

THE NECESSITY FOR AN ORGANIC MEDICAL SERVICE WITHIN THE UNITED STATES AIR FORCE

EDITORIAL NOTE: In the last months of 1950, just one year after the creation of the Air Force Medical Service, House Representative Carl Vinson introduced H.R. 8889, 81st Congress, "Air Force Organization Act of 1950." Section 305(a) of the Bill provided that: "Under such regulations as the Secretary of Defense may prescribe -

(1) The Surgeon General, United States Army; the Army Medical Service; the Surgeon General, United States Navy; and the Medical Department, United States Navy, shall, in addition to the functions and duties performed by them for their respective departments, be charged with similar functions and duties for the Department of the Air Force. The hospitals and other medical facilities of the Department of the Army and Department of the Navy shall be available to personnel of the Department of the Air Force and their dependents to the same extent as personnel of the operating agency."

The Office of the Surgeon General, directed by Maj. Gen. Harry G. Armstrong, responded vigorously in opposition to this attempt to abolish the new-found independence of the Air Force Medical Service.

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By

The Office of the Air Force Surgeon General, Fall 1950

Draft #1 of the proposed bill "To provide for the organization of the Air Force and the Department of the Air Force and for other purposes" has been reviewed with particular reference to the effect of Section 305 which would, in effect, assign responsibility for the provision of the medical support required by the Air Force to the Medical Departments of the Army and Navy jointly, as well as require the transfer from the Air Force to the Army of all, or a portion of all Air Force Medical Service personnel, including Medical Corps, Dental Corps, Veterinary Corps, Air Force Nurse Corps, Women's Medical Specialist Corps, and Medical Service Corps.

The Department of the Air Force is unalterably opposed to those actions which Section 305 of the proposed bill would entail, as well as to the application of the concept of cross-servicing to such a vital personal relationship as that of Air Force personnel who are patients and their doctors. Many aspects of military functions and responsibilities are readily susceptible to common, joint, or cross-servicing arrangements, and unification of the Military Establishment has effected numerous economies based upon the

implementation of this principle. In the field of Medical Service, for example, an Armed Services Medical Procurement Agency, jointly staffed by the three Medical Services is responsible for both the standardization of requirements for, and the procurement of, all of the items of medical material and supplies by the three military Medical Services. Similarly, the United States Armed Forces Medical Journal has replaced the earlier Medical Service Bulletins published independently. The Army Institute of Pathology and the Army Medical Library are to be operated as joint enterprises. The hospitals of each of the three services are available to personnel from all of the three services. Air Force Medical Service personnel participate in the management and operation of the Army general hospital system which, in turn, provides definitive treatment type medical support for the Department of the Air Force. Not one single additional medical installation has been constructed by the Department of the Air Force as a result of the separation of the Air Force Medical Service from its parent Army organization and its subsequent integration into the structure of the USAF. Furthermore, the Office of the Director of Medical Services, which was established at the level of the Secretary of Defense as one corollary of the unified military establishment is vested with the authority to standardize medical requirements, survey operating methods, eliminate duplication of medical service activities, and promote the advancement of the Armed Services program for medical care and attendance of the sick and injured. More effective management of the military medical services has stemmed from their recent unification under two broad principles of sound military and business management. Those principles were recommended by Mr. Cooper's Medical Advisory Committee especially appointed by the Secretary of Defense to study the entire problem of medical service in the military establishment: that is, first, the principle of Service-identification of the operating elements of the medical program, entailing the operation of an organic medical service within each major force; and, second, the principle of centralized, coordinated civilian management control of the medical program at OSD level as currently embodied in the functions of the Office of the Director of Medical Services.

The Cooper Board concept of medical attendance in the Military Establishment, which was also emphasized by the Eberstadt and Voorhees Committees of the Hoover Commission, has been in effect for little more than one year, yet already it has been responsible for bringing marked economies and unprecedented efficiency into the operation of the military medical program. The Department of the Air Force, in consequence, cannot support Section 305 of the proposed legislation which would restore the medical organization of 1941-1947, an organization which all responsible medical authorities have agreed to be incapable of adaptation into the pattern of unification as set forth in the National Security Act of 1947.

The foregoing considerations represent a general explanation of the principal factors determining the Air Force position in opposing the introduction of a bill which would terminate Department of the Air Force responsibility for the provision of its required program of medical attendance. Certain specific effects of the proposed action incorporated in Section 305 of Draft #1 of the Organization Bill are herewith enumerated in further substantiation of our basic position:

(1) The proposed inactivation of the Air Force medical Service is contrary to the recommendatons of outstanding and competent medical authorities.

Major General Norman T. Kirk, then Surgeon General of the Army, Admiral Clifford A. Swanson, Surgeon General of the Navy, and Major General Malcolm C. Grow, Air Surgeon, in their testimony before the Senate Armed Services Committee in April 1947 emphasized the necessity for the close identifiaction of medical activities with station and base level with the military service which they directly support. Admiral Swanson and General Grow particularly emphasized the desirability of Service-identification for the personal physician-patient relationships aspects of medical care, and all three Surgeons called for the unification of such common features of medical service as the procurement of medical material, the medical research program, recruiting activities, and the like, under the coordinated direction of a single civilian medical authority at the level of the Secretary of Defense. Essentially similar recommendations were submitted by the Voorees Committee and the Eberstadt Committee of the Hoover Commission, each of which groups advocated the establishment of an Air Force medical service as one vital requirement in the development of a unified medical structure. This viewpoint was further amplified and emphasized by the medical advisory board under the chairmanship of Mr. Charles P. Cooper, which was convened by the Secretary of Defense to study the problem of medical attendance within the armed services and received extensive testimony from outstanding civilian and military authorities including the Service Secretaries, the Chiefs of Staff, the Chief of Naval Operations, the Surgeons General, the Air Surgeon and others. Furthermore, the establishment of the Air Force Medical Service was concurred in by the Surgeon General of the Army, the Army Chief of Staff, and the Secretary of the Army, prior to the implementation of the transfer authority by the Secretary of Defense.

(2) The American Medical Association has endorsed the present organization of the military medical services. Similar endorsements of the present organization have been received from the professional societies representing the contests, veterinarians, and nurses, and from the American Hospital Association. A retrogressive change such as that embodied in the proposed reorganization of the present unified medical system would inevitably undermine the support for the military medical services now being received from the representative professional societies. This support is a vital in the successful promulgation of the service recruitment programs for members of the professional categories. Antagonism of the professional societies would be detrimental to all Medical Service personnel procurement programs.

(3) A basic responsibility of the Secretary of the Air Force and the Chief of Staff for the health and welfare of the USAF would be delegated to another agency. The responsibility for the health and welfare of troops is so fundamental and generally accepted throughout the military organization that it is doubtful if it could be either morally or legally

delegated to, or assumed by, another department. While it is obvious that the Army could and did provide medical attendance for the Army Air Forces when the latter agency was charged with a subsidiary mission representing a part of the overall mission of the Army, it must be recognized that the USAF, as an independent entity within the Department of Defense, is now charged with a primary mission of its own. This mission includes the organization, training and equipment of combat Air Forces; the conduct of prompt and sustained combat operations in the air; and responsibility for the maintenance of general air supremacy, for the defeat of enemy air forces, for the establishment of local air superiority, for the provision of the personnel, facilities and equipment required, and for the conduct of strategic air warfare. The successful discharge of the expanded mission of the Air Force demands the complete integration of the personnel, equipment, installations and machinery necessary for the exploitation of air power into an efficient and closely knit team. Such an arrangement obviously entails the right to "hire and fire" as well as to reward and punish the individuals who comprise the personnel elements of the team. This situation would not be obtained under the proposed organization where a medical appendage of the Army Medical Department subject to Army administration and career control would be charged with a provision of medical service for the USAF. It is apparent that an operational veto would remain in the hands of the Army, whose failure or inability to provide the medical attendance required by the Air Force in an emergency might impair the mission of the latter Arm. The dangerous implications of this situation are emphasized when it is recalled that the Medical Service of the Army is geared to support a long buildup, a progressive mobilization, and a ground war of attrition, while the Air Force requires a medical service designed to support an almost instantaneous worldwide retaliatory application of strategic air power. Furthermore, it would be difficult to minimize the effects of the proposed organization upon the morale of those medical officers who have served with the Air Force and contributed so much to the advancement of aviation medicine.

(4) The Army Medical Department is not sympathetic to the needs and requirements of the Air Force. There were numerous instances of failure of the Army Medical Department during World War II to understand or appreciate realistically the specialized requirements of the Army Air Force for medical service. The medical department was unable to meet the Air Force requirements for physicians to fill Air Force tactical units being deployed to overseas theaters in the early stages of the war. These commitments were met only when the Army Air Forces obtained independent medical officer procurement authority. The requirements of the Army Air Forces for hospital installations in overseas theaters were never fully appreciated by the Army Surgeon General. No distinction was made between flying and nonflying personnel in Army installations, and aeromedical standards and concepts were never employed in the

disposition of military aviators. The services of highly trained flying personnel were lost for long periods of time because the Army medical evacuation system was based upon the support of a larger ground-type force. Similarly the forward echelonment of major hospital installations in active theaters often made a hit or miss proposition of the medical support of major Air Force tactical elements. The Army Medical Department was slow to accept the possibilities of air evacuation, whereas early recognition of the potentialities of this activity for the rapid evacuation of large numbers of sick and wounded patients to the Zone of Interior would have obviated the necessity for the transportation of many thousands of hospital beds to the overseas theaters with air co-incident impedimenta in terms of equipment and personnel. The Army Air Forces convalescent program encountered considerable opposition from the Army Service Forces, although it was eventually adopted intact for implementation throughout the Army. Medical units destined for support of Air Force major commands in overseas theaters were sometimes appropriated for assignment to other elements of the Army without regard for the fundamental and air support mission of the units concerned, or for the effect upon the combat Air Forces of this diversion. Nurses destined for air evacuation squadrons were shuttled into Army hospitals. Medical Supply Platoons earmarked for air depot groups were seized upon by Theater service forces. An attempt was made to reduce to dispensary status a large number of hospitals at air stations throughout his Zone of Interior despite the ever-present danger of aircraft crashes at those installations demanding the maintenance of competent professional staffs. New facilities were constructed by the Army Service Forces for the hospitalization of casualties returning from overseas despite the ability of the Air Force to absorb many of these cases within the Air Force regional hospital system. These and other similar incidents have served to exemplify the inefficiency and discrimination resulting from the assignment to the responsibility for the medical attendance of one major force to another major force possessing a dissimilar mission and operating under a different concept of logistic support.

(5) The proposed organization would destroy the esprit de corps of the Air Force Medical Service personnel. There can be no compromise with quality, loyalty, spirit or efficiency in the state of preparedness of the Air Force. This premise implies the unequivocal allegiance and ready availability of a Medical Service which has become identified with the parent organization in fundamental thinking, in concept of medical requirements and in the development of facilities, organizations and training programs to insure complete medical coverage for every phase of aeronautical operations. The desired quality, loyalty, spirit and deficiency cannot be bought, legislated or commanded into being. They must be derived from a close and integrated association of Medical Service personnel with flying personnel as members of one team, wearing one uniform, and inspired by a common purpose. A considerable number of

Air Force doctors would request separation from the Service in preference to their return to Army administrative control. Such an arrangement, if enforced, could only be regarded as a retrograde action entirely contrary and at variance with the lessons and experience the World War II, a resurrection of the very organizational ills which the Unification Act has gone so far to correct.

(6) Care of flying personnel requires emphasis upon the specialty of aviation medicine. The military Flight Surgeon has been accepted as a necessary adjunct to the program of medical attendance since 1918. Meanwhile, ever-increasing emphasis upon aircraft performance at the extremes of velocity, altitude and engineering performance serves to underscore the difficulties in adapting flying personnel to the deleterious effects and hazards of such operations. The entire Air Force medical program must be increasingly conditioned to the concept of the protection of flying personnel, and it must be oriented to this end under the direction of experience the air-minded physicians who are themselves identified, as well as in sympathy, with the aeronautical concept and the possibilities and potentialities of air power.

In conclusion, it is believed that the organization for medical attendance within the Military Establishment as presently constituted, which is less than one year old, should have a full and complete trial of its effectiveness before any radical changes in its structure are advocated. Certainly the promise of efficiency and sound management which the unified organization has revealed in its short year of existence has justified the perpetuation of the present system for many years to come.