

CHAPTER 5

COMMAND, CONTROL, AND COMMUNICATIONS**Section I. INTRODUCTION****5-1. General**

Chapter 4 discusses six general tasks that must be performed by dental units to accomplish the overall mission of providing dental service. Command and control is yet another task which must be successfully accomplished. It is addressed separately because it is an inherent part of each of the previously discussed tasks, as well as the means of coordinating all of the tasks toward the single objective of mission accomplishment.

5-2. Concept of Command and Control

a. Title 10 of the US Code directs that dental officers be organized into dental units commanded by dental officers. This is true for the dental officers assigned to area support dental units which comprise the largest portion of the dental force in the theater. However, some means must be provided for coordinating the overall dental service effort with those dental assets not assigned directly to

dental units, as well as among the dental units themselves. It is important, therefore, to understand the various dental command and technical control chains and the communication systems which support them.

b. Command and control of dental units assigned to a medical battalion is relatively straightforward; however, overall control of dental services in the CZ and within the entire theater is complicated for two reasons. First, approximately one-third of the dental officers within the CZ do not fall under direct dental command and control. Second, dental battalion headquarters detachments are usually late deployers, or may be nondeployers into the theater. It is imperative in either case that those dental resources present in a theater synchronize their work through available channels to provide a coordinated system of dental services. In many cases this will call for flexible and innovative application of normal command and control doctrine. It also requires a great deal of cooperation between all the separate dental elements in the theater. Field Manual 101-5 provides the basis for design of dental command and control.

Section II. COMMAND AND CONTROL**5-3. General**

According to FM 101-5, command is the authority a commander lawfully exercises over subordinates by virtue of rank or assignment. Inherent in command is the responsibility for the soldiers' health, welfare, morale, discipline, and training, as well as authority under the Uniform Code of Military Justice (UCMJ) and ethical responsibilities under the laws of land warfare. Command also includes the responsibility and authority for planning, employing, organizing, directing, coordinating, controlling, and maintaining the units' resources in a ready condition. The latter processes can be thought of collectively as control and are often delegated, in part, to members of the staff. In the case of commands with staff dental surgeons and subordinate dental units, delegation of some degree of control over dental operations by the non-dental commander to his dental surgeon is the most effective means of providing coordinated dental services.

5-4. Command Relationships

Command responsibility and authority are established through various standard relationships described in FM 101-5, most of which can be applied to dental units. The type of command relationship established for dental units depends on a number of factors, the most important of which is the presence of a dental battalion. When the dental battalion is not present, some modification of standard relationships may be necessary.

a. Organic. An organic unit is an integral part of the unit and is listed in the TOE. For example, the HHD of the medical battalion (dental service) is organic to the battalion.

b. Assigned. An assigned unit is one that has been permanently placed in an organization. The parent organization controls and provides administrative assistance to the assigned unit. For example, the medical company (dental service) is assigned to

the medical battalion (dental service) for command and control.

c. Attached. An attached unit is one that has been temporarily placed in an organization. The attachment is done formally by a written order. This order delineates any limitations on the commander's command and control of the attached unit. It also specifies what type of support the unit will require such as billeting or feeding support. The commander to which the unit is assigned normally retains the responsibility for promotion and for actions taken under the provisions of the UCMJ.

d. Collocated. When two or more units are physically placed at a specifically defined location, but have no formal attachment, they are said to be collocated. There may or may not be any reciprocal support between them.

e. Operational Control (OPCON). Operational control is another temporary measure by which a unit or element is provided to another commander to accomplish a specific mission. This arrangement is normally limited by function, time, or location. The relationship of OPCON does not include administrative and logistics responsibility, discipline, internal organization, and unit training.

5-5. Technical Control

Technical control is an ill-defined term; however, it is the basis for some degree of dental control and subsequent coordination of dental services within the TO. Field Manual 101-5 states that when the technical or professional nature of certain activities requires a special relationship, command responsibility and authority may rest with a commander outside the normal organizational chain of command. With respect to dental operations, technical control applies only to professional matters and aspects of the dental portion of the overall HSS plan. Technical control does not usurp command prerogative with regard to employment and OPCON; however, it can greatly influence conduct of operations at subordinate levels. Technical control guidance is usually in the form of policy and command directive. Dental commanders exercise technical control over their subordinates as part of their command authority. At higher levels, technical control is exercised by the medical brigade

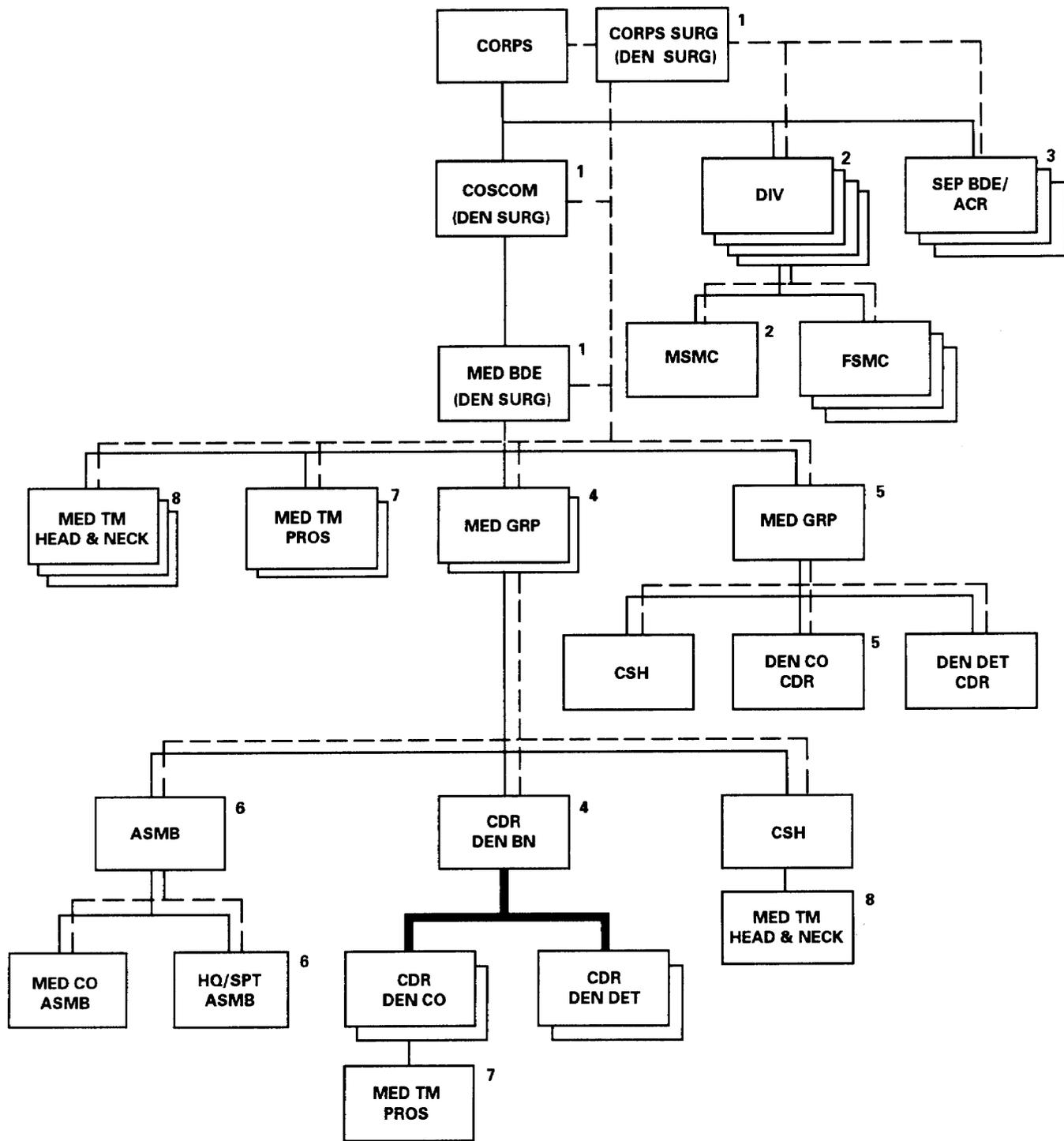
dental surgeon whose authority over divisional dental assets is a result of his extended responsibility as the corps dental surgeon. The MEDCOM dental surgeon exercises technical control over all dental assets in the theater and may be delegated OPCON over dental units in the COMMZ by the MEDCOM commander. Chapter 2 discusses the role of the dental surgeons and their technical areas of responsibility.

5-6. Command and Technical Control Chains

Figure 5-1 illustrates the dental command and technical control relationships in a five-divisional notional corps model used in the Total Army Analysis 96 force planning. Though notional and based strictly on bases of allocation for the units depicted, it is a fairly standard laydown. Health service support organization in the COMMZ is far more variable; however, the basic dental command and technical control relationships would be fairly similar. The continuous, solid lines in the figure represent the notional command chain overall, and the wide lines highlight the pure dental portion of the command chain. The broken lines represent the dental technical control chain based on the principles discussed in paragraph 5-5. In many cases the technical control chain crosses over the standard command chain, highlighting the difficult challenge posed to the senior dental surgeon in orchestrating a coordinated dental service program.

5-7. Interim Relationships

Dental resources are a scarce asset within the TO. It is, therefore, essential that they be employed in a manner which maximizes their capabilities. In LIC situations and in an immature theater, dental command and control units (medical battalion [dental service]) may not be deployed to the theater prior to the arrival of the medical companies (dental service), medical detachments (dental service), and medical teams (prosthodontics). An example is illustrated in Figure 5-1 where the medical brigade has three assigned medical groups, but only two medical battalions (dental service), causing one medical group to be without a dental command and control headquarters. The senior dental officer must, therefore, actively pursue support alternative which



LEGEND:

- 1 DEN SURG ORGANIC TO MED BDE ACTS AS COSCOM AND CORPS STAFF DEN SURG
- 2 MSMC DEN OFF ACTS AS DIV STAFF DEN OFF
- 3 FSMC/MED GRP DEN OFF ACTS AS BDE STAFF DEN SURG
- 4 CDR DEN BN ACTS AS MED GRP STAFF DEN SURG
- 5 CDR DEN CO ACTS AS GRP STAFF DEN SURG

- 6 HQ/SPT CO DEN OFF ACTS AS ASMB STAFF DEN SURG
 - 7 MED TMs ARE ASSIGNED TO MED BDE AND FURTHER ATTACHED TO DEN BN
 - 8 ASSIGNED TO MED BDE AND FURTHER ATTACHED TO CSH
- _____ COMMAND
 - - - - - TECHNICAL CONTROL / STAFF SUPERVISION
 _____ DEN COMMAND AND CONTROL

Figure 5-1. Corps dental organization.

most effectively support the delivery of dental care within the command. These different avenues may include organizational structure, delegation of authority, and formal or informal support agreements.

a. *Command.* In the absence of a dental command and control headquarters, the dental units would be assigned to the senior medical command and control headquarters. If the headquarters does not have a dental surgeon assigned, the commander of the dental company/detachment/team will also serve as the command dental surgeon. For example, prior to the arrival of a medical battalion (dental service) in the corps, the deployed medical company (dental service) would be assigned to a medical group for command and control. The dental company commander would also serve as the medical group dental surgeon. In this scenario, the *commander* of the dental company also serves in the staff position of the dental surgeon. Since he is a *commander*, additional dental companies/detachments/teams deployed may be attached to the medical company (dental service) for OPCON. In this arrangement, as the command dental surgeon he provides technical supervision and advice on the delivery of dental support, and as the commander exerts control over the employment of the dental assets commandwide.

b. *Technical Control.* If the senior medical headquarters has a dental surgeon assigned, he has *staff* responsibility (to include technical supervision) over the dental assets assigned to the command. However, he does not have a command relationship

with these units. To facilitate dental care delivery, this staff officer must ensure that the dental support effort is synchronized and uses the available dental assets efficiently. Because of his position, the dental surgeon has the ability to identify and analyze the dental support needs of the entire command, rather than only a specific dental element's area of operations. To enhance the medical headquarters commander's ability to provide dental services throughout his command, the dental staff surgeon may reach an understanding with the medical headquarters commander to facilitate this process. This agreement may permit the dental surgeon, in the name and authority of the medical headquarters commander, to dictate and coordinate the employment of the dental assets within that command.

5-8. Theater Army Dental Surgeon

The MEDCOM dental surgeon wears the dual hat of theater Army dental surgeon. In this vital role, he is the primary interface with the CONUS base for transfer of dental information. In addition to establishing overall theater dental policy, he is also the primary Army consultant to the unified command surgeon on joint service dental matters. In many instances, a formal MEDCOM is not present in the theater. It is important, however, that there be effective dental representation on the Army surgeon staff, or in any provisional MEDCOM that is formed, regardless of the size of the theater. Again, the senior dental officer (by position) assumes this role.

Section III. COMMUNICATIONS

5-9. General

Effective command and control depends on a reliable system of communications for transfer of information. On the battlefield, the Army relies on some form of electronic transfer as its primary means of communication. Communication equipment organic to HSS units is relatively limited. The HSS system, therefore, depends on direct and general support signal corps services. Health service support commanders must understand the total Army communications system to effectively communicate on the

battlefield and with the CONUS base. Field Manual 24-1 provides guidance on basic battlefield communication systems. The HSS commanders must incorporate support available from signal support systems into their overall communication plan.

5-10. Organic Communication Equipment

Current communication capability in dental units is extremely austere, limited in most cases to field telephones. Some relief for dental units and their

sister HSS units will be realized with the completed fielding of single channel ground and airborne radio systems (SINCGARS) radios, mobile subscriber equipment, computers, and data transfer equipment. Discussion in this manual, however, is limited to currently assigned equipment.

a. Radios. The HHD, medical battalion (dental service), and the medical company (dental service) are the only dental units currently equipped with secure frequency-modulated (FM) voice radio communication capability. The medical detachment (dental service) and the medical team (prosthodontics) do not have organic radios. They require communication support from the units to which they are assigned or attached. Therefore, the HHD has voice communication capability with its higher headquarters, the medical company (dental service), or other units equipped with FM radio capability. The reader must keep in mind the limitations imposed by the range of organic FM radios in such situations, which may require alternate means of communication.

b. Field Telephones. All dental units are equipped with TA-312/PT telephones in sufficient numbers to provide at least one for each of their organic elements. Additionally, each headquarters section is equipped with a manual telephone switchboard, SB-22/PT. The field telephone system provides both internal communication and external linkage to supporting units or communication nodes.

5-11. External Communications Support

Dental units are dependent on other units for varying degrees of communication support. This is particularly true for detached dental elements which have no capability other than a single field phone instrument, yet must still maintain contact with their unit headquarters. The two most likely possibilities for communication support are described below.

a. Supporting Medical Unit. The ideal supporting unit for dental units and their elements is a hospital. Army hospitals have radio capability with their parent headquarters and in most cases with other hospitals. Additionally, they are equipped with

a switchboard into which the dental element could link its field telephone.

b. Signal Corps Units. Dental units are unlikely to have a direct relationship with signal corps units in the area. However, they will be able to access a network system either through their supporting unit, or through direct wire linkage to the signal node. Landline telephone networks established by signal corps units are of particular benefit to dental units.

5-12. Alternate Communication Means

Alternative means of communication are available in addition to radio nets and voice telephone. Most involve the passage of hard-copy data either handwritten or machine transmitted. The advantage of hard-copy is that it is addressed specifically to the recipient, reducing the possibility of radio operators failing to pass on relayed information. It is also more appropriate for the transfer of voluminous statistical data and reports. Listed below are some possible alternatives to radio and voice telephone communication.

a. Teletype. If adjacent units have teletype capability, dental elements may be able to use that equipment to send the addressed message and rely on the receiver to deliver the message as appropriate.

b. Facsimile. Facsimile (FAX) machines are becoming more common on the battlefield. Dental elements with access to units equipped with FAX machines may be able to establish a support arrangement similar to that for teletype systems described above.

c. Message Center Distribution. Medical brigades and medical groups may have an established message center distribution network which can be used by assigned dental units.

d. Unit Courier. When all else fails, dental units may have to rely on an internal unit courier system, using organic vehicles. A wise economy would be to couple message traffic with scheduled and unscheduled supply distribution runs.

Section IV. COMMUNICATION OF DENTAL INFORMATION

5-13. General

Extremely limited capability for voice communication organic to dental units is offset somewhat by the limited amount of information which needs to be transmitted in real time. Most dental information is adaptable to “roll-up” and hard-copy transmission on a periodic basis. Dental commanders and staff dental surgeons should identify that information which must be transmitted and the appropriate channel for transmission.

5-14. Command and Staff Communications Channels

Command and staff channels are means of passing or communicating orders, instructions, advice, recommendations, and information within a headquarters and from one headquarters to another.

a. Command Channel. This channel is the direct, official link between headquarters and commanders. All orders and instructions to subordinate units pass through this channel. Within the dental units, instructions from the dental commander to his subordinate units or elements pass through command channels. Most command channel information relates to the immediate tactical situation and requires rapid transmission and dissemination.

b. Staff Channel. This channel is the staff-to-staff link between headquarters. Within dental units the staff channel deals primarily with day-to-day administration and support activities.

c. Technical Channel. Commanders and staff use this channel to send technical instructions between commands. Unlike the command channel and the staff channel, there is generally no dedicated technical communications channel. This is particularly true for dental technical information. However, the overall dental care system relies heavily on technical channels for dissemination of patient treatment policy and other professional guidance.

5-15. Types of Dental Information

Given limited communication capability, dental commanders and staff dental surgeons must choose carefully which information must be passed and the mode of transmission to use. Described below are various items of information pertinent to dental units and the probable mode of transmission. This description is not absolute and is open to modification to suit a particular situation; however, it does provide a good basis for establishing an effective dental information network.

a. Command Information. Command information is disseminated through command channels to dental units and their subordinate elements, if dispersed. The command channel generally consists of a secure radio net which is used to transfer immediate information concerning the tactical situation. The medical battalion (dental service) commander is part of the command net via his FM radio. Subordinate units not collocated with the medical battalion (dental service) headquarters are dependent on the supporting unit to relay command information transmitted over the radio net. Command information that is less time sensitive is usually transferred by hard copy or field telephone, if appropriate. Examples of command information are orders, directives, NBC reports, and tactical spot reports. Routine dental service operational matters generally are not transmitted over command channels.

b. Routine Information. The majority of dental information constitutes routine business and is passed through staff channels, both within the dental battalion and from the battalion to its higher headquarters. Most data-type information and standard reports passed through staff channels are transmitted either by wire or FAX, if available, or by courier if necessary. Bulk information is generally passed by courier. The primary means of voice transmission is by field telephone and available landline networks. Generally, dental units do not pass routine staff information through radio networks; however, in certain situations some units may require passage of formatted daily status reports by radio.

For convenience, the reports and information required on a regular basis by higher headquarters are generally formatted by SOP. Staff channel information pertinent to dental units covers the full spectrum of administration, support, and clinical operation matters including—

- Personnel actions.
- Supply.
- Work load reporting.
- Clinic status reports.
- Maintenance.

c. *Technical Information.* Dental technical information generally addresses professional matters and patient treatment policy and is issued in the form of written policy or directive “FOR THE COMMANDER.” Dental technical information is generally not time sensitive and is passed in hard copy either by wire or distribution. There maybe rare instances, however, when information such as drug or materiel safety alerts requires urgent priority for wire transmission. An important link in the dental technical channel is with the CONUS sustaining base through the office of The Assistant Surgeon General for Dental Services. The MEDCOM dental surgeon or the senior dental surgeon in the theater must establish this link. This is done either through the mail for bulk information, or using strategic communication capability, if accessible, for more time-sensitive information.

5-16. Patient Treatment Data

Capture of patient treatment data is necessary for planning current dental service support and dis-

tribution of resources. It also serves as a basis for future research and analysis of dental force structure requirements. Patient treatment information must be recorded, consolidated, and forwarded through the appropriate communication chain for further analysis and consolidation at each level.

a. *Patient Treatment Data Chain.* At the dental battalion level, information from subordinates is received and consolidated for transfer to the medical brigade dental surgeon through normal staff channels. In his role as medical group dental surgeon, the medical battalion (dental service) commander also solicits and consolidates dental patient treatment information from hospitals and area support medical battalions assigned to the group. The medical brigade dental surgeon, in his role as corps dental surgeon, also solicits and consolidates data through the corps surgeon’s office from the division dental surgeons. The medical brigade dental surgeon then consolidates dental information into a corps report and forwards it to the MEDCOM (senior dental surgeon if no MEDCOM is present) which develops a theater report for transmission to the CONUS base.

b. *Patient Treatment Data.* Figure 5-2 is a proposed format for a dental status report to be forwarded through the dental information chain, as required. At lower levels, it is forwarded daily by DTFs to their parent unit which will, in turn, consolidate input for forwarding to higher levels. Consolidating and forwarding from the medical brigade may be on a less frequent basis, but should be timely enough to allow senior staff dental surgeons to react to developing trends and situational changes. This status report is a consolidation of key items of information for planning purposes; however, the requirement remains to forward normal work load reports as discussed in Chapter 3.

SAMPLE FORMAT

DAILY DENTAL UNIT STATUS REPORT

UNIT _____
 LOCATION _____

DATE _____
 (Day/Month/Year)

DESCRIPTION	ARMY	AF	N/M	OTHER
DENTAL EMERGENCIES				
Disease and Nonbattle Injury				
Battle Injury				
Dental Emergency Follow-Up				
NONEMERGENCIES				
POSTMORTEM EXAMINATIONS				
PREVENTIVE DENTISTRY				
Dental Prophylaxis				
Other Preventive Services				

ADMINISTRATION (Remarks)

Personnel _____

Equipment _____

Supplies _____

Facilities _____

Other _____

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Figure 5-2. Daily dental unit status report.