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WILL AMERICA BE ABLE TO TREAT ITS BATTLEFIELD WOUNDED ?

INTRODUCTION

The U.S. long has taken pride in its ability to care for its battlefield wounded. Rapid medical attention in South Vietnam, for instance, enormously increased the chances for survival of wounded GIs. How well American casualties will be treated medically in future and possibly larger conflicts, however, is a matter of growing concern. The medical care on hand, available, or currently programmed is insufficient to treat the numbers of casualties likely to result from heavy armed conflict.

"The Military Departments' medical force structures do not provide sufficient personnel authorizations and units to assure an adequate level of support either overseas or in the United States in the event of war," was the assessment of one senior Defense official.[1]

While a war in Europe would create a crisis in medical care for the Armed Forces, "the situation is no less grave in the Far East," said Assistant Secretary of Defense John H. Moxley, III, at the 1982 Association of Military Surgeons Conference.[2] He added:

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1 Letter, Office of the Assistant Secretary of Defense to Major General Henry Mohr (U.S. Army, Retired), October 12, 1984.

2 Keynote Address by John H. Moxley, III, M.D., at the 38th Annual Meeting of the Association of Military Surgeons of the U.S., San Antonio, Texas, November 2, 1982.

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> It is the medical support for the Rapid Deployment Joint Task Force (RDJTF), however, which poses our greatest problem....
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> Shore-based hospitals cannot support the initial stages of RDF (Rapid Deployment Joint Task Force) operations when casualties can be expected to be the heaviest....

Although this has been apparent for some time, efforts to correct it have been painfully slow and inadequate. Some lawmakers seem to believe that a draft of doctors, nurses, and medical technicians when war begins will produce instant medical support. Regrettably, it will not. Action is needed now to prevent what could be an insurmountable problem in a sudden crisis involving large numbers of casualties.

THE PROBLEM

The United States generally has had long lead times to mobilize for war. World War II mobilizations, for example, commenced two years before the U.S. actually entered the war. Today major hostilities could erupt without warning. Short-warning scenarios require suitable medical support to be at hand before or whenever hostilities erupt.

The "Wartime Medical Posture Study," completed in 1980 by the Armed Services and the Office of the Secretary of Defense is the benchmark analysis of wartime requirements and capabilities. This two-year study evaluates comprehensively the requirements for supporting a large-scale conflict. It calls attention to the critical needs within a theater of war for operating rooms and acute care facilities.

Deficiencies in medical capabilities and evacuation methods, which media reports claimed could have resulted in 10,000 to 30,000 additional losses, were discovered during a major Pentagon exercise in 1978. The report in The Washington Star on November 2, 1979, which noted this, was called by a senior Defense official "one of the best unclassified reviews...I have seen...."[3]

Studies following Armed Forces readiness exercises in 1978, 1979, and 1980 each disclosed massive shortages of deployable medical units. Of those available, many units reportedly were so deficient in medical professionals that they were incapable of mission performance.

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[3] Office of the Secretary of Defense Letter, November 1979, to Chairman and members of the Reserve Forces Policy Board, Subject: "Nifty Nugget."

A 1981 General Accounting Office (GAO) report to the Congress, asks "Will There Be Enough Trained Medical Personnel in Case of War?"[4] At the end of 1980, states the GAO, only 18 percent of the Army's wartime requirements for operating rooms were available for use in Europe. The Air Force had only 10 percent. The Navy and Marine Corps were reported to have nothing, except the Marine Corps' organic Navy field units and Navy facilities afloat. Battlefield operating rooms are very important because wounded often cannot be evacuated safely until they are treated. The conclusion of the GAO report was that the numbers and the types of medical personnel in active and reserve forces fall short of projected requirements for any wartime scenarios.

The report also concluded that medical personnel on active duty had insufficient training in combat casualty care. Its recommendations to correct this included pre-registering civilian medical personnel with the Selective Service System, improving medical mobilization planning by the Defense Department, convincing civilian hospitals to plan to accept military casualties, and increasing active duty personnel training in combat casualty medicine. The Department of Health and Human Services, meanwhile, stated that revised standby legislation was needed to permit registration and induction of medical personnel after the Pentagon more precisely identified its requirements for an emergency. Overall the GAO determined that the Services had only 53 percent of the trained personnel necessary.

The Department of Defense has not yet confessed to this shortage, insisting that most of the needed medical personnel are on hand. The difficulty is that they are not addressing wartime needs realistically. Despite their own studies and that of the GAO, the Defense Department seems content with manning levels that reflect a peacetime situation. The immediate picture--should hostilities break out--may be even more bleak than it appears. In such a case, many of those skilled in combat casualty care would have to train new personnel. This could leave the combat zones even more shorthanded than the numbers indicate.

In 1981, Dr. John F. Beary, III, then Acting Assistant Secretary of Defense for Health Affairs, using conservative computer-generated casualty estimates for a NATO conventional war scenario, determined that only one in ten wounded servicemen would receive necessary lifesaving care, using both the active and reserve resources then available.

During November 1982, Assistant Secretary of Defense John H. Moxley told the Association of Military Surgeons of the United States:

> The harsh reality is that if the United States committed its forces to major combat today, whether in the Far East, Southwest Asia, or Europe, we could not care for a significant portion of our casualties. We do not have enough deployable hospitals of any kind to

> provide even the emergency surgical treatment required to prepare the predicted numbers of patients for evacuation.[5]

On May 1, 1984, Assistant Secretary of Defense for Health Affairs William Mayer, M.D., told the House Appropriations Defense Subcommittee that while the "military departments have made great strides toward improving our ability to meet this responsibility... we still have some significant medical readiness deficits." Explained Mayer,

> Our wartime scenarios have predicted that, if a full-scale conventional conflict broke out in Europe tomorrow, we would have sufficient medical capability to provide initial surgery for only 20 percent of the estimated casualties....We are woefully short of deployable medical systems for wartime, and much of the deployable equipment and materiel that we do have is old and obsolete. We are still faced with critical shortages of key medical personnel who would be needed in wartime, most notably surgeons and nurses....[6]

The following month, Mayer warned the Senate Appropriations Defense Subcommittee that about three-quarters of American servicemen wounded in a major conflict would not get the "lifesaving, stabilizing, hemorrhage-stopping surgical care" needed to survive.[7] These statements differ little from appraisals made of military health care capabilities for the Armed Forces in 1978, 1980, and 1982. The situation has not improved significantly, despite the continuing recognition of the problems.

POSSIBLE CHANGE THROUGH THE SELECTIVE SERVICE ACT

Medical care shortages could even create a major obstacle to mobilization in case of an emergency. The Selective Service Act of 1948, as amended in 1973 and 1980, states:

> No person shall be inducted...until adequate provision shall have been made for such...medical care, and hospital accommodations...as may be determined by the Secretary of Defense or the Secretary of Transportation to be essential....

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4 Comptroller General (GAO) Report to the Congress, "Will There Be Enough Trained Medical Personnel in Case of War?" HRD-81-67, June 24, 1981.

5 Moxley, op.. cit.

6 Statement, Honorable William Mayer, M.D., Assistant Secretary of Defense for Health Affairs before the Subcommittee on Defense, Committee on Appropriations, U.S. House of Representatives, May 1, 1984.

7 Statement, Honorable William Mayer, M.D., Assistant Secretary of Defense for Health Affairs before the Subcommittee on Defense, Committee on Appropriations, U.S. Senate, June 12, 1984.

This provision could restrain Selective Service from drafting anyone for military service until medical support, including doctors, nurses, technicians, and facilities is procured and in place. Failure to correct existing problems in advance of an emergency involving heavy combat could result in devastating military consequences to the nation.

Preventing this almost surely requires at least a peacetime registration, classification, physical examinations, and full readiness for induction of doctors, nurses, and certain medical technicians. Needed, too, are at least 60,000 additional male and female "corpsmen" (uniformed medical specialists), who are as essential to the casualty treatment process as doctors and nurses.[8]

Though the Pentagon claims that it is taking steps to enhance medical preparedness, its letter of October 12, 1984, admits:

> If we entered a major conventional war today, the Department of Defense could not provide an adequate level of medical support to our forces.[9]

HOW TO ATTRACT MEDICAL SUPPORT TO THE SERVICES

Several factors are responsible for the present shortage of military medical personnel. Under the so-called Doctor Draft Law, between 1950 and 1973, thousands of physicians entered military service to satisfy service requirements. This law, however, was repealed along with the demise of the draft in 1973. The measure had permitted physicians to complete their medical education rather than be drafted while in training, but it extended their liability for induction to age 35. These physicians remained on active military service for two years and had an additional obligation to remain in the Reserve for four years after discharge.

Under the Doctor Draft, approximately 30,000 health professionals were called for induction. Most were physicians, although osteopaths, dentists, veterinarians, nurses, and other health professionals also were conscripted. The majority of these accepted Reserve Force commissions on a voluntary basis in lieu of induction. Only about 70 of the professionals called refused to enter the military and had to be drafted.

A precedent exists for drafting women in health care professions. President Franklin D. Roosevelt in 1945 proposed to draft nurses, and the House of Representatives passed such a measure, but by the time the Senate came to act on the bill, the number of nurses responding to the President's appeal for volunteers had

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8 Mohr, op. cit.
9 Ibid.

increased to meet wartime needs. The matter consequently was dropped.

Since 1973, the military services have had to compete with the civilian market for physicians. This predictably places the military at a disadvantage, as physicians in the private sector can earn considerably more money than military doctors can, and further, need not be separated from their families. Because of this, recruiting medical health professionals is difficult, even for the Reserves.

The military Services attacked the problem, beginning in 1972, by creating the Uniformed Services University of the Health Sciences. It has begun to train doctors, and the first class graduated in 1980. This institution, however, will produce only about 25 percent of the Services' needs--and the peacetime needs at that. The balance is to be provided under the Health Professions Scholarship Program, which trains doctors at civilian schools. This, however, is only a partial solution. It still does not address the problem of potential wartime requirements. And it does nothing toward solving the problem of health care professionals, other than supplying more doctors.

Issues and Current Initiatives

The 1981 GAO Report recommended that the Secretary of Defense and the Director of the Selective Service System jointly develop provisions to be included in a standby legislative proposal for a postmobilization draft of medical personnel "as soon as possible." It further recommended that possible registration and induction of health care personnel be coordinated with the Federal Emergency Management Agency (FEMA), because of its responsibilities for mobilization of civilian personnel and other resources.

Though the Pentagon agreed with these recommendations, and though the Senate Appropriations Committee was severely critical of reports that up to 75 percent of casualties at the onset of hostilities would not receive necessary care, neither the Administration nor Congress has submitted the needed legislation.

The Defense Department and military services have a wide range of initiatives underway. These include heavy reliance on the Reserve Forces to fill the gap between wartime requirements for medical care and facilities and those on hand. But in expecting the shortages of health care personnel to be provided by the Reserve Forces, the Pentagon fails to recognize that the Reserve Forces, too, are short of doctors, nurses, and medical specialists and equipment. The Pentagon is playing a shell game: pretending that authorizing such a structure in the Reserves is the same as having it in place.

On the other hand, the Pentagon has recognized the shortage of deployable medical systems for overseas medical treatment, hospitalization, and evacuation systems. It plans to increase

those capabilities by spending $3 billion between 1986 and 1990 to obtain "adequate" theater hospitalization and evacuation capabilities by 1993, augmented by pre-positioning medical supplies and equipment at or near possible operational sites, and by use of "host nation support."

Contracts have been awarded to convert two tankers into hospital ships. Each ship will have the capability to support 1,000 beds and 12 operating rooms. The first ship is scheduled for delivery in October 1986 and will be stationed in Norfolk. The second, to be stationed in San Diego, says the Defense Department, will be ready in July 1987.

Pentagon policy is to use "host nation support" to the greatest extent possible in meeting wartime requirements. The Defense Department states it has "approved medical support agreements with friendly nations and has other agreements currently under negotiation." However, there is no assurance that the next major war will be where the U.S. has prepositioned medical supplies or where host nation support is available. It is reasonable to expect, moreover, that host nations will place highest priority on their own needs in the event of military conflict and that their obligations to care for U.S. wounded may be of relatively low priority.

Senior U.S. field commanders are concerned about this but are more or less resigned to it with an uncomfortable sense that "it is the best we can get at the present time." Reliability in a crisis is questionable and, at best, a calculated--perhaps dangerous--risk.

The Services and the Defense Department have other initiatives in progress, such as more realistic field exercises, more combat-oriented medical training, enhanced medical manpower mobilization data, and increased Reserve component medical personnel and unit readiness. These actions would appear to be in recognition of and reaction to the persistent problems inhibiting adequate military medical support. They fall short of being sufficient to cope with the inevitable crisis as to the medical treatment capability if a major war were to develop without warning. An appropriate sense of urgency is not reflected in current initiatives dealing with these widely recognized shortages.

In addition, there is growing concern about sustaining the necessary level of medical care should major hostilities continue over a prolonged period of time.

MILITARY MEDICAL SUPPORT IN THE U.S.

The Defense Department also is considering the need to increase medical care facilities in the U.S. in order to care for returning combat casualties. Among these measures are:

1) Use of Veterans Administration hospitals, where an estimated 31,577 beds could be available.

2) Use of civilian hospitals through the Civilian-Military Contingency Hospital System, a voluntary arrangement with civilian hospitals and supporting staff in case of war. So far, 770 hospitals have pledged 61,000 beds. In 1985, this system will be incorporated into a new National Disaster Medical System designed to respond medically to natural or man-made disasters. Its goal is 100,000 beds in 71 metropolitan areas across the country.

These initiatives, however, will not meet the wartime medical needs of the Armed Forces if they are suddenly plunged into heavy combat, producing large numbers of casualties. And as more deployable and U.S. hospitals are activated, more and more doctors, nurses and medical specialists will be needed.

CONCLUSION

The current state of military medical facilities and manpower is such that the armed forces would be severely short of combat medical care if major hostilities erupted today or in the near future. And this care crisis is not receiving sufficient attention. Initiatives in progress within the military Services and the Defense Department are steps in the right direction, but they cannot hope to cope with a major war. As such, the existing shortages of doctors, nurses, medical specialists, and facilities cannot be alleviated under current and planned programs to a level adequate to treat the casualties of heavy combat. Nor can the Reserve Forces recruit enough personnel in these skills.

Knowing that adequate medical care for casualties is not on hand to back them up, combat commanders might be extremely reluctant to take their troops into combat. To do so would trigger justifiable public resentment and protest.

No legislative authority exists to provide the means for calling into military service the health care personnel required at the outbreak of major hostilities. Until medical care facilities and personnel are in place, the Selective Service Act prohibits inductions. The Administration, therefore, should ask Congress to modify the Selective Service Act and to grant the federal government authority to draft medical specialists, including women. Registration, physical examinations, and qualification by skills are the minimum peacetime requirements to assure immediate accountability.

More attention needs to be given to the procurement of equipment and field medical care facilities. In addition, field and combat zone training must be improved for medical units and health care personnel if they are to function in remote areas and under the relatively primitive conditions often found in combat.

RECOMMENDATIONS

The Department of Defense should:

1. Be prepared to provide more "medics" in case of war or mobilization.

The Defense Department should accelerate its program of initiatives for improving health care for military personnel, especially under combat conditions. This calls for immediate action to introduce and pass an amendment to the Military Selective Service Act that requires the registration of all persons between the ages of 18 and 46 years who are trained in a health care occupation. This age range is necessary because of the length of time required for education, training, and credentialing of qualified health care personnel, and for the provision of a pool of qualified registrants large enough to spread the liability for induction over a wider segment of the population. The new measure should include all those with technical medical skills, females as well as males, not previously registered. This would apply to health care personnel only, and should not extend to regular registrants. The identification of health care specialists must not be deferred until a military emergency occurs.

2. Review promises of host nation medical support.

Programs for reliance on host nation support for medical care should be reexamined realistically in light of potential crisis conditions and conflicting needs of those nations.

3. Add medical units to the force structure.

Funds should be authorized for establishment in the Reserve Forces of additional surgical field and 1,000-bed general hospitals, plus other required medical units. Sustaining medical care in severe and continuing combat should be carefully considered, and appropriate measures adopted to assure the capability of providing proper medical attention and health care in combat zones over prolonged time periods, if necessary.

4. Be better prepared to receive casualties back home.

Agreements must be finalized with Veterans Administration and civilian hospitals to assist in care of casualties in an emergency.

5. Reevaluate the stated requirements for trained medical personnel in combat.

Numerous studies have shown real shortages of qualified, essential medical capabilities. Current planning does not address these shortages. The Pentagon must create medical units in the

active and reserve forces on the basis of up front, wartime--not peacetime--needs.

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No. 1. Theodore J. Crackel, "Reforming 'Military Reform,'" Heritage Backgrounder No. 313, December 12, 1983.
No. 2. Robert K. Griffith, "Keeping the All-Volunteer Force Healthy," Heritage Backgrounder, No. 353, May 18, 1984.
No. 3. J.A. Stockfisch, "Removing the Pentagon's Perverse Budget Incentives," Heritage Backgrounder No. 360, June 19, 1984.
No. 4. Mackubin Thomas Owen, "The Utility of Force," Heritage Backgrounder No. 370, August 1, 1984.
No. 5. Richard L. West, "Military Compensation: A Key Factor in America's Defense Readiness," Heritage Backgrounder No. 387, October 18, 1984.
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