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ARMY MEDICAL SERVICE STAFFING
IN THE COSTAR CORPS

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CLARKE M. BRANDT
Major 0-70132

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1. PURPOSE. The purpose of this study is to determine if the Army Medical Service staffing of TOE 52-1T, Headquarters and Headquarters Company, Corps or Airborne Corps, is adequate.

2. SCOPE. Army Medical Service personnel, henceforth referred to as AMEDS personnel, are listed in three paragraphs of TOE 52-1T. First, the medical section or medical special staff; second, the aid station section or treatment section; and third, the augmentation to the medical section consisting of additional special staff personnel. Each paragraph will be examined to determine if sufficient AMEDS personnel are allocated to accomplish the mission of that particular section.

3. BACKGROUND. In 1961 a study was undertaken of the combat service support of the field army. This study was the beginning of what is now known as COSTAR, combat service support to the army. Objectives were to modernize and simplify combat service support, establish a clear cut command structure, and create a tailorable force structure. To accomplish these goals, new concepts and new or revised organizations were needed.

Not only logistical units were scrutinized but also the headquarters of field army and corps. As a result, the corps TOE was modified. TOE 52-1D, Headquarters, Corps or Airborne Corps and TOE 52-2D, Headquarters Company, Corps or Airborne Corps were consolidated into one TOE.

Combat Developments Command published TOE 52-1T, Headquarters and Headquarters Company, Corps or Airborne Corps on 1 June 1965. This "T" series TOE is for use during development and as AR 310-31 states must be replaced within one year by the Plan TOE (5: para 15). AMEDS staffing of this new TOE reflects some significant changes from TOE 52-1D and TOE 52-2D. It is because of these changes that this study is undertaking to determine if TOE 52-1T provides for adequate AMEDS personnel.

4. MEDICAL SECTION. To properly assess the adequacy of the medical section staff, it is necessary to determine the mission. On the scope of the mission will hinge the size staff required.

A corps surgeon has the multitude of responsibilities common to a surgeon of any command. Additionally, there are functions peculiar to a corps surgeon. These have been enumerated in FM 8-16, Medical Service, Field Army.

FM 8-16 was published to set forth new doctrine developed within the Army Medical Service as a result of the COSTAR concept. It is therefore important in evaluating the AMEDS staffing of TOE 52-1T. The functions of a corps surgeon contained therein must, however, be compared to the functions and responsibilities prior to COSTAR. Inclosure 1 summarizes the functions before and after COSTAR.

Many duties of the corps surgeon remain essentially the same. Under COSTAR, certain duties are stated in broader terms than before. Evaluation, coordination and liaison in medical matters are emphasized. Certain specific tasks previously listed have been eliminated. Duties such as coordinating with FASCOM medical units and a requirement for processing certain medical reports have been added.

It must be realized that the duties as enumerated in field manuals are not entirely encompassing. Certain functions are, or have been, performed whether or not specifically mentioned. Such functions are necessary to fulfill the requirements of broadly stated tasks.

To summarize the responsibilities of the corps surgeon under COSTAR it can be said that he retains basically the same overall responsibilities as before but has fewer specified tasks. It is in this light that the AMEDS staffing of TOE 52-1T must be examined.

The extent of the corps surgeon's supervision is a factor that must be considered in judging the size staff needed to help him fulfill his responsibilities. The following comments are based on the type corps in a type field army.

Staff supervision is exercised over the medical service of the four divisions through liaison with the division surgeons. This relationship is generally understood and no further comment is needed.

(Only seldom will the corps surgeon have ^{the} operational control over any medical units. (He must, however, insure that efficient medical support is rendered to the corps. In order to do this the surgeon must maintain close contact with the forward medical group supporting the corps. (The surgeon must be constantly aware of the tactical situation in order to effectively coordinate with the medical group commander the activities of the twelve hospital units, ten separate medical companies, and various medical detachments present in the group.

The impact of supervising the medical sections of corps non-medical units is often overlooked. Within corps troops there are 42 battalion size units having medical sections and two medical companies capable of providing division level medical service. The separate mechanized brigade, the engineer brigade, and the armored cavalry regiment all have a surgeon on whom the corps surgeon relies for supervision of AMEDS personnel in subordinate units. Corps artillery has no surgeon so supervision of AMEDS personnel of the corps artillery battalions is coordinated through the two artillery group surgeons. No surgeon is authorized in the air defense group therefore the corps surgeon must maintain liaison directly with the battalion surgeons of the seven air defense artillery battalions. The importance of these medical sections becomes apparent when one realizes that they provide unit level medical service to over 30,000 troops. A corps surgeon would be remiss if he allowed these medical sections to become orphans.

As in the case of any principle staff officer, the surgeon needs assistants to accumulate data, prepare plans and policies and help in supervising their implementation. Remembering that the basic functions of the corps surgeon have changed but little under COSTAR, a comparison of his staff before and after publication of TOE 52-1T is worthwhile. Such an examination shows a reduced capability. Inclosure 2 is a detail comparison. Essentially the medical section has been reduced from five officers and six enlisted men to three officers and two enlisted men.

This constitutes a 55 percent decrease in staff without a comparable decrease in work load. The question arises, is the present medical section of five AMEDS personnel sufficient to perform the required duties in a satisfactory manner?

A commander relies on his surgeon to keep him informed of the medical situation so that maximum use may be made of his most valuable asset, manpower. The need for a surgeon is recognized and has been provided in the staffing. Because of the accepted need for this position, no further discussion of this point will be pursued.

The second officer listed in TOE 52-1T is the medical operations officer. Here is a change in the TOE as now this one officer is provided to do what two officers formally did. Is this one officer, then, really enough?

It is the operations officer or officers who in all probability will carry the bulk of the work load in the command post proper. This arrangement frees the surgeon of routine matters thereby enabling him to coordinate many medical activities away from the command post.

What is the work load that the operations officer can normally expect? Duties of the surgeon as shown in FM 8-16 list developing policies, evaluating and coordinating plans (9: para 27 (1) (2)). It is expected that the surgeon will provide the guide lines while the operations officer performs the detail work. To accomplish the detail work as well as keeping the surgeon fully briefed on the essentials, a thorough knowledge of all medical and nonmedical plans effecting the medical support is required. Constant effort is required to keep current as the situation changes.

Normal duties of the operation officer will include preparation of the medical portion of the corps administrative order or annex, compilation of the medical notes for presentation at the daily staff briefing, and preparation of policies developed by the surgeon.

It may seem that the duties described above are routine and would present no undue problem. It is well to examine them in the proper perspective.

Here is one officer with no enlisted assistant per se responsible for accumulating and preparing the detail work for the surgeon. With the increasing mobility inherent in today's army, changes occur much faster than before. Rapid changes require rapid, but correct decisions. Initiation of active nuclear warfare will bring increased difficulties. Medical problems with the accompanying need for immediate coordination is a major concern during an active nuclear environment. Under such battlefield conditions, 24 hour per day, 7 day per week coverage will be required. One officer cannot perform alone for this period.

Another look at the duties of a corps surgeon as outlined in FM 8-16 shows three which are related directly to administrative type duties (9: para 27 (6) (7) (8)). Briefly these are processing medical reports, monitoring medical supply activities, and monitoring AMEDS personnel matters. TOE 52-1T provides only one nonprofessional officer, the operations officer, in the medical section. No provision is made for an administrative officer as was the case in TOE 52-1D.

Is the performance of the three administrative duties large enough to be of concern? A comment on each is appropriate:

The first is processing of medical records and reports. This is phrased "as required" in FM 8-16 (9: para 27 (6)) but in reality will be required. In addition to monitoring division medical reports, reports originating in corps must be considered. Medical sections of corps units will submit certain periodic statistical reports to the surgeon. Examples are data for the Outpatient Report, Morbidity Report, and the monthly transmittal of completed individual medical records. Other reports will be processed such as the Command Health Report and STANAG No. 2075; SOLOG No. 74. The medical records and reports requirement is therefore more than just an occasional report.

The second administrative duty is monitoring medical supplies. Emphasis is on critical items that might affect the medical support of tactical operations. Since routine supply matters are not entered into, the scope of medical supply activities is decreased considerably.

Monitoring critical items and recommending allocations will require up-to-date information on the tactical plans as well as the medical supply situation.

The third administrative duty is monitoring AMEDS personnel matters. Evaluation of requirements and recommendations for assignment of critical personnel is a major portion of this task. Considering that the corps is tailored according to the tactical plan and that both divisions and corps units may be changed, it can be seen that effort must be applied in this area. Unlike the division surgeon who has a fixed organization to monitor, the corps surgeon must be concerned with a continually changing organization.

When considered as a group, the three administrative duties discussed above do present a recognizable work load for the medical section.

With a definite need for 24 hour coverage in the medical section, the work load resulting from the operations and administrative duties indicate the need for more than one officer. There are two possible solutions to this problem. One, utilize the nuclear medical officer; two, add another Medical Service Corps officer.

Utilization of the nuclear medical officer to perform nonprofessional duties has basic drawbacks. A nuclear medical officer is a highly specialized professional officer and using him in largely nonprofessional duties would be a waste of his training. He is also the preventive medicine officer which would detract from his ability to devote time to administrative or operational type duties. The advantage of using this officer is that no increase in staffing is required.

Addition of one Medical Service Corps officer has advantages. It would allow better 24 hour per day operation by insuring that one Medical Service Corps officer is on duty at all times. Better division of the work load can be accomplished thereby providing better flexibility. An additional Medical Service Corps officer also allows the professional officers to devote the majority of their time to their primary duties. A disadvantage of this solution is that an added position is required.

The nuclear medical officer is the third and final officer authorized by TOE 52-1T for the medical section. Here we find a new addition to the section. As the title implies, this officer is an expert in the effects of radiation on humans. His expertise provides the commander better recommendations concerning effects of nuclear warfare on the troops within the corps. Policies dealing with preventive measures, effects, treatment, and evacuation of radiation casualties can be effectively promulgated and disseminated to surgeons at lower echelons. In a nuclear environment, the presence of a nuclear medical officer should be of value to both command surgeons and commanders alike. TOE 52-1T also designates the nuclear medical officer as the assistant surgeon as well as a preventive medicine officer (27: remark 60 p. 25).

Preventive medicine functions within a command is inherent in the responsibilities of the surgeon. It is interesting to note that FM 8-16 makes no reference to preventive medicine functions within the corps as did FM 8-10. TOE 52-1T deletes the preventive medicine personnel previously authorized. This function is now an additional duty of the nuclear medical officer.

Divisions are authorized a preventive medicine officer as is field army, yet a type corps with over 38,000 corps troops does not have one individual whose full time duty is preventive medicine. Only through additional personnel can the preventive medicine capability of the section be increased.

After the preceding discussion of the officers assigned to the medical section, it is time to evaluate the enlisted staffing.

It is in the enlisted staff that we find the most drastic reduction in strength. Under TOE 52-1T only the sergeant major and one clerk remain. The clerical capability of the medical section has been greatly diminished. A closer look will show what impact this has on the operation of the section.

Both TOE 52-1D and TOE 52-1T provide for a senior noncommissioned officer designated as the sergeant major. Due to the austere staffing, the incumbent of the sergeant major's position may be required to perform more of a variety of duties than before. As the need for a senior non-commissioned officer has been recognized and provided for in both TOEs, no further discussion will be made on this position.

Loss of the preventive medicine specialist has already been alluded to in the comments on preventive medicine. Failure to provide for this specialty decreases the assistance available to the officer performing preventive medicine duties. To furnish better preventive medicine support to the corps, serious considerations should be given to reinstating this specialty in the TOE.

The second and last enlisted man authorized by TOE 52-1T is a clerk typist. With the elimination of one each stenographer, clerk typist and general clerk, it is readily apparent that the clerical capability of the medical section is greatly reduced. Can the one remaining clerk adequately cope with the work load generated by the other members of the section?

Reviewing the activities of the assigned officers it is found that a need exists for 24 hour per day coverage in the section, that preparation of reports is a recurring necessity and that medical plans need constant revision. All these activities plus routine daily matters require clerical assistance. The scope and hours required for coverage exceeds the capability of one clerk typist.

To provide the manpower necessary for minimum coverage an additional clerical position is indicated. Reliance on the sergeant major to assist in these matters should not be counted on since his MOS is medical not administrative.

After a rather close inspection of the duties, organization, and staffing considerations of the corps medical section, it is now time to examine the second section of corps staffed with AMEDS personnel, namely the aid station section.

5. AID STATION SECTION. Unit level medical service - this is the function of the corps aid station section. Day to day medical care is given to the 247 members of the corps staff as well as corps units normally situated in the vicinity of the corps command posts. These additional corps troops increase the number of personnel supported by several hundred depending on the situation.

Both TOE 52-2D and TOE 52-1T make provisions for an aid station. The basic difference is a reduction of two enlisted men in the COSTAR TOE. Inclosure 3 shows the staffing authorized by both TOEs.

Echelonment of the corps command posts creates special problems in providing unit level medical service to all members of the corps headquarters. Establishment of an aid station at both corps rear and main is impossible due to limitations in personnel and in equipment which is based on a one area operation.

The one medical officer assigned will operate in the area of greatest troop density so as to be available to the largest number of personnel possible. Only five enlisted men are authorized to operate the aid station and to conduct evacuations when necessary. This number is very austere and permits but limited flexibility in operations. Depletion of this small number by diverting one or more aidmen to corps rear would hinder aid station operations as well as providing only marginal medical support at corps rear.

In order for the aid station section to be capable of providing medical support at corps rear, both equipment and personnel would have to be increased. Assignment of additional AMEDS personnel, particularly a medical officer, would probably not be feasible due to the relatively small number of troops located in the vicinity of corps rear.

Three solutions to the medical support problem at corps rear are possible. First, increased personnel and equipment of the aid station section. Second, an arrangement for personnel at corps rear to be brought to the aid station at corps main. Third, rely on the supporting medical

group to establish a facility in the vicinity of corps rear and provide necessary medical service from there. The third solution is the most practical as it requires no additional men or equipment.

While the staffing of the aid station section can be considered adequate for routine operations, it is not large enough to cope with any unusual increase in work load. Under such circumstances, outside assistance will be required.

6. AUGMENTATION TO THE MEDICAL SECTION. Under certain conditions the corps may be assigned an independent mission. When such a situation arises, the corps assumes responsibility for its own combat service support. The corps surgeon must then act in the capacity of a field army surgeon. Since the corps medical section is austere staffed, augmentation is absolutely necessary.

Before examining the AMEDS augmentation provided by TOE 52-1T, a review of the field army surgeon's duties is in order. By becoming familiar with functions normally performed at field army, a point of reference will be established when analyzing the corps AMEDS augmentation. In making the review TOE 51-1T, Headquarters and Headquarters Company, Army, dated 30 November 1965 and FM 8-16 dated June 1965 are used. These are the documents developed as a result of the COSTAR concept.

The field army surgeon will develop, prepare and coordinate medical policies; provide current information on the medical situation to surgeons of higher and subordinate headquarters; exercise professional supervision over the field army medical service; operate an AMEDS personnel branch; furnish professional consultation service and prepare or consolidate medical statistical reports and records of events (9: para 5). His commissioned staff has in addition to those found at corps, a dental surgeon, a preventive medicine officer, a medical statistical officer and professional consultants.

The presence of the additional specialties represented among the officer personnel indicates field army has a much larger scope of

activities than corps. Since corps will be assuming duties connected with these specialties, provision should therefore be made in the corps augmentation for personnel who can perform similar functions.

Comparison of the medical section augmentation as provided by TOE 52-1D and TOE 52-1T is shown in Inclosure 4. Present authorization is nine officers and three enlisted men as compared to the seven officers and eight enlisted men provided before.

Changes among authorized officer positions is not large. Enlisted staffing however, reflects the same drastic reduction as in the medical section.

The professional type officers, dental, medical and surgical consultant, and nurse are authorized as before. The same is true of the sanitary engineer and the medical supply officer. Both the nurse and medical supply officer warrant further consideration.

Because TOE 51-1T has recently been published, certain discrepancies now exist concerning the nurse and medical supply officer. This new TOE has deleted both positions from the previous field army organization contained in TOE 51-1D.

FM 8-16 mentions a nursing branch in the army surgeon's office, yet TOE 51-1T makes no provision for any army nurse. Neither the FASCOM surgeon's section nor the medical brigade is authorized a nurse. It would seem that until a decision is made regarding if a nurse is to be included in field army and at what level, the inclusion of a nurse on the corps augmentation is open to question.

FASCOM surgeon's section is now charged with the responsibility of planning and supervising medical supply matters. Deletion of the medical supply officer from the army TOE has been in effect a transfer of this position and responsibility to the medical brigade and FASCOM. Inclusion of a medical supply officer on the corps augmentation is warranted under present conditions. During independent corps operations the medical group assuming the medical brigade duties does not have a

medical supply and maintenance staff officer who can provide staff assistance in these matters as FASCOM can for the army surgeon.

Addition of a preventive medicine officer is merely replacing the position eliminated in the basic staffing. By placing this specialty in the augmentation the nuclear medical officer is freed of his preventive medicine duties and can devote full time to nuclear medicine during the independent corps operations. Better preventive medicine capability results.

For the first time a veterinary staff officer appears at corps. He will assume veterinary responsibilities normally performed at FASCOM. Supervision of veterinary activities is appropriate from the corps surgeon's office because, as in the case of the medical supply officer, the supporting medical group is not able to furnish this staff advice.

A medical reports and statistical officer is the last addition to the corps augmentation. His skill aids in fulfilling the surgeon's responsibilities in the areas of medical reports and administration.

While field army provides a medical, surgical, and psychiatric consultant, the corps augmentation has only the first two. Because of parallel authorizations of both medical and surgical consultants at field army and corps, a professional evaluation of the need for a psychiatric consultant at corps would be appropriate.

Deletions in the new augmentation is limited to the operations officer. What effect this has will be discussed shortly.

Five enlisted personnel have been deleted in the current augmentation. They represent enlisted assistants to the operations officer, the medical supply officer plus an administrative noncommissioned officer. Clerical personnel balance out with the addition of a stenographer and deletion of a clerk typist.

In considering the combined medical section and augmentation three areas stand out; namely operations, medical supply, and administration.

During independent corps operations a medical group is tailored and attached to the corps support command to provide medical support

to the corps. The corps surgeon must therefore provide direction to the medical group in the same manner as the field army surgeon does the medical brigade. The operations officer will be the surgeon's principle staff officer in developing and effecting coordination with the medical group. This function will be in addition to those normally performed. Operations personnel authorized by both the medical section and the augmentation have been decreased from three officers and one noncommissioned officer to one officer. This lone officer authorized by TOE 52-1T appears to have a work load in excess of his ability to accomplish it.

The second area of interest is medical supply. Here medical supply personnel have been cut from one officer and three enlisted men to one officer. While FASCOM surgeon's office has only a medical supply staff officer, the supply section of the medical brigade does include enlisted supply specialists. During independent corps operations the corps medical supply officer must do the jobs of both FASCOM and the medical brigade. Limitations of the supporting medical group in this area has already been noted. Accomplishment of both jobs would seem to create a need for at least one enlisted supply specialist to help the medical supply officer.

The third area of interest is administration. Under TOE 52-1D one officer and eight enlisted men were designated by administrative titles. TOE 52-1T authorizes only four administrative enlisted personnel. The number of officers supported in both instances is 12.

In addition to a constant number of officers to support administratively, consideration must be given to the elimination of enlisted assistants to the operations, medical supply, and preventive medicine officers. There could very well be a tendency under such circumstances to utilize administrative personnel in nonclerical duties, thereby further decreasing the administrative capability.

Any analysis of augmentation to the corps medical section must be accomplished not as a separate entity but as an integral part of the overall section. If this is done we find that TOE 52-1T does provide

for most of the necessary skills in the augmentation but that the number of personnel assigned is limited in certain areas.

7. OPINIONS FROM THE FIELD. AR 310-31 states the purpose of a tentative TOE is to provide a document to be used in developing and testing for optimum organization prior to publication of a standard TOE (5: para 15a). Since now is the test period for corps, questionnaires concerning the tentative AMEDS staffing of corps were sent to various corps surgeons. Opinions of corps medical staffs are extremely worthwhile as these are the people who must live with the personnel authorizations. Questionnaires completed by 5th and 7th Corps as well as 18th Airborne Corps are attached as Inclosures 5, 6, and 7. 1st Corps is still organized under TOE 52-1D and TOE 52-1T was not available for comparison. The medical section of 3rd Corps has not been reconstituted since it was depleted last fall and was therefore also unable to complete a questionnaire.

Naturally each headquarters has a slightly different view on exactly what is needed in staffing their medical section. No attempt is made to discuss each questionnaire in detail but a general summation on major points is included here.

There was a unanimous consensus of opinion that the medical section as staffed under TOE 52-1T is inadequate. All three corps indicated a need for one additional Medical Service Corps officer to assist in administrative and operational type functions.

Preventive medicine was the second area commented on by all corps. A need for increased capability in this field was indicated by the recommendations of adding a specialist in preventive medicine. Whether this person should be officer or enlisted was a point of difference.

An increase in enlisted personnel was felt to be a necessity. Differences in the specialties required was reflected although two of the three corps expressed a need for additional clerical personnel while the third was inclined towards an operations sergeant.

In the aid station section one corps felt the present staffing was satisfactory while two considered an increase desirable. The increase would basically reinstate the two medical aidmen deleted from TOE 52-2D.

Largest variance of opinion was found to exist in the responses concerning suitability of the medical section's augmentation. All corps were generally satisfied with the officer staffing, but additional enlisted personnel were desired by everyone. These additions, however, ranged from one to eight. The only common factor in all corps responses was a recommendation for one additional person in the operations area. Other enlisted personnel were based on providing specialists to assist specific staff officers.

Representative opinions on the medical staffing of corps were obtained from two noncorps units. Both the Surgeon, USCONARC, and personnel of the Medical Field Service School completed questionnaires which are attached as Inclosures 8 and 9. Here again only a summary of major points will be discussed.

There was a difference of opinion regarding the officer personnel in the medical section. Medical Field Service School felt the present number was sufficient while USCONARC indicated a need for an additional Medical Service Corps officer. Both thought one more enlisted man was desirable.

In the aid station section there again was a split decision with USCONARC accepting the present staffing while Medical Field Service School wanted one additional enlisted man.

Regarding the augmentation, there was agreement that the officer staffing was acceptable as is but that there should be additional enlisted men. A difference exists in the MOS's. USCONARC prefers an operations sergeant while Medical Field Service School tends toward assistants to the preventive medicine officer and the medical supply officer.

It can be said after reviewing all completed questionnaires that there is a unanimous opinion that the AMEDS staffing of TOE 52-1T is

inadequate. The majority felt that both a Medical Service Corps officer and at least one enlisted man should be added to the medical section. Staffing of the aid station section seems to be a border line case because of the fairly even differences of opinion. Augmentation to the medical section was generally felt adequate in the officer staffing but insufficient in enlisted men.

8. CONCLUSIONS. Based on this study conclusions concerning AMEDS staffing of TOE 52-1 are:

- The overall AMEDS staffing is inadequate.
- Staffing of the medical section is not commensurate with the functions outlined in paragraphs 27 and 30, FM 8-16.
- The medical section lacks sufficient personnel in the operations, preventive medicine and administrative fields.
- AMEDS personnel assigned to the aid station section are barely adequate.
- Only one location can be medically supported by the aid station section. Echelonment of the corps headquarters requires additional AMEDS personnel and equipment or support by other medical units if medical service is desired at both main and rear command posts.
- The medical section staffing must be considered when formulating AMEDS personnel requirements for augmentation.
- Augmentation to the medical section generally provides the necessary skills among officer personnel to supervise medical operations during an independent corps operation.
- Assignment of a nurse to the augmentation is questionable at this time due to tentative elimination of a comparable position at field army level.
- There is a need to determine if a psychiatric consultant is warranted since this is the only consultant present in the army surgeon's office not represented in the corps augmentation.
- A shortage of operations personnel exists within the augmentation.

-- Enlisted personnel are limited in the augmentation.

9. RECOMMENDATIONS. Based on this study the following recommendations are proposed regarding AMEDS staffing of TOE 52-1T:

-- The medical section be increased by one Medical Service Corps officer, one full time specialist in preventive medicine and one clerk typist.

-- Augmentation to the medical section be increased by one in the operations area and one in the administrative area.

-- The need for a nurse and a psychiatric consultant in the augmentation be determined and deleted or included as appropriate.

-- Branch, grade, and MOS of additional AMEDS personnel listed above be designated by the Army Medical Service Agency, Combat Developments Command.

-- All recommended changes be incorporated into the corps Plan TOE when published.

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28. TOE 52-1D, Headquarters, Corps or Airborne Corps, (Department of
the Army, 2 May 1961).
29. TOE 52-1T (Tentative), Headquarters and Headquarters Company, Corps
or Airborne Corps, (Combat Developments Command, 1 June 1965).
30. TOE 52-2D, Headquarters Company, Corps or Airborne Corps, (Department
of the Army, 2 May 1961).
31. Watson, Major Robert E., MSC, Executive Officer, Medical Section,
XVIII Airborne Corps, questionnaire (27 December 1965).
32. Welch, Lieutenant Colonel Philip H., MC, Surgeon, VII Corps, Ques-
tionnaire (December 1965).

33. Wickam, Major General Kenneth G., USA "COSTAR," Military Review,
(Fort Leavenworth, Kansas, USACGSC, March 1965).

DUTIES OF THE CORPS SURGEON

BEFORE COSTAR

1. Keep corps commander informed of the medical situation in all divisions so far as it may influence tactical operations.
2. Plans for employment and supervises operation of attached medical units.
3. Exercise functions of field army surgeon when corps is operating independently.
4. Supervises and inspects medical supply matters. Takes appropriate staff action to correct deficiencies.
5. Makes recommendations in matters regarding AMEDS personnel attached or assigned to the corps.
6. Exercises responsibility for preventive medicine of corps troops and maintains statistical data on disease and nonbattle injuries.
7. Supervises medical training of non-medical troops.

UNDER COSTAR

1. Keeps corps commander advised of medical support situation.
2. Maintains liaison with surgeons of higher and subordinate commands.
3. Exercises staff supervision of medical service within corps and divisions.
4. Develops medical policies in agreement with policies of higher headquarters.
5. Evaluates, coordinates, and implements medical plans in agreement with plans of higher headquarters.
6. Assumes duties of field army surgeon when corps is operating independently.
7. Monitors medical supply activities with emphasis on critical items affecting medical support of the combat mission.
8. Monitors AMEDS personnel matters.
9. Keeps constant and accurate information on the health of the command.

BEFORE COSTAR

UNDER COSTAR

10. Process medical records and reports as necessary.

Data from paragraphs 230, 231, and 232, FM 8-10 and paragraphs 27, 28, and 30, FM 8-16.

CORPS MEDICAL SECTION

<u>POSITION</u>	<u>BRANCH</u>	<u>MOS</u>	<u>TOE 52-1D</u>	<u>TOE 52-1T</u>
Surgeon	MC	3000	1 Colonel	1 Colonel
Medical Plans Operations Officer	MC	3000	1 Lt Colonel	-
Medical Operations Officer	MSC	2162	-	1 Lt Colonel
Nuclear Medical Officer	MC	3400	-	1 Lt Colonel
Assistant Operations Officer	MSC	2162	1 Major	-
Preventive Medicine Officer	MC	3005	1 Major	-
Medical Administrative Assistant	MSC	3506	1 Lieutenant	-
Chief Medical NCO	NCO	911.90	1 E9	1 E9
Chief Preventive Medicine Specialist	NCO	933.70	1 E7	-
Stenographer		712.20	1 E5	-
Clerk Typist		711.10	2 E4	1 E4
General Clerk		710.00	1 E3	-
Total Officers			5	3
Total Enlisted Men			6	2

Data from paragraph 18, TOE 52-1D and paragraph 15, TOE 52-1T.

CORPS AID STATION SECTION

<u>POSITION</u>	<u>BRANCH</u>	<u>MOS</u>	<u>TOE 52-2D</u>	<u>TOE 52-1T</u>
General Medical Officer	MC	3100	1 Captain	1 Captain
Section Sergeant	NCO	911.60	1 E6	1 E6
Medical Assistant		911.30	1 E6	1 E6
Senior Medical Aidman		911.20	1 E5	1 E5
Ambulance Driver		911.10	1 E4	1 E4
Medical Aidman		911.10	2 E4	1 E4
Aid Station Attendant		910.00	1 E3	-
Total Officers			1	1
Total Enlisted Men			7	5

Data from paragraph 6, TOE 52-2D and paragraph 21, TOE 52-1T.

AUGMENTATION TO CORPS MEDICAL SECTION

<u>POSITION</u>	<u>BRANCH</u>	<u>MOS</u>	<u>TOE 52-1D</u> (1)	<u>TOE 52-1T</u>
Dental Surgeon	DC	3178	1 Lt Colonel	1 Lt Colonel
Medical Consultant	MC	3139	1 Lt Colonel	1 Lt Colonel
Surgical Consultant	MC	3150	1 Lt Colonel	1 Lt Colonel
Preventive Medicine Officer	MC	3005	-	1 Lt Colonel
Operations Officer	MC	2162	1 Lt Colonel	-
Veterinary Staff Officer	VC	3203	-	1 Lt Colonel
Medical Supply Officer	MSC	4490	1 Major	1 Major
Chief Nurse	ANC	3430	1 Major	1 Major
Sanitary Engineer	MSC	7960	1 Captain	1 Major
Medical Reports Statistical Officer	MSC	2431	-	1 Captain
Medical Operations Sergeant	NCO	911.80	1 E8	-
Medical Supply Sergeant	NCO	767.60	1 E8	-
Administrative Supervisor	NCO	717.60	1 E6	-
Senior Stenographer		712.20	-	1 E5
Clerk Typist		711.20	-	2 E4
		711.10	3 E4	-
Medical Supply Specialist		767.10	1 E4	-
Supply Clerk		760.00	1 E3	-
Total Officers			7	9
Total Enlisted Men			8	3

(1) Includes Dental Section

Data from paragraphs 30 and 32, TOE 52-1D and paragraph 27, TOE 52-1T.

QUESTIONNAIRE

All questions pertain to the medical staffing as shown in TOE 52-1T, Headquarters, United States Combat Developments Command, dated 1 June 1965.

SECTION I

Questions relate to basic staffing when corps is operating as part of field army.

A-MEDICAL SECTION (Paragraph 15):

1. a. Is the medical section staffed with an adequate number of officers to perform the mission? No.

b. If not, what additions are required?

A medical admin ass't of a medical reports-statistic officer.

2. a. Is the medical section staffed with an adequate number of enlisted personnel? No.

b. If not, what additions are required?

1 Prev med spec (E-7) MOS 91S40

1 Clerk typist (E-4) " 71B30

1 Stenographer (E-5) " 71C30

3. a. Are the MOSs of all personnel those that are desired? Yes.

b. If not, what changes should be made?

4. a. Considering that a Nuclear Medicine Officer is assigned to the field army surgeon's office, is a Nuclear Medicine Officer required at corps level? Yes, he is required to provide timely advise to the Corps commander and staff.

b. If not, why not?

5. Is it realistic to require that the Nuclear Medicine Officer, MOS 3004, also be qualified as a Preventive Medicine Officer, MOS 3005, as indicated by Remark 60? Yes, because Corps units, other than divisional, do not have prev med officers assigned.

6. Is successful completion of special weapons training necessary for the Surgeon or the Medical Operations Officer, as required by Remark 55 if:

- a. A Nuclear Medicine Officer is assigned?
Not mandatory, but certainly advantageous.
- b. A Nuclear Medicine Officer is not assigned?
Yes.

B-AID STATION SECTION (Paragraph 21):

- 1. a. Is the section staffed with adequate officers?
Yes.
- b. If not, what additions are needed?
- 2. a. Is the section staffed with sufficient enlisted personnel?
No.
- b. If not, what changes should be made?
The following should be added:
1 Clerk typist MOS 71B30
2 Aidmen " 91B10
- 3. a. Are the MOSs those that are desired?
Yes.
- b. If not, what changes should be made?
- 4. a. Can the section provide the necessary medical treatment support when the corps is echeloned in a tactical disposition of a corps tactical command post and a main and rear echelon? (Consider personnel, equipment, and vehicles) No.
- b. If not, what means can be taken to provide the necessary support? Necessary medical support is furnished by medical group providing army level support to the Corps sector.

SECTION II

Questions relate to the augmented staff when corps is operating independently.

A-MEDICAL SECTION (Paragraph 27):

1. a. Does the augmentation provide for sufficient officers?
Yes.
b. If not, what additions are required?

2. a. Does the augmentation provide for the proper specialities?
Yes.
b. If not, what changes should be made?

3. a. Are sufficient enlisted personnel provided?
No.
b. If not, what additions should be made?
4 Clerk typists

4. Should an assistant, either officer or enlisted, be provided the Medical Operations Officer? Yes, a medical operations sargent

5. Should a Preventive Medicine Specialist be provided to assist the Preventive Medicine Officer and Sanitary Engineer?
Yes.

6. Should a Medical Supply Specialist be assigned to assist the Medical Supply Officer? Yes,

SECTION III

1. What TOE is your headquarters operating under at this time?
(Corps only) TOE 52-1E

2. If operating under TOE 52-1T, has local augmentation been provided to the section for peacetime operations? If so, how much?
(Corps only)

Presently there is no indication that this Hq will go under TOE 52-1T, however, strong recommendations have been made to augment the Med Sec with two additional officers and two enlisted men.

3. Remarks and/or other comments.

During a recent FTX we where asked to determine the adequacy of personnel staffing for the Corps medical section. The evaluation of that objective is inclosed for your perusal.

To give you a further insight, a copy of briefing notes is also inclosed. Frankly, we find it next to impossible to operate the Corps med section with the auth 2 officers and 2 EM. Very happy to see that someone else is interested in our problems -

Wol Heiwinkel XESC

Medical Section, Hq V Corps
Preparing Headquarters

8 Dec 1965
Date

OBJECTIVE: To determine the adequacy of Personnel Staffing for the Corps Medical Section.

DISCUSSION: TOE 52-1E limits the staffing of this section to 2 officers and 2 EM. This manning level does not provide sufficient personnel for proper liaison to and supervision of the medical service operations of attached divisions and army level medical support. Further, the section cannot effectively perform its various staff functions on a sustained 24 hours basis as usually required during field exercises. Accordingly, its capability is necessarily limited to advising the commander and staff on the "force-wide" aspects of technical and professional medical matters and can only provide "broad" supervision over the medical support operations.

CONCLUSION: The responsibilities outlined in chapter 4, FM 8-16 cannot be effectively performed without administrative augmentation.

RECOMMENDATION: That Corps Medical Section be augmented with the following listed personnel;

1 Officer MSC 2162

1 N80 91S40

1 Officer MSC 2431

1 EM 71B30 E-4

INCL #1

BRIEFING FOR CHIEF OF STAFF
PERSONNEL AUGMENTATION

Workload:

Consists of two functions

1. Staff work (normal requirement)

Tech supervision of medical service in divisions & dispensary.
Supervise Army Medical support (treatment, Evac, PM, Med Sup).
Med Plans & Prof Training (Expert Med Soldier (QJ)).

2. Peace-time requirement of higher headquarters.

600-800 separation medical exams - review & approve, @ 20 min
Each 233 man hours per month (USAREUR Reg 40-102)
Review & approve Command Health report of Corps troops
and preparation of report for this headquarters.
Prev Med activities - AGI support - billet standards, environmental
sanitation - Review and analyze all medical reports.

Impact:

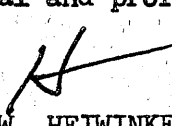
Staffing of this section with 2 officers (both MC) and 2 EM (Sgt Maj & Clk Typist) will reduce the overall capability to that of advising the Corps Commander and staff on "force-wide" aspects of medical support matters and "broad" supervision over medical operation and plans.

Justifications:

Manpower requirements for supervision over medical sections of Corps troops exist because no staff surgeons, comparable to Division Surgeon, are authorized at Group level for medical elements operating at battalion level. As a comparison, a division has 25 MC and 26 MSC officers authorized. Corps troops has 19 MC and 5 MSC officers authorized. The shortage of MSC officers in Corps troops necessarily increases the workload of the Corps Surgeons office (next higher staff Surgeon) by two spaces, one Plans & Operations officer and one Preventive Medicine Specialist.

Further, because of the requirement by USAREUR of minute review and approval of separation (rotation, 208, 209, etc.) medical examinations, an additional officer (Med Adm Asst) and one clerk typist are required to meet this workload (600-800 examinations per month).

Also, it is the opinion of the former Surgeon (Col Bralley) that a definite need exists for a Preventive Medicine Officer (Capt) in order to function more satisfactorily in the significant area of preventive medicine and to assist the Corps Surgeon in other technical and professional areas and visits to Corps troops medical elements.


HANS W. HEIWINKEL
Lt Col, MSC
Executive Officer

Incl #2

MEDICAL SECTION

TOE 52-1E

(AUTH)

2 OFF
0 EM

SURGEON

XO

(REQ)

1 OFF

P & O DIV

P & O OFF 2162 2

(AUTH)

0 OFF
2 EM

(REQ)

1 OFF
1 EM

ADMIN DIV

Sgt Maj 911.90
Clk Typist 711.20
Med Adm Off 3506 1
Clk Typist 711.20 2

(REQ)

1 OFF
1 EM

PREV MED DIV

Prev Med Off 3005 4
Prev Med Spec 933.70 5

RECAPITULATION

	OFF	EM
AUTH	2	2
REQUIREMENTS	5	4
SHORTAGE	3	2

- 1 USE PAR 27, LINE 09, TOE 52-1T - MGD RPT - STAT OFF, 2431 - CAPT MS
- 2 USE PAR 15, LINE 02, TOE 52-1T - MED OP OFF, 2162 - LT COL
- 3 USE PAR 27, LINE 10, TOE 52-1T - SR STENO, 712.20 - E-5
- 4 USE PAR 27, LINE 04, TOE 52-1T - PREV MED OFF, 3005 - LT COL (CAPT)
- 5 USE PAR 01, LINE 02, TEAM LA, TOE 8-500D - CH PREV MED SPEC, 933.6 - E-6

QUESTIONNAIRE

All questions pertain to the medical staffing as shown in TOE 52-1T, Headquarters, United States Combat Developments Command, dated 1 June 1965.

SECTION I

Questions relate to basic staffing when corps is operating as part of field army.

A-MEDICAL SECTION (Paragraph 15):

1. a. Is the medical section staffed with an adequate number of officers to perform the mission? No

	<u>STRENGTH</u>	
b. If not, what additions are required?	FULL	REDUCED
Corps Surgeon	1	1
PM Officer	1	
Nuclear Officer	1	
Med Ops Officer	1	1
Med Admin Officer	1	1

2. a. Is the medical section staffed with an adequate number of enlisted personnel? No

b. If not, what additions are required?	FULL	REDUCED
Ch Med NCO	1	1
PM Specialist	1	1
Nuclear Specialist	1	
Clerk Typist	2	2
Radio Telephone Operator	1	

3. a. Are the MOSs of all personnel those that are desired?

No

b. If not, what changes should be made?

(1) PM officer or nuclear officer should be ass't Corps Surgeon depending upon seniority.

(2) Med Admin Officer may have primary MOS Supply, secondary plans ops or visa versa.

(3) PM officer or Nuclear officer should be capable of*

4. a. Considering that a Nuclear Medicine Officer is assigned to the field army surgeon's office, is a Nuclear Medicine Officer required at corps level? Yes, but dependent upon decision of Theater of OPS CO e.g. not necessary at present in Vietnam. However, unclassified*

b. If not, why not?

5. Is it realistic to require that the Nuclear Medicine Officer, MOS 3004, also be qualified as a Preventive Medicine Officer, MOS 3005, as indicated by Remark 60?

Probably not, but answer should be left up to a committee of specialists in these MOS's.

6. Is successful completion of special weapons training necessary for the Surgeon or the Medical Operations Officer, as required by Remark 55 if: The problem refers to prefix 5 training, this is desirable and preferable but should not be mandatory

a. A Nuclear Medicine Officer is assigned?

b. A Nuclear Medicine Officer is not assigned?

B-AID STATION SECTION (Paragraph 21):

1. a. Is the section staffed with adequate officers?

Yes

b. If not, what additions are needed?

Please note that peacetime mission is probably more extensive than war time mission. The dispensary has a pharmacy, lab, EKG, audiometer, etc. It is staffed with 12-13 people including a civilian M.D.

2. a. Is the section staffed with sufficient enlisted personnel?

No

b. If not, what changes should be made?

Reference to ques. 4 below an additional ambulance driver and medical aid man probably justified for a Corps CP main area. The supporting ambulance and other equipment should also be added.

3. a. Are the MOSs those that are desired?

Yes

b. If not, what changes should be made?

4. a. Can the section provide the necessary medical treatment support when the corps is echeloned in a tactical disposition of a corps tactical command post and a main and rear echelon? (Consider personnel, equipment, and vehicles) See 2(b) Remarks: The aid station Section is part of Hq & Hq Co and not related directly with Corps Surgeon mission.*

b. If not, what means can be taken to provide the necessary support?

SECTION II

Questions relate to the augmented staff when corps is operating independently.

A-MEDICAL SECTION (Paragraph 27):

1. a. Does the augmentation provide for sufficient officers?
No
b. If not, what additions are required?
See 4
2. a. Does the augmentation provide for the proper specialities?
Yes
b. If not, what changes should be made?
3. a. Are sufficient enlisted personnel provided?
No
b. If not, what additions should be made?
(1) PM Sepcialist
(2) Med NCO
4. Should an assistant, either officer or enlisted, be provided the Medical Operations Officer? Yes
5. Should a Preventive Medicine Specialist be provided to assist the Preventive Medicine Officer and Sanitary Engineer? Yes
6. Should a Medical Supply Specialist be assigned to assist the Medical Supply Officer? No

SECTION III

1. What TOE is your headquarters operating under at this time?
(Corps only) TOE 52-1T

2. If operating under TOE 52-1T, has local augmentation been provided to the section for peacetime operations? If so, how much?
(Corps only) An excess PM NCO E7 is currently part of coincidence rather than design.

3. Remarks and/or other comments.

(a) Answers to Section II are based upon the requirement that such augmentation be available in Corps. That is to say that reduplication with the capability to the assigned Medical Group should not occur. In fact it is my opinion that the Medical Group CO and Corps Surgeon should be the same individual.

Ref #3B(3)- performing other medical corps duties as prescribed by Corps Surgeon. (4) PM Specialist should be of sufficient grade (E8) or at least (E7) to perform duties of Ch Med NCO, in his absence.

Ref #4(a)- sources indicate sufficient stock piling in Europe to expect decentralization at least to Corps level to cover needed medical planning, inspection, and supervision of requirements.

Ref B-Aid Station Section, #4(a)- responsibility or resources. Exception is that the segment of the medical aid section described in para 4 should be located under hegemony of Corps Surgeon in Corps CP Main.

It's always a pleasant surprise to discover the whereabouts and doings of an old acquaintance. I am pleased that your career is progressing so well.


PHILIP A. WELCH
Lt Col, MC
Surgeon

Preparing Headquarters

Date

HEADQUARTERS XVIII AIRBORNE CORPS
Office of the Surgeon
Fort Bragg, North Carolina 28307

AJBMD-C

27 December 1965

SUBJECT: Answers to Questionnaire Submitted by Major Clarke M. Brandt, MSC

SECTION I

A-MEDICAL SECTION

1. a. No
b. O-3 - 3506 (1) Contingency Planning
(2) Administration
2. a. No
b. E-6 - Operations NCO
3. a. No
b. We feel that a Preventive Medicine Officer (3005) should have been authorized and that the 3004 should be in augmentation.
4. a. We do not feel so.
b. Considering nuclear weapons employment doctrine we feel this is probably a duplication of effort.
5. Yes, unless the change indicated in 3b is effected. The short PM course at Ft Sam Houston would at least give him basic orientation in order to assist the Corps Surgeon.
6. a. No
b. Without a Nuclear Medicine Officer it is highly desirable that the Operations Officer have training in the use of special weapons. I do not feel that it is necessary that he be a prefix 5 however. The course at Command and General Staff College would be adequate.

B-AID STATION SECTION

1. a. Yes, for normal operations.
b. N/A
2. a. Yes
b. N/A
3. a. Yes
b. N/A

Incl 7

27 December 1965

SUBJECT: Answers to Questionnaire Submitted by Major Clarke M. Brandt, MSC

4. a. Yes

b. Considering the intended mission of the Aid Station Section (e.g., dispensary type service for the company) and the resources available from the Medical Brigade I feel that this section is adequate. We envision that medical support for Corps rear echelons can be provided on an as needed basis from these resources. This allows the Aid Station Section to support the Corps tactical CP.

SECTION II

1. a. Yes

b. N/A

2. a. Yes

b. N/A

3. a. No

b. E-6 or above, Operations NCO.

4. See 3b, above.

5. I do not feel this necessary at Corps level.

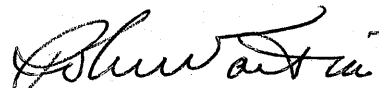
6. Our experience with XVIII Airborne Corps indicates that the Medical Supply Officer is primarily a consultant and can function without special assistance.

SECTION III

1. 52-1T

2. Surgeon, XVIII Airborne Corps, has requested that one Captain 3506 be added for CONUS operations (MEDO Letter). This officer will be utilized for work in contingency planning.

3. When 52-1T is augmented the Medical Supply Officer, as well as others, can be utilized to assist the Operations Officer. Without augmentation 52-1T is not adequately staffed.



ROBERT E. WATKINS
Major, MSC
Executive Officer

QUESTIONNAIRE

All questions pertain to the medical staffing as shown in TOE 52-1T, Headquarters, United States Combat Developments Command, dated 1 June 1965.

SECTION I

Questions relate to basic staffing when corps is operating as part of field army.

A-MEDICAL SECTION (Paragraph 15):

1. a. Is the medical section staffed with an adequate number of officers to perform the mission?

b. If not, what additions are required?

2. a. Is the medical section staffed with an adequate number of enlisted personnel?

b. If not, what additions are required?

3. a. Are the MOSs of all personnel those that are desired?

b. If not, what changes should be made?

4. a. Considering that a Nuclear Medicine Officer is assigned to the field army surgeon's office, is a Nuclear Medicine Officer required at corps level?

b. If not, why not?

5. Is it realistic to require that the Nuclear Medicine Officer, MOS 3004, also be qualified as a Preventive Medicine Officer, MOS 3005, as indicated by Remark 60?

6. Is successful completion of special weapons training necessary for the Surgeon or the Medical Operations Officer, as required by Remark 55 if:

a. A Nuclear Medicine Officer is assigned?

b. A Nuclear Medicine Officer is not assigned?

B-AID STATION SECTION (Paragraph 21):

1. a. Is the section staffed with adequate officers?

b. If not, what additions are needed?

2. a. Is the section staffed with sufficient enlisted personnel?

b. If not, what changes should be made?

3. a. Are the MOSSs those that are desired?

b. If not, what changes should be made?

4. a. Can the section provide the necessary medical treatment support when the corps is echeloned in a tactical disposition of a corps tactical command post and a main and rear echelon? (Consider personnel, equipment, and vehicles)

b. If not, what means can be taken to provide the necessary support?

SECTION II

Questions relate to the augmented staff when corps is operating independently.

A-MEDICAL SECTION (Paragraph 27):

1. a. Does the augmentation provide for sufficient officers?
b. If not, what additions are required?
2. a. Does the augmentation provide for the proper specialities?
b. If not, what changes should be made?
3. a. Are sufficient enlisted personnel provided?
b. If not, what additions should be made?
4. Should an assistant, either officer or enlisted, be provided the Medical Operations Officer?
5. Should a Preventive Medicine Specialist be provided to assist the Preventive Medicine Officer and Sanitary Engineer?
6. Should a Medical Supply Specialist be assigned to assist the Medical Supply Officer?

SECTION III

1. What TOE is your headquarters operating under at this time?
(Corps only)

2. If operating under TOE 52-1T, has local augmentation been
provided to the section for peacetime operations? If so, how much?
(Corps only)

3. Remarks and/or other comments.

Preparing Headquarters

Date



DEPARTMENT OF THE ARMY
HEADQUARTERS UNITED STATES CONTINENTAL ARMY COMMAND
FORT MONROE, VIRGINIA 23351

IN REPLY REFER TO
ATMED

11 January 1966

SUBJECT: Evaluation of Medical Staffing, TOE 52-1T

TO: Major Clarke M. Brant
13 Walker Avenue
Fort Leavenworth, Kansas

To provide information that may assist you I have submitted the questionnaire to members of my staff for their personal comments.

In utilizing this information it must be accepted that these are informal observations and are not to be construed as reflecting the official position of this headquarters.

The employment of the Corps in the new doctrinal concepts presents an interesting area for study and I wish you success in your endeavor.

A handwritten signature in cursive script, reading "William S. Smith", is positioned above the typed name.

WILLIAM S. SMITH
Colonel, MC
Surgeon

1 Incl
Questionnaire

Incl 8

QUESTIONNAIRE

All questions pertain to the medical staffing as shown in TOE 52-1T, Headquarters, United States Combat Developments Command, dated 1 June 1965.

SECTION I

Questions relate to basic staffing when corps is operating as part of field army.

A-MEDICAL SECTION (Paragraph 15):

1. a. Is the medical section staffed with an adequate number of officers to perform the mission? No

b. If not, what additions are required?

Medical Administrative Assistant; also, Nuclear Medicine Officer should have Preventive Medicine background and training.

2. a. Is the medical section staffed with an adequate number of enlisted personnel? No

b. If not, what additions are required?

Another clerk

3. a. Are the MOSs of all personnel those that are desired? No

b. If not, what changes should be made?

See 2 above

4. a. Considering that a Nuclear Medicine Officer is assigned to the field army surgeon's office, is a Nuclear Medicine Officer required at corps level? Yes

~~b. If not, why not?~~

His nuclear knowledge would be good insurance; however, the 3005 capability is the most essential on a day-to-day basis.

5. Is it realistic to require that the Nuclear Medicine Officer, MOS 3004, also be qualified as a Preventive Medicine Officer, MOS 3005, as indicated by Remark 60?

In non-nuclear war, he will function as PMO a large part of the time

6. Is successful completion of special weapons training necessary for the Surgeon or the Medical Operations Officer, as required by Remark 55 if:

a. A Nuclear Medicine Officer is assigned? Yes

b. A Nuclear Medicine Officer is not assigned? Yes

B-AID STATION SECTION (Paragraph 21):

1. a. Is the section staffed with adequate officers? Yes

b. If not, what additions are needed?

2. a. Is the section staffed with sufficient enlisted personnel? Yes

b. If not, what changes should be made?

3. a. Are the MOSs those that are desired? Yes

b. If not, what changes should be made?

4. a. Can the section provide the necessary medical treatment support when the corps is echeloned in a tactical disposition of a corps tactical command post and a main and rear echelon? (Consider personnel, equipment, and vehicles) The 911.3 can provide aid station support to the forward (smaller) echelon. Yes

b. If not, what means can be taken to provide the necessary support?

SECTION II

Questions relate to the augmented staff when corps is operating independently.

A-MEDICAL SECTION (Paragraph 27):

1. a. Does the augmentation provide for sufficient officers? Yes
b. If not, what additions are required?
2. a. Does the augmentation provide for the proper specialities? Yes
b. If not, what changes should be made?
3. a. Are sufficient enlisted personnel provided? No
b. If not, what additions should be made?
Operations NCO
4. Should an assistant, either officer or enlisted, be provided the Medical Operations Officer? Yes
Enlisted operations NCO
5. Should a Preventive Medicine Specialist be provided to assist the Preventive Medicine Officer and Sanitary Engineer? No
6. Should a Medical Supply Specialist be assigned to assist the Medical Supply Officer? No

SECTION III

1. What TOE is your headquarters operating under at this time?
(Corps only)

2. If operating under TOE 52-1T, has local augmentation been
provided to the section for peacetime operations? If so, how much?
(Corps only)

3. Remarks and/or other comments.

Preparing Headquarters

Date

QUESTIONNAIRE

All questions pertain to the medical staffing as shown in TOE 52-1T, Headquarters, United States Combat Developments Command, dated 1 June 1965.

SECTION I

Questions relate to basic staffing when corps is operating as part of field army.

A-MEDICAL SECTION (Paragraph 15):

1. a. Is the medical section staffed with an adequate number of officers to perform the mission? *YES*

b. If not, what additions are required?

There is an apparent error in branch for the Nuclear Medical Officer - branch should be MC not MS

2. a. Is the medical section staffed with an adequate number of enlisted personnel? *No -*

b. If not, what additions are required?

Light vehicle driver and 1/4 trucks should be added - I realize that other vehicles will be supplied by Transportation Units assigned to

3. a. Are the MOSs of all personnel those that are desired? *Corps*

b. If not, what changes should be made?

YES -

4. a. Considering that a Nuclear Medicine Officer is assigned to the field army surgeon's office, is a Nuclear Medicine Officer required at corps level? *Yes if nuclear war is expected -*

b. If not, why not?

otherwise no. However it is desirable to have an MC who can function as assistant Corps Surgeon

5. Is it realistic to require that the Nuclear Medicine Officer, MOS 3004, also be qualified as a Preventive Medicine Officer, MOS 3005, as indicated by Remark 60?

Yes - These two specialities are compatible and probably the Preventive Medicine aspect is more important than nuclear medicine

6. Is successful completion of special weapons training necessary for the Surgeon or the Medical Operations Officer, as required by Remark 55 if:

a. A Nuclear Medicine Officer is assigned?

No -

b. A Nuclear Medicine Officer is not assigned?

YES -

B-AID STATION SECTION (Paragraph 21):

1. a. Is the section staffed with adequate officers?

b. If not, what additions are needed?

YES

2. a. Is the section staffed with sufficient enlisted personnel?

b. If not, what changes should be made?

No -

Need surgical technician added

3. a. Are the MOSs those that are desired?

b. If not, what changes should be made?

*Add surgical technician
. 3 level*

4. a. Can the section provide the necessary medical treatment support when the corps is echeloned in a tactical disposition of a corps tactical command post and a main and rear echelon? (Consider personnel, equipment, and vehicles)

No -

b. If not, what means can be taken to provide the necessary support?

Utilize existing medical units providing area coverage for medical support of two portions of the Corps and the medical section provide medical support for the other (remaining) portion of the Corps. Other alternative is to triple the medical section as (over)

it can provide coverage
for 3 echelons of the Corps
simultaneously. This would
probably be a luxury.

1/4 ton vehicle would be a
desirable addition to the medical
section equipment.

SECTION II

Questions relate to the augmented staff when corps is operating independently.

A-MEDICAL SECTION (Paragraph 27):

1. a. Does the augmentation provide for sufficient officers? *Yes*
b. If not, what additions are required?

2. a. Does the augmentation provide for the proper specialities? *Yes*
b. If not, what changes should be made?

3. a. Are sufficient enlisted personnel provided? *No*
b. If not, what additions should be made?

4. Should an assistant, either officer or enlisted, be provided the Medical Operations Officer?
No - majority of work in operations field should be done by Med Groups Ltys - Corps operations office for long range planning
5. Should a Preventive Medicine Specialist be provided to assist the Preventive Medicine Officer and Sanitary Engineer?
Yes

6. Should a Medical Supply Specialist be assigned to assist the Medical Supply Officer?
Yes

SECTION III

1. What TOE is your headquarters operating under at this time?
(Corps only)

2. If operating under TOE 52-1T, has local augmentation been
provided to the section for peacetime operations? If so, how much?
(Corps only)

3. Remarks and/or other comments.

Robert D. Moxter Lt Col MC.
Medical Field Svc School
Preparing Headquarters

10 January 1966
Date