From USEUCOM Surgeon

Medical Support to Desert Shield/Storm: The USEUCOM Surgeon's Perspective

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Late on the afternoon of Aug 2, 1990, Colonel Bob O'Brien, Senior Medical Staff Officer, US European Command (USEUCOM) received a telephone call from Colonel Ben Knisely, Deputy Surgeon, US Central Command (USCENTCOM). Col Knisely informed Col O'Brien that USCENTCOM might be coming to USEUCOM for assistance with noncombatant evacuation operations (NEO) from Kuwait following the sudden and complete success of Saddam Hussein's military forces in the capture of Kuwait earlier that day. Col O'Brien agreed to pass on the alert within USEUCOM and asked Col Knisely to keep USEUCOM informed about further developments.

The following day, Knisely called O'Brien again. The situation in Kuwait had changed, and looked as though more than NEO assistance might be needed. There was new concern about the possibility of US military casualties in the Persian Gulf. Later that evening, O'Brien called Knisely to get an update. In addition to the threat to US military forces, Iraqi tanks had surrounded the American Embassy in Kuwait City, and the situation was becoming increasingly tense. Knisely and O'Brien agreed to maintain regular and frequent communication.

Four days later, as international tension and concern about the situation increased, US Secretary of Defense Dick Cheney approved a joint deployment order initiating the flow of significant US military forces to the Persian Gulf region to deter further aggression on the part of Saddam Hussein, and to encourage him to withdraw his forces from Kuwait.

The events of those several days—Aug 2-7, 1990—set the stage for one of the most eventful periods in the history of USEUCOM and the Office of the Command Surgeon (ECMD).

The purpose of the following discussion is to provide an ECMD perspective of those events, with particular attention to the planning and execution process which was followed, and the factors which influenced the decisions on how to provide medical support from USEUCOM. Following that narrative description of key events of that period, attention will be devoted to some of the successes, some of the problems and to some questions which were not answered.

This narrative will begin with a description of the unique background for the events which took place in USEUCOM, followed by a discussion of the essential functional areas of contingency medical support which required involvement by ECMD.

Background

The primary purpose of the US military presence in Europe since the end of World War II has been participation in a partnership with the other NATO nations to deter and, if necessary, defeat aggression on the part of the Soviet Union and the other Warsaw Pact countries. For more than four decades, all efforts in USEUCOM had focused on the preparation and possible execution of plans to defend Western Europe, with the Commander-in-Chief, US European Command (USCINCEUR) as the supported United States unified command CINC. With the start of Operation Desert Shield in the Persian Gulf region, USEUCOM assumed a new and somewhat unfamiliar role—that of a supporting CINC, in this case, in support of the Commander-in-Chief, US Central Command (USCINCCENT). There were no plans for what was about to take place within USEUCOM. The keys to success would be adaptation, improvisation, innovation and perseverance.

From the very beginning of Operation Desert Shield, the USEUCOM staff had the following CINC guidance on how to respond to requests for support to USCINCCENT: "The answer is yes. What is the question?" The only individual with the authority to refuse a request was the USCINCEUR, General John R. Galvin.

Requests for support to USCENTCOM were honored as received from either the Joint Staff or directly from HQ USCENTCOM. These requests were then passed to the USEUCOM components, first in the form of what was called an "asker" to determine the feasibility and impact of granting the request, and then in the form of a "tasker" to provide the support, if at all possible. This asker/tasker process worked very well because it facilitated and encouraged open dialogue on the precise needs of USCINCCENT, and how those needs might be best and most expeditiously met by USEUCOM.

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USCINCEUR's medical mission was to provide communication zone (COMMZ) medical support in Europe for USCINCCENT. For USEUCOM, that simple mission statement translated into the provision of a large and complex organization consisting of medical command and control, hospitalization, evacuation, dental services, veterinary services, laboratory services, blood management, preventive medicine services, medical logistics, medical regulating and medical host nation support.

Command and Control

For the most part, medical command and control within USEUCOM was exercised through the channels which were in place prior to Operation Desert Shield.

Over the past several years, the US European Command Surgeon has met quarterly with the Command Surgeons from the three USEUCOM Component Commands—US Army Europe (USAREUR), US Air Forces in Europe (USAFE) and US Naval Forces, Europe (NAVEUR). That group of Command Surgeons, known collectively as the USEUCOM Medical Coordinating Committee (UMCC), was the principal vehicle used to arrive at and execute medical policy within the European Command during Operations Desert Shield and Desert Storm (DS/S). Virtually every area of contingency medical support was discussed at one or more of the seven UMCC meetings which were held between Aug 14, 1990 and Feb 14, 1991. Medical problems and questions were identified, taskers were distributed to various work groups and individuals, and solutions and medical policy were determined. In sum, the functioning of the UMCC was an unqualified major success during the preparations for and conduct of the war. Had that policy group not existed and been functional prior to Operation Desert Shield, it would have been necessary to create it. The peacetime UMCC made a smooth transition to providing medical support to a war-fighting CINC.

Hospitalization

The major USEUCOM medical mission was to provide hospitalization to US forces evacuated to Europe from Southwest Asia (SWA). With that mission from USCINCCENT in hand, the first step for USEUCOM was to determine the number of hospital beds necessary to accomplish that mission.

The principal initial planning parameters were as follows:

- A population at risk in SWA of 350,000 US personnel.
- An evacuation policy of seven days in SWA, and 15 days for USEUCOM. That 15-day policy for USEUCOM was later amended by agreement between the USEUCOM and USCENTCOM Surgeons to 60 days prior to hostilities and 15 days following the commencement of hostilities.
- All patients evacuated from USCENTCOM would flow through USEUCOM (rather than directly from SWA to CONUS).

Two different medical planning models were used to arrive at the decision on the number of DS/S hospital beds USEUCOM would operate. Using the Medical Planning Module (MPM), the Joint Staff recommended that USEUCOM operate 5300 hospital beds. Other similar recommendations came from MPM analyses run at the USCENTCOM Surgeon's Office. A third estimate was provided in response to a request for an analysis using the Army's Patient Flow Model.

All operating bed estimates for USEUCOM fell into a range of numbers between 5,200 and 5,800. The USEUCOM Surgeon recommended that the UMCC adopt 5,500 operating beds as the theater objective. The next question was how to provide the 5,500 operating beds.

The peacetime USEUCOM hospital bed structure could not possibly accommodate 5,500 extra USCENTCOM patients without seriously disrupting on-going services. The Desert Shield beds had to come from contingency resources. Prompt availability was most important. Mobility was not a significant factor. Since USAFE had a number of "turn-key" contingency hospitals established in Germany and the United Kingdom, and nearly 4000 of those hospital beds were close to available C-141 capable airfields, USAFE was tasked to provide 3,740 of the required beds. USAREUR was tasked to provide the remaining 1,760 beds.

USAFE opened contingency hospitals at Zweibrucken, Germany and at RAFs Little Rissington, Bicester and Nocton Hall in the United Kingdom. Peacetime facilities were expanded at Wiesbaden, GE; RAF Upper Heyford and Lakenheath in the UK; Torrejon AB, Spain; and later —for Operation Proven Force—at Incirlik AB, Turkey.

USAREUR and 7th Medical Command (MEDCOM) expanded their three largest hospitals in Germany — at Landstuhl, Frankfurt and Nuernberg.

NAVEUR was tasked to be prepared to support USEUCOM hospital bed expansion as required while initially committed to the Mediterranean maritime interdiction mission.

In November 1990, the National Command Authorities made the decision to shift from a defensive posture to an offensive posture with the deployment of USAREUR's VII Corps to SWA. Resulting recalculations of the number of hospital beds required to support the larger USCENTCOM force more than doubled the 5,500 requirement figure. Realizing that the CONUS medical base was already busy enough trying to minimize the impact of Desert Shield on the accomplishment of its own health care delivery mission, USCINCCENT made the decision to forego medical returns to duty from Europe and changed the USEUCOM medical mission to one of stabilization and flow of all patients back to CONUS. That change in mission for USEUCOM significantly reduced the COMMZ operating bed requirement for the more robust USCENTCOM force to where the UMCC was comfortable with relying on European Host Nation Support hospital beds for requirements of over 5,500.

Medical support of DS/S would

require a level of national commitment which had not been seen since World War II. Personnel to operate the 5,500 beds in Europe would have to come from CONUS, and many of those personnel would have to come from a Reserve Component call-up.

In November 1990, the ante for the USEUCOM medical buildup went up again, as it became clear that the Army would have to do more than augment 7th MEDCOM to enable operating 1,760 DS/S hospital beds. Deployment of VII Corps meant that a back-fill for the departing VII Corps medical support slice would also be necessary.

The subject of hospital beds in SWA was a matter of considerable concern and interest on the part of USEUCOM and the UMCC, as well as for the USCENTCOM Surgeon and his staff. While the Air Force and the Navy provided their required hospital beds very early and very quickly, the Army hospital units were not apportioned the necessary strategic lift to respond as quickly. Consequently, there was considerable concern during the early days of Desert Shield that the strategic aeromedical evacuation system and USEUCOM might have to bear the burden of the limited number of Army hospital beds in SWA.

Evacuation

The medical transportation of SWA patients within USEUCOM began, and later ended, with the operation of the USAF Aeromedical Staging Facilities (ASFs) at each of the reception airfields, or Aerial Ports of Debarkation (APODs). (These same ASFs would also later serve patients departing for CONUS from the same airfields, then known as Aerial Ports of Embarkation [APOEs]). Three ASFs, one with Canadian augmentation, were operated in Germany to flow patients into five supported hospitals. Three ASFs were also established in the UK to flow patients into five supported hospitals there, and one ASF was established at Torrejon AB, Spain. A total of 1,450 USEUCOM ASF beds were in operation during the crisis in the Persian Gulf.

The intratheater, or tactical, evacuation mission in USEUCOM was split along conventional lines between USAREUR, USAFE, Military Airlift Command (MAC) and host nation support units.

One third of the 12 USAF peacetime aeromedical evacuation (AE) crews stationed in USEUCOM were deployed to SWA. Nearly 2,500 AE personnel, most from the Reserve Components, deployed from CONUS to USEUCOM to provide a total of 294 AE crews in support of DS/S.

From the ASFs in Germany, patients were evacuated to DS/S hospitals by USAREUR's reinforced 421st Medical Battalion (Evacuation). The 421st had command of all USAREUR and German rotary wing ambulances and all ground evacuation assets in Germany. These ground assets included units from USAREUR and Germany, as well as elements from the Canadian Medical Group Headquarters based in Lahr, Germany. USAFE and British units moved patients on the ground in the UK, and USAFE was prepared to move patients in Spain.

Patient evacuation between Germany and the UK by C-9 and C-130 aircraft was a MAC mission. Had this mission been necessary, it would have been used to redistribute certain categories of patients, and would have been very important to servicemembers hospitalized in the UK who desired to be closer to family members in Germany, and visa versa.

The strategic AE of patients from SWA to USEUCOM was, of course, a MAC mission. MAC had been flying the strategic AE missions with unscheduled (ie, opportune) aircraft since the beginning of the crisis in SWA.

After the war began, the strategic AE mission was to be accomplished in accordance with a concept originated by MAC and agreed to by USCENTCOM and USEUCOM medical planners at an AE conference in Riyadh in early January 1991. In accordance with the concept, patients departing SWA from a specific APOE were to be routinely flown to a specific APOD in USEUCOM. Five such so-called hub-to-hub links were established. For example, patients departing SWA from King Kahlid Military Center (KKMC) would routinely be flown to Ramstein Air Base in Germany, which served the 2d General Hospital at Landstuhl and the USAF Contingency Hospital at Zweibrucken.

The hub-to-hub concept was intended to compensate for the planning assumption in SWA that the patient workload in SWA hospitals and ASFs would be too high for doctrinal patient regulating and redistribution or sorting of patients (ie, sorting by destination USEUCOM hospitals) prior to strategic AE. The concept was a sound one, and would have worked. Unfortunately, the precise timing of its implementation was not sufficiently understood by all concerned.

Some medical planners and operators who attended the AE conference in Riyadh believed the hub-to-hub idea would be put into practice on D-Day, which turned out to be Jan 17. Others—especially MAC operations people—believed that the concept would be implemented when the number of casualties dictated the initiation of scheduled (ie, preplanned) AE missions, not necessarily on D-Day.

Message traffic put out after the AE conference confirmed adherence to the plan put out at the AE conference—whatever that meant to the various attendees. Some conversations with perceived authorities on the plan confirmed the use of the hub-to-hub plan on D-Day. Other written communications stated that retrograde missions could be requested to fly to APODs where the patients had been regulated, but if that was not possible, the retrograde missions would fly to Rhein-Main or Ramstein Air Bases. Unfortunately, the inadvertent lack of precision about exactly when the hub-to-hub connections would be initiated was not apparent until long after it mattered.

What actually happened, and

what did matter, was that patients being evacuated from SWA to USEUCOM were being regulated by both USCENTCOM and USEUCOM using the hub-to-hub concept as of D-Day. That was done to avoid changing procedures after the war actually started. On the other hand, MAC was still flying AE missions only as unscheduled missions, using some hub-to-hub routes only by coincidence when flying to Rhein-Main or Ramstein Air Bases was most advantageous to crew and airframe utilization. Most AE missions were flown to Rhein-Main or Ramstein, while patients were being regulated not only to those APODs but also to Nuernberg, Upper Heyford, Waddington, etc, in accordance with the hub-to-hub plan. In addition, patients who should have been taken to Ramstein AB landed at Rhein-Main AB, and patients regulated through Rhein-Main landed at Ramstein.

The hub-to-hub concept would have worked as intended if MAC had actually flown the strategic AE missions with scheduled aircraft instead of opportune aircraft. The good news was that casualties never reached the level prescribed for the initiation of scheduled AE missions. The bad news was that none of the planners at the Riyadh AE planning conference anticipated the situation which actually developed—we had a war with so few casualties that the plans for using scheduled MAC aircraft for strategic AE never had to be implemented. Thus, MAC never flew all of the hub-to-hub routes to all of the patient regulating APODs. All the while, the patient regulators thought they were sending patients to all of the hub-to-hub APODs as of D-Day, and there was precious little insight into why patients were going primarily to Ramstein or Rhein-Main supported hospitals and not arriving at the other hospitals as regulated. At the macro-level, there were so many hospital beds available for so few casualties that it made little difference. However, at the level of the individual patient, there was still the issue of efficient patient management.

The question which remains is this: How can we expect to provide efficient and effective strategic AE for our patients with a system in which (1) there is a specific destination for the patient (recorded on his/her DD Form 602, Patient Evacuation Tag), (2) there is a specific destination for the aircraft, (3) there may be an obvious disparity between the patient destination and the aircraft destination and (4) either no one checks on those details or no one tries to reconcile differences. That is like a passenger with a ticket for Los Angeles being put on a plane bound for New York with no one trying to be sure that both passenger and plane are going to the same destination. That part of the system is broken, does not serve the patient well, and leads to hospital commanders not knowing when which patients are to arrive at their medical treatment facility (MTF).

The USEUCOM Joint Evacuation Work Group has been tasked to conduct a comprehensive study of the entire evacuation system using the Total Quality Management process to determine where the system can be improved to better serve our patients.

Veterinary Services

After the dust settled from determining the number of hospital beds to operate, how they were to be provided, the interface between the two JMROs, etc, it was time to turn to other matters.

The ECMD planners learned that tracking the number and location of working dogs in the deploying force, the number and location—if any—of approved food sources in the supported CINC's AOR, and the number and types of TO&E veterinary teams necessary to support the operation are planning factors which should not be taken lightly.

As things turned out, 7th MEDCOM was able to build a JB veterinary team for USCENTCOM from resources within Germany, and deploy it to SWA before eating on the local economy (instead of using MREs) caused a serious health problem for some early deploying units.

Medical Logistics

Desert Shield/Storm demonstrated the effectiveness of the single tri-service manager concept for medical logistics. This system, known as Theater Medical Logistics System, Europe (TMLOGS-EUR), was pioneered in 1987, with USAREUR as the executive agent, and the US Army Medical Materiel Center, Europe (USAMMCE) as the operator.

At the risk of giving too little credit for a vital and huge mission superbly accomplished, USAMMCE did the following.

- Managed the initial build-up and resupply of medical supplies to all MTFs in SWA. This included the construction and shipment of over 200 Medical Resupply Sets and Level II Medical Sets, Kits and Outfits in support of units in SWA.
- Provided Class VIII materiel support for all of the "expanded" USEUCOM hospital system.
- Deployed a Medical Supply, Optical and Maintenance (MEDSOM) unit to SWA to support VII Corps.
- Integrated a US Army Reserve MEDSOM into the TMLOGS-EUR mission.
- Restructured a number of Deployable Medical Systems (DEPMEDS) hospital equipment sets from their original configuration (type and size of hospital) to other configurations for shipment to SWA.
- Shipped 4,709 short tons of Class VIII materiel valued at $56.9 million from August 1990 to March 1991.
- Filled 70,821 optical prescriptions for spectacles and protective mask inserts.

Unique to the medical logistical support provided USCENTCOM from USEUCOM was the provision and initial operation of a prototype liquid oxygen (LOX) generator system.

A final, and conspicuously noteworthy, logistical accomplishment was the successful shipment of 17 DEPMEDS hospital equipment sets to SWA only weeks prior to the mid-January 1991 deadline.

Blood Management

Work on establishing blood program requirements for USCENTCOM was done by the members of the USEUCOM blood management community, and blood products were shipped to SWA soon after the publication of the deployment order. Blood management personnel and blood transshipment centers from Hahn and Helenikon Air Bases were sent to SWA to begin a blood program until the USCENTCOM blood program office was established.

Medical Regulating

It is useful to think of the Joint Medical Regulating Office (JMRO) as the agency that books an out-of-town hotel room for a traveler. Travel agencies book the room, but they do not take the traveler to the hotel; that is the job of the airline—in this case the patient evacuation system.

The USEUCOMJMRO had to accomplish two important actions simultaneously: expand internally to deal with the new demands of a rapidly growing 10-hospital, 5,500 bed medical system for DS/S patients, and reach out externally to link up with the embryonic USCENTCOMJMRO operation and help it to become a mature and capable operation ready to regulate thousands of patients to Europe with maximum efficiency and effectiveness.

The task of providing a suitable and reliable communication link to span the nearly 3,000 miles between the USEUCOMJMRO and SWA was initially accomplished on Oct 18, 1990 by the Defense Medical Systems Support Center (DMSSC)-Europe with the installation of an initial MTF Defense Medical Regulating Information System (DMRIS) computer in Riyadh. A local area network including the Automated Patient Evacuation System (APES) was added to the USCENTCOMJMRO in January 1991 to mirror the capability of the USEUCOMJMRO.

In USEUCOM, DMRIS terminals were installed to link three DS/S hospitals in UK to the sub-JMRO at Upper Heyford, and two DS/S hospitals in UK and all five in Germany to the JMRO at Rhein-Main. One additional DMRIS terminal was also installed for the Canadian Armed Forces in Lahr, Germany.

On Jan 16, 1991, in anticipation of and preparation for large numbers of casualties to evacuate to USEUCOM, the USCENTCOMJMRO discontinued using the by-name patient reporting system and began using the DMRIS contingency regulating report format. The significance of this decision was that all individual patient identification information dropped out of the medical regulating system. From that time on, the basic information which was passed for medical regulating was the number of patients in each of the 12 contingency medical specialty code categories.

By itself, the decision to use the reduced information reporting format might not have been of any serious consequence. (It is important to note, however, that DMRIS in a reduced edit mode is capable of handling greater data transmission workloads than were projected for Operation Desert Storm.) When contingency (no name, etc) regulating was combined with the aforementioned USCENTCOM decision to not redistribute or sort patients by destination MTF, and with the confusion about when MAC would actually begin to fly the hub-to-hub strategic AE routes, the probability of conducting efficient medical regulating between SWA and USEUCOM was rather low, to say the least. The result was considerable turmoil for virtually everyone in the USEUCOM medical system—the patients, ASFs, patient regulators, evacuators and hospital staffs. Unfortunately and frequently, there were many hours of uncomfortable delay for patients at the APOD while initial regulating or reregulating of the patients was accomplished because the patients were not expected at that APOD.

In Germany, it was not unusual to then fly or drive one or more patients to the initially intended hospital because of unique patient requirements which could be best met at that specific hospital.

The USEUCOMJMRO had to acquire and place regulators at six locations throughout Germany and the UK to accomplish regulating which normally should have been completed before the patients left SWA. Instead of being efficiently done between the two JMROs, most patient regulating did not actually begin until the patients reached one of the APODs in Europe.

Hospital commanders never knew who they were getting as patients, and rarely knew how many patients they were getting or when they were getting them until after the AE mission had landed at the supporting APOD.

A total of 11,465 DS/S patients were evacuated to USEUCOM and hospitalized there between Aug 27, 1990 and May 31, 1991 (Table I).

Table I. *DS/S Patient Hospitalizations in USEUCOM.*

Hospital	Aug 27, 90 thru May 31, 91
Wiesbaden	3,026
Frankfurt	2,758
Landstuhl	3,415
Nuernberg	1,117
All Others	1,149
Total	**11,465**

Host Nation Support

The subject of host nation support (HNS) has been a staple of US contingency planning overseas for many years, and necessarily takes up a significant amount of the time and energy devoted to readiness planning.

One of the most heartening experiences of the preparations for and conduct of USEUCOM support for DS/S was the magnificent way in which twelve of our allies, NATO and non-NATO countries alike, quickly came forward with offers to provide medical support, mostly staffed hospital beds, in Europe. These offers —actually totaling many more beds than needed for any anticipated casualty scenario — would have been used when census levels in USEUCOM DS/S hospitals reached specific, predetermined levels.

In each case, HNS offers were received, agreements were made

at the HQ USEUCOM level, and then were turned over to the components for operation. USAREUR managed HNS from Germany and Canada, USAFE managed HNS from the United Kingdom, Spain and Denmark and NAVEUR managed HNS from Cyprus. All HNS programs were handled with outstanding success.

Several examples of HNS illustrate the extraordinary breadth and depth of these offers.

- With the invaluable assistance and cooperation of the Surgeon General, Federal Armed Forces, Germany, USEUCOM and USAREUR were able to secure agreements for the following German HNS: medical logistics; medical evacuation (ground and rotary wing); 1,000 fully staffed hospital beds in five German military hospitals; acute care in specialties such as thoracic surgery, orthopedics, ophthalmology and burn care; and convalescent care near US military communities.
- Bilateral agreements with the British for HNS in the UK have existed in some form since 1973. The high level relationships which stem from the US/UK HNS plan development process proved to be absolutely invaluable in preparing the way for USAFE operators to request and receive the support required to open and operate their contingency hospitals in the UK. There is no way those hospitals could have opened when they did without the HNS that the UK provided so graciously and responsively.
- The Government of Denmark, through the Chief of Defense, approached the United States with an offer to open, staff and operate the 500 bed USAFE contingency hospital in Holstebro, Denmark. The offer also included operation of an aeromedical evacuation B-737 aircraft and operation of an ASF at the Holstebro airfield. Personnel for this offer were to come from a Danish reserve component call-up. An agreement was drawn up and signed by the Chief of Defense and the USEUCOM Surgeon, and the Danes had the entire package up and ready to receive patients when the war started in January 1991.
- Spain was equally generous, offering use of 1,000 fully staffed, full service military hospital beds at five sites.

As planning for the new NATO environment progresses, many of the offers for host nation support will be revisited to develop bilateral agreements to improve medical readiness in and for USEUCOM and for the medical readiness of the NATO multinational forces of the future.

Lessons Learned

What did we learn from DS/S, good and bad? What questions still linger unanswered?

Successes: Many very good things happened during DS/S. Some of the more notable include:

- The Reserve Components did a great job; DS/S could never have been completed as successfully as it was without them.
- Medical jointness works very well. The USEUCOM Component Surgeons did an outstanding job, both individually and collectively. It could not have been done any better. There was complete cooperation and coordination throughout the entire operation.
- The UMCC is an effective forum for medical decision and policy making during a contingency.
- The time and effort invested in building the US/German HNS relationship and the US/UK lines of communication has been very well spent. Similar bilateral processes are being developed in many other parts of USEUCOM.
- The prompt willingness of many of our allies to offer medical HNS was a very pleasing development.
- The USAF contingency hospital program worked.
- The asker/tasker process works well. It facilitates open communications between the tasking and the tasked headquarters, and usually provides maximum possible time for working the problem to a mutually satisfactory conclusion.

Problems: Many problems in the conduct of DS/S have been and will be identified and documented. A few that merit time and attention in this discussion are as follows.

- There is widespread lack of understanding of the roles, missions and relationships of the Joint Staff, the unified commands, the specified commands, the services and the service major commands. Staff personnel at service headquarters and major commands in CONUS, where the Joint Staff and the unified command plan are not so much a part of everyday life, need to learn more about how the unified and specified command system is supposed to work if they have dealings with overseas commands. Taskings or agreements for missions were frequently not properly channeled through either the Joint Staff or the unified command headquarters. As a result, units did not move as some expected because JCS deployment orders were never requested by the unified command. (Including the unified command as an information addressee on a tasker message from one service major command to another, or from a service staff to the major command, does not count as using proper channels.)
- Unified commands need a better understanding of when, or for which units, a JCS deployment order is necessary. The JCS deployment order procurement process is much too slow.
- We need to find a win-win way to meet both the needs of the patient and the need to have MAC perform the strategic and tactical AE missions as efficiently as possible. The difficulties in the present system need to be reviewed to find the best possible way to organize and command/control the strategic AE mission system and related functions.
- Less than prompt and reasonably efficient response by one part of the total system places inappropriate responsibility or burdens on the rest of the players. This is simply a restatement of the golden rule, applicable at the highest as well as the lowest levels. Services and/or major commands violated that principle several times.

- Out of area (outside of NATO or outside of USEUCOM) and supporting CINC operations need to be planned.
- Headquarters need to develop and maintain viable mobilization staff augmentation plans. When a peacetime staff is required to suddenly support several 24 hours-a-day, 7 days-a-week duty posts, there are not enough people to go around, especially people with proper security clearances.
- If reporting is bad during usual peacetime operations, it is not likely to get any better during a contingency. The attention to detail necessary for reliable reporting needs to be a matter of training every day (ie, every reporting period), not just when a contingency is working.
- All four Services need to plan to send trained liaison teams to all hospitals receiving casualties during a contingency. They must be able to handle routine personnel, finance and supply actions for their respective patients.
- Policies and procedures need to be followed or possibly questioned, but should never be ignored or unilaterally violated. The 60-day evacuation policy which was in force for the first three months of Desert Shield was rarely followed. If a patient was evacuated to Europe, the patient was sent home to CONUS —and then sometimes back to the unit in SWA again. Failure to comply with the stated evacuation policy results in great waste of time, energy and dollars. Only the JMRO should regulate patients, unless the patient's medical condition dictates otherwise. No one else has the required information or authority to perform that function. Nevertheless, patients coming into one particular APOD ASF were routinely reregulated by the ASF administrative staff, even when the arriving patients had already been properly regulated and flown to the correct APOD.
- Medical planners should not overlook the possibility of being tasked to provide medical care for DoD civilians and contractors, as well as for prisoners of war and/or refugees and displaced persons.
- Plans for the orderly drawdown of forces and retrograde of equipment must be made early. Everyone cannot go home first. Rhetorically speaking, how quickly can the CONUS filler personnel be released? Should the personnel returning from the mission automatically be given leave? Should the Reserve Component personnel called in to back-fill the people who deployed automatically be held over until the deployed personnel return to duty? There were a lot of different expectations about who would go home and when they would go home. The Services did a great job of sending some 10,000 people to Europe to support the medical expansion. Withdrawal did not always go quite as well. The key is early planning which clearly addresses the "ground rules" and likely expectations for return of filler personnel to home station. It takes two or three — maybe more — times longer to properly reconstitute and repack medical sets, kits and outfits than it does to unpack them. The time to do this has to be properly provided and properly used.

Questions: Last, there are some unknowns or questions which are still lingering, and are noted here to stimulate some thought.

- Would we ever have been able to regulate and strategically evacuate as many as 2,000 patients per day from SWA to USEUCOM — either with the systems in place in January 1991, or with systems which would have been developed later? If so, could that ever have been done really efficiently?
- Would we have been able to flow 1,000 to 2,000 patients per day through the USEUCOM MTFs to CONUS to keep beds open for the next planeloads of patients from SWA?

CONCLUSION

This article is intended to be a narrative of the more significant actions which were observed from ECMD during DS/S, not a definitive account of all that happened medically in USEUCOM during DS/S.

The points made are intended to prompt some good, solid, innovative thought about preparations for medical support for the next contingency, not to better prepare for the last one.

The key nonclinical question which emerges is this: Can we provide appropriate patient management for more than just a few patients at a time? Can we move patients through the total patient care system efficiently and effectively, in a way which will enhance, and certainly not detract from, the patient's welfare and the patient care provided along the way?

It appears that there is still much to do! ●