USAWC STRATEGY RESEARCH PROJECT

JOINT MEDICAL COMMAND – DO IT NOW

by

Lieutenant Colonel Darwin D. Kumpula
United States Army Reserve

Colonel Thomas J. Williams
Project Advisor

U.S. Army War College
CARLISLE BARRACKS, PENNSYLVANIA 17013

Report Documentation Page

Form Approved
OMB No. 0704-0188

1. REPORT DATE	2. REPORT TYPE	3. DATES COVERED
18 MAR 2005		**-**

4. TITLE AND SUBTITLE	5a. CONTRACT NUMBER
Joint Medical Command Do It Now	5b. GRANT NUMBER
	5c. PROGRAM ELEMENT NUMBER
6. AUTHOR(S)	5d. PROJECT NUMBER
Darwin Kumpula	5e. TASK NUMBER
	5f. WORK UNIT NUMBER
7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES)	8. PERFORMING ORGANIZATION REPORT NUMBER
U.S. Army War College,Carlisle Barracks,Carlisle,PA,17013-5050	
9. SPONSORING/MONITORING AGENCY NAME(S) AND ADDRESS(ES)	10. SPONSOR/MONITOR'S ACRONYM(S)
	11. SPONSOR/MONITOR'S REPORT NUMBER(S)

12. DISTRIBUTION/AVAILABILITY STATEMENT
Approved for public release; distribution unlimited

13. SUPPLEMENTARY NOTES

14. ABSTRACT
See attached.

15. SUBJECT TERMS

16. SECURITY CLASSIFICATION OF:			17. LIMITATION OF ABSTRACT	18. NUMBER OF PAGES	19a. NAME OF RESPONSIBLE PERSON
a. REPORT	b. ABSTRACT	c. THIS PAGE			
unclassified	**unclassified**	**unclassified**		**33**	

ABSTRACT

AUTHOR: Lieutenant Colonel Darwin D. Kumpula

TITLE: Joint Medical Command – Do It Now

FORMAT: Strategy Research Project

DATE: 18 March 2005 PAGES: 33 CLASSIFICATION: Unclassified

The Army is transforming into a modular expeditionary force while at war. Our uniformed medical professionals are doing wonderful work of saving lives and helping rehabilitate our most valuable asset – Soldiers. However, our ability to do this in the future may be in jeopardy if we do not transform as swiftly as the warfighters. The U.S. military environment is swiftly moving toward joint interoperability and joint interdependability. The three service medical departments of the Army, Navy, and Air Force collaborate on issues, but it is a long process centered on their specific service interests. This limited collaboration must be changed to ensure the Soldiers on future battlefields are assured lifesaving care. Presently, each service independently constructs a force to provide medical support. It is in the Army's best interest to structure its assets with the other services for interoperability and interdependence. The Joint Medical Command will reduce redundancies, conserve resources, and implement efficient collaboration among the services. This jointness has been proposed many times since World War II. The time has come to make this commitment for the future of medical health services in the DoD, thereby ensuring superior medical support to the next generation of Soldiers.

TABLE OF CONTENTS

PREFACE

This paper deals with the current issues and reinforces the need for a unified functional medical command. Throughout the United States healthcare costs are skyrocketing. Medical coverage has become a part of recent elections and political rhetoric. In the last few years, the military health care system has seen continued increases in operating expenses. The projection for the future is much the same with no end in sight. Current operations in Iraq and Afghanistan are generating large numbers of wounded, increasing the pressure on limited resources. The subject of a Joint Medical Command has been written about many times in the past, but now the concept has viability within the Pentagon. Implementation of this concept could be on the horizon which is reflected in next year's Program Budget Decision. The insight and discussion in this paper should provide some basics for exploration and implementation.

First, I would like to thank Colonel Thomas J. Williams, my faculty advisor, for his patience, encouragement, and guidance in the completion of this research project. His support and advice ensured a professional product and a personally rewarding experience for the author. I would like to extend my sincere thanks to Professor Jim Hanlon for editing the paper after the initial draft. Finally, I owe a great debt to my wife, Wendi, for her enduring support while contending with the constant trials of military life.

JOINT MEDICAL COMMAND – DO IT NOW

Now is the time to create a Joint Medical Command (JMC). Implementing this change would establish a unified functional command to address looming issues. This strategic research project is not the first time the JMC issue has been addressed. There have been several studies written within the three Senior Service Colleges, referencing historical examples and recent lessons learned in other functional areas of the military that provide insight into the issue of unified functional commands. Each of the studies discuss thorny issues, relevant history, and the inefficiencies of our present structure. To cope with the present environments, all three medical departments need a lucid unity of effort. There are multiple pressures from multiple environments affecting organizational effectiveness of the separate medical departments of the Army, Air Force and Navy. Organizational decisions made now under transformation will have far-reaching effects long into the future. The creation of a JMC will move us beyond current ad hoc attempts to achieve interoperability and interdependence among the Services. A JMC will prepare us for future joint operations while continuing to ensure the health of the military members and other beneficiaries.

Presently, the medical departments have no centralized command and control for the common functional mission of health service support across the services. This lack of a unified command lends itself to inefficiency in manpower, resources, coordination, planning, and innovation. It is time to move forward and ensure success of our military through unity of command by means of a JMC. Our joint publications state this principle very clearly: "Command is central to all military action, and unity of command is central to unity of effort."[1]

A unified JMC would also leverage limited resources against the numerous requirements focused on promoting health and preserving life. Parochial service interests must be set aside; all medical personnel and organizations must focus on a common mission – to provide world class health care to all service members and their families. We must provide health service support to our most valuable weapon system – Soldiers, Sailors, Marines, and Airmen - in peace and at war. Lieutenant General Thomas Metz recently affirmed that, "Soldiers have always been our Army's most valuable asset."[2] It is imperative the military health system, even with diminishing resources, continues protecting our most valuable asset through innovation and optimization.

In practice the military health system (MHS) resembles a civilian managed health care organization. However, the MHS has unique functions and responsibilities arising from dual missions and the effects of 11 September 2001, which created a third mission.[3] Each service

medical department must conduct the first two missions; each quite different from the other but related in the process. The two missions are: (1) to provide medical support to all beneficiaries and (2) to ensure readiness of the force before, during, and after deployment.[4] In basic terms, the medical departments have a garrison support mission and an operational support mission. The care and support provided to service members is interwoven in two ways to each support mission.[5] The linkages are: (1) TRICARE contributes to operational readiness through the health care provided to service members, and (2) the same medical personnel are used for both missions.[6] However, there is now a third mission of domestic support since the 11 September 2001, terrorist attacks. These attacks forced the military into a very active role in homeland defense to respond to the threat of weapons of mass destruction (WMD) and emergency preparedness. The medical services play vital response roles in this mission of domestic support. According to joint doctrine, the third mission is considered part of operations other than war (OOTW).[7] The three missions now require the services to work in unison, instead of remaining service-centric. In the past, jointness seemed like a good idea. Post 9/11, jointness is an absolute necessity.

Domestic support has now become an on-going mission, requiring manpower and resources. For the first time in history, specific units are identified and resourced for this mission. The increased authorized level of organization (ALO) of units has required focusing funds, personnel and equipment to increase readiness. The Reserve Component forces are integral parts of our civil communities and possible first responders. The civil authorities will influence how the military responds to support domestic needs. The Department of Defense (DoD) will play primarily a support role in domestic crises,[8] requiring in-depth planning and coordination at the interagency level. Coordination at the interagency level requires continuous staff interaction.

RECENT EVENTS FORCING CHANGE

The events of 11 September 2001 made it very clear that the military services must continue to transform at a faster rate. Our enemies are no longer only nation states. Nations around the world have been feeling the effects of malevolent non-state actors and transnational actors for some time. The term “transnational” has been coined by academics to indicate that international relations are not limited only to governments.[9] It has become apparent that a nation’s sovereignty can be affected by non-state and transnational actors with the globalization of the world economies.[10] Globalization has created a huge dynamic interdependent economy between nations and corporations. Large international corporations can directly affect a nation’s

ability to wage war by failing to produce the parts hastily or by intentionally slowing production, shipment, or sale of needed parts. Despite globalization, nations still build militaries to counter the threat posed by another nation's military power. Nations must now plan for the additional threat that the transnational and non-state actors present to sovereignty. The 11 September attack struck many blows to our nation's psyche, economy, intelligence community, financial structure, and the future of warfare. President Bush has laid out the military's future direction as we wage the global war on terrorism:

> …a future force that is defined less by size and more by mobility and swiftness, one that is easier to deploy and sustain, one that relies more heavily on stealth, precision weaponry and information technologies.[11]
>
> - George W. Bush

Current conditions reflect the ambiguous and volatile world our nation must contend with in the future. Now in the current information age, our military must contend with new and evolving threats. Medical assets that support the military must be able to meet the challenge of the President's direction for the future.

Transformation is not a new idea, but recent world events have accelerated the need to transform our military. This process is happening in all services and moving swiftly in our Army, even as we wage war. The Army is transforming into a modular expeditionary force centered on the brigade unit of action. This modular force will provide predictability for planners in the areas of capabilities, size, and logistics. The modular force is designed to deploy the correct capability with the ability to expand if the need arises. The new modular force will compel medical assets to do more with less, in less time and with a smaller footprint. Transforming while at war has been equated to working on an engine while it is running or building an airplane while in flight.[12] Time is not on our side.

Transformation will affect how the medical departments of each service provide health care to Soldiers in future endeavors around the world. Our current ad hoc structures have achieved successes through the hard work of individuals, consuming time and massive man-hours. Presently, the medical services do not have the luxury of time or the man-hours to manage ad hoc organizations in future operations. However, our medical professionals have had great success in saving lives and ensuring the health of military forces. To have continued success in this transformed environment, we must immediately unify the efforts of the separate medical departments. The individual services cannot remain independently successful to

achieve the requirements of the future. Ad hoc organizations can complete the mission only at the expense of efficiency.

HISTORICAL PERSPECTIVE

Prior to World War II, the military medical system was based on proximity of treatment assets to the injured, specifically on ships or battlefields. This original approach to military medical services was modeled after the British system used during the Revolutionary War.[13] The separate military service medical departments were designed to provide direct support to their service members. Great credit is due the medical services for innovations and standards established for the medical community throughout their history. The Army Medical Department (AMEDD) website states:

> The Continental Congress created a medical service for a 20,000-man Army, on July 27, 1775, and named Dr. Benjamin Church of Boston as director general and chief physician… Dr. Benjamin Rush, signer of the Declaration of Independence, ran a Continental Army hospital and wrote the first American preventive-medicine text for Army physicians, which was used until the Civil War. A historic first occurred in 1777, when George Washington ordered the inoculation of all Continental Army recruits to prevent smallpox. Never before had an entire Army been immunized… it worked.[14]

Such contributions continued with advances in preventive medicine to surgical techniques. The military physicians were civilians in service of the military until 1847 when Congress authorized medical officers to receive military ranks.[15] In 1862, Congress made the Surgeon General a general officer, marking the undisputed acceptance of medical services within the military.[16] Since medical care was rendered on or close to the battles, separate medical service systems were required for appropriate support.

The success of unified command can be traced back to General George Washington, during the Revolutionary War. However, until Goldwater-Nichols forced it, service interests have historically obstructed unifying combatant or functional commands. Consider George Washington's recognized status in 1781-1783 as a military leader or "généralissme" of Congress.[17] The word généralissme, based on eighteenth-century French meaning, is best translated today as "supreme allied commander" for the campaign region.[18] General George Washington was the first unified coalition commander to synchronize the Continental forces, the French Army and French Navy to defeat the British.[19]

In World War II, General Eisenhower was the Supreme Allied Commander for the European Theater. This unified command exercised command and control over all forces, regardless of branch of service or country. After the war ended, the Army Surgeon General believed unified wartime medical services would be more effective; he raised this proposal with Congress.[20] The concept of a single military health service was not well received and was opposed by the Navy and Air Force.[21] However, General Eisenhower supported the concept of a single unified command and viewed the idea of separate service medical departments as indefensible.[22] However, unification did not survive the Navy and Air Force opposition; military medical systems remained separate. This is reminiscent of the Pacific Theater in World War II, where service interests precluded the subordination of the two commanders in the area.[23] General McArthur and Admiral Nimitz retained command over their specific services in the region. The unified command for military health services after World War II was the victim of specific service interests, just as were attempts to unify the Pacific Theater during the war.

The end of the Cold War set in motion many changes for the military services. With the enemy behind the iron curtain gone, Congress began slashing the military budget. The military had to reevaluate its role and structure, and determine the direction for the future force. This direction had to be articulated to Congress, who ensures the nation's security needs are met. The new vision of the future had to support the nation's needs while retaining the resources for the present and future of each service. Restructuring occurred throughout the Army; the medical department followed suit by shuffling assets. After the Persian Gulf War, it became apparent that very few nations could rival the military might of the United States. This war created many "lessons learned" for the services and their medical departments. The deployable medical systems (DEPMEDS), developed during the Vietnam Era[24], proved adaptable, but lacked the ability to move to support the force. The AMEDD answered with the Medical Re-engineering Initiative (MRI) which attempted to reduce effects of identified issues during the Gulf War. The initiative eliminated large field and general hospitals and converted them to combat support hospitals. The combat support hospitals, reduced in size, had the ability to split into smaller pieces for short periods of time. However, this was a meager attempt to become more mobile to push support far forward on the battlefield while keep lifesaving capability readily available.

Why a Joint Medical Command? Answers to this question lie in reviewing problems in recent history with service-centric views of a common mission and the desires for service involvement in all operations. Congress eventually decided to curb service rivalries. The Goldwater-Nichols Act pushed the military services in the joint arena through the strengthening

of the Chairman of the Joint Chiefs of Staff and the establishment of regional unified commands. The three military services had separate missions of transportation and special operations, which were functionally aligned in nature. The creation of the United States Special Operations Command (USSOCOM) and the U.S. Transportation Command emerged on the foundation of the Goldwater-Nichols Act. USSOCOM was formed after Desert One failed to rescue the American hostages in Iran and because of recurring issues with the invasion of Grenada in 1983. In anticipation of potential Congressional action, DoD created the Joint Special Operations Agency (JSOA), on 1 January 1984, to correct these problems.[25] The JSOA did little to "fix" the issues of readiness, capability, or policy for Special Operations Forces (SOF), because it had no operational or command authority. [26] Congressional supporters for special operations then pushed for amendments to the Goldwater-Nichols Act, which resulted in protection of SOF funding and a voice on the DoD staff, as the Assistant Secretary of Defense for Special Operations and Low Intensity Conflict.[27] Indeed the experiences of the JSOA's inability to effect change arose from a lack of command authority.

Why should the medical community attempt to travel down this road? Unfortunately, the success of some unified commands has taken the focus away from other service-centric issues, obstructing more interoperable and interdependent operations. The medical services must use the USSOCOM model for change, before legislative actions force this upon us.

OPERATIONAL SUPPORT MISSION

According to joint doctrine, the primary objective of Health Service Support is to conserve the fighting strength of the military forces.[28] The arguments against the JMC seem to be centered on the uniqueness of each service's mission, environment, and role.[29] This dispute does have some credibility based on the type of injuries service members may sustain and the sets, kits, and outfits required to treat the injuries. Even though each service's medical department may have a unique situation, there is the common objective to conserve the fighting strength.

The requirement to contend with Gulf War Syndrome reinforced this common objective. After deployment in the Persian Gulf War, many service members began complaining of illnesses. These illnesses reflected a wide range of symptoms with no documentation to support the claims. The lack of documentation adversely affected the investigation into the cause of the illnesses. In response, Public Law 105-85 was enacted in November 1997, requiring the DoD to establish a system to assess the medical condition of service members before and after deployments.[30] The DoD issued a mandate for implementation of the joint

medical surveillance program for deployments by prescribing procedures and assigning responsibilities.[31] The legislation led to the Force Health Protection (FHP) capstone vision document, published by the Joint Chiefs of Staff Logistics (J4), Health Service Support Division, with contributions from the DoD FHP Council, Deployment Health Support Directorate, the Joint Preventive Medicine Policy Group, and the Joint Readiness Clinical Advisory Board.[32] The FHP consists of three pillars with one infrastructure to underpin it.[33] The three pillars are a healthy fit force; prevention and protection; and casualty care and management (medical and rehabilitative care).[34] This document focuses on protecting our fighting forces through preventive and interdictive health care programs. The FHP document clearly states that success is a collective effort, dependent on commanders, service members and the military health care system. Joint doctrine reemphasizes the responsibility of commanders for implementation of the FHP in their areas of responsibility; it directs aggressive enforcement of the first two pillars in reducing casualties.[35]

In evaluating the progress of the FHP[36] the last Government Accounting Office Report shows marked improvements, but the Air Force and Army still have not achieved full compliance, while the Marines show slightly worse percentages than the other two services.[37] However, the investigators did not thoroughly review the records of the Marines and the Navy in previous reports.[38] The Marines lag in compliance could infer lower compliance in the Department of the Navy. There are many redundancies in the implementation of this program across each service; implementation varies by installation, location, and service. If the DoD expects unified action, it must start with a unified direction for all services.[39] Command authority is the only way to unify this program. The staff surgeons for a command lack this authority and the broad influence needed to effect change. The JMC would have command authority and broad influence over the separate services to unify the FHP.

DoD Directives require each service to construct or modify automation information systems to capture the data for FHP. The systems are components of other service-specific systems used to provide commanders with situational awareness for critical decision-making.[40] Service members cannot afford another failure to protect them due to data management and record maintenance. The JMC would synchronize the automation efforts and effective management through command.

HUMANITARIAN ASSISTANCE (INSTRUMENT OF POWER)

The primary objective of operational medicine is to conserve the fighting force, but we cannot ignore the care provided to non-combatants, coalition forces, and enemy combatants.

The humanitarian effort can provide great dividends in stability operations following combat. Based on our doctrine, military hospitals will receive any wounded from the battle area including, civilian men, women and children. In Iraq, surgeons went to war without supplies for children after being told they would not be seeing them, but found themselves improvising to help innocent injured children.[41] An orthopedic surgeon, deployed to Iraq, lacked materials and equipment needed to repair bone fractures incurred by Iraqi National Guard members.[42] Because all service members requiring definitive care are evacuated out of country, per joint doctrine and FHP, this leaves the physicians short on supplies for definitive care and unable to complete some repairs on non-combatants and Iraqi National Guardsmen. Service members on the battlefield will tend to put their life at risk if they know the support is there to help them if they are injured. However, the Iraqi soldier, willing to put his life on the line for his country, will be crippled for life because the local hospital does not have the assets to care for his injuries. The same concept of a supportive environment applies to the Iraqi military members when they are injured on the battlefield. Iraqi soldiers, willing to risk more to win, against the insurgency could be affected by the care received when injured in battle. The medical professionals presently deployed are providing world class care to service members and anyone else who enters the facility. The cost of support would increase, but could be a true combat multiplier and produce lavish rewards that money could not buy.

Using medical support as a medical instrument of power[43] requires greater strategic thought and guidance. The JMC could initiate strategic discussion and guidance to combatant commanders for inclusion in their theater security cooperation plan (TSCP).

FUTURE EMPLOYMENT OF MEDICAL ASSETS

Presently, the Joint Force Surgeon (JFS), appointed by the geographic combatant commander, is responsible for coordination and integration of support among the services.[44] The JFS integrates what he is given from the services to accomplish the mission. Again the JFS, a staff officer, has no command authority or a robust staff to truly synchronize the integration among the services.

There are redundancies between the services' medical departments in providing care to deployed forces. Redundancies give flexibility in operations only if you have a proper mix; otherwise it is a waste of assets. In the present war, the Army is learning fast that interdependability is the future direction in joint operations.[45] Consider the recent example about reduction in field artillery units because the Air Force and Marine Air assets could provide precision guided munitions to support ground troops.[46] However, the Army cannot give up total

artillery capability because factors such as weather can affect air assets and not the ground field artillery assets.[47] This gives the Army the capability to reassign artillery assets to force protection or other needed assets, without increasing the personnel end strength.[48] If this concept is applied to health service support, we could reap the same rewards and orient the services' medical departments on a basis of speed of employment with the ability to expand capabilities.

Speed of employment is based on short, moderate and extended deployment to theater times – which dictate logistical force flow. For example, the Air Force's Expeditionary Medical Support (EMEDS) System can be loaded on only 25 pallets and transported for the most part on a single C-17 aircraft.[49] The Air Force would become the short suspense medical deployment asset; the Army the moderate asset; and the Navy the extended asset. The Army would not want to do away with all of its combat support hospitals for the same reason it should not shed all field artillery assets. The Navy would retain its hospital ships and its large fleet hospitals because they have all the assets to set up the hospital, including engineers, heavy equipment, and heavy equipment operators. The Army must set up their large hospitals with the assigned personnel, without heavy equipment - but perhaps with reluctant engineer support. Evacuation assets would remain in their current configuration. The key is to be prepared for all possibilities and focus on the strengths of each service to best support the force, based on the kind of operation. The concept of expandability uses appropriate service capabilities by adding them to a facility or operation, regardless of branch of service. To accomplish this, a JMC would establish unity of command and doctrine for employment of the right assets, at the right locations, and at the right times.

Why does the medical and logistical community attempt to accomplish such a task without a unified command? The combat arms would never attempt to accomplish these tasks without a responsible and accountable commander.[50] True innovation in the employment and integration of service medical assets will not be achieved without a JMC.

MANAGEMENT OF RESOURCES

The DoD operates one of the largest and most complex health care organizations in the nation.[51] Its sheer size and breadth of coverage transcends most civilian managed care organizations. The military's managed care system, TRICARE, provides care to 8.6 million beneficiaries.[52] These beneficiaries are service members, their families and retirees. The care is provided through a network of 75 military hospitals, 461 military clinics, and 7 regional Managed Care Support (MCS) contracts valued at about $5.5 billion in FY 2004.[53] This care is

provided not only in the United States but also overseas in military facilities and by contractors around the world. This system is managed through the three service Surgeons General and coordinated with the Assistant Secretary of Defense for Health Affairs (ASD (HA)). The system is disjointed and inefficient because no single entity has control over all the parts. The Surgeons General have command and control over their respective service medical treatment facilities, but not the civilian contracting in each regional area. The ASD (HA) has control over resources and civilian contract responsibility for TRICARE management across service specific areas and interests.[54] Currently, we have limited unity of effort with coordination only happening between the services' medical departments and the ASD (HA). We have massive redundancies through duplication of effort, lack of true control over TRICARE, and enormous coordination problems. The Chairman of the Joint Chiefs of Staff in 2001 warned in a memo to the Secretary of Defense that a "critical fiscal situation" for the health care "is exacerbated by a diluted organizational structure" struggling to provide "essential medical benefits to dependents and retirees while ensuring the availability of contingency medical capabilities for our active duty troops."[55] This loose organization lends itself to inefficiency and poor resource management of a large complex organization.

As noted earlier, the Goldwater-Nichols Act of 1986 solidified the position and power of the Chairman of the Joint Chiefs of Staff. The Act was formulated to unify the effort of the services to better protect the nation by removing inefficiencies and service centric policies. However, over time inefficiencies grew within the Joint Chiefs of Staff and DoD in their attempt to manage this bureaucratic process. These inefficiencies were identified by an independent, two-phased study, called the "Beyond Goldwater-Nichols (BG-N) Defense Reform for a New Strategic Era."[56] The phase one report was released in March 2004, and phase two began in May 2004 and will last 12 months.[57] The report refers to the issues as hidden failures because the U.S. military has been very successful recently and is held in high regard in the public eye.[58] These hidden failures, while not preventing our operational successes, are stifling innovation and squandering critical resources, both time and money.[59] The report identified and analyzed problems facing the DoD and recommended solutions to both internal and external issues. This report is helpful in evaluating our current status without a unified medical command.

The ASD (HA) has gradually received enhanced authority in the areas of resource management and civilian contract responsibility.[60] Resource management is accomplished in two ways for the medical services: The authorizations and funding for military personnel are resourced from Congress to the Services, but the medical activities are funded under a single appropriation called the Defense Health Program (DHP).[61] The DHP is included in the Office of

Secretary of Defense's (OSD) budget and developed each year by the TRICARE Management Activity (TMA) under the ASD (HA).[62] The BG-N report identified unnecessary overlaps in the current organizational structure of the Military Departments, the Joint Staff, and the Office of Secretary of Defense (OSD).[63] The overlaps result in duplicative and overtly large staffs that require wasteful coordination processes and impede necessary innovation.[64]

A JMC would bring unity of command and effort to the medical assets. Funding should be sheltered by Congress, as it was for Major Force Program–11 (MFP-11) for the special operations community.[65] This would give the medical command control over all its resources to better manage medical activities and modernize its force. The JMC would unify funding and responsibility under one organization, while eliminating our current unrecognized hidden failures. This would help avert what one previous Surgeon General of the Air Force referred to as a medical budget in a "death spiral."[66]

The BG-N report recommended consolidating housekeeping within DoD; and warned them against the temptation to manage programs.[67] This recommendation would renew focus on policy formulation and oversight within OSD.[68] Currently, the ASD (HA) manages the budget for medical activities through the TMA. The joint medical staff would assume the responsibilities of the TMA, to include contracting support.[69] This would be accomplished along current service lines of command, and services would assume technical oversight performed by managed care contractors.[70] This responsibility for regional oversight would be decentralized and assigned to medical treatment facility commanders.[71]

If we do not correct these inefficiencies, the costs will only get worse. Under Secretary of Defense for Personnel and Readiness, David Chu declared there is "terrible inefficiency" and the:

> "DMOC [Defense Medical Oversight Council] has been used to provide some level of oversight and efficiency that was lacking. The bottom line is you have this large budget number in medical [$18 billion a year] that is basically managed by a staff, instead of a command, and through three separate services. If they are going to get these costs under control, it's not going to happen as the system is organized now."[72]

So, the problems with the current structure are recognized by OSD. The JMC would provide the needed command, would maintain civilian authority, and would refocus ASD (HA) on policy formulation and oversight.

DOMESTIC RESPONSE MISSION

The U.S. military has a long history of responding to civil authorities. However, doctrine advises a leader to proceed cautiously and obtain an opinion from the supporting staff judge advocate prior to executing the needed support.[73] The health services logistical planner is advised to be knowledgeable of the funding or reimbursement mechanisms.[74] This long history of civil response has been marred by political actions and reactions. The Posse Comitatus Act, which limits the use of military by civil authorities, is one such Congressional reaction. Congress has since made a laundry list of exceptions under Title 10 United States Code (USC) for the military to assist civil authorities. When the next terrorist attack or natural disaster occurs, we will not have time for consultation or caution. Our plans and coordination must be complete to reduce the loss of life with swift support rendered to the federal, state, and local civil authorities.

The joint publications place this mission of domestic support under OOTW.[75] For domestic support, medical support missions will undoubtedly take place under disaster conditions, without the full complement of logistical support.[76] OOTW specify six joint principles to guide the commander and planner of health services assets: objective, unity of effort, legitimacy, security, restraint, and perseverance.[77] Unity of effort requires the joint health services planner to ensure close coordination with all service participants, U.S. agencies, religious groups, non-governmental organizations (NGOs), private volunteer organizations (PVOs), and many others if deployed overseas.[78]

Domestic response has become a third mission in support of homeland defense. The domestic response mission can consist of national assistance, evacuation and humanitarian assistance. In direct reaction to the terrorist attacks here in the United States, units have been directly identified for possible support; their ALO levels have been increased specifically for this reason. The most likely units to respond on short notice are the National Guard and Reserve Components. The Army Reserve contains over sixty percent of the total medical assets for the Army; many are located within civilian communities.

The JMC would synchronize the response across the three medical services and their Reserve Components. Currently, the ASD (HA) is directed to develop systems and plans to ensure that sufficient medical assets are ready to deploy to meet health care needs in an emergency.[79] The JMC would take over this responsibility thus releasing ASD (HA) for oversight and policy formulation. To be successful in this third mission, we must be prepared and trained for many possible scenarios. Due to other operations a limited number of assets

are available, so they must be carefully managed. No longer can we just react to an occurrence. We must be prepared to act.

The military medical departments bring capabilities to domestic response that few, if any, civilian agencies can provide on short notice. The key component to success in providing support in a domestic response mission is prior coordination and planning at the interagency level. There are many players in this mission of domestic response, such as the separate components of each service (National Guard and Reserve), the services, the services' medical departments, the DoD, the Joint Chiefs of Staff, the unified commands, U.S. Northern Command, and many civilian agencies. If a structure can be created through which all assets cooperate systematically to achieve a coordinated response to support homeland defense, we can succeed. Sun Tzu says it best, "Generally, management of the many is the same as management of the few. It is a matter of organization."[80]

Our success at this third mission will depend on our organization and prior preparation to respond to an attack or national disaster. The JMC would speak with one voice for the uniformed medical services at the interagency level and establish a true unity of effort for the medical assets of the Active and Reserve Components.

CONCLUSION

How can we have unity of effort if we have no unity of command, which is essential to successful military actions. The joint doctrine states clearly that command is central to all military action, and unity of command is central to unity of effort.[81] A familiar saying within the military is: "If it isn't broke, don't fix it."[82] However, the present volatile environment facing our nation's military could "break" the present ad hoc medical support system. Future medical requirements require true interdependence among the services. We can no longer wait for it to break and then fix it. The BG-N studies found "silent failures" in the DoD which stifle innovation and squander valuable resources. The problems are already becoming visible, therefore change is required to ensure our continued success. The Honorable David Chu has observed that the staffs are managing TRICARE, not the commands. He claims that the present system will not reduce these costs. The volatility, uncertainty, complexity and ambiguity of the future require wise use of our finite resources.[83] The JMC would ensure proper use of these resources through unity of command.

Transformation issues are directly affecting the medical services' ability to support service members with speed while maintaining lifesaving capability. Support can no longer be service-centric in nature. We must now draw from the wealth of capabilities in each services medical

department. The military health system has established joint organizations and utilized them with success, such as the DoD Pest Management Board and Defense Medical Readiness Training Institute. However, we have many ad hoc committees and organizations that exist only as long as service-centric needs are met. The medical departments can no longer afford the mistakes that forced the changes for the special operations community or the creation of FHP. Historically, dating back to WWII, it has been proven that the concept of a unified command is not only viable but desirable. Many proposals have been offered, ranging from a complete dissolution of all medical assets into one command with no service orientation, to a joint command and control of resources, and many ideas ranging in between. These promising suggestions or proposals have met with disdain primarily due to service parochialism. The Army's transformation to a modular force will require quick and easy movement of medical assets. As the Army moves increasingly joint, so must the AMEDD. Interdependence with the other services is the key to a successful future. Successes will require a unified direction under a unified command.

The JMC, as a unified command, would help fix issues of readiness, capabilities, and policies for the military medical community. It would provide unity of direction for the services for FHP and other DoD policies. The command would centralize the budget for readiness and medical activities. It would assume responsibilities for the management of TRICARE, decentralizing the process and giving regional responsibility to medical treatment facility commanders. ASD (HA) would then be able to renew its focus on policy formulation and oversight. Unlike the special operations community in the early 1980's, the medical community already has a voice in OSD through the ASD (HA). This voice would be more effective if it were relieved of management of TRICARE management and other issues affecting the military medical system. The JMC would not dissolve the present service structures of the medical departments. However, the redundancies within each separate medical department would provide the personnel for the JMC. The Commander of the JMC would advise to the Secretary of Defense and Chairman of the Joint Chiefs of Staff on uniformed military medicine issues, working with the ASD (HA).

The JMC's formation, planning, and funding should be executed now to ensure future success for the military medical departments. Solutions delayed mean solutions denied; only making things worse.[84] This needs to be a true "joint" process and not a struggle among the services and/or the OSD. The solution is a JMC to ensure unity of direction and unity of effort through unity of command.

WORD COUNT=5,974

ENDNOTES

[1] Joint Chiefs of Staff, *Joint Doctrine Capstone and Keystone Primer,* Joint Reference Pub, (Washington, D.C.: Joint Chiefs of Staff, 10 September 2001), 14.

[2] Thomas F. Metz, "View From the Top," available from <http://www.pentagon.mil/home/articles/2004-12/a121504j.html>; Internet; accessed 18 December 2004.

[3] Susan D. Hosek and Gary Cecchine, *Reorganizing the Military Health System: Should There Be a Joint Command?* (Santa Monica: RAND, 2001), 2.

[4] Ibid.

[5] Ibid., 3.

[6] Ibid.

[7] Joint Chiefs of Staff, *Joint Tactics, Techniques and Procedures For Health Services Logistics Support In Joint Operations, Joint* Pub 4-02.1, (Washington, D.C.: Joint Chiefs of Staff, 6 October 1997) V-4.

[8] Department of Homeland Security, *National Response Plan*, (Washington, D.C.: Secretary of Homeland Security, Department of Homeland Security, December 2004), 10.

[9] Peter Willetts, *Transnational Actors and International Organizations In Global Politics*. USAWC Readings: Volume I, Core Curriculum Course 2, Academic Year 2005 (Carlisle Barracks: US Army War College, 2004), 151.

[10] Ibid., 149-150.

[11] Department of Defense, *Transformation Planning Guidance*, (Washington, D.C.: Secretary of Defense, Department of Defense, April 2003), 3.

[12] The ideas in this sentence are based on remarks made by speakers in Bliss Hall Lectures.

[13] Larry J. Godfrey, *A Unified Medical Command: The Next Step In Joint Warfare Development*, Strategy Research Project (Carlisle Barracks: US Army War College, 2001), 2.

[14] United States Army Medical Department, "Highlights In Army Medical Department History." available from <http://www.armymedicine.army.mil/about/history/highlights.htm>; Internet; accessed 17 December 2004

[15] Ibid.

[16] Godfrey, 4.

[17] Expédition Particulière Commemorative Cantonment Society, "Rochambeau's Instructions For Service In Allied Command," 3 September 2004: available from <http://xenophongroup.com/mcjoynt/orders.htm>; Internet; accessed 23 January 2005.

[18] Ibid.

[19] Morris J. MacGregor, Jr. and Robert K. Wright, Jr., *Soldier-Statesmen Of the Constitution* (Washington, D.C.: U.S. Army Center of Military History, 1987), 59; available from <http://www.army.mil/cmh-pg/books/RevWar/ss/washington.htm>; Internet; accessed 23 January 2005.

[20] Richard W. Hunter and Benjamin R. Baker, *Report For the Secretary Of Defense On the Feasibility and Benefits To Be Gained From Creating the Defense Health Agency* [note re: DoD contract for Systems Research and Applications…], (Arlington, VA: Systems Research and Applications, 26 August 1983), 2-1.

[21] Ibid.

[22] Richard V. N. Ginn, "Of Purple Suits and Other Things: An Army Officer Looks At Unification Of the Department Of Defense Medical Services," *Military Medicine* 143, (January 1978); 18.

[23] Ronald H. Cole et al., *The History Of the Unified Command Plan 1946 – 1993* (Washington, D.C.: Joint History Office, Chairman of the Joint Chiefs of Staff, 1995), 11.

[24] Online Highways, Inc., "Historical Eras," n.d.; available from <http://www.u-s-history.com/pages/eras.html>; Internet; accessed 16 March 2005.

[25] United States Special Operations Command (USSOCOM). *United States Special Operations Command History, 15th Anniversary Edition.* (MacDill AFB, Florida: USSOCOM History and Research Office, 16 April 2002), 3.

[26] Ibid.

[27] Ibid., 4-5.

[28] Joint Chiefs of Staff. *Doctrine For Health Service Support In Joint Operations,* Joint Pub 4-02 (Washington, D.C.: Joint Chiefs of Staff, 30 July 2001), II-1.

[29] Paul E. Casinelli, *The Joint Medical Command: Boon Or Bane For The Supported CINC?* Strategy Research Project (Newport: U.S. Naval War College, 18 May 2001), 5.

[30] General Accounting Office, *DOD Needs To Improve Force Health Protection and Surveillance Processes* (Washington, D.C.: U.S. General Accounting Office, 16 October 2003), Highlights section inside front cover.

[31] Department of Defense, *Implementation and Application Of Joint Medical Surveillance For Deployments,* DOD Instruction 6490.3 (Washington, D.C.: U.S. Department of Defense, 7 August 1997), 1.

[32] Joint Chiefs of Staff. *Force Health Protection,* Capstone Document, (Washington, D.C.: Joint Chiefs of Staff, 2004), Inside front cover.

[33] Ibid., 13.

[34] Ibid.

[35] Joint Chiefs of Staff, *Doctrine For Health Service Support In Joint Operations,* I-1.

[36] Congress requested a determination (1) of the extent to which the services met DoD's policies for Operation Iraqi Freedom and (2) what steps DoD has taken to establish a quality assurance program to ensure compliance with FHP and surveillance policies. This information taken from the inside cover of the report dated November 2004 (see endnote 36).

[37] Government Accounting Office, *Force Health Protection and Surveillance Compliance Was Mixed, But Appears Better For Recent Deployments,* (Washington, D.C.: U.S. General Accounting Office, 12 November 2004), 4.

[38] Ibid, 4.

[39] Joint Chiefs of Staff. *Joint Doctrine Capstone and Keystone Primer,* 12.

[40] There are three different automated information systems to collect the data and two clinical data repositories (theater and clinical). These systems are called the Composite Health Care System II (CHCS II), the Theater Medical Information Program (TMIP), and the TRANSCOM Regulating and Command & Control Evacuation System (TRAC2ES). The TRAC2ES system was developed by USTRANSCOM to track patients during evacuation. These automated systems are components of other systems and made of separate components. For instance the TMIP is the medical component of the Global Combat Support System (GCSS). The TMIP's components are Medical Surveillance System (MSS) and Joint Medical Workstation (JMeWS), which the theater commander gains medical situational awareness. The CHCS II system is integrating over 40 existing or developing DoD and service specific automation systems.

[41] David R. Welling, "Interservice Cooperation Improves Medical Care For the Troops In the War Zone," *Army Times*, 7 June 2004, p. 54.

[42] The thoughts in this sentence were taken from the emails of a physician deployed in Mosul, Iraq.

[43] Robert G. Claypool, *Military Medicine As an Instrument Of Power: An Overview and Assessment*, Strategy Research Project (Carlisle Barracks: US Army War College, 31 March 1989).

[44] Joint Chiefs of Staff. *Doctrine For Health Service Support In Joint Operations,* I-1.

[45] The idea in this sentence is based on remarks made by a speaker participating in the Commandant's Lecture Series.

[46] Ibid.

[47] This idea in this sentence is based on required reading, seminar discussions and remarks by speakers.

[48] The idea in this sentence is based on remarks made by a speaker participating in the Commandant's Lecture Series.

[49] Bruce D. Callander, "In Iraq, A New Type Of Expeditionary Medic Provides Care Around the Clock. After M*A*S*H," *Air Force Magazine Online* December 2004 Vol. 87, No. 12. [Journal on-line]; available from <http://www.afa.org/magazine/Dec2004/1204mash.html>; Internet; accessed 20 December 2004.

[50] The idea in this sentence is based on remarks made by a speaker participating in the Noontime Lectures.

[51] RAND, "The Military Health System. How Might It Be Organized?" 2002; available from <http://www.rand.org/publications/RB/RB7551/>; Internet; assessed 30 November 2004.

[52] Department of Defense, "Defense Health Program, Fiscal Year (FY) 2004/FY 2005 Biennial Budget Estimates," 9 February 2003; available form <http://www.ha.osd.mil/budget/2004/C-PB DHP PBA-9 Feb 03 Web.doc>; Internet; assessed 25 December 2004.

[53] Ibid.

[54] Susan D. Hosek and Gary Cecchine, *Reorganizing the Military Health System: Should There Be a Joint Command?* (Santa Monica: RAND, 2001), xi and 13.

[55] Tom Philpott, "Rumsfeld Team Retrieves Reins Of Military Medicine," Proceeding Of the United States Naval Institute, Proceedings, August 2001 vol. 127, no. 8, pg. 90, 1 pgs, (856 words) [database on-line]; available from ProQuest; accessed 6 December 2004.

[56] Center for Strategic and International Studies, "Beyond Goldwater-Nichols: Defense Reform for a New Strategic Era Reports," n.d., available from <http://www.csis.org/isp/bgn/reports.htm>; Internet; assessed 30 December 2004.

[57] Ibid.

[58] Clark A. Murdock, et. al., *Beyond Goldwater-Nichols: Defense Reform For A New Strategic Era, Phase 1 Report*, (Washington, D.C.; Center for Strategic and International Studies, March 2004), 6.

[59] Ibid.

[60] Hosek, xi.

[61] Ibid., 13.

[62] Ibid., 13.

[63] Murdock, 7.

[64] Ibid.

[65] United States Special Operations Command (USSOCOM). *United States Special Operations Command History, 15th Anniversary Edition.* (MacDill AFB, Florida: USSOCOM History and Research Office, 16 April 2002), 5.

[66] Philpott.

[67] Murdock, 8.

[68] Ibid.

[69] Hosek, 19.

[70] Ibid.

[71] Ibid. Figure 2.8 from the RAND report gives a graphical representation of the Joint Medical Command organization.

[72] Philpott.

[73] Joint Chiefs of Staff, *Joint Tactics, Techniques and Procedures For Health Services Logistics Support In Joint Operations*, V-4.

[74] Ibid, V-5.

[75] Ibid, V-4.

[76] Ibid, V-3.

[77] Ibid, V-1.

[78] Ibid.

[79] Department of Defense, *Assignment Of National Security Emergency Preparedness (NSEP) Responsibilities To DoD Components,* DoD Directive 3020.36 with Change 1, (Washington, D.C.: U.S. Department of Defense, November 2, 1988), 14.

[80] Joint Chiefs of Staff, *Joint Tactics, Techniques and Procedures For Health Services Logistics Support In Joint Operations*, V-1.

[81] Joint Chiefs of Staff. *Joint Doctrine Capstone and Keystone Primer*, 14.

[82] Clark A. Murdock, et al., "Beyond Goldwater-Nichols: Defense Reform For A New Strategic Era Phase 1 Report," Master Slides, 16 March 2004; available from <http://www.csis.org/isp/bgn/bgn_ph1_mb.pdf>; Internet; accessed 24 October 2004.

[83] The idea in this sentence is based on seminar discussions and readings in course 1 on strategic leadership.

[84] Murdock, Master Slides.

BIBLIOGRAPHY

Allgood, Brian D. *DoD and the Biological Weapons Domestic Response Plan: Does It Contribute?* Strategy Research Project. Carlisle Barracks: US Army War College, 9 April 2002.

Arnold, Marilyn, Joseph Hale, and Jim Holland. "2002 Congressional Report: Joint Medical Executive Skills Program Report." March 2002. Available from <http://jmesi.army.mil/documents.asp>. Internet. Accessed 6 December 2004.

Callander, Bruce D. "In Iraq, A New Type Of Expeditionary Medic Provides Care Around the Clock. After M*A*S*H." *Air Force Magazine* December 2004 Vol. 87, No. 12. Journal on-line. Available from <http://www.afa.org/magazine/Dec2004/1204mash.html>. Internet. Accessed 20 December 2004.

Carlton, Paul K. Jr. "New Millennium, New Mind-Set." *Aerospace Power Journal* Winter 2001. Journal on-line. Available from <http://www.airpower.maxwell.af.mil/airchronicles/apj/apj01/win01/carlton.html>. Internet. Assessed 16 November 2004.

Casinelli, Paul E. *The Joint Medical Command: Boon or Bane For the Supported CINC?* Strategy Research Project. Newport: U.S. Naval War College, 18 May 2001.

Cecchine, Gary. David Johnson, John R. Bondanella, J. Michael Polich, and Jerry Sollinger. *Army Medical Strategy: Issues For the Future.* Santa Monica: RAND, 2001.

Center for Strategic and International Studies.. "Beyond Goldwater-Nichols: Defense Reform For a New Strategic Era Phase 1 Report." Master Slides. 16 March 2004. Available from <http://www.csis.org/ isp/bgn/bgn_ph1_mb.pdf>. Internet. Accessed 24 October 2004.

Center for Strategic and International Studies. "Beyond Goldwater-Nichols: Defense Reform For a New Strategic Era Reports." n.d. Available from <http://www.csis.org/isp/bgn/reports. htm>. Internet. Assessed 30 December 2004.

Claypool, Robert G. *Military Medicine As an Instrument Of Power: An Overview and Assessment*. Strategy Research Project. Carlisle Barracks: US Army War College, 31 March 1989.

Cole, Ronald H., Walter S. Poole, James F. Schabel, Robert J. Watson, and Willard J. Web. *The History Of the Unified Command Plan 1946 – 1993*. Washington, D.C.: Joint History Office, Chairman of the Joint Chiefs of Staff, 1995.

Conard, Rey. *Joint Medical Command and Transformation*. Strategy Research Project. Newport: US Naval War College, 16 May 2003.

Congress, House of Representatives, House Armed Services Committee, Subcommittee on Personnel. *The Military Health System: A Joint Overview Statement*. 15 March 2000.

Congress, Senate, Committee on Armed Services, Subcommittee on Personnel. *The Military Health System: Overview Statement*. 4 March 2003.

_____. *The Military Health System: Overview Statement*. 13 March 2002.

Davis, Lois M., Susan D. Hosek, Michael G. Tate, Mark Perry, Gerard Hepler, and Paul S. Steinberg. "Army Medical Support For Peace Operations and Humanitarian Assistance." 1996. Available from <http://www.rand.org/publications/MR/MR773/>. Internet. Accessed 1 December 2004.

Department of Defense. *Assignment Of National Security Emergency Preparedness (NSEP) Responsibilities To DoD Components.* DoD Directive 3020.36 with Change 1. Washington, D.C.: U.S. Department of Defense, 2 November 1988.

_____. *Assistant Secretary Of Defense (Health Affairs).* DoD Directive 5136.1. Washington, D.C.: U.S. Department of Defense, 15 April 1991.

_____. *Comprehensive Health Surveillance.* DOD Directive 6490.2. Washington, D.C.: U.S. Department of Defense, 21 October 2004.

_____. *Delivery Of Healthcare At Military Treatment Facilities (MTFs).* DOD Instruction 6015.23. Washington, D.C.: U.S. Department of Defense, 9 December 1996.

_____. *Force Health Protection (FHP).* DOD Directive 6200.4. Washington, D.C.: U.S. Department of Defense, 9 October 2004.

_____. *Implementation and Application Of Joint Medical Surveillance For Deployments.* DOD Instruction 6490.3. Washington, D.C.: U.S. Department of Defense, 7 August 1997.

_____. "Defense Health Program, Fiscal Year (FY) 2004/FY 2005 Biennial Budget Estimates." 9 February 2003. Available form <http://www.ha.osd.mil/budget/2004 /C-PB DHP PBA-9 Feb 03 Web.doc>. Internet. Assessed 25 December 2004.

_____. "Joint Preventive Medicine Policy Group (JPMPG) Charter." August 1998. Available from <http://www.hooah4health.com/toolbox/Library/JointPrevMed PolicyGpCharter.doc>. Internet. Accessed 22 November 2004.

_____. "Medical Situational Awareness In the Theater (MSAT): White Paper." 28 January 2004. Available from <http://deploymentlink.osd.mil/current_issues/actd/white_paper_p. pdf>. Internet. Accessed 16 November 2004.

_____. "Medical Situational Awareness In the Theater (MSAT): Quad Chart." 28 January 2004. Available from <http://deploymentlink.osd.mil/current_issues/actd/quad_chart_p. pdf>. Internet. Accessed 16 November 2004.

_____. "Medical Situational Awareness In the Theater (MSAT): Advanced Concept Demonstration (ACDT) FY05 Candidate–Briefing Slides." 28 January 2004. Available from <http://deploymentlink.osd.mil/current_issues/actd/msat.pdf>. Internet. Accessed 16 November 2004.

_____. "MHS 2020 Focused Study: OOTW In the 21st Century–an MHS Virtual Community Of Practice." August 1998. Available from <http://www.hooah4health.com/toolbox/Library/ MHS2020OOTW21stCentury.doc>. Internet. Accessed 22 November 2004.

_____. "MHS Strategic Plan." August 1998. Available from <http://www.hooah4health.com/toolbox/Library/MHSStrategicPlan.doc>. Internet. Accessed 22 November 2004.

_____. *Transformation Planning Guidance*. Washington, D.C.: Secretary of Defense, Department of Defense, April 2003.

_____. *Use Of Investigational New Drugs For Force Health Protection.* DOD Directive 6200.2. Washington, D.C.: U.S. Department of Defense, 1 August 2000 current as of 24 November 2003.

Department of the Army. "The Army In 2020 Functional Area White Papers: Medical." n.d. Available from <http://www.fa-57.army.mil/refs/2020wh-pprs/Medical.pdf>. Internet. Accessed 1 December 2004.

_____. *Force Health Protection (FHP): Occupational and Environmental Health (OEH) Threats*. HQDA Ltr 1-03-1 Washington, D.C.: U.S. Department of the Army, 28 July 2003.

Department of Homeland Security. *National Response Plan.* Washington, D.C.: Secretary of Homeland Security, Department of Homeland Security, December 2004.

Doyle, Dennis D. *Tri-Service Medical Transformation – Time For a Unified Medical Command (USMEDCOM)*. Strategy Research Project. Carlisle Barracks: US Army War College, 7 April 2003.

Expédition Particulière Commemorative Cantonment Society. "Rochambeau's Instructions For Service In Allied Command." 3 September 2004. Available from <http://xenophongroup.com/mcjoynt/orders.htm>. Internet. Accessed 23 January 2005.

General Accounting Office. *Defense Health Care: Tri-Service Strategy Needed To Justify Medical Resources For Readiness and Peacetime Care*. Washington, D.C.: U.S. General Accounting Office, November 1999.

_____. *Defense Health Care: DoD Needs To Improve Force Health Protection and Surveillance Processes*. Washington, D.C.: U.S. General Accounting Office, 16 October 2003.

_____. *Defense Health Care: Force Health Protection and Surveillance Compliance Was Mixed, But Appears Better For Recent Deployments*. Washington, D.C.: U.S. General Accounting Office, November 2004.

_____. *Information Technology: Greater Use Of Best Practices Can Reduce Risk In Acquiring Defense Health Care System* . Washington, D.C.: U.S. General Accounting Office, September 2002.

_____. *VA and Defense Health Care: Evolving Health Care Systems Require Rethinking of Resource Sharing Strategies*. Washington, D.C.: U.S. General Accounting Office, May 2000.

_____. *VA and Defense Health Care: Potential Exists To Savings Through Joint Purchasing Of Medical and Surgical Supplies.* Washington, D.C.: U.S. General Accounting Office, 26 June 2002.

Ginn, Richard V. N. "Of Purple Suits and Other Things: An Army Officer Looks At Unification Of the Department Of Defense Medical Services." *Military Medicine*, vol. 143, no. 1 (January 1978): 15-24.

Godfrey, Larry J. *A Unified Medical Command: The Next Step In Joint Warfare Development*. Strategy Research Project. Carlisle Barracks: US Army War College, 10 April 2001.

Gouge, Steven F. *Combat Health Support Of the Transformation Force In 2015*. Strategy Research Project. Carlisle Barracks: US Army War College, 10 April 2001.

Hosek, Susan D. and Gary Cecchine. *Reorganizing the Military Health System: Should There Be a Joint Command?* Santa Monica: RAND, 2001.

Hunter, Richard W. and Benjamin R. Baker. *Report For the Secretary Of Defense On the Feasibility and Benefits To Be Gained From Creating the Defense Health Agency* [note re: DoD contract for Systems Research and Applications…]. Arlington, VA: Systems Research and Applications, 26 August 1983.

Institute of Medicine. Protecting Those Who Serve, Strategies To Protect the Health Of Deployed U.S. Forces. Washington, D.C.: National Academy Press, 2000.

Joint Chiefs of Staff. *Force Health Protection.* Capstone Document. Washington, D.C.: Joint Chiefs of Staff, 2004.

_____. *Doctrine For Health Service Support In Joint Operations.* Joint Pub 4-02. Washington, D.C.: Joint Chiefs of Staff, 30 July 2001.

_____. *Joint Doctrine Capstone and Keystone Primer.* Joint Reference Pub. Washington, D.C.: Joint Chiefs of Staff, 10 September 2001.

_____. *Joint Tactics, Techniques and Procedures For Health Services Logistics Support In Joint Operations.* Joint Pub 4-02.1. Washington, D.C.: Joint Chiefs of Staff, 6 October 1997.

_____. *Joint Tactics, Techniques and Procedures For Patient Movement In Joint Operations.* Joint Pub 4-02.2. Washington, D.C.: Joint Chiefs of Staff, 30 December 1996.

Joseph, Stephen C. "Speech–Planning For 21st Century Military Medical Readiness." 19 March 1995. Available from <http://www.defenselink.mil/speeches/1995/s19950327-report.html>. Internet. Accessed 6 December 2004.

Little, Bernard S. "Deployable Medical System Provides Care Under Canvass." 28 March 1987. Available from <http://www.dcmilitary.com/army/stripe/archives/mar28/str_care 032897 .html>. Internet. Accessed 27 December 2004.

McCarter, Mickey. "JMeWS." n.d. Available from <http://www.acq.osd.mil/actd/articles/JMeWS .doc>. Internet. Accessed 6 December 2004.

MacGregor, Morris J. Jr. and Robert K. Wright, Jr. *Soldier-Statesmen Of the Constitution.* Washington, D.C.: U.S. Army Center of Military History, 1987. Available from <http://www.

army.mil/cmh-pg/books/RevWar/ss/washington.htm>. Internet. Accessed 23 January 2005.

Metz, Thomas F. "View From the Top." Available from <http://www.pentagon.mil/home/articles/2004-12/a121504j.html>. Internet. Accessed 18 December 2004.

Murdock, Clark A. Michele A. Flournoy, Christopher A. Williams, and Kurt M. Campbell. *Beyond Goldwater-Nichols: Defense Reform For A New Strategic Era, Phase 1 Report*. Washington, D.C.; Center for Strategic and International Studies. March 2004.

Online Highways, Inc. "Historical Eras." n.d. Available from <http://www.u-s-history.com/pages/eras.html>. Internet. Accessed 16 March 2005.

Philpott, Tom. "Rumsfeld Team Retrieves Reins Of Military Medicine." Proceeding of the United States Naval Institute. Proceedings. August 2001, vol. 127, no. 8, pg. 90, 1 pgs (856 words). Database on-line. Available from ProQuest. Accessed 6 December 2004.

RAND. "The Military Health System. How Might It Be Organized?" 2002. Available from <http://www.rand.org/publications/RB/RB7551/>. Internet. Assessed 30 November 2004.

Rumbaugh, Jack R. *DoD Medical Unification: A Necessity For the Combatant Commander and Homeland Defense*. Strategy Research Project. Newport: US Naval War College, 13 May 2002.

Smith, Arthur M. "Joint Medical Support: Are We Asleep At the Switch?" *Joint Force Quarterly Online* Summer 1995. Journal on-line. Available from <www.dtic.mil/doctrine/jel/jfq_pubs/1908.pdf>. Internet. Accessed 6 December 2004.

Smith, William H. *Combat The Unified Quandary: Consolidation of the Navy, Air Force and Army Medical Corps*. Research Paper. Fort Leavenworth: US Army Command and General Staff College, 2003.

United States Army Medical Department. "Highlights In Army Medical Department History." <http://www.armymedicine.army.mil/about/history/highlights.htm>. Internet. Accessed 17 December 2004.

United States Special Operations Command (USSOCOM). *United States Special Operations Command History, 15th Anniversary Edition*. MacDill AFB, Florida: USSOCOM History and Research Office, 16 April 2002.

Welling, David R. "Interservice Cooperation Improves Medical Care For the Troops In the War Zone." *Army Times*. 7 June 2004, vol. 64, no. 46, p. 54.

Willetts, Peter. *Transnational Actors and International Organizations In Global Politics*. USAWC Readings: Volume I, Core Curriculum Course 2, Academic Year 2005. Carlisle Barracks: US Army War College, 2004.

Womack, David E. *Medical Engagement As National Security Tool A Prescription For Joint Doctrine.* Strategy Research Project. Maxwell Air Force Base: US Air War College, April 1999.