THE JOURNAL interviews --
Lt Gen Alexander M. Sloan
The Surgeon General of the US Air Force

by Ingeborg Sosa

JOURNAL: General Sloan, your counterpart, Lt Gen Frank F. Ledford, Jr., the Surgeon General of the US Army, stated right after the conflict in the Persian Gulf region that this was "the fastest mobilization in US history. We did in three months what it took us three years to do in Korea." Since the Air Force was first on the scene of the war, preparing for what was basically to become an air war, was it also the first service to have medical capabilities in Southwest Asia? What were those capabilities?

SLOAN: I could not agree more with Lt Gen Ledford regarding the rapid mobilization of our forces that supported the conflict in the Persian Gulf. We arrayed the largest projection of US medical personnel and equipment at a pace and with an efficiency never before achieved in our history. Initial medical support at Air Force deployment locations was provided by our air transportable clinics (ATCs). The first ATCs left the United States on Aug 8, 1990--just six days after Iraq's invasion of Kuwait. The first of 15 air transportable hospitals arrived in theater the following week and was ready to receive patients within 24 hours.

You asked about capability. Each of our ATCs contains first aid and emergency medical supplies and is staffed by a squadron medical element (SME) consisting of a flight surgeon and three technicians. An ATC is assigned to and supports each tactical combat flying squadron. The ATH represents our next level of medical capability and provides surgical (two operating rooms), x-ray and laboratory services, blood storage, a range of medical and dental outpatient services, and beds for 50 patients. We have designed each of our ATHs to meet the medical needs of a deployed tactical fighter wing with up to 72 aircraft and about 4,000 personnel. Our early arriving ATHs were the primary source of medical care for forward deployed USAF units and other nearby units from the other services. With the ATH we were able to provide initial theater surgical capability.

Lt Gen Alexander M. Sloan, was the EUCOM Surgeon during Desert Shield/Storm. He is now the Surgeon General of the Air Force.

JOURNAL: Did the Air Force have major problems in moving its first volume of required equipment, medical supplies and hospital structures to and within Saudi Arabia?

SLOAN: We experienced no major problems in moving our initial requirements for medical equipment, supplies and personnel into the theater of operations. Each ATC is an integral part of a tactical combat flying squadron deployment package, and when and where the squadron goes, so goes their "organic medical support," if you will. We were able to deploy most of our ATHs successfully within two to three days of their required arrival dates in theater. Occasional delays were a function of competition for airlift resources.

JOURNAL: During the early days of Desert Shield, the Air Force also took care of the medical problems that developed in members of the Army, since the Army medical service experienced problems getting its equipment shipped to and operational in the desert area. How did this work out, and how do you judge the overall interservice cooperation?

SLOAN: The interservice cooperation demonstrated in Operations Desert Shield/Storm was nothing short of truly outstanding. The medical system was tailored throughout to meet the operational theater's needs. As the mission of the deployed force evolved from deterrence to offensive operations, the medical support requirements expanded and were adjusted accordingly. Each Service did its part to provide comprehensive medical capability throughout the operation. Although the Air Force and the Navy provided early-on medical treatment, sustainment of medical services would not have been possible without the Army resupply system. In addition, an elaborate air evacuation network ultimately linked the Services together.

JOURNAL: What was your experience with the coalition forces?

SLOAN: While our experience with coalition medical forces was not as extensive as perhaps the Army's or Navy's, it was nonetheless positive. Host nations provided upwards of 20% of the available hospital beds in the theater of operations, which were staffed by Army and Navy personnel.

JOURNAL: The Air Force and Army in Europe had almost six months to achieve the 5,500 bed expansion capability they had been tasked to establish. The Army decided to expand its existing medical centers, while the Air Force elected to open its "turn key" contingency hospitals. How did you go about getting these hospitals operational during the almost six months before the combat started? Would you have been able to have them operational sooner had circumstances warranted it?

SLOAN: As stated earlier, the medical system that supported the Persian Gulf conflict was tailored throughout to meet the

CINCENTCOM's needs based upon the operational threat and evolved accordingly. Concerning our "turn-key" contingency hospitals, each has a full-time caretaker force assigned to ensure the facility and the equipment are maintained in a ready state, requiring only medical staffing to attain operational capability. In addition, during Operation Desert Shield, we deployed a small cadre of medical personnel from various selected functional areas to each of our selected contingency hospitals to anticipate potential problems and help the respective sites to receive the full medical staff. Within the framework of our standard planning and execution procedures, we would have been able to activate these facilities sooner had circumstances and mission dictated.

JOURNAL: How well did you manage to maintain quality care for those soldiers and other beneficiaries that were not in the Gulf region?

SLOAN: During the initial stages of Desert Shield, medical services at selected Air Force bases were reduced or curtailed as medical personnel deployed to the Gulf region. This circumstance forced many beneficiaries to seek medical care under the auspices of CHAMPUS. Once authority to call up reservists was granted, however, medical staffing and accessibility to medical services returned to pre-deployment levels, and the quality of military medical care was never at issue.

JOURNAL: The Air Force deployed its medical units up front with its fighters. How were they prepared to deal with severe burn cases? Were special preparations made to take care of these casualties both in Europe and stateside?

SLOAN: In the example of severe burn cases, early on we assured the status of the appropriate medical equipment and supplies in the theaters of operation. Training in combat casualty care management and advanced trauma life support ensures stabilization of the seriously ill or injured for aeromedical evacuation to a source of appropriate care. Individuals requiring specialized medical care primarily available in the civilian sector (eg, burn beds) were sent to a military medical facility that arranged for care at nearby civilian hospitals, using established procedures. Special arrangements for burn patients were established in Europe, the United Kingdom and in CONUS during the Gulf conflict.

JOURNAL: In retrospect, what do you judge your medical evacuation capabilities to have been? Are you satisfied with those capabilities?

SLOAN: I believe that our medical evacuation capabilities would have been adequate to address the casualty levels predicted in Operation Desert Storm. In addition to C-130 aircraft for tactical missions and C-141s for strategic missions (both dedicated and retrograde), airframes from the Civil Reserve Air Fleet (CRAF) could have been made available for overseas and stateside medical evacuation. Operation Desert Storm highlighted some refinements to

be made in equipment and staffing of aeromedical evacuation units that we have already begun addressing. Although more than 12,000 patients were evacuated from the Persian Gulf to Europe and on to the United States, casualties from the Gulf War were far fewer than anticipated, and our medical evacuation capabilities were not fully challenged.

JOURNAL: What special preparations did the Air Force make to ready the over 500,000 soldiers deployed to the Gulf region for possible attacks with chemical and biological weapons? Were medical personnel ready to deal with large numbers of these casualties?

SLOAN: Initially, the Services experienced some shortcomings with regard to addressing the full range of chemical and biological warfare. However, before the beginning of hostilities we had maximized our capability. For example, initial deployment was so rapid that many operational units left for the Persian Gulf without a full set of chemical antidotes, but US Central Command rapidly remedied the problem with in-theater stocks.

From the Air Force view, we deployed specially trained decontamination teams with each of our air transportable hospitals. Also, theater-specific protocols were developed for use at casualty collection points and medical treatment facilities in coordination with the DoD Executive Agent for Chemical and Biological warfare training, the Army. In sum, extensive preparations were made to meet this medical threat, and the strides made underscore and highlight interservice cooperation experienced throughout the Gulf conflict.

JOURNAL: Brig Gen Charles H. Roadman, II, who was the Air Force Surgeon in Europe during Desert Shield/Storm, stated that his biggest difficulty during this time was "trying to lean forward and anticipate requirements from a rational point of view while many of the political decisions were being made." Was the Air Force medical service prepared to deal with combat under rather unusual circumstances (geographical, sand, dehydration, specific diseases like diarrhea)?

SLOAN: Not all difficulties relating to a deployment of this magnitude, and employment in one of the harshest environments in the world, can be anticipated. However, with the aid of timely medical intelligence from the Armed Forces Medical Intelligence Center on diseases endemic to the combat region and environmental health threats, together with advances in preventive medicine and environmental health, disease and non-battle casualties were remarkably low. Much credit must be given to commanders for rigidly enforcing principles of preventive medicine, and to medical readiness field training programs that helped prepare our troops for deployment.

JOURNAL: There apparently were problems in the area of medical regulating--keeping track of patients and their records. USAFE Commander General Robert C. Oaks directed Brig Gen Roadman to "fix it." Was it fixed and how? What improvements are planned for the future?

SLOAN: Providing the appropriate medical care for the Gulf War participants via the established air evacuation network was not a problem. The Defense Medical Regulating Information System was used to match patients' specialty medical care needs and capabilities at medical treatment facilities in the theater of operations, Europe and the United States. However, with regard to patient tracking, some operational difficulties were experienced and substantial effort is underway to provide the required systemic resolution. Brig Gen Roadman responded to his charge from Gen Oaks at the time with the development of a theater-specific contingency hospital locator system that was successfully employed to track patients of all services.

JOURNAL: Did the Air Force medical units experience the same problems with communication between units, or did you manage to secure the use of satellite communications and directional equipment?

SLOAN: Among the lessons learned or reinforced by our Gulf experience, regardless of Service, is that communication capability needs to be upgraded and become even more interoperable. New communications systems such as the portable satellite communications systems you refer to are needed to support technological advancements and enhance communications on both the battlefield of today and of the future.

JOURNAL: Flexibility and inventiveness were key words during Desert Shield/Storm. Can you relate one or two incidences that demonstrated these qualities?

SLOAN: Flexibility and inventiveness are key words during the execution of any military campaign. The CENTCOM theater of operations was no different and offered its own unique set of challenges that were met with innovation and ingenuity. For example, owing to the vast expanse of the desert and the speed with which Army combat units advanced, some tactical evacuation legs became too long for Army medevac helicopters, and USAF C-130s were used to satisfy this requirement. In that same vein, Army medevac helicopters were used to transport patients to and from Navy hospital ships.

JOURNAL: This war really rallied the people of the United States in support of the deployed forces. How did you experience this support?

SLOAN: Communities around the country offered immediate, enthusiastic and generous support to our deploying troops. Certainly the men and women of the Air Force Medical Service were among the beneficiaries of this tremendous support, so vital to unit morale. Many Guard and Reserve members--our citizen airmen--volunteered their services well before the official mobilization took place, prepared to leave their homes, families and civilian practices to serve the Medical Service. Finally, institutions as well as individuals in our local communities stood

ready to assist us. Many civilian hospitals, as part of the National Disaster Medical System, were prepared to accept military casualties if the need arose.

JOURNAL: The Persian Gulf War proved that the military's echelons of care system "works, but parts of the program need to be fine-tuned," an Army official was quoted as saying in Medicine. What were the major problems encountered and lessons learned? What improvements does the Air Force medical service plan for the future?

SLOAN: We have already touched upon some of the lessons we've learned from our experiences in the Gulf conflict (eg, the need for communication systems enhancements, both in terms of state-of-the-art and interoperability, especially with regard to aeromedical evacuation). But we also experienced the value of the maintenance and sustainment of medical War Reserve Materiel (WRM) assets and the essentiality of making sure they are capable when needed.

Moreover, we learned that the most ambitious field medical readiness training program in Air Force history that we initiated in FY 90 is on-target and worth the full measure of its cost. And while we learned much from the Gulf conflict from which we will profit, the rapidly changing world environment dictates adjustments we must make to carry out our assigned medical support missions. We will be refining our medical wartime support force structure to increase flexibility and to enhance the preparation of our deployable medical facilities for the future threat. With force reductions imminent, the vital importance of the Air Reserve Component cannot be overstated. We will be working hard at streamlining the activation process and enhancing the integration and utilization of our reserve personnel into the active force when and if called upon.

JOURNAL: Are there any final comments that you would like to make?

SLOAN: I would take this time in closing to reiterate my pride in the professional teamwork of our active and reserve component who mobilized, deployed and worked together to meet the challenges of Desert Storm. The early volunteers and those later called up from the Air Force Reserve and Air National Guard formed a significant part of the Air Force Medical Service cadre deployed to Europe and the Arabian Peninsula. Reserve forces also made up the largest portion of the aeromedical evacuation system. Their enthusiasm and professionalism assured that our forces were well cared for. •