Preparing and Organizing Medical Support to VII Corps: Operations Desert Shield and Storm

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On Nov 9, 1990 at Kelley Barracks, Stuttgart, Germany, Lt Gen Frederick M. Franks, Jr., VII (US) Corps Commanding General (CG), and his staff dedicated a memorial to the fall of the Berlin Wall. While meaningful in it's own right, the event symbolically ended an era for the Corps as a key player in the defense of Western Europe and began another as a powerful, mobile, armored, desert force. Immediately following the ceremony, Lt Gen Franks was briefed by his staff on plans, already well underway, to deploy the Corps to Southwest Asia (SWA) and establish operations. An essential requirement to meet this logistical challenge was the design for health service support. Planning was initially undertaken by the Corps Surgeon's staff but rapidly expanded to include all corps medical planners. Cooperation among medical planners was evident throughout Operation Desert Shield/Storm and contributed significantly to the success of the mission.

Planning for combat operations in SWA actually began shortly after the Aug 2, 1990 invasion of Kuwait by Iraq. Corps planners, including medical planners, began tracking operations closely because they realized that a Heavy Mobile Armored Force might ultimately be needed; the mission would demand flexibility; VII Corps was closest to SWA; and the Corps might be considered because it had been identified for drawdown under the Conventional Forces Europe (CFE) reductions. These factors, plus the fact that the concept of the "Agile Corps" had been addressed and tested by the VII Corps through its Battle Command Training Program (BCTP), led to many informal meetings, discussions and seminars to consider how to execute rapidly if chosen. By Saturday, Nov 3, 1990, when 7th Medical Command (MEDCOM) operations contacted the Deputy Corps Surgeon, VII Corps and asked for the requirements to support a corps deployment, most issues concerning medical support for the Corps had already been addressed. Five days later, when the Corps officially received the mission to deploy to SWA, the concept was established and ready for implementation.

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Televised Announcement

With the formal announcement, the Corps headquarters began urgent preparations. Resolution of logistical issues, including medical, became paramount. The Corps Surgeon's staff immediately established coordination with medical planners from the 2d Corps Support Command (COSCOM) and the 30th Medical Group (MEDGP) to synchronize the enormous task of planning medical support. Immediate, short-term issues included projecting the composition and structure of the medical brigade; the build-up of Class VIII stocks; cross-leveling of Class VIII supplies from CFE units to deploying units; and receiving professional and supporting officer and enlisted personnel fillers. In conjunction with the 7th MEDCOM Clinical Services Division, Medical Corps Commanders were selected. Medical company commanders were all Board Certified family physicians, and most had prior TO&E clinic command experience. Hospital commanders were all experienced colonels. Longer term issues included resolving inadequate and/or outdated supplies of nerve agent antidote kits; queuing medical units for training on new equipment and for departure to ports on rail, barge and Heavy Equipment Transport; drawing vehicles and supplies for the Corps Surgeon's office; and integrating medical support into the Corps Operations Plan (OPLAN).

Abbreviations Used

AD	Active Duty
ARCENT	Army Central Command
ARNG	Army National Guard
C2	Command and Control
CFE	Conventional Forces, Europe
CG	Commanding General
COSCOM	Corps Support Command
CSH	Combat Support Hospital
DCG	Deputy Commanding General
EVAC	Evacuation Hospital
MASH	Mobile Army Surgical Hospital
MEDBDE	Medical Brigade
MEDCOM	Medical Command
MEDGP	Medical Group
MEDSOM	Medical Supply, Optical and Maintenance Unit
OPLAN	Operations Plan
SWA	Southwest Asia
USAR	US Army Reserve

Most critical was the conceptual planning of medical support for the Corps OPLAN. This was managed predominately by the Corps Surgeon in concert with the 2d COSCOM Commander in a tightly controlled planning cell at Kelley Barracks beginning in early December. Contact with the 332d Medical Brigade prior to deployment was extremely limited. However, due to time constraints the basic medical support options had to be fully delineated at Kelley Barracks prior to deployment of the Corps main body. Although not irreversible, the medical support concept which was ultimately utilized was initiated. Fortunately, this concept plan was validated when the Medical Brigade Commander arrived in Southwest Asia and was briefed on the Corps Operation Plan. At that time he immediately proposed essentially the same plan as had been developed.

Detailed planning for medical support began with design of the Medical Brigade. The design preferred and promulgated was that outlined in FM 8-55 and based on a five division force. Initially corps medical planners anticipated activation of the Corps' CAPSTONE Medical Trace with the 213th Medical Brigade (MEDBDE). (The CAPSTONE Trace consists of US Army Reserve (USAR) and Army National Guard (ARNG) units designated and trained to mobilize and deploy to Europe joining VII Corps in its combat mission.) However, for a variety of reasons, the 332d Medical Brigade was instead selected to mobilize and deploy to SWA to Command and Control (C2) all Corps-level medical support—a mission for which the 332d was neither equipped nor trained.

Two issues further complicated matters for the 332d Medical Brigade. First, 60 other units, most of which had no prior working relationships, were designated to join the 332d Medical Brigade in SWA. Second, an unprecedented, non-doctrinal alignment of Corps-level hospitals into horizontal bands rather than the doctrinal vertical hierarchy was being seriously considered by corps medical planners as the alignment best suited to support the projected Corps Operation Plan (Figs 1&2). This alignment had been tested by VII Corps and the 213th Medical Brigade during the CAPSTONE exercise Vulcan Knight at Camp Shelby, MS, in August 1990. Although not foolproof, and not without skeptics, the concept did have merit for the projected operation.

A short ground campaign was anticipated with greater depth than width. Evacuation (EVAC) Hospitals were to be placed well in advance of the onset of the ground campaign (G-day) along Tapline Road, and would not move. Combat Support Hospitals (CSH) would be placed as far forward as possible prior to G-day and were unlikely to move considering the anticipated duration of the ground campaign. Only the Mobile Army Surgical Hospitals (MASH) were planned to accompany forces into Iraq. Hence, distances between the MASHs and between the CSHs would be less than the distance from the MASHs to the CSHs. By creating MASH, CSH and EVAC Groups, Group Commanders could place themselves at the center of mass and would be in the best position to make decisions at the critical place and time to shape events. Another distinct advantage would be the ability to concentrate on the unique missions and problems of each type hospital as they arrived, received equipment, moved forward and established operations.

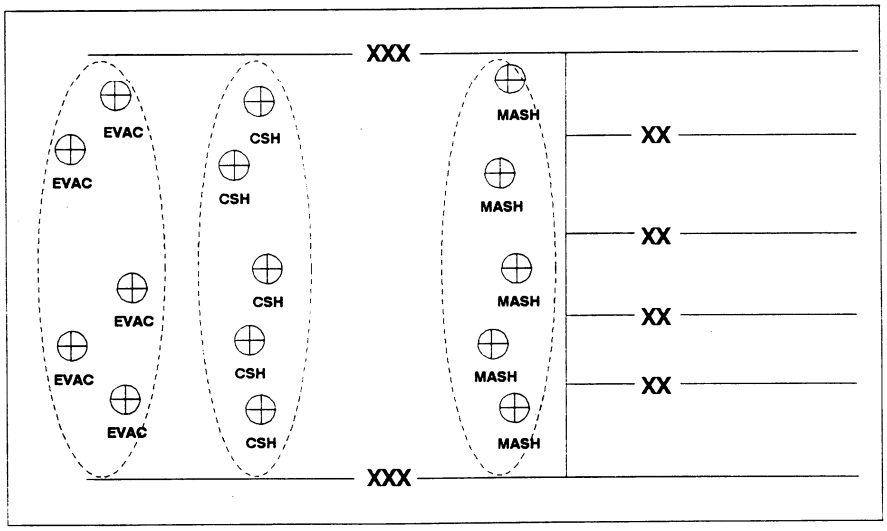

Figure 1. Illustration demonstrating horizontal alignment of command and control for medical units. Medical Groups are represented by broken lines. Medical regulating takes place between groups, moving patients form lower to higher hospitals.

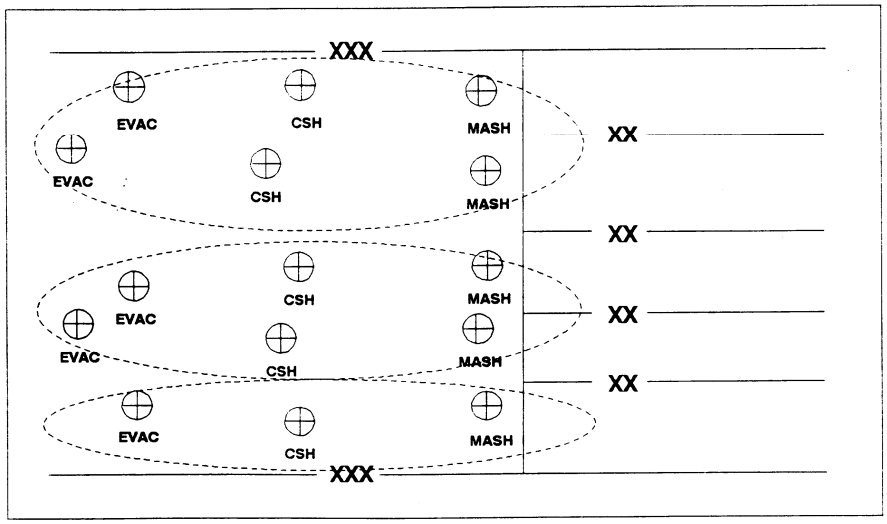

Figure 2. Illustration demonstrating vertical alignment of command and control for medical units. Medical Groups are represented by broken lines. Medical regulating takes place within groups, from lower to higher level hospitals.

Deployment

To increase United Nations options and upgrade to an offensive capability, President Bush ordered the VII (Combined) Corps to SWA. In addition to the corps headquarters, major subordinate commands included the 1st Infantry Division; 1st and 3rd (US) Armored Division; 1st (UK) Armored Division; 1st Cavalry Division; 2d Armored Division (FWD); 2d Armored Cavalry Regiment; 11th Combat Aviation Brigade; and the 2d Corps Sup-

port Command (COSCOM), which included the 332d Medical Brigade.

In coalition warfare, health services is a national responsibility; thus the 1st (UK) Armored Division was supported by British medical elements, including field hospitals. A detailed description of their medical support is beyond the scope of this paper, but it must be noted that there was a close working relationship with daily contact and coordination between the commanders of the British medical forces and the 332d Medical Brigade.

The 332d Medical Brigade is organized as a USAR Medical C2 Headquarters, and is designated as the CAPSTONE Medical Brigade for the Third US Army (ARCENT). It was therefore staffed, equipped and trained for a Theater Army level medical support mission. This mission focuses on C2 of EVAC and higher level hospitals, interfacing with US Air Force and Navy Medical Systems and evacuating to the communications zone. Movement and placement of MASH and CSH hospitals and evacuation of battlefield casualties requires a different focus and level of detail in planning and is not an appropriate mission for a theater-level medical headquarters. Therefore, adjustments were needed.

The Commanding General, 332d Medical Brigade, Brig Gen Michael D. Strong, soon realized greater depth was required to manage all Corps-level medical support. As an initial solution, he suggested to the Deputy Corps Commander (DCG) that the Corps Surgeon's office merge with his headquarters. Although the DCG

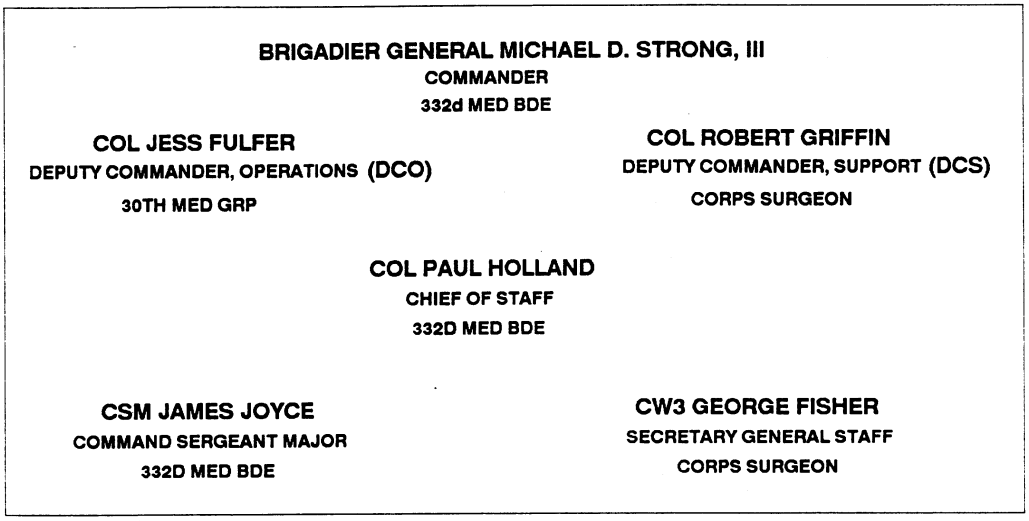

Figure 3. Key members of the 332d Medical Brigade Command Group with original organization indicated.

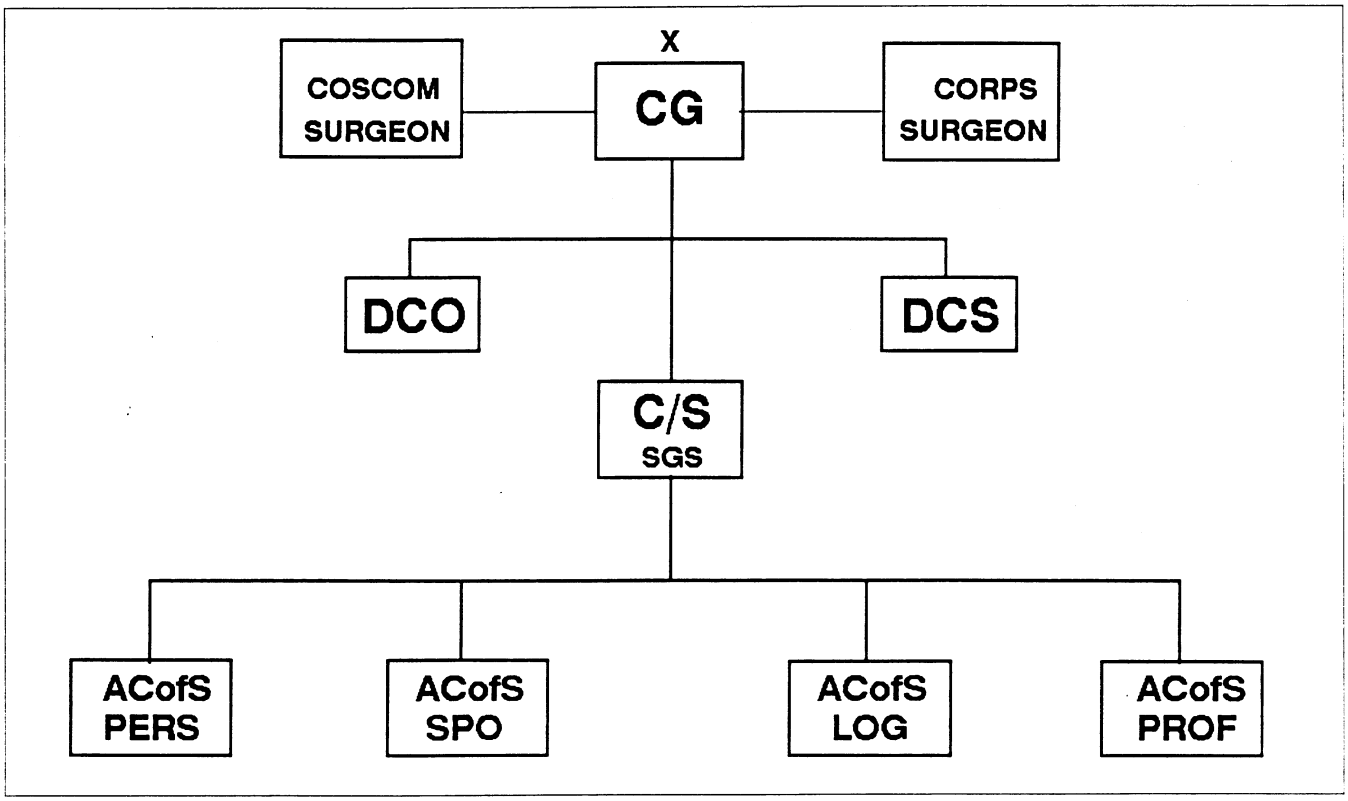

Figure 4. 332d Medical Brigade Organization depicting "triple hatted" role of the commander.

concurred and this was accomplished, it was still apparent that this augmentation of 14 personnel was not sufficient. Further discussions with the CG, 2d COSCOM resulted in a decision to also incorporate Headquarters and Headquarters Detachment, 30th Medical Group into the brigade headquarters. This action created a brigade staff with the depth and experience needed for planning, preparing and executing all Corps-level medical support. After this unprecedented restructuring, Brig Gen Strong became "triple-hatted" as the Corps Surgeon, COSCOM Surgeon and Medical Brigade Commander. The former Corps Surgeon joined the brigade as the Deputy Brigade Commander, Support; the former Commander, 30th Medical Group, joined the brigade as the Deputy Brigade Commander, Operations; and the incumbent Chief of Staff remained in that role (Fig 3). With these actions completed, a Reserve Component Medical Officer had become the Corps Surgeon and Commander of all Corps-level medical assets for an active duty corps. He, in turn, was supported by three colonels—one Medical Corps [AD] (Active Duty) and two Medical Service Corps (one AD, one USAR) and a hybrid staff of Active, ARNG, and USAR personnel (Fig 4). Innovative, proactive application of the Total Force Concept by corps medical leadership set the example for cooperation.

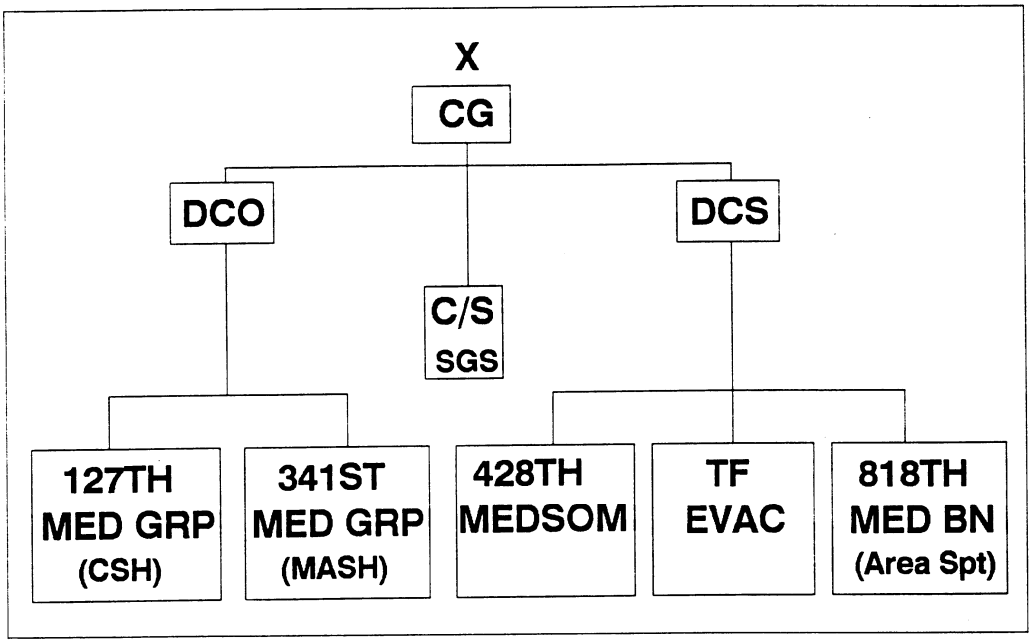

Figure 5. 332d Medical Brigade Command Structure depicting authority and responsibilities of the two Deputy Commanders.

Organizing for Combat

The 332d Medical Brigade deployed to SWA on Dec 17, 1990 and quickly moved to the Tactical Assembly Area. After restructuring, a relook at the Corps OPLAN revealed that the doctrinal relationship of a medical group in direct support of each division could never be achieved. The tremendous distances involved over desert terrain made it obvious that three linear bands of hospitals were needed in place of the doctrinal direct line of ascension in capability. Although there was initial resistance to this structure as proposed, the organization was implemented with the 341st Medical Group (USAR-Texas) providing C2 for all MASH and evacuation units in the most forward band of support. Their mission was to clear the battlefield across the front and provide initial resuscitative surgery as required. The 127th Medical Group (ARNG-Alabama) provided C2 for the CSH and all evacuation units in the second band of support. Their mission was to clear the MASHs and provide more definitive surgery. The maintenance of the five evacuation hospitals as direct reporting units soon proved too cumbersome. Task Force EVAC was therefore created as a Medical Group equivalent to provide C2 to all evacuation hospitals. The 818th Medical Battalion (ARNG-North Dakota) provided area medical support for the corps rear and C2 of the sole VII Corps UH-60 medevac unit, the 236th Medical Company (7th MEDCOM). This created a balanced support package structured similar to a heavy division, with one deputy commander controlling maneuver elements (CSHs & MASHs) and the other support elements (EVAC and MEDSOM) (Fig 5). As predicted, this placed the group headquarters where they could best make command decisions to influence events at the critical time and place.

CONCLUSION

Medical support for the VII (Combined) Corps was successful for two reasons. First, concepts and plans were developed early, non-doctrinal options were implemented and all Corps-level medical planners joined in a synchronized effort. Second, over the past decade the Army Medical Department has steadily improved in quality, and is now perhaps the single finest organized health system in the world. During Desert Storm, all branches and components joined together to use innovation, teamwork and determination to succeed. ●