

Changing Tides

The refinement of health services support
in the Marine Logistics Group

by Capt Sean Alexander

Marine Corps Technical Publication 3-40B, *Tactical-Level Logistics*, defines logistics as, “planning and executing the movement and support of forces.” At the tactical level of war, the Marine Corps divides logistics into six functional areas: supply, maintenance, transportation, general engineering, services, and health services.¹ These functional areas require the deliberate employment of logistics capabilities to support the MEF scheme of maneuver. The MEF directs the MLG to provide task organized forces capable of meeting these logistical requirements, specifically employing the medical battalion to provide health service support. Gen Berger recently published his *Commandant’s Planning Guidance*, identifying force design as our number one priority. Since 1967, the Navy and Marine Corps team has failed

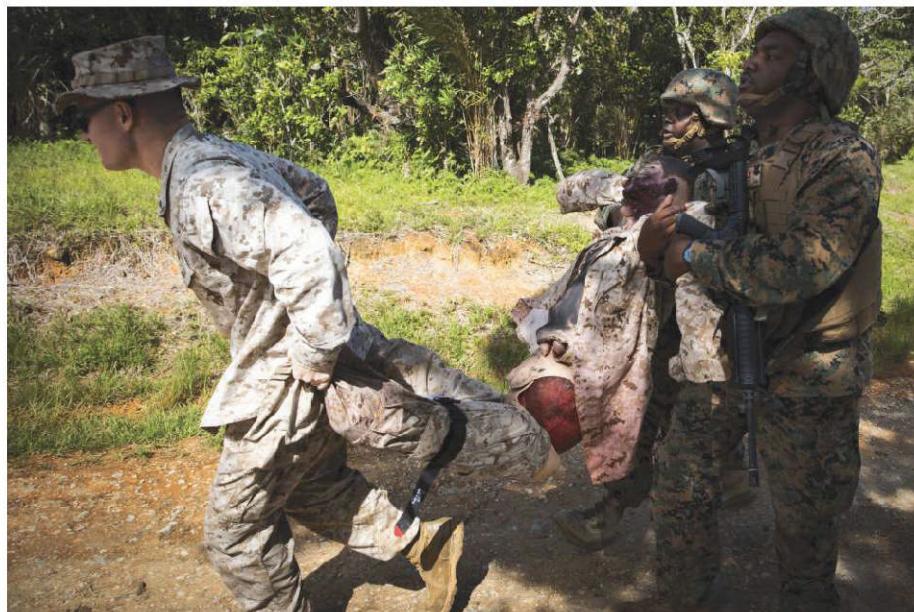
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to deliberately design a medical unit thoroughly integrated into our operating force. We failed to understand the increasingly complex operating environment while referencing our philosophical warfighting approach. Accordingly, I recommend a force structure modification to the table of organization (T/O) for all medical battalions. My recommended changes seek to provide small and precise opportunities for greater integration between the Navy and the Marine Corps—providing a blueprint for future force design.

First, we must acknowledge the timeless nature of warfare, that warfare is a “violent clash of interests between groups characterized by the use of military force.”² The acceptance of this premise lays the foundation for the manning, training, and equipping of our Corps. This fact necessitates the existence of a force capable of caring for the wounded and preventing the many ills that sap a force’s ability to achieve our national objectives. Historically, the Navy and Marine Corps team tackled this challenge together by pairing Marine combat power ashore with trained Navy Corpsmen at the operational and tactical level. These combined capabilities hardened the hearts of young Marines, allowing commanders to accept the level of risk required to deliver decisive blows against our enemies.

Historical Background: Vietnam War—Operation IRAQI FREEDOM

Following the end of World War II, the Navy and Marine Corps further refined their amphibious partnership. During the Vietnam War, the Navy provided a robust capability within the South East Asia Area of Operations. Specifically, the Navy and Marine Corps team employed medical battalions, aligning these units with the Marine infantry division. In June 1965, the Marine Corps landed 3d Medical Battalion at DaNang, Vietnam, providing medical support to the 3d MarDiv.³ 3d Medical Battalion executed their assigned mission, primarily executing the “triage, sorting, transportation, and temporary hospitalization, and evacuation after first aid and emergency surgical measures had been performed.”⁴ Based upon this mission statement, the battalion staff correctly assumed their mission would be short in nature



Health service support for Marines at the tactical level remains a priority as the Corps designs the force for renewed great power competition. (Photo by Cpl Kyle McNan.)

and would require the ability to rapidly reposition in support of the division's main effort.

Over the next 36 months, this assumption proved incorrect—and the battalion encountered significant friction because of the shortage of trained personnel and consumable medical supplies.⁵ Indeed, the situation concerning available medical supplies proved so dire that the commanding officer reported, "the receipt of medical supplies was still considered unsatisfactory ... lead time of 50–60 days was considered excessive and priority classification had little meaning or significance."⁶ Concerning personnel, the battalion struggled to maintain sufficient quantities of trained enlisted and officers. The situation deteriorated in September 1967, forcing the 3d MarDiv surgeon to consider hiring local Vietnamese medical personnel.⁷ These shortages directly affected the operational capacity and effectiveness of 3d Medical Battalion.

From 1987–2007, the DOD actioned the administrative and substantive changes outlined in the Goldwater-Nichols Department of Defense Reorganization Act of 4 October 1986. Primarily, the Goldwater-Nichols Act sought to capitalize on the strongest elements of U.S. national power—our economic and informational overmatch against the Soviet Union. During this period, the Marine Corps re-structured the FMF's primary logistics capability from the Force Service Support Group (FSSG) to the MLG. This structural shift re-aligned the Marine Corps' to meet the intent described within the Goldwater-Nichols Act. Specifically, this created a streamlined command and control (C2) structure from the strategic to the tactical level of war. Functionally, this eliminated the requirement for the FSSG to task-organize independent battalions to support the MEF's scheme of maneuver. This greatly increased tempo by creating habitual command and support relationships between LCE and GCE units. Unfortunately, the current structure deprived the MLG of its economy of scale.⁸ During this period, the MLG rapidly increased the number of headquarter functions, at a loss of field-level

operators. The MLG grew from eight battalions to twelve battalions and three regiments. This increase in headquarters staff did not affect the MLG's Medical Battalion—whose T/O has largely remained unchanged since 1967.

Historically, the T/O of the FSSG's Medical Battalion included Navy enlisted and officers who were trained and equipped to execute the battalion's core mission. The Marine component within the battalion's T/O remained relatively unchanged from 1967–2009, despite Service-wide changes caused by the Goldwater-Nichols Act. Most noticeably, the T/O reflected few Marine officers or enlisted personnel within the headquarters company, the primary component of the battalion tasked with C2 and the sub-functions of logistics.

responsibility for the promulgation of their intent, providing their staff guidance and direction during all phases of an operation.¹⁰ As a Service, we have embraced this philosophy and expect all elements of the MAGTF to prepare for combat with these principles in mind. Throughout the last decade, the Marine Corps sought to improve our organization through various initiatives, including the *Marine Operating Concept*, *Marine Corps Vision and Strategy 2025*, and the re-publishing of the *Commandant's Planning Guidance*. These foundational documents have informed the Marine Corps' priorities concerning manpower and equipment but have thus far failed to address the need for Navy and Marine Corps integration within the MLG.

The Navy and Marine Corps team

Medical Battalion	1967	1999	2009	2019
Marine Enlisted on T/O	0	21	60	64
Marine Officers on T/O	0	0	1	4
Marine Total on T/O	0	21	62	68

Figure 1. (Figure provided by author.)

Figure 1 above depicts the steady increase of the Marine component within the MLG's Medical Battalion.⁹ During this 50-year period, the Navy and Marine Corps team fought numerous large- and small-scale conflicts but did not significantly modify the T/O to support the increasing complex and disaggregated nature of conflict in the 21st century. The complete absence of Marine officers within the medical battalion primary staff demonstrates a failure of Navy and Marine Corps leadership. Historically, the Marine Corps has not viewed the MLG's medical battalion as a key supporting effort; it has simply been a matter of fact that quality medical care could be provided by our overwhelming naval apparatus.

Why This Matters

MCDP 5, Planning, details the importance of planning to support the Marine Corps' maneuver warfare philosophy. Specifically, *MCDP 5* states, "Commanders are the single most important factor in effective planning." The commander bears the primary

must reexamine the structure of the Medical Battalion. The dynamic nature of the current operating environment was the muse spawning Gen Berger's 2019 *Commandant's Planning Guidance*. Most importantly, Gen Berger noted, "Significant change is required to ensure we are aligned with the 2018 *National Defense Strategy (NDS)* and DPG, and further, prepared to meet the demands of the Naval Fleet in executing current and emerging operational naval concepts. Effecting that change will be my top priority as your 38th Commandant."¹¹ These comments serve as my point of departure for framing my recommendations: modifications to the medical battalion command screening process and assignment of a Marine Corps field-grade officer to serve as the operations officer for all medical battalions.

Currently, the battalion's primary staff are exclusively filled by Navy personnel. The Navy Bureau of Medicine and Surgery fills the key leadership (Commanding Officer and Executive Officer) via a command screening

board. The selection criteria for those seeking these billets is codified within *Navy Bureau of Medicine and Surgery Instruction 1412.1C* but lacks sufficient detail to truly understand the qualities the command screening board deems necessary for assignment.¹² Additionally, the command screening boards do not appear to include Marine Corps officers or senior staff-noncommissioned officers as members. This process demonstrates an organizational failure: the selection process identifies Sailors to lead a Marine unit, but they are not

Interestingly, the T/O for the MAW provides a prime example of the skillful assignment of Marine leadership. The Marine Wing Support Squadron provides aviation ground support to enable a Marine aircraft group to conduct expeditionary operations.¹³ Their mission statement directly shapes the composition of the staff, ensuring the unit can meet their core mission essential tasks. Accordingly, a field-grade (lieutenant colonel) engineer officer serves as the commanding officer, while the executive officer may be any field-grade

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subject to the Marine Corp's approval. In the future, the Navy and Marine Corps should cooperatively screen personnel who will serve in these two key leadership positions within the LCE.

The employment of a medical battalion poses one of the most difficult challenges within the LCE and requires a seasoned leader with a breadth and depth of experience. The operations officer of any Marine Corps unit serves as the key link between the commander and the primary staff, receiving the commander's intent and driving the execution of the Marine Corps Planning Process. Operations officers must understand a myriad of topics to succeed within LCE to anticipate the supported unit's requirements. The execution of a medical battalion's mission essential tasks requires significant external support, as they lack sufficient training and equipment to conduct operations across our warfighting functions. These shortfalls are the reality that the Marine Corps accepts, but we could improve these battalion's ability to operate by assigning a Marine Corps field-grade logistics officer to serve as the operations officer. This assignment would ensure the battalion's primary staff thoroughly understands the LCE's concept of operations, and the resources higher and adjacent units possess.

(major) pilot/naval flight officer. These assignments clearly prioritize the experience and skills both occupational specialties develop, enabling the staff to effectively support the MAW.

In the future, our Navy and Marine Corps team will seek opportunities to further integrate our Services into one cohesive fighting force. Our organizational leaders will most likely prioritize naval integration at the MEF and naval fleet, providing our headquarters elements the ability to develop and issue guidance to subordinate commands. This approach will surely educate our senior leaders but will delay the development of company and field-grade leaders at all echelons of command. Alternatively, we should aggressively create small-scale opportunities to integrate our forces. As a Marine Corps, we can immediately affect the process by which we man, train, and equip our Corps' medical battalions. These proposed changes are modest in nature but directly support the Marine Corps' five priority focus areas as defined in Gen Berger's *Planning Guidance*.

Notes

1. Headquarters Marine Corps, *Marine Corps Technical Publication 3-40B*, (Washington, DC: 2016).
2. Headquarters Marine Corps, *MCDP 1, Warfighting*, (Washington, DC: 1997).
3. Leon P. Eisman, *Brief History of: 1st Hospital Company, 1st Medical Battalion, 3rd Medical Battalion in Republic of Vietnam*, (Washington, DC: U.S. Department of Defense, Military Blood Program Office, April 1973).
4. Ibid.
5. Ibid.
6. Ibid.
7. Ibid.
8. Joslyn Hemler, Yuna Huh Wong, Walt L. Perry, and Austin Lewis, *Research Report. Vol. RR-1572-USMC, Developing a Capacity Assessment Framework for Marine Logistics Groups*, (Santa Monica, CA: RAND Corporation, 2017).
9. Headquarters Marine Corps, "United States Marine Corps Report Fiscal Year: 1967, 1999, 2009, and 2019 Total Force Structure Management System," (Washington, DC).
10. Headquarters Marine Corps, *MCDP 5, Planning*, (Washington, DC: 1997).
11. Gen David H. Berger, *Commandant's Planning Guidance*, (Washington, DC: July 2019).
12. Bureau of Medicine, Department of the Navy, *Command Qualification program for Active Component Medical Department Officers, 2019*, (Washington, DC: 2019).
13. "United States Marine Corps Report Fiscal Year: 2019 Total Force Structure Management System."



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