Operation Desert Shield/Storm—A Dental Service Detachment Commander's Perspective

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The 123rd Medical Detachment's desert experience began November 8, 1990. On that day President George Bush announced that he was sending European and stateside based troops to Saudi Arabia to provide offensive capability to the allied coalition against Saddam Hussein's Iraqi Army in Kuwait. We were told to have our vehicles and equipment ready for movement in ten days. A myriad of tasks had to be performed before we would be mission capable.

We were ALO 4, meaning we were short personnel, equipment, and vehicles. The 123rd had a dental-oriented FTX in May; when many deficiencies in the dental field equipment were identified and fixed. We were also preparing for a 7th Medical Command IG in January 1991 and had spent much time working on our vehicles and TO&E equipment. In September, following the completion of the new addition to the 67th Evacuation Hospital, we had moved the TO&E storeroom into more spacious basement quarters. Preparations on the magnitude of Desert Shield/Desert Storm and a possibility of a six to twelve month deployment take time and space. The FTX and the IG had forced us to prepare our equipment. The warehouse move facilitated our preparations. I thought we were in reasonably good shape with what we had, but work and preparation still needed to be done. Even with one month's notice, a "come as you are war" still applies.

7th Medcom cross leveled necessary MOSs, dental sets and vehicles from throughout Germany to us. Although we had been doing alternate wartime role classes and common task training prior to the alert, additional classes were scheduled and this time soldiers were truly motivated to learn the material. Of special note was an abbreviated two-day Chemical Casualty Care Course. The class was short and intense, but gave deployed officers needed feeling of confidence toward working and surviving in a chemical environment.

Our DENTAC was gutted. To Southwest Asia we would lose 15 of 34 dental officers, five of eight OICs, five of eight NCOICs and all but six enlisted soldiers. We had to go through Preparation for Overseas Movement (POM) procedures and treat deploying 3rd Infantry Division soldiers and prepare for own deployment as well. Thankfully, the IG inspection was postponed until February.

Most of the 3rd ID remained in Germany. Soldiers still had to be POM'ed. Dental Care still had to be provided to 22,000 beneficiaries. The DENTAC was back-filled with the 204th Medical Detachment from Little Rock, Arkansas. The integration of this unit into our communities and clinics was smooth and relatively uneventful. Without their dedicated support, care in the Wuerzburg area would have been reduced to emergency care only. Instead, access to care for family members increased in fact, because of fewer troops to family members. The 204th did an outstanding job during their tour here, and because their practices and livelihood at home suffered in their absence, they were truly heroes during Desert Storm.

We convoyed our vehicles and equipment through a blizzard to Mannheim, Germany on November 29. There barges took the support materiel to the North Sea for transit by freighter to Southwest Asia. We flew in two increments from Rhein Main to Dhahran on December 7, and 20. Our vehicles had not yet arrived, so for ten days we lived at the Dhahran port in large warehouses, each holding about 1,000 troops.

Our mission was to provide dental support to echelons above corps. We were subordinate to the 2nd Med Det, our command and control unit from Heidelberg. We were to be headquartered in Riyadh, approximately 450km from the port city.

Dental service in any theater of operations can be divided into three categories of care:

(1) Emergency care relieves pain. We are talking about temporary fillings and pulpectomies and treatment of trauma. The "keep it simple" rule applies. The division dentist would be expected to provide this level of care.

(2) Sustaining care is treatment designed to keep the soldier functioning in the division area. Simple restorations, denture repairs, perhaps an extraction or initial periodontal therapy would fall into this category.

(3) Maintaining care is more involved and resource-dependent. It consists of comprehensive restorative care, prosthetic appliances, preventive dentistry, and surgical procedures to include impaction.

As we prepared for SWA we lacked a clear mission statement. The lack of an advance party or any credible information from the theater hurt our planning. Initially, we did not know where we would be billeted and working. We did not know requirements for tentage or heaters or field sanitation equipment. Because we expected to be in a tent in the sand doing essentially emergency work only, we left some of the equipment in Wuerzburg. However, the 123rd set up in "fixed" facilities in Saudi and were able to provide definitive dentistry in a sustainment and even a maintenance mission. Had we known about the need for definitive prosthetic care we would have brought a cast grinder, a curing unit, flasks, and a multitude of prosthetic laboratory equipment. Light curing systems, ultrasonic scalers, and glass ionomer cements and porcelain were all in

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short supply and had to be acquired in Riyadh. All of these supplies and equipment were available in Germany, although they would have had to be transferred from the TDA.

Compounding our shortsightedness on what to bring was the problem of a nearly nonfunctional supply system. The Medsom, or Army Medical Supply Optical and Maintenance unit in Riyadh was not operational until late February, and then with limited line items. Fortunately, we had not only stuffed our chests to the maximum with expendable supplies, but we were also able to set up blanket purchase accounts with modern dental supply houses in Riyadh to acquire most of the equipment or supplies we needed.

We shipped some dental equipment, morale support equipment, and personal belongings in a 40-foot milvan. It got lost, and eventually arrived three weeks after the war ended. While the delay of the van did not impact on the mission, its delay contributed to needless frustrations and sagging morale.

Our first clinic was set up in Eskan Village in Riyadh. Initially, we had 17 TO&E dental chairs set up in two suites of a four-story apartment building. Eskan was a planned community built for the Bedouin people approximately ten years ago. For cultural reasons the Bedouins never moved in, and this multi-million dollar project had stood vacant. At the peak, perhaps 15,000 soldiers and airmen inhabited about two thirds of Eskan. We had 110 electricity, although we kept blowing fuses and had to supplement electricity to our dental clinic with our generators. Eventually, we got air conditioning. The compressors were placed outside the building on ledges for noise abatement.

Workload at first was very slow. It gradually grew, and by March it peaked, only to slowly dissipate as troops redeployed. It is a tribute to the Army health care system that so few soldiers reported to the clinic in a Class 3 Dental Readiness status. From those dentists who served in SWA, a huge thank you is conveyed to the many members of the dental teams in Health Services Command and 7th Medcom who spent long and arduous hours treating the mouths of the deploying soldiers. Our life was much easier there because of their efforts.

In another apartment building nearby we had five suites in which our headquarters and billets were colocated. Each suite had five bedrooms, three baths, and a kitchen. It is difficult to imagine an orderly room without computer and word processing capability. We still had to report dental workload, submit reports, and perform innumerable personnel actions. Computers, be it wartime or peacetime, beat stubby pencils. The two lap tops we took were essential, and we acquired two additional computers in theater. A photocopy machine was also needed, but we were unable to purchase one either in Germany or in Saudi. Manual typewriters and carbon paper are simply World War II vintage, even in a harsh desert environment.

Alternate wartime role utilization was an issue. In Riyadh we augmented the chemical decontamination team, the ambulance company, and the mass casualty team. We, also gave approximately 10,000 anthrax inoculations. The philosophy of alternate wartime role training needs to be reevaluated. The fact that the dentists had to do routine dentistry in a wartime theater actually adversely affected morale, at least, initially. The longstanding annual requirement for wartime training and the emphasis placed on such training during FTX's and continuing education sessions had given most of us a false mission statement. We, in fact, were in Saudi Arabia to do routine dentistry. Some dentists expressed disappointment at being required to plug amalgams and not pump anesthesia gases. Desert Storm casualties were blessedly very light and medical support plentiful. Requirements for dental personnel to be used in an operating room were few. Although the 123rd, and I'm sure other units, had dentists assist in operating rooms and perform in other medical roles, one might question the continued emphasis on this training. The limited number of annual training hours do not properly train one to be proficient at these tasks. The wartime roles need to be more clearly and expressly defined, and then sufficient training be offered to meet those roles. The MEDCOM Commander expressly forbid that any dentist act as Triage Officer, yet we continue to receive extensive annual training in this role. I would suggest that dentists can be utilized in an OR environment as first assistants, especially in oral-maxillofacial cases. Most have had some OR experience, and are already competent in the use of instruments and procedures. Likewise, we can be taught chemical decontamination in association with emergency medical treatment. The 123rd's officers received excellent training at the chemical casualty course at Neubrucke, Germany prior to deployment. This course should be expanded to include the enlisted soldiers, and more time should be spent on the decontamination station.

Our second clinic was in King Khalid Military City (KKMC), a huge Saudi military post some 475 kilometers north of Riyadh. This was the center of the logistical and operational efforts in the north. They had a modern hospital that was two years old, and within it a state-of-the-art 12-chair dental clinic. We sent three dentists and three auxiliaries there to boost their capability. This was, I believe, the first attempt for American soldiers to go into a fixed Saudi facility and work alongside the civilian work force. This cooperation among medical assets eventually occurred in many facilities in Riyadh and Dhahran, but this small dental contingent successfully set the stage.

These three dentists eventually treated soldiers from 28 different

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countries, as well as many veiled Muslim women whose cultural isolation made dentistry an extremely sensitive encounter. Here again, the dentists also performed alternate wartime roles by helping to develop and implement plans for a decontamination site and augment the mass casualty team.

Thumama was our third clinic, located approximately 30 miles north of Riyadh. Thumama was a very graphic example of the relationship between access to care and mission. About 5,000 troops were there, to include a brigade from the 82nd Airborne. The division dentist was set up in a tent and seeing perhaps one or two emergency patients a day.

We set up two dentists in a fixed facility, the King's summer retreat where he would greet visitors. Before the week was up they were seeing 30 to 35 patients a day for simple restorative care and cleanings. The need for dental care was there, but could only be filled by an HA team performing the sustainment mission.

Thumama was truly an unusual clinic. Because it once had belonged to the King himself, the surroundings were stupendous. Huge chandeliers, Persian carpets, and French provincial furniture decorated the clinic. Soldiers ate their MREs at a mahogany dining room table that seated 150.

Not everyone had it so good. In late January we were tasked with setting up a 4th clinic, one of two clinics that would provide dental care to the projected enemy prisoner of war population. This clinic was established in the sand approximately 50 miles north-northeast of KKMC. By the time the three dentists and four enlisted closed down operations 92 days later they had examined over 16,000 and treated over 5,000 Iraqi prisoners. It was emergency treatment, and with the extremely poor condition of the Arab mouths, it was essentially an extraction practice. Given the wretched state of the Iraqi Army by this time after the war had ended, the care could almost be considered humanitarian, although that was not the mission.

In conjunction with the 122nd Medical Detachment from Frankfurt, we also set up a clinic in Kuwait City five days after the cease fire. It remained in operation only seven weeks. As the redeployment got into full swing and Riyadh's population began to shrink and Dhahran's to grow, we attached dentists and assistants to work with the 122nd in Dhahran.

Six soldiers remained behind an additional month with the 122d Med Det when we redeployed to Wuerzburg on May 24, 1991. One cannot stress enough the need for communication and cooperation and flexibility among the limited dental assets. As Commander, I at first, resisted releasing any soldiers to another dental unit. As the populations began to shift, I realized how sectarian this view was. If I were left with a feeling of pride in our operations in Southwest Asia, it is that very feeling of cooperation that worked toward the successful accomplishment of the dental mission.

Our deployment lasted just over five months. We returned safely and with a record of successful service to the many great soldiers in Southwest Asia. ●