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OPERATION DESERT STORM

Full Army Medical Capability Not Achieved

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Madam Chairman and Members of the Committee:

We appreciate the opportunity to be here today to discuss the Department of the Army's ability to provide medical support for Operation Desert Shield/Desert Storm. We plan to more fully address the issues discussed today in a report to be issued later this year. Our work was based on visits and interviews with medical personnel from units that deployed to the Persian Gulf, observations of senior Army and theater medical officers, and reviews of Army "after action" reports.

BACKGROUND

To support the combat forces of Operation Desert Shield/Desert Storm, the U.S. Army deployed 198 medical units, such as hospitals, air and ground ambulance companies and detachments, logistic support units, and special surgical teams. The size of the hospitals ranged from 60-bed Mobile Army Surgical Hospitals to a 1,000-bed General Hospital. These units were in addition to the medical aides and battalion aid station staff of the individual combat divisions.

Army medical units deployed to the Persian Gulf area in two phases. The first, to support the XVIII Corps, began to deploy in August 1990 and consisted of active duty units. The second phase, to support the VII Corps and an echelon above corps, involved active duty units from Europe and Reserve and National Guard units from the United States. This deployment began in November 1990. Approximately 55 percent of the Army medical forces deployed to the Persian Gulf were Army Reserve and National Guard units, while the remaining 45 percent were active duty units. According to an Army report, during the 6 months of the buildup the Army deployed a larger medical force than the peak medical deployment to Vietnam.

SUMMARY OF RESULTS

The Army had to overcome numerous and significant problems to make medical units operational in the Persian Gulf before the start of the ground war. The personnel information systems used to identify doctors and nurses for assignment to active units contained incomplete and outdated information. Many of the doctors and nurses who were scheduled to deploy could not do so for a variety of reasons. The units' peacetime status reports did not adequately reflect this condition.

Many doctors and nurses in active, Reserve, and National Guard units had not trained during peacetime to perform their wartime mission. Field training was lacking and as a result doctors and nurses were not familiar with their unit's mission or equipment.

The Army also faced equipment and other logistical support problems. Even with a massive effort to field equipment and supplies to hospital units, hospitals did not receive equipment and supplies or received only partial shipments. Shortages of transportation and material-handling equipment limited the mobility of hospitals. In some cases, hospitals were able to move only a portion of their surgical capability and bed capacity in order to keep up with highly mobile combat divisions. Evacuation of casualties was hampered because of long distances, poor communications, and a lack of navigational equipment.

By most accounts, the Army was able to provide adequate care for those soldiers in need. However, had the predicted number of casualties occurred, had the ground war started earlier, or lasted longer, the Army would not have been able to provide adequate care.

AUTOMATED INFORMATION FOR ASSIGNING MEDICAL PERSONNEL INCOMPLETE OR OUT OF DATE

During peacetime, units are required to ensure that U.S. Forces Command, the commanding organization for all active duty combat forces in the continental United States, is kept aware of their wartime needs for medical personnel. Forces Command is responsible for validating and monitoring units' needs and forwarding information on these needs to Health Services Command, the commanding organization for all medical units. Health Services Command operates the "Professional Officer Filler System" (PROFIS), which is the Army's automated system for identifying active duty doctors and nurses for assignment to units in the event of war. Because the units, Forces Command, and Health Services Command were not following these procedures, the information in the system was incomplete and out of date. The Army therefore, could not provide all the doctors and nurses within 72 hours as required.

During the first phase of deployment in August 1990, this system should have enabled the Army to identify and assign 100 percent of the doctors and nurses for the 40 active medical units, but it could identify only 46 percent of them. This failure in the system occurred because (1) units had not updated their requirements, (2) Forces Command had not properly validated and forwarded these requirements to Health Services Command, and (3) Health Services Command had not ensured that the information in PROFIS was complete or kept up to date. To compensate for these failures, Health Services Command had to scramble to locate and assign 54 percent of the doctors and nurses required by these units.

In the second phase of deployment, when the Army began to deploy medical units from the VII Corps in Europe, it experienced similar problems. While the U.S. Army, Europe, is required by

Army regulations to use PROFIS, it did not do so, preferring instead to use its own "personnel augmentee" system. The information in this system, however, was similarly out of date and one third of the personnel designated by the system to fill needed positions were no longer in theater. As a result, the U.S. Army, Europe, used medical specialty consultants to identify 236 active duty doctors and nurses for assignment to the units, enabling them to deploy.

PERSONNEL WERE NON-DEPLOYABLE

Many doctors and nurses assigned to medical units were non-deployable for Operation Desert Shield/Desert Storm. For example, 329 of the 778 active duty personnel identified by PROFIS did not deploy with their assigned unit. Similarly, when Army Reserve and National Guard units reported to their mobilization station, the Army found large numbers of non-deployable personnel.

Active duty, Reserve, and National Guard personnel were non-deployable for a variety of reasons:

-- Their physical conditions were unacceptable. In one case, a surgeon who had retired from private practice reported to his mobilization station unable to stand for more than 30 minutes. Another surgeon reported with Parkinson's disease. In both cases, the surgeons had been reported as filling authorized slots.

-- Their skills were not current. Some doctors reported to their mobilization station after they had been in teaching positions and were no longer qualified in their field of specialty. They had to be replaced before the units could deploy.

-- Their skills did not match specialty requirements. A Reserve Thoracic Surgeon Team mobilizing at Fort Carson, Colorado, is one example of a unit that did not have the required skills. Surgical teams are small and specialized and designed to join a hospital in the field to augment the unit's surgical capability. Total requirements for this unit were seven personnel, including two thoracic surgeons. However, when the unit arrived at the mobilization station, it had no thoracic surgeons and was commanded by a gynecologist filling one of the two thoracic surgeon slots. According to the Fort Carson Mobilization team this physician admitted that he was not qualified for the position he was filling and, in fact, "the only chest he had opened was in medical school and belonged to a goat." Without thoracic surgeons, the unit could not perform its mission and was not deployable. The mobilization team was subsequently able to transfer one thoracic surgeon into the

unit so it could deploy. Although a second surgeon was to join the unit in theater, the unit never received a second surgeon.

-- Officers had not taken the required basic training. This unanticipated training deficiency forced the Army to condense a legislatively required 12-week course for officers on basic soldiering skills to a 2-week course. Since the officers could not deploy without having taken the course, the Army conducted this condensed course to enable critically needed medical personnel to deploy. An Army "lessons learned" report stated that 1,600 medical officers had not taken the officers' basic course and, therefore, were initially non-deployable.

-- Their medical training was incomplete. Some doctors reporting to their mobilization station could not deploy because they were still in residency programs. For example, a National Guard unit arrived at its mobilization station with 13 of its required 15 doctors. However, 10 of the doctors were still in residency programs. Without transfers of doctors from other units, the unit would have been unable to perform its mission.

-- Their positions were in excess of unit requirements. Reserve and National Guard hospital units that mobilized for Operation Desert Shield/Desert Storm had many excess personnel assigned that were not needed to carry out their mission. Excess personnel consisted of those individuals who were above authorized levels for various positions or those who were not authorized to the unit, such as cannon crewmembers or infantrymen. Our analysis of the most current Reserve Medical Management Information System report available at the time of mobilization for 28 Reserve and National Guard hospital units, revealed that of the 10,600 personnel assigned, 2,100 were in excess of authorized levels for individual skill positions and about 1,200 were not authorized. While these statistics were as of September 1989, the situation appears to have been relatively unchanged during mobilization for Operation Desert Shield/Desert Storm. For example, a National Guard Evacuation hospital reported to the mobilization station with 58 personnel either in excess of authorized levels or not authorized to the unit.

UNIT STATUS REPORTS DID NOT ADEQUATELY REFLECT PERSONNEL DEFICIENCIES

Periodic reporting by medical units in peacetime did not accurately reflect the status of personnel in the units. Unit commanders must reflect in their unit status reports any personnel deficiencies that could affect mission capability.

These deficiencies are to include personnel shortages, shortages of critical skills, and training needs. In many cases, however, the commanders had not reported these deficiencies, and managers and decision makers, therefore, did not know the actual status of the units. As previously stated, many Reserve and National Guard units arrived at the mobilization stations with large numbers of non-deployable personnel; consequently, the Army had to transfer the needed personnel from other units. This was the case with the Fort Carson thoracic surgeon team, which was selected for mobilization based in part on its reported 100 percent personnel strength. If the unit status reports for this and other units had been accurate, the Army might have either not mobilized that unit or had the required personnel at the mobilization station when the units arrived.

MANY PERSONNEL NOT TRAINED FOR WARTIME MISSIONS

Many doctors and nurses in active, Reserve, and National Guard units had not been trained during peacetime to perform their assigned wartime jobs. In addition to lacking basic soldiering skills, as previously mentioned, many doctors and nurses had not participated in field training and were not familiar with their unit's mission or field equipment. In peacetime, Reserve and National Guard units are required to train on designated weekends and during a 2-week training exercise. However, during these weekend drills and annual training exercises, many Reserve and National Guard doctors and nurses are assigned to Army hospitals to supplement hospital staffing. Doctors and nurses in the active units are assigned to Army hospitals during peacetime.

As a result of this lack of training with the unit, according to the Army Central Command Surgeon, doctors and nurses were unfamiliar with the equipment and supplies in the field hospitals, known as Deployable Medical Systems (DEPMEDS). In many cases, doctors and nurses preferred to use equipment and supplies that they were more familiar with rather than the equipment and supplies that were part of the DEPMEDS. The Army agreed to provide the equipment and supplies that met the individual physicians' preferences.

Another impact of this lack of training was that many of the physicians did not understand the missions of the units they were to join. A physician's peacetime mission is to provide care at a medical activity or center to active duty personnel, their dependents, and retirees. In meeting that mission, the physician provides comprehensive treatment until the patient is discharged from the hospital. Typically, physicians joining forward deployed units did not understand that their role was to stabilize the patient so that the patient could be evacuated to the rear where more intensive care could be provided. The Army Central Command Surgeon stated that this misunderstanding had the greatest impact on Mobile Army Surgical Hospital and Combat

Support hospital units, where, if it were left to the physicians, all beds would have remained occupied, diminishing the unit's ability to treat incoming patients.

In addition, 10 hospital units were scheduled to operate DEPMEDS sets having never trained on the equipment. Prior to the war, these units had been assigned older equipment. Consequently, the Army established an 8-day "crash" course to teach units how to operate a DEPMEDS hospital. However, the course taught little except how to assemble the hospital's tents. This course was given to four units in theater, and the remaining units were taught at the mobilization stations.

EQUIPMENT, SUPPLY, AND LOGISTICS ISSUES

Older Hospitals Were Ineffective

The first hospital units that were operational in theater set up older hospital equipment. Shortly thereafter, the Army found that these hospitals' tents could not withstand the sand and wind storms. Further, the temperature in the tents could not be brought below 100 degrees, a temperature too high for medical care. The Army decided to replace older hospital sets with DEPMEDS.

Some New Hospitals Were Never Fully Equipped

All DEPMEDS sets stored for emergencies were short some critical equipment. For example, of the 19 hospital sets deployed from storage facilities in Europe, the average set contained only 60 percent of its required equipment, with one set having only 28 percent. Missing equipment included X-ray equipment, ventilators, defibrillators, dental equipment, and electrocardiograph monitors. Officials of the Army Medical Material Agency, which is responsible for managing the DEPMEDS and Army medical equipment and supply, said that they had been aware of the shortages in the DEPMEDS sets and that the missing equipment was to be sent to the units in theater in what was called "ship short" packages.

Some hospital commanders, however, complained that their units either received their missing equipment late or never received it at all. One commander told us that some of the equipment his unit received in the ship-short package was incompatible with the unit's DEPMEDS set. Army officials told us that equipment was missing or incompatible with the DEPMEDS sets because the ship-short packages had not been matched up with the DEPMEDS sets for which they were intended.

Limited Medical Supplies Delayed Mission Capability

Army hospital units deploying to the Gulf were directed not to procure medical supplies prior to deployment because they would be furnished in theater. A 10-day initial supply of potency and dated items was to be shipped to each unit in theater. However, some units received packages that contained only 3 days supply of critical items such as narcotics, anesthesia, antibiotics, and X-ray film, and other units received none. Many of these supplies were not received by the hospitals until just days before the ground war started.

In-theater Supply Centers Did Not Operate According to Doctrine

Army medical supply centers in the Persian Gulf could not adequately respond to the medical supply demands of in-theater units. The doctrinal mission of these supply centers is to serve only as a resupply point for Army medical units. But during Operation Desert Shield/Desert Storm they were also required to act as the initial supply points for Army medical units and as resupply points for the Air Force, Navy, and Marine Corps medical units. These new requirements were extensions of the centers' basic mission, and the centers were neither trained nor equipped to adequately respond to the additional demands.

Another problem faced by these supply centers was the lack of supply discipline on the part of the units. Because of the uncertainty as to when a unit might have to provide services, some medical units hoarded supplies and requisitioned excess quantities from the supply centers. Hoarding was particularly prevalent among units that arrived in theater first and resulted in some of the later-arriving units not being able to obtain their authorized level of supplies. For example, hospitals arriving first were instructed to carry enough supplies to last 15 days, but some units requisitioned additional quantities and eventually obtained more than 30 days of supplies. One unit was found with 120 days of supplies.

Movement of Supplies Was Difficult Because Transportation Was Unavailable

The supply centers also had difficulties in transporting supplies. An Army-wide shortage of trucks made it difficult for the centers to obtain the supplies after they arrived in country. One center commander said that even when supplies arrived in-theater, it would take 3 weeks to obtain transportation to move them to the centers. This lack of transportation also impeded the distribution of supplies to the units.

DEPLOYED HOSPITALS COULD NOT OPERATE ACCORDING TO DOCTRINE

Some hospitals could not perform their doctrinal mission because of a lack of mobility. As a result, only portions of these hospitals' bed capacity and surgical capability were moved forward when the ground war started. For example, the 60-bed Mobile Army Surgical Hospitals are expected to move with the combat units and operate in the rear combat areas. To do this the hospitals are designed to be 100 percent mobile. However, because of the speed of the battle and the shortage of trucks and materiel-handling equipment, some Mobile Army Surgical Hospitals took only a portion of their bed capacity and surgical capability in order to be in position to provide surgical support early in the ground campaign. According to Army reports, over 40 percent of the bed capacity of these units was left behind the line of departure.

PROBLEMS WITH PATIENT EVACUATION AND REGULATION

During Operation Desert Shield/Desert Storm problems arose in the effective use of ambulances and in the evacuation of patients. Ground ambulances could not be used as much as planned because of the rugged terrain, lack of navigational equipment, and the distances between hospitals and the front lines. Even the air evacuation units were taxed by the distances from pickup points to the hospitals. The long distances required frequent refueling, and the crews had trouble locating fuel points. Some air ambulances reported landing next to tanker trucks, tanks, and Bradley Fighting Vehicles to ask for fuel or for directions to the nearest fuel supply.

Medical regulators are to manage the evacuation of casualties so they are taken to the hospitals where they can receive the best treatment and hospitals are not over or under used. During Operation Desert Shield/Desert Storm, however, the medical regulators were unable to perform their mission because of a lack of proper communications equipment. The radios they used had an operating range of only 15 miles, whereas the corps area was about 250 miles deep and 100 miles wide. Medical evacuation units were operating with similar equipment and, therefore, could not communicate with the regulators or the hospitals. One air ambulance crew reported that after picking up casualties, it flew directly to a hospital and during the trip flew over enemy tanks and infantry. They stated that if it had been a "shooting war," the company would have lost all of its aircraft and aircraft crews because they could not be given directions to fly over friendly territory. To overcome the lack of communications equipment, the VII and XVIII Corps had air ambulances making repeated round trips between a designated forward collection

point near the battlefield and a drop-off point in the rear near hospitals.

The inability of the medical regulators to manage the evacuation of patients could have led to an inefficient use of hospital beds since ambulances took patients only to the hospitals whose locations they knew. The unmanaged evacuation system could have led to the under use of some hospitals while others would have been overwhelmed--a potentially tragic situation if the numbers of projected casualties had occurred.

CONCLUSION

In conclusion, Madam Chairman, the Army is aware of the issues we discussed today. In some cases the Army has started initiatives to deal with the issues. We believe that key to an efficient operation is more aggressive management attention and not necessarily more money. Specifically, the Army must

-- establish effective controls to ensure more accurate and complete information in PROFIS;

-- establish controls to ensure that commanders accurately report the personnel conditions of their units;

-- require realistic mission-related training for its medical corps, including doctors and nurses;

-- review established doctrine regarding who Army theater supply centers are to support; and

-- ensure that the doctrine for employing battlefield hospitals and evacuation units is consistent with the battlefield of the future and sufficiently resourced to get the job done.

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Madam Chairman, this concludes our testimony. We will be happy to answer any questions you or the committee members may have at this time.

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