One Man's Opinion

After Desert Storm—The Future of the Medical Reserves

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How about an *involuntary* draft next time America goes to war? You know, the kind of draft in which Uncle Sam gives you just enough time to pack your bags, give your patients a reassuring but hasty squeeze of the hand, and your spouse and kids a quick kiss before you head out to the front. A draft in which not just you and one other colleague, but maybe most of your department or practice, leave one or two lucky (or unlucky, depending on your viewpoint) souls to bear the total patient and financial burden.

Imagine that scenario. Judging from the recent disparaging response toward medical reserves by many in the American medical community, few have.

If Desert Storm proved anything, it proved the need for the medical reserves. The logistics of the medical support were awesome: According to Hines, in four months, the US deployed 3000 physicians to the Gulf and prepared over 14,000 beds for casualties.[1] The tertiary facilities were as sophisticated as the university centers at home, complete with computed tomography (CT) scanners and fully monitored intensive care beds. All of the facilities were linked by a complex transport system that was prepared to handle the worst predicted bloodshed: an estimated 33,000 men and women, roughly one in 16 of all US troops in the area, and more than three times the number in Vietnam at the height of that conflict. Overall, the Department of Defense created a pool of 16,000 doctors and their supporting staffs by the activation of 46,000 medical personnel from the military reserves.

Fortunately, the network was not needed. The US losses in the 38-day air war and 100 hours of ground combat included 208 dead and 21 missing. Another 108 Americans died in accidents during the preceding Desert Shield operation. In contrast, Iraqi losses probably exceeded 60,000 and may have even been as high as 100,000 troops.

Curiously, the success of this deployment has not won the expected approbation from the medical community. News stories have focused on the disruptions caused by the loss of a partner from a clinic, the absence of several teachers from academic programs, the drop in incomes by the mobilized reservists and the inconvenienced patients who had to see other doctors or travel greater distances.

Instead of praise for the efficiency of this medical mobilization and the patriotism of the volunteers, recruitment is strongly discouraged. There are now threats to the returning reservists that they must resign their commissions if they are to remain members of their clinics or if they expect to gain tenure in academia. Yet, an involuntary physician draft would be far more disruptive and unwelcome than the current system that depends on volunteers who, by the way, enjoy military life and are well trained in military medicine.

Trained in military medicine? Yes, military medicine. Similar to other branches of health care, military medicine has developed into a sophisticated specialty that cannot be learned in a few days of orientation. More than just the management of battle trauma (a different challenge in its own right), military medicine includes such disciplines as tropical medicine, nuclear warfare, chemical weapons, flight surgery, industrial medicine (an aircraft carrier is more hazardous than a steel plant), hygiene, disaster triage, transport and the care of the wounded during that transport, combat nutrition, immunizations, epidemiology, management of venomous bites and stings and the emotional disorders of military life. In addition, as officers, military physicians must learn how to deport themselves as such, capable of command, knowledgable in military courtesy, and capable, if needed, to administer the Uniformed Code of Military Justice. It takes a lot more than a uniform to make a military physician, and it cannot be done well during a week or two of mobilization when war threatens.

Perhaps one reason for the disdain of some for military medicine is the notion that the physician in uniform supports war and is insensitive to the cruelty and human costs of military conflict. After an address about military medicine at our medical school, Lt Gen Mittemeier, the former US Army Surgeon General, was asked by one of our students why he, as a physician, was willing to wear a military uniform, a mode of dress that signified so much suffering and death. I cannot recall his exact answer, but I was struck by his sincerity when he replied that physicians go to war as missionaries, not to wage battle, but to ease suffering and save lives. He pointed out that the soldiers he had cared for did not participate in the decisions to make war, but instead, were its victims. He went on to say that he had had an enemy soldier die in his arms, and he challenged the student by asking, "If physicians are not willing to go to the battlefield, who will provide the care?" The class responded with a standing ovation. The physicians who served during Desert Shield and Desert Storm deserve a similar approbation and, even more important, encouragement to continue.

Another reason for disdain of the medical reservist is the mistaken impression that most of the "weekend wariors" serve because of large bonuses and high pay for little performance. As a matter of fact, most medical reservists have never received a bonus, most served at less pay than their active-duty counterparts, and virtually all could earn a lot more by moonlighting. Few reservists serve for financial gain, most serve because of a search for adventure, the excitement of military life, and an urge to serve their country.

Nor is it true that medical reservists merely sit around armories, paging through outdated manuals. In the 3274th USA Hospital of Durham, NC, we often worked harder during our weekends than we did during the week, providing broad levels of health care at Fort Bragg. Some of our reservists served during the week to provide specialty services that would not have been available otherwise, and others supported such activities as quality assurance and infection control. During the summers, the drills were often challenging exercises. In 1988, our unit provided the health care for National Guard and Army Reserves combat maneuvers for 10 weeks. No, boredom is not a problem.

In short, it would be a tragedy if the great medical successes of Desert Shield/Storm resulted in the loss of our military reserves.

So what is your choice for the next war? For inevitably, there will be a next war. Your grateful support for your reservist colleague who is assuming the responsibility for many—or an involuntary physician draft?

REFERENCE

1. Hines W: Doctors at the front. *MD* April 1991, pp 45-53. ●

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