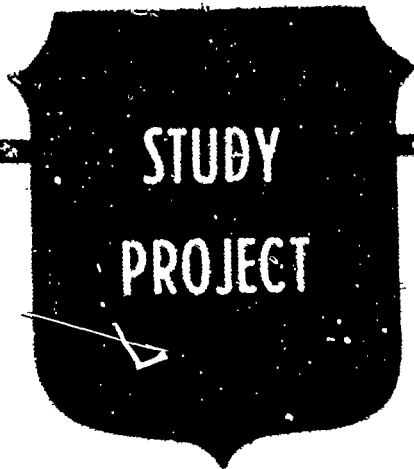


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STANDBY MEDICAL DRAFT: ANSWER TO THE MILITARY MEDICAL SHORTFALL?

BY

COLONEL RICHARD G. KIRCHDOERFER, MC

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USAWC MILITARY STUDIES PROGRAM PAPER

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STANDBY MEDICAL DRAFT:
ANSWER TO THE MILITARY MEDICAL SHORTFALL?

AN INDIVIDUAL STUDY PROJECT

by

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U.S. Army War College
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ABSTRACT

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STANDBY MEDICAL DRAFT: ANSWER TO THE MILITARY MEDICAL SHORTFALL?

CHAPTER I

INTRODUCTION

The United States military faces a tremendous shortfall in capabilities to meet the medical requirements arising from future conflicts requiring partial, full, or total mobilization of the reserves.¹ At the end of fiscal year 1988, only 65 percent of the total wartime medical requirements were available in the active and reserve components (a shortage of over 130,000 personnel).²

The Department of Defense does however, have various mechanisms to fill these personnel shortfalls. The most obvious is to expand the size of the active and reserve components. This is done by increasing budgeted end strength and then, if necessary, using recruiting and retention incentives to ensure maximum fill of authorized positions. However, medical personnel increases must compete for funding with other personnel authorizations and programs such as training, sustainment, and modernization. The relative cost of procuring, training, and retaining medical personnel is high. Increasing the number of these individuals within a fixed budget would require decreases in other areas, potentially having a negative impact on combat and sustainment capability.

If the shortfall cannot be met through expanding the medical strength of the active and reserve components, then in time of national emergency two other methods are available. These are to rely on volunteers or to activate compulsory military service (the draft) of currently registered young males. Neither of these is likely to provide the military with many medical personnel.

Another method was provided in 1987 when Congress amended the Military Selective Service Act to set up, within the Selective Service System, a structure for registration and classification of health care personnel.³ This standby system would be available in time of national emergency to assist the military in meeting its specific medical personnel needs. However, as opposed to the regular draft, registration of medical draft eligibles is not permitted.

In the past, the military medical departments have benefitted from procurement of medical personnel through various drafts both in peace and war. However, our military presently needs large numbers of medical personnel in a very short time. This requirement is much greater than at any time in our history and the Selective Service cannot meet it without registration of medical personnel. Therefore, the Department of Defense presently views the medical draft as only a mechanism to provide medical personnel even if they arrive somewhat later than

really needed; maintain medical strength in a prolonged conflict; and encourage medical personnel to volunteer early.⁴

This paper will examine the scope of the Department of Defense medical personnel requirement and review the options available to meet the shortfall. These options (increasing the size of the active or reserve components, relying on volunteers, and using the medical draft) will be examined in both the context of their cost-effectiveness and their ability to meet military needs.

ENDNOTES

1. Organization of the Joint Chiefs of Staff, United States Military Posture FY 1989, p. 80.
2. U.S. Department of Defense, Manpower Requirements Report- FY 1990: Medical Manpower Annex, pp. 5-14.
3. U.S. Laws, Statutes, etc., Public Law 100-180. Section 715.
4. Interview with Joseph E. Salko, COL, Deputy Director of Personnel, Office of the Assistant Secretary of Defense (Health Affairs), Washington, 27 October 1989.

CHAPTER II

THE SCOPE OF THE PROBLEM

The seriousness of the current shortfall in medical support was identified in a series of Department of Defense mobilization exercises between 1978-1982. The problem was so severe the lack of medical care capability was identified as a "war stopper."¹ The Assistant Secretary of Defense, Dr. William Mayer, testifying before the Senate Appropriations Committee in 1984 reported:

Our wartime scenarios have predicted that, if a full scale conventional conflict broke out in Europe tomorrow, we would have sufficient medical capability to provide initial surgery for only 20 percent of the estimated casualties...[because of this situation] our forces would be unable to sustain action for an extended period of time...We are still faced with critical shortages of key medical personnel who would be needed in wartime, most notably surgeons and nurses.²

SIZE OF THE SHORTFALL

It is difficult to precisely define the scope of the medical personnel shortfall. There are two major factors: personnel requirements and actual number of personnel on hand. Within these large categories are multiple subcategories of different enlisted and officer medical specialties. While the individual services use the standardized Medical Planning Module (MPM) to compute wartime casualties, each uses different methods to compute wartime personnel requirements. As such, the accuracy of these requirements has been questioned by the Government

Accounting Office. The Office wants to have all of the
 information on the number of personnel in the DoD. The numbers
 in Figure 1 are directly the total authorized strength of
 the overall medical personnel shortfall.

Figure 1

DoD Medical Manpower Summary (FY 88)

Active and Selected Reserve⁵

<u>Group</u>	<u>Wartime Requirements</u>	<u>Budgeted End Strength</u>	<u>Actual End Strength</u>
Doctors	28,900*	21,983	19,700 (68%**)
Dentists	9,896	6,941	7,212 (73%)
Nurses	58,986	27,686	24,886 (42%)
Other***	27,555	20,172	24,886 (76%)
<u>Enlisted</u>	<u>249,007</u>	<u>185,791</u>	<u>171,780 (69%)</u>
Total	374,344	262,573	244,559 (65%)

* Includes decrement of 2714 requirements identified in 1989 DoD review

** Percent of Wartime Requirement

*** Includes Medical Service/Biomedical Science, Veterinary and Warrant Officers

The data in Figure 1 point out two problems: current Budgeted End Strength (BES) is far below wartime requirements and the total actual end strength is below BES. While the overall number of personnel authorized by BES meets 70% of total requirements (111,771 short), the actual number of personnel on hand drops this figure to only 65% (nearly 130,000 short). The nurse group is the most seriously underfilled at 42%. The Army, with over

55% of the total DoD wartime needs, is also the service having the most trouble meeting these requirements: the average fill of wartime requirements at the end of FY88 was well below DoD averages, e.g. 56% doctors, 38% nurses, and 64% enlisted.⁶

Specialty Fill

The problem with the overall inadequate fill of requirements is intensified when the individual medical specialties within the larger groups are examined. For example, in 1988, the Army filled 56% of its wartime physician requirements, but within that group only 7% of the plastic surgeon needs, 19% of emergency medicine doctors, and 41% of thoracic and orthopedic surgeons.^{7,8} To ameliorate some of the shortages, each service has devised substitution plans. Substitution involves using individuals in either overstrength skill areas or in non-wartime required specialties to fill vacancies in critical wartime skills areas. For example, in wartime, an obstetrician could be used as a general surgeon and an obstetric nurse could be used as a medical-surgical nurse. While substitution of personnel has helped improve fill in some specialty areas, this solution can only be used for relatively few skills and is of limited value when shortages are found in so many areas.

CONCLUSIONS

To sustain the medical needs of the military, sufficient numbers of personnel with the proper mix of medical specialties are required. Large shortages exist throughout the Department of Defense in nearly every category of officer and enlisted skill. Some method or combination of several different methods must be found to provide additional medical manpower if the military is to field a credible, capable medical force.

ENDNOTES

1. John Moscato, "Medical Manpower for Mobilization: The Problem and the Solution," in The Anthropo Factor, we are: Conscripts, Volunteers and Reserves, by Mobilization Concepts Development Center, National Defense University, p. 366.
2. Richard Halloran, "Few Injuries Could Be Treated in War, U.S. Says," New York Times, 4 June 1984, p. A15.
3. U.S. General Accounting Office, Report to the Chairman, Armed Services Committee, House of Representatives: Medical Readiness-- Progress in Stating Manpower Needs, pp. 12-13.
4. U.S. Department of Defense, Manpower Requirements Report- FY 1990: Medical Manpower Annex, p. 3.
5. Ibid., pp. 5-14.
6. Ibid., pp. 6-7.
7. Ibid.
8. U.S. Congress, House, Committee on Armed Services, National Defense Authorization Act for Fiscal Year 1988, p. 207.

CHAPTER III

MECHANISMS TO MEET PERSONNEL SHORTAGES

The medical departments can use several options to meet wartime requirements. However, for all the challenges associated with transitioning to full and total mobilization for the military in general, problems for the medical departments are compounded as they must start with a force that is proportionately more understrength to support the current active and reserve force. The logical option to provide adequate support would be to increase the medical strength in the active and reserve components. Unless this is done, the medical departments would have to wait for a time of national emergency. At that time, they would need to rely on either an influx of volunteers or the activation of compulsory military service to expand to required strength.

THE ACTIVE COMPONENT OPTION

One mechanism to ensure that adequate medical personnel would be available would be to increase the number on active duty. There are three issues associated with this mechanism of expansion. First, the necessary budgetary approval to expand current strength must be obtained. Second, if approval is given, individuals with the needed skills must be attracted and

retained. Third, these individuals must be trained in their wartime duties.

Funding the Active Component Option

The cost of medical personnel is high. Additionally, although authorizations for personnel in combat and combat service/support areas are justified on the basis of readiness, the medical departments must justify most of their existence on their ability to provide cost-effective peacetime health care. The service medical departments maintain two distinct active component medical structures: the peacetime health care system and the medical personnel and units assigned to combat support missions. Medical units to support combat are often staffed with the full complement of enlisted personnel, and only some of the required officers and non-commissioned officers. In wartime, military personnel from the peacetime health care system fill vacancies to bring the unit to full strength. Thus, although there is a reluctance to add more strength to the medical structure in the direct support of military forces in combat, the peacetime health care system provides a means to man these medical units.

Therefore, any increases in end strength in the medical departments is usually tied to the cost-effectiveness of peacetime health care. This health care in military facilities is an entitlement for active duty military. However, for their families and retired military and their families, health care is

provided in military facilities on a space-available basis. When it is not available, members of these groups are entitled to civilian care on a cost-sharing basis. Thus, the military pays for most of this care whether it is provided through civilian or military medical organizations. Generally, because of the absence of a profit margin and certain efficiencies in size, the cost of health care in the military is less than comparable care in the civilian sector. Thus, if the relative proportion of care provided by the medical departments were increased, this would be a relatively cost-effective method to increase medical personnel available for wartime requirements.

Recruitment and Retention

Over the last several years, Congress and the Department of Defense have been convinced that increasing the active duty personnel strength of the medical departments is a cost-effective method of meeting wartime needs. For example, between FY88 and 89, when the total active duty force was decreasing, the number of physicians and nurses on active duty increased by 2% and 3% respectively.¹ However, there is still a problem in filling newly-created positions. Although the services nearly filled the total budgeted end strength (BES) in fiscal year 1988 for all medical personnel, only 94% of the BES was actually filled with doctors and 93% with nurses.² It is still too early to forecast the effect of additional recruiting and retention incentives authorized by Congress in the last two fiscal years as they were

poorly implemented initially. However, if the mechanism of increasing active duty strength were used to offset the wartime personnel shortfall, the ability of the services to man these new authorizations would be of paramount importance.

The Unit Training Problem

Even having an adequate number of personnel available does not mean they will be able to perform their wartime duties. For those individuals assigned to peacetime health care duties, field/wartime training is often neglected as peacetime health care takes priority. While the military provides excellent individual training in the form of the Combat Casualty Care Course to most physicians, training with the wartime unit is often less than satisfactory. The potential adverse effects of this can be seen in at least two areas: team-building and familiarity with facilities and equipment.

In any medical institution the staff works as a team. While cohesion could be expected to develop rapidly once a unit begins to perform its wartime mission, there will be a time of reduced capability. Combat forces are not expected to man a tank, aircraft, or ship crew from individual fillers immediately prior to going into battle, because of this teamwork requirement. Those crews involved in the care of the ill or injured also need to practice together.

Additionally, individual knowledge gained in training with the unit will be critical. Military field hospitals are

constructed to be durable, mobile, and therefore austere. They don't contain the state-of-the-art equipment, diagnostic and therapeutic options, and selection of medical supplies and pharmaceuticals found in civilian facilities. To adequately function in field hospitals, personnel must be knowledgeable in the equipment and supplies available in these facilities.

Assessment of the Active Duty Option

The active duty option to meet wartime manpower requirements has the advantage of cost-effectiveness by enlarging the peacetime health care system. Yet, sufficient wartime medical units must also be maintained with some cadre strength for individuals from the peacetime system to fill upon mobilization. In addition, training must be regularly conducted. Finally, recruiting and retention incentives need to be sufficient to maintain authorized strengths.

RESERVE COMPONENT OPTION

Increasing the strength of medical personnel within the reserve components provides another good solution to achieve the requirements for medical personnel upon mobilization. The correct mix of wartime skills could be obtained without enlarging the peacetime health care system. Historically, this approach to meet potential wartime manpower needs was used before World War I. The predicted need for increased numbers of physicians

prior to the war resulted in an act of Congress in 1908 authorizing a Medical Reserve Corps, the forerunner of the current Army Reserve system.³

There are two problems with this approach. First, the relative cost of recruiting and retaining fully capable medical personnel in the reserves is high and unless the total strength of the reserve components could be increased, trade-offs must be made with combat or support positions. Second, some of the programs designed to attract skilled medical professionals into the reserves discourage them from training in their wartime missions.

Cost of Reserve Medical Personnel

The Department of Defense pays a premium for medical personnel in the reserve components. Additionally, there is no offset to the reserve component costs since these individuals contribute minimally to the peacetime health care system. During medical school physicians can receive from one-half (\$332/month) to full (\$664/month) health profession scholarships or after graduation receive repayment of federal educational loans (\$3000 annually, up to \$20,000 total). Once in the reserves, those having critical skills can receive \$10,000 in special pay annually.^{4,5,6} Nursing students are also eligible for one-half health profession scholarships or up to a \$100/month stipend for the 3rd and 4th years of training.⁷ Additionally, in the Army Reserve, the service most critically short, physicians and nurses

are now allowed to join national and local detachments which would not tie them to monthly unit drills and provide them options for annual training (AT) and inactive duty training (IDT).⁸ These options include training in the hospitals where they normally work and attending medical education courses/conferences.⁹

Unfortunately, since the inception of many of these programs in November 1985, the reserve components still have not been very successful in filling authorized budgeted end strength (BES) positions.¹⁰ At the end of fiscal year 1988, actual end strength for physicians was only 75% of BES, for nurses only 76%, and 77% for enlisted medical personnel.¹¹ Within the Army Reserve, authorized positions for critical surgical specialties increased from 986 in fiscal year 1980 to 1075 in 1987, yet only 386 of these positions were filled in 1987. Likewise, for selected surgical nursing specialties, authorizations grew from 1139 in fiscal year 1980 to 1610 in 1987, but only 786 positions were filled.¹² Obviously, increasing end strength authorizations and some recruiting and retention incentives will not correct the problem of shortfalls in medical personnel. Any additional incentives are cost prohibitive. Considering there was a shortfall from wartime requirements at the end of fiscal year 1988 of approximately 9200 doctors, 34,000 nurses, and 77,000 enlisted personnel, the total cost of this force including pay, benefits, training, incentives, and administrative overhead would be tremendous.

Capability of the Reserves

Even if the required number of medical personnel could be recruited and retained in the reserve components, there would still be questions concerning their capability to perform their duties in wartime. These questions evolve around the training physicians and nurses receive while members of various optional programs. The National Augmentation Detachment (NAD), set up by the Army Reserve, is probably the best example. As discussed above, it is designed to be a recruiting and retention tool. Physicians assigned to the NAD are also attached to a reserve unit--to fill a slot and for administrative support. They need only report to one unit IDT annually (to ensure the administrative paperwork is correct) and can choose a wide variety of activities to fulfill IDT and two-week (or two split one-week) ADT requirements. These activities can range from performing peacetime health care at a hospital or clinic to attending a medical conference. These alternative programs do identify personnel available on short notice to fill unit shortages, but, because of the lack of training with their units, the ability of these individuals to perform their wartime duties on mobilization is questionable.

Assessment of the Reserve Component Option

Overall, the reserve components do provide a source of medically trained personnel, available on relatively short

notice, who have some familiarity with the military system and management of casualties. It is difficult, in times of zero or negative growth in the Reserve Components, to be able to predict the ability of the medical departments to have positive growth. However, because of the cost involved in recruiting and retaining medical personnel, it is unlikely that there will be any significant increases.

THE VOLUNTEER OPTION

If the United States were to become involved in a major conflict, some individuals would step forward voluntarily to enter the military service. If large numbers of medical personnel willingly entered the medical departments by an early date, they could fill currently vacant requirements. However, historically this has not been the case. Plus, there would still be the problem of ensuring their capabilities to perform uniquely military medical assignments.

Additionally, the United States has not been in a position where large numbers of volunteers were needed rapidly for the medical departments. World Wars I and II provided ample opportunity for troop preparation. In addition, combat troops could not be moved overseas rapidly even after the United States entered these wars. In Vietnam, the conflict expanded slowly, again allowing sufficient time to meet the medical needs of the combat forces through a draft system. However, the Korean War, occurring with little or no warning and with the military medical

departments significantly understrength, provides the best example of the need for rapid expansion. Although a regular draft was in place, physicians were able to obtain deferments to avoid the regular draft, while "efforts to persuade doctors to volunteer had no more success after the war [began] than before."¹³ Nearly three months after the start of the Korean war, Congress authorized a special doctor draft, yet even with this pressure, "few men who were liable to the draft volunteered for reserve commissions, despite the Army's initial hopes."¹⁴

Doctors, because of their unique patient responsibilities and the economics of leaving their practice, may not be representative of all the different types of medical personnel required by the military. However, it would seem unlikely, unless the conflict involved a perceived direct threat to the nation, that the military could count on volunteers to meet the current unfilled requirements.

THE REGULAR DRAFT OPTION

If sufficient medical personnel can not be brought on active or reserve duty in peacetime and if few volunteers step forward, the only other option to meet wartime needs is compulsory military service--a draft. Presently, the Selective Service System has approximately 15 million men registered, with around 11 million in the current eligible draft age, 20 to 25 year groups.¹⁵ The first inductees would be available to the military within 13 days and 100,000 within 30 days of activation of the

system.¹⁶ This rapid procurement of draftees is directly related to the existence of the peacetime registration system. It could be expected that some medically trained personnel would be found within the ranks of these inductees.

However, there is no mechanism to identify medical personnel before they report for induction and therefore no method to selectively draft these individuals. Because of the length of time to train physicians, a minimum 26 or 27 years of age before they are able to practice independently as a general practitioner and older for specialists, there would be no draft eligible physicians. Likewise, there would be few other medical professionals, e.g. podiatrists, pharmacists, physical therapists, and psychologists, as they would be represented in the older groups of draft eligibles. In addition to the effect age would play in limiting the number of medical personnel in the draft eligible group, the small numbers of males in many of the health professions (95% of nurses are females) makes it extremely unlikely that many individuals trained in critical wartime specialties would be found through the regular draft.¹⁷ If the draft option is required to meet medical personnel requirements, a special medical draft approved by Congress is necessary. To obtain sufficient numbers of medical personnel, the Selective Service System projects a need for the special registration and call-up of males and females in the 20 through 44 year age groups.¹⁸

ENDNOTES

1. U.S. Department of Defense, Manpower Requirements Report- FY 1990: Medical Manpower Annex, pp. 7, 10 and 13.
2. Ibid.
3. John Moscato, "Medical Manpower for Mobilization: The Problem and the Solution," in The Anthroppo Factor in Warfare: Conscripts, Volunteers and Reserves, by Mobilization Concepts Development Center, National Defense University, p. 361.
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6. William F. Ward, Posture of the U.S. Army Reserve FY 1989, pp. 23-24.
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8. Ibid., p. 24.
9. Moscato, p. 386.
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15. Samuel K. Lessey Jr., Statement of the Director of the Selective Service System before the VA, HUD, and Independent Agencies Subcommittee of the House Committee on Appropriations, 1989, p. 3.

16. Ibid., p. 1.

17. U.S. Congress, House, Committee on Appropriations, Subcommittee on VA, HUD and Independent Agencies, Departments of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations for 1990, Pt. 1, p. 542.

18. Interview with Richard S. Flahavan, Director of Operations, Selective Service System, Washington, 11 September 1989.

CHAPTER IV

THE MEDICAL DRAFT OPTION

If wartime medical manpower needs cannot be met through increasing active or reserve component personnel, by large numbers of early volunteers or with the regular draft, the only other option is a special draft of medical personnel.¹ The pool of health care workers in the United States for the Department of Defense to draw on is very large. There were nearly five million civilians (males and females) in health care occupations in 1988 and 3.4 million in the draft eligible 20 to 44 year age groups.²

HISTORY OF THE MEDICAL DRAFT

World War II

The idea of a draft of specially identified medical personnel is not new. During World War II, two different systems provided for the large need for physicians. These mechanisms which operated simultaneously were: the identification and call-up of medical personnel by the Selective Service System and volunteers obtained through special medical recruitment boards run by the Army Surgeon General.³ As opposed to later drafts, medical personnel were registered with the regular draft pool. Every male in the 21 to 35 year age group was liable for

induction and deferments were used to balance the competing needs of the military and civilian industry.⁴

The Korean War

With the rapid demobilization of troops after World War II, the Army found itself in a situation of medical personnel shortages not unlike that of today. In July 1948, the Deputy Surgeon General, Brigadier General George E. Armstrong's opinion was that "the Medical and Dental situation relative to the Armed Forces is more critical than at anytime in the last 25 years...the supply of professional personnel is deficient in both quality and quantity."⁵ Shortages of 1200 physicians, 3800-5700 nurses, and 600 administrative officers were reported.⁶

The Selective Service Act enacted in June 1948 brought in over 100,000 new men, few of which were doctors, thus increasing the workload for the medical departments.⁷ Attempts to pass legislation for a special medical draft met with opposition from organized medical groups, particularly the American Medical Association, and were unsuccessful. Understandably, a "personnel crisis followed the outbreak of the war."⁸

After the war started on 25 June 1950, the medical situation in Korea rapidly became critical causing the services to empty medical training programs to fill requirements.⁹ On 9 September, Congress passed an amendment to the Selective Service Act of 1948 authorizing, for the first time, special registration and calls for males in medical, dental, and related specialties (during

World War II, these individuals were brought in under the provisions of the regular draft).¹⁰ Various inducements, including the threat of loss of eligibility for special medical pay and possible service as enlisted, were used to encourage those called to accept commissions rather than face induction. These attempts were successful, as less than forty of the 16,000 physicians, dentists, and veterinarians called by the end of 1955 had to be inducted.¹¹

Post-Korean War

By 1955, three large professional associations (medical, dental, and veterinary) proposed that the special provisions of the medical draft were no longer needed. They argued that the needs of the services could be met by special calls through the regular draft with the stipulation that those receiving deferments to continue their medical education would remain subject to the draft for an extended period.¹² After initial Defense Department objections, the special registration of health care personnel was dropped in 1957. However, the new draft law still allowed for special calls for medical personnel and extended their liability to age thirty-five for those granted educational deferments.¹³

With the end of the regular draft in 1973, special provisions for the call up of medical personnel also ended. From 1950 through 1973, the period of the medical draft, the military made forty-six calls for over 30,000 health care personnel from

six professions. Nearly 78 percent of these personnel were physicians, 17 percent were dentists, 3 percent were male nurses, and less than 1 percent each were veterinarians, optometrists, and osteopaths. Although registered, no podiatrists were called.¹⁴

HISTORICAL PROBLEMS WITH THE DRAFT

All in all, the various drafts worked well in providing medical personnel for the services both in peace and war. Still, there were some problems. There was resistance to the draft from professional organizations and individuals, but not of the magnitude of the general resistance to the regular draft. Potentially more serious were three specific problems: the timeliness of response in an emergency, the inability to draft females, and the adverse impact on the civilian community caused by large losses of medical personnel to the military.

Timeliness of Response

As evidenced in every major conflict in this century, except the Korean War, the United States has had time to build up its military. At the start of the Korean War, a regular draft with its administrative apparatus had already been in place for two years. Still, it took three months for Congress to authorize a special medical draft and an additional three months for the first of the desperately needed physicians to reach Korea.¹⁵

The Female Draft

Compounding the issue of timeliness was the one of the inability to draft females. Problems with an all-male draft were first identified during World War II. Then as now, nursing was primarily a female profession and the draft could not meet the needs of the military when there were insufficient numbers of volunteers. President Roosevelt, in his State of the Union Message of 6 January 1945, urged amendment of the Selective Service Act to include female nurses to make up a 30% shortage. Although Congress generally considered the measure favorably, by the time action would have been taken, the success of the war in Europe caused the bill to be dropped as no longer necessary.¹⁶

Similarly during the Korean War, a severe nursing shortage developed in 1951 and the military hospitals in the United States were forced to hire numerous civilian nurses to free the military for rotation to Korea. Enlisted medics were given greater clinical responsibilities and greater reliance was placed on allied facilities for health care in the theater. Fortunately, with the war stabilizing in 1952 and fewer casualties, the Army medical system was able to continue to perform its mission even though the shortage did not improve.¹⁷

Effect of Draft on Civilian Community

World War II was the only recent conflict that took large numbers of medical personnel from the civilian community and placed them into the military services (by June 1945, over 31% of all practicing physicians were in the military). The Procurement and Assignment Service of the War Manpower Commission ensured that the medical needs of the civilian population were balanced with military requirements.¹⁸

CURRENT MEDICAL DRAFT PLANS

In 1987, Congress reacted to the known shortage of medical personnel by amending the Military Selective Service Act. The amendment directed the Selective Service System to set up a "structure for the registration and classification of persons qualified for practice or employment in a health occupation essential to the maintenance of the Armed Forces."¹⁹ This was to be a standby system only, while not actually registering any individuals.²⁰

Current Concept

The Selective Service System has begun development of a system to meet the legislative requirement and Department of Defense needs. Their current concept envisions the medical draft process, after an initial registration of medical personnel, to

operate similarly to the regular draft process in most respects. The Selective Service System has in place a mechanism, the Registrant Information and Management System (RIMS), which includes the procedures and automated data systems for processing regular draft registrants. Using this model, they are developing a similar system, the Health Care Personnel Delivery System (HCPDS) to be used for registering and processing medical personnel.²¹

Once given legal authority, the Selective Service System would obtain a Presidential proclamation and communicate this through the national media.²² This would direct initial registration of all identified health care personnel age 20 through 44 years at U.S. Postal Service sites for a seven-day period. To assist in the notification of potential registrants, several national organizations of health professionals have promised to provide data on their members. Registration data would be entered into Selective Service System data bases and computer programs would generate the selection of individuals to be called. Criteria to be used would be health care specialty, year of birth, and random draft sequence number within that year.

Registrants selected will be notified by mailgram to report to a Military Entrance Processing Station (MEPS) on a date not later than ten days after the order was mailed. To ensure adequate numbers of individuals are provided to the military (losses are expected due to postponements, exemptions, and deferments), notifications will be sent to more individuals than

the services require. To prevent double jeopardy for individuals also at risk for the regular draft, medical draft registrants will be removed from the regular draft data base.

In addition to being eligible for postponements, deferments, and exemptions similar to those available for regular registrants, medical personnel could also qualify for two additional deferments.²³ These are community essentiality deferments, for individuals needed by their community for health care, and occupational deferments, for those engaged in activities judged to be critical by the National Security Council. Local and State Health Care Advisory Boards will advise local boards on community essentiality deferments. A National Health Care Personnel Advisory Committee will advise the Director, Selective Service System on the administration of the medical draft.

POTENTIAL PROBLEMS WITH THE CURRENT PLAN

In designing the system to meet the needs of the Department of Defense, the Selective Service System faces the major challenge of obtaining a large number of personnel from many medical specialties in a short period of time. The magnitude of the current problem in comparison to the previous medical draft can be seen at Figure 2.

Figure 2

Comparison: Doctor Draft Era (1950-73) vs Current Needs²⁴

	<u>Doctor Draft</u>	<u>Current</u>
Specialties	7	62
Numbers/Time	30,000/23 yrs	72,000/10 days
Delivery Schedule	6 months	10 days

In addition to the 72,000 medical personnel the Department of Defense estimates it would need in the first ten days, an additional 28,000 would be required within the next twenty days and 10,000 more by the end of six months.²⁵ The specialties include not only those professional medical personnel normally offered commissions, but also a wide diversity of enlisted medical occupations. Obviously the magnitude of previous efforts pale in comparison. Because of these requirements, the three previously identified historical problems with medical drafts will need to be re-examined in the context of the new concept. These issues were: the timeliness of response, the draft of females, and the effect of a large medical draft on the civilian community.

Timeliness of Medical Draft

Currently, the Selective Service System will not be able to meet the stated Defense Department delivery time of 10 days. Although significant progress has been made in developing the Health Care Personnel Delivery System, the estimated first

arrival of personnel for military processing would occur from 42 to 89 days after legislative authority to begin the medical draft was given.²⁶ Sometime this year, the registration structure will be in place and a delivery time of 35 days will be reached. However, this is the best the Selective Service System will be able to do without pre-registration of health care personnel. With pre-registration, the system could nearly meet military requirements for first delivery (13 days versus 10 days).²⁷

It is important to remember that although some of the individuals called up by the draft will be working in military hospitals, some will be sent to a combat theater. Current law requires that in time of war or national emergency, a member of the armed forces may not be assigned overseas until he has completed twelve weeks of basic training. However, draft legislation has been submitted to Congress which would allow the military departments to establish the length of training required. Doctors and nurses were specifically used in justifying this request as examples of occupational areas which could be deployed early.^{28,29} Even if the services are granted authority to send medical personnel overseas early, training in basic military medical skills will still delay movement for several weeks.

The Draft of Females

Without the draft of female health care personnel, it is unlikely that the Selective Service System will be able to meet

the total medical personnel needs of the Department of Defense. During Congressional hearings on the stand-by medical draft, the subject of the requirement to include women was raised and not rejected.

Of course, Congress must make the final decision at the time a medical draft might become necessary. Still, to obtain the large numbers of medical personnel needed by the Department of Defense, women will have to be drafted. There is a high percentage of females in most health care occupations and a trend towards increasing these numbers in those previously dominated by males. Although only 19.5 percent of physicians were female in 1987, nearly 31 percent of new doctors were female in 1986.³⁰ Registered nurses are over 95 percent female.³¹ To meet the military need of nearly 31,000 would require drafting over 41 percent of the approximately 74,000 male nurses in the United States.^{32,33} Within the 62 medical specialties required in the 20 to 44 year age group, 83 percent are women.³⁴ Still, the Selective Service System is making contingency plans in the event a female draft is not authorized.³⁵ However, with expected attrition of personnel from registration to actual entry into the service based on deferments, it would be nearly impossible to meet the large requirements without a male and female draft.

The Effect of the Draft on the Civilian Community

It would seem that a sudden loss of over 100,000 medical personnel from the civilian community would have a tremendous

negative effect. Yet, only around 2 percent of the civilians working in health care occupations would be required.³⁶ This does not mean there would be no effect. The greatest problem would be for physician and dentist specialties required for the care of combat casualties. Of the total available civilians, the military would need 8 percent of the anesthesiologists, 11 percent of the oral surgeons, 13 percent of the orthopedic and thoracic surgeons, and 23 percent of the prosthodontists.³⁷ Additionally, there will be a detrimental effect on civilian health care as the over 100,000 reserve component personnel also mobilize out of their communities at the same time the draft begins. The net effect will be the loss of at least some of the medical services expected by many members of the population. However, by one means or another, these health care personnel would leave the civilian community as volunteers, members of the mobilized reserve, or as draftees. The Selective Service System, with its national, state, and local advisory boards, is probably the best mechanism to ensure that the civilian community most equitably shares any shortages.

In summary, the Selective Service System has devised a sound plan for identifying, registering, and calling health care personnel. It is very cost effective in peacetime and can channel large numbers of personnel efficiently to the military services in times of national emergency. Although there is a potential problem if Congress elected not to permit the draft of females, the major weakness is the timeliness of response. The

services must provide some training to medical personnel before sending them overseas or even placing them in a military hospital. As long as pre-registration of medical personnel is not allowed, the medical draft cannot be viewed as a valid mechanism to meet present military manpower needs.

ENDNOTES

1. U.S. Congress, House, Committee on Appropriations, Subcommittee on VA, HUD and Independent Agencies, Departments of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations for 1990, Pt. 1, p. 542.

2. Interview with Richard S. Flahavan, Director of Operations, Selective Service System, Washington, 11 September 1989.

3. John Moscato, "Medical Manpower for Mobilization: The Problem and the Solution," in The Anthroppo Factor in Warfare: Conscripts, Volunteers and Reserves, by Mobilization Concepts Development Center, National Defense University, p. 362.

4. Ibid.

5. Albert E. Cowdrey, The Medics' War, United States Army in the Korean War, p. 29.

6. Ibid., pp. 16, 18-19 and 21.

7. Ibid., p. 29.

8. Ibid., p. 140.

9. Ibid.

10. Moscato, p. 363.

11. James M. Gerhardt, The Draft and Public Policy-- Issues in Military Manpower Procurement 1945-1970, p. 225.
12. Ibid.
13. Moscato, p. 365.
14. Ibid.
15. Cowdrey, p. 230.
16. Moscato, pp. 362-3.
17. Cowdrey, p. 234.
18. Moscato, p. 362.
19. U.S. Laws, Statutes, etc., Public Law 100-180, Section 715.
20. U.S. Congress, House, Committee on Armed Services, National Defense Authorization Act for Fiscal Year 1988, p. 213.
21. Selective Service System, Health Care Personnel Delivery System (Draft), p. 1.
22. Ibid., pp. 3-6.
23. Ibid., p. 10.
24. Flahavan interview.
25. Ibid.

26. Ibid.

27. Ibid.

28. Interview with Kenneth W. Leisher, LTC, Military Personnel Management Division, Office of the Surgeon General, U.S. Army, Washington, 27 October 1989.

29. Allen K. Ono, LTG, Deputy Chief of Staff for Personnel, U.S. Army, "Memorandum Thru Chief of Staff, Army For Chief of Legislative Liaison, Subject: Proposed Legislative Change to Title 10, USC 671--Action Memorandum."

30. U.S. Department of Commerce, Statistical Abstract of the United States--1989, pp. 99 and 158.

31. Ibid., p. 388.

32. Ibid.

33. Note: Selective Service System (Flahavan interview) estimates 1.48 million registered nurses eligible for the draft, above reference identifies 4.9% as males. Therefore there are approximately 74,000 male nurses eligible for the draft.

34. Flahavan interview.

35. Selective Service System, p. 2.

36. Flahavan interview.

37. Ibid.

CHAPTER V

CONCLUSIONS AND RECOMMENDATIONS

The Future

The military will be restructured in the future and the military medical departments will be affected by these changes. The size of the military will certainly decrease as a result of domestic economic priorities and the perceived reduced threat. The military will need to shift its focus from high- to low-intensity conflicts with greater emphasis on regional conflicts and nation building. New tasks such as drug suppression and verification of arms control and confidence building measures agreements will compete for resources with more conventional missions. This new, smaller, restructured military will continue to need medical support sufficient to promote health and fitness and provide care for the ill and injured in peace and war. In addition, based on a smaller active and reserve force, increased importance will be placed on our country's ability to mobilize the requisite numbers to meet any commitment. Certainly, medical support must be organized differently to support these significant changes.

Even with new missions and structure, competition within the defense establishment for funding of personnel, equipment, supplies, and training will continue.

Requirements for medical manpower will compete for this funding. So the question of how to most efficiently meet the medical personnel needs of the military continues to remain valid.

Composition of the Medical Force

Clearly, the current peacetime military health care system is competitive with the civilian sector and is a cost-efficient method of maintaining medical personnel strength. It will, however, remain a difficult task to balance the peacetime and wartime requirements in this system, maintain individual technical and military proficiency, and ensure adequate training for the wartime positions they will fill. As a complement to this system, a structure of field medical units (filled to varying degrees depending on the need for rapid deployment) is still required. These medical personnel and units should provide the flexibility and capability to fully support our active duty forces in any contingency and, at least initially, to provide care for patients returning to the United States. The continuation or expansion of the peacetime medical system will provide a large body of readily available, trained personnel to fill a wide variety of the military needs.

The reserve components must supplement the medical requirements both in the theater of war and in the United

States for support of the total force. The high cost of recruiting and retaining medical personnel in the reserves must be faced. There must be no compromise of either military medical and unit training standards in these components just to increase numbers.

The Contribution of the Medical Draft

In various contingency plans, there will be some reserve component medical units that will deploy late (primarily because of a shortage of strategic lift). Also, there will be a delay from the commencement of hostilities until large numbers of patients are returned to the United States military hospital system. Thus, the argument can be made to rely on a medical draft to fill these needs. In comparison to maintaining large numbers of personnel in the reserve components, the Health Care Personnel Delivery System portion of the Selective Service System is relatively inexpensive. Initial delivery of medical personnel thirty-five days after legislation was signed allows some training with late deploying (ninety or more days) units and sufficient training to function in a CONUS military hospital.

The problem with what appears to be a cheap, easy solution to some of the requirements for military medical manpower rests in a lack of ability or commitment to decide and react rapidly. This may not be fault of Congress. The

services may initially underestimate the size of forces required for the conflict and not immediately request the activation of the medical draft. Of course, Congress may take an inordinate amount of time to pass enabling legislation. Even if the need to support U.S. entry into the conflict is accepted, which is not a given, there will be concern with the political implications of a medical draft. On humanitarian grounds, a separate medical draft without an accompanying general draft might seem more politically acceptable. Yet, the segment of the population disrupted, the powerful medical community, will certainly give the lawmakers second thoughts.

Therefore, the Department of Defense position on the medical draft legislation, as an insurance policy only if current medical personnel shortages persist, seems logical. Certainly, the medical draft is also a valid mechanism to sustain medical strength in a prolonged conflict. If the lessons of the past persist, however, it will not be much of a factor in encouraging medical personnel to volunteer early. For medical personnel that are normally offered a commission, only the immediate threat of induction as an enlisted man would cause these individuals to volunteer.

The medical draft therefore is a significant factor in meeting military medical manpower needs. Efforts still must continue in balancing evolving medical structure to support the active and reserve forces. Historically, the medical

draft has played an important part in providing medical personnel to support our young men and women in uniform. The current Selective Service System medical draft plan can play a similar role in ensuring that our armed forces will be fully capable of upholding our nation's goal and interests.

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