Ready To Assist–The One Navy Medical Department in Operation Desert Shield/Storm

Lt Christine M. Grabowski, MS*

Charlie Golf One—Standing By Ready To Assist. This Navy Medical Department slogan was put to the test when the Bureau of Medicine and Surgery (BUMED) was tasked to provide medical support to the troops deployed to the Persian Gulf.

Within five days of the Iraqi invasion of Kuwait, activation orders were implemented for the hospital ships *USNS Mercy* (TAH-19) and *USNS Comfort* (TAH-20), and for Fleet Hospital Five (FLT HOSP 5). Active duty personnel were deployed to these platforms which made BUMED responsible for backfilling the military treatment facilities (MTFs)—the Naval hospitals and clinics from which these personnel deployed. As of Aug 14, 1990, this meant a potential for recall of 4,538 medical reservists to backfill ten MTFs. The next few days allowed for reassessing and prioritizing needs as well as acquiring legal guidance. The Judge Advocate General's office interpreted codes and laws relating to recall to mean that medical units were not constrained to the unit integrity concept for recall purposes. Further, a unit was defined as a free-standing, self-supporting entity. Only the reserve fleet hospitals could be so categorized.

The Total Force and Mobilization Branch of the Chief of Naval Operations (OP-601) granted BUMED authority to recall by Naval Officer Billet Code (NOBC) and Naval Enlisted Code (NEC), which are similar to the Army's Military Occupational Specialty (MOS). With this policy, the recall was focused to replace specialties and not merely numbers. On August 23, the CNO mandated that a maximum of 2,380 Navy Medical Department reservists could be recalled. The Secretary of Defense issued recall authority to the service Secretaries.

The subsequent days were ones of intense bureaucratic activity as guidance amplification, clarifications and new guidelines were formulated and sent to the Reserve Centers, Readiness Commands and others with a need to know. Through this all, BUMED did not lose sight of its objective–to continue to provide medical care to non-deployed military, keep the MTFs functioning and provide the deployed personnel with adequate medical support.

BUMED remained proactive in the recall process as Selected Reservists (SELRES) began inprocessing on the weekend of August 25, and reporting for duty by August 29. The Operation Desert Shield Status Report (ODSSR) was developed as a tool to monitor and adjust the medical support requests. Shortfalls or excesses could be addressed and subsequently rectified by BUMED-03. Excess personnel were transferred to facilities that were in need of that particular specialty indicated by NOBC or NEC. Personal transfer or exemption requests were being addressed as preparations were being made for the second recall wave, which was to occur on September 14. The cap on the number of medical reservists that could be recalled was raised. Inquiries concerning the possibility of volunteering were overwhelming. Additional funding was requested of the Secretary of the Navy to support the voluntary medical recall effort.

The month of September was primarily a time of reassessing needs at the CONUS facilities, reassigning personnel to meet established needs and making logical preparations for a worst-case scenario. In mid-September, request and authorization for an additional 350 individuals to be recalled were processed, followed on October 4, by yet another request for 350. At this time, Navy planning departments calculated that 6,126 reservists were recalled, of which 2,750 were medical.

Assistant Secretary of Defense Atwood provided direction on October 22 to recall sufficient selected reservists to maintain quality and quantity of care in all CONUS military treatment facilities. These assets from Program 32 were reservists earmarked to provide backfill to MTFs. Realizing that this could be a transient asset pool, BUMED-07 (Reserve Matters) requested, on November 6, that the Naval Military Personnel Command (NMPC-9) freeze all personnel and billets in Program 32. Additionally, fleet hospital deployment was anticipated so that on November 20, Surface Reserve Force (SURFRESFOR) sent Director of Naval Reserve Force (OP-095) its manning plan for FLT HOSP 22, which was one of two reserve fleet hospitals eventually deployed. On November 21, an additional 850 medical recalls were authorized to meet these new demands. Navy medicine at this time was allotted 3,600 of a total 9,510 Navy recalled reservists. An additional recall of 8,500 and a stop-loss policy were requested of the chief of Naval Personnel (OP-01). Stop-loss became the policy for implementation on December 3 for the Marine Corps, and on December 13 for the Medical Corps, the Nurse Corps, for oral surgeons, clinical Medical Service Corps members, physican assistants and Hospital Corpsmen of the Navy Medial Department.

Although the Navy did not, by policy, activate medical program residents, Reserve Forces (RESFOR) was tasked on November 30 by the CNO to identify all SELRES in such programs. The results of this task indicated that 25% of SELRES with NOBC 2,105 (medical officers) were in a residency program. The Individual Ready Reserve (IRR) was also reviewed for the possibility of utilizing its 3,700

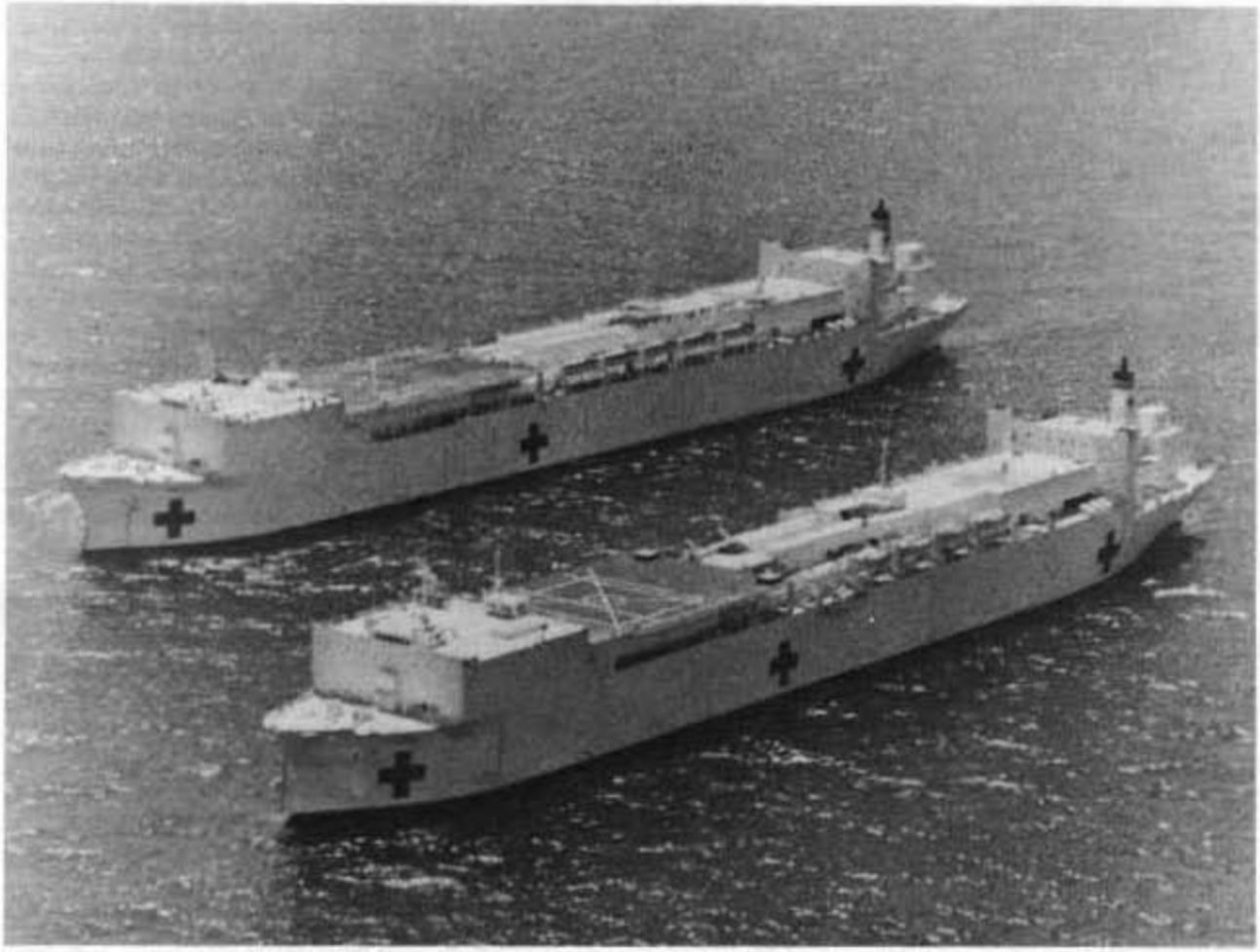
*Department of the Navy, Bureau of Medicine and Surgery, Public Affairs Office (BUMEDVOP), 2300 E St NW, Washington, DC 20372-5120.

medical assets. This group was not recalled.

In anticipation of a possible lengthy scenario, with no authorization to keep reservists on board for longer than 90 days, a Rotation Task Force was formed on September 14. The possibility of utilizing reserve fleet hospitals in theater and fleet hospital personnel for CONUS backfill was presented by BUMED-07 to Plans and Policy Division of Naval Medicine (OP-932).

In his December 28 message to RESFOR, the Navy Surgeon General requested permission to break program lines. This allowed for MTF backfill, and for fleet hospital and National Defense Medical System (NDMS) personnel to become part of a composite medical asset pool to supplement manpower where needed. On an January 18, 1991 executive order, the Secretary of the Navy (SECNAV) allowed implementation of a one-year recall of reservists under Title 10 of the US Code. This action provided a mechanism for retaining reservists already on board. The one-year recall would result in a more stable manpower base. By this time, the Navy was authorized to recall up to a limit of 20,850. Of these, 6,575 were earmarked for CONUS casualty receiving sites and 11 for European theater hospital liaison.

As of February 6, when the air war in the Gulf progressed and a ground war became imminent, the Navy Medical Department was allowed an additional 7,000 recalls. Out of a total 44,000 authorized Naval reservists, 17,000 could be medical personnel. By February 28, 10,452 Navy Medical Department reservists were involved in Operation Desert Storm (ODS). Volunteers in support of ODS contributed substantially to total reserve assets. This allowed for a deployment of more than 12,000 health professionals to five major medical platforms, to staff host-nation hospital beds and to support organic medical elements of the fleet and Fleet Marine Forces. Navy Medicine was able to provide almost 7,000 acute care beds. This swift mobilization of medical assets was not without unique accomplishments. As indicated in the Annual Report of the Surgeon General (Aug 1, 1990-Jun 30, 1991), some of the more significant were:



USNS Mercy (foreground) and USNS Comfort steam together for the first time in the Persian Gulf. Both hospital ships were part of Operation Desert Shield. (US Navy photo by HM2 Thomas C. Balfour.)

- The first Purple Heart of ODS was awarded to a Corpsman serving with the Fleet Marine force.
- The Navy Blood Program provided more than 20,000 units of liquid whole blood and 4,000 units of frozen blood to the theater.
- Medical personnel were deployed to approximately 100 ships in-theater.
- The Navy Forward Laboratory in Saudi Arabia detected a diarrhea disease which could have led to a major epidemic if not treated. This facility was the only laboratory in-theater capable of identifying minute amounts of biological warfare threat agents.
- Arthroscopic and laparoscopic surgery instruments, argon beam coagulators and 10,000 items of medical equipment to support the fleet hospitals and hospital ships were successfully deployed.
- The hospital ships *Mercy* and *Comfort*, each with a 1,000 bed capacity and Computerized Tomography (CT) scan, were deployed within five days of activation.

Although a major casualty scenario did not develop, the medical operational platforms treated 2,074 cases during Operation Desert Shield and 2,052 during Operation Desert Storm. Approximately 22% of these total cases were from armed forces other than the Navy or Marine Corps personnel.

As in any troop movement of such magnitude, this mobilization and deployment was not executed without personal hardships. The Navy Department was proactive in its attempt to alleviate and/or prevent these. As early as August 24, 1990 a CNO OP-01 message detailed a reserve activation deferment and exemption policy. This allowed for specific medical, legal and personal hardships to be reviewed and considered for delayed mobilization or exemption. More than 80% of those recalled reported, willing and able, to gaining commands. The Assistant Secretary of Defense for Reserve Affairs, on August 29, called for legislation to be drafted to update benefits for recalled reservists. The first site visit took place on August 30 when RADM Roberts, Assistant Chief for Reserve Matters, spoke to assembled recalled reservists at the National Naval Medical Center, Bethesda. On October 16, OP-01 released its policy on dependent ID cards, and on October 19 released its policy on per diem and BAQ eligibility. Authorization to extend medical coverage to recalled reservists and their dependents for 30 days after release from active duty was granted in April. Recalled reservists were given priority for accession to active duty in critical billets if criteria were met. The Bureau of Personnel (BUPERs) processed 830 enlisted and 114 officer active duty applications. Of these, 199 enlisted and 50 officer applications were approved as of late July.

The personal aspect of personnel management was addressed on a daily basis during the recall and demobilization. Special consideration was given to: mobilizing individual reservists to gaining commands geographically close to their homes, not disrupting professional education, making allowances for single parents and demobilization on a first-in/first-out and special consideration policy. Total Quality Management (TQM) was actively implemented in preparing for and fighting the war, and in all other aspects dealing with recalled reservists.

Recalled reservists served both alongside and in place of active duty personnel in all areas of operation. Stateside orders were executed for 6,500 reservists, while nearly 4,000 served in the AOR. Specifically in the Medical Department, reserve Hospital Corpsmen accounted for nine times more than any other Navy specialty called in support of ODS. More physicians and nurses were recalled than any other officer specialty in the Navy. Together, the Navy medical reserves and active duty provided continued professional manpower in CONUS and were capable of support in-theater to all combat forces. Two reserve fleet hospitals (FLT HOSPS 20 and 22) were deployed to the Gulf. To accomplish this, it was necessary to coordinate an effective training program (to prepare the personnel for desert warfare conditions) with an efficient staging platform for deployment. This was achieved through teamwork among various active duty codes and BUMED-07, along with successful coordination with the Army for the use of Fort Dix as the training site. Almost 700 medical reservists served on the hospital ships. The "One Navy" concept was never better evidenced than in this mobilization. The reservists were called upon not just to stand by, but they were ready to assist, and many did. ●