

The Hidden Casualty Load

Integrating Dental Emergencies into Large-Scale Combat Operations Planning

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In March 2025, retired Air Force Maj. Gen. Paul Friedrichs warned the US Senate Committee on Armed Services about the growing number of soldiers “pulled off the line” for dental emergencies—an issue he identified as especially acute within the National Guard and Army Reserve.¹ Dental readiness has long challenged modern militaries, but its consequences are magnified in large-scale combat operations (LSCO). Disease and nonbattle injuries (DNBI) have compromised combat effectiveness throughout military history. Modern medicine and public health practices like food and water sanitation have minimized the

threat to life, but DNBI remains a significant cause of morbidity. Dental emergencies are a subset of DNBI in a deployed theater of operations that can degrade the combat strength of brigades and divisions. Dental teams play a critical role in sustaining the force by treating emergencies swiftly and returning soldiers to duty, thereby preserving combat power and operational momentum. Yet, despite this essential contribution, deployable dental capabilities continue to decline. This trend underscores the urgent need for accurate dental emergency modeling in war-gaming to emphasize the importance of DNBI and dental emergencies. To give



A patient receives dental care at a field dental clinic during a January 2023 field training exercise at Fort Bragg, North Carolina. (Photo by Lt. Col. Gamal Baker, US Army)

commanders a true picture of medical risk in future conflicts, Warfighter exercises (WFX) must incorporate historically grounded casualty estimates that fully account for DNBI.

The Operational Challenge for Commanders

In contested logistics environments characteristic of LSCO, commanders face stark choices about scarce evacuation assets. A dental emergency—while not life-threatening—creates the same immediate non-mission-capable status as a combat injury. A dental emergency is any acute oral condition impairing a service member's mission readiness, operational performance, or ability to consume normal daily rations, which increases the risk of mission failure.

Severe dental pain renders a soldier unable to operate weapons, make tactical decisions, or sustain physical exertion. Oral conditions that are expected to result in a dental emergency within twelve months are designated as Dental Readiness Category 3 (DRC 3).² Per Department of Defense Instruction 1332.45, *Retention Determinations for Non-Deployable Service Members*, DRC 3 is now an individual medical readiness deficit rather than a barrier to deployment; thereby, allowing commanders to deploy their soldiers in this status.³ Consequently, medical operations planners must recognize the increased likelihood for dental emergencies in theater and ensure robust, forward-deployed dental support to prevent mission degradation. Unfortunately, current WFX models don't force commanders to make triage decisions

involving dental casualties because these casualties aren't included in scenarios.

Unrealistic expectations regarding casualty estimates for wounded in action (WIA) and DNBI were discussed during the 2024 LSCO Symposium. While acknowledging the severity of projections, senior leaders admitted training objectives must be balanced with the need to train fires and maneuver.⁴ But the methodology and design of WFXs must include all types of casualties and with the appropriate proportion. Experiments that solely focus on the number of WIA will invariably produce flawed results since they only consider a portion of the total expected casualties. What distinguishes dental casualties is their return-to-duty (RTD) potential. When dental capability exists, 96 percent of dental casualties RTD within one to two visits.⁵ This contrasts sharply with many surgical casualties requiring prolonged recovery. In LSCO's attritional environment, the ability to restore combat power within hours rather than days has strategic value—but only if planning accounts for this requirement.

Dental Emergencies: The Persistent Problem

The history of warfare has shown that armies incur more casualties from DNBI than from direct combat.⁶ The burden of dental emergencies on combat effectiveness must be historically understood within the overall context of medical readiness. During World War II from 1942 to 1945, the US Army Dental Service performed approximately 12.6 million fillings and 2.5 million extractions while overseas.⁷ During the Korean War in 1952, the 7th Infantry Division dental surgeon reported that 23 percent of their entire division required emergency dental treatment.⁸ In 1968, during the Vietnam War, field commanders reported that dental emergencies incapacitated their soldiers for up to seven days, with an annual rate of 142 dental emergencies per one thousand soldiers.⁹ During Operation Iraqi Freedom, dental emergencies accounted for 19 percent of all treatment at a US Role 2 medical treatment facility, far exceeding the number of WIAs.¹⁰ In 2016, a Canadian-led Role 2 medical treatment facility deployed to Iraq and reported that dental emergencies comprised 46 percent of all patient encounters.¹¹ James A. Nicholson et al. estimated that dental emergencies will account for 17 percent of all casualties during prolonged field care scenarios.¹²

The war in Ukraine has shown the gritty reality of large-scale combat with a near-peer adversary. The over seven hundred attacks on Ukrainian hospitals reflect a targeted destruction of civilian medical infrastructure.¹³ These attacks include 181 ancillary facilities like pharmacies and dental clinics, which often serve as casualty collection points.¹⁴ The degradation of civilian dental facilities has allowed dental disease to progress for years, resulting in severe treatment needs and compromised readiness among the Ukrainian military.¹⁵ Even potential adversaries acknowledge challenges—Russian military medical literature explicitly identifies dental casualty management as an operational planning factor requiring dedicated resources and capability.¹⁶ The Russian military has documented its own struggle addressing dental emergencies on the battlefield. Dense artillery fire across the entire operational depth endangers Russia's ability to deploy standard dental equipment. These reports emphasize dental's strain on the ability to clear future battlefields and how the movement of dental patients can limit a commander's freedom of movement.

Evacuation of Dental Emergencies

The Russian and Ukrainian experiences are not unique. French forces deployed to Mali reported that 16 percent of all medical evacuations were for dental emergencies.¹⁷ For this reason, North Atlantic Treaty Organization (NATO) allies, including Canada and the United Kingdom, maintain dental capabilities at Role 2 facilities, recognizing that forward treatment minimizes evacuation burden. A review from 2009 to 2023 shows that within the US Central Command (USCENTCOM), there were 34,318 service members, civilians, and contractors who required evacuation to a dental treatment facility.¹⁸ The staggering volume of intratheater patient movement for dental needs peaked during narrow windows of combat operations. In Afghanistan, 14,514 (90 percent) of these evacuations occurred from 2010 to 2014.¹⁹ In Iraq, 13,660 (96 percent) occurred from 2010 to 2011, with an average of 723 evacuations per month.²⁰ Unfortunately, USCENTCOM's reported dental evacuations underrepresents the true burden throughout the Global War on Terrorism. The system tracking these metrics, implemented in 2009, lacks data from earlier periods.²¹ Given the implementation



Soldiers from 3rd Brigade Combat Team, 101st Airborne Division, converse outside the entrance of a Role 2 medical facility on 3 June 2024 at the Joint Multinational Readiness Center, Hohenfels Training Area, Germany. (Photo by Capt. Roland Alonzo, US Army)

timeline, data from the 2003–2008 surge periods remain undocumented, indicating an even greater historical burden. Escalating the problem of patient movement, 58 percent of the dental emergency evacuations within USCENTCOM occurred by ground vehicle, predominately casualty evacuation.²²

In LSCO, the absence of air superiority renders air medical evacuations infeasible. Consequently, ground vehicles will serve as the primary means for patient movement. The avenues of egress away from the forward line of troops will likely be congested with materiel and personnel. Furthermore, service members will continuously experience dental emergencies outside the context of prolonged conflict and combat operations. In 2016, the 101st Airborne Division deployed in support of Operation Inherent Resolve and did not forward deploy their dental officer. Without dedicated organic dental treatment options available in theater, patients were evacuated to Kuwait for dental emergencies. This became so problematic that the division surgeon cell tasked a dental officer in Kuwait to conduct battlefield circulation in theater.

Medical planners and combatant commanders must anticipate that dental emergencies, as shown, will account for a significant burden on movement

and present from outside their formations. Among NATO allies, dental standards and capabilities vary significantly, with some nations prioritizing pre-deployment screenings due to minimal deployable dental assets. This disparity can complicate multinational operations, making interoperability in dental care critical to maximize RTDs. Additionally, the demand for dental care extends to detainees, who often present untreated chronic conditions, further straining limited evacuation assets and requiring dedicated protocols for humane treatment without compromising force readiness. To offset the rearward movement of thousands of dental casualties, the forward deployment of small expeditionary dental teams is necessary. Unique to the profession of dentistry, dental teams can diagnose and treat most service members' emergencies within the same day, maximizing RTD. Recently, US dental teams supported a population of partner forces and 96 percent were successfully RTD with one or two visits.²³ Expeditionary dental teams

conducting battlefield circulation during LSCO can move along supply routes from Role 2 and Role 3 units to provide care. This approach ensures each soldier maintains optimal performance while minimizing evacuation delays on patient movement platforms.

Degradation of Role 2 and Role 3 Dental Support

Ongoing cuts to operational dental billets threaten expeditionary support and capabilities, further exacerbating the burden of dental emergencies. The Army Structure Memorandum for Fiscal Years 2025–2029 will inactivate a Role 3 dental asset from the Army's formation and significantly reduce the number of active-duty dental company (area support) (DCAS) units providing area support for the division and corps.²⁴ In addition to increasing the risk of untreated dental emergencies in the division area of operations, this DCAS inactivation will limit access to care and reduce training opportunities for dental teams. Reductions to Role 3 dental support will create greater demand at Role 2 units, namely the brigade support medical company (BSMC) and medical company area support.

Experiments removing organic Role 2 dental support from the BSMC and medical company area support, especially without accurate dental casualties, will inevitably degrade access to care. Eliminating organic brigade dental surgeons from the BSMC will delete an entire medical function from US Army divisions and disregard the increased reliance on the BSMC following DCAS cuts. This substantially reduces the division's ability for prolonged care of dental patients, as there are few available providers on the battlefield to fill this gap. After dental officers, the next most formally trained providers to manage dental emergencies are the 18D Special Forces medical sergeant who receives sixteen hours of dental training and the 65D physician assistant with ten hours of dental training. A 68W combat medic receives zero dental training in the Advanced Individual Training course.

In addition to their primary mission of providing operational dental care, dental officers serve as supplementary medical manpower during critical moments. The Dental Corps' Individual Critical Task Lists prepare dental officers to augment medical personnel during mass casualty (MASCAL) events. These skills can be expanded through Army dental residency programs offering

courses, such as Pre-Hospital Trauma Life Support and Combat Casualty Care Course, to further prepare dentists for medical emergencies. Moreover, dentists' skills with soft tissue management, conscious sedation, and triage protocols allow them to assist in times when medical providers will be overwhelmed with wounded patients. A cut to US Role 2 dental support would result in the same capability gap observed in Ukrainian Armed Forces, who place dentists at Role 3 or 4. Consequently, Ukrainian medics report sending critical dental treatment to hospitals.²⁵ The elimination of dental teams from the modified table of organization and equipment creates the conditions for dental emergencies to accumulate near the forward line of troops, relying on fewer and smaller DCASs as the contingency.

Casualty Estimates in LSCO Must Include DNBI

To accurately strain and test the medical system prior to conflict, WFXs must include dental emergencies and all forms of DNBI among MASCAL events. Doing so may reveal that the medical system could also be overwhelmed with a MASCAL of DNBI patients. Matthew Fandre reported that during the Mission Command Training Program WFXs, a force of one hundred thousand soldiers will incur up to fifty-five thousand casualties.²⁶ To accurately model dental casualties, WFXs should incorporate a volume that 15–20 percent of DNBI casualties are dental, comprising 8,250–11,000 for a fifty-five-thousand-casualty scenario. The distribution of dental casualties means a steady accumulation of twelve to fifteen cases per brigade per day rather than spikes during engagements. If there is forward dental capability, then there would be a 90 percent plus RTD within twenty-four hours, and without a forward dental capability, RTD would take three to seven days. The evacuation mode would be primarily ground transportation with implications for convoy composition and protected persons requirements. It is noteworthy that eleven thousand dental casualties would represent nearly 30 percent of the real-world intratheater dental evacuations that occurred in USCENTCOM from 2009 to 2023. WFXs must include a volume of dental emergencies to accurately test the medical treatment and evacuation system. These parameters would allow commanders and staff to test medical task organization, evacuation priorities,

and resource allocation against the complete casualty burden rather than a subset.

Furthermore, the Military Health System (MHS) is obligated to care for soldiers after a war has ended. At the 2024 MHS Research Symposium, the chief surgeon for the Ukrainian Armed Forces outlined ten tactical medical priorities. Among the challenges he discussed was the need for “prosthetics with modern dentures.”²⁷ Because routine dental decay had progressed for years without dental care, over half of Ukrainian dental emergencies could only be treated by extractions.²⁸ This observation validates the Ukrainian chief surgeon’s assertion of the need for dentures among Russo-Ukrainian War veterans. If tooth extraction is the only option for soldiers engaged in real-world large-scale combat, then there will be a significant need to replace missing teeth with dentures. These circumstances necessitate planning for the dental treatment needs a military population will require after a war ends and as soldiers reintegrate back into civilian life.

The long-term costs extend beyond individual health. Service members requiring extensive prosthetics in their twenties and thirties will need ongoing care throughout their lives. The lifetime cost of prosthetic rehabilitation (\$5,000–\$50,000 per case with ongoing maintenance) dramatically exceeds the cost of early preventive and restorative care (\$200–\$2,000). Multiply these costs by thousands of service members experiencing progressive disease during LSCO, and the long-term financial burden to the MHS and Veterans Affairs becomes substantial—likely exceeding the cost of properly resourcing forward dental capability during operations. Beyond economics, allowing preventable dental disease to progress due to inadequate planning creates service-connected disabilities that could have been avoided through proper force health protection measures.

Recommendations

For WFX planners—include dental casualties at historically accurate rates (15–20 percent of DNBI) with appropriate distribution patterns, treatment timelines, and evacuation modes. Track dental RTD rates as a measure of medical system effectiveness.

For medical planners—preserve organic Role 2 dental capability pending operational analysis that

includes dental casualty rates and evacuation burden. Reconsider active-duty DCAS inactivation or identify alternative capability to maintain sufficient deployable dental assets for multidivision operations.

For operational commanders—include dental emergency projections in medical estimates alongside battle injuries and other DNBI. Task organize dental capability based on anticipated casualty rates and evacuation constraints. Establish dental readiness metrics as a component of unit readiness reporting.

For the Defense Health Agency and services—consider developing dental emergency predictive models that holistically assess overall health and oral health to better address the needs of the most vulnerable warfighters before deployment. Consider updating the dental readiness classification system to quantify risk for a dental emergency based on patient dental history and oral health risk factors. Update Department of Defense Instruction 1332.45 to reflect DRC 3 nondeployable to reduce dental emergencies in theater.

Conclusion

Sean O’Keefe, deputy under secretary of war for personnel and readiness, echoes Friedrich’s warning, stating, “Dental health issues are often the largest cause of nondeployability within a military unit.”²⁹ Excluding dental-related DNBI from casualty estimates in large-scale combat WFXs creates a dangerously incomplete picture of operational risk. Planning to react after capabilities degrade is planning for failure—at the expense of both combat effectiveness and the long-term health of the force. Real-world experience shows that dental emergencies place significant strain on Role 2 medical treatment facilities and evacuation assets; WFXs must therefore incorporate historically accurate DNBI data to reflect these demands. Only by accurately simulating the full medical burden can exercises reveal the true value of forward-deployed dental teams. Future large-scale combat will likely feature brief, intense MASCAL events separated by extended periods of disease, injury, and attrition. To sustain lethality through these cycles, the MHS must prioritize rapid RTD capabilities—delivered by expeditionary dental teams positioned at the point of need—to include Role 2 BSMC. ■

Notes

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