CHAPTER 9

DENTAL SERVICES

Section I. CONCEPT FOR DENTAL SERVICE SUPPORT

9-1. Dental Mission

The dental mission in a TO is to conserve the oral health of the soldier by—

- Preventing oral disease.
- Promoting dental health.
- Providing dental treatment to eliminate or reduce the effects of dental disease and injury.
- Providing early treatment of severe oral and maxillofacial injuries for casualties that must be evacuated.

9-2. Dental Support in the Continuum of Care

The EAC discussed in FM 8-10 includes dental care beginning at Echelon II through Echelon IV. Each higher echelon reflects an increase in capability, but can perform the functions of each lower echelon. Field Manual 8-10-19 provides a comprehensive discussion of dental support.

9-3. Categories of Dental Care

Dental treatment is classified into four categories: emergency, sustaining, maintaining, and comprehensive. These categories are not absolute in their limits; however, they are the general basis for the definition of capability at the various echelons of HSS. Each category is successively greater in service provided and corresponding resources required to provide that service. Sustaining care is capable of less definitive treatment than maintaining care, but requires less equipment and is more suited to use farther forward in the battlefield where weight and mobility are greater concerns. Conversely, maintaining care provides a much wider spectrum of services, but is far more resource dependent and less suited to use in a rapidly moving scenario. Again, categories of dental care are not intended as absolute boundaries. They are better thought of as additive zones with each higher category including the capability of those lower ones. Of the four categories of care, only the first three—emergency, sustaining, and maintaining—are available in the TO.

a. Emergency Care. Emergency dental care is given for relief of oral pain, elimination of acute infection, control of life-threatening oral conditions (hemorrhage, cellulitis, or respiratory difficulties) and treatment of trauma to teeth, jaws, and associated facial structures. Consistent with the HSS tenet of return to duty, this care is expeditious and is available throughout the TO. It is the most austere type of care and is even available to soldiers engaged in tactical operations. Common examples of emergency treatments are simple extractions, antibiotics, pain medication, and temporary fillings.

b. Sustaining Care. Sustaining care is the dental treatment necessary to intercept potential emergencies. This type of care is essential for prevention of lost duty time and preservation of fighting strength. Soldiers with potential dental emergencies should be provided sustaining care as the tactical situation permits (see FM 8-10-19 for a discussion of dental classifications). Common examples of sustaining care procedures are basic restorations, extractions, interim pulpal therapy (pulpectomy), treatment of periodontal conditions, and simple prosthetic repairs. Sustaining dental care is consistent with Echelon II HSS. Dental modules organic to divisions, separate brigade

medical companies, area support medical companics, SFGs, and forward treatment sections of area support dental units are equipped to provide sustaining care.

c. Maintaining Care. Maintaining care is intended to maintain the overall oral fitness of soldiers at a level consistent with combat readiness. Soldiers who have oral conditions that, if not treated or followed up, have the potential but are not expected to result in dental emergencies within 12 months should be provided maintaining care as the tactical situation and availability of dental resources permit. Maintaining care is the highest category of care available in the TO and is provided by area support dental units. The scope of services includes restorative, exodontic, minor oral surgical, periodontics, endodontics, prosthodontic, and preventive procedures.

d. Comprehensive Care. Comprehensive dental care consists of those highly specialized procedures normally accomplished in fixed facilities in CONUS. Examples are reconstructive maxillofacial surgery, maxillofacial prosthodontics, and extensive oral rehabilitation and dental restoration. Though usually not available in the TO, comprehensive care is nevertheless a critical part of the dental continuum of care which extends from forward areas of the CZ, through the COMMZ, to the CONUS base.

Section II. ORGANIZATION OF FIELD DENTAL SUPPORT

9-4. Unit Dental Support

Unit dental support is provided by dental personnel organic to Echelon II medical units. Dental modules are organic to the area support squads in the medical companies of divisions, separate brigades and ACRs, and the medical element of the SFG. Dental modules are also found in the area support squads of the area support medical company (ASMC) located throughout the CZ and COMMZ. The dental modules which are the basis of unit dental support have the capability to provide sustaining care as discussed in Section I. Their primary objective, however, is to return the soldier to duty as rapidly as possible consistent with the tactical situation. At times, circumstances may allow provision of expedient emergency care only, while at other times circumstances may allow the full range of sustaining care.

9-5. Unit Dental Support Organization

a. Dental modules are organic to the area support squad in the medical companies of each division, separate brigade/ACR, SFG, and area support medical battalion (ASMB). Each division has one major (MAJ), area of concentration (AOC) 63B (comprehensive dentist), in the dental module of the MSB medical company and a captain (CPT), AOC 63A (general dentist), in the dental module of each FSB. A MOS 91E10 (dental specialist) is also assigned as part of each of these modules.

b. The modules in separate brigade/ACR medical companies and SFGs have a CPT, AOC 63A, and a MOS 91E10. Similar to the division, the dental modules in separate brigades/ACRs are in the area support squads of the medical company/ troop at the support battalion/squadron. The dental module in the SFG is located in the medical platoon of the service companies.

c. Each unit support dental officer also functions as the dental surgeon for his supported unit—a special staff position. In the division, the comprehensive dentist, AOC 63B, of the main support medical company is the division dental surgeon.

9-6. Unit Dental Support Concept of Operations

a. Unit dental personnel are not present in sufficient numbers to provide dental care to all the members of their supported units on a continuous basis without support from area support dental units. Therefore, depending on the situation, it may be necessary to return personnel to their units with other than definitive treatment (for example, temporary as opposed to permanent restorations). The primary concern of unit dental personnel is to return the soldier to duty as expeditiously as possible in a condition to continue his duties. Unit dental support relies on corps-level area dental support units for provision of higher categories of care (maintaining). Modules of area dental support units also augment or reconstitute unit dental elements when necessary.

b. Dental casualties in maneuver battalions are evacuated from forward areas to the BAS. Here they are evaluated and, if required, are further evacuated to the division clearing station of the medical company to be seen by the dental officer assigned to the area support squad. This officer will examine the patient and provide treatment necessary to return him to duty. If the treatment required is beyond the capability available, the patient will be evacuated or referred to the supporting corps area dental support or hospital unit, consistent with the patient's condition and the tactical situation.

9-7. Hospital Dental Support in Corps and Communications Zone

Hospital dental support is provided by dental personnel organic to the CSH, TOE 08705L; the FH, TOE 08715L; and the GH, TOE 08725L. Under MF2K, the MASH has no capability for dental support, Prior to the L-edition TOE, the dental sections organic to the hospitals were different from one type hospital to another. Under the L-edition TOES, all hospital dental sections are identical.

9-8. Hospital Dental Support Organization

a. The primary mission of hospital dental sections is to minimize loss of life and disability resulting from severe oral and maxillofacial injuries and wounds. When casualty care work load permits, dental resources provide dental treatment to hospital patients and staff. In addition, treatment is provided to patients referred by other dental and medical facilities when required oral and maxillofacial care is beyond the capability of the referring facility,

b. All three types of hospitals with organic dental capabilities (CSH, FH, and GH) are organized under the modular concept. (See Chapter 5 for a discussion of the modular concept.)

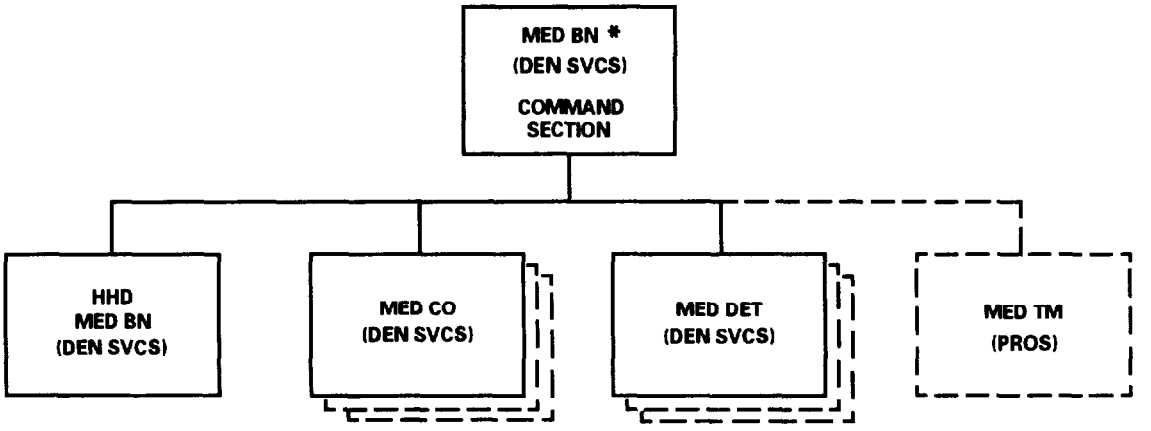
c. The dental capability of all three hospitals is found in the HUB.

d. The maxillofacial surgery capability in these hospitals can be augmented by attaching a Medical Team, Head and Neck Surgery, TOE 08527LA. As with other units under the modular concept, the dental sections of the different hospitals are interchangeable.

9-9. Area Dental Support

Area dental support is provided by dental personnel and equipment organized into dental service units capable of providing all categories of dental care up to and including maintaining care. These units are the Medical Company (Dental Service), TOE 08478L; Medical Detachment (Dental Service), TOE 08479L; and Medical Team (Prosthodontics), TOE 08588L. They are usually assigned to and under the command and control of the

medical battalion (dental service) (see Figure 9-1). As the name suggests, area dental support is provided within a designated geographic AOR. However, within this AOR, area dental support units may be tasked to provide DS to unit or hospital dental support elements. They may also be tasked to reconstitute unit dental support modules with like modules from within their own unit. Area dental support represents a major share of the dental capability within the TO. The remainder of this section will focus primarily on area dental support and the units which provide it.



*COMMANDS AND CONTROLS FROM 3 TO 8 ASSIGNED OR ATTACHED DENTAL UNITS

LEGEND:

DEN	DENTAL
PROS	PROSTHODONTICS
SVCS	SERVICES

Figure 9-1. Medical battalion (dental service).

9-10. Headquarters and Headquarters Detachment, Medical Battalion (Dental Service),TOE 08476L

a. Mission. The HHD provides command and control to assigned and attached dental organizations. (This unit also provides administrative, logistics, and personnel support to the headquarters and technical guidance to subordinate units on medical equipment maintenance and Class VIII supply.)

b. Assignment. This unit is assigned to MEDCOM, TOE 08611L; Medical Brigade, TOE 08422L; or Medical Group, TOE 08432L.

c. *Capabilities.* This unit provides—

(1) Command and control of three to eight assigned or attached dental units.

(2) Allocation of dental resources (personnel and equipment) to ensure adequacy of dental service to all units within the assigned AOR.

(3) Technical expertise, coordination, and support to subordinate units for accomplishing their medical equipment maintenance and Class VIII supply.

(4) Current information concerning the dental aspects of the CSS situation to higher headquarters.

d. Basis of Allocation. One unit is allocated for each three to eight subordinate dental service organizations.

e. Mobility. This unit is capable of transporting 50 percent of its personnel and equipment in a single lift using organic vehicles.

9-11. Medical Company (Dental Service), TOE 08478L

a. Mission. This unit provides emergency, sustaining, and maintaining dental care.

b. Assignment. This unit is assigned to the HHD, Medical Battalion (Dental Service), TOE 08476L.

c. Capabilities. This unit provides maintaining care, including prosthodontic specialty care, for 20,000 troops or sustaining care for 30,000 troops on an area basis. It is composed of from one to eight field DTFs, consisting of one or two base DTFs providing maintaining care, and up to six dental treatment modules which can reinforce or reconstitute the division dental modules, when necessary, or provide sustaining care for small or forward troop concentrations. The unit also provides unit maintenance of organic equipment for the HHD, Medical Battalion (Dental Service), TOE 08476L. The medical company, dental service is capable of augmenting the ATM capabilities of other MTFs during MASCAL situations.

d. Basis of Allocation. One for each 20,000 troops supported. Seethe medical company (dental service) organizational diagram in Figure 9-2.

e. Mobility. This unit is capable of transporting 50 percent of its personnel and equipment in a single lift using organic vehicles.

9-12. Medical Detachment (Dental Service), TOE 08479L

a. Mission. This unit provides emergency, sustaining, and maintaining dental care.

b. Assignment. This unit is assigned to the HHD, Medical Battalion, (Dental Service), TOE 08476 L000.

c. Capabilities. This unit provides maintaining care for 8,000 troops, or sustaining care for 12,000 troops on an area basis. It is composed of from one to four field DTFs. These DTFs consist of a base DTF that provides maintaining care and up to three dental treatment modules to reinforce or reconstitute the division dental modules, when necessary, or to provide sustaining care for small or forward troop concentrations. This unit is capable of augmenting the ATM capabilities of other MTFs during MASCAL situations.

d. Basis of Allocation. One for each 8,000 troops supported. See the medical detachment, dental service in Figure 9-3.

e. Mobility. This unit is capable of transporting 50 percent of its personnel and equipment in a single lift using organic vehicles.

9-13. Medical Team (Prosthodontics), TOE 08588L

a. Mission. This unit provides additional prosthodontic dental support when required by augmenting existing dental and hospital organizations.

b. Assignment. This unit is assigned to the medical brigade (CZ) or medical brigade (COMMZ) with further attachment to a medical battalion (dental service).

c. Capabilities. This unit provides additional fixed and removable prosthodontics support for up to 40,000 troops.

d. Basis of Allocation. As required, based on stated capabilities.

e. Mobility. This unit is capable of transporting 33 percent of its personnel and equipment in a single lift using organic vehicles.

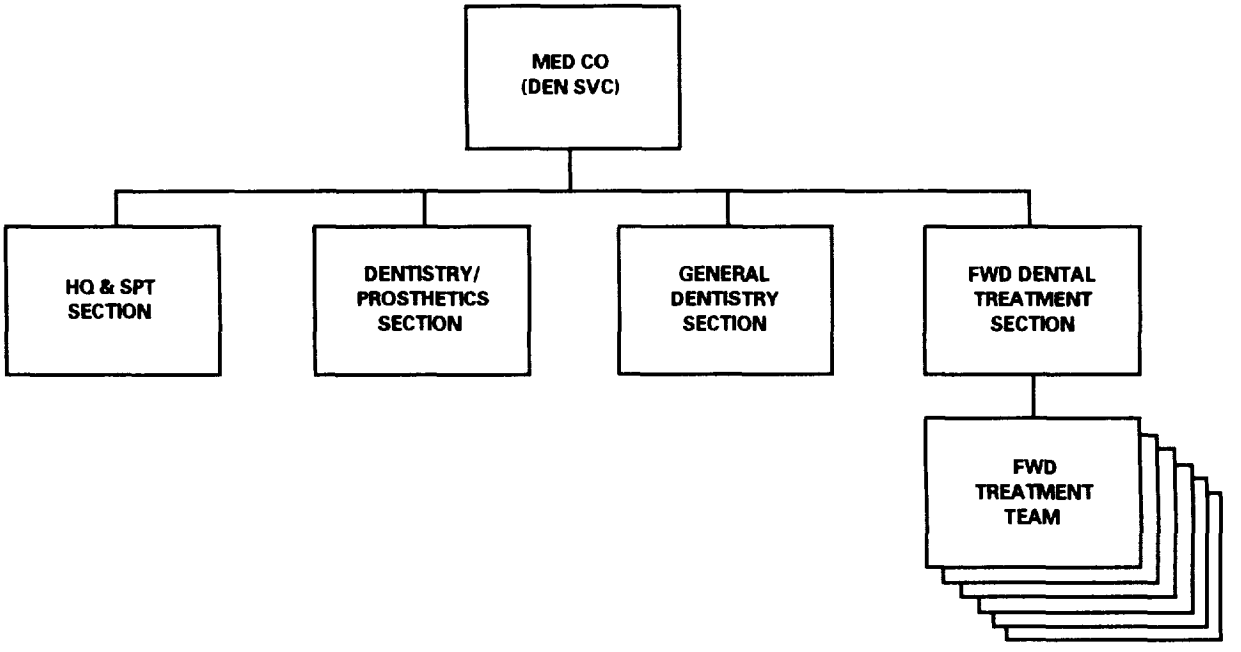


Figure 9-2. Medical company (dental service).

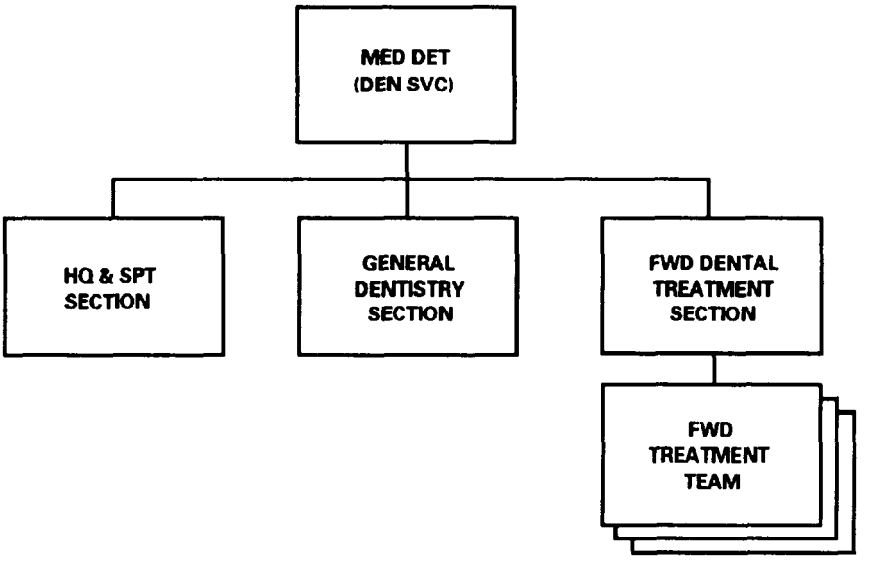


Figure 9-3. Medical detachment (dental service).

Section III. DENTAL STAFF

9-14. Dental Surgeon

Coordination of the collective efforts of unit, hospital, and area dental support activities with the overall HSS operation is accomplished through dental representation on appropriate command and control staffs, usually in the form of a command dental surgeon. The dental surgeon is a *special staff officer* under the coordinating staff supervision of the S1/G1). In the medical brigade, the dental surgeon is a separate TOE position. In divisions, this position is filled by the comprehensive dental officer, AOC 63B, assigned to the MSB of the division support command (DISCOM). A dental unit commander who also serves as dental surgeon is described as being *dual-hatted.* In some cases, the dental surgeon position is not clearly identified and becomes an ad hoc arrangement. Staff advocacy is a critical element in the development of a coordinated dental service support system throughout the TO.

9-15. Responsibilities

a. The dental staff officer provides input to the commander on policy, procedures, and plans that concern oral health and dental care. He prepares the dental estimate and assists in preparing the dental portion of the HSS OPLAN. He assists in writing the dental support portion of OPORDs. He provides technical guidance on dental matters to subordinate dental resources. He monitors the oral health of the supported population, the readiness of unit dental assets, and the tactical and strategic situation of supported units. He also

assesses HSS plans to determine dental resource requirements. Specific duties may include surveillance of—

(1) The oral health and dental readiness of supported units.

(2) Severe oral and maxillofacial surgery cases in hospitals.

(3) Status of dental resources in the AOR.

(4) Operational requirements of supported troops (for example, number and types of units supported or in the AOR; number of troops in supported units or AOR; tactical and strategic situation; location and distribution of supported units; and expressed needs of commanders).

(5) The provision of dental services to EPW, refugees, and others.

b. The dental staff officer also serves as advisor to the commander on dental matters. On the basis of the information from surveillance, he will make recommendations concerning oral health and dental delivery for plans, OPORDs, and policy.

9-16. Dental Staff Officer Positions

a. Division. The senior dental officer in a division is assigned to the MSB. In addition to his patient care responsibilities, he acts as the division dental surgeon and exercises technical supervision over the dental assets in FSBs of the division. Dental officers in the FSBs serve as dental surgeons to the supported maneuver brigades.

b. Separate Brigades, Armored Cavalry Regiments, and Special Forces Groups. The dental officer in the medical element of these units also serves as dental surgeon for the parent unit.

c. Medical Brigade (Corps: TOE 08422L1; COMMZ: TOE 08422L2). A dental surgeon, colonel (COL), AOC 63R, is located in the headquarters company, command section. He exercises technical control over dental assets in hospitals and dental units subordinate to the medical brigade. Dental surgeons of corps medical brigades are dual-hatted as the corps dental surgeon and provides technical supervision for unit-level dental support (in divisions, separate brigades, and ACRs), as well as for dental assets assigned within the brigade. The medical brigade dental surgeon is complemented by a senior dental noncommissioned officer (NCO) (MOS 91E50) assigned to the security, plans, and operations section.

d. Medical Command (MEDCOM: TOE 08611L). There are three dental staff officers in the headquarters company.

(1) The MEDCOM dental surgeon, a brigadier general (BG), AOC 00B, establishes and disseminates Army theater policy on dental matters. He exercises technical control over all dental units in the TO through the medical brigade dental surgeons. He directs the dental services element of the headquarters and provides dental staff support to the MEDCOM commander.

(2) The MEDCOM assistant dental surgeon, COL, AOC 63R, is located in the dental services element of the headquarters. He assists the MEDCOM dental surgeon by recommending policies and procedures and providing dental coordination with other staff elements.

(3) The MEDCOM preventive dentistry officer, lieutenant colonel (LTC), AOC 63H, supports the MEDCOM dental surgeon and assistant dental surgeon in all staff actions. Specific duties include—

Ž Providing oral health surveillance information in support of policy and procedure development,

Ž Developing plans and orders concerning oral fitness and preventive dentistry programs.

Ž Recommending treatment policies.

Ž Developing programs for dental support of humanitarian and civic action operations.

Section IV. THE DENTAL ESTIMATE OF THE SITUATION

9-17. Factors and Premises

a. The primary consideration in dental planning is the development of a dental estimate of the situation. To do this effectively, dental staff officers must have access to the necessary details of operational planning. This information will enable them to coordinate the dental plan with the OPLAN so that the required dental support will be provided. The dental surgeon must have knowledge of the policies established by the commander. He must also know the commander's decisions on new situations for which a policy has not been established. All planning must be based on accurate information as to the status of the dental health of the troops so that those in greatest need are provided for first.

b. When possible, dental services must also be coordinated with those of the Navy and the Air Force to effect unity of effort and make the best use of available resources through such actions as shared use of DTFs or designated AOR.

9-18. Development of the Estimate

a. The dental estimate is a logical thought process used by the dental surgeon to—

Ž Decide what has to be done to accomplish the dental mission.

• Consider all aspects affecting the dental situation. Some examples are—

Ž Population to be supported.

Ž Category of dental care to be provided.

Ž Availability and source of fuel.

ŽAvailability of electrical power to supplement the power sources available to the dental unit.

Ž Availability of water to support dental treatment.

Ž Climatic conditions which adversely affect dental materials.

Ž Flexibility of plans to support alternate roles for dental personnel and/or MASCALs.

Ž Maintenance support for medical/dental equipment.

Ž Participation by dental personnel in rear area protection. (See FM 8-10 for information on the effects of the laws of land warfare on HSS.)

b. The estimate is a checklist of steps used to plan dental service. Circumstances vary with the type of the command, but the fundamental steps of the thought process in preparing the estimate remain unchanged: the mission, the situation and considerations, the HSS analysis, the evaluation and comparison of COA, and the conclusions. (These steps are discussed separately in paragraphs 9-19a through 9-19e below.)

c. Normally, the dental surgeon begins his estimate based on available tactical and administrative information. When he does this, his estimate is well under way by the time the commander's guidance is announced. Waiting to start the estimate until the commander provides his guidance may delay dental planning.

d. Preparation of the dental plan may begin before the dental estimate is completed. As each problem is recognized and solved, a part of the dental plan is automatically formulated. As soon as these fragments of information are accumulated, they should be passed on to subordinate dental surgeons and commanders to help them prepare adequate implementing plans. (See Appendix B for the suggested format for the dental estimate.)

9-19. Format

a. Mission.

(1) The dental mission is stated in the first paragraph. Like the mission of the HSS estimate, it is always stated in terms of the tactical situation. Broadly speaking, the mission of all dental units is to provide dental service to the troops which they support. The mission of the troops served determines the general type of dental operations. This mission will guide the dental surgeon—

- In changing and adjusting the dental support as required.
- In granting priorities to combat troops and others as the need arises.

(2) A clear statement as to what type of operation is to be supported must be included; for example, "To provide dental support to the Thirtieth US Army in offensive operations to the east to seize Euralandia." The mission is the primary guiding consideration for the remainder of the dental estimate. It must be stated as clearly and as concisely as possible. If several categories of personnel are to be provided different types of dental service, the fact should be stated in this paragraph. The estimated duration of the operation will be included.

b. The Situation and Considerations. The situation and considerations are stated in paragraph 2 of the dental estimate. The various factors affecting the dental service of the particular operation are given. Those facts, assumptions, and deductions that can influence the dental staff officer in choosing the best way to accomplish his mission are set forth in an orderly manner. Paragraph 2 is broken down into factors or elements selected by the dental surgeon as important to the situation. The consideration of each factor or element divides itself into a statement of facts as known and a deduction from these facts.

(1) The enemy situation. Information for this part of the estimate is provided by the Assistant Chief of Staff (Intelligence) (G2). When the estimate is written, a brief summary or reference to the latest periodic intelligence report may be sufficient. Considered here will be the enemy's—

- Strength and disposition,
- Combat efficiency.
- Capabilities that might affect ability of the dental service to perform its mission.

Ž Logistics situation.

Ž State of health.

• Weapons.

(2) *The friendly situation.* Information for this portion is obtained from the commander's planning guidance and the Assistant Chief of Staff (Operations and Plans) (G3). It includes—

Ž Strength and present disposition of the troops to be supported.

• Combat efficiency.

• Present and projected operations, if known.

• Logistics situation.

• Weapons.

(3) *Characteristics of the area of operations.*

• Terrain.

• Weather.

• Civilian population.

• Flora and fauna.

• Local resources.

• Other.

(4) *Strengths to be supported.* This information is obtained from the G1. Consideration is given to the following:

• The present dispositions of administrative units and installations (other than logistical or CA) for which dental support must be provided.

• Availability of troops to receive dental care and units phasing into the area, including the flow of replacements.

Ž Projected developments within the personnel field which may influence dental support of the operation (for example, sudden changes of troop strength, or institution of a rest and rehabilitation leave policy).

• Dental requirements for the estimated number of Army, Navy, Air Force, Marines, allied personnel, EPW, indigenous civilians, detainees, and civilian interns.

(5) *Oral health of the command.* (This includes at least dental conditions of arriving troops and preparation of replacements for oversea movement [POR] dental requirements.)

(6) *Assumptions.* Assumptions may be required in the preparation of an estimate, but they should be eliminated or modified as appropriate when factual data and specific planning guidance become available.

(7) *Special factors.* At this stage of the dental estimate, it is advisable to link the current dental situation with all that has been considered above. This should include the strength, location, and mission of the dental units available; quality and status of training of dental units; local civilian dental personnel available; attitudes and capabilities of the civilian population; buildings and utilities; construction and use of existing facilities; base development; degree of permanency; and back-up support such as CONUS-based area dental laboratories.

c. Dental Support Analysis. The analysis(paragraph 3 of the dental estimate) is a logical comparison of the estimated dental requirements

of the command with the dental resources available for support of the operation. Under each of the following subheads and for each COA, the requirements, availability, or capability will be determined and any limiting features indicated.

(1) *Dental service personnel estimate.*

(2) *Patient estimates.*

(3) *Support requirements and resources available.*

(a) *Supply.* The dental surgeon considers here whether normal supply requirements are being met for this operation, or whether certain supply shortages are causing a reduced capacity of dental units to perform their mission. He also considers any unusual supply requirements for this particular operation. Since the dental service is not primarily responsible for its supply requirements, the command surgeon must be informed. Providing him this information is the responsibility of the dental surgeon. Therefore, any equipment or supply discrepancies which are likely to influence the successful accomplishment of the dental mission should be immediately brought to the attention of the command surgeon.

(b) *Transportation.* Transportation requirements are determined for the different COA chosen. The necessary mobility to exploit opportunities to furnish dental treatment wherever and whenever it can have its maximum effect must be considered. The availability of additional transportation, if required, is considered. The vehicle status of the individual dental units is a big factor. For example, if several vehicles of a dental unit are deadlined for maintenance, this unit may need additional transportation; whereas, if priority were to be given to the repair of those vehicles, no additional transportation would be needed. The actual condition of the roads and bridges may be a limiting factor on the transportation means available to move the dental units and supplies.

(c) *Services.* Information received from other special staff officers regarding the location, capabilities, and limitations of their services and various COA are analyzed. For example, it is determined which organizations are best located and capable of providing the necessary logistical support, such as rations, administration, and motor maintenance, for dental units.

(4) *Medical evacuation and hospitalization.* This includes a consideration of diseases likely to affect the operation, status, and capability of the hospital dental service; any unusual requirements for head and neck surgery teams; and plans for medical evacuation and hospitalization (extent and locations).

(5) *Miscellaneous.*

(a) Included here are any special or unusual considerations which might affect the ability to accomplish the mission. The dental staff officer should consider at least the following factors when evaluating and determining the troop requirements for the dental service:

- Determining the functions and tasks to be performed.
- Determining the quantitative work load.
- Selecting the type of dental unit(s) having the capabilities required.
- Calculating the number of dental units required, including any augmentation required.
- Providing adequate command and control. For example, an insular or

circular theater may require only one battalion headquarters, while a broad or elongated theater might function more effectively with two battalion headquarters.

(b) The dental surgeon must consider not only the dental units organic to or attached to the command, but also those dental units supporting the command such as the CONUS-based area dental laboratories, the supporting Navy or Air Force dental units, or available host-nation dental support. He must review the dental troop ceiling to determine the possibility of securing additional units, if required. Securing additional dental units must be considered early to ensure adequate dental service when needed.

(c) When required to provide dental support for indigenous personnel, the dental surgeon should consider using locally trained dental personnel and locally procured dental supplies, if available. Likewise, the provision of dental support to EPW personnel should be accomplished using captured health care personnel and supplies, if available. Use of indigenous personnel and captured dental supplies to provide care to EPW will promote maximum effectiveness of the Army Dental Service in providing care to US Army troops and will conserve scarce resources.

(6) *Dental courses of action.* From the foregoing comparison of requirements versus means, the dental surgeon has determined what the major dental problems will be. He must now develop the general COA which are available to combine these two elements and provide proper dental support for the operation. The general policies and procedures that will do the job best are listed here. A comparison of the various COA listed is not made in this paragraph, but in paragraph 4 of the dental estimate.

d. Evaluation and Comparison of Dental Courses of Action. Paragraph 4 of the dental estimate contains a dental evaluation of the COA under consideration. The outstanding dental elements and the controlling limiting features considered in paragraph 2 of the estimate are listed. The COA listed at the end of paragraph 3 are then compared with one another in the light of these major dental elements, and advantages and disadvantages of each are noted. Conclusions are not drawn at this step but are deferred until the evaluation of all COA in the light of the controlling dental elements is complete.

e. ***Conclusions.***

(1) The conclusions of the dental surgeon are set forth in paragraph 5 of the dental estimate. This paragraph provides the decision of the dental surgeon and corresponds with the decision paragraph of the commander's estimate, but the paragraph is designated as "conclusions" rather than "decision" due to the dental surgeon's position as special staff officer of the command.

(2) This paragraph provides the staff and the commander with a statement as to whether the operation can be supported with an adequate dental service. If it cannot, a clear outline of the reasons must be given. The dental surgeon makes a general statement here of the COA that will best support the commander's mission with the maximum economy of dental means. Economy of dental means, while secondary to provision of good dental support, is of extreme importance both to the dental surgeon and to his commander. It helps to ensure dental resources for the next operation.

(3) This decision or conclusion of the dental surgeon guides subordinate dental surgeons in their planning. Listed in this paragraph also are the unavoidable dental limitations or deficiencies that must be recognized by everyone associated with the dental service of the command. Such a listing will ensure coordinated efforts by all to reduce the effects of such limitations.

Section V. THE DENTAL PLAN

9-20. Development of the Plan

a. After determining the nature and extent of the dental problem (the dental estimate), the procedures to be followed, and the requirements for additional dental support, the final stage is the fixing of responsibility for dental functions and services. This is done by considering the resources available to each subordinate tactical and dental unit commander and the tasks to be performed.

b. The statement of dental support and service policies and the specific fixing of responsibilities for dental functions is the generally accepted form in which the dental plan is presented. Dental plans are not usually formal or written at echelons lower than medical command/medical brigade level. Regardless of whether or not the plan is written in detail and published, the dental surgeon should carry out the planning procedure to ensure that all pertinent points are covered.

9-21. Format for the Dental Plan

a. The dental plan is a part of the HSS plan and is included in it or, if very detailed, appended to it. It bears the same relationship to the dental estimate that the HSS plan does to the HSS estimate. A standard format for the dental plan is of value as a checklist for any dental surgeon arranging dental support of a military operation. This format also facilitates use of the information it contains by lower echelons.

b. Appendix C provides a suggested format for the dental plan. Each operation may require a special tailored plan to meet the requirements of a specific tactical operation. Dental surgeons may develop checklists to ensure all pertinent areas are considered. Essentially, the dental plan will be divided into the following six parts:

(1) *Assignment of responsibilities.* (A separate subparagraph is included for each unit giving location, mission, and attachments if indicated.)

(2) *Prevention.* (Identify preventive measures to be performed by the individual, troop units, and dental units to reduce dental casualties.)

(3) *Treatment.* (Include types of dental care to be provided and prioritization of treatment.)

(4) *Alternate wartime role.* (Establish guidelines for dental personnel to support hospital units when required by heavy patient loads.)

(5) *Reporting.* (Include basic information to be reported, such as number of patients seen, type of care provided, and patient dental classification. This information is reported from the DTF through the dental operational chain of command. This information is essential for planning and resource allocation. Commanders and dental staff officers at all levels evaluate this information, identify trends, and make operational decisions accordingly.)

(6) *Miscellaneous dental matters.* (Include specific clinical protocols appropriate for the situation such as “definitive crown and bridge procedures will not be initiated.”)