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## Matching Fleet Medical Readiness to the New Naval Strategy

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**I**N ANY OPERATIONAL LOGISTIC EQUATION, history clearly demonstrates that military medical capability, composed of sound doctrine and supported by mobilization-ready assets, is not only an integral component of an effective force but also an absolute requirement for its success. In today's Navy, unfortunately, fleet medical support doctrine remains insufficiently defined, inadequately validated, and not specifically integrated into the "Line's"\* warfighting concepts of operations. These limitations render it difficult to define requirements for medical readiness in the fleet. Furthermore, such ill-defined readiness goals prevent the setting of standards for measuring or reporting progress.

Why have Navy Line commanders not insisted upon specific accountability for medical readiness prior to conflict? Ultimately, the reason is that the Line has been afforded no metric for defining the compliance of medical readiness preparations with operational doctrine. Such absence of command oversight and input has resulted in differing interpretations of fleet medical readiness and has produced uneven priorities in preparing for the medical support of the littoral

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\* The "Line," or "line community," refers to U.S. naval officers (of whatever specialty, e.g., surface warfare, aviation, etc.) specifically designated to carry out combat operations and command combatant forces.

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warfighting strategy. Line officers have the responsibility and authority to rectify these problems; this article recommends what should be done.

### Medical Materiel and Line Doctrine

Recent changes in international relations have shifted the Navy's focus from countering a global threat on the high seas to influencing world events in coastal waters and inland areas vulnerable to the striking power of sea-based forces. The Navy's projected littoral responsibilities encompass not only sea-based assaults and raids but noncombatant evacuations and humanitarian assistance operations as well. The new emphasis on the world's littorals, often at the end of very long logistical and medical support chains, implies significant dependence upon on-site and shipboard medical facilities.

Concomitant alterations have occurred in Marine Corps amphibious doctrine, with the goal of more effective and flexible operational maneuver from the sea. Consistent with the mandate for compactness and simplicity of maneuver units, landing force medical battalions have been "lightened" and downsized. Despite the fact that operations launched from the littorals could penetrate some two hundred miles inland, the technical capabilities of Marine medical assets have become more constrained than they were. Traditional patient-holding capacities within operational medical units, for example, have been much reduced, with multispecialty consultation virtually eliminated. These changes assume rapid evacuation of sick and wounded to offshore fleet assets. The new lightness and mobility of the Marine assault force, with its downsized and reconfigured supporting medical units, means greater dependence upon afloat platforms than ever before.

***Medical Support Is Problematic.*** What are the specific expectations of line leadership regarding fleet medical support? Furthermore, are existing ships with medical facilities suitable for the changing environment? While the fleet has a robust operational medicine system, that system was designed for major Cold War conflicts, and there has been no coordinated effort between the responsible agencies within Navy medicine and the Line to ensure that the doctrinal mission of afloat medical resources has been altered to support the new focus of "Forward . . . from the Sea." Unfortunately, neither what the Navy line community expects nor what the Marine Corps now requires of fleet medical assets has yet been clearly defined, much less adequately validated.

An example is the hospital ship (T-AH). Though the USNS *Mercy* (T-AH 19) and *Comfort* (T-AH 20) each possesses remarkable medical capabilities (twelve operating rooms and an eighty-bed intensive care unit) and delivers large numbers of beds (for about a thousand regular patients) to a theater, their thirty-three-

foot drafts restrict them to deep-water anchorages. Furthermore, they offer only limited access for casualties, via a single, potentially vulnerable helicopter pad, because both the port and starboard access systems (for boat transfers) have been found to be unsafe even in minimal sea states. Further, such ships require enormous logistical support.

Conversely, the casualty receiving and treatment ships (or CRTSs) of the amphibious fleet—the large-deck multipurpose assault ships of the LPH, LHA, and LHD types\*—will inevitably have conflicting operational missions. Their combat responsibilities will preclude a full commitment to medical support. Questions must also be raised about the validity of the current “AMALS” or Authorized Medical Allowance Lists (i.e., of supplies to be carried aboard ship) for CRTSs. The AMALs were not designed to support any specific doctrine or scenario, and the stocks they represent have grown in volume and weight by virtue of treatment protocols developed at shore-based facilities in peacetime. As a result, fleet casualty receiving and treatment ships are now finding it difficult to find space for the AMAL stocks.

Recent changes in Navy and Marine Corps warfighting doctrine, therefore, necessitate a thorough review of the capability and adaptability of T-AHs and CRTSs in the context of their new missions.

Another group of deployable assets, Navy fleet hospitals (forward, land-based, combat-zone facilities), were designed for, and are critical to, the support of extended naval warfare in a global or Korean War-type scenario. Today, these large but essentially immobile five-hundred-bed units (which are self-sustained except for fuel, water, and waste disposal) are staged in various parts of the world. Others are carried by the Maritime Prepositioning Fleet. The fleet hospitals, however, are bulky, tactically immobile, and suited only for large-scale military operations with a well developed logistical network. These characteristics reduce the fleet hospitals' likelihood of involvement with a mobile littoral strategy or with humanitarian assistance operations.

Many additional questions remain concerning the Line's willingness and ability to incorporate not only medical supply and resupply requirements into fleet operational doctrine but also other prerequisites for carrying out the fleet medical support mission. For example, when and where would amphibious assault ships—having both combat and medical missions—stand by to receive casualties? If judged to be in danger from mines, coastal defenses, or air and missile attack, these ships may be retired a considerable distance from shore once an assault force has been landed;<sup>1</sup> that would greatly complicate patient evacuation from shore sites. Furthermore, the casualty “throughput” of these ships, in terms of where and how casualties will be transferred when the afloat medical

\* Amphibious assault ships of the *Iwo Jima* (LPH), *Tarawa* (LHA), and *Wasp* (LHD) classes.

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facility reaches capacity, has not been well defined or validated in operational exercises. Have the use and characteristics of helicopters, utility landing craft, air-cushioned landing craft, future iterations of the Advanced Amphibious Assault Vehicle, and the MV-22 Osprey aircraft been factored into the resolution of these dilemmas?

We contend that fleet medical support requirements have not been well coordinated with the new littoral doctrine. In the absence of an adequate integration of medical doctrine with warfighting plans and expectations, the requirements for medical readiness cannot be identified, codified, or quantified. Consequently, neither the Navy's "Forward . . . from the Sea" nor the Marine Corps's "Operational Maneuver from the Sea" can be properly supported in medical terms.

**Remedies: Overcoming Materiel Barriers.** Any fleet medical concept of operations, or CONOPS, for supporting the "Forward . . . from the Sea" strategy and adjusting to the evolving Marine Corps doctrine must focus upon mobility, flexibility, and, ultimately, combat casualty care—even in isolated settings or operations other than war. Current operational medical support concepts must be validated or new approaches developed. We believe that a number of fundamental steps must be taken. First, medical equipment and supply inventories for ships must be developed specifically to support the new environment. Second, smaller hospital ships should be designed which can respond to the needs of littoral warfare as well as disaster relief and humanitarian assistance operations. Three to five ships of relatively shallow draft and with about one hundred beds should be developed, with emphasis upon primary care and basic surgical services. Design considerations should include operation in unimproved ports; physical dimensions allowing more use of piers than is possible now; seaborne evacuation vehicle access; and access by helicopter, MV-22, or, for ambulatory or stretcher patients, from pierside.

Third, contingency afloat shock and stabilization platforms need to be provided as an alternative, or in addition, to the hospital ship and large amphibious assault ship in littoral warfare. Beyond providing medical treatment, these ships could also be used as "ambulance vessels" to evacuate stable or minimally injured casualties from the T-AHs and CRTSs. Vessels suitable for these purposes, such as mobile logistics force ships of the Military Sealift Command or commercially chartered craft such as cruise ships, which already have the hotel, laundry, and other facilities required by a hospital, should be provisionally identified. Conversion plans should be developed and kept "on the shelf" for implementation. Once adapted for non-surgical minimal care and casualty evacuation, these ships would be able to offer stabilization and short-term management of patients—contingent, that is, upon their being appropriately staffed with medical personnel.

Pods with medical equipment and supplies could be quickly loaded for the care of casualties being carried rearward.

Finally, an easily insertable, land-based, modular "Navy expeditionary hospital" (NEH), built around a self-sustainable core of a hundred beds, should be developed. It would be a far more flexible adjunct to forward casualty care than either the five-hundred-bed fleet hospital or its alternative, an "over-the-horizon" LHA or LHD. The NEH could be augmented by specialized modules of equipment and personnel for "tailored" medical services in specific missions, whether combat or humanitarian in nature.

### Medical Readiness Training

Aside from the availability and functional readiness of equipment and supplies, fleet medical readiness is directly tied to the proficiency of personnel assigned to augment aboard the T-AHs, LHAs, and LHDs, as well as Marine Corps medical support units. All medical personnel are subject to assignment to an operational or combat environment, but in Operations DESERT SHIELD and STORM not all potential augmentees were qualified for deployment. Some had not even completed the basic military training required by law.

***Peacetime Hospital Experience as Preparation for War.*** The Surgeons General of the military services and health experts within the Defense Department have repeatedly contended that providing peacetime care for a largely non-active duty population is the best way to train medical personnel for wartime. They claim that current peacetime training practices also serve other goals, such as helping to attract and retain military physicians, thereby contributing to wartime readiness. Many argue that military graduate medical education (GME) residency training programs aid in recruiting and retention by offering the possibility of teaching; the appeal of teaching, they suggest, may help keep physicians who might otherwise leave military service for civilian practice. As proof of this, the Surgeons General point out that these physicians, trained in GME programs, constitute the majority of today's military medical leadership.<sup>2</sup>

Within the limits set by the patient conditions that arise, military medical facilities do in fact provide credible training. Medical centers serve as excellent instructional settings for physician trainees in graduate medical education programs, and some small proportion of the training is directly relevant to wartime readiness. But the type of treatment that military facilities provide during peacetime, to the extent that it crowds out other operationally specific training, makes it difficult for many resident and staff physicians to prepare adequately for war-related conditions.

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Examination of U.S. Marine casualty data from Vietnam is informative: almost two-thirds of Marine Corps personnel hospitalized there suffered from diseases or non-battle injuries (DNBI). That is, only a third of hospital admissions were for wounds in action. According to a 1995 Congressional Budget Office (CBO) survey, however, the most common wartime DNBI diagnoses do not appear very often in the peacetime workload of military medical centers. Of the twenty-five most frequent diseases and non-battle injuries seen among U.S. Marines in Vietnam, only about 20 percent are among the fifty most common peacetime primary diagnoses encountered in military hospitals.

It is very likely, moreover, that in operations along the African littoral or southern or eastern Asian shores, disease will create more casualties than will combat. In previous conflicts in these regions, up to 75 percent of casualties have been the result of disease. In such areas as sub-Saharan Africa, malaria infection rates among deployed troops may approach 100 percent. Also, the human immunodeficiency virus (HIV) is profoundly altering the medical risk to troops worldwide. These realities could easily render a U.S. force ineffective without a severe engagement ever taking place. In addition, medical care responsibilities for indigenous civilian populations, many bearing diseases unique to their region, could have an impact upon the military evacuation chain.

The value of peacetime practice is even more limited, according to the CBO, when compared to combat conditions. *None* of the fifty most frequent diagnoses seen at military medical centers during peacetime matches a wound received in action. Certainly, various skills obtained from treating peacetime conditions are directly transferable to managing battle casualties. But a CBO comparison of medical conditions resulting from battle injury with those treated at military hospitals and medical teaching centers suggests that peacetime care gives personnel very limited opportunity to develop and practice war-related surgical skills.<sup>3</sup>

These conclusions should not be surprising. After all, the conditions treated at military hospitals during peacetime reflect the health status and treatment of a wider mix of patients, young and old, living in far different circumstances, than would be the case in wartime. A military dependent or retiree typically does not face perils, such as fighting an enemy or operating dangerous equipment, that are routine for military personnel during a conflict. Most important, the extent of wounding and general physiological stress upon the combat wounded have few equivalents in the peacetime military hospital setting.

Of even greater significance is the fact that the priorities exercised in peacetime as to which patients are treated first, and how, are diametrically opposed to those of wartime. The wartime approach, commonly referred to as "triage," has always created great problems for physicians in the military. Whereas in peacetime the most seriously ill receive highest priority for medical attention and logistical support, the opposite may be true in combat, where "preserving fighting

strength” requires that the most attention be directed toward the lightly wounded who can be returned to duty. Most military physicians are totally unprepared to deal with the harsh realities of wartime triage, where life-and-death decisions must be made that conflict with every ethic they have learned and practiced in peacetime medicine.

***The Impact of Medical Unreadiness upon Deployment.*** “Deployability” of fleet medical assets ultimately requires that a unique combination of medical equipment and personnel qualifications be identified, verified, and maintained. Unfortunately, following DESERT STORM, the Department of Defense Inspector General found that “current readiness information systems do not support medical mobilization decisions, nor does the information contained in those systems accurately reflect the capabilities of medical units. As a result, planners are not able to assess the actual status and usability of medical units.”<sup>4</sup>

Today, problems with medical deployability continue to reveal distinct “disconnects” between requirements and capabilities. A recent example is illustrative. When the hospital ship USNS *Comfort* first “stood up” for DESERT SHIELD and STORM, all augmentees were obtained from the Washington, D.C., area. This had a severe impact upon medical services to the local community; in response, the Bureau of Medicine and Surgery redistributed the augmentation requirements over numerous Navy hospitals. This approach was subsequently tested during the Cuban contingency mobilization on 31 May 1994, and that for Haiti on 11 September 1994. However, in both episodes there were significant manning and training problems with the medical augmentation force assigned to *Comfort*. Due to insufficient skills (as defined by Navy doctrine) of personnel reporting to the ship, significant readiness shortfalls arose. Subsequent exercise mobilizations (dock trials) in April 1995 and September 1995 again called into question whether USNS *Comfort* could, as required, get underway with the prescribed crew complement within five days of receiving the order to sail.<sup>5</sup>

Indeed, there was no way to predetermine *Comfort*'s personnel readiness status. Because of an evident lack of attention to tracking mobilization billets, persons with specific skills might have already been transferred to a different naval hospital and so never even see the fleet unit or fill the specific billet to which they were originally detailed.

Even so, the true magnitude of this kind of problem is being masked by the fact that most exercises in peacetime do not simultaneously “flex” all deployable medical augmentation personnel. For these exercises, treatment facilities can provide anyone to fill billets, whether assigned to a specific mobilization billet or not. Problems are likely when billet-specific critical skills are required. In the event of activation to support (as strategic thinking now envisions) two simultaneous major regional conflicts, full augmentation would involve many fleet units.



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Shortages in specific skills could then be expected, as well as significant delays in finding people for certain key fleet billets. (No doubt, as was done in the past, commanders in chief and type commanders would be obliged to “divert,” “cross-deck,” and temporarily assign personnel to correct short and long-term shortages on deploying units.)

The current fleet operational medical training requirements and syllabi, although mandated by instruction, are neither current, well defined, nor adequately funded to ensure a ready medical force. They are not grounded in doctrine, and they were, to a large degree, developed without the benefit of current operational medical expertise. For example, the needs of T-AHs are overstated and unrealistic, whereas medical training requirements for other platforms, such as the CRTSs, are poorly defined. Finally, no regular, standardized operational medical training appears to be taking place. It must also be noted that training procedures for deployable medical facilities, such as fleet hospitals, must make plain that they will never contain the latest “state of the art” equipment, due to funding factors and procurement lead-time. Training must be carried out on the equipment that will be available in these facilities, however, and emphasize the austere nature of the medical practices that are feasible and permissible within this setting.

**Remedies: Overcoming Training Readiness Barriers.** A new training doctrine is needed to ensure that the medical personnel augmenting hospital ships and large amphibious assault ships serving as CRTSs are properly trained for their roles in the new littoral warfighting doctrine. A useful option would be to assign Fleet Surgical Teams and Mobile Medical Augmentation Readiness Teams (which, when mobilized, are typically assigned to CRTSs) to facilities—such as civilian trauma centers, or foreign voluntary relief hospitals near areas of conflict—where they can gather experience, as functional groups, in dealing with war wounds and managing indigenous diseases.

For all potential fleet medical augmentees, proficiency is imperative in general survival skills such as damage control and firefighting. Tracking specialty skill sustainment and progression among enlisted health care specialists entering the fleet is likewise indispensable. Minimum competency levels for senior medical officers in the fleet should also be set in such areas as leadership, planning, communications, logistics, casualty evacuation, and in specialties like the afloat management of chemical and burn casualties. The advanced leadership skills required for integrating and synchronizing the combat health system—to support the requirements of commanders in chief, including those for peacekeeping and humanitarian missions—are also critical.

Those who might serve aboard casualty receiving ships also need training to ensure proficiency in contingency medical skills. These competencies include triage and initial management of combat-specific wounds and mass casualties brought to ships from shore, and also the management of trauma occurring in shipboard combat action and mishaps. (During DESERT STORM, for example, despite the recognized likelihood of burn casualties in armored warfare and missile hits on ships, medical personnel of all services assigned to burn-care facilities were later judged to have been ill prepared; in addition, training packages for burn facility expansion were not available. Personnel in forward-deployed units required additional training even to provide adequate preliminary burn care.)<sup>6</sup>

To accomplish these various goals, there must be clearly articulated training syllabi, training venues, and supporting AMALs. Instructions for implementing programs must also be developed, including metrics for effectiveness and accountability.

To validate training requirements, exercise plans must be developed. According to the Defense Department itself, the current medical exercise planning and coordination process does not provide medical units an opportunity to train as they will fight. Medical involvement in exercises held by the unified commands has decreased markedly since 1989. Failure to include medical activities in exercises prevents operational testing of combat medical systems and assessment of their impact on force capability. Consequently, medical operations must become an integral part of training, and Defense-wide utilization of field medical training sites must be maximized to enhance shared training and interoperability.<sup>7</sup> Recent Navy medical integration into such exercises as KERNEL BLITZ 95 and other subsequent joint task force exercises suggests that the value of realistic medical participation is slowly becoming recognized.

### Accountability

“Readiness” is commonly defined as the ability of forces, units, weapon systems, or equipment to perform as they were designed; it includes the ability to deploy and act without unacceptable delay. Readiness reporting, in turn, is based on an organization’s self-assessment of personnel, training, and equipment with respect to this criterion. Reporting has generally been accomplished through the Status of Resources and Training System (SORTS). The Joint Staff, the warfighting commanders in chief, and the services use the data to assess the status and availability of combat and support units. Each combat and combat support command reports an overall resource and training category (a “C-level”), which reflects the status of the unit’s personnel, equipment, and training, measured

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against the resources required to undertake its wartime mission. Category levels range from "C-1," fully ready, to "C-5," or unprepared for the wartime mission.<sup>8</sup>

At the operational level, SORTS provides field commanders a standardized snapshot of a unit's readiness to execute its primary mission, reflecting both that unit's current capabilities and the projected operational environment. (A major input is the number and severity of casualty reports, or CASREPs, submitted by the unit; CASREPs employ a "C-rating" system analogous to the overall C-levels.) SORTS is the reporting methodology universally accepted and understood by the Line. During DESERT SHIELD and STORM, however, there was significant evidence that SORTS data did not support medical mobilization decisions; the C-level rating often seemed a poor measure of a medical unit's status. In the personnel area, for example, SORTS assigns ratings in proportion to the number of people on board; a unit that is 98 percent staffed would earn a higher rating than one only 75 percent manned. In a medical unit, however, a shortage in a specific specialty (such as anesthesiology or surgery) can render an entire unit incapable of performing its wartime mission; therefore, a system based upon total counts can be very misleading. "SORTS does not provide other key information about a medical unit, such as the status of Deployable Medical Systems, . . . equipment conversion, critical manning by essential specialists, or the number of functional operating rooms."<sup>9</sup>

The SORTS codes summarizing a unit's condition are determined by a complex series of comparisons and aggregations. Notwithstanding the difficulty of the process, the Defense Department Inspector General has suggested, in medical units the computations are frequently performed by individuals who lack the training to understand correctly the manual, with its many specific rules and exemptions. Furthermore, the system's complexity almost guarantees that different individuals will interpret existing conditions differently. As a result, the readiness information in SORTS is often misleading if not inaccurate.<sup>10</sup>

At present, no fleet operational vessel other than the T-AHs has medical support as a primary mission. Consequently, except for T-AHs, medical readiness is not specifically tracked through SORTS; that is, since medical capability is not designated a primary mission of any large amphibious assault ship, even significant degradation of medical equipment cannot result in a CASREP worse than C2. Realistically, however, the medical capabilities of the LPHs, LHAs, and LHDs must be taken into account when assessing their readiness for either combat or noncombat operations. With their several operating rooms, intensive-care units, and specialized medical teams (when augmented), these vessels can provide substantial medical support, for which a readiness measurement would be desirable.

On the other hand, widespread but misguided sentiment exists that medical readiness does not in any case lend itself to measurement under the SORTS

program, and that the currently available software (like the medical augmentation application) is not sufficiently sophisticated. Consequently, neither the Inspector General of the Navy nor that of the Bureau of Medicine and Surgery has included operational medical readiness in regular inspections. Furthermore, responsible administrative offices of the Navy Staff and the Bureau do not appear adequately staffed to provide proper oversight of readiness issues.

Ultimately, the operational readiness of medical augmentation personnel and of medical platforms must be reported to commanders in chief in the same manner as the combat readiness of line units. Despite clear need, however, neither the Navy medical department, fleet hospitals, nor hospital ships are presently reporting either their own medical materiel readiness or that of augmentation personnel intended for themselves or the Fleet Marine Force. Accordingly, readiness of personnel and platforms cannot be determined. This institutionalized inattention to materiel and personnel operational readiness and its reporting should be regarded as a serious liability.

***Remedies: Improving Medical Readiness Reporting.*** A standardized medical SORTS for large amphibious assault ships would provide commanders a more reliable method for appraising the readiness of these ships to execute a specific medical mission at any given time. Modification of the SORTS reports could enable commanding officers of casualty receiving and treatment ships to submit C3 CASREPs for critical medical equipment (e.g., sterilizers, anesthesia machines, x-ray units, or critical-care monitors) that would significantly degrade their medical mission capability if malfunctioning. Furthermore, since the permanently assigned medical personnel of these ships are, by doctrine, insufficient to make it fully mission-capable for medical operations, a method of tracking the readiness of such augmenting units as Fleet Surgical Teams and Mobile Medical Augmentation Readiness Teams must be developed as well.

### **Adjustments to Meet the New Doctrines Are Required**

Medical support for the new operational concepts of both the Navy and Marine Corps must be accorded serious consideration by combatant commanders as well as by those responsible for preparing forces for operational duties, *prior* to the time of mobilization. Furthermore, medical considerations and personnel will need to be integrated fully into plans for future littoral operations. Policies for medical care of forward forces must account for the actual conditions to be encountered and recognize the ability of disease to produce casualties even when troops are not engaged in combat.

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It is unrealistic and grossly inefficient to expect that in the event of conflict well prepared medical personnel and equipment can be produced by transfer between units. It is essential that immediate action be taken to remove existing barriers to medical readiness in the fleet and that medical reporting to responsible line commanders become accurate and useful.

In some cases, medical training requirements may have been made too comprehensive to meet. In others, not only are training requirements ill-defined but funding for them is inadequate. Furthermore, commanding officers of Navy hospitals, charged with training and reporting the readiness of augmentation personnel, have not been held accountable—preoccupied as they often are with the pressures of peacetime medical care—for their readiness and reporting responsibilities. Consequently, line commanders are only infrequently alerted to the readiness of their respective reporting hospitals and are unable to provide adequate oversight.

In the final analysis, the greatest shortfall of all is a failure to articulate a fleet medical support concept of operations and to establish the necessary metrics and time frames for achieving readiness goals. The Defense Department itself has recognized that medical readiness standards for individuals and units must be identified and evaluated. It has recommended that minimum acceptable standards be established and that medical readiness training activities be developed to achieve such standards.<sup>11</sup> Since a reliable mechanism for monitoring and reporting compliance with these mandates is necessary, a standard method for documenting readiness confirming the completion of medical training must be established. The most pragmatic option is to modify the existing system to facilitate accurate assessment of medical readiness. It could then provide operational commanders a more reliable method for appreciating the readiness status of fleet medical support assets.

Without responsible line oversight and the active participation of the combat arms in ensuring the congruence and relevance of medical support with and to warfighting doctrine, the sustainability of fleet operational activity will never be assured.

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### Notes

1. Arthur M. Smith, Daniel P. Shaw, Dominic P. Zito, and Paul S. Jandreau, "Casualty Care in Over-the-Horizon Amphibious Operations Requires Contingency Options!" *Navy Medicine*, January-February 1995, pp. 14–20.

2. Congressional Budget Office, "CBO Paper: Restructuring Military Medical Care" (Washington, D.C.: July 1995), pp. 5–10.

3. *Ibid.*

4. U.S. Dept. of Defense Inspector General [hereafter DoD IG], "Medical Mobilization Planning and Execution," Report 93-INS-13 (Arlington, Va.: 30 September 1993), pp. 15–21.

5. Commander in Chief Atlantic Fleet Surgeon message, "USNS COMFORT: Deployable Medical/Nonmedical Personnel Augmentation," 29 November 1995.

6. DoD IG Report 93-INS-13, pp. 82–4.

7. *Department of Defense Medical Readiness Strategic Plan 2001*, MRSP-2001 (Washington, D.C.: 20 March 1995), pp. A93–A101.

8. DoD IG Report 93-INS-13, pp. 15–6.

9. *Ibid.*, p. 17.

10. *Ibid.*, p. 19.

11. *Medical Readiness Strategic Plan 2001*, pp. A93–A94.

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