MEDICAL SERVICE IN THE CO-STAR II FIELD ARMY

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DURING THE TIME that the divisions have passed through the square, triangular, and pentomic phases, and assumed the ROAD configuration, the field army has remained virtually unchanged. This state of bliss now ceases. Under CO-STAR II, the field army is reorganized to closely parallel the ROAD division. Thus, no change occurs in the combat organizations, while some realignment is made in the combat support units. However, it is in the area of combat service support that the change comes, and a radical one it is. The field army combat service support units are reorganized into a horizontal, composite, functionalized, logistical structure to replace the existing vertical technical service system. This new creation is readily identifiable with the support command of the ROAD division and follows the same philosophy.

The elimination of the vertical technical service oriented organization in the field army and the creation of a horizontal, composite, functionalized, logistics support system is intended to create a more efficient, responsive, and less cumbersome logistics organization. It eliminates the vertical alignment of support operations on the multi-tracked channels of ordnance, quartermaster, chemical, etc., and substitutes therefor a series of composite organizations, each intended to provide a "complete" service to any given piece of equipment, handle all classes of supplies, or provide all types of service. In other words, a completely self-contained, self-sustaining element. A "one-stop" service to serve all the equipment installed on a tank, truck, etc. It remains to be seen if this elimination of the technical services, with their highly trained and specialized personnel, and replacement by "composite" units, will sustain logistic support at an acceptable level. CO-STAR II is the short title, or acronym, for "Combat Service Support for the Army." The "II" designation is an obvious indication that the first study efforts were not acceptable by the directing authority so that restudy and a higher numerical identity resulted.

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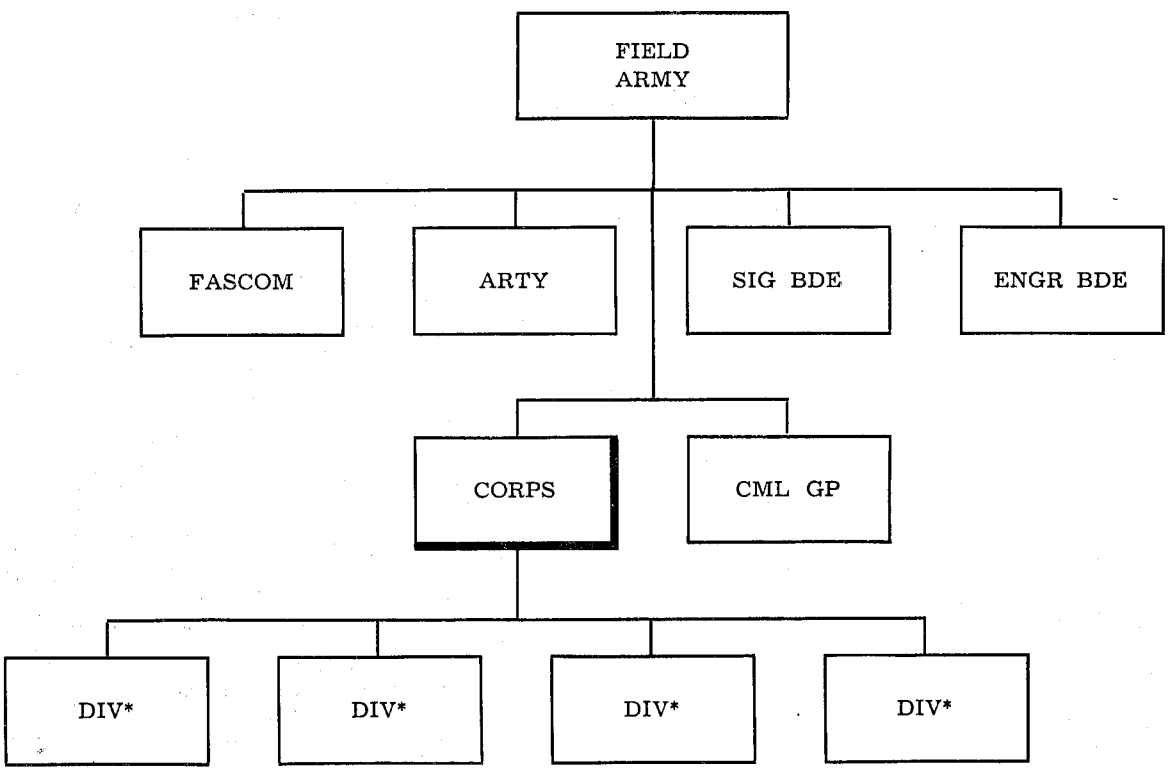

Figure 1.

TYPE FIELD ARMY ORGANIZATION

*May be infantry, mechanized, and armored divisions.

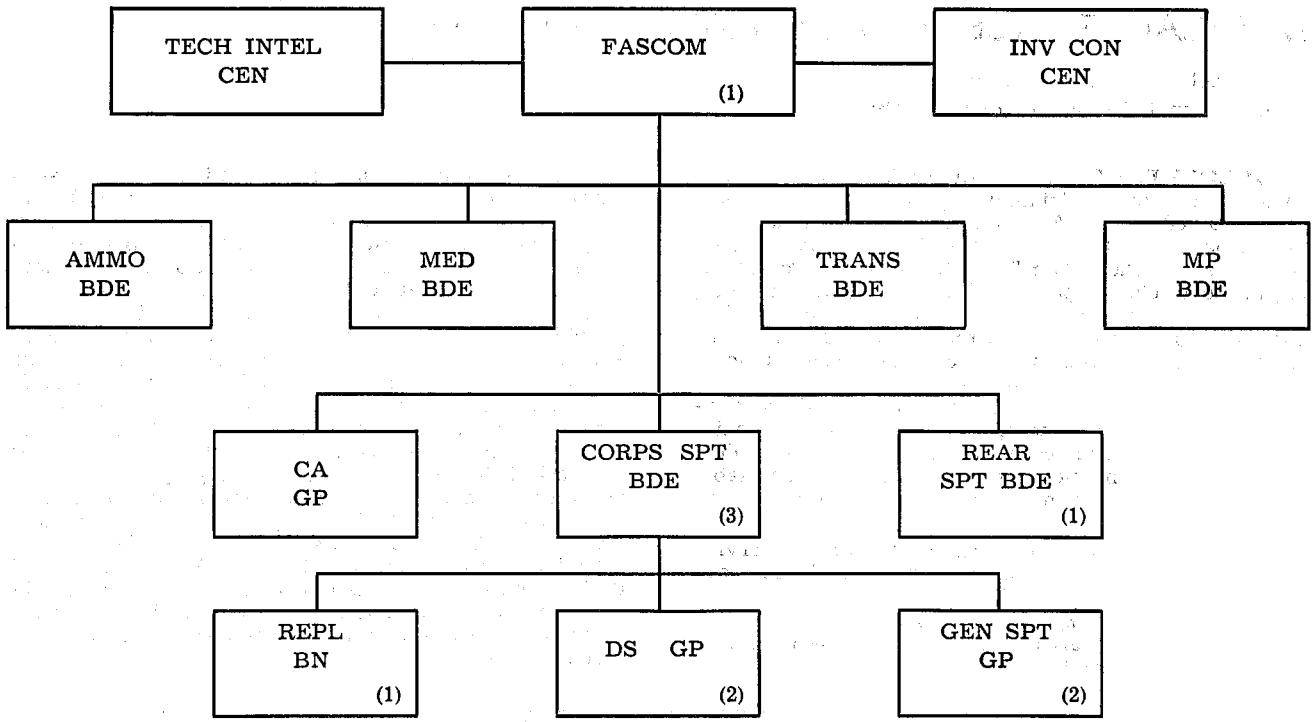

Figure 2.

TYPE FASCOM ORGANIZATION

CO-STAR II is the second of three phases in a series of reorganizations of theater logistics. The first step was the establishment of the ROAD division support command which resulted, medically, in the placement of the medical battalion under the support command commander thereby placing an intervening commander between the Division Surgeon and the major medical operational element of the division. This same alignment has been carried into the field army. Here a Medical Brigade is formed, placed under a Field Army Support Command (FASCOM), and divorced from the Army Surgeon's operational control and direct influence. Thus, the Army Surgeon is relegated to a secondary advisory role while the brigade commander, under a subordinate command, becomes the principal operator of Army level medical service.

The third phase in the reorganization is "The Administrative Support, Theater Army" (TASTA), which carries the same concept to theater level. Here again there is a medical command organized but placed under a "Theater Army Support Command" (TASCOM), a command subordinate to theater Army. As in the ROAD Division and the CO-STAR Field Army, the theater Army Surgeon assumes a purely advisory staff role at Theater Army level, while the medical operational elements are under a subordinate command.

The CO-STAR type field army organizational chart in Figure 1 shows only the major command elements. The type field army contains 12 divisions controlled by three corps. Co-equal with the corps on the command line is the FASCOM. It is the entry of the FASCOM, and the concurrent elimination of the technical services which comprises the radical departure from previously proven doctrine.

Under previously proven doctrine the logistical support required for the field army was provided by technical service units under the staff guidance, and frequently operational control, of technical service specialists on the army headquarters staff. The service provided was vertical in nature, and once equipment of a particular technical service entered the first echelon operated by the "branch" concerned, it remained in that channel until placed in the hands of the user. Technical service units were placed in direct support, and backed up by general support organizations of the same general identity. Thus, each technical service had a vertical alignment, from the front line divisions, to CONUS, for the provision of the technical function required at any level. Each technical service was represented by a "chief" on the division, army, and theater staffs. However, with the advent of ROAD, CO-STAR and TASTA, the technical service units and staff representatives, except medical, disappear. The technical service plans and operations specialists previously provided at each major headquarters level are now spread between the G3 and G4 in the various headquarters, while the supply and maintenance officers of these technical services appear in the Support Command, FASCOM and TASCOM headquarters or become integrated into new composite supply and maintenance units. At no level in the staff is there found a Quartermaster, Ordnance, Chemical, or Transportation "Chief" who is the acknowledged fountainhead of information in these technical areas.

CURRENT

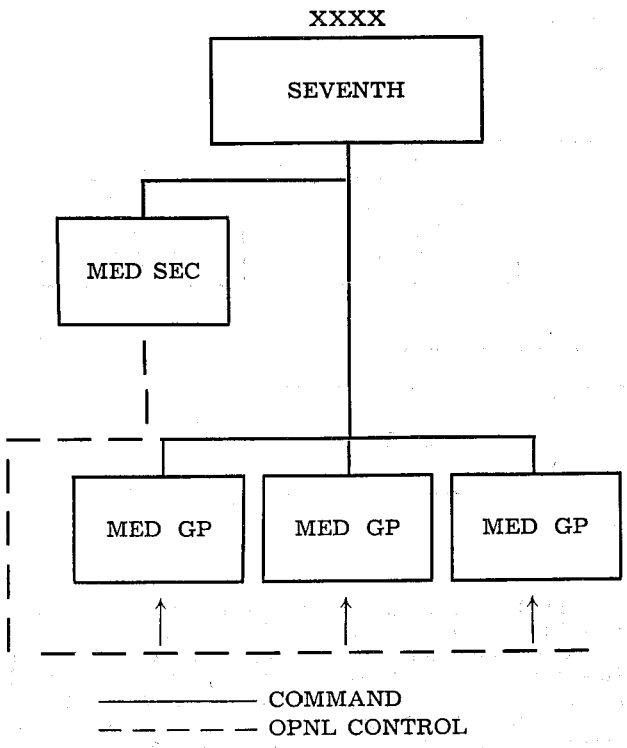

Figure 3a

CO-STAR II

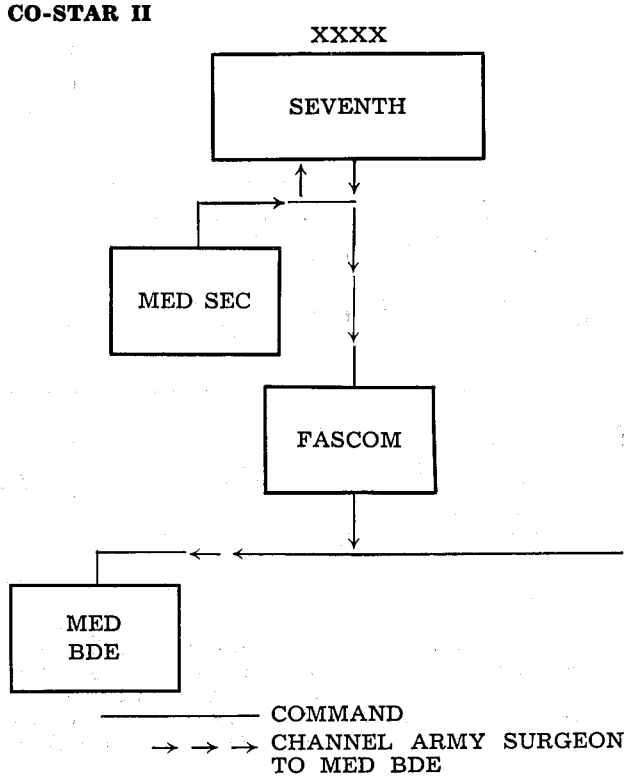

Figure 3b

At the Army level, in place of the technical services, the FASCOM headquarters, through the Support Brigades, will provide services, supply, and maintenance. Army-wide services such as Medical, Transportation, Ammunition, and Military Police, are formed into medical, transportation, ammunition and Military Police brigades all being controlled by the FASCOM Commander (Figure 2). The support brigades, one for each of the Corps and one for the Army Service Area, are organized into Groups and Battalions which operate a composite "country store" complex for supply and maintenance of the units supported at which, theoretically at least, "one stop" service is provided. Regardless of the type equipment and the multiplicity and diversity of items requiring attention, the direct supply and maintenance support unit of the Support Brigade accomplishes necessary repair, replacement, or resupply. The Direct Support units are reinforced and provided back-up support by General Support organizations. Thus, at all levels of command in the field army there are horizontal, composite, theoretically self-sustaining, logistics elements. In principle, this is supposed to permit rapid and ideal tailoring of support elements to provide necessary support to the rapid formation of tactical elements to meet sepcific tactical situations dictated by nuclear warfare. It is also designed to free the Army headquarters to concentrate on tactical operations per se. Essentially, the vertical, single technical service channels are eliminated and a series of multi-purpose organizations replace them. Notwithstanding the above, the Army Medical Service, because of the very nature of its mission, must retain its vertical posture. However, as already noted, the command and control of the medical service is interrupted by virtue of the Support Command, the FASCOM, and the TASCOM headquarters being interposed between the responsible surgeons and the principal operating medical elements at each level.

ARMY LEVEL MEDICAL SERVICE

The major change arising in the Army Medical Service with the advent of CO-STAR II comes in the matter of command and control. Medical support of the divisions and corps will be virtually unchanged. Radical changes occur, however, in the relationship of the Army Surgeon to the medical units of the field army.

The Army Surgeon

As was previously stated, prior to implementation of CO-STAR II the Army Surgeon exercised operational control over all army level medical units. Thus, the Surgeon was able to insure a responsive, cohesive, and effective medical effort to support any operation having a requirement for such support. To exercise this operational control, the staff provided for the Army Surgeon was tailored to assist him in all the responsibilities inherent in the position, as well as to aid the Surgeon in the fields of professional consultants, preventive medicine, nursing service, personnel, supply, and the varied facets of plans and operations. The line of communication to initiate action

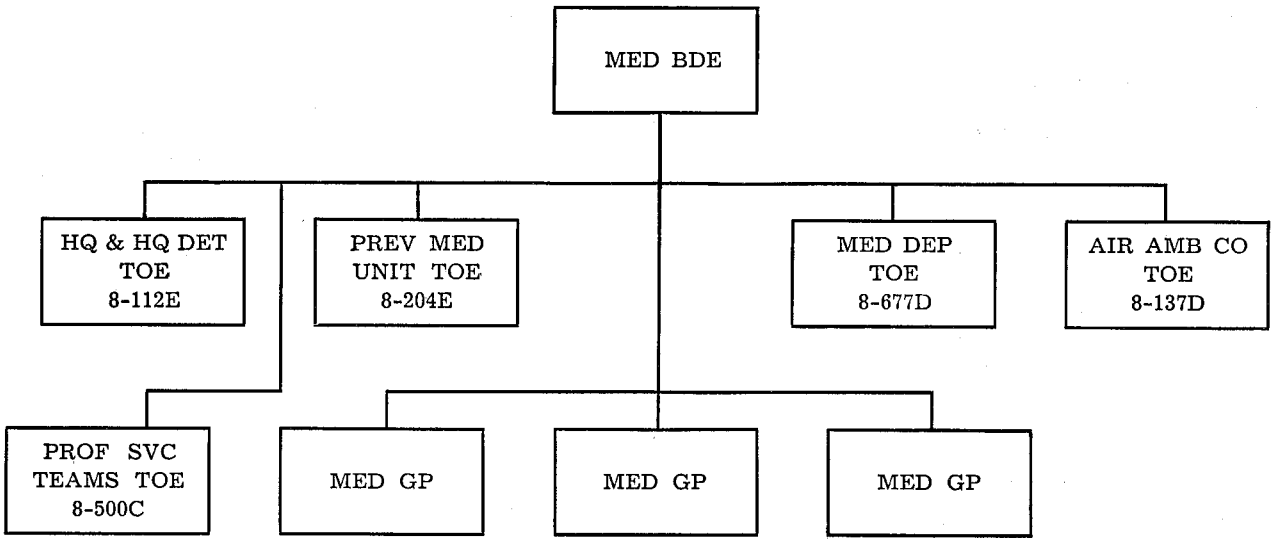

Figure 4

was direct from the Army Surgeon to the commanders of the medical groups and hospitals controlling the medical units required for any given situation. No intervening headquarters was encountered between the Army Surgeon and his operational elements (Figure 3a).

CO-STAR II removes the Army surgeon from the realm of control of medical units and makes the position (in the traditional meaning of the word) one of "staff" only. Further, the staff of the Surgeon is reduced to approximately one-third of its former strength and many of the positions previously provided are eliminated or transferred elsewhere.

Thus, the Army Surgeon is placed in the position of only establishing medical policies; determining "broad" requirements for medical supplies, equipment, service and troops; advising the commander on the health of the command; and accomplishing "broad" plans and similar "broad" actions.

The detailed planning, execution of operations, etc., is vested in a newly created medical organization which is placed under the FASCOM Commander, and can only be influenced by the Army Surgeon through the FASCOM Commander when the "personal working relationship" between these two individuals is harmonious. This working relationship will influence, to a great degree, the quality of medical service provided within the field army (Figure 3b).

The Medical Brigade

The operating headquarters and controlling agency for all army level medical units is the Medical Brigade. This new unit is assigned directly under the FASCOM and the brigade commander and answers directly to the commander of the FASCOM. There is no medical representation in the FASCOM, unless a liaison section is provided from the brigade. The medical brigade commander serves as the FASCOM Surgeon.

The Medical Brigade (Headquarters and Headquarters Detachment) consists of the conventional headquarters command and staffing elements, while the Headquarters Detachment is made up of the personnel necessary to operate any TOE unit. The Medical Brigade commands and controls the medical groups and those "separate" units which the brigade commander wishes to have respond directly to his desires. A Personnel Service Company, staffed with specialists in the field of personnel actions, may be included as an integral part of the brigade. This company has Data Processing Unit augmentation to mechanize personnel actions for the entire brigade. The organizational structure of the brigade is determined by the number and type of units assigned or attached. Flexibility in alignment permits almost any alignment. A possible configuration of the brigade in Seventh Army is presented by means of Figure 4.

DOCTRINAL IMPLICATIONS

The AMEDS has always contended that it is a necessary prerequisite of medical service that it must be under control of the competent professional authority of AMEDS officers. A major departure from this concept occurs in CO-STAR II, as well as in ROAD and TASTA. The chain of control of medical effort is interrupted in that the Army Surgeon has no direct influence on the army level medical service (Figure 3b). Instead, a line commander is interposed between the Army Surgeon and the Medical Brigade. Thus, a non-professional commander (FASCOM) and staff are in the position of controlling the field army element of the medical service, a major portion of the chain of medical service. Decisions of this non-medical commander could well be made in the context of the FASCOM mission and not necessarily in the best interest of good medical service and the patient. The FASCOM commander, likewise, will be expected to make decisions concerning medical care which he is not by training, or position, qualified to make. This situation is analogous to the Medical Battalion of the

division being under the Support Command Commander. Through the testing period of the ROAD divisions all indications point to the fact that the virtue of separating the operational elements of the medical service from the principal staff officer concerned with insuring proper medical support will operate to the degradation of patient care. It is certain to be compounded at the field army level by placing the Medical Brigade under the FASCOM.

It is not intended to censure, nor criticize, the developers of the concepts of ROAD, CO-STAR, and TASTA. Neither is the Support Command or FASCOM commander's integrity or interest in accomplishing his medical mission suspect. What is worthy of questioning, and further development, is the effectiveness of a medical service which is not controlled at all levels by those whose training and professional efforts are concentrated on insuring that every soldier receives the highest level of medical care that he has every right to expect.

SUMMARY

The medical support of the divisions and corps will not be greatly changed by implementation of the CO-STAR II field army organization. In providing army level medical service, the same medical groups will work with the same combat units as they have in the past, but these groups will conduct their operations under the guidance of the Medical Brigade Commander instead of the Army Surgeon.

The Brigade Commander, on the other hand, will answer to the FASCOM Commander who, in turn, responds directly to the Army Commander. The relationship between the FASCOM Commander and the Army Surgeon will be the same as that between any major commander and a special staff officer of a higher headquarters.

The Army Surgeon will be an advisor, having most of those staff functions for which he has always been responsible, but having an extremely limited capability to execute his responsibilities due to the reduced staffing afforded his office. He is responsible for medical service, but no longer has the tools with which to provide the necessary actions.

Suspect in the concept of this reorganization is the attempt to place all military activities into an organizational structure without proper analysis and appreciation of the inherent qualities of the activity. In other words, the concept is an attempt to oversimplify the organizational structure of diversified and complex activities. Since this oversimplification can only lead to degradation of individual skills, as well as lowered group effectiveness, this concept will inevitably lead to a leveling process with a concomitant reduction in the quality of medical care. Medically, in many ways, the concept is a retrogression to the organizational system which existed in the Civil War. After the Second Battle of Bull Run, General McClellan abandoned a similar system at the instigation of Jonathan Letterman and our current concepts of the military medical care system had its birth. This system has been proven in all of our wars since, as well as having been adopted by almost all nations of the world having major military forces, and should not be abandoned without full realization of the consequences in the degraded quality of medical care which will result.

9th HOSPITAL CENTER MSC'S ARE VERSATILE

Colonel Elwood M. Wright, MSC*

WINGING A "CHOPPER" into a tight landing for an emergency pickup, commanding a two-car diesel, sorting medical information for possible intelligence items or even translating a Lebanese medical claim is nothing new to you — these things you do every day.

"You" may be one of the 275 Medical Service Corps officers who help make up the largest medical command in the United States Army — the 9th Hospital Center.

Providing for the health and welfare of some 425,000 military personnel and their families in an area roughly the size of the state of New York is your daily mission. Your diverse skills are required in order to operate the command's 110 separate units and over 200 medical facilities in West Germany.

Under the capable leadership of nine hospital executive officers, over 80 per cent of the command's Medical Service Corps officers concern themselves with the effective organization and functioning of the

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