Maximizing Far-Forward Dental Support by Reinstating the Division Dental Surgeon

Preparing the Army Dental Corps for Casualty Care in LSCO

Col. Michael Hoffman, DDS, MS, ABGD, FAGD, US Army
Lt. Col. Gamal Baker, DDS, MS, ABGD, FAGD, US Army

At the conclusion of World War I in 1918, the Army Dental Corps had 4,620 active-duty officers.[1] Currently, the US Army Dental Corps remains one of the largest dental corps of any military in the world with over one thousand dentists holding both clinical and nonclinical roles across the globe. However, many of these dentists possess less than five years of dental and/or military experience. Despite this, many of these same officers are expected to serve as the subject-matter expert on dental issues from clinical care to the application of dental capabilities across the battlefield. With limited logistical experience, clinical practice, and equipment familiarity, the task often exceeds the knowledge base of the junior dental officer.

As the US Army shifts its focus from counterinsurgency operations to large-scale combat operations (LSCO), the division is recognized as the unit of action.[2] Historically, each US Army division had multiple dentists assigned to brigades within it, and this generally remains true.[3] Maximum utilization of these dental assets across the battlefield relies on Medical Service Corps or Medical Corps officers to interpret and apply dental capabilities as best possible since the dentists often lack military knowledge and clinical experience. The unique and often misunderstood nature of dentistry often leads to inappropriate utilization of this asset, often resulting in dental teams with inappropriate proximity, too far from the point of need, or lacking critical supplies to accomplish the mission.

Background

Oral health is a critical component to soldier readiness as missing teeth, untreated infections, trauma, and pain can limit combat effectiveness.[4] Across all US military services, the Dental Readiness Classification System serves as the measure of a soldier's readiness to deploy. For commanders, the Dental Readiness Classification is a significant indicator of unit readiness. The prominence of the Army's approach to dental care was not an overnight process;



Maj. Frederick Dawson, a comprehensive dentist assigned to the 512th Field Hospital, 30th Medical Brigade, performs a dental exam in a dental tent set up inside a former Soviet Union missile bunker in May 2025 at Vepriai Rocket Base in Lithuania. The unit was operating in combat gear under the threat of a simulated attack during exercise DEFENDER 25. (Photo by Staff Sgt. Haydee Cruz, US Army)

for much of the nineteenth century, dentistry in the Army was ad hoc and provided by civilian contract dentists or medical officers with limited training.[5] Over time, as dentistry professionalized itself, its importance in comprehensive healthcare took hold. Eventually, a link between dental readiness and unit effectiveness presented itself, and the Army incorporated dental officers into its structure. In 1911, the creation of the Army Dental Corps marked a defining moment that enabled the placement of dental officers within divisions and other echelons.[6]

When the United States entered World War I in 1917, the Dental Corps expanded rapidly. Initially, the dental section in the Surgeon General's Office was small, but mobilization required formal organization of dental services in the American Expeditionary Forces to France and to the southern border of the United States.[7] Dental officers were assigned to base hospitals, evacuation hospitals, and sanitation trains of divisions. The concept of a division dental surgeon (DDS) "responsible for the supply, technical supervision, assignment, and evaluation of the division's dentists" became operational.[8] In World War II, the DDS became a recognized position with clearly articulated responsibilities. Official histories describe the role as coordinating multiple distinct dental services within the division, ensuring equitable care across regiments and attached units, and managing the division's dental elements.[9] The Korean and Vietnam wars again tested Army dentistry's ability to deliver care in forward areas. Dental officers staffed division medical structures and provided preventive care to reduce dental morbidity and early treatment to maintain readiness.[10]

Current Structure and Capability Gaps

At the division level, medical and dental assets are managed by members of the division surgeon cell. This

group of medical leadership's purpose is to serve as the primary medical advisors to the division commander and provide oversight of medical assets and movement across the division.[11] As proactive planners and advisors, the division surgeon cell aids in a multitude of medical functions prior to and during deployment including casualty estimates and medical asset capabilities guidance. As reactive trackers, the division surgeon cell provides information on current casualty numbers, medical readiness, and real-time adjustments to medical operations. In addition to these functions, the division surgeon cell communicates laterally with G-1 (personnel readiness), G-3 (operations), G-4 (logistics), G-9 (civil affairs), medical brigades and multifunctional medical battalions in the area, veterinary assets, public health, dental companies organic to medical brigades, and the garrison dental health activity (DHA). With the unofficial loss of the DDS position around 2005 (as reported by previous DDSs; no documented evidence of its elimination exists), these tasks informally fell to *brigade* dental surgeons, Medical Service Corps officers, and company-level leadership.

While brigade dental surgeons provided a connection among brigade medical support companies, brigade-level leadership, and the local DHA, coordination between brigades and the DHA often proved inadequate. Overall, utilizing brigade dental surgeons in this fashion proved a sufficient strategy in counter-insurgency operations when entire divisions or corps did not deploy simultaneously.[12] It also worked during peacetime operations when brigades within divisions were afforded a reduced operations tempo, allowing leadership to communicate with garrison dental assets through informal means. However, this lack of direct connection between maneuver units and dental assets not organic to the unit often resulted in an increase in man-hours required to ensure unit readiness. Consequently, readiness suffers in garrison and bleeds into deployment operations as dental capabilities become a limited resource and company-level leadership is faced with competing priorities. When multiple units encounter similar issues, little oversight and understanding between maneuver units and garrison dental assets exists, and a competition for dental support develops. The result provides two avenues to failure: a scramble to attain dental readiness that is likely extended beyond a simple dental exam or commanders assuming risk by deploying a dentally unready force.

The division surgeon cell currently consists of staff at O-4 (major) and below with the division surgeon having the highest rank as an O-5 (lieutenant colonel). Other key positions within the cell include the deputy surgeon for medical operations, typically a Medical Service Corps officer in the grade of O-4, and a deputy surgeon for clinical operations (CLINOPS), also a Medical Service Corps officer in the grade of O-4. Occasionally, individual healthcare providers can be included into the CLINOPS section as needed. All individuals in the medical operations and CLINOPS sections are typically in the grade of O-3 (captain) or O-4.

Historically, DDSs were included in the CLINOPS section and performed the following tasks while in garrison: coordination and supervision of dental detachments and assigned dental officers, preventive dentistry


The Role of Expeditionary Dentistry in Large-Scale Combat Operations

Lt. Col. Andres Mendoza, DDS, U.S. Army
Maj. Ross Cook, DMD, U.S. Army

Military Review Recommends "The Role of Expeditionary Dentistry in Large-Scale Combat Operations"

By Lt. Col. Andres Mendoza, DDS, US Army; and Maj. Ross Cook, DMD, US Army

Soldiers with dental injuries could face prolonged return-to-duty periods during large-scale combat operations if adequate dental support is not available. Two dentists offer recommendations on how properly trained dental officers and adequately staffed surgeon's sections can help maintain a unit's combat power. Read "The Role of Expeditionary Dentistry in Large-Scale Combat Operations" online at https://www.armyupress.army.mil/Journals/Military-Review/English-Edition-Archives/September-October-2022/Mendoza-Cook/.



Capt. Hugh Sherrill and dental technicians from the 257th Medical Company (Dental Area Support) complete dental treatment on a soldier during an April 2026 field training exercise focused on bringing dental care to far-forward maneuver units on Fort Bragg, North Carolina. (Photo by Col. Michael Hoffman, US Army)

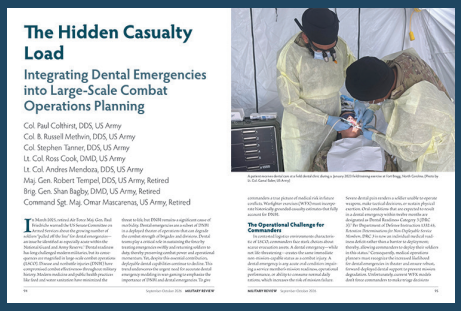
and readiness management to include exams and early treatment, and operations and logistical planning to ensure supplies and evacuation routes.[13] During forward operations, DDSs aid in clinical treatment and contingency medical support.[14] Transitioning to a dental provider role, they can assist in providing emergency dental care. They can also function as a liaison between the brigade dentists and the division coordinating dental support allocation and providing dental evacuation recommendations.

A 2024 poll of brigade dental surgeons across the active-duty Army population revealed multiple concerns for these junior officers. Most issues revolved around equipment failure and a lack of guidance/mentorship. One brigade dental surgeon stated, "The various discrepancies started in the fall of 2023," and he "was unable to provide dental support due to equipment malfunction" during a field training exercise.[15] Other brigade dentists state they were limited to performing dental exams during US European Command deployments because of equipment failure/malfunction.[16] To prevent mission failure and ensure his soldiers received the dental care needed, one brigade dentist purchased dental equipment with his own money. This same dentist noted a 298 percent increase in Dental Readiness Class 3 patients since equipment issues began, significantly reducing unit readiness.[17]

The most recent data on return-to-duty (RTD) rates for US Army soldiers shows a significant difference between medical and dental; in 2022, approximately 41.19 percent of dental patients were not RTD after initial treatment compared to 63.57 percent for other outpatient services such as physical therapy and vision.[18] However, an increase to 45.91 percent in 2024 shows a negative trend and a need for oversight of this readiness metric.[19] Rather than a lack of garrison dental efficiency, these trends demonstrate a lack of adequate supervision and prioritization; a gap exists between dental assets and maneuver units that must be filled.

Filling the Gaps

LSCO requires preservation of combat power under conditions of contested evacuation, extended care timelines, and degraded medical infrastructure.[20]


The Hidden Casualty Load

Integrating Dental Emergencies into Large-Scale Combat Operations Planning

Col. Paul Colthirst, DDS, US Army
Col. B. Russell Methvin, DDS, US Army
Col. Stephen Tanner, DDS, US Army
Lt. Col. Ross Cook, DMD, US Army
Lt. Col. Andres Mendoza, DDS, US Army
Maj. Gen. Robert Tempel, DDS, US Army, Retired
Brig. Gen. Shan Bagby, DMD, US Army, Retired
Command Sgt. Maj. Omar Mascarenas, US Army, Retired

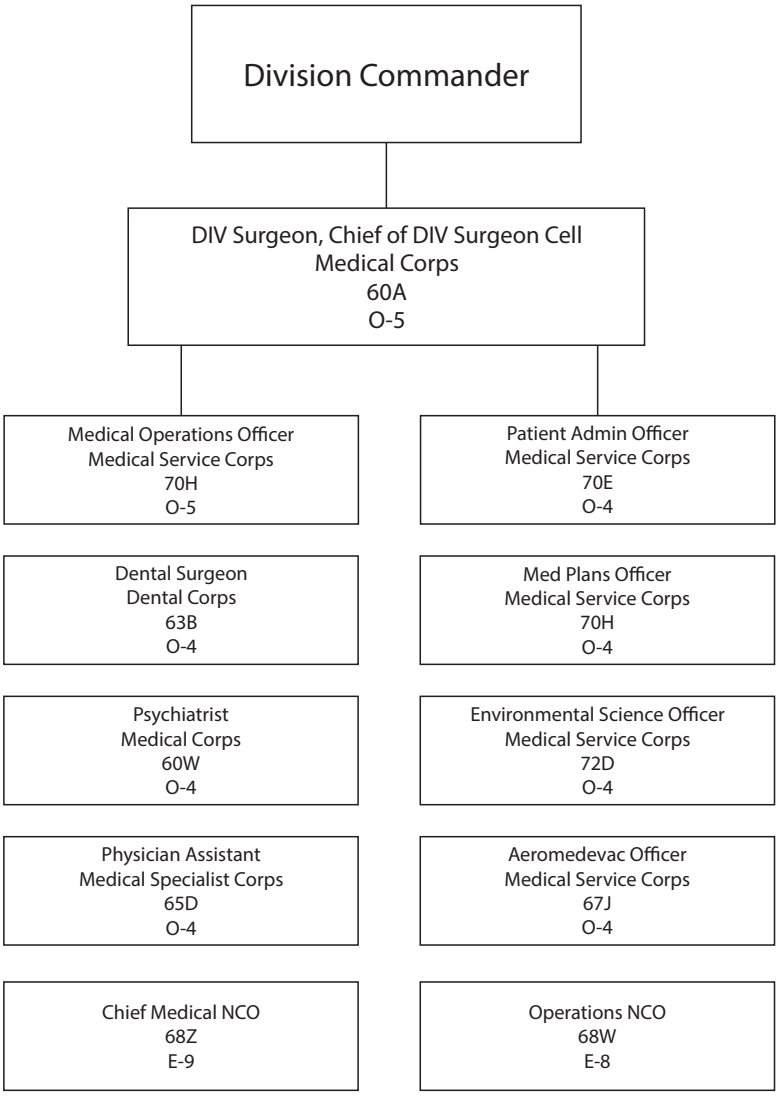
Military Review Recommends "The Hidden Casualty Load: Integrating Dental Emergencies into Large-Scale Combat Operations Planning"

By Col. Paul Colthirst, DDS, US Army; Col. B. Russel Methvin, US Army; Col. Stephen Tanner, DDS, US Army; Lt. Col. Ross Cook, DMD, US Army; Lt. Col. Andres Mendoza, DDS, US Army; Maj. Gen. Robert Tempel, DDS, US Army, Retired; Brig. Gen. Shan Bagby, DMD, US Army, Retired; and Command Sgt. Maj. Omar Mascarenas, US Army, Retired

To give commanders a true picture of medical risk in future large-scale combat operations, Warfighter exercises must incorporate historically grounded casualty estimates that fully account for disease and nonbattle injuries including dental emergencies. Read "The Hidden Casualty Load" online at https://www.armyupress.army.mil/Journals/Military-Review/English-Edition-Archives/September-October-2026/Hidden-Casualty-Load/.

Casualty estimates highlight a persistent, inadequately addressed gap in dental and maxillofacial integration at the brigade level and, subsequently, at the division level. While battle injuries dominate planning assumptions, nonbattle injuries or illnesses, termed disease nonbattle injury (DNBI), account for a substantial proportion of combat power loss with approximately 30 percent of Role 1 and Role 2 encounters attributed to DNBI in LSCO-like environments.[21] Within this category, dental DNBI alone have been reported at rates as high as 84–155 per 1,000 soldiers annually during deployment operations. Some projections go as high as 19 percent of the force affected and nearly one-fifth of Role 2 encounters requiring dental care.[22] Furthermore, in the absence of forward dental capability, affected soldiers may be lost to duty for up to ten days, significantly degrading unit effectiveness. Medical evacuations in contested environments will become combined-arms maneuver operations, relying on both lethal and nonlethal effects to create windows where air or ground assets can backhaul casualties to higher levels of care. The time it takes for these windows to be created is indeterminate, with current projections extending beyond seventy-two hours.[23] In the US Pacific Command, where medical facilities will have greater geographical distance, these timelines may be further extended. Concurrently, head and neck injuries, which comprise a notable subset of battlefield trauma, require specialized evaluation and intervention that is not organically addressed within standard brigade medical structures. No other role within the brigade combat team is specifically trained or tasked to integrate these dental and maxillofacial requirements into operational planning, casualty management, and RTD optimization. Brigade dental surgeons often participate in this process, but they often find themselves out of their depth with a lack of knowledge and experience.

The solution proposed is not novel. Quite the contrary, the solution existed less than twenty years ago. Then, the DDS ensured dental capabilities were utilized properly, equipment was ready, and, in the absence of trained dentists at the brigade level, provided dental support to subordinate units. Col. Charles Lambert, the last DDS for 4th Infantry Division and current commander of DHA–Hawaii, recalls being flexed into the brigade dental surgeon position for the new 4th Brigade Combat Team, 4th Infantry Division in 2005, then accompanying his new unit to US Central Command.[24] Being organic to the division surgeon cell provided the division the flexibility to move dental assets and ensure no gaps existed in dental coverage for the soldiers. As we transition into LSCO, it is important that this flexibility is maintained throughout the organic nature of war and conflict at that level (see figure 1). Furthermore, as inquiries emerge from subordinate units and inexperienced

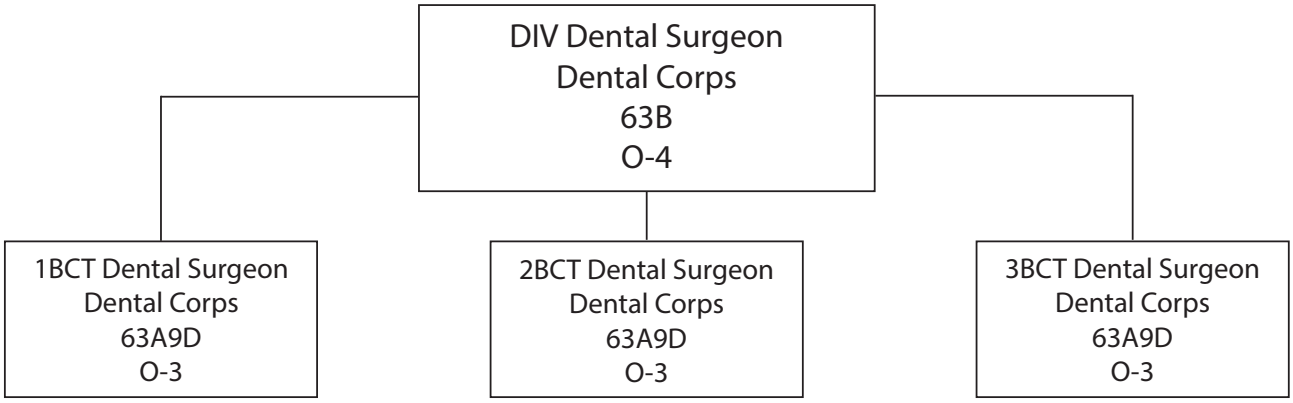


(Figure by authors)

Figure 1. Proposed Division Surgeon Cell Structure Incorporating Division Dental Surgeon into Organization

dentists, the DDS serves as both advocate and information resource.

To be an asset to the division surgeon cell and subordinate units, the DDS must have experience as a brigade dentist, understanding the issues present and solutions available, while also having the rank and authority to mentor and guide junior officers (see figure 2). Retired Command Sgt. Maj. Omar Mascarenes, former division surgeon cell sergeant major for the 101st Airborne Division, recommends this individual be in the rank of major to coincide with other division surgeon cell staff. In his experience, "Dental coordination must exist at the division surgeon cell level by dentists that have served in [the brigade dental surgeon] role to ensure the dental voice gets heard and considered, maximizing return-to-duty efforts of brigade dental providers."[25] Other individuals, including Col. Michael Evans, former DDS for 82nd Airborne Division, served in this role as a lieutenant colonel.[26] This potentially places the DDS in the same rank as the division surgeon, which is typically a lieutenant colonel or colonel. An understanding of rank versus position, as well as time in grade, aids in reducing conflict and deconflicting rating schemes when the ranks are equal.



Administrative and tactical control of dental assets remain with the brigade support medical companies. The division dental surgeon serves as the dental proponent and advisor at the division level for subordinate dental assets and dental support. (Figure by authors)

Figure 2. Division Dental Surgeon Relationship to Brigade Dentists Within the Division

However, whether the role is reestablished as an O-4 or O-5 billet, it is experience that proves tantamount.

To be an asset for the brigade dental surgeons, the DDS must have advanced residency training and clinical skills that allow the individual to guide the junior dentists at the brigade level. Comprehensive dentists are graduates of the military's Advanced Education in General Dentistry 2-Year Program and would serve best in this role as they are well-versed in multiple specialties within dentistry, particularly those associated with dental emergencies. The DDS may also serve as the dental expert within the brigade dental surgeons' rating chains, potentially serving as intermediate rater for these junior officers and providing a critical dental perspective to their professional development. Uniquely filling dental planning gaps, the DDS links clinical expertise with operational decision-making, reducing preventable evacuations, accelerating return-to-duty timelines, and directly preserving combat power in a resource-constrained LSCO environment.

Army Dentists and the Profession of Arms

Establishing a DDS billet would create a key developmental milestone for Dental Corps officers, providing a staff and broadening assignment that builds competency at the division and corps levels while making Dental Corps officers more competitive for Army Medical Department Central Selection Board (CSL) assignments.

Staff and broadening assignments are critical to an officer's development and career progression. Exposure to a wide breadth of operational and institutional experiences prepares officers to function effectively in complex command-and-staff environments and ultimately benefits the Army by ensuring officers understand how they fit into the broader mission. Currently, most staff and broadening opportunities available to the officers are limited to US Army Medical Command or Defense Health Agency billets, leaving few pathways for meaningful operational experience. Serving on a division staff would change that, exposing Dental Corps officers to the full scope of division-level health service support planning including training exercises, clinical operations, medical logistics, medical evacuation, and force health protection. In addition, it would provide Dental Corps officers with shared understanding of the language and culture of operational units.

A DDS billet would also directly address a structural gap in the Dental Corps officer career progression. Department of the Army Pamphlet 600-4, *Army Medical Department Officer Career Management*, emphasizes the importance of toggling between operational and institutional assignments throughout an officer's career.[27] Medical Corps officers, for example, are expected to serve as brigade and division surgeons at the major and lieutenant colonel levels to remain competitive for Army Medical Department commands. No equivalent operational pathway exists for Dental Corps officers. There is a lack of

clear opportunities for Army Dental Corps officers in specific staff roles they should hold during early field grade years. This places the officers at a distinct disadvantage in the CSL process, which rewards operational credibility, breadth of experience, and demonstrated performance in progressively complex environments. Without modified tables of organization and equipment billets that embed them inside the operational formation, Dental Corps officers are structurally excluded from accumulating these credentials.

Embedding a DDS within the division surgeon's cell would resolve this inequity. Rather than limiting Dental Corps officers to clinical roles within dental activities, this assignment would provide the operational credential the CSL process values. It would also generate officer evaluation reports authored by operational commanders' narratives that carry significant weight in promotion and command selection decisions.

Conclusion

The DDS occupies a critical but often overlooked role within the division surgeon's cell. As the subject-matter expert on dental readiness, dentoalveolar trauma, and dental support operations, the DDS directly contributes to the medical readiness and combat effectiveness of the force. Dental disease and oral injuries have the potential to degrade operational capability just as surely as other medical conditions, particularly during prolonged or austere operations where access to definitive care is limited.

Beyond clinical expertise, the DDS provides essential operational planning, synchronization with all roles of medical care, and guidance on the employment of dental capabilities across the division and battlefield. As a member of the division surgeon cell, the division dentist maintains oversight of dental assets across the operating environment, awareness of these assets' capabilities and supplies, and the ability to influence reallocation of those assets as supplies and lines of communication are limited. This integration ensures that dental support is aligned with maneuver operations, casualty care planning, and sustainment considerations. In LSCO and other contested environments, where medical resources are constrained and evacuation timelines are uncertain, the ability to anticipate and mitigate dental threats to readiness becomes even more important. While brigade-level leadership is often aware of other maneuver assets across the area of operations, dental capabilities possess reduced priority and become an afterthought. The DDS ensures that medical planning includes dentistry, since dentistry maintains the highest RTD rate of any medical specialty.

It is for these reasons that the DDS should be recognized not simply as an advisor on dental matters, but as an integral member of the division medical staff whose expertise informs operational planning, enhances force health protection, and preserves the fighting strength of the formation. Effective integration of dental leadership at the division level strengthens the medical system as a whole and ensures that dental readiness remains a deliberate component of combat power. Providing opportunities to serve in staff positions creates Army dentists with an increased understanding of combat arms, not only allowing them progress as strategic thinkers within the military but also providing the Army an additional asset for managing the garrison and forward deployed healthcare of its soldiers. ■

Neither the Defense Health Agency, any other component of the Department of War nor the US government has approved, endorsed, or authorized this product.

Notes

1. John M. Hyson Jr. et al., "Preparing the Dental Corps for France, 1917–1918," chap. 12 in *A History of Dentistry in the US Army to World War II* (Borden Institute, Office of the Surgeon General, 2008), https://medcoe.army.mil/pfw-images/borden/dental/DCchapter12.pdf.

2. Field Manual (FM) 3-0, *Operations* (US Government Publishing Office [GPO], 2025).

3. Hyson et al., *A History of Dentistry in the US Army to World War II*, 407–11.

4. Andres Mendoza and Ross Cook, "The Role of Expeditionary Dentistry in Large-Scale Combat Operations," *Military Review* 102, no. 5 (September-October 2022): 38, https://www.armyupress.army.mil/Portals/7/PDF-UA-docs/Mendoza-Cook-2022-UA.pdf.

5. John King et al., eds., *Highlights in the History of U.S. Army Dentistry* (Office of the Surgeon General, 2012), https://apps.dtic.mil/sti/tr/pdf/ADA557422.pdf.

6. King et al., *Highlights in the History of U.S. Army Dentistry*, 14–15.

7. Hyson et al., *A History of Dentistry in the US Army to World War II*, 407.

8. Hyson et al., *A History of Dentistry in the US Army to World War II*, 479.

9. "United States Army Dental Service in World War II," AMEDD Center of History and Heritage, accessed 14 July 2026, https://achh.army.mil/history/corps-dental-wwii-chapterviii-wwii.

10. King et al., *Highlights in the History of U.S. Army Dentistry*, 26–29.

11. Field Manual 4-02.21, *Division and Brigade Surgeons and the Medical Company (Role 2)* (US GPO, 2019).

12. John Simecek et al., "The Incidence of Dental Disease Nonbattle Injuries in Deployed U.S. Army Personnel," *Military Medicine* 179, no. 6 (2014): 666–73, https://doi.org/10.7205/MILMED-D-13-00511.

13. Hyson et al., *A History of Dentistry in the US Army to World War II*, 807.

14. John M. Hyson, "African-American Dentists in the U.S. Army: The Origins," *Military Medicine*, 161, no. 7 (July 1996): 375–81, https://doi.org/10.1093/milmed/161.7.375.

15. Inkyu Kim, memorandum for record, "Dental Equipment Failure," Charlie Company/426 Light Support Battalion/101 Division Support Brigade/101st Airborne Division, 10 December 2024.

16. Brandi Schoenthaler, memorandum for record, "Non-Functional Dental Autoclave for 101 BSB, 1ABCT, 1ID," Charlie Company/101st Brigade Support Battalion/1st Armored Brigade Combat Team/1st Infantry Division, 30 September 2024.

17. Peter Heitman, memorandum for record, "Dental Equipment Issues for 426 BSB, 1 BCT, 101st ABN DIV (AASLT)," Headquarters/1st Brigade Combat Team/101st Airborne Division, 3 October 2023.

18. Defense Health Agency, *Calendar Year 2022 Outpatient Medical, Dental, and Elective Cosmetic Procedure Reimbursement Rates and Guidance* (Defense Health Agency, 2022), https://comptroller.war.gov/Portals/45/documents/rates/fy2022/2022_i.pdf.

19. Defense Health Agency, *Calendar Year 2024 Outpatient Medical, Dental, and Elective Cosmetic Procedure Reimbursement Rates and Guidance* (Defense Health Agency, 2024), https://comptroller.war.gov/Portals/45/documents/rates/fy2024/2024_i.pdf.

20. Matthew Fandre, "Medical Changes Needed for Large-Scale Combat Operations: Observations from Mission Command Training Program Warfighter Exercises," *Military Review* 100, no. 3 (May-June 2020): 36–45, https://www.armyupress.army.mil/Journals/Military-Review/English-Edition-Archives/May-June-2020/Fandre-Medical-Changes/.

21. Mary Krueger Izaguirre et al., "To Conserve Fighting Strength in Large-Scale Combat Operations," *Military Review* Online Exclusive, 31 March 2025, https://www.armyupress.army.mil/journals/military-review/online-exclusive/2025-ole/conserve-fighting-strength-in-lsco/.

22. Martin Smallidge et al., "Dental Readiness Classification and Treatment Provided for Dental Emergencies of Deployed Army Personnel," *Medical Journal* (Summer 2025): 55–59, https://medcoe.army.mil/pfw-images/dbimages/Dental%20Classification%2022Sep2025.pdf.

23. Jennifer M. Gurney et al., "When the Golden Hour Goes Away: Prolonged Casualty Care in LSCO—Considerations for Commanders and Decision-Makers," *Military Review* 105, no. 4 (July-August 2025): 126–37, https://www.armyupress.army.mil/Portals/7/military-review/Archives/English/JA-25/Golden-Hour-Prolonged-Care/Golden-Hour-Prolonged-Care-UA.pdf.

24. Charles Lambert (colonel, US Army), email interview with Gamal A. Baker, 17 February 2026.

25. Omar Mascarenes (command sergeant major, US Army), phone interview with Gamal A. Baker, 6 March 2026.

26. Michael Evans (colonel, US Army), phone interview with Gamal A. Baker, 30 March 2026.

27. Department of the Army Pamphlet 600-4, *Army Medical Department Officer Career Management* (US GPO, 27 April 2023), 8.

Col. Michael Hoffman, US Army, is a comprehensive dentist assigned to US Army Special Operations Command at Fort Bragg, North Carolina. He holds a DDS from the University of Michigan and an MS from the Uniformed Services University of the Health Sciences. During his career, Hoffman has served as brigade dental surgeon with 2nd Brigade Combat Team, 10th Mountain Division; group dental surgeon with 3rd Special Forces Group (Airborne); and commander of Dental Health Activity on Fort Campbell, Kentucky.

Lt. Col. Gamal Baker, US Army, is a comprehensive dentist and assistant program director for the Advanced Education in General Dentistry 2-Year Program on Fort Bragg, North Carolina. He holds a DDS from Meharry Medical College School of Dentistry and an MS from the Uniformed Services University of the Health Sciences. During his career, Baker has served as the brigade dental surgeon for 4th Brigade Combat Team, 1st Infantry Division; and 1st Brigade Combat Team, 82nd Airborne Division. He has also served as the chief dental officer for 257th Medical Company (Dental Area Support), 44th Medical Brigade on Fort Bragg.