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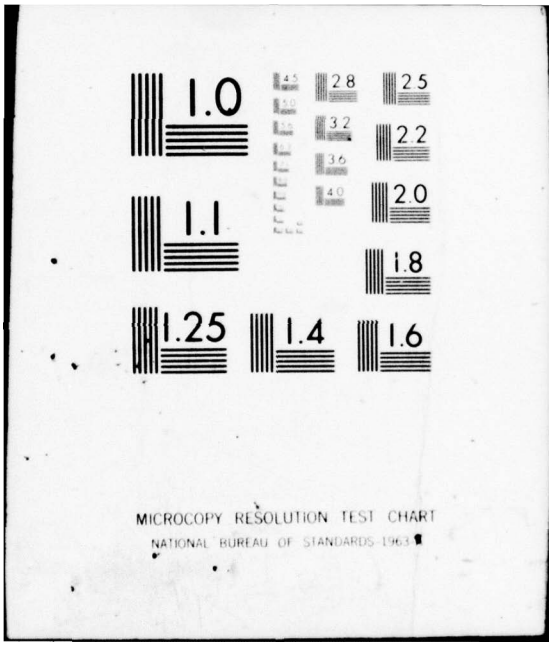
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STUDENT ESSAY

30 OCTOBER 1976

DENTAL SERVICE RESOURCES OF THE UNITED STATES ARMY RESERVE, THE CONCEPTS AND THE REALITY

BY

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REPORT DOCUMENTATION PAGE		READ INSTRUCTIONS BEFORE COMPLETING FORM
1. REPORT NUMBER	2. GOVT ACCESSION NO.	3. RECIPIENT'S CATALOG NUMBER
4. TITLE (and Subtitle) Dental Service Resources of the United States Army Reserve, the Concepts and the Reality.		5. TYPE OF REPORT & PERIOD COVERED Essay 6. PERFORMING ORG. REPORT NUMBER
7. AUTHOR(s) Blanch, William H., LTC		8. CONTRACT OR GRANT NUMBER(s)
9. PERFORMING ORGANIZATION NAME AND ADDRESS US Army War College Carlisle Barracks, Pennsylvania 17013		10. PROGRAM ELEMENT, PROJECT, TASK AREA & WORK UNIT NUMBERS
11. CONTROLLING OFFICE NAME AND ADDRESS Same		12. REPORT DATE 30 October 1976 13. NUMBER OF PAGES 26
14. MONITORING AGENCY NAME & ADDRESS(if different from Controlling Office)		15. SECURITY CLASS. (of this report) Unclassified 15a. DECLASSIFICATION/DOWNGRADING SCHEDULE

16. DISTRIBUTION STATEMENT (of this Report)

Approved for public release; distribution unlimited.

17. DISTRIBUTION STATEMENT (of the abstract entered in Block 20, if different from Report)

18. SUPPLEMENTARY NOTES

19. KEY WORDS (Continue on reverse side if necessary and identify by block number)

20. ABSTRACT (Continue on reverse side if necessary and identify by block number)

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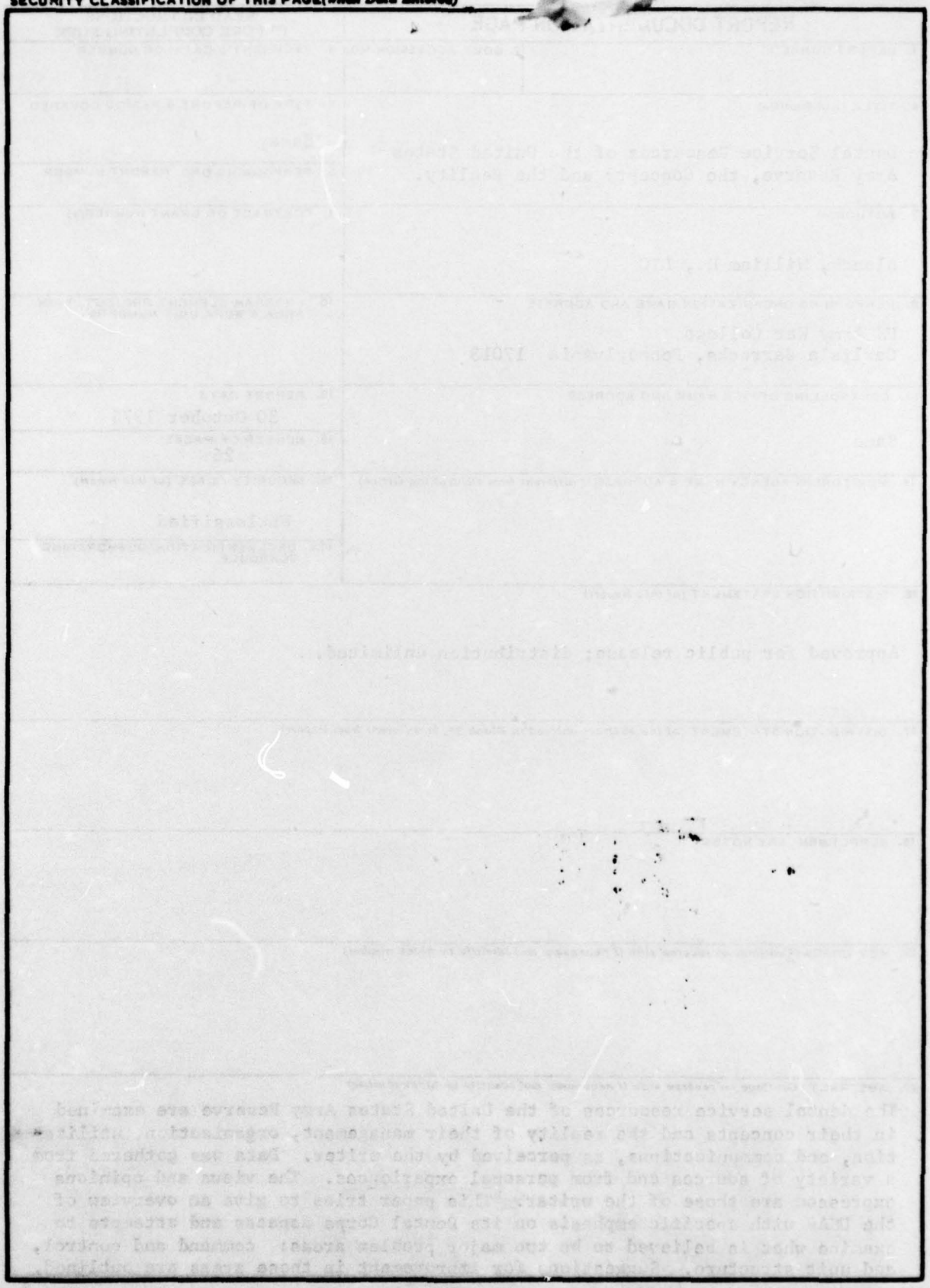


USAWC ESSAY

(6) DENTAL SERVICE RESOURCES OF THE UNITED STATES ARMY RESERVE: THE CONCEPTS AND THE REALITY

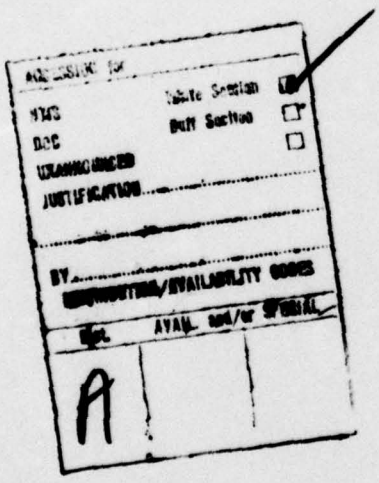
(9) Student essay,

by

(10) Lieutenant Colonel William H. Blanch
Dental Corps United States Army Reserve

(11) 3d Oct 76

(12) 30 p.



US Army War College
Carlisle Barracks, Pennsylvania
30 October 1976

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AUTHOR: William H. Blanch, LTC, DC-USAR.
Title: Dental Service Resources of the United States Army Reserve: The Concepts and the Reality
FORMAT: Essay
DATE: 30 October 1976 PAGES: 26

The dental service resources of the United States Army Reserve are examined in their concepts and the reality of their management, organization, utilization, and communications, as perceived by the writer. Data was gathered from a variety of sources and from personal experiences. The views and opinions expressed are those of the writer. This paper tries to give an overview of the USAR with specific emphasis on its Dental Corps aspects and attempts to examine what is believed to be two major problem areas: command and control, and unit structure. Suggestions for improvement in these areas are outlined.

DENTAL SERVICE RESOURCES OF THE UNITED STATES ARMY RESERVE: THE CONCEPTS AND THE REALITY

THE CONCEPTS

Described in Section 262, Title 10, United States Codes is the purpose of the Reserve Forces of the Army. That purpose is to provide the active Army with those trained units and individuals needed in time of war or national emergency and at other times as the national security requires.[1]

What the codes do not tell is what the best method of achieving this purpose should be. This essay will attempt to examine a small, but necessary, part of the US Army Reserves in its concepts and in its reality as perceived by one of its officers.

The role of the citizen-soldier can be traced to pre-Revolutionary War days. It is believed that the first recognition by law of the need for a ready reserve force was the Militia Act of 1792.[2] Another step was taken on 28 July 1866, when the President signed an act which defined the Army and established four infantry regiments composed of men wounded in service, constituting the Veterans Reserve Corps. The formation of the Army Medical Reserve Corps on 23 April 1908, marked the official beginning of a reserve of the United States Army. The National Defense Act of 1920 combined all reserve units into the Organized Reserve Corps. The present structure of the Army Reserve has been brought about mainly by the Universal Military Training and Service Act of 1951,

the Armed Forces Reserve Act of 1952, and the Reserve Forces Act of 1955. The actual term "United States Army Reserve " was designated in 1952.[3]

In virtually all past US wars, it was necessary to rely extensively on citizen-soldiers. It is true today, perhaps more now than ever because of the smaller active Army and no active Selective Service System. The importance of the Reserves has been aptly stated:

> "The 'Reserves' is a sleeping giant, as never before, the active Army needs the Reserves and the Reserves, in turn need us."[4]

The first law to conscript dentists for troop dental care in this country was passed by the Confederate States Congress at Richmond, Virginia, in January of 1864. On 3 March 1911, an act of Congress established a US Army Dental Corps of commissioned officers. The National Defense Act of 1916 permitted the immediate commissioning of dental officers and paved the way for a dental reserve for the Army.[5]

Since World War II the Army Reserve has undergone a series of dramatic revisions in an attempt to remain responsive to the needs of the active Army. This has not been altogether true of dental reserve forces. This essay will deal with only US Army Reserve dental units and personnel and what and where they are, how they are controlled and what they need. These dental reserve forces shall be referred to as the dental service resources of the US Army Reserve (USAR). Army National Guard dental resources

will not be considered.

The dental service resources of the USAR may be found in USAR units and the non-unit manpower control group. Dental re-resources of the USAR are combat service support. Dental officers of the US Army Reserve are classified into the Ready Reserve, Standby Reserve, and the Retired Reserve.

The Ready Reserve consists of individuals assigned to USAR troop program units and to the non-unit control groups of the USAR and the Individual Ready Reserve (IRR). Because all elements of the Ready Reserve are available for immediate mobilization in the event of war or national emergency, the largest share of available assets is expended toward increasing their readiness. Troop program units consist of members of USAR units who attend 48 paid training assemblies consisting of a minimum of 4 hours each and perform approximately 2 weeks of annual active training each year. The prevalent system in most units is to conduct multiple unit training assemblies (MUTA) consisting of one weekend per month. The training objective is that each unit attain company-level proficiency in its premobilization status. Members are gained primarily through unit recruiting efforts. Losses occur primarily for such reasons as expired term of service, resignation, and retirement. Dental units are usually attached to and commanded by larger medical units. Within the USAR, however, there is no uniform chain of command for dental units.

The Individual Ready Reserve (IRR) control groups have dental

resources in the Ready Reserve who are not members of an organized unit and are assigned to one of the control groups that are administered by the US Army Reserve Components Personnel and Administration Center (RCPAC). The control groups consist primarily of the mobilization designee(MOBDES), annual training (AT), reinforcement, and active duty obligation.

The mobilization designee (MOBDES), is a non-unit officer in a Ready Reserve status who is pre-selected, trained, and available to fill key authorized augmentation positions in selected active Army table of distribution units as required during early mobilization.

The other categories of the IRR are non-unit members who may or may not spend two weeks annual training (AT), or obtain retirement points for any reserve participation other than membership. The nature of these IRR categories is that the members are not required to be recalled for training, or it is very difficult to recall them if they are required and they do not desire to cooperate.

The Standby Reserve is the second category of the Army Reserve which has dental resources. Standby reservists are individuals who have completed all active duty and reserve training requirements or who have been removed from assignment to the Ready Reserve for cogent reasons. They may not be ordered to active military service or reserve training unless a national emergency is declared. Standby reservists are not required to participate in an

active reserve program, however, in certain cases they may participate in non-unit programs for retirement points.

The Retired Reserve has dental resources consisting of individuals who are eligible and requested transfer to the Retired Reserve. Included are those individuals who have completed 20 or more qualifying years of reserve and/or active service for which retirement benefits are not payable until they are 60. In addition, dental officers who are retired after completing 20 or more years of active Federal service are, by statute, members of the Retired Reserve. Regular Army enlisted men retired after 20 years, but less than 30 years of service, are transferred to the Retired Reserve of the Army Reserve until they have completed 30 years of service. Members of the Retired Reserve are not provided any form of training and are not available for military service except in time of war or a congressionally declared national emergency.[6]

All dental Army reserve troop program units are commanded by Forces Command (FORSCOM) through the continental US (CONUS) armies. Included in these are 55 TDA medical and dental units which are not "tactical" units. They have CONUS missions and upon mobilization are commanded by the US Army Health Services Command (HSC).

Although not in the reserve chain of command, HSC is affiliated with dental reserve resources. HSC has shown a deep, sincere, and continuing interest in the training and the utilization of dental reserve resources. The role of the US Army Health

Services Command in the reserve field is one of coordination and training support, to assist the Commanding General, US Army Forces Command, in his mission of attaining maximum readiness posture for the US Army Reserve and National Guard.[7]

Regulations require that all USAR units be assigned to either an Army Reserve Command (ARCOM) or to a General Officer Command (GOCOM). Some medical GOCOM's include hospitals and dental units. The ARCOM, authorized a major general as a commander, is an organization that has command of Army Reserve units located in a specific geographical area and that reports directly to a CONUS army. Some GOCOM's are assigned to an ARCOM, and others are independent of ARCOM's. Units not reporting directly to a CONUS army and which are spread across ARCOM and/or Army boundaries are commanded by the CONUS army in which the ARCOM headquarters is located.

The primary sources of dental officers for the Army Reserve are prior service officers and direct appointments. Dental officers of USAR troop program units, if militarily educationally qualified, are either mandatorily promoted or selected for promotion by virtue of an authorized unit vacancy that exists for the higher rank. Mandatory promotions are based on time in grade or years of commissioned service, whichever occurs later. Mandatory promotions are through the rank of Lieutenant Colonel. When a unit has an authorized vacancy in a given rank, the unit commander may submit recommendations for the unit promotion. Unit pro-

motion includes that of Colonel. Non-unit members of the Army Reserve may achieve only mandatory promotions. There is no General Officer position within the USAR dental troop program units. There is one General Officer (MOBDES) assigned to the Surgeon General's office as a Deputy Assistant for dental services.

THE REALITY

Since the 1973 reorganization of the Army, which resulted in a realinement of the Army Medical Department and the establishment of the US Army Health Services Command, significant progress has been made in improving the readiness training of USAR dental units. At the same time, utilization of these units which augment the capability of the active Army to accomplish its mission of dental care delivery has also been enhanced. The active Army reorganization, however, did not change the command and control of the Reserves, and much more can and needs to be accomplished in this area. While it seems to be generally accepted that some USAR dental units are best utilized as tactical forces and properly assigned to FORSCOM, this may be an unrealistic concept and will be considered further in this paper. The dental Reserves function for the most part with Table of Organization (TOE) type units. These units are not flexible and their chain of command, to say the least, is as complex and burdensone as it is varied and fragmented.

Dental training, if it is to be realistic, effective, and

maintain interest, is best accomplished in a patient-care arrangement. MSC, along with the Army Readiness Regions and Groups, has made much headway in fulfilling this responsibility, yet much remains to be accomplished.

There are, however, some major impediments to the complete realization of the advantage of joint readiness and utilization concepts. These impediments have to be defined and removed in the interest of maximizing the opportunities that are available. The dental resources of the USAR need improvement in two major areas: (1) Their command and control and (2) their unit structure.

Command and Control

The command and control of USAR dental resources is fragmented among a variety of headquarters, with no standard pattern. It frustrates policies unique to dental resources with obvious adverse effects on morale, recruitment, retention, and readiness.[8] The command and control presently utilized manifests a lack of direction in priority especially to the dental units, which are usually smaller units at lower levels.

There are approximately 61 dental units with approximately 669 dental officers and 1342 enlisted personnel in the US Army Reserve. Approximately another 300 dental officers are assigned to USAR hospitals and/or medical-type units. There are approximately 1673 non-unit dental officers assigned to RCPAC.

FORSCOM controls 45 per cent of these dental resources.

Within FORSCOM there are 19 ARCOM's, 9 GOCOM's, and other commands. No two of which report alike, have a similar organization, or even manage their resources in the same way.[9] As a consequence a situation exists in which no single command is responsible for the training, management, planning, and mobilization of dental service resources available to the United States Army in peacetime or in time of emergency.

The largest volume of routine dental treatment for troops in the combat zone is performed by area support units. Centralized control of dental resources is essential to the needs of combat units.[10] In the Reserves, with regard to dental units and resources there is no centralized control. Dental resources within the Reserves are a valuable and diminishing resource. Dental resources should be consolidated under a single command that allows for the most efficient management and utilization of them. Dental resources and operations are becoming increasingly more complex and more expensive. The leadership and guidance and decisions required need specific dental knowledge and experience.

> "You can't choose the optimal way or even a good way without knowing about the alternatives and what the alternatives might achieve and what they would cost."[11]

Channels of communications between appropriate dental commanders of the USAR and between USAR commanders and their appropriate counterparts in the active Army are not clearly established. This hampers the achievement of affiliation that is possible among the dental resources. It interferes with the provision of advice and

assistance in issues that are unique to dentistry, and it complicates unnecessarily, the scheduling, training, and utilization of these resources.

The importance of this communication and its resulting feedback to the development and growth of dental service resources of the reserves should not be overlooked or underestimated. It is a very important reason for a more responsive dental command and control system. As Robert McMurry has stated:

> "For communication to be effective it must be two-way: There has to be feedback to ascertain the extent to which the message has actually been understood, believed, assimilated and accepted."[12]

Any realinement of command and control of USAR dental resources force structure must enhance the overall objective of improving both individual and unit readiness. Dental problems impacting on training and readiness, as well as the whole gamut of administration and operations would be best advanced through dental channels, not through the present maze of channels.

Dentists in the Army Reserve are fully trained professionals, and they have learned a method of communicating which, although continued in the Army, was not learned in the Army, and extends beyond the Army, and is uniquely dental. This axiom was recently recognized again in the active Army and resulted in the establishment of the Director of Dental Services Concept, and a more responsive dental chain of command. It is a well known principle that "espirit de corps" depends on leadership and in this case, leader-

ship needs specialized dental knowledge to be effective. If this "espirit" is not revitalized and engendered, the dental resources of the USAR have a dark future ahead.

USAR dental resources are not aligned to provide dental command and control in the management of dental resources. In many instances in the reserve structure, medical commanders, for instance, are assigned dental units, which are the unwanted children of their medical family, and treated as such by being simply tolerated and given resource leftovers. The only advantage derived from these units to non-dental commanders is the command stature is enhanced by the greater number of units and/or personnel assigned or attached.

Over the years, by department regulations and/or public law, dental corps officers have had varying degrees of command and/or control of dental resources dependent on the primary mission of the specific military department.[13] In the Army Reserves, a dental chain of command has been nil. The dental commanders and staff officers must use frustrating channels to accomplish anything.

Reserve medical officers, in particular, have all they can do to manage medical resources and problems, and that is an awesome responsibility. It is a great disservice to them and to the dental resources to further burden them with dental resources and their problems, with which they are not knowledgeable, and even if they were, would have little time for. This is not meant as a

criticism of medical commanders. By the nature of their assignments and responsibilities, they have their priorities and consequently cannot adequately judge dental resources and their priorities.

Placing dental resources in a medical chain of command often results in the physician and dentist occupying adversary roles. This does not serve the best interests of either, or for that matter, the Army in general. A separate chain of command, at least at the lower and intermediate levels, for both these disciplines would contribute to greater cooperation between physician and dentist as colleagues rather than adversaries.

This lack of a dental chain of command is a constant complaint of both active and Reserve dental officers,[14] and steps should be taken to improve the situation in the Reserves, as it has been in the active Army. It is especially frustrating in the USAR, because of the limited time available to Reservists to accomplish anything.

There is little doubt that the structure of the Reserve forces and the caliber of the people that man it is going to determine the success or failure of the Reserve components.[15] Improvement will not be accomplished by piecemealing dental units throughout Forces Command, without a uniform and responsive dental management system. Only dental officers can best understand where military dental problems exist, and most importantly, the best means of correcting them. Too few of them in the Reserves are getting both the clinical and administrative training and experience necessary.

Fewer still have the military command and management interests, and more importantly, command and management abilities. The present system is frustrating to those who have these interests and abilities, and discourages many who might otherwise aspire in this direction.

The establishment of area dental command and control units under one command, similar to the Navy system, would permit the immediate response to the needs of the active Army and the training activities that they serve, while at the same time reducing the layering and administration and fiscal burdens of existing command channels.[16] It would allow a more effective and efficient use of dental resources available to the Army in peace and war.

Unfortunately the nature of the Reserve system at the present time makes this a difficult, but not impossible, task. Reserve units are located geographically, usually in large cities. Most have been in the same locations for many years. This geographic inflexibility needs further consideration and study beyond the scope of this paper, for it limits many who would otherwise participate in Reserve activities if they were more geographically available, and it removes some officers from unit command position consideration because of geographic ineligibility. This inflexability thus manifests itself in command and control, and might be overcome, to a degree, by an expanded MOBDES program and greater utilization of the MOBDES officer in management. Presently commanders are selected primarily because of their geo-

graphic availability rather than their ability.

It is fundamental that dental resources of the Reserves should be more directly controlled by the active Army Dental Corps, and through HSC rather than FORSCOM with a specific dental chain of command. It is here that the expertise lies. If the dental resources of the Reserves are to be truly responsive in a timely and efficient manner, this reorganization should take place.

Properly trained dental officers will then have the authority and the responsibility to manage dental assets, so they can evaluate, improve, and make timely redistribution of resources within a reasonable period when required. In the military there is no substitute for command. If dentists must bear the responsibility for dental resources, they must also have the authority of command to manage dental resources. There are no panaceas for the problems of the Reserves, but a uniform dental Reserve organization, with dentists given both the responsibility and authority for their own assets is a step in the right direction.

Further, if dental Reserve units are under dental control, they can be more accurately evaluated as to their capabilities and requirements. Reserve dentists would be more responsive to their peers and the effectiveness and potential of performing assigned mobilization missions could be more effectively accomplished. Training programs could be enhanced. Dentists would be more likely to remain in the Reserve programs.

The Unit Structure

The second problem area is the Dental Table of Organization and Equipment (TOE) Unit, which is authorized and sometimes given expensive equipment that is rarely utilized, difficult to store and maintain, and rapidly becomes obsolete. The units themselves are difficult to adapt to Reserve resources and to the new modular training concepts. It is unrealistic to expect the average dental Reserve unit to be equiped with field dental equipment, weapons, vehicles, and the sundry equipment their TOE calls for, and effectively utilize, store, and maintain this equipment to prescribed Army standards.[17] To my knowledge, in peacetime no active Army dental unit does this. Tactical active Army dental units are in garrison status and are not fully equiped for tactical missions. A cost/benefit analysis with regard to the best means of providing equipment to individual dental Reserve units is surely indicated.

Field training for all USAR dental units could best be accomplished by assigning the dental resources periodically to field or maneuver areas with field dental sets and necessary equipment available at the active Army site that would be utilized. In other words, bringing the dental resources to the equipment in a field environment for training is more realistic and effective than giving a dental unit a single field set or two. This would also adapt better to modular training, although in a field situation unit integrity should be maintained whenever possible.

The dental Reserve unit of the future should be a flexible general puspose Table of Distribution and Allowances (TDA) Unit with multiple capabilities, garrison or field, which can be utilized, staffed, and distributed totally or in part, or in conjunction with other dental resources. A modular unit, could be expanded or contracted to suit the mission and resources. In training status it has no expensive equipment to store and maintain, and its administration can be kept to a minimum. The units would have a uniform, but flexible TDA, and general purpose missions, and could be tailored to resources available in training and to any assigned mission when mobilized, utilizing to maximum advantage the distribution of dental resources available in the USAR. A modular TDA dental unit could be designed to accomodate the various dental specialities, both clinical and management, to maximum advantage to the Army. This type of unit is more adaptable to the modular training concepts for dental Reserves now being implemented. The hallmark of this type of unit would be adaptability to changing situations.

> "What is so different today is not the fact of change, but the rate of change. The world is changing so rapidly that it is no longer possible even to train for given situations - people must be educated to cope with whatever changes may occur."[18]

In summary, future Reserve dental units would not necessarily be exact copies of active Army TOE units, but uniform, planned units for the Reserve dental resources, managed, trained, and when necessary, employed to take the best possible advantage of

available dental resources. It is time we planned in the Reserves to make our units make the maximum use of available resources. These units could be designed to accept IRR dental members by attachment, avoiding wasting valuable dental resources attached to non-dental units or in the non-participating IRR.

The dental resources of the IRR is rapidly declining in strength. No really good solution has been found.[19] Affiliation with dental units might be of some help to IRR retention. IRR dental resources could be attached to specific units to attend at their convenience both active and inactive training, avoiding all or no Reserve participation choices. If all the dental resources of the USAR can be integrated with themselves and the active Army and developed to their best potential, recognizing at the same time that they are civilian soldiers and more closely relating their professional interests in both the civilian and the military, the sooner we can reach desired goals.

Obtaining dentists in time of emergency should not prove difficult. Time is the critical factor, so is the necessary framework to accomodate them. Selective service systems can be utilized effectively to obtain dentists. Taking a civilian dentist from a peacetime dental chair and placing him at a wartime dental chair does not require a major adjustment for the dentist, his adaption to military life, however, might require an adjustment. It is here that command and control, leadership by the dentist with whom he serves, is most important. The organization and management of

dentists collectively, in the best interests of the Army, does require a trained cadre of professionals, both Active and Reserve, who speak the "Army language" as well as the "Dental language", who will effectively mobilize and administer the entire operation in the shortest possible time.

AN APPRAISAL

It is unrealistic to expect Reserve component dental units to deploy in less than 30 days. It is folly to predicate mobilization or war plans on this premise. It is further unrealistic to expect Reserve components to accomplish this objective in 39 training days a year or less.[20]

The Army should realize that there is no need for every unit, especially dental units in the Reserves to obtain C-1 readiness. Vast differences in attitude and interest exist between the average Reserve and active Army dentist, and even wider differences exist between dentist and non-dentist. With the active Army dentist, military life is his only life, his principal occupation, while the Reserve dentist has a more limited regard for the Army's needs and is chiefly concerned with other matters by necessity. There is no doubt that the dental resources of the USAR has a great many highly dedicated members. For most dentists, even when they are highly dedicated to the Army, Reserve participation means a loss of income and leisure time. If the Reserves are to keep good people, rely upon them in time of great need, improve-

ments in the Reserve dental structure must be made. These people are the very people the Reserves need most and can ill afford to lose them.

The Congress has recently passed legislation which gives the President authority to order up to 50,000 Reserve unit members to active duty for 90 days without a declaration of war or national emergency. Should a national emergency be declared, the President can then call up to nearly one million Reservists and hold them for two years. In my view, it is more likely that dental units would be needed far more in the latter than the former situation. However, declaring a national emergency is considered a massive response and occasions are envisioned where the US might wish to increase its defensive capabilities or respond more limitedly to minor emergencies. Without this authority the President and Congress are left with only three alternatives: declaring war, declaring a national emergency, or relying on volunteers.[21]

In the event of actual combat activities involving US forces, the active Army, rather than the Reserves would have to bear the initial burden. The role of the Reserves, in that case, would be to support the active duty forces. It is unlikely that dental units would initially be in high priority. If a continued mobilization were necessary, more than 90 days, dental resources would play a greater and greater role as the number of forces increased. In response to a major contingency, and as a possible step to full mobilization, effective and timely dental service resources will

surely be needed. Initially, in either instance, Reserve dental resources would best be utilized by replacing active Army units deploying from the United States.

If tactical dental units are indispensible to the Force structure of the Army for 90 day contingencies, they should be active Army units not Reserve units. This is not to state that Army Reserve dental units could and would not be used tactically. It is simply that it will take longer to make most dental Reserve units operationally proficient in this area.

The opinions and views expressed in this paper were derived in the light of my experiences, interest, and research. Some impressions are validated by this experience, other impressions may be colored by a lack of the overall perspective. In either case, opinions and views put forth seem germaine to the issues today. Tomorrow, with more experience and further knowledge and a greater perspective, they may be subject to alteration, revision, and change. Change seems always with us, yet it is rarely accepted without misgivings. All organizations seem to share common problems. In the military, especially in the Reserves, we seem to lack a common valuation for objectives and resources. Perhaps we try too closely to emulate the active Army, without realistically judging our capabilities. Without a common value, we have to use one of two weaker maxims; maximize objectives for the given resources or minimize resources for given objectives. These are hard choices. Resources are rarely adequate to the objectives,

emphasizing the importance of proper management.

Alterations in military management and structure are slow, complex, and usually controversial. To effect changes requires the alteration or addition of new military activities, and the adjustment of the old service programs. It often, as in this case, requires changes in service concepts and doctrine. In all it requires time.[22] In reality, as Ginzberg and Reilly have said, "It is never an event but always a process."[23]

WILLIAM H. BLANCH
LTC DC-USAR

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