command did not concur with this observation and referred the 44th Medical Brigade to AR 220-5 as the authority to retain control of detached personnel.⁵¹ There are no further mentions of control over medical personnel after the January 1967 quarterly report. This comment in the Commander’s observations points to a poor understanding of command and support responsibilities of forces that are under the operational control of another unit.

⁴⁹ Spurgeon Neel, *Vietnam Studies: Medical Support of the U.S. Army in Vietnam 1965-1970*. (Washington, DC: United States Office, 1973 Government Printing), 19.

⁵⁰ Before writing *Vietnam Studies*, Neel dictated his belief that the USARV Command Surgeon’s Office was responsible for mid to long-range planning and the 44th Medical Brigade was responsible for day-to-day operations in a Senior Officer Debriefing conducted while he was the commander of the 44th Medical Brigade in 1969.

⁵¹ Adjutant General’s Office (Army). “Operational Report – Lessons Learned, HQ, 44th Medical Brigade.” 7 June 1967. (Combined Arms Research Library, Ft. Leavenworth, KS), 13.

In June of 1966, Colonel Wier relinquished command of the 44th Medical Brigade to Colonel Ray Miller and became the USARV Surgeon.⁵² Colonel Wier was not the USARV Surgeon long before receiving a promotion to brigadier general. As the size of the force in Vietnam expanded, so did the workload of the USARV Surgeon's Office, requiring it to double its staff requirement. Much of the expanded workload was related to planning for future operations and compiling medical statistics. As the 44th Medical Brigade Commander, General Wier had been a proponent for eliminating the USARV Surgeon's Office. As the USARV Surgeon, he found it necessary to increase the size of his staff to meet the increasing responsibilities and offset the inability of the 44th Medical Brigade to respond to requests in a timely manner. His change of heart about the value of the USARV Surgeon's Office did not stymie his intention to place the 44th Medical Brigade under the direct control of USARV rather than 1st Logistics Command. In the last few months of his time as USARV Surgeon, Brigadier General Wier staffed an action within the command to release the 44th Medical Brigade from its assignment to 1st Logistics Command. The effort failed to gain approval.⁵³

Brigadier General Glenn J. Collins replaced Wier as the USARV Surgeon in July of 1967. General Collins picked up where General Wier left off and presented a second more detailed recommendation to the USARV staff that received the USARV Commander's approval. Neel attributed the approval to two things. First was the placement of a force ceiling on USARV in July 1967. The USARV Surgeon's Office determined that a force allocation savings could be made by removing division medical assets from theater. However, the only way to do this would be for the USARV Surgeon to have direct control over all medical assets. It was also determined that placing the USARV Surgeon in direct control of all medical assets would guarantee

⁵² CPT Darrell G. McPherson, "Army Medical Service Activities Report (RCS MED-41 R4) CY 1966." (The Office of Medical History, Falls Church, VA), 6.

⁵³ Spurgeon Neel, *Vietnam Studies: Medical Support of the U.S. Army in Vietnam 1965-1970*. (Washington, DC: United States Office, 1973 Government Printing), 19-23.

immediate medical reinforcement when conditions called for it. Regardless of who, the Surgeon or 1st Logistics Command, had control of the medical assets, the order to reposition units would have to come from the USARV G-3. It is hard to believe that the 1st Logistics Command would have ignored an order from its higher headquarters, especially an order to provide medical assistance to a supported division. The second item Neel attributes to the success of General Collins recommendation was the emphasis placed on the ability to reduce delays in medical planning and reporting. Placing the 44th Medical Brigade directly under USARV streamlined the management of medical personnel.⁵⁴

In reviewing 1st Logistics Command documents, it appears that the Commander of 1st Logistics Command did not see any issues with the 44th Medical Brigade being under the control of 1st Logistics Command. The Commander's Debriefing Report for the 1st Logistics Command covering the period from April 1966 to August 1967 provides nothing but laudatory comments about the medical service provided. Under the "Summary of Major Improvements" section, the first item listed is the "unparalleled medical service for troops."⁵⁵ This paragraph goes on to describe how the wounded in action to killed in action ratio had improved due to the performance of "dustoff" aircraft and modern hospitals on the battlefield. Regardless of the 1st Logistic Commander's impression of medical services, the 44th Medical Brigade was released from the 1st Logistics Command and became a subordinate command to USARV on 10 August 1967. Upon the assignment of 44th Medical Brigade directly under USARV, General Collins became the USARV Surgeon and the Commander of 44th Medical Brigade⁵⁶ (Figure 7).

⁵⁴ Spurgeon Neel, *Vietnam Studies: Medical Support of the U.S. Army in Vietnam 1965-1970*. (Washington, DC: United States Office, 1973 Government Printing), 23-27.

⁵⁵ MG Shelton E. Lollis, 1st Logistical Command Debriefing Report, 11 August 1967, Combined Arms Research Library, Fort Leavenworth, Kansas, 24b.

⁵⁶ CPT Leland Gannaway, "Army Medical Service Activities Report (RCS MED-41 R4) CY 1967." (The Office of Medical History, Falls Church, VA), 3.

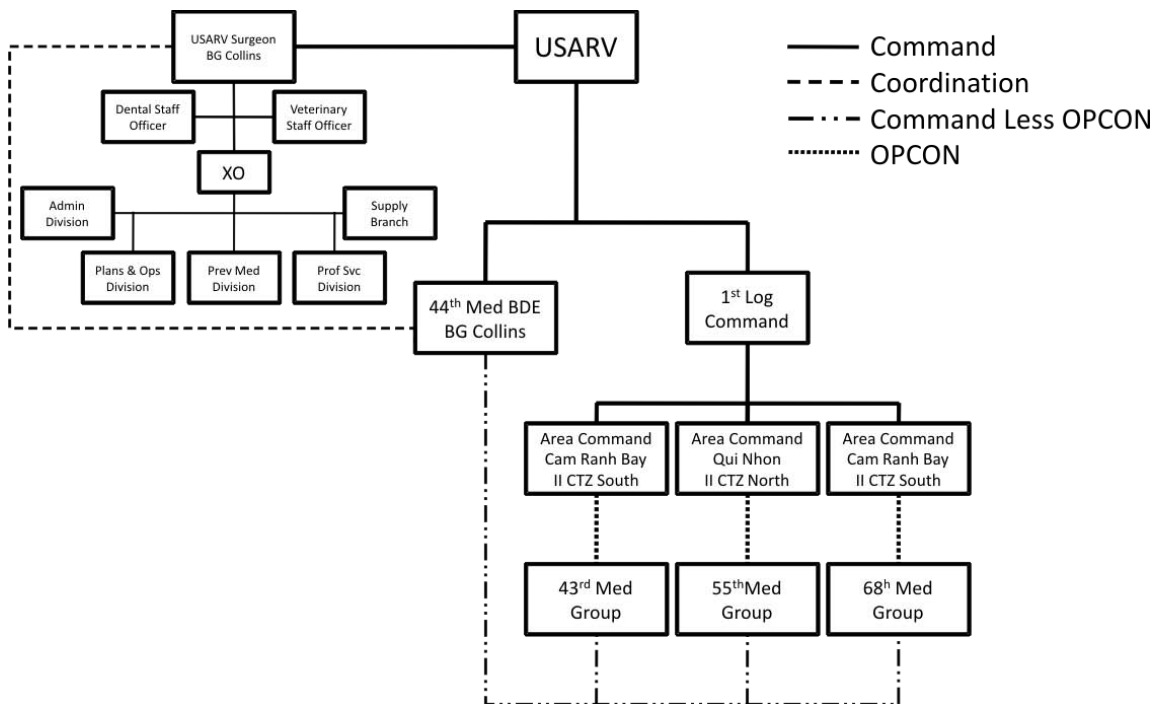


Figure 7 - USARV medical command and control structure, 10 August 1967.⁵⁷

General Collins now had two staffs working for him, with some of the same individuals serving on both staffs (Figure 8). Responsibilities for the two staffs remained the same. The USARV Command Surgeon's Office continued to have all the responsibilities of a command surgeon and was still concerned about the overall command, whereas the brigade staff remained focused on the day-to-day operations of non-divisional medical support. With the exception of being able to save some personnel spaces, this new arrangement did not eliminate the confusion related to operational medical planning responsibilities. In trying to delineate planning responsibilities between the USARV Surgeon's Office and the 44th Medical Brigade, there was an attempt to change the name of the USARV Surgeon's Plans, Operations Division to the Plans,

⁵⁷ CPT Leland Gannaway, "Army Medical Service Activities Report (RCS MED-41 R4) CY 1967." (The Office of Medical History, Falls Church, VA), 3-9; Spurgeon Neel, *Vietnam Studies: Medical Support of the U.S. Army in Vietnam 1965-1970*. (Washington, DC: United States Office, 1973 Government Printing), 23-27.

Programs, and Analysis Division. The name change only caused further confusion and the original name was quickly restored.⁵⁸

..... Same Individual

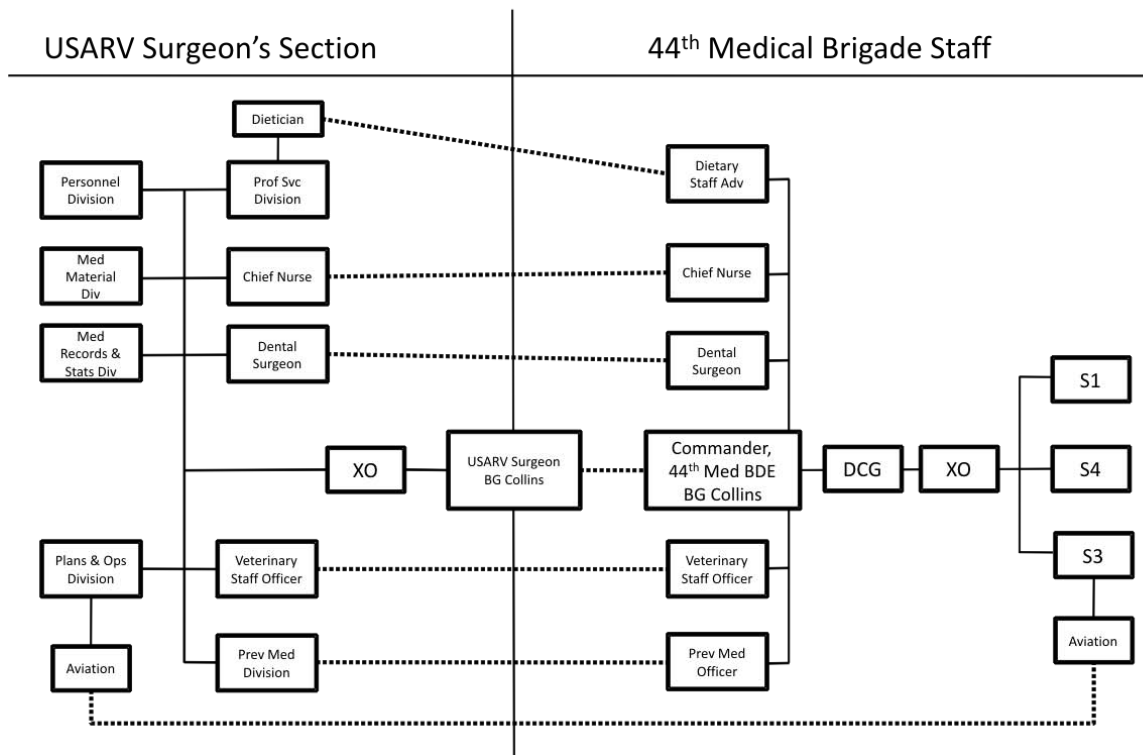


Figure 8 - Individuals working on both USARV Surgeon's and 44th Medical Brigade's staffs.⁵⁹

As he departed Vietnam in May of 1968, the out-going deputy commander of the 44th Medical Brigade, Colonel F. W. Timmerman, Medical Corps, sent a memorandum with the subject “Departing” Observations to Brigadier General Collins. Colonel Timmerman took command of the 44th from Colonel Miller and then relinquished command almost two months

⁵⁸ CPT Michael A. Beringer, “Army Medical Service Activities Report (RCS MED-41 R4) CY 1968.” (The Office of Medical History, Falls Church, VA), 30-54; and Spurgeon Neel, *Vietnam Studies: Medical Support of the U.S. Army in Vietnam 1965-1970*. (Washington, DC: United States Office, 1973 Government Printing), 27.

⁵⁹ Author’s figure created from CPT Leland Gannaway, “Army Medical Service Activities Report (RCS MED-41 R4) CY 1967.” (The Office of Medical History, Falls Church, VA), 3-9; Spurgeon Neel, *Vietnam Studies: Medical Support of the U.S. Army in Vietnam 1965-1970*. (Washington, DC: United States Office, 1973 Government Printing), 21-22.

later to Brigadier General Collins when the 44th Medical Brigade was released from 1st Logistics Command.⁶⁰ Colonel Timmerman's memorandum is very direct and at some points gives a very scathing assessment of the professionalism of some officers in the brigade. Most important is his second paragraph in which he stated:

First and foremost, there is nothing wrong with AMEDS (Army Medical Service) doctrine, general Army organization, or standard military staff procedures. It has been painfully obvious that the vast majority of our administrative and operational problems have resulted from key medical personnel not adhering to published guidance. Many medical personnel thrown into key jobs cannot be expected to be experts in the command and staff field, however there is no excuse for guessing. Basic publications are available – and if read and followed, most of the daily problems encountered in the Brigade would never develop. Again, **the body of our doctrine is absolutely sound.** (Emphasis added.)⁶¹

This paragraph bluntly puts the onus of command and control problems on the inability of AMEDD personnel to perform staff actions properly. Timmerman then goes on to criticize AMEDD officer insight on the value of the radio and more importantly the inability to use a radio. Several paragraphs later, he writes, “technical control should be uninterrupted – as it is in the USARV with the brigade directly under Army headquarters.”⁶² The sentences involving sound doctrine and uninterrupted technical control contradict themselves because the doctrine at the time called for the Medical Brigade to fall under the 1st Logistics Command.⁶³

It must be noted that the USARV command surgeon always had uninterrupted “technical” control over the 44th Medical Brigade because the technical line ran straight from the USARV command surgeon to the 44th Medical Brigade Commander/1st Logistics Command

⁶⁰ CPT Leland Gannaway, “Army Medical Service Activities Report (RCS MED-41 R4) CY 1967.” (The Office of Medical History, Falls Church, VA), 3.

⁶¹ Memorandum by F. W. Timmerman, 3 May 1968, Subject: “Departing” Observations, The Office of Medical History, U.S. Army, Falls Church, Virginia.

⁶² Ibid.

⁶³ Headquarters, Department of the Army, *Medical Service, Field Army, FM 8-16* (Washington, DC: United States Government Printing Office, 1965), 8-9. Although the struggle to place the 44th Medical Brigade directly under USARV, there was no change made to doctrine between the 1959 version of FM 8-10 and the publishing of FM 8-16 in 1965 which superseded the portions of FM 8-10 that referred to the field army.

surgeon. The difference in technical control and command authority is confused here. The only thing that changed when the 44th was subordinated under USARV was that a layer of command authority was removed from between the USARV and the 44th Medical Brigade. What this memorandum shows is that having uninterrupted “command” authority gave some relief to the greater problem of a staff that had difficulties working as an operational military staff.

In 1969 as US Forces began to draw down their presence in Vietnam, the medical units began to reorganize to maintain continuity of care. The reorganizations provided the USARV Surgeon/44th Medical Brigade Commander the opportunity to commission a study on the feasibility of combining the USARV Surgeon’s Section and the 44th Medical Brigade. At the outset of the study the requirement was that any new medical command “must perform all functions of both activities with no loss of efficiency.”⁶⁴ The study found that the combination of the two staffs was feasible and would reduce redundant functions between the two staffs. The combination of the two staffs would provide a 17% reduction in staff requirements and retain all of the required functionality. As a result of the study’s findings, the USARV Command Surgeon’s Office and the 44th Medical Brigade were combined to form the US Army Medical Command, Vietnam (MEDCOMV) on 1 March 1970. Although there was now only one staff, the commander of MEDCOMV still served as the USARV command surgeon. The first operational report of the MEDCOMV reports the realization of the following benefits from the reorganization:

- -Elimination of duplicate efforts and increased efficiency in the functional areas of command, administration, and plans and operations.
- -Enhancement of the management of medical personnel.

⁶⁴ Adjutant General’s Office (Army). “Lessons Learned, Headquarters, US Army Medical Command Vietnam (Provisional).” 15 May 1970. (Defense Technical Information Center, Ft. Belvoir, VA), 6.

- -Improvement in the responsiveness and flexibility to change in medical support.⁶⁵

The report goes further to recommend that “the dual function concept of the command surgeon also commanding the subordinate medical unit be considered at all levels as a method of reducing manpower requirements and gaining best utilization of limited medical resources.”⁶⁶ The recommendation as it was written is incomplete. The recommendation does not mention combining the command surgeon’s and medical brigade’s staffs. Thus, the recommendation leads to the false conclusion that the efficiencies are gained solely by assigning a single individual to fill the posts of command surgeon and medical commander. Does it not also require some consolidation of the two staffs? The USARV command surgeon and 44th Medical Brigade commander were the same individual for almost three years before the two staffs were consolidated. The efficiencies of subordinating the 44th Medical Brigade directly under the USARV did not come to fruition until the formation of the MEDCOMV.

The study of medical command and control in Vietnam shows that the simple theory of the ASCC Command Surgeon’s Division being responsible for long range planning and the MEDCOM(DS) being only responsible for day-to-day operations is easier said than done. Having two organizations with similar staffs and similar authority only leads to confused command and control. The lesson learned from the evolution of medical command and control in Vietnam is not that the command surgeon should fill the dual function of the subordinate medical command. The lesson is actually that for the ASCC command surgeon to have the most effective and efficient control over medical support in theater, he and his staff need to serve as both the theater level medical command headquarters and the surgeon’s division. In other words, the desire to have a physician in “command” of HSS and FHP assets at the theater level with a staff similar to the

⁶⁵ Ibid.

⁶⁶ Ibid.

ASCC command surgeon only confuses command and control relationships. By regulation, the ASCC command surgeon has complete technical control over all Army HSS and FHP assets in theater and through his informal authority derived from the ASCC commander virtually has command authority. Thus, the MEDCOM(DS) duplicates the ASCC Command Surgeon's Division and as seen by the creation of the MEDCOMV, it is unnecessary to have both organizations.

Theory versus the reality of the Current Operating Environment

Although the lessons from Vietnam impacted medical doctrine and organizational structure, the difficulties in deploying medical capabilities in Operation Desert Shield/Storm led to the AMEDD's most recent organizational changes. Under the auspices of the Medical Reengineering Initiative (MRI) the AMEDD began redesigning its force structure with the purpose of reducing the medical footprint in theater through lighter and more flexible units. To make medical units easier to deploy and more responsive, a modular construct was used to redesign combat support hospitals and medical command and control infrastructure.⁶⁷ The initiation of Army Modularity in 2004 provided further clarification of MRI initiatives. Under MRI, medical command and control architecture had two types of Medical Commands, theater and corps, and two types of Medical Brigades, echelon above corps (EAC) and corps.⁶⁸ The AMEDD was still in the process of transforming medical units upon the initiation of Operation Iraqi Freedom (OIF).

Three Medical Brigades, all commanded by Colonels, deployed in support of initial combat operations in support of Operation Iraqi Freedom. The 30th Medical Brigade was assigned

⁶⁷ United States Army Medical Department (AMEDD), "Army Medicine White Paper: Transforming Medical Support to a Modular Army." (AMEDD Center and School, Fort Sam Houston, TX, March 09, 2005), 2-6.

⁶⁸ This construct is the basis on which the February 2003 version of FM4-02 (FM 8-10) is based on.

to V Corps as an EAC Medical Brigade with 1st Medical Brigade subordinated to it as a reinforcing corps medical brigade. The 62nd Medical Brigade was originally attached to Task Force Iron Horse (4th Infantry Division). When Task Force Iron Horse was diverted from Turkey to enter Iraq through Kuwait, the 62nd Medical Brigade was detached and subordinated under 30th Medical Brigade. No MEDCOM deployed into the Iraqi theater to provide medical command and control.⁶⁹

However, what is more important is what the medical footprint has become since the end of initial combat operations in May of 2003. As the force structure in Iraq stabilized, the Army became the lead component for medical support with the medical command and control structure. A single Medical Brigade provided command and control for all echelon above division medical units. As the Iraqi theater stabilized, the medical footprint was reduced and has remained consistent with a Medical Brigade providing command and control over three to four combat support hospitals and two multi-functional medical battalions. Although units have rotated in and out of Iraq, the scope and responsibilities of the Medical Brigade have changed very little. However, because of the various MTOEs in use from MRI/Army Modularization, the rank of the Commander and type of unit filling the Medical Brigade role has varied from rotation to rotation. The 30th, 2nd, and 62nd Medical Brigades deployed and filled the role of senior medical command in Iraq with colonels in command. Whereas the 44th MEDCOM, a corps medical command, deployed with a brigadier general in command. The 3rd MEDCOM, a theater army medical command, commanded by a major general has also been deployed in the Medical Brigade role.⁷⁰

⁶⁹ Headquarters, 1st Medical Brigade. "Operational Overview: EAD CHS During OIF." AMEDD Lessons Learned, https://secure-ll.amedd.army.mil/Reports/OIF/Bradley-FSHTX_RockDrillAARBriefing_files/frame.htm (accessed January 19, 2009); Headquarters, 30th Medical Brigade. "Operation Iraqi Freedom After Action Review." AMEDD Lessons Learned, [https://secure-ll.amedd.army.mil/ll/showsub.aspx?CatID=65&cat=AMEDD Operation Iraqi Freedom AAR](https://secure-ll.amedd.army.mil/ll/showsub.aspx?CatID=65&cat=AMEDD%20Operation%20Iraqi%20Freedom%20AAR) (accessed January 19, 2009).

⁷⁰ Headquarters, 3rd Medical Command "Command Deployment History OIF 06-08." AMEDD Lessons Learned, [https://secure-ll.amedd.army.mil/Reports/OIF/3rd_MEDCOM_Deployment_History_06-](https://secure-ll.amedd.army.mil/Reports/OIF/3rd_MEDCOM_Deployment_History_06-08)

A review of the deployment histories and after action reports of these units shows the rank of the commander had little effect on the overall performance of the unit. What is noted, is that units commanded by colonels had fewer assigned personnel than those commanded by generals and required augmentation to perform at the same level.⁷¹

The deployments have not slowed the development of doctrine or force structure under Army Modularization. The Army Medicine White Paper *Transforming Medical Support to a Modular Army*, proposes creating permanent standing regionally aligned theater army medical commands. FMI 3-0.1, *The Modular Force* codifies this concept in doctrine. The FMI describes the ASCC command surgeon as a provider of policy and technical guidance and the MEDCOM(DS) as the developer of “plans, procedures, and programs for medical support in the theater army.” As has been described earlier, the ASCC command surgeon and his staff are responsible for developing the plans, policies, and procedures for the theater army. In the case of current operations, those serving as the U.S. Army Central (USARCENT) Surgeon are aware of and are performing these duties as reflected in their mission statement: “plans and coordinates health service support as Title X / Executive agent to deployed U.S. and Coalition forces.”⁷² The FMI goes on further to describe how the MEDCOM(DS) may command up to four medical brigades that will be “attached” or under the operational control of a corps/division or joint

07(2).pdf (accessed January 19, 2009); Headquarters, TF 44th Medical Command, “Health Service Support Futures: Task Force 44th MEDCOM’s top OIF Issues.” 14 September 2005. AMEDD Lessons Learned, https://secure-ll.amedd.army.mil/reports/OIF/v4_MG_Weightman_Top_Issues.htm (accessed January 19, 2009); and Headquarters, 62nd Medical Brigade, “TF 62nd MED OIF 07-09: Command Report (Redacted Version),” (AMEDD Lessons Learned, Ft. Sam Houston, TX, 1 October 2008).

⁷¹ COL Scott Avery and LTC Vincent Holman, “Employment of a Joint Medical Task Force in a Counterinsurgency Operational Environment,” *The United States Army Medical Department Journal* (October – December 2008): 39.

⁷² COL Brian Lein. “Third Army/ARCENT/CFLCC Surgeon Medical Lessons Learned, OIF 06-08.” 2 August 2006. AMEDD Lessons Learned, https://secure-ll.amedd.army.mil/Reports/OIF/3rdArmySurgeon-LL-VTC_files/frame.htm (accessed January 19, 2009).

headquarters (Figure 9).⁷³ This structure replicates that of the 44th Medical Brigade in Vietnam commanding medical groups that were under the operational control of the Area Support Groups and caused confusion in lines technical and command authority.

The AMEDD maintains that there is a need for a regionally focused MEDCOM(DS). The MEDCOM(DS) monitors regional medical threats and infrastructure, oversees with ASCC planning efforts, and serves as a force provider.⁷⁴ As a staff function, the ASCC Command Surgeon's Division already monitors regional medical threats and is involved in the ASCC planning process. A medical headquarters will only duplicate these efforts. Under modularity, commands at this level have no permanently assigned forces to provide and are incapable of being a force provider. The commands are only headquarters elements until the forces are assigned to them for a specific theater mission. There has yet to be anything published or presented showing the gap between the capabilities of the ASCC Command Surgeon's Division and the requirements that demand a permanently standing medical theater army headquarters. However, a 2001 Rand study on future Army medical issues found that the AMEDD's assignment of colonels (O-6) as command surgeons in various Joint and Army 4 star level commands hampers medical planning when compared to the Navy's use of flag officers (O-7 or O-8) in similar positions.⁷⁵ Although there is no direct evidence, one could infer a similar effect at the ASCC level because a command surgeon in the rank of brigadier general (O-7) is required but not authorized. This inference can be made because as the Rand study points out the amount of control the command surgeon has at highest levels of command is based more on the rank of the individual than the amount of specialized knowledge. Hence, a brigadier general in the position of

⁷³ Headquarters, Department of the Army. *The Modular Force, FMI 3-0.1*, Washington, DC: U.S. Government Printing Office, 2008, 3-17.

⁷⁴ Ibid.

⁷⁵ Checchine, Gary et al., *Army Medical Strategy: Issues for the Future* (Santa Monica: Rand Arroyo Center, 2001), 34-37.

the ASCC command surgeon would put the power of a flag officer behind the informal authority already granted to the ASCC command surgeon.

In contrast to the RAND study, a review of lessons learned and transcripts from command interviews from Operation Iraqi Freedom does not identify a need for a theater army medical headquarters. Rather, the reports contain two enduring themes. First, officers serving in the Command Surgeon's Office at Corps level or higher lack training and experience. Second, control over Naval and Air Force medical assets when deployed in lieu of Army assets is absent. These issues are documented at all levels. They are found in the notes from the CFLCC Surgeon's Medical Conference in 2004, recent interviews, and after action review comments from the Multi-National Corps – Iraq Surgeon.⁷⁷ The overall assessment was that AMEDD personnel are unprepared for duties at the operational and strategic levels. The comments noted in particular the inability of medical personnel to speak in common military terms rather than medical terms, as well as, the difficulty experienced getting personnel to the right training before filling positions at these levels.⁷⁸ It is interesting that COL Timmerman made a similar assessment of medical staffs in Vietnam over 40 years ago and yet the problem persists. How well the AMEDD Officer and Enlisted Education System prepares individuals to serve on staffs of echelons above division commands are areas in need of further study.

Because the Army possesses only a small number of medical units and has faced the need to provide medical coverage in extended combat operations, Air Force and Navy medical units are replacing Army medical units to allow Army medical units time to regenerate. Although Air Force and Navy units are replacing Army units in kind, they are not falling seamlessly into the

⁷⁷ LTC John Loughlin, "Interview, COL(P) Joseph Carvalho, Multinational Force-Iraq (MNF-I) and Multinational Corps (MNC-I) Surgeon. 6 May 2008" Center for Army Lessons Learned, <https://call2.army.mil/toc.asp?document=4965> (accessed January 19, 2009).

⁷⁸ Center for Army Lessons Learned. *Initial Impressions Report: Operation Iraqi and Enduring Freedom CFLCC Surgeon's Medical Conference*. Initial Impressions Report Number 05-4, Fort Leavenworth: CALL, December 2004, 23.

Army's medical footprint. Because these units operate under service component command and control and the service component administrative functions are different, such as medical supply management and information technology systems, the problem of integrating medical units below the theater level has become a Joint rather than Army issue. What this means for the AMEDD organization has not yet been explored.

The deployment of a MEDCOM was necessary during initial combat operations of Operation Iraqi Freedom when there were three medical brigades deployed, all with colonels in command. The force structure and the doctrine provided the justification for that, yet there has never been an obvious need since then that demands it. The CFLCC/ARCENT Surgeon's Section is performing its doctrinal duties and is maintaining a permanent theater focus without the need for a permanent theater level medical command. Both medical brigades and MEDCOMs have served in the same role as the senior medical command and control element in the Iraqi theater with no degradation in performance. Based on the performance in Iraq of the CFLCC/ARCENT Surgeon's Section and the single medical brigade there seems to be no compelling need for a permanent standing regionally focused MEDCOM(DS). Such a command would waste manpower and would only duplicate the efforts of the ASCC Command Surgeon's Division. By not having a permanently standing MEDCOM(DS) Headquarters, the ASCC command surgeon's position could actually be filled by a flag officer. Having a flag officer as the command surgeon would increase the effectiveness of the ASCC Command Surgeon's Division by matching the rank of the individual with the level of informal authority the position possesses.

Conclusion

As shown through the application of the line and staff model to the command surgeon in Section 2, the Command Surgeon does not fit neatly into either the line or staff. Due to the command surgeon's specialization in HSS and FHP and the responsibility given to him by the commander to manage those two functions, the commander gives the command surgeon a great

amount of informal authority. Although the commander retains the authority to make the final decision on HSS and FHP issues, he has abdicated the entire decision-making process to the command surgeon. Thus, what makes the command surgeon a “special” staff officer is the amount of informal line authority that he possesses.

The doctrine review showed that the command surgeon’s informal authority is misunderstood. Doctrine clearly articulates all of the staff responsibilities of the command surgeon, but does not capture how the specialization of those responsibilities makes him an authoritative figure within the ASCC. The result is the creation of a theater level medical headquarters with a staff that mirrors the command surgeon’s staff. The main difference between the ASCC command surgeon and the MEDCOM(DS) commander is that the MEDCOM commander has “command” authority. This “command” authority, however, comes into conflict over the ASCC command surgeon’s responsibility to provide technical supervision of all HSS and FHP assets and the informal authority given to him by the ASCC commander.

As was seen in the evolution of medical command and control during Vietnam, having two different organizations with similar responsibilities and authorities confuses lines of command and control. The theory that the staff section of the ASCC command surgeon is responsible for long range planning and the MEDCOM(DS) is responsible for day-to-day operations was proven to be an oversimplification of responsibilities that duplicate efforts in both organizations. Additionally, untrained staff within USARV Command Surgeon’s Office and the 44th Medical Brigade exacerbated the confusion and tensions that arose from the overlapping responsibilities of the two organizations. Although it was under the auspices of a drawdown in forces, the formation of the MEDCOMV through the consolidation of the USARV Command Surgeon’s Office and the 44th Medical Brigade made clear that the two organizations were duplicates. The lessons drawn from the Vietnam experience were that the command surgeon and senior medical commander can be the same individual and that the medical command ought not

be subordinated to a logistics command. Unfortunately, no one noted the need to consolidate the command surgeon and medical brigade staffs.

The misunderstanding of the lessons learned in Vietnam surrounding the evolution of medical command and control has driven today's medical doctrine and organizational development. As a result, under modularization the MEDCOM(DS) has the same organizational structure and functional role as the ASCC Command Surgeon's Division. This, however, has not led to the confusion seen in Vietnam because no such unit has deployed in the role of a theater level medical command. The ASCC Command Surgeon's Division in Iraq is successfully filling the need for a regionally focused medical element tied to the ASCC's planning process. The individuals serving as the ASCC command surgeon recognize the informal authority of the position. However, the position has not reached its full potential because the AMEDD has not filled the position with individuals holding the rank appropriate to the level of responsibility. The only way to explain the continued push for a theater level medical command is the desire to exercise command authority. Unfortunately, the desire for having command authority has only led to the creation of medical headquarters in the form of the MEDCOM(DS) which is a redundancy of the ASCC Command Surgeon's Division and unnecessary.

The research presented here leads to several conclusions. First, AMEDD doctrine does not establish a clear need for a theater level medical command. The historical and contemporary experiences strongly argue that such a command is unnecessary, hence, redundant. Second, manning documents and doctrine both recognize the possibility that the ASCC command surgeon and the MEDCOM(DS) commander may be the same officer. Current experience in Iraq shows that continues to be the actual case. However, the habit of assigning colonels instead of a flag officer to this position significantly lessens the command surgeon's authority and may interfere with performance when joint medical units are involved. While it was not a focus of the research, the evidence uncovered suggests the AMEDD needs to examine the preparation of medical officers for service in senior level command surgeon sections and to explore in some detail the

requirements created by the integration of Air Force and Navy medical units into the Army system of medical support.

APPENDIX A

Command Surgeon's Duties and Responsibilities⁷⁹

a. The command surgeon is responsible for ensuring that all AMEDD functional Areas are considered and included in OPLANs and operation orders (OPORDs). The command surgeon retains technical supervision of all HSS operations. At higher levels of command, the scope of duties and responsibilities expand to include all subordinate levels of command.

b. The duties and responsibilities of command surgeons may include, but are not limited to –

- Advising the commander on the health of the command.
- Ensuring early presence/arrival of preventive medicine resources into the Theater of Operation.
- Developing and coordinating the HSS portion of OPLANs to support the combatant/tactical commander's decisions, planning guidance, and intent.
- Determining the medical workload requirements (patient estimates) based upon the casualty estimate developed by the Assistant Chief of Staff (Personnel)(G1) and/or Adjutant, U.S. Army (S1)
- Maintaining situational understanding by coordinating for current HSS information with surgeons of the next higher, adjacent, and subordinate headquarters.
- Recommending task organization of HSS units/elements to satisfy all mission requirements.
- Recommending policies concerning support of civil-military operations (CMO).
- Monitoring the availability of and recommending the assignment, reassignment, and utilization of AMEDD personnel within his AO.

⁷⁹ This entire annex is copied from *Force Health Protection in a Global Environment, FM 4-02 (FM 8-10, February 2003, pages 3-3 to 3-7.*

- Developing, coordinating, and synchronizing health consultation services (to include telemedicine and teleconsultation, as appropriate).
- Evaluating and interpreting medical statistical data.
- Recommending policies and determining requirements and priorities for Health Service Logistics (to include blood and blood products, medical supply/resupply, medical equipment and maintenance and repair services, production of medical gases, optometric support and fabrication of single-and multi-vision optical lens, and spectacle fabrication and repair).
- Recommending medical evacuation policies and procedures.
- Monitoring medical regulating and patient tracking operations.
- Developing policies protocols, and procedures pertaining to medical and dental treatment of sick, injured, and wounded personnel.
- Ensuring field medical records are maintained on each soldier at the primary care MTF in accordance with AR 40-66 and FM 4-02.4.
- Ensuring compliance with the theater blood bank service program.
- Ensuring a viable veterinary program is established.
- Ensuring a medical capability or procedures for obtaining this support from out of theater resources are established for the identification and confirmation of the use of suspect BW and CW agent by opposition forces. This also includes the capability for specimens/samples packaging and handling requirements and escort/chain of custody requirements.
- Planning for and implementing preventive medicine operations.
- Planning for and ensuring pre- and post-deployment health assessments are accomplished.
- Establishing and executing a medical surveillance program.

- Establishing and executing an occupational and environmental health surveillance program.
- Recommending Combat Operational Stress Control/Mental Health and substance abuse control programs.
- Coordinating for medical intelligence with the supporting intelligence officer/section/unit. Pursuing other avenues to obtain medical intelligence and/or medical information such as the-
 - Armed Forces Medical Intelligence Center (AFMIC).
 - United States Army Center for Health Promotion and Preventive Medicine.
 - Centers for Disease Control and Prevention (CDC).
 - Ensuring that the general threat, medical threat, and medical intelligence considerations are integrated into HSS plans and orders.
 - Identifying the commander's critical information requirements (CCIR) which include priority information requirements (PIR), essential elements of friendly information (EEFI), and friendly forces information requirements (FFIR) as they pertain to the medical threat; ensuring they are incorporated into the command's intelligence requirements.
 - Coordinating for humanitarian assistance, disaster relief, medical response to NBC or terrorist incidents, and refugee and domestic support operations when authorized and so directed.
 - Advising the commanders on HSS NBC defense actions (such as immunizations, use of chemoprophylaxis, antidotes, pretreatments, and barrier creams.)
 - Ensuring that investigational new drug protocols are established and implemented.

- Assessing special equipment and procedures required to accomplish the HSS mission in specific environments such as urban operations, mountainous terrain, extreme cold weather operations, jungles, and deserts.

- Recommending disposition instructions for captured medical supplies and equipment. Under the provisions of the Geneva Conventions, medical supplies and equipment are protected from intentional destruction and should be used to initially treat sick, injured, or wounded enemy prisoners of war (EPW).

- Submitting to higher headquarters those recommendations on professional medical problems/conditions that require research and development.

- Coordinating and monitoring patient decontamination operations.

c. The command surgeon is responsible for the standard of care which is provided to sick, wounded, and injured soldiers by subordinate medical personnel.

(1) The command surgeon must ensure that standardized protocols for the alleviation of pain (to include the administration of pain relief medication by nonphysician health care providers) are established and disseminated.

(2) The command surgeon is also responsible for ensuring that all controlled substances are stored, safeguarded, issued, and accounted for in accordance with the provisions of AR 40-3.

APPENDIX B

Comparison of MEDCOM(DS) and ASCC Surgeon Section Officer Authorizations and Requirements⁸⁰

MEDCOM					
Title	Grade	AOC	Branch	REQ	AUTH
Commander	MG	00B	GO	1	0
Deputy Commander	BG	00B	GO	1	1
Chief of Staff	O6	67A	MS	1	1
Clinical Services					
Deputy CDR, Professional Serv	BG	00B	GO	1	1
Medical Consultant	O6	61F	MC	1	1
Surgical Consultant	O6	61J	MC	1	0
Nursing Consultant	O6	66N	NC	1	1
Dental Surgeon	O6	63R	DC	1	1
Senior Veterinarian	O6	64Z	VC	1	0
Psychiatrist	O6	60W	MC	1	0
Pharmacy Officers	O6	67E	MS	1	0
Optometry	O5	67F	MS	1	0
Nuclear Medical Science Off	O5	72A	MS	1	0
Social Worker	O5	73A	MS	1	1
Public Health Dentist	O5	63H	DC	1	0
Dietetic Consultant	O6	65C	SP	1	0
DCS Personnel					
DCS Personnel	O6	70F	MS	1	1
Health Service Personnel Off	O5	70F	MS	1	1
Personnel Management Officer	O4	42H	AG	1	1
Personnel Staff Officer	O4	70F	MS	1	1
Theater Patient Movement Ctr					
Aeromedical Evac Officer	O4	67J	MS	1	1
Patient Admin Officer	O4	70E	MS	1	1
Patient Admin Officer	O3	70E	MS	1	1
DCS, Security, Plans, Operations					
DCS, Security, Plans, Operations	O6	70H	MS	1	1
Curr Ops Branch					
Medical Operations Officer	O5	70H	MS	1	1
Medical Operations Officer	O4	70H	MS	2	1
Medical Operations Officer	O4	70H	MS	1	1
Plans Branch					
Medical Operations Officer	O5	70H	MS	1	1
Medical Plans Officer	O4	70H	MS	1	1
Medical Operations Officer	O4	70H	MS	1	1

ASCC Command Surgeon's Office					
Title	Grade	AOC	Branch	REQ	AUTH
Surgeon	BG	00B	GO	1	0
Deputy Surgeon	O6	60A	MC	1	1
Consultants					
Chief Medical Services	O6	61F	MC	1	0
Trauma Coordinator	O6	61J	MC	1	0
Chief Nursing Services	O6	66N	NC	1	0
Dental Surgeon	O6	63R	DC	1	0
Vet Prev Medicine	O6	64B	VC	1	0
Medical Personnel Management					
Health Service Personnel Mgt	O5	70F	MS	1	1
Health Service Personnel Mgt	O4	70F	MS	1	1
Theater Patient Movement Ctr					
Patient Admin Officer	O5	70E	MS	1	1
Aeromed Evac Officer	O4	67J	MS	1	1
Patient Admin Officer	O4	70E	MS	1	1
Medical Operations					
Medical Operations Officer	O6	70H	MS	1	1
Current Ops					
Medical Operations Officer	O5	70H	MS	1	1
Medical Operations Officer	O4	70H	MS	1	1
Med Ops Officer	O3	70H	MS	1	1
Med Ops Officer	O3	70H	MS	2	2
Medical Plans					
Medical Plans Officer	O5	70H	MS	1	1
Medical Plans Officer	O4	70H	MS	1	1
Plans Officer	O3	70H	MS	1	1

⁸⁰ Compiled from MTOEs UIC (WJN2AA) – Operational Command Post, HQ, Army Edate 16 OCT 08; MTOE UIC (WATGAA) – Main Command Post, HQ, Army, Edate 16 OCT 08; and UIC (WNF5AA) - 0030 MD HHC MED DEPLOY, EDATE 16-OCT-08." FMSWeb: <https://webtaads.belvoir.army.mil/> (accessed September 16, 2008).

APPENDIX B

Comparison of MEDCOM(DS) and ASCC Surgeon Section Officer Authorizations and Requirements (Continued)

MEDCOM						ASCC Command Surgeon's Office					
Intel/Ops Br. G2/3											
Medical Operations Officer	O5	70H	MS	1	1						
Intelligence Officer	O4	70H	MS	1	1						
Medical Operations Officer	O3	70H	MS	1	1						
DCS, Logistics						Medical Logistics					
DCS, Logistics	O6	70K	MS	1	1	Health Service Materiel Off	O6	70K	MS	1	1
Health Services Materiel Officer	O4	70K	MS	1	1	Health Service Materiel Off	O4	70K	MS	1	1
Command Maint Off	W4	670A	MS	1	1	Health Service Materiel Off	O5	70K	MS	1	1
Sr. Automation Mgt WO	W3	915E	OD	1	1						
Property Book Officer	W3	920A	QM	1	1						
Medical Logistics Support											
Chief Logistics	O5	70K	MS	1	1						
Supply Management Officer	O4	70K	MS	1	1						
Health Service Materiel Off	O4	70K	MS	1	1						
Clinical Lab Officer	O4	71E	MS	1	0						
Clinical Lab Officer	O4	71E	MS	1	0						
Transportation Officer	O3	88D	TC	1	1						
Transportation Officer	O3	88D	TC	1	1						
Preventive Medicine						Preventive Medicine					
Preventive Medicine Officer	O6	60C	MC	1	0	Environmental Sci Off	O6	72D	MS	1	1
Environmental Science Officer	O5	72D	MS	1	1	Environmental Sci Off	O4	72D	MS	1	1
Entomologist	O5	72B	MS	1	0	Environmental Sci Off	O3	72D	MS	1	1
Environmental Science Officer	O5	72D	MS	1	1						
Environmental Engineer	O5	72E	MS	1	1						
DCS, Info Management						Health Service Systems Manager					
DCS, Info Management	O6	70D	MS	1	0	Health Service Systems Manager	O4	70D	MS	1	1
Biomed Info Management Off	O5	70D	MS	1	1						
C-E Officer	O4	25A	SC	1	1						
C-E Officer	O4	25A	SC	1	1						
Biomed Info Management Off	O4	70D	MS	1	1						
Health Services System Mgr	O3	70D	MS	1	1						
Info Sys Tech	W2	251A	SC	1	1						
Info Sys Tech	W2	251A	SC	1	1						

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