21st-Century Medical Readiness

Lessons from MWX

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In 2019, the Marine Corps embarked on processes to streamline its combat service support structure to increase the flexibility and lethality of the MAGTF. The targets of reduction focus on ways to minimize fuel consumption and storage, ammunition requirements, and ground transportation. However, while there are many noteworthy discussions about the reduction of these combat service support functions, a larger logistics function is health service support. The lack of survivable, affordable, and redundant negatively impacts maneuver elements as witnessed at the MAGTF WARFIGHTING EXERCISE (MWX), the largest and most dynamic peer-on-peer, free-play exercise in the DOD. Tactical through strategic health service support, as executed in accordance with joint, operational, and strategic publications, to include *MCDP 1-4, Competition*, should be updated. Currently, the Marine Corps purchases Navy billets for MEF's medical battalions to maintain high-demand, low-density medical specialties such as emergency room physicians, anesthesiologists, nurses, and surgeons, at the ready for FMF tasking. These sailors are often sent on temporary orders to support base hospitals. This is an example of talent mismanagement in relation to the needs of the FMF preparing for conflict and applying an expensive price for Headquarters Marine Corps in competition. Fundamentally, there is a dichotomy between the desire to maintain the best in worldwide medical care while reducing personnel and equipment in the weapons engagement zone with a smaller physical space maneuver. These observations are in addition to the complex, high-demand/low-density requirements of medication supplies. Ammunition management is simple when compared with the regulations surrounding narcotics or the means in which to provide lifesaving drugs, at the right time, for every Marine throughout the globe. To support more effective management and placement of health service support capabilities for the geographic combatant commander (GCC), the DOD must create a larger pool of volunteer surgeons, emergency room physicians, and anesthesiologists in the competition phase for deployment worldwide in the crisis and conflict phase.

Marines, sailors, and the American public expect the best medical care in locations of need to preserve life and limb and a full reorganization of the current DOD medical system is required. Small steps have already been taken but much more is required. Combat readiness is medical readiness in the fight now and in the future.

During the most recent three MAGTF MWXs, medical battalion forward resuscitative surgical system and shock trauma platoons (approximately 22 sailors) were noticeably relegated or absent. Often lifesaving medical capability was represented by four to five corpsmen. The Marine Corps' medical platoons were often small footprints, preventing commanders from having to truly manage the large authorized medical allowance list and support structure required to support medical care supplies that were needed to care for the notional injuries.

Discussions within the training audience of the MAGTF MWX focused on how close or far away the forward resuscitative surgical system should be established to care for what ultimately leads to less than twenty notional wounded in action. The most recent MWX did not provide in-depth medical scenarios for the assigned battalion corpsman to practice their craft. These examples demonstrate the ease to plan away—through the lack of Medical Battalion participation and game rule design—and the very difficult application of health service support in the conflict phase.

One positive takeaway from the most recent MWX, which was not seen in earlier iterations, was commands' attempts to regain combat power through the use of the battalion aid station. Reality aside and previously noted this clearly demonstrates the need to make the lifesaving capabilities present at the lowest maneuver commands. Lifesaving cases should no longer be viewed as an exquisite capability but instead should exist in every battalion during the conflict phase of operations. In support of a

clear need but lack of ability for a more responsive health service support solution, the DOD should advocate for the establishment of a health service support functional command, adjacent to the GCC and tasked with support to the command's requirements. The Department of the Navy should also make a change to current recruiting processes for specific medical professionals in the competition phase, as well as a reorganization of medical capabilities within the MAGTF. These proposed changes will ensure more effective medical and combat readiness facilities by a DOD health service support command. The Marine Corps and DOD should accept if the technology existed to make medical equipment and medications smaller, faster, and cheaper, the civilian economy would have done it already. The DOD, and the Marine Corps as an advocate, should make bold changes now to better prepare for the next conflict.

To gain the funding needed to recruit and maintain a much larger pool of medical professionals the Department of Navy, Department of the Air Force, and Department of the Army should no longer manage the training and management of health service support within their Services. A separate and new functional command will take on the task of managing and assigning correct capabilities to the GCC for execution. The recommended newly established functional command will coordinate with assigned GCC's assigned logistics lead services throughout the globe to support base operations support integrator requirements. Finally, the recommended new functional command will manage all U.S. military hospitals and assigned primary care physicians. The functional command will coordinate with Tricare to manage training opportunities for high-demand, low-density doctors with needs of the active-duty forces' preventive and routine medical requirements throughout the phases of the competition continuum. On behalf of the Marine Corps and Navy, the Department of Navy will advise the newly established health service support function to meet requirements.

The Department of Navy will continue to support Title 10 recruiting efforts for medical personnel. Corpsman recruiting processes are unchanged in this recommendation. However, in the future, DOD and the new health service command will provide funding to public and private hospitals to support doctor and nurse training. The DOD will also require recruited doctors at those hospitals to sign agreements to serve during periods of crisis or conflict, determined by the DOD. These doctors and nurses will enter an inactive commissioned status during the competition phase. Similar to the program used by the DOD with United States-flagged airliners, the Department of the Navy will coordinate with the health service support functional command to activate highly trained and specific capabilities from civilian hospitals when needed during crisis and conflict.

An example of this future process would involve the GCC providing a requirements capability to the health service support command. The functional command could then activate a doctor or nurse as an O-3 or O-4 paygrade, and then following a short military indoctrination course, deploy. At the proposed short military indoctrination course, if a doctor or nurse is slated for deployment in support of the Army, the individual would review peculiarities to that Service—same with the Space Force or Marine Corps. If this proposal was enacted, the new structure would increase medical specialties across the phases of conflict, reduce the price of maintaining redundant health service support for the Services, and reduce the need to manage base hospitals.

While Naval Logistics Integration efforts between the Marine Corps and Navy continue to improve, an area sorely lacking is the medical logistics system. Effective and responsive in the competition phase, the current pull system and the requisitioning process will not support medical supply requirements in crisis or conflict. Particulars of planning health service support are not a high-priority training and readiness standard with logistics Marines and commissioned officers. The closest Navy medical planner for a battalion is found at the major subordinate element. Tactical logistics planning factors are understood regarding the use of 5.56 mm rounds but under the current construct, narcotics, and even notional required antibiotics quantities are foreign to Marine planners until absolutely needed. To support training that is more effective and gain familiarity with the medical logistics process, the Marine Corps should change the table of organization and move the current medical battalions under the MEF Divisions. This newly structured medical battalion will maintain a training allowance" of fifteen percent of current-day organization but could adjust based on the health service support functional command and FMF expectations. This training allowance of capability will primarily serve the role of training the FMF leadership and participating in select training events outlined by the GCC, MEF, or division—like the training and readiness team currently embedded with the Marine Logistics Groups.

There are issues within the Department of Navy, which negatively impacts medical and combat readiness. MWX demonstrates a lack of realistic tactical health service support considerations. This is not due solely to a lack of effective equipment but also a mismanagement of talent. The Department of Navy should advocate to the DOD and Congress to establish a new functional command. The Marine Corps should create a new training element or battalion within MEF Divisions. The littoral logistics battalion is assigned to a division regiment, why not a medical battalion? These implemented recommendations will reduce fiscal strain in the competition and increase FMF medical and combat readiness in the competition through the conflict phases of war.

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