FM 4-02

ARMY HEALTH SYSTEM

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No. 4-02

Headquarters
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Washington, D.C, 08 August 2025

Army Health System

1. This change replaces the term "gender" with "sex" in accordance with Executive Order 14168.

2. A plus character (+) marks new material.

3. FM 4-02, 08 August 2025, is changed as follows:

Change Version Pages	Change Description
page xi	corrects text in introductory table-2
page 4-3	corrects text in table 4-1

4. An updated Authentication Page has amended the prior authentication reflected after Change 1 and in the rear of this publication.

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Field Manual
No. 4-02

Headquarters
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Washington, D.C., 17 November 2020

Army Health System

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Preface

FM 4-02 provides doctrine for the Army Health System (AHS) in support of the modular force. The AHS is the overarching concept of support for providing timely AHS support to the tactical commander. It discusses the current AHS force structure which was modernized under the Department of the Army-approved Medical Reengineering Initiative and the Modular Medical Force. These modernization efforts were designed to support the brigade combat teams and echelons above brigade units.

The principal audience for FM 4-02 is all members of the profession of arms. Commanders and staffs of Army headquarters serving as joint task force or multinational headquarters should also refer to applicable joint or multinational doctrine concerning the range of military operations and joint or multinational forces. Trainers and educator throughout the Army will also use this publication.

Commanders, staffs, and subordinates ensure that their decisions and actions comply with applicable United States, international, and in some cases host-nation laws and regulations. Commanders at all levels ensure that their Soldiers operate in accordance with the law of war and the rules of engagement. (See FM 6-27/MCTP 11-10C). It is to be used as a guide in both obtaining and providing AHS support in an area of operations. Information in this publication is applicable to decisive actions in support of unified land operations. It is compatible with the Army's sustainment and protection doctrine and is also in agreement with Joint Publication 4-02.

This publication implements or is in consonance with the following North Atlantic Treaty Organization (NATO) Standardization Agreements (STANAGs); American, British, Canadian, Australian, and New Zealand (ABCANZ) Standards.

TITLE	NATO STANAG	ABCANZ STANDARDS
Blood Supply in the Area of Operations		815
Identification of Medical Materiel for Field Medical Installations AMedP-1.5	2060	
Forward Aeromedical Evacuation—AAMedP-1.5	2087	
ABCA Medical Professional Credentialing/Privileging		2108
Documentation Relative to Initial Medical Treatment and Evacuation— AMedP-8-1	2132	
Allied Joint Doctrine for Medical Support—AJP-4.10	2228	
Road Movements and Movement Control—AMovP-1(A)	2454	
Orders for the Camouflage of Protective Medical Emblems on Land in Tactical Operation—ATP 79	2931	
Minimum Requirements for Blood, Blood Donors and Associated Equipment	2939	
Aeromedical Evacuation—AAMedP-1.1	3204	

FM 4-02 uses joint terms where applicable. Selected joint and Army terms and definitions appear in both the glossary and the text. Terms for which FM 4-02 is the proponent publication (the authority) are italicized in the text and are marked with an asterisk (*) in the glossary. Terms and definitions for which FM 4-02 is the proponent publication are boldfaced in the text. For other definitions shown in the text, the term is italicized and the number of the proponent publication follows the definition.

This publication applies to the Active Army, Army National Guard/Army National Guard of the United States, United States Army Reserve, Army Civilian Corps, and Army contracted medical providers, unless otherwise stated.

Due to the nature of the medical profession which is highly regulated throughout both the civilian and military communities, Army Medicine doctrine is heavily influenced by—

- United States and international law (including respective U.S. and allied-nation health regulating agencies).
- Policy guidance in the form of Army Regulations and Department of Defense (DOD) policy promulgated in the form of DOD Directives (DODD) and DOD Instructions (DODI) and other documents.
- Medical standards established by civilian organizations (such as The Joint Commission).
- Technical guidance from both military and civilian organizations charged with medical/scientific oversight responsibilities.

Throughout this publication, as appropriate, reference is made to the major policy guidance impacting each specific topic. These references should not be considered as the only policy guidance available. When issues arise that require consideration of policy guidance, the issue should be thoroughly researched and, as appropriate, coordinated with the supporting staff judge advocate or governmental/nongovernmental agency involved.

The proponent of FM 4-02 is the United States Army Medical Center of Excellence. The preparing agency is the Doctrine Literature Division, United States Army Medical Center of Excellence. Send comments and recommendations on Department of Army (DA) Form 2028 *(Recommended Changes to Publications and Blank Forms)* to Commander, United States Army Medical Center of Excellence, ATTN: MCCS-FD (FM 4-02), 2377 Greeley Road, Suite D, JBSA Fort Sam Houston, TX 78234-7731; by e-mail to usarmy.jbsa.medical-coe.mbx.ameddcs-medical-doctrine@mail.mil or submit an electronic DA Form 2028.

Introduction

The content of this update remains generally consistent with the 2013 publication on key topics while adopting updated terminology and concepts as necessary. Key topics include AHS, FHP, Health Service Support, ten medical functions, and law of land warfare and medical ethics.

The material presented in this publication reflects enduring practices in providing timely AHS support to the tactical commander. This publication depicts AHS operations from the point of injury or wounding through successive roles of care within the area of operations and evacuation to the continental United States-support base.

Summary of changes include:

- Aligning this publication with Army hierarchy publications including FM 3-0 and FM 4-0.
- Aligning this publication with Joint Publication 4-02, Joint Health Services' FHP and HSS definitions and descriptions.
- Reorganizing the order of the publication; FHP is now Part Two while HSS is Part Three.
- Revising the definitions of the following terms: Army Health System, force health protection, health service support, definitive care, essential care, and triage.
- Replacing the mission command medical function with medical command and control; this is in line with ADP 6-0.
- Replacing "field preventive medicine" with "operational public health" according to AR 40-5.
- Adding Global Health Engagement information.
- Adding hospital center information.
- Adding an appendix discussing AHS support to the Army's strategic roles (shape operational environments, prevent conflict, prevail in large-scale ground combat, consolidate gains).
- Adding an appendix derived from FM 3-0 discussing command and support relationships.
- Adding a surgeon and surgeon section appendix.
- Adding the approved medical symbols appendix.

As the Army's AHS doctrine statement, this publication identifies medical functions and procedures that are essential for operations covered in other Army Medicine proponent manuals. This publication depicts AHS operations from the point of injury or wounding, through successive roles of care within the area of operations, and evacuation to the continental United States (U.S.)-support base. It presents a stable body of operational doctrine rooted in actual military experience and serves as a foundation for the development of Army Medicine proponent manuals on how the AHS supports unified land operations.

The AHS mission falls within two warfighting functions- protection and sustainment. To clearly delineate the two AHS missions of force health protection (FHP) and health service support (HSS), this publication is divided into three parts- AHS overview, FHP, and HSS.

Field Manual 4-02 consists of three parts and 12 chapters:

Part One, AHS, provides a holistic view of the entire AHS and the complexities and interdependence of each medical function in successfully accomplishing the Army Medicine's mission to conserve the fighting strength. This part of the manual describes and provides operational guidance on the AHS's echelon above brigade headquarters, as well as the medical aspects of the law of land warfare.

- Chapter 1 provides an overview of the AHS to include introduction information on tactical combat casualty care, global health engagement, and the AHS principles.
- Chapter 2 discusses AHS command and control, overview of Army echelons, Army command and support relationships, the AHS Team and its primary tasks, medical command and control

organizations, and the roles and responsibilities of the medical commander, command surgeon, and commander.

- Chapter 3 provides information regarding AHS and the effects of the law of land warfare and medical ethics information.
- Chapter 4 discusses Army Health System operations; operational and mission variables; AHS support to decisive action- offensive, defensive, stability tasks, defense support of civil authorities; setting the theater; detainee operations; and maneuver units.

Part Two, FHP, encompasses the preventive and treatment aspects of the following medical functions: veterinary services, combat and operational stress control, dental services, operational public health, and laboratory services (area medical laboratory) including the testing of suspect biological and chemical warfare agent samples.

- Chapter 5 describes operational public health's mission, primary tasks, organizations and personnel.
- Chapter 6 discusses veterinary services missions and primary tasks, consisting of the food protection mission, animal care mission, and veterinary public health.
- Chapter 7 provides information on combat and operational stress control including primary tasks, responsibilities, and programs and resources.
- Chapter 8 provides information on the preventive and treatment aspects of dental services.
- Chapter 9 discusses environmental and clinical medical laboratory services.

Part Three, HSS, encompasses medical treatment, medical evacuation (including medical regulating), and medical logistics (including blood management). Health services support three mission sets include all of the medical functions involved with direct patient care (medical treatment [organic and area support] and hospitalization) to include diagnostic medical laboratories and the medical functions of medical evacuation and medical logistics.

- Chapter 10 discusses direct patient activities including medical treatment (organic and area support) and theater hospitalization (combat support hospital and hospital center).
- Chapter 11 provides information on medical evacuation to include integrated medical evacuation system, medical regulating, and strategic medical evacuation and patient movement.
- Chapter 12 discusses medical logistics to include medical logistics management in an operational environment, medical logistics command and control organizations, medical logistics support for Roles 1 through 3 medical treatment facilities, and as theater lead agent for medical materiel and the single integrated medical logistics manager.

The Medical Center of Excellence, Doctrine Literature Division is reorganizing the placement of terms and definitions found in proponent publications within the Army Medicine Doctrine Publication Library. It was determined that some of the terms are best suited in other publications within the Army Medicine Doctrine Publication Library.

Based on current doctrinal changes, certain terms for which FM 4-02 is proponent have been added, rescinded, or modified for purposes of this publication. The glossary contains acronyms an defined terms. See introductory table-1, introductory table-2 on page xi for specific term changes.

Introductory Table-1. Rescinded Army terms

Term	*Remarks*
hospital	Rescinded. Adopts common English usage. No longer formally defined.
preventive medicine	Rescinded.

Introductory Table-2. Modified Army terms

Term	*Remarks*
Army Health System	Modifies the definition.
casualty evacuation	Modifies the definition.
combat and operational stress control	Modifies the definition.
continuity of care	Modifies the definition.
definitive care	Modifies the definition.
essential care	Modifies the definition.
+ first aid (self-aid/buddy aid)	Modifies the definition.
Force Health Protection	Modifies the definition.
Health Service Support	Modifies the definition.
triage	Modifies the definition.

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PART ONE

Army Health System

The *Army Health System* (AHS) is a component of the Military Health System (MHS) that is responsible for operational management of the health service support and force health protection missions for training, predeployment, deployment, and postdeployment operations. The Army Health System includes all mission support services performed, provided, or arranged by the Army Medicine to support health service support (HSS) and force health protection (FHP) mission requirements for the Army and as directed, for joint, intergovernmental agencies, coalition, and multinational forces. The AHS is a complex system of systems that is interdependent and interrelated and requires continual planning, coordination, and synchronization to effectively and efficiently clear the battlefield of casualties and to provide the highest standard of care to our wounded or ill Soldiers. Part One of this publication provides a holistic view of the AHS; specifically describing its composition, along with its overarching architecture of its design and functions without regard to the specific warfighting functions under which it operates.

This part of the publication—

- Discusses the foundations of the Army Medicine and the fundamental principles which have guided the provision of AHS support on the battlefield throughout its history. It describes the roles of medical care which facilitate providing care at the point of injury (POI) or wounding and describes the system of phased and incrementally increasing capabilities which enables the wounded or ill Soldier to be stabilized and evacuated to the appropriate medical treatment facility. The goal is then to care for their specific medical condition and to restore them to health, limit long-term disability, and either return then to duty or to their civilian life as a productive member of that community. The term s*tabilized patient* refers to a patient whose airway is secured, hemorrhage is controlled, shock treated, and fractures are immobilized. (Joint Publication [JP] 4-02)

- Provides an in-depth discussion on the provisions of the Geneva Conventions, the law of land warfare, and medical ethics and their impact on conduct of AHS operations. It describes the primary tasks of the AHS in support of operations characterized by offensive, defensive, stability, and defense support of civil authorities tasks. Further, it discusses AHS support to detainee operations and the roles and responsibilities of the detainee operations medical director.

- Discusses the AHS medical command and control organizations, their functions, and responsibilities. It also provides an in-depth discussion of the Army Medicine team, the medical commander, the command surgeon, and the involvement required of the commander.

- Provides information on the role of the institutional force and the support provided to the operational Army. It also provides a brief description of the Warrior

Transition Program for the continued care, convalescence, and rehabilitative treatment of our returning wounded Warriors.

- Provides information on the importance of medical intelligence for the identification of health hazards affecting deployed forces and the medical aspects of intelligence preparation of the battlefield (IPB).

Chapter 1
Army Health System Overview

The AHS is a component of the Department of Defense (DOD) MHS. Although the MHS is an interrelated system which may share medical services, capabilities, and specialties among the United States (U.S.) Service components, it is not a joint command and control system. Each Service component develops its medical resources to support its Service-specific mission. This results in the development of different types of organizations with varying levels of capability, mobility, and survivability. Although joint medical resources may have similar nomenclature to describe the unit, they are not usually interchangeable. For information on joint health services refer to JP 4-02.

SECTION I — OPERATIONAL ENVIRONMENT

1-1. The Army accomplishes its mission by supporting the joint force in four strategic roles: shape operational environments, prevent conflict, conduct large-scale ground combat operations, and consolidate gains. The benchmark for Army readiness is its ability to conduct large-scale combat operations (LSCO) fighting a near peer/peer threat with potential overmatch across multiple domains (including land, air, maritime, space, cyberspace as well as electromagnetic spectrum and information environment).

1-2. A multi-domain approach to operations is not new. Army forces have effectively integrated capabilities and synchronized actions in the air, land, and maritime domains for decades. Rapid and continued advances in technology and the military application of new technologies to the space domain, the electromagnetic spectrum, and the information environment (particularly cyberspace) require special consideration in planning and converging effects from across all domains. Refer to FM 3-0 for more information.

THREATS

1-3. An operational environment (OE) has a number of threats that consist of enemies, adversaries, neutrals, and hybrid threats (force that combines traditional, irregular, disruptive, or catastrophic capabilities). These threats are protracted confrontation among individuals, groups of individuals, paramilitary or military forces, state actors, and nonstate actors increasingly willing to use violence to achieve their political and ideological ends. There is a probability that in the future, United States Army forces will conduct operations in an urban environment and in and around megacities. Urban areas are becoming safe havens and support bases for terrorists, insurgents, or criminal organizations. For information on the OE see FM 3-0.

1-4. Commanders and staffs analyze an OE using the eight operational variables: political, military, economic, social, information, infrastructure, physical environment, and time (See FM 6-0 for more information on the operational variables).

1-5. The Army Medicine views threats from two perspectives: the general threat and the health threat. Although the Army Medicine's primary concern is that of the health threat, the general threat must also be fully considered as it influences the—

- Character, types, and severity of wounds and injuries to which our forces may be exposed.
- Enemy's ability and willingness to disrupt AHS operations and to respect the conditions of the Geneva Conventions in regards to the protection of AHS personnel while engaged in their humanitarian mission.

HEALTH THREAT

1-6. The health threat faced by deployed U.S. forces is depicted in Table 1-1. The health threat is a composite of ongoing or potential enemy actions; adverse environmental, occupational, and geographic and meteorological conditions; endemic and emerging diseases; and employment of chemical, biological, radiological, and nuclear (CBRN) weapons (to include weapons of mass destruction that have the potential to affect the short- or long-term health [including psychological impact] of personnel).

Table 1-1. Health threat

Injuries	Musculoskeletal injuries (primarily from physical training and recreational activities)
Diseases	Endemic, emerging, epidemic, and pandemic Foodborne Fomites Waterborne Arthropodborne Zoonotic Breeding grounds for vectors
Occupational and Environmental Health (OEH) hazards	Climatic (heat, cold, humidity, and significant elevations above sea level) Toxic industrial materials Accidental or deliberate dispersion of chemical, biological, and radiological material Disruption of sanitation services/facilities (such as sewage and waste disposal) Effects of industrial operations and industrial and operational noise
Poisonous or toxic flora and fauna	Toxic poisonous plants, bacteria, and fungus Poisonous reptiles, amphibians, arthropods, and animals
Medical effects of weapons	Conventional (to include blast and mild traumatic brain injury/concussion) Improvised (to include improvised explosive devices) Chemical, biological, radiological, and nuclear warfare agents Directed energy Weapons of mass destruction Thermal (from nuclear blast or direct energy) Combined injury (chemical, biological, radiological agent plus thermal, blast, explosive, or projectiles)
Physiologic and psychological stressors	Continuous operations Combat and operational stress reactions Wear of mission-oriented protective posture ensemble Stability tasks Home front issues

SECTION II — WARFIGHTING FUNCTIONS

1-7. The Army Health System medical capabilities (ten medical functions) are grouped under two Army warfighting functions- FHP under protection and HSS under sustainment warfighting functions. These interrelated and interdependent medical functions are complex in nature and require medical command and control for synchronization and integration. This ensures the interrelationships and interoperability of all medical assets and optimizes the effective functioning of the entire system. To clearly delineate which medical functions are grouped under which warfighting function, the Army is aligning with the joint Services (according to JP 4-02) in grouping these ten medical functions.

SYSTEM OF SYSTEMS

1-8. The AHS is a complex system of systems (Figure 1-1). The systems which comprise the AHS are divided into medical functions which align with medical disciplines and scientific knowledge. These systems are interrelated and interdependent and must be meticulously and continuously synchronized to reduce morbidity and mortality and to maximize patient outcome. The ten medical functions are:

- Medical command and control.
- Medical treatment (organic and area support).
- Hospitalization.
- Medical evacuation (to include medical regulating).
- Dental services.
- Operational public health.
- Combat and operational stress control.
- Veterinary services.
- Medical logistics (to include blood management).
- Medical laboratory services (to include both clinical laboratories and environmental laboratories).

1-9. The AHS medical functions are in consonance with joint doctrine, as described in JP 4-02. Figure 1-2 below depicts the Army Health System operational framework. For more information on operational framework refer to ADP 3-0 and FM 3-0.

FORCE HEALTH PROTECTION MISSION

1-10. The Army *force health protection* are measures that promote, improve, or conserve the behavioral and physical well-being of Soldiers comprised of preventive and treatment aspects of medical functions that include: combat and operational stress control, dental services, veterinary services, operational public health, and laboratory services. Enabling a healthy and fit force, prevent injury and illness, and protect the force from health hazards.

HEALTH SERVICE SUPPORT MISSION

1-11. The Army *health service suppo*rt is support and services performed, provided, and arranged by the Army Medicine to promote, improve, conserve, or restore the behavioral and physical well-being of personnel by providing direct patient care that include medical treatment (organic and area support) and hospitalization, medical evacuation to include medical regulating, and medical logistics to include blood management. Additionally, as directed, provide support in other Services, agencies, and organizations. Health service support includes the treatment of CBRN patients.

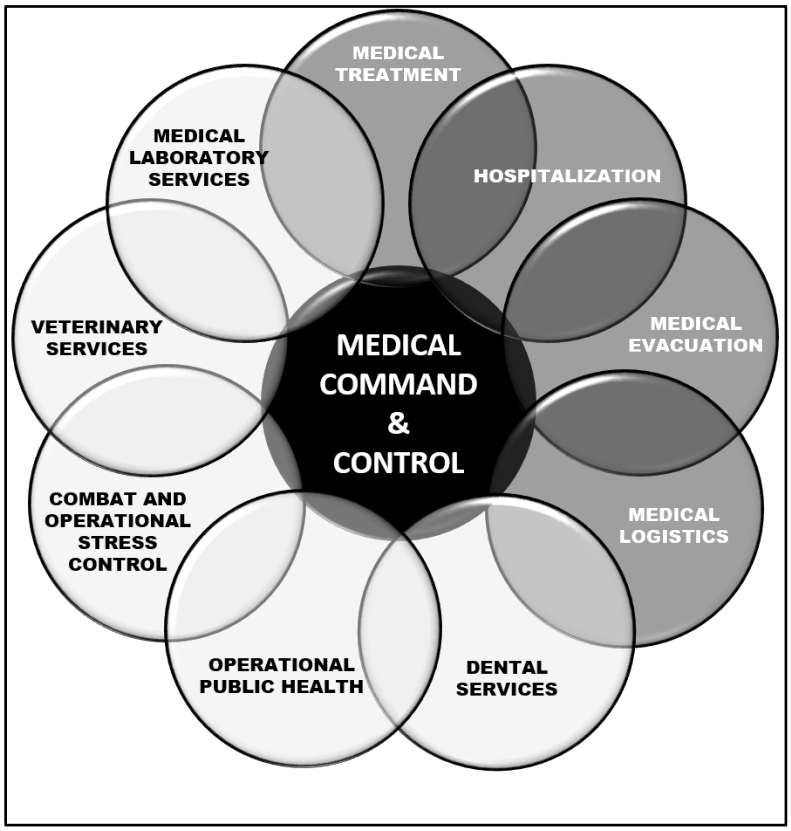

Figure 1-1. System of systems

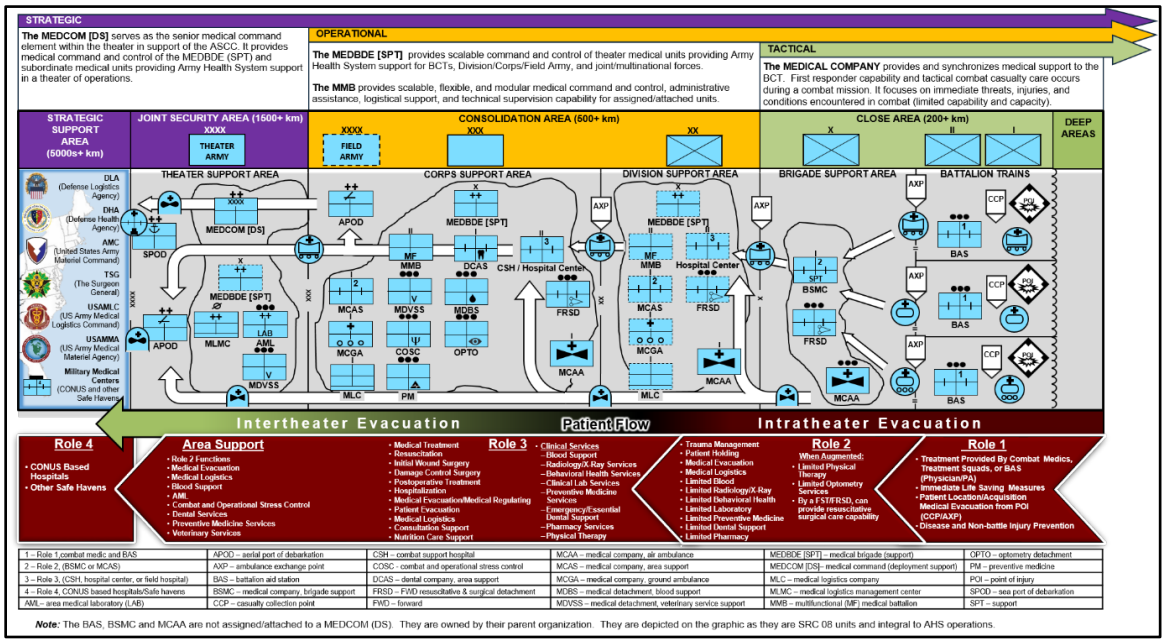

Figure 1-2. Army Health System support operational framework

SECTION III — TACTICAL COMBAT CASUALTY CARE

1-12. Tactical combat casualty care (TCCC) is divided into the three phases- care under fire, tactical field care, and tactical evacuation care. Tactical combat casualty care occurs during a combat mission and is the military counterpart to prehospital emergency medical treatment. Tactical combat casualty care in the military is most commonly provided by enlisted personnel and includes self-aid and buddy aid (first aid), combat lifesaver (enhanced first aid), and enlisted combat medics and critical care flight paramedics in the Army, corpsmen in the United States Navy (USN), United States Marine Corps, and United States Coast Guard, and both medics and pararescue men in the United States Air Force (USAF). Tactical combat casualty care focuses on the most likely threats, injuries, and conditions encountered in combat and on a strictly limited range of interventions directed at the most serious of these threats and conditions.

CARE UNDER FIRE

1-13. In the care under fire phase, combat medical personnel and their units are under effective hostile fire and are very limited in the care they can provide. In essence, only those lifesaving interventions that must be performed immediately are undertaken during this phase.

TACTICAL FIELD CARE

1-14. During the tactical field care phase, medical personnel and their patients are no longer under effective hostile fire and medical personnel can provide more extensive patient care. In this phase, interventions directed at other life-threatening conditions, as well as resuscitation and other measures to increase the comfort of the patient may be performed. Physicians and physician assistants at battalion aid stations or during tailgate medicine support also provide TCCC. During tactical field care, personnel must be prepared to transition back to care under fire, or to prepare the casualty for tactical evacuation, as the tactical situation dictates. ***Tailgate medical support*** **refers to an economy of force device employed primarily to retain maximum mobility during movement halts or to avoid the time and effort required to set up a formal, operational treatment facility (for example, during rapid advance and retrograde operations)**. For more information on tactical field care see ATP 4-02.3.

TACTICAL EVACUATION

1-15. In the tactical evacuation phase, casualties are transported from the battlefield to medical treatment facilities (MTFs). ***Medical treatment facility*** **refers to any facility established for the purpose of providing medical treatment. This includes battalion aid stations, Role 2 facilities, dispensaries, clinics, and hospitals.** Evacuation can be by either medical evacuation (MEDEVAC) (dedicated platforms [ground or air] manned with dedicated medical providers) or casualty evacuation (CASEVAC) (ranging from nondedicated, but tasked, platforms [ground or air] augmented with medical equipment and providers to platforms of opportunity without medical equipment or providers).

Note. The TCCC initiative originated with the Naval Special Warfare Command and later continued by the United States Special Operations Command. Special operations forces do not have a dedicated, designed, and equipped MEDEVAC capability. Therefore, they use nonmedical platforms augmented with medical personnel to perform the evacuation function. The conventional force doctrinal categories of MEDEVAC and CASEVAC as defined in Army doctrine on MEDEVAC are not changed, however, during this phase of TCCC both types of evacuation occur depending upon the availability of assets and the time window available to execute the evacuation process. Time is of the essence to remove the casualty as quickly as possible to where further treatment can be provided.

CASUALTY EVACUATION

1-16. ***Casualty evacuation*** **is the movement of casualties aboard nonmedical vehicles or aircraft without en route medical care. Also called CASEVAC.** (Currently the proponent for this term is FM 4-02 but will be moved to ATP 4-02.13 when revised). Casualty evacuation encompasses a wide spectrum of potential capability- depending on the mix of transport platform, medical equipment, and medical providers allocated to the mission. At the upper end of the spectrum, nondedicated platforms can be outfitted with the requisite medical equipment and MEDEVAC assets. At the lower end of the spectrum, CASEVAC can be no more than the transport of casualties using platforms of opportunity with no medical equipment or medical providers (in using such assets, the risk of not moving the casualty must outweigh the risk evacuating him/her in such a manner). Effective CASEVAC complements MEDEVAC by providing additional evacuation capacity when number of casualties (workload) or reaction time exceeds the capabilities of MEDEVAC assets. Casualty evacuation requires detailed assessment and planning in order to achieve an effective integration of MEDEVAC and CASEVAC capabilities. For more information on CASEVAC, refer to ATP 4-25.13. For more information on MEDEVAC, refer to ATP 4-02.2.

WARNING

Casualties transported in CASEVAC platform may not receive proper en route medical care or be transported to the appropriate MTF that can best address the casualty's medical needs. This may have an adverse impact on the casualty's prognosis, long-term disability or even death may result.

MEDICAL EVACUATION

1-17. *Medical evacuation* is the timely and effective movement of the wounded, injured, or ill to and between medical treatment facilities on dedicated and properly marked medical platforms with en route care provided by medical personnel. Also called MEDEVAC (ATP 4-02.2). **A *patient* is a sick, injured or wounded individual who receives medical care or treatment from medically trained personnel.**

1-18. The Army MEDEVAC system is comprised of dedicated, standardized MEDEVAC platforms (ground and air ambulances). These ambulances have been designed, staffed, and equipped to provide en route medical care to patients being evacuated and are used exclusively to support the medical mission, in accordance with the law of land warfare and the Geneva Conventions. The focus of the MEDEVAC mission coupled with the dedicated ambulances permit a rapid response to calls for medical support. The provision of en route care on medically equipped vehicles or aircraft greatly enhances the patient's potential for recovery and may reduce long-term disability by maintaining the patient's medical condition in a more stable manner. *En route care* refers to the care required to maintain the phased treatment initiated prior to evacuation and the sustainment of the patient's medical condition during evacuation. (ATP 4-02.2).

1-19. The United States Army is tasked with providing intratheater aeromedical evacuation (AE) as the only Service with dedicated air ambulances. The United States Army provides intratheater AE to all land maneuver forces (once ashore) and also provides support to ship-to-shore and shore-to-ship patient movement requirements.

1-20. The USAF AE system operates within the "operational or strategic" environment and provides the vital linkage between the roles of care for regulated patients over extended distances and to continental United States (CONUS) for final patient disposition. The USAF AE is performed by designated fixed-wing platforms configured with standardized medical equipment and staffed with medical professionals who provide the timely, efficient movement and en route care of the wounded, injured, or ill personnel. The standardization of equipment and medical professionals aboard USAF AE assets ensures the continuity of care between roles of medical care. For these reasons, USAF AE is the sole provider of patient movement from Role 3 to Role 4 and is the preferred means of patient movement over great distances within a given area of operations (AO). *Patient movement* is the act of moving a sick, injured, wounded, or other person to

obtain medical and/or dental treatment. Functions include medical regulating, patient evacuation, and en route medical care. (ATP 4-02.2). For more information on aeromedical evacuation, refer to DODD 5100.01, JP 4-02, and ATP 4-02.2.

PATIENT EVACUATION

1-21. In today's OE, the reduced medical footprint forward places a high demand on en route care capabilities. Consequently, patient evacuation capabilities are even more critical than in the past and the United States Army in coordination with the other Service medical elements must integrate with lift operations, as well as with the associated capabilities of multinational forces.

SECTION IV — ARMY HEALTH SYSTEM PRINCIPLES

1-22. The principles of the AHS are the foundation (enduring fundamentals) upon which the delivery of health care in a field environment is founded. The principles guide medical planners in developing operation plans (OPLANs) which are effective, efficient, flexible, and executable. Army Health System support plans are designed to support the operational commander's scheme of maneuver while still retaining a focus on the delivery of health care.

1-23. The AHS principles apply across all medical functions and are synchronized through medical command and control and close coordination and synchronization of all deployed medical assets through medical technical channels. Figure 1-3 depicts the AHS principles.

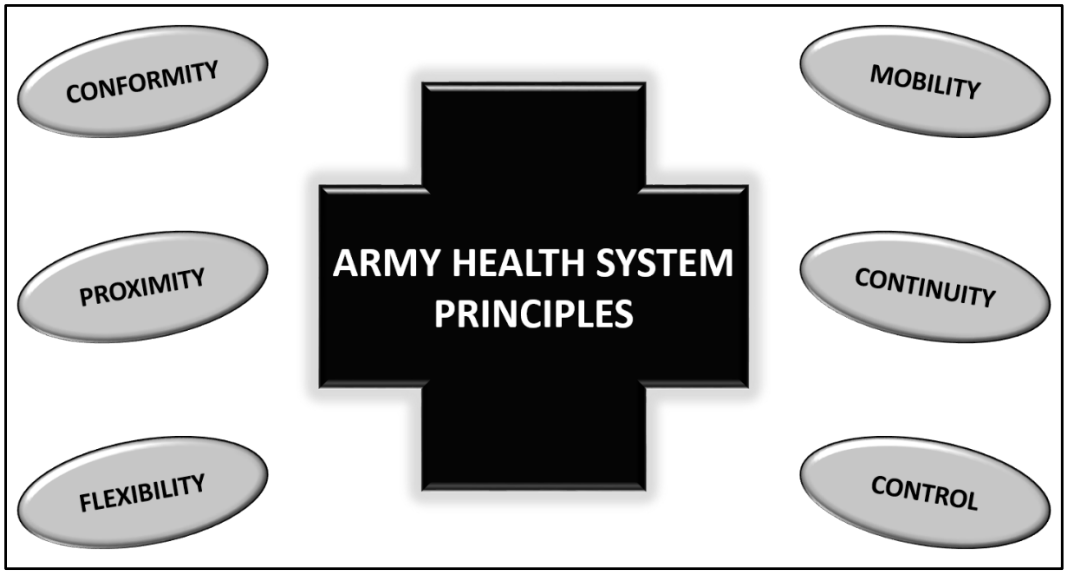

Figure 1-3. Army Health System Principles

CONFORMITY

1-24. Conformity with the operation order (OPORD) is the most basic element for effectively providing AHS support. In order to develop a comprehensive concept of operations, the medical commander must have direct access to the operational commander. Army Health System planners must be involved early in the planning process to ensure that we continue to provide AHS support in support of the Army's strategic roles of shape OEs, prevent conflict, prevail in large-scale ground combat, consolidate gains and once the plan is established it must be rehearsed with the forces it supports. In operations with a preponderance of stability tasks, it is essential that AHS support operations are in consonance with the combatant commander's (CCDR) area of responsibility (AOR) engagement strategy and have been thoroughly coordinated with the supporting assistant chief of staff, civil affairs (CA) operations (G-9).

PROXIMITY

1-25. Proximity is to provide AHS support to sick, injured, and wounded Soldiers at the right time and the right place and to keep morbidity and mortality to a minimum. Army Health System support assets are placed within supporting distance of the maneuver forces which they are supporting, but not close enough to impede ongoing operations. To support the operational commander's plan, it is essential that AHS assets are positioned to rapidly locate, acquire, treat, stabilize, and evacuate combat casualties. Peak workloads for AHS resources occur during combat operations.

FLEXIBILITY

1-26. Flexibility is being prepared to, and empowered to, shift AHS resources to meet changing requirements. Changes in plans or operations make flexibility in AHS planning and execution essential. In addition to building flexibility into the OPLAN to support the commander's scheme of maneuver, the medical commander must also ensure that he has the flexibility to rapidly support the transition from one level of violence to another across the competition continuum (cooperation, competition below armed conflict, and armed conflict). Medical commanders may be supporting simultaneous actions characterized by decisive action elements- offensive, defensive, and stability. The medical commanders exercise their command authority to effectively manage their scarce medical resources so that they benefit the greatest number of Soldiers. For example, there are insufficient numbers of forward surgical teams (FSTs) or forward resuscitative surgical detachments (FRSDs) to permit the habitual assignment of these organizations to each brigade combat team (BCT). Therefore, the medical commander, in conjunction with the command surgeon, closely monitors these valuable assets so that he can rapidly reallocate or recommend the reallocation of this lifesaving skill to the BCTs in contact with the enemy and where the highest number of Soldiers will potentially receive traumatic wounds and injuries. Prolonged combat, intense engagements, and LSCO diminish unit combat effectiveness. When a medical unit is degraded to become combat ineffective and no longer able to provide AHS support effectively, reconstitution may be required.

1-27. Reconstitution consists of those actions that commanders plan and implement to restore units to a desired level of combat effectiveness commensurate with mission requirements and available resources (ATP 3-21.20). Reconstitution may include: removing a unit from combat, assessing it with external assets, reestablishing a chain of command, training a unit for future operations, and reestablishing unit cohesion. For more information on reconstitution, refer to FM 4-0 and ADP 3-90.

1-28. Maximizing the return to duty rate of injured or ill personnel in forward operating units is a major portion of the AHS contribution to the reconstitution effort. Maximizing the return to duty rate of combat Soldiers contributes to the pool of personnel available for reconstitution of degraded units.

MOBILITY

1-29. Mobility is the principle that ensures that AHS assets remain in supporting distance to support maneuvering forces. The mobility, survivability (such as armor plating), and sustainability of AHS units organic to maneuver elements must be equal to the forces being supported. Major AHS headquarters in echelons above brigade (EAB) continually assess and forecast unit movement and redeployment. Army Health System support must be continually responsive to shifting medical requirements in an OE. In noncontiguous operations, the use of ground ambulances may be limited depending on the security threat in unassigned areas and air ambulance use may be limited by environmental conditions and enemy air defense threat. Therefore, to facilitate a continuous evacuation flow, MEDEVAC must be a synchronized effort to ensure timely, responsive, and effective support is provided to the tactical commander. The only means available to increase the mobility of AHS units is to evacuate all patients they are holding. Army Health System units anticipating an influx of patients must medically evacuate patients they have on hand prior to the start of the engagement.

CONTINUITY

1-30. Continuity in care and treatment is achieved by moving the patient through progressive, phased roles of care, extending from the POI or wounding to the CONUS-support base. ***Continuity of care*** **refers to an**

attempt to maintain the role of care during movement at least equal to the care provided at the preceding facility. Each type of AHS unit contributes a measured, logical increment in care appropriate to its location and capabilities. In recent operations, lower casualty rates, availability of rotary-wing air ambulances, and other mission, enemy, terrain and weather, troops and support available, time available, and civil considerations factors often enable a patient to be evacuated from the POI directly to the supporting combat support hospital (CSH) or hospital center. In more traditional operations, higher casualty rates, extended distances, and patient condition may necessitate that patients receive care at each role of care to maintain their physiologic status and enhance their chances of survival. The medical commanders, with their depth of medical knowledge, their ability to anticipate follow-on medical treatment requirements, and their assessment of the availability of their specialized medical resources can adjust the patient flow to ensure each Soldiers receive the care required to optimize patient outcome. The medical commander can recommend changes in the theater evacuation policy to adjust patient flow within the deployed setting. A major consideration and an emerging concern in future conflicts is providing prolonged care at the point of need when evacuation is delayed. The Army's future OE is likely to be complex and challenging and widely differs from previous conflicts. Operational factors will require the provision of medical care to a wide range of combat and noncombat casualties for prolonged periods that exceed current evacuation planning factors.

CONTROL

1-31. Control is required to ensure that scarce AHS resources are efficiently employed and support the operational and strategic plan. It also ensures that the scope and quality of medical treatment meets professional standards, policies, and U.S. and international law. As the Army Medicine is comprised of 10 medical functions which are interdependent and interrelated, control of AHS support operations requires synchronization to ensure the complex interrelationships and interoperability of all medical assets remain in balance to optimize the effective functioning of the entire system. Within the operational area, the most qualified individuals to orchestrate this complex support are the medical commanders due to their training, professional knowledge, education, and experience. In a joint and multinational environment it is essential that coordination be accomplished across all Services and unified action partners to leverage all of the specialized skills within the operational area. Due to specialization and the low density of some medical skills within the MHS force structure, the providers may only exist in one Service (for example, the U.S. Army has the only Veterinary Corps officers in the MHS).

ROLES OF MEDICAL CARE

1-32. A basic characteristic of organizing modern AHS support is the distribution of medical resources and capabilities to facilities at various levels of command, diverse locations, and progressive capabilities, which are referred to as roles of care. ***Definitive care*** **refers to care or treatment which returns an ill or injured Soldier achieving maximum medical improvement.**

1-33. Definitive care embraces all care, treatment, and medical interventions provided at any role of medical care. These interventions can range from self-aid when a Soldier applies a dressing to a grazing bullet wound that heals without further intervention; to two weeks bed-rest in theater for the treatment of Dengue fever; to multiple surgeries and extensive rehabilitation with a prosthesis at a CONUS-based medical center or Department of Veterans Affairs hospital after a traumatic amputation. Injured Soldiers' dispositions may range from return to full duty without limitations to medical discharge from the military secondary to persistent physical limitations resulting from illness or injury.

1-34. ***Definitive treatment*** **refers to the final role of comprehensive care provided to return the patient to the highest degree of mental and physical health possible. It is not associated with a specific role or location in the continuum of care; it may occur in different roles depending upon the nature of the injury or illness.**

1-35. As a general rule, no role of care will be bypassed except on grounds of medical urgency, efficiency, or expediency. The rationale for this rule is to ensure the stabilization/survivability of the patient through TCCC, and far forward resuscitative surgery is accomplished prior to movement between MTFs (Roles 1 through 3).

NONMEDICAL PERSONNEL

1-36. Nonmedical personnel performing first aid procedures assist the combat medics in their duties. First aid is administered by an individual (self-aid or buddy aid) and enhanced first aid is provided by the combat lifesavers. A ***combat lifesaver*** **is a nonmedical Soldier of a unit trained to provide enhanced first aid as a secondary mission.** (Currently the proponent is FM 4-02 but will be moved to ATP 4-02.3 when revised).

Self-Aid and Buddy Aid

1-37. Each individual Soldier is trained in a variety of specific first aid procedures. These procedures include aid for chemical casualties with particular emphasis on lifesaving tasks. This training enables the Soldier or a buddy to apply first aid to alleviate potential life-threatening situations. Each Soldier is issued an individual first aid kit to accomplish first aid tasks. ***First aid*** **(self-aid/buddy aid) refers to urgent and immediate lifesaving and other measures which can be performed for casualties (or performed by the victim themselves) by nonmedical personnel when medical personnel are not immediately available**.

Combat Lifesaver

1-38. The combat lifesaver is a nonmedical Soldier selected by the unit commander for additional training beyond basic first aid procedures. A minimum of one individual per squad, crew, team, or equivalent-sized unit should be trained. The primary duty of this individual does not change. The additional duty of the combat lifesavers is to provide enhanced first aid for injuries, based on their training, before the combat medic arrives. Combat lifesaver training is normally provided by medical personnel during direct support of the unit. The training program is managed by the senior medical person designated by the commander. Members of Special Forces operational detachment teams receive first aid training at the combat lifesaver level.

ROLE 1

1-39. The first medical care a Soldier receives is provided at Role 1 (also referred to as unit-level medical care). This role of care includes:

- Immediate lifesaving measures.
- Disease and nonbattle injury (DNBI) prevention.
- Combat and operational stress preventive measures.
- Patient location and acquisition (collection).
- Medical evacuation from supported units (POI or wounding, company aid posts, or casualty/patient collection points) to supporting MTFs.
- Treatment provided by designated combat medics or treatment squads. (Major emphasis is placed on those measures necessary for the patients to return to duty or to stabilize them and allow for their evacuation to the next role of care. ***Return to duty*** **refers to a patient disposition which, after medical evaluation and treatment when necessary, return Soldiers for duty in their unit**. These measures include maintaining the airway, stopping bleeding, preventing shock, protecting wounds, immobilizing fractures, and other emergency measures, as indicated).

1-40. Role 1 medical treatment is provided by the combat medic or flight paramedic during air evacuation or by the physician, the physician assistant, or the health care specialist in the battalion aid station/Role 1 MTF. ***Emergency medical treatment*** **refers to the immediate application of medical procedures to the wounded, injured, or sick by specially trained medical personnel**. In Army special operations forces, Role 1 treatment is provided by special operations combat medics, Special Forces medical sergeants, or physicians and physician assistants at forward operating bases, Special Forces operating bases, or in joint special operations task forces. Role 1 includes:

- Tactical combat casualty care (immediate far forward care) consists of those lifesaving steps that do not require the knowledge and skills of a physician. The combat medic is the first individual in the medical chain that makes medically substantiated decisions based on medical military occupational specialty-specific training.

- At the battalion aid station, the physician and the physician assistant are trained and equipped to provide TCCC to the combat casualty. This element also conducts routine sick call when the operational situation permits. Like elements provide this role of medical care at brigade and EAB.
- During MEDEVACs, Role 1 treatment is provided by the combat medic (during ground evacuation) or by the critical care flight paramedic (during air evacuation) to an MTF. Critical care flight paramedics are trained and equipped to provide advanced en route care to the combat casualty.

ROLE 2

1-41. At this role, care is rendered at the Role 2 MTF which is operated by the area support squad, medical treatment platoon of medical companies. Here, the patients are examined and their wounds and general medical condition are evaluated to determine their treatment and evacuation precedence, among other patients. Medical treatment including trauma management and beginning resuscitation is continued, and if necessary, additional emergency measures are instituted, but they do not go beyond the measures dictated by immediate necessities. The Role 2 MTF provides a greater capability to resuscitate trauma patients than is available at Role 1. Those patients who can return to duty within 72 hours (1 to 3 days) are held for treatment. This role of care provides MEDEVAC from Role 1 MTFs and also provides Role 1 medical treatment on an area support basis for units without organic Role 1 resources. The Role 2 MTF has the capability to provide packed red blood cells (liquid), limited x-ray, clinical laboratory, operational dental support, combat and operational stress control (COSC), operational public health, and when augmented, physical therapy and optometry services.

1-42. Patients who are nontransportable due to their medical condition may require resuscitative surgical care from an FST or FRSD collocated with a medical company (refer to Army doctrine on the FST or FRSD). *Nontransportable patient* is a patient whose medical condition is such that he could not survive further evacuation to the rear without surgical intervention to stabilize his medical condition. (ATP 4-02.2). The FST or FRSD is assigned to the medical command (deployment support) or medical brigade and attached to a CSH or hospital center when not operationally employed however, the FST or FRSD is only attached to a medical company for resuscitative surgical care capability support when employed.

1-43. Role 2 AHS assets are located in the—

- Medical company (brigade support), assigned to modular brigades which include the armored BCT, infantry BCT, and the Stryker BCT.
- Medical company (area support) which is an EAB asset that provides direct support to the modular division and support to EAB units.

1-44. The NATO descriptions of Role 2 are—

- A Role 2 Basic MTF can provide reception, triage, resuscitation, and damage control surgery, short term holding capacity for at least six and a postoperative care capability for at least two patients.
- An Enhanced Role 2 MTF can provide enhanced diagnostics and mission essential specialist care (including in theater surgery). They have at least two surgical teams, with respective emergency and postoperative care capabilities, x-ray, laboratory, blood bank, pharmacy, sterilization, dentistry, and a short term holding capacity of 25 patients.

Note. The United States Army forces subscribe to the basic definition of a Role 2 MTF providing greater resuscitative capability than is available at Role 1. It does not subscribe to the interpretation used by NATO forces Allied Joint Publication-4.10(B) (Role 2 Basic and Role 2 Enhanced) and JP 4-02 (Role 2 Light Maneuver and Role 2 Enhanced) that a surgical capability is mandatory at this role.

The United States Army does not provide damage control surgery and does not provide surgical capability at Role 2 unless a FST or FRSD is collocated with the medical company to provide forward surgical intervention.

ROLE 3

1-45. At Role 3, the patient is treated in an MTF staffed and equipped to provide care to all categories of patients, to include resuscitation, initial wound surgery, damage control surgery, and postoperative treatment. This role of care expands the support provided at Role 2. Patients who are unable to tolerate and survive movement over long distances receive surgical care in a hospital as close to the supported unit as the tactical situation allows. This role includes provisions for—

- Coordination of patient evacuation through medical regulating.
- Providing care for all categories of patients in an MTF with the proper staff and equipment.
- Providing support on an area basis to units without organic medical assets.

1-46. Role 3 AHS assets are located in the—

- Combat support hospital.
- Hospital Center.

ROLE 4

1-47. Role 4 medical care is found in CONUS-based hospitals and other safe havens (to include robust overseas MTFs). If mobilization requires expansion of military hospital capacities, then the Department of Veterans Affairs and civilian hospital beds in the National Disaster Medical System are added to meet the increased demands created by the evacuation of patients from the operational area. The support-based hospitals represent the most definitive medical care available within the AHS.

ELIGIBILITY OF CARE DETERMINATION

1-48. During unified land operations, one of the most pressing questions is who is eligible for care in a United States Army-established MTF and the extent of care authorized. Numerous categories of personnel seek care in U.S. facilities that are located in austere areas where the host-nation civilian medical infrastructure is not sufficient to provide adequate care. A determination of eligibility and whether reimbursement for services is required is made at the highest level possible and in consultation with the supporting staff judge advocate. Additionally, Department of State and other military staff sections (such as the assistant chief of staff, CA) may also need to be involved in the determination process. Each operation is unique and the authorization for care is based on the appropriate U.S. and international law and policies. Other factors impacting on the determination of eligibility are command guidance, practical humanitarian and medical ethics considerations, availability of U.S. medical assets (in relationship to the threat faced by the force), and the potential training opportunities for medical forces. The sample format provided in Table 1-2 on page 1-15 is just one approach to delineate and disseminate this information to MTF personnel and may not be all-inclusive based on specific scenarios.

Note. The examples for the authority to provide treatment are only illustrative in nature and should not be used as the basis for providing or denying medical care.

KNOWLEDGE OF HEALTH CARE CAPABILITIES

1-49. The MTF staff must be familiar with the medical care available in the operational area from other sources. These sources could include unified action partners such as multinational force military (tactical and strategic), nongovernmental organizations or intergovernmental organizations (such as the United Nations), and local civilian resources. When appropriate, and by knowing the level and types of care available, the MTF staff can plan for the continued care of the patient after initial stabilization is provided in the United States Army MTF and the patient can be transferred to another facility for continued care.

DISSEMINATION OF ELIGIBILITY FOR CARE INFORMATION

1-50. It is essential that eligibility for medical care guidance is disseminated and understood by the chain of command and all civilians and military members of the deployed force. The AHS commander must be able

to articulate the basic principles for medical eligibility determinations. This means that he will need to condense them into simple, easily understood instructions, and widely disseminate them through electronic means or other media (such as pocket-sized cards). As the chief planner for medical support operations, the AHS commander must ensure that this information is contained in appropriate OPLANs and OPORDs and briefed to the appropriate senior leadership of the command.

DOCUMENTATION

1-51. Basic documents required for determining eligibility of beneficiaries include Army Regulation (AR) 40-400; FM 6-27/MCTP 11-10C; relevant sections of Title 10, United States Code; relevant DODD and DODI; multinational force compatibility agreements; acquisition and cross-servicing agreements; orders from higher headquarters; interagency agreements (memorandums of understanding and memorandums of agreement); status of forces agreements; and appropriate unified action partners guidance for the specific operation. If contractor personnel are present, a copy of the relevant sections of their contracts should be on file to delineate specific medical services to be rendered. Additionally, for contract personnel, points of contact for the contracting company, and for the administration of the contract should be maintained. Finally, the political-military environment of the operational area must be taken into account as the medical command and control headquarters and its higher headquarters develop the eligibility matrix.

1-52. The eligibility matrix should be as comprehensive as possible. If necessary, it should include eligibility determination by name (see example in Table 1-2 on page 1-15). If individuals arrive at the emergency medical service section of the MTF who are not included in the medical/dental support matrix, the MTF must always stabilize the individual first and then determine the patient's eligibility for continued care. The command point of contact for eligibility determinations should be contacted immediately. Further, care will be provided in accordance with the standard operating procedure (SOP) pending eligibility determination. For example, a host-nation civilian presents himself at the gate and requests medical treatment. Although on the surface it may appear that he is not eligible for care, this determination can only be made after a medical assessment is completed by competent medical personnel. In some cases, the individual may have to be brought into the MTF to accomplish an adequate medical assessment. Conducting a medical assessment does not obligate the U.S. military to provide the full spectrum of medical care. Although it does obligate the MTF to provide immediate stabilization for life-, limb-, and eyesight-threatening medical conditions and to prepare the patient for evacuation to the appropriate civilian or national contingent MTF when the patient's medical condition permits.

Note. Any individual requesting medical care should receive a timely medical assessment of his condition. Even though the individual is not eligible for treatment, life-, limb-, or eyesight-saving procedures warranted by the individual's medical condition are provided to stabilize the individual for transfer to the appropriate civilian or other nation MTF.

SAMPLE ELIGIBILITY FOR CARE MATRIX

1-53. Table 1-2 on page 1-15 provides a sample eligibility for medical and dental care support matrix for treatment in a United States Army MTF.

Table 1-2. Sample eligibility for medical and dental care support matrix

ELIGIBILITY FOR MEDICAL AND DENTAL CARE SUPPORT MATRIX (DATE) (THIS DOCUMENT IS SUBJECT TO FURTHER VERIFICATION AND AND/OR MODIFICATION)		
Category	***Medical/dental***	***Information/authority****
Multinational military personnel	Yes[1]	The following nations have acquisition and cross-servicing agreements and multinational force compatibility agreements with the U.S. which are administered by *(combatant command): List nations*.
Department of Defense Civilian employees	Yes	Invitational travel order.
U.S. Government employees (non-Department of Defense)	Yes[2]	Invitational travel order.
U.S. Embassy personnel	Yes	U.S. citizens on official business.
U.S. Congressional personnel	Yes	U.S. citizens on official business.
Army and Air Force Exchange Service U.S. citizen employees	Yes	Invitational travel order.
Army and Air Force Exchange Service Local national employees	Yes[3]	U.S. law.
Nonappropriated fund instrumentality morale, welfare, and recreation U.S. employees	Yes	Invitational travel orders.
Contracted college instructors	Yes	Invitational travel orders.
United Nations personnel (includes all personnel employed by the United Nations and its agencies, such as the United Nations High Commissioner for Refugees)	Yes[3]	U.S. law.

HEALTH INFORMATION TECHNOLOGY

1-54. Information management in support of both Army and Joint health services includes the ability to identify, capture, organize, disseminate, and synthesize required operational health and medical force information in support of a commander's plans, operations, and sustainment activities within the OA. Deploying units are required to begin using Joint Operational Medicine Information Systems (JOMIS) and other available medical information systems within 24 hours of the unit's initial operating capability. Information systems deployed in the operational environment are required to adopt and use data exchange standards that are appropriate to, and facilitate interoperability with systems that are used in that domain.

1-55. There are two critical success factor to ensure units are utilizing their assigned systems with 24 hours of initial operating capability. The first is to introduce health information technology planning, to include network design, into the early stages of the military decision making process following receipt of an OPORD. The second is ensuring collaboration among primary staff section leaders and that the S6/Health Information Systems Officer is working with, and guiding, the chief of clinical operations, medical logistics, patient administration and operations as it relates to health information technology and communications.

Table 1-2. Sample eligibility for medical and dental care support matrix (continued)

ELIGIBILITY FOR MEDICAL AND DENTAL CARE SUPPORT MATRIX (DATE) (THIS DOCUMENT IS SUBJECT TO FURTHER VERIFICATION AND AND/OR MODIFICATION)		
Category	***Medical/dental***	***Information/authority****
Contractor #2 all employees POC: Mr. Michaels (XXX) XXX-XXXX ADMIN: Mr. Johns DSN XXX-XXXX	Yes[3] No[5]	Contractor did not contract for the provision of medical care by military medical treatment facilities. Contractor stated in writing that they contracted with the host-nation medical infrastructure for the required care. **NOTE:** A separate determination may be required for individual cases, as the individual may be eligible for care under a different provision. Contact Mr. Patrick, DSN XXX-XXXX if additional information is required.
Contractor #4 Mr. Edward Dean (company name classified) POC: Ms. Emory (XXX) XXX-XXXX ADMIN: Mr. Johns DSN XXX-XXXX	Yes	Per Mr. Patrick, Mr. Dean is entitled to full medical and dental support without reimbursement. The terms of the contract and the name of the contracting company are classified. Contact Mr. Patrick, DSN XXX-XXXX, if additional information is required.
Contractor #5 Mr. Michael James (company name classified) POC: Ms. Emory (XXX) XXX-XXXX ADMIN: Mr. Johns DSN XXX-XXXX	Yes[6]	Per Mr. Patrick, Mr. James is entitled to full medical and dental support; however, this care is reimbursable. The terms of the contract and the name of the contracting company are classified. Contact Mr. Patrick, DSN XXX-XXXX, if additional information is required.
Dependents of U.S. active duty or retired military personnel	Yes[4]	Only if space is available and appropriate medical services/care are available in the operational setting. AR 40-400. Contact Mr. Patrick, DSN XXX-XXXX, if additional information is required.
Personnel in custody of U.S. military forces	Yes	Enemy prisoner of war and detained personnel. Extent of care rendered is the same as that provided to U.S. military forces within the geographical area. (Army Techniques Publication 4-02.46, and Field Manual 27-10).

1-56. The applications from numerous program offices to support the ten medical functions include JOMIS, the Defense Medical Logistics – Enterprise Systems, U.S. Transportation Command (USTRANSCOM), Defense Medical Information Exchange, Solutions Delivery Division and Infrastructure and Operations Division. Combined, these program offices develop and support applications that permit, electronic viewing and documentation of health care delivery, medical logistics (MEDLOG), medical situational awareness, medical communication and control and patient movement. Joint Operational Medicine Information Systems currently provides the Legacy Theater Medical Information Program – Joint suite of applications to the operating forces.

Table 1-2. Sample eligibility for medical and dental care support matrix (continued)

Category	*Medical/dental*	*Information/authority**
Individual injured as a result of military operations	Yes	U.S. and international law (Field Manual 6-27) and status of forces agreements. If the U.S. military injures an individual (such as in an automobile accident involving a military vehicle), the U.S. is responsible for providing immediate care (or paying for local care). Coordinate with Mr. Patrick, DSN XXX-XXXX and Lieutenant Colonel Hall, supporting staff judge advocate, DSN XXX-XXXX.

LEGEND:

* Illustrative in nature only.

1 Multinational force member nations are provided food, water, fuel, and medical treatment pursuant to reciprocal agreements. The amount of food, water, fuel, and medical care provided must be accounted for by the providing nation to the assistant chief of staff, Civil Affairs operations (G-9). Logistical support is not permitted for those nations with whom the U.S. does not have both an acquisition and cross-servicing agreement and multinational force compatibility agreement. However, the acquisition and cross-servicing agreement and multinational force compatibility agreement requirements may be waived for those nations whom the commander, in conjunction with the supporting staff judge advocate, feels are supporting the missions of the command.

2 If not working for, contracted to, or on DOD multinational force compatibility agreement for logistical support, non-DOD U.S. Government employees must pay for meals received at DOD dining facilities.

3 Emergency medical and dental care only. Emergency care is that care required to save life, limb, or eyesight.

4 Space available.

5 Routine.

6 Reimbursable.

Admin	administration
AR	Army regulation
DOD	Department of Defense
DSN	Defense Switched Network
POC	point of contact
U.S.	United States

1-57. Health information technology in support of the AHS will continue to transform and include a deployable version of MHS GENESIS (the new electronic health record for Role 3/4 military treatment facilities) designated as JOMIS Increment 1. Other changes will include moving AHS applications to a cloud based platform and increased use of the JOMIS Mobile Computing Capability (MCC). The following are the primary systems used to support the AHS in the AO:

- Electronic TCCC- Standard Form (SF) 600 (*Chronological Record of Medical Care)* and medical references such as the Algorithm Directed Troop Medical Care Manual are available on the JOMIS MCC platform. The MCC is currently available as an Android device and is intended for the combat medic and first responders that are typically operating in a disconnected environment. The data stored on the device can be transferred to any computing device with access to the Armed Forces Health Longitudinal Technology Application-Theater (AHLTA-T).
- The AHLTA-T is the operational medicine version of the current AHLTA application utilized in all MTFs to provide clinicians a system to document health care delivery to include the diagnosis and treatment of Service members and civilians authorized by Title 10 and Status of Forces Agreements. Signed/completed medical encounters from AHLTA-T are transmitted to the Theater Medical Data Store (TMDS) before final submission into the Clinical Data Repository.

Patient encounters within the Clinical Data Repository are further available to all authorized health care providers throughout the MHS regardless of location. The TMDS also transmits discrete data from each medical encounter related to public health to the Medical Situational Awareness Theater (MSAT).

- The Joint Legacy Viewer application is accessible within TMDS. The Joint Legacy Viewer is a Non-classified Internet Protocol Router Network web-application that provides an integrated, read-only view of Electronic Health Record data from the DOD, Veterans Affairs, and Virtual Lifetime Electronic Record eHealth Exchange partners, within a single application. The Joint Legacy Viewer also provides healthcare providers access to view pre-deployment allergy, documentation, laboratory, medication and radiology records.
- Theater Composite Health Care System Cache (TC2) is used to register and admit patients, order pharmacy, laboratory and imaging studies (includes computed tomography, digital radiology, magnetic resonance imagining, and ultra-sound) and document laboratory and imaging results. Similar to AHLTA-T, signed/completed TC2 encounters are transmitted to TMDS.
- The TMDS is a web-based portal that offers health care delivery professionals several capabilities to include:
  - Viewing signed encounters from other locations and points of care.
  - Managing theater blood inventories.
  - Access to Service member life-time medical records through the Joint Legacy Viewer.
- The MSAT is web-based portal that aggregates information from multiple sources to provide a joint medical common operational picture. The MSAT contains 2 distinct features:
  - The first aggregates clinical data from AHLTA-T and TC2 and uses a complex algorithm to identify situations involving public health, CBRN issues and exposures.
  - The second is a unit readiness report providing information related to a variety of information to personnel, equipment and the overall operating status of medical units such as bed status.
- Medical References are available with the Medical Computing Capability application on Medical Communications for Combat Casualty Care issued handhelds. The medical reference application is also available on Medical Communications for Combat Casualty Care laptops and serves as the medical reference tool that provides a series of medical guides to assist the provider while performing a clinical diagnosis. The medical reference application provides access to a collection of databases with disease, drug, acute care, and toxicology information.
- Defense Medical Logistics – Enterprise Systems is the program and portfolio name for all MEDLOG applications. LogiCole is the name for the refreshed Defense Medical Logistics Standard Support (DMLSS) environment that integrates all the legacy MEDLOG applications to include DMLSS, theater electronic warehouse logistics system, joint medical asset repository and the DMLSS Customer Assistance Module into web-based environment. The DMLSS is used throughout all CONUS and outside CONUS-based Role 4 MTFs and deployed Role 3 MTFs. The theater electronic warehouse logistics system and DMLSS Customer Assistance Module are used by all Roles 1 and 2 MTFs in both combatant command (command authority) (COCOM) and U.S. Army Forces Command domains to order and manage Class VIII medical supplies.
- The DMLSS Customer Assistance Module allows tactical units to interface with LogiCole, the Defense Medical Logistics enterprise system used by theater medical supply support activities to—
  - Submit medical supply orders and download catalog data, stock availability, order status, and quality control alerts.
  - Enable these unit to manage their medical supply levels and generate orders while disconnected for submission when Non-classified Internet Protocol Router Network communications are available.
- Personnel can easily access an online nonsecure web-based portal clinical decision support tool. This tool is for travel medicine practitioners that provides medical professionals access to medical information to prepare Soldiers and travelers for health threats and other concerns related to international travel. This online tool supplements DOD medical information with data integrated from international and regional health organizations plus additional information and analysis

developed collaboratively through a network of trusted medical advisors. This information is also integrated in MSAT. For more information, go to www.travax.com.

- The U.S. Transportation Command Regulating and Command and Control Evacuation System (TRAC2ES) is a web-based portal that provides patient movement and in-transit visibility to medical facilities. The TRAC2ES combines transportation, logistics and clinical decision elements in order to support tactical and strategic operations.

1-58. Department of Defense policy requires the Services to document exposures and manage health risks during all phases of military operations. The Defense Occupational and Environmental Health Readiness System (DOEHRS) - Industrial Hygiene (IH) is a DOD application funded by the MHS. It is the DOD system of records used to manage unclassified OEH data, including selected veterinary PH data, for garrison and deployment operations. The DOEHRS-IH is also the DOD's system of records for informing OEH risk management, as well as a foundational system for the individual longitudinal exposure record. It contains seven business areas-Industrial Hygiene, Environmental Health, Food Protection, Radiation, Incident Reporting, Registries, and Digital Library-and includes a module for filtering and reporting data from these areas. The DOEHRS-IH is a common access card-enabled, web-based system available at https://doehrs-ih.csd.disa.mil/.

SECTION V — GLOBAL HEALTH ENGAGEMENT

1-59. Department of Defense Instruction 2000.30 instructs the DOD to conduct global health engagement activities in support of U.S. national security policy and defense cooperation strategy. The U.S. government will use the full spectrum of DOD health capabilities to execute and support—

- Force Health Protection (DODD 6200.04).
- Foreign Humanitarian Assistance (JP 3-29).
- Foreign Disaster Relief (DODD 5100.46).
- Humanitarian and Civic Assistance (DODI 2205.02).
- DOD Countering Weapons of Mass Destruction Policy (DODD 2060.02).
- Stability Operations (DODD 3000.05).
- DOD Veterinary Public and Animal Health Services (DODD 6400.04E).
- DOD Policy and Responsibilities Relating to Security Cooperation (DODD 5132.03).

1-60. These health capabilities will be leveraged in military-to-military, military-to-civilian, or multilateral global health engagement activities as tools to—

- Promote and enhance partner nation's stability and security.
- Develop military and civilian partner nation capacity.
- Build trust, confidence, and resilience.
- Share information.
- Coordinate mutual activities.
- Maintain influence to enable implementation of the guidance for the employment of the force and to support the achievement of U.S. government national security objectives.
- Enhance DOD's awareness of global health engagement and improve its relationship and interoperability with each partner nation to achieve security cooperation objectives.
- Seek to develop and improve the human and animal health capabilities and capacities of DOD and partner nation personnel.

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Chapter 2

Army Health System Command and Control

The complexities of the competition continuum, the myriad of medical functions and assets, and the requirement to provide health care across unified land operations to diverse populations (U.S., joint, multinational, host nation, and civilian) necessitate a medical command authority that is regionally focused and capable of utilizing the scarce medical resources available to their full potential and capacity. Each of the medical command organizations (medical command [deployment support] [MEDCOM (DS)], medical brigade [support] [MEDBDE (SPT)], and medical battalion [multifunctional] [MMB]) is designed to provide scalable and tailorable command posts for early entry and expeditionary operations which could be expanded and augmented as the operational area matures and an Army and joint integrated health care infrastructure is established. The AHS command and control consists of both formal medical command organizations and the surgeon's technical supervision at echelon of medical assets.

SECTION I — OVERVIEW OF ARMY ECHELONS

2-1. To ensure a seamless continuum of care from the POI or wounding to the CONUS-support base exists, and in order to decrease morbidity and mortality and to reduce disability, a synergistic effort is required between AHS table of organization and equipment (TOE) (operational forces) and table of distribution and allowances (the institutional force) organizations and resources and those found in other sectors of the CONUS-support base. The ability of the deployed medical commander to reach into the CONUS-support base for medical, technical, clinical, and materiel support is paramount to optimizing the medical outcomes of our Soldiers who become wounded, injured, or ill while on deployments. This reachback capability enhances the care given and maximizes the utilization and employment of scarce medical resources.

OPERATIONAL ENVIRONMENT

2-2. The future operational environment and our forces' challenges to operate across the competition continuum represents the most significant readiness requirement. The logic chart (Figure 2-1 on page 2-2) depicted on the next page begins with an anticipated OE that includes considerations during LSCO against a peer threat. It depicts the Army's contribution to joint operations through the Army's strategic roles. Within each phase of a joint operation, the Army's operational concept of unified land operations guides how Army forces conduct operations. In unified land operations, Army forces combine offensive, defensive, and stability tasks to seize, retain, and exploit the initiative in order to shape OEs, prevent conflict, conduct large-scale ground combat operations, and consolidate gains. Mission command guides commanders, staffs, and subordinates in their approach to command and control. The command and control warfighting function enables commanders and staffs of theater armies, corps, divisions, and brigade combat teams to synchronize and integrate combat power across multiple domains and the information environment. Throughout operations, Army forces maneuver to achieve and exploit positions of relative advantage across all domains to achieve objectives and accomplish missions.

2-3. The logic chart (Figure 2-1 on page 2-2) depicts how the AHS supports the operating force. The AHS support logic chart is aligned with ADP 3-0, FM 3-0, ADP 3-37, ADP 4-0, FM 4-0, and JP 4-02.

2-4. For more information on AHS support to the Army strategic roles, refer to Appendix A.

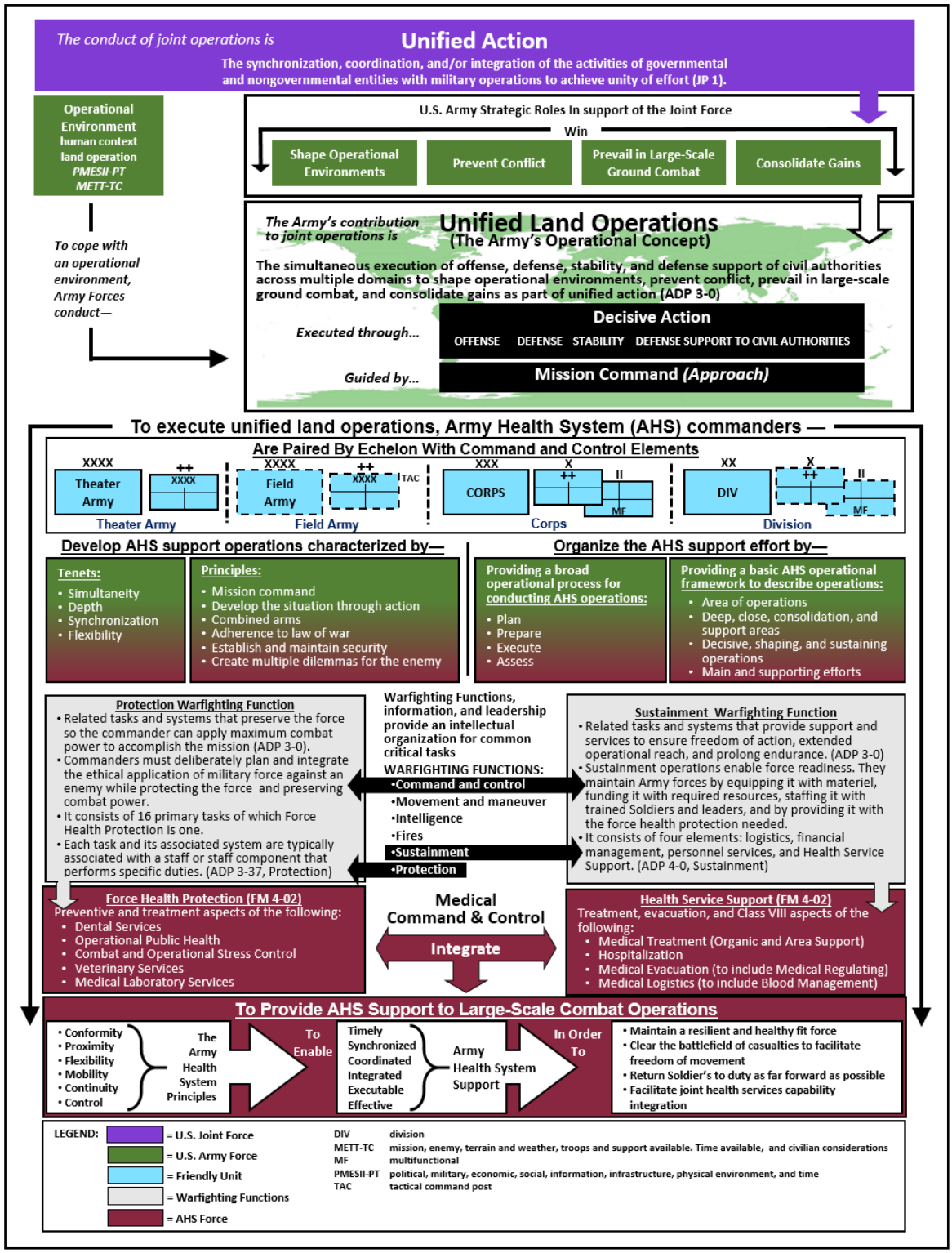

Figure 2-1. Army Health System support logic chart

ARMY COMMAND AND SUPPORT RELATIONSHIPS

2-5. Army command and support relationships are similar but not identical to joint command authorities and relationships. Differences stem from the way Army forces task-organize internally and the need for a system of support relationships between Army forces. Another important difference is the requirement for Army commanders to handle the administrative support requirements that meet the needs of Soldiers. These differences allow for flexible allocation of Army capabilities within various Army echelons. Army command and support relationships are the basis for building Army task organizations. Certain responsibilities are inherent in the Army's command and support relationships. For more information on command relationships for joint force, refer to JP 3-0.

ARMY COMMAND RELATIONSHIPS

2-6. Commanders recognize that effectiveness is built on mutual trust and confidence between superior, subordinate, supporting and supported organizations. This trust and confidence is developed through relationships. Generally the longer a relationship lasts, a greater degree of trust and confidence results. Between organizations that have had long-term habitual relationships, authorities and responsibilities are typically well known. For more information regarding mission command and command and control of Army forces, refer to ADP 6-0 and FM 6-0.

2-7. Army command relationships define superior and subordinate relationships between unit commanders. By specifying a chain of command, command relationships unify effort and enable commanders to use subordinate forces with maximum flexibility. Army command relationships identify the degree of control of the gaining Army commander. The type of command relationship often relates to the expected longevity of the relationship between the headquarters involved, and it quickly identifies the degree of support that the gaining and losing Army commanders provide. The five Army command relationships include:

- Organic.
- Assigned.
- Attached.
- Operational Control (OPCON).
- Tactical control (TACON).

2-8. See Appendix B for more information regarding Army command relationships according to FM 3-0 and FM 4-0.

ARMY SUPPORT RELATIONSHIPS

2-9. Army support relationships are not a command authority and are more specific than joint support relationships. Commanders establish support relationships when subordination of one unit to another is inappropriate. Army support relationships are:

- Direct support.
- General support.
- Reinforcing.
- General support-reinforcing.

2-10. Refer to Appendix B for more information on Army support relationships according to FM 3-0 and FM 4-0.

2-11. See Figure 2-2 on page 2-4 for an example of AHS organizations' command and support relationships during an operation or when deployed. Refer to Appendix C for more information on the synchronization, coordination, and integration of medical support at echelon between medical and sustainment (FM 4-0), protection, and other warfighting functions/staff cells.

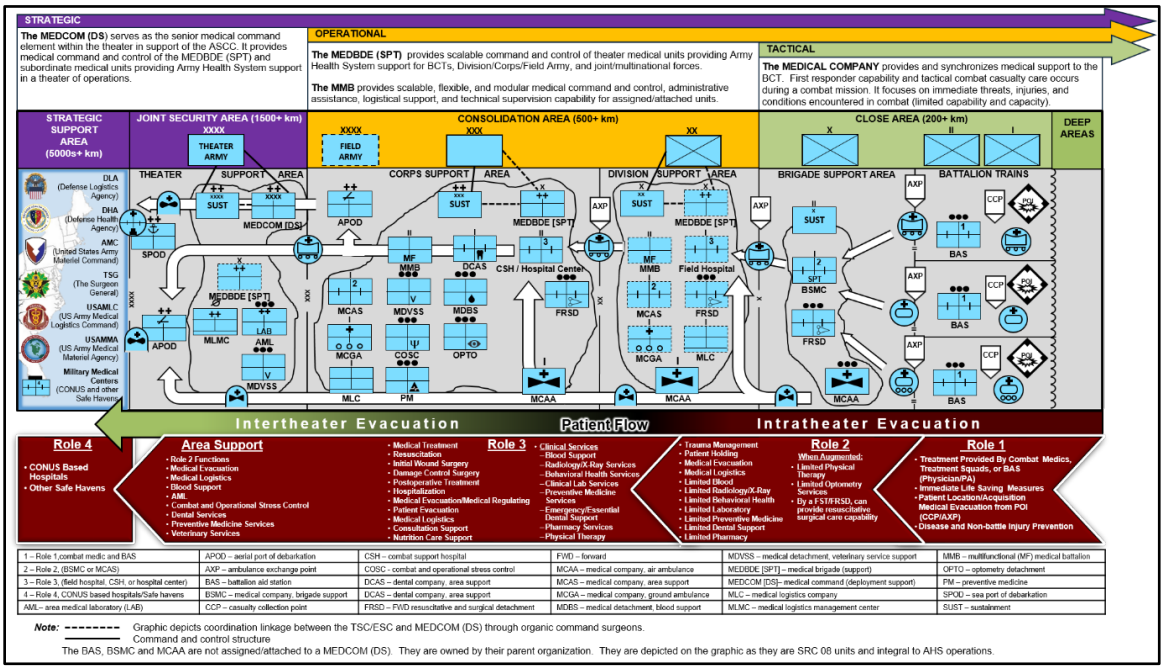

Figure 2-2. Army Health System command and support relationships

THEATER ARMY

2-12. The theater army is the senior Army headquarters in an AOR, and it consists of the commander, staff, and all Army forces assigned to a combatant command. Each theater army has operational and administrative responsibilities. Its operational responsibilities include command of forces, direction of operations, and control of assigned AOs. Its administrative responsibilities encompass the Service-specific requirements for equipping, sustaining, training, unit readiness, discipline, and personnel matters. As required, the theater army provides Army support to other services and common user logistics.

2-13. The theater army always maintains an AOR-wide focus, providing support to Army and joint forces across the AOR, in accordance with the geographic combatant commander (GCC)'s priorities of support. For example, the theater army continues shape and prevent activities in various operational areas at the same time it is LSCO.

2-14. The theater army serves as the Army Service component command (ASCC) of the geographic combatant command. It is organized, manned, and equipped to perform that role. The ASCC is the command responsible for recommendations to the joint force commander (JFC) on the allocation and employment of Army forces within a CCDR's AOR. For additional information refer to FM 3-94.

2-15. According to ATP 3-93 (Theater Army Operations), theater armies are assigned or provided access to five enabling capabilities (sustainment, signal, medical, military intelligence, and civil affairs), and an assortment of functional and multifunctional units, based on specific requirements for the area of responsibility.

2-16. The MEDCOM (DS) is assigned to the ASCC. As one of the theater enabling commands, the MEDCOM (DS) is the theater medical command responsible for integration, synchronization, and command and control for the execution of all AHS support operations within the AOR. The MEDCOM (DS) may have a direct support or general support relationship with the corps or the division. The MEDCOM (DS) has a command relationship with the ASCC and a general support relationship with the theater sustainment command (TSC) or expeditionary sustainment command (ESC). A high level of coordination between command and staff channels develops the situational understanding necessary to recommend priorities and courses of action to echelon commanders. The medical staff channels (surgeon cells) conduct planning,

coordination, synchronization, and integration of AHS support to plans. Refer to Appendix C for detailed discussion regarding the coordination, synchronization, and integration of medical support at echelons. The chain of medical commanders execute the AHS support to OPLANs, and maintain the medical technical channel throughout echelons.

THEATER ARMY SURGEON'S SECTION

2-17. The ASCC surgeon is the theater army staff proponent responsible for (in coordination with the MEDCOM [DS] commander) the provision of AHS support within the AOR. The ASCC surgeon has staff responsibility for medical planning, coordination, and policy development for AHS support to deployed forces. This officer advises the ASCC commander concerning the health of the command, recommends changes to the theater evacuation policy, and provides input to and personnel in support of the theater patient movement requirements center, as required. Organizations from battalion through ASCC level are authorized a surgeon. The Army Medicine leverages the chain of surgeon's cells (staff channels) and medical command channels (through the MEDCOM [DS], medical brigade [support], and medical battalion [multifunctional] to provide AHS support to the deployed force. Integration of these two chains and other elements of sustainment occur at command headquarters at echelon and not just between sustainment organizations.

2-18. The ASCC surgeon and the surgeon cells at each echelon identify, assess, counter and/or mitigate health threats across the competition continuum. They advise commanders on medical capabilities and capacities necessary to support plans, and interface with logistical, financial management, and personnel elements to coordinate AHS support across the warfighting functions. The ASCC surgeon and the surgeon cells at each echelon (including the TSC, ESC, and sustainment brigade surgeon cells) work with their staff to conduct planning, coordination, synchronization, and integration of AHS support to plans to ensure that all 10 medical functions are considered and included in running estimates, OPLANS, and OPORD in coordination with the MEDCOM (DS). Refer to Appendix C for more information on the synchronization and integration of AHS support at echelon.

2-19. The MEDCOM (DS) commander is responsible for maintaining a regional focus in support of the GCC and ASCC theater engagement plan, while providing effective and timely direct FHP and HSS to tactical commanders and general support (on an area basis) to theater forces at EAB. The enduring regional focus of the ASCC drives organizational specialization in the supporting MEDCOM (DS) to address unique health threats, specific needs of the local populace, availability of other Service medical capabilities, and geographic factors that are distinctly related to a particular region. The MEDCOM (DS) coordinates with the ASCC surgeon (as the staff proponent with execution through G-3 channels under the authority of the ASCC commander) to provide AHS support within the AOR.

2-20. As the theater medical command, the MEDCOM (DS) integrates, synchronizes, and provides command and control of MEDBDE (SPT), MMBs, and other AHS units providing force health protection and health service support to tactical commanders. The MEDCOM (DS) employs an operational command post (CP) and a main CP that can deploy autonomously into an operational area and is employed based on the size and complexity of operations or the support required. Refer to Figure 2-3 on page 2-6 for an overview of a theater medical structure. Key tasks of a MEDCOM (DS) in support of the ASCC include:

- Providing command and control of MEDBDE (SPT) and subordinate medical units assigned and attached.
- Task-organizing medical elements based on specific medical requirements.
- Monitoring health threats within each operational area and ensuring the availability of required medical capabilities to mitigate those threats.

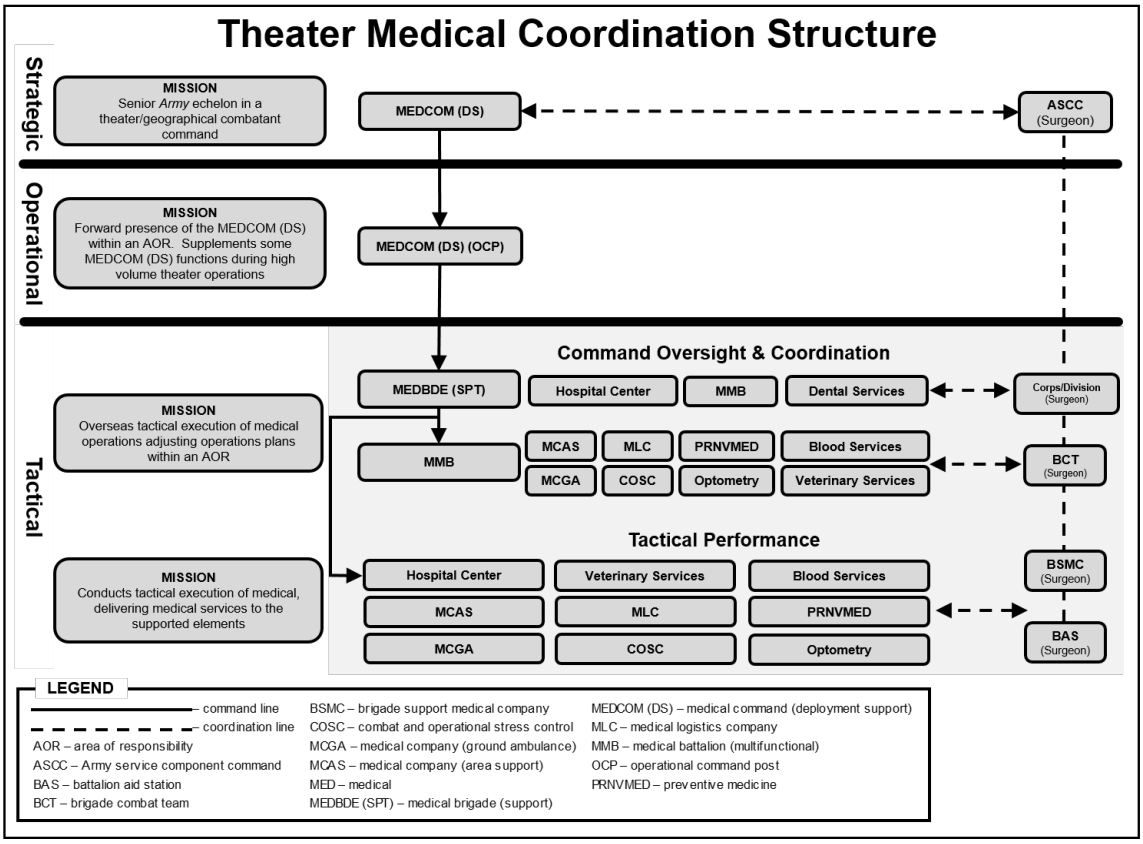

Figure 2-3. Medical structure in theater

THEATER SUSTAINMENT COMMAND

2-21. The TSC is the Army's command for the integration and synchronization of sustainment in the AOR. The TSC connects strategic enablers to the tactical formations. It is a theater-committed asset to each ASCC and focuses on Title 10 support of Army forces for theater security cooperation and the CCDRs daily operational requirements. The TSC commands assigned human resources sustainment centers and Financial Management Support Centers. The TSC commander also commands and task organizes attached ESCs, sustainment brigades, and additional sustainment units. The TSC executes the sustainment concept of support for planning and executing sustainment-related support to the AOR for all the Army strategic roles (shape OEs, prevent conflict, prevail in large-scale ground combat, and consolidate gains).

2-22. The TSCs execute sustainment operations through their assigned and attached units. The TSC integrates and synchronizes sustainment operations across an AOR from a home station command and control center or through a deployed CP. The TSC has four operational responsibilities to forces in theater: theater opening, theater distribution, sustainment and theater closing.

2-23. The task-organized TSC is tailored to provide operational-level sustainment support within an assigned AOR. It integrates and synchronizes sustainment operations for an ASCC including all Army forces forward-stationed, transiting, or operating within the AOR. The TSC coordinates Title 10, Army support to other Services, DOD executive agent (EA), and lead service responsibilities across the entire theater.

2-24. The TSC organizes forces, establishes command relationships and allocates resources as necessary to support mission requirements, and exercises command and control over attached sustainment forces. The TSC supports the ASCC sustainment cells with planning and coordinating theater-wide sustainment. The execution of sustainment is decentralized, performed by the human resources sustainment centers, Financial Management Support Centers, ESCs, sustainment brigades, and other sustainment organizations. The

medical logistics management center (MLMC) forward team collocates with the distribution management center (DMC) of the TSC or ESC to serve as the liaison to the MEDCOM (DS). The MEDCOM (DS) is responsible for integrating and executing medical operations. The DMC is the principal staff section for coordinating sustainment across an operational area. It is headed by the support operations officer and is a coordinating staff section unique to TSCs and ESCs. The DMC is responsible for sustaining the force in accordance with the theater army priorities. The staff focuses on detailed planning for operational area opening, distribution, sustainment, and operational area closing operations. See ATP 4-94 for additional information.

ARMY MEDICAL SUPPORT TO OTHER SERVICES

2-25. The Surgeon General is the principal military adviser to the Secretary of the Army and the Chief of Staff of the Army on the health and medical aspects of manning, training, and equipping the Army as in Title 10 United States Code. In this role, The Surgeon General serves as the Headquarters, Department of the Army medical integrator and synchronizer with expert oversight for material development for assigned programs and responsible for medical research, development and acquisition functions. United States Army medical forces provide AHS support to the joint force through oversight and assigned DOD EA or lead Service responsibilities for a number of medical functions. This requires the synchronization and integration of operational medical resources across the unified action partners to meet CCDR's global mission objectives. The Surgeon General's EA or lead Service responsibilities include:

- Serves as the DOD EA for medical research for prevention, mitigation, and treatment of blast injuries.
- Coordinates for joint patient movement across the joint force.
- Provides intratheater aeromedical evacuation (includes medical evacuation from ship-to-shore and shore-to-ship for United States Navy and Marine personnel).
- Coordinates for medical support to joint special operations forces. See ATP 4-02.43 for additional information.

2-26. The MEDCOM (DS), MEDBDE (SPT), and subordinate units are responsible to the ASCC commander (through coordination with the ASCC surgeon) for regionally focused execution and oversight of AHS support to other Services within the AO. When designated, the MEDCOM (DS) is also responsible for providing operational medical logistics support to other Services. In cases where the ASCC is designated by the CCDR as the single integrated medical logistics manager (SIMLM), these functions are most commonly executed under the direction of the MEDCOM (DS) in coordination with the ASCC surgeon, the TSC, and the supported service components.

2-27. For the Class VIII single integrated medical logistics manager mission, the MLMC provides information management and distribution coordination; the medical logistics company provides medical supply and medical maintenance support; the MEDBDE (SPT) provides planning and supervision; and the MEDCOM (DS) provides theater-level oversight of MEDLOG operations. The medical detachment (blood support) provides collection, manufacturing, storage, and distribution of blood and blood products for brigade and echelons above brigade AHS units and other Services as required. The MEDCOM (DS) maintains a command link with the MEDBDE (SPT) and coordination link with the TSC and/or ESC through the MLMC (forward team) collocated with the DMC.

HEALTH CARE AND THE COMMAND SURGEON IN JOINT OPERATIONS

2-28. The AHS is a strategic enabler of joint medical operations and provides the only standing theater-level medical command and control within the DOD. In joint operations, each Service operates its own health care delivery system, however, health care facilities, medical equipment, supplies, and personnel may be provided on a joint basis, when directed by the joint force commander. Although joint staffing is not a requisite to joint use, staff augmentation from Service components may be required. When one Service uses personnel or medical elements from another Service, the borrowing Service assumes operational control over those elements, however, administrative responsibility remains with the lending Service.

2-29. Upon activation of a joint task force, a command surgeon is designated from one of the component Services. Joint Publication 4-02 states that a joint force surgeon should normally be appointed for each

combatant command, subordinate unified command, and joint task force. As a specialty advisor, the joint force surgeon reports directly to the joint force commander or the joint force land component commander. The joint force surgeon coordinates medical matters for the joint force commander. The joint force surgeon's staff should be jointly manned (when possible) and should be of sufficient size to effectively facilitate joint coordination of medical initiatives; review of plans; and integration with overall operations. The command surgeon must assess component forces medical requirements and capabilities and provide guidance to enhance effectiveness of health care through shared use of assets. Refer to JP 4-02 for additional information on the duties and responsibilities of the joint force surgeon.

2-30. Liaison must be established between the joint force surgeon and each Service component command surgeon to ensure that mutual understanding of medical capabilities and procedures, unity of purpose and action, and joint health care is maintained.

UNIFIED ACTION PARTNERS

2-31. In the OE, a unity of effort must be achieved by all participants and in many scenarios the AHS will provide responsive medical care to unified action partners within the operations determination of eligibility for care. Likewise, our unified action partners may provide first responder and health care services for U.S. troops engaged in multinational operations. The synchronization with our unified action partners of all health care delivery to U.S. Soldiers and multinational forces is essential to ensure the appropriate medical resources are available when needed in the OE.

SECTION II — MEDICAL COMMAND AND CONTROL ORGANIZATIONS

2-32. The AHS is a foundational capability that supports the CCDR's efforts to prevent conflict and shape OEs. The Army medical forces participate in expeditionary operations, integrate with other Services, and support unified action partners. Leaders must understand that the Army Health System medical functions are complex in nature and that medical command and control of FHP and HSS support require integration, coordination, and synchronization to ensure the interoperability of all medical assets remain in balance to optimize the effective functioning of the entire system.

2-33. The medical command and control function includes the centralized medical chain of command that provides command and control of EAB medical assets. Most importantly, it also includes the surgeon's technical supervision at echelon of assigned or attached medical assets.

2-34. All command and control headquarters perform the same basic military tasks. According to ADP 6-0, *command and control* is the exercise of authority and direction by a properly designated commander over assigned and attached forces in the accomplishment of the mission. Medical command and control is not just the exercise of command and control over assigned or attached medical units. It is an overarching function including the technical, clinical, and medical control of all FHP and HSS support. A key to the successful accomplishment of the AHS support is the synchronization of health care activities and the surgeon's technical supervision at echelon of ongoing medical and clinical operations. For more detailed information refer to Appendix C. Specific medical command and control tasks are addressed in Table 2-1 on page 2-9.

Table 2-1. Primary tasks and purposes of the medical command and control function

Primary task	*Purpose*
Command forces	Ensure unity of Army Health System support effort. Train subordinates on command and control and the application of mission command. Make timely and effective Army Health System support decisions and act. Inform and influence leaders to provide the right mix of medical capabilities.
Control operations	Regulate the Army Health Service support of subordinate and supporting units. Direct and coordinate the actions of medical assets to meet commander's intent. Ensure the medical functions within the protection and sustainment warfighting functions are coordinated and synchronized for linkage between these varied commands and staffs. Direct actions by establishing responsibilities and limits that prevent subordinate medical unit actions from impeding one another. Maintain situational understanding of Army Health Services command and control systems and the common operational picture.
Drive the operations process	Employ the operations process to integrate and synchronize the force health protection and health service support medical functions. Integrate numerous processes such as intelligence preparation of the battlefield, medical intelligence, and the military decision-making process. Ensure execution of Army Health System support supports the CCDR's decisions and intent.
Establish the command and control system	Support the commander's decision making. Prepare and communicate directives to subordinate and supporting medical units. Facilitate the integration of medical information systems in support of Army Health System.
Provide technical supervision	Advise the commander on the health of the command and how best to provide Army Health System support for commander's freedom of movement. Ensure medical standards are established, implemented, and monitored throughout the operational area. Advise commanders on implementation of protective action posture including chemoprophylaxis, restriction of movement, isolation, and quarantine to prevent and control the spread of diseases. Provide consultation and support to subordinate medical units or elements. Provide reachback capability to the Defense Health Agency (DHA) continental United States-support base medical treatment facilities in the areas of various medical disciplines and specialties. Provide oversight over medical care to Soldiers, civilians, and detainees.

2-1. For a more detailed discussion on command and control, refer to ADP 3-0, ADP 5-0, and ADP 6-0.

MEDICAL COMMAND (DEPLOYMENT SUPPORT)

2-35. The MEDCOM (DS) conserves the fighting strength of the operational commander through integration, synchronization of AHS operations and providing command and control of MEDBDE (SPT), MMBs, and/or other AHS units assigned/attached to the headquarters providing HSS or FHP to operational commanders and AO forces while simultaneously conducting stability tasks.

MISSION, ASSIGNMENT, AND BASIS OF ALLOCATION

2-36. The MEDCOM (DS) serves as the theater medical command within the AO. The MEDCOM (DS) commander identifies and evaluates health care requirements throughout the AO. Within the MEDCOM (DS) AO, medical resources may be dispersed over an extended area and may include numerous areas with increased patient densities, transient troop populations, varying levels of hostilities, and significantly different health care requirements. To successfully execute medical operations, the MEDCOM (DS) commander must have the ability to rapidly task-organize and reallocate medical assets across command and geographical boundaries. This ability is crucial to ensure the medical force package is effectively tailored to optimize the use of scarce medical resources.

2-37. The MEDCOM (DS) is composed of an operational command post (OCP) and a main command post (MCP) that can deploy autonomously into the AO.

- The OCP is a deployable and versatile module. The OCP can conduct early entry operations and serves as the forward command and control element of the MEDCOM (DS). The OCP expand the reach of the MEDCOM (DS) to provide connectivity between the headquarters and headquarters company, MEDCOM (DS) in CONUS and/or deployed home station and the medical units in the AO. It—
  - Provides command and control, administrative assistance and technical supervision of assigned or attached medical units.
  - Can deploy autonomously into the AO during early entry and theater opening operations. Further, the OCP can be deployed to other AOs outside its habitually supported theater to provide medical command and control in support of another operation.
  - Provides interface and liaison with supported forces in the AO. The OCP has an assigned standard requirements code to facilitate the placement of personnel in the command post and to integrate the command post into the Time Phased Force Deployment List.
  - Can be incrementally expanded or be augmented as the force builds within the AO.
  - Builds the structure required to provide campaign-quality health care to the deployed force.
- The MCP provides appropriate staff sections for command, control, and support to assigned or attached units in the theater of operation. The MCP can be deployed to expand or enhance the Operational Command Post or remain in a sanctuary as the primary command and control medical element of the HHC, MEDCOM (DS). The MCP provides connectivity between CONUS and medical units in the theater. If the OCP is deployed and needs additional personnel or clinical skills, the MCP can deploy personnel to the OCP to provide more robust command and control capabilities. The MCP provides a robust planning, controlling, and coordinating capability to facilitate the provision of health care to expanding forces. The MEDCOM (DS) MCP provides—
  - Medical staff planning, operational and technical supervision, and administrative assistance for subordinate units operating in the AO.
  - Increased capability for medical and surgical consultation services, technical advice, and policy development in the areas of hospitalization, nursing services, pharmacy, optometry, medical laboratory, dental services, COSC, behavioral health, and neuropsychiatric services, veterinary services (zoonotic disease control, investigation and inspection of subsistence, and animal medicine), nutrition care, and operational public health (entomology, epidemiology, occupational and environmental health (OEH) surveillance, potable water inspection, pest management, food facility inspection, and control of medical and nonmedical waste).

2-38. The MEDCOM (DS) possesses the authority to effectively and efficiently task-organize medical elements based on specific medical requirements. The MEDCOM (DS) serves as the theater medical

command for the AOR and focuses on medical OPLANs and medical contingency plans. It monitors threats and ensures required medical capabilities to mitigate these health threats, and maintains visibility and utilization of medical infrastructure, treatment, and evacuation capabilities. It accomplishes Title 10 responsibilities and Army support to other Services for the AO. The MEDCOM (DS) partners and trains with host-nation and multinational AHS units. It maintains a command relationship with the theater army and the CCDR to influence and improve the delivery of health care and is linked to the TSC by the MEDLOG management center for coordination and planning. The MEDCOM (DS) is assigned to the theater army and is allocated on a basis of one per theater.

2-39. Refer to Figure 2-4 for notional deployed MEDCOM (DS).

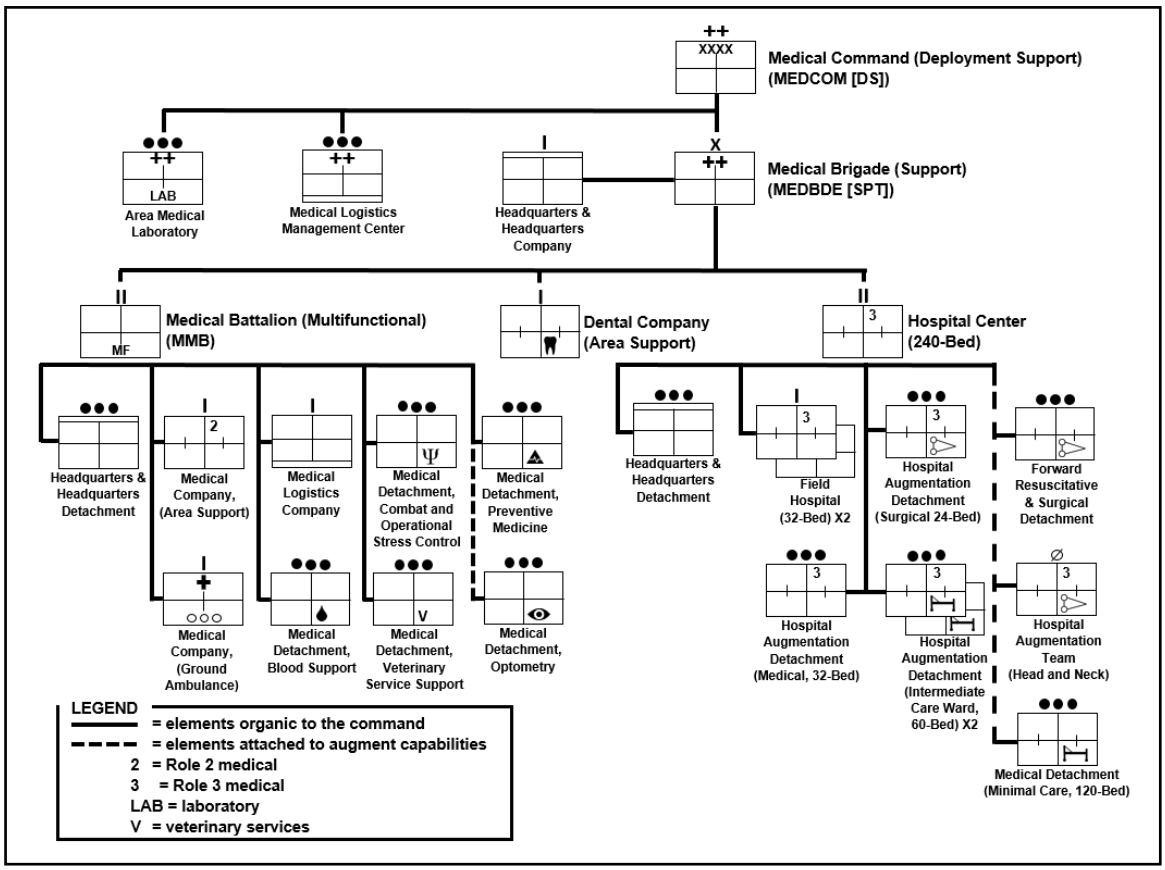

Figure 2-4. Notional deployed medical command (deployment support)

CAPABILITIES AND DEPENDENCIES

2-40. The MEDCOM (DS) provides—

- Command and control of AHS units providing medical support within the AO.
- Subordinate medical organizations to operate under the MEDBDE (SPT) and/or the MMB in order to provide medical capabilities to BCTs.
- Advice to the theater army commander and other senior-level commanders on the medical aspects of their operations.
- Staff planning, supervision of operations, and administration of assigned and attached AHS units.
- Assistance with coordination and integration of strategic capabilities from the sustaining base to units in the AO.
- Advice and assistance in facility selection and preparation.

- Coordination with the USAF theater patient movement requirements center for medical regulating and movement of patients from Role 3 MTFs.
- Consultation services and technical advice in all aspects of medical and surgical services.
- Functional staff to coordinate medical plans and operations, hospitalization, operational public health, operational and strategic MEDEVAC, veterinary services, nutrition care services, COSC, medical laboratory services, dental services, and area medical support to supported units.
- Coordination and orchestration of MEDLOG operations to include Class VIII, distribution, medical maintenance and repair support, optical fabrication, and blood management.
- Plan and direct the execution of single integrated MEDLOG manager responsibilities, when designated.
- Veterinary support for zoonotic disease control, food protection and quality assurance of subsistence, and animal medical care.
- Operational public health support for medical and OEH surveillance, potable water inspection, pest management, food facility inspection, and control of medical and nonmedical waste.
- Legal advice to the commander, staff, subordinate commanders, Soldiers, and other authorized persons.
- Health threats monitoring within the AO and identification of required capabilities to mitigate threats.
- Religious support to the command. This includes coordination by the MEDCOM (DS) headquarters chaplain section with subordinate unit ministry teams assigned to subordinate medical commands for required religious support throughout the AO.
- Maintenance personnel to augment the maintenance unit that performs maintenance on the unit's organic vehicles and power generation equipment.
- Coordination with DOD contracting authorities on addressing HSS and FHP challenges associated with contracted services.

2-41. This unit is dependent upon appropriate elements of the TSC for sustainment, finance, supplemental transportation, security during operational moves, sustainment area security and area damage control, CBRN decontamination assistance, and laundry and shower facilities.

2-42. This unit (its TOE and supplies) is 100 percent mobile using organic assets.

2-43. Refer to Figure 2-5 (on page 2-13) for a depiction of a MEDCOM (DS) organizational structure.

REGIONAL FOCUS

2-44. The MEDCOM (DS) maintains a regional focus that encompasses all of the CCDR's AOR. As in all regions of the world, neighboring countries often have economic, social, and religious ties and deal with similar health issues. The issues which may be at the heart of the social unrest in the deployment area can usually be found to exist in the other countries within the same region. Medical forces, due to their humanitarian mission, are more acceptable to host nations than the operational Army. The medical commander's ability to cultivate medical professional contacts within a nation or group of nations, facilitates the planning for and execution of regional strategies that will potentially mitigate the underlying social, economic, cultural, health, and political conditions which can foster civil unrest.

2-45. By establishing linkages to the civilian and governmental health care authorities in each nation, the senior medical command headquarters can actively monitor existing health threats, develop regional strategies to mitigate these threats, enhance the host-nation government's legitimacy with the affected population, and reduce human suffering. The medical commander provides the CCDR with an effective tool to assist in shaping the security environment by mitigating the adverse health conditions that impact the development of strong social, economic, and political infrastructures. The CCDR can deploy medical experts to provide consultation, training support, and advice to assist host nations in broadening their medical capacity in both the public and private health sectors through the development and implementation of health care programs specifically designed to address the particular health challenges faced by the host nation.

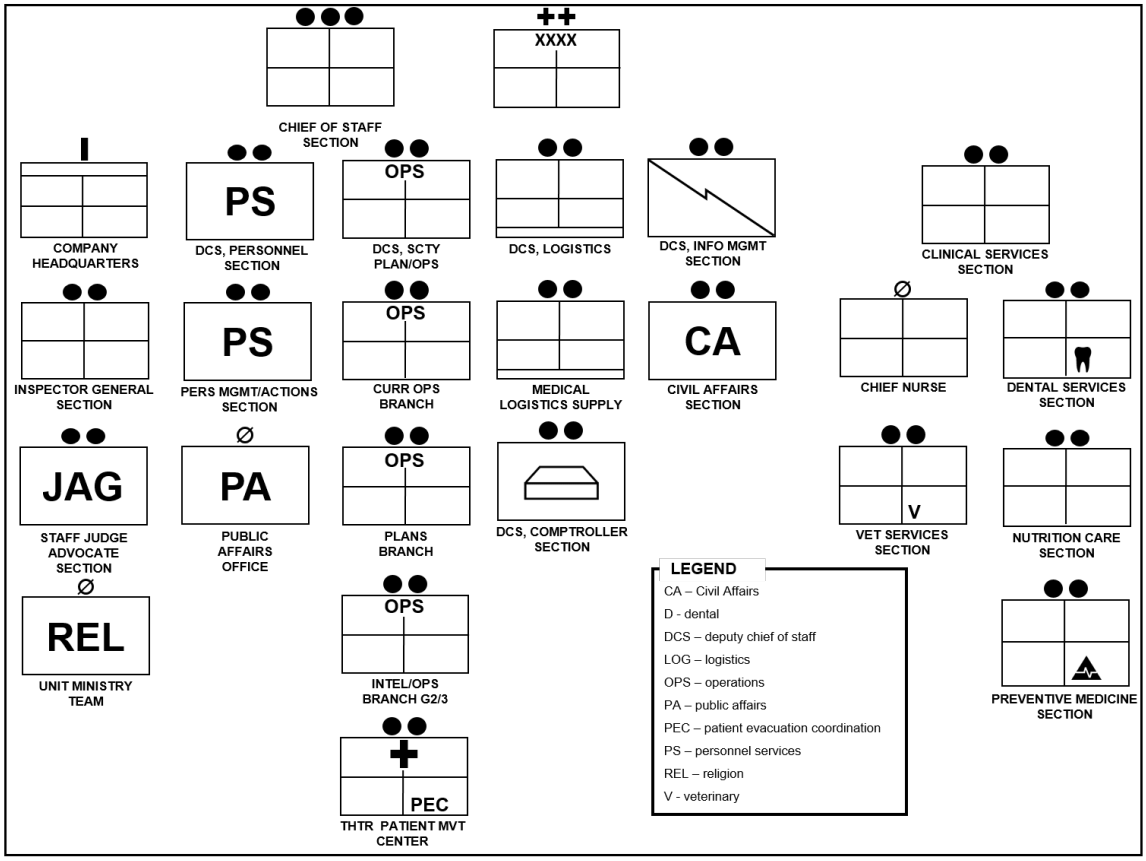

Figure 2-5. Medical Command (deployment support) organizational structure

2-46. Military medical training exercises can be mutually beneficial to the host nation and U.S. forces. These exercises provide a forum for training medical personnel in the identification and treatment of diseases and conditions that are not endemic in the U.S. and provide the host-nation military or civilian medical personnel training on emerging state-of-the-art technologies and medical protocols. The care provided which is incidental to the training mission, assists the host nation in overcoming the adverse impacts of the diseases/conditions treated and enhances its legitimacy in the eyes of its citizens.

2-47. The effects of focusing on interregional cooperation are to eradicate diseases or the environmental conditions that promote the growth of disease vectors. The interregional cooperation which results may also favorably affect the economic, social, and political fabric of the nation, remove obstacles to interregional cooperation in other sectors, and enhance the standard of living of the host-nation residents. For more information on MEDCOM (DS) in support of setting the theater, refer to Chapter 5.

STAFF ORGANIZATION

2-48. This section combines various command posts of the MEDCOM (DS) to provide a description of the composition and capabilities of the command's coordinating, special, and personal staff structure. For additional information on the composition, duties, and responsibilities of the various Army staffs refer to ADP 5-0. Refer to Figure 2-6 on page 2-14 for the depiction of the MEDCOM (DS) coordinating, personal, and special staff structure.

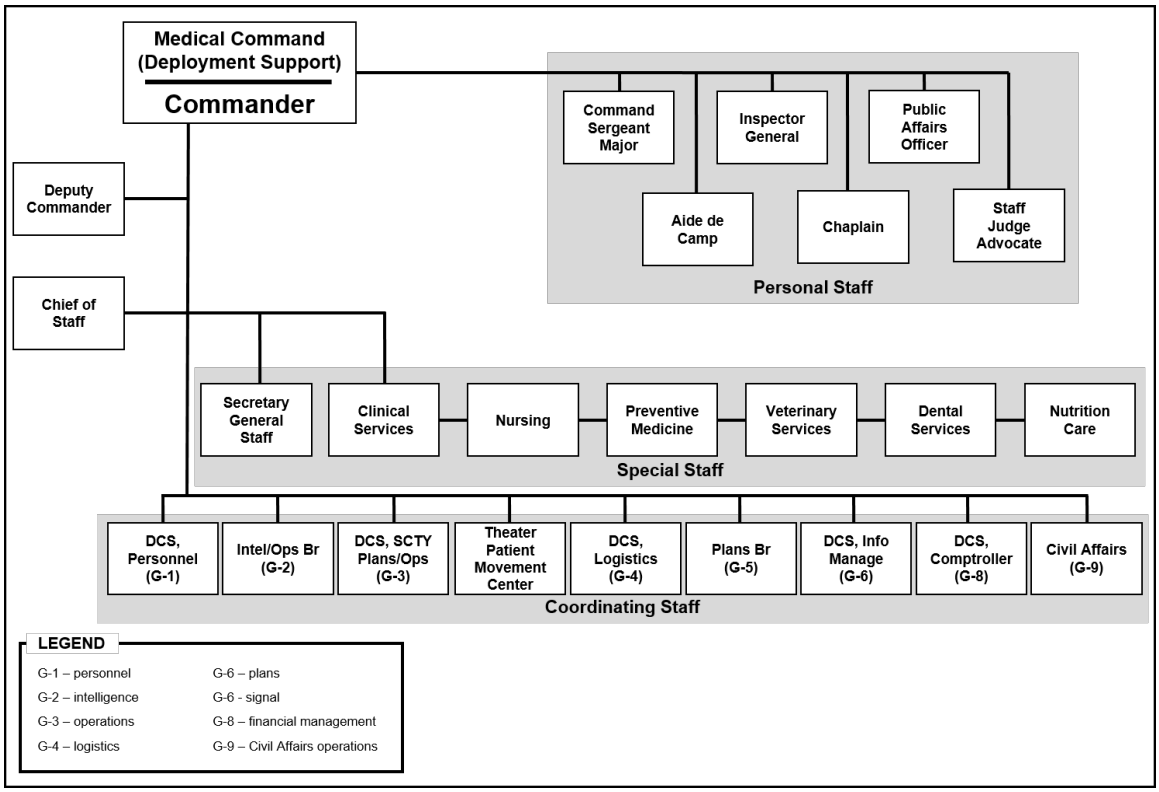

Figure 2-6. Medical command (deployment support) staff structure

Coordinating Staff

2-49. The coordinating staff officers are the commander's principal staff assistants and are directly accountable to the chief of staff. Coordinating staff officers are responsible for one or a combination of broad fields of interest. They help the commander coordinate and supervise the execution of plans, operations, and activities. Collectively through the chief of staff, they are accountable for the commander's entire field of responsibilities. The staff is not accountable for functional areas the commander decides to personally control.

Special and Personal Staffs

2-50. The special staff helps the commander and other members of the staff in their professional and technical functional areas. Special staffs are organized according to functional areas.

2-51. The personal staff works under the commander's immediate control. They also serve as special staff officers as they coordinate actions and issues with other staff members.

STAFF FUNCTIONS

2-52. This section discusses staff functions.

Command Section

2-53. The command section provides command, control, and management of all MEDCOM (DS) services. Personnel of this section supervise and coordinate the operations and administration of the command section.

Chief of Staff Section

2-54. The chief of staff section plans, directs, and coordinates the execution of staff functions. It reviews organizational activities and recommends changes, as necessary, to the MEDCOM (DS) commander. This section ensures synchronization of staff activities and ensures that required coordination is accomplished.

Deputy Chief of Staff, Personnel

2-55. The deputy chief of staff, personnel serves as the advisor to the commander on personnel issues and provides administrative services for the command.

Personnel section

2-56. This section is responsible for establishing, monitoring, and assessing MEDCOM (DS) human resources policies. This section coordinates responsibility for MEDCOM (DS) strength management; finance support; casualty management; casualty estimates; morale, welfare, and recreation activities; education; safety and accident prevention; alcohol and drug abuse programs; and equal opportunity activities. Further, this section provides overall administrative services for the command, to include: personnel administration, mail distribution, awards and decorations, and leaves. This section coordinates with elements of supporting agencies for finance, human resources, and administrative services, as required. This section receives and processes actions including promotions, reassignments, awards, personnel accounting, and strength management. The section prepares the MEDCOM (DS) personnel estimate and recommends priorities of fill for replacement to the MEDCOM (DS) commander and the deputy chief of staff, security/plans/operations.

Personnel Management and Actions Branch

2-57. Personnel management and actions branch develops personnel policies for promotions, appointments, demotions, classifications, assignments, reassignments, decorations, awards, and separations for the MEDCOM (DS) according to theater policy. It maintains continuous personnel loss data and obtains summarized personnel information for use in preparing support plans. In coordination with the CA section, this branch provides policy and guidance on procurement, administration, and utilization of civilian personnel in the command. This branch is also responsible for establishing and monitoring Family readiness groups.

Deputy Chief of Staff, Security, Plans, and Operations

2-58. Deputy chief of staff, security, plans, and operations is the principal staff section in matters concerning security, plans, intelligence, operations, organization, training, and CBRN defensive activities. It prepares broad planning guidance, policies, and programs for command organizations, operations, and functions. This section is responsible for plans and operations, deployment, relocation, and redeployment of the MEDCOM (DS). It directs and coordinates MEDEVAC operations, both ground and air. It provides 24-hour continuous operations capability. This section develops policies and guidance for training and training evaluation of the command. This section has four principal functional elements: the current operations branch, the plans branch, the intelligence and operations branch, and the theater patient movement center.

Current Operations Branch

2-59. The current operations branch is responsible for all operational planning functions to include deployment, relocation, and redeployment of the MEDCOM (DS).

Plans Branch

2-60. The plans branch provides security, plans and operations, deployment, relocation, and redeployment of the command. This branch exercises staff supervision over medical activities, assists the commander in developing and training the unit's mission essential task list, and identifies training requirements based on medical missions and the unit's training status. This branch is responsible for developing and implementing

training programs, directives, and orders and maintaining the unit readiness status reports of each unit in the MEDCOM (DS). It authenticates and publishes OPLANs and OPORDs.

Intelligence/Operations Branch

2-61. The intelligence/operations branch provides security, plans and operations, deployment, relocation, and redeployment support in the command. The branch acquires, analyzes, and evaluates intelligence, to include health threat information, medical, and OEH surveillance data. In coordination with the preventive medicine officer, it identifies DNBI trends and processes data accordingly. The branch identifies the commander's critical information requirements and other intelligence requirements. It also presents intelligence assessments, evaluations, and recommendations to the deputy chief of staff, security, plans, and operations. The branch provides threat analysis to support operations security planning. The branch develops plans and requirements for terrain studies, mapping, and charting. It collects and distributes weather data. The branch assists the deputy chief of staff, security/plans/operations in preparing OPLANs. Further, the branch provides advice and consultation on all activities comprised by the protection warfighting function and risk management.

Theater Patient Movement Center

2-62. The theater patient movement center is responsible to the deputy chief of staff, security/plans/operations for maintaining 24-hour continuous operations and conducting split-based operations. The theater patient movement center is responsible for medical regulating of all patients in the operational area and preparation of patient statistical reports. This center coordinates with the theater patient movement requirements center for intertheater evacuation of all patients leaving the theater and for specific patient movement item requirements and medical attendant requirements. The theater patient movement center interfaces with the theater patient movement requirements center for intratheater AE when evacuation distances exceed the capabilities of United States Army rotary-wing aircraft. This section synchronizes intratheater evacuation plans with the intertheater evacuation plan to ensure a seamless transition between operational and strategic evacuation systems. This section performs patient tracking procedures and monitors in-transit visibility of MEDCOM (DS) patients. Refer to JP 4-02 for additional information on MEDEVAC and medical regulating. Additionally, this section provides advice and consultation on the maintenance and disposition of medical records. Refer to AR 40-66 and AR 40-400 for information on the maintenance and disposition of health records for deployed forces.

Deputy Chief of Staff, Logistics

2-63. The deputy chief of staff, logistics, has primary responsibility for monitoring all logistics support to MEDCOM (DS) units, including Class VIII supply/resupply, medical equipment, medical equipment maintenance and repair, optical fabrication, medical gases, medical contractors, general supply, maintenance, transportation, food services, and construction support. The deputy chief of staff, logistics, integrates those functions that sustain the MEDCOM (DS) assigned and attached units in the operational area. This section provides staff supervision and overall coordination for internal logistics support of MEDCOM (DS) units.

2-64. Another section under the Deputy Chief of Staff, Logistics is the Medical Logistics Support Section. The MEDLOG support section monitors, coordinates, and facilitates MEDLOG operations within the command. This includes Class VIII supply and resupply, blood management and distribution, medical equipment maintenance and repair, medical gases, and optical lens fabrication and repair. This section plans for the single integrated MEDLOG manager mission, when designated. As the single integrated MEDLOG manager, it coordinates with and provides MEDLOG support to all Services deployed in the operational area. This section coordinates with and establishes a liaison with the MEDLOG management center forward team. The MEDLOG management center forward team provides centralized, theater-level management of critical Class VIII materiel, patient movement items, and medical maintenance. Refer to ATP 4-02.1 for additional information on the MEDLOG management center. Further, this section coordinates and facilitates contracting operations in support of the medical mission. (The availability of contracting support for medical services and supplies may be limited by the stringent requirements of the Food and Drug Administration for medical supplies and U.S. standards for professional services).

Assistant Chief of Staff Civil Affairs Operations

2-65. The G-9 integrates considerations analysis and evaluation planning within the MEDCOM (DS) operational area. The G-9 plans for the area assessments and estimates on the impact of the local populace on MEDCOM (DS) operations to include the assessment of the host-/foreign-nation medical infrastructure. The G-9 facilitates and develops assessments of the host-nation medical infrastructure to assist the MEDCOM (DS) commander in planning and executing AHS support in the operational area. The G-9 plans civil reconnaissance and civil engagements with local cultural and religious leaders to facilitate interpersonal relationships in a host-nation environment. The G-9 assists the MEDCOM (DS) commander in preparing medical functional studies, assessments, and estimates of how the host-nation civilian and military populations affect patient workloads in U.S. MTFs. It provides assistance to and liaisons for nongovernmental organizations and the International Committee of the Red Cross that offers medical treatment/supplies to the host nation involved in the conflict/operation. The G-9 can provide detailed input for the requirements, location and establishment of a civil-military operations center, if available, to facilitate the commander's civil-military planning and execution.

Note. For detailed information on the requirements and capabilities of the G-9, see FM 6-0, Commander and Staff Organization and Operations and FM 3-57, Civil Affairs Operations).

Deputy Chief of Staff, Information Management

2-66. The deputy chief of staff, information management is responsible for all aspects of automation and communications-electronics support within the MEDCOM (DS). This section establishes a medical automation office and is responsible for medical information systems policy and guidance for all subordinate commands. This section identifies communications-electronics requirements for data transmission services and coordinates these requirements with the signal command. This section provides advice and consultation on the integration of medical information systems in support of AHS and with other command and control systems within the operational area.

Deputy Chief of Staff, Comptroller

2-67. The deputy chief of staff, comptroller is responsible for budget preparation and resource management analysis and implementation for the command. It provides staff assistance on budget matters; establishes funding ceilings for subordinate units; and monitors budget program execution. This section coordinates funding of foreign humanitarian assistance and other operations which may require special and/or additional funding. This section funds approved contractual services and materiel. Further, it monitors and provides advice and assistance on reimbursement for medical services rendered from third parties, other Services, and multinational forces, as specified by regulations, memorandums of agreement or understanding, or cross-servicing agreements.

Clinical Services

2-68. The clinical services personnel serve as the commander's principal consultants and technical advisors for the command in general medicine, surgical, neuropsychiatry, COSC, behavioral health (BH), pharmacy services, clinical practices, procedures and protocols, and optometry. This section is responsible for developing and implementing clinical policies and procedures for the commander. Further, this section monitors and coordinates with subordinate medical functional staff sections.

This paragraph implements ABCA Standard 2108.

2-69. This staff section is responsible for—

- Neuropsychiatry, BH, and COSC to include establishing and monitoring policies, programs, and consultation and education services; advising on the MEDEVAC priorities, procedures, medications, and types of platforms to use for stress-related or mentally ill patients; and coordinating for reconstitution, reinforcement, or augmentation of forward-deployed BH assets.

- Medical and surgical services to include providing consultation and education support; monitoring patient statistical data on types of wounds, injuries, and illnesses to identify trends; ensuring required professional skills are available and requesting augmentation when required; monitoring the care of a detainee or personnel in U.S. custody; and recommending the designation of MTFs for specific situations or medical conditions (such as for detained patients only or all cases of head trauma). This section also develops and implements medical and surgical clinical policies and guidelines which are in consonance with the Defense Medical Materiel Program Office Deployable Medical Systems Clinical Policy and Guidelines and Patient Treatment Briefs. This section identifies medical issues requiring research and clinical investigation.
- Pharmacy to include developing and establishing a theater formulary; monitoring pharmacy operations within the command to ensure compliance with regulatory requirements; providing consultation and education on prescription and investigational new drugs; establishing policy and procedures for dispensing over-the-counter drugs; monitoring proficiency of enlisted pharmacy personnel; and establishing training programs as required.
- Optometry to include monitoring the occupational vision program, providing consultation on all matters pertaining to vision evaluation and correction, and developing protocols for the diagnosis and treatment of ocular injuries and diseases in concert with supporting ophthalmologist.
- Medical laboratory to include monitoring medical laboratory operations within the command to ensure adequate capability is available to meet medical laboratory requirements, coordinating for reconstitution, reinforcement, or augmentation of medical laboratory resources, as required, and providing consultation to subordinate medical laboratory personnel.

2-70. This section ensures that health care providers are properly credentialed and their scope of practice is defined. They also establish quality assurance measures and peer review of technical matters. Further, this section is responsible for establishing and monitoring professional medical education and training programs and policies. For more information on health care professional credentialing and privileging assigned to a multinational medical unit, refer to ABCA Standard 2108.

2-71. This section, in conjunction with the patient administration officers in the theater patient movement center, monitors the maintenance and disposition of patient medical records.

Dental Services

2-72. Dental services personnel serve as the commander's principal consultants and the command's technical advisor in dentistry. This section directs the establishment and implementation of policy and programs for all dental activities, this includes preventive dentistry and educational programs, operational dental care (emergency and essential), and oral and maxillofacial surgical procedures. This section ensures oral health surveillance policies, programs, and procedures are developed and implemented within the operational area. It also advises the commander on the dental aspects of foreign humanitarian assistance operations, plans, and programs, as required.

Veterinary Services

2-73. Veterinary services personnel serve as the commander's principal consultants and the command's technical advisor for veterinary services' activities and employment of veterinary assets for the joint force. This section provides technical supervision of food protection, animal medical care, and veterinary public health support. The United States Army is the sole provider for veterinary services for all Services (DODD 6400.04E) (with the exception of food inspection operations on USAF installations).

2-74. This section develops, plans, and implements veterinary services policies and programs for the joint operational area. It also evaluates host-nation capabilities and integrates veterinary services policy with multinational forces. The veterinary services section coordinates with the CA officer to advise the command and staff concerning local zoonotic disease transmission, providing animal medical care for local livestock and other animals, and building relationships with local food production facilities and agricultural and veterinary medical agencies.

Nutrition Care Services

2-75. Nutrition care services personnel serve as the commander's principal consultant and the command's technical advisor in nutrition care. This section ensures the coordination required to obtain medical supplemental rations is accomplished and that assigned and attached hospitals have required items to prepare medical diets. This section also coordinates with the chaplain section to ensure appropriate available rations for hospitalized patients with religion-based dietary restrictions. This section coordinates with CA officers when nutrition issues arise in the conduct of stability tasks.

Nursing Services

2-76. The chief nurse serves as the commander's principal advisor on all issues affecting nursing practices and personnel. This section develops, plans, and implements policies for nosocomial infection control and quality assurance nursing programs. The chief nurse (nursing consultant) is responsible for nursing policy, resourcing, and technical supervision of subordinate nursing personnel. This section analyzes and evaluates nursing care and procedures in subordinate units. The nursing consultant evaluates host-nation health care delivery systems and hospitalization capabilities and integrates clinical policy with joint and multinational forces.

Preventive Medicine Section

2-77. The preventive medicine section serves as the commander's principal consultant and the command's public health and environmental sciences advisors. This section develops, plans, and implements operational public health policies and programs for the operational area. These programs include medical surveillance, OEH surveillance, pest management activities, epidemiological investigations, food service facility sanitation and hygiene, and inspection of potable water supplies. This section monitors and analyzes DNBI reports submitted by subordinate AHS units. It performs trend analysis which is used to identify shifts from the baseline of diseases within the operational area (as a shift may indicate the use of biological warfare agents against the deployed force). It also evaluates host-nation capabilities and integrates operational public health policy with joint and/or multinational forces. This section coordinates with the CA section for operations to restore essential services in the host nation during operations characterized predominantly by stability tasks. Refer to AR 40-5 and Department of the Army Pamphlet (DA PAM) 40-11 for additional information on the Army Public Health Program. This section provides advice and consultation on personnel protective measures and issues arising in theater detention facilities.

2-78. This section, in conjunction with the CBRN officer, advises the deputy chief of staff, security/plans/operations and the MEDCOM (DS) commander on the medical aspects of CBRN defensive measures. This includes, but is not limited to, policies, programs, and procedures pertaining to immunizations; chemoprophylaxis; barrier creams; pretreatments; and the use of investigational new drugs. For additional information on operational public health refer to Table 5-1 on page 5-3 of this publication.

Inspector General Section

2-79. The inspector general section is responsible to the commander for inquiring into and reporting on matters that impact the overall efficiency of the command to include the performance of the mission, state of discipline, operating efficiency, and economy. The inspector general section conducts inspections, investigations, surveys, and studies as the commander directs and as laws and regulations prescribe.

Public Affairs Section

2-80. The public affairs section serves as the commander's focal point for command information, public information, and community relations matters. The MEDCOM (DS) public affairs officer has the overall responsibility for building an understanding of AHS services/programs within the operational area. Additionally, as the official spokesperson for the command, releases information, as appropriate, on the medical aspects of—

- Incidents, engagements, or accidents involving other commands, Services, and/or multinational forces.
- Stability tasks in conjunction with the CA officer.

- Controversial issues that are likely to attract national media attention.
- Detainee medical operations.

Staff Judge Advocate Section

2-81. The functions of the staff judge advocate are to provide legal advice and services to the commander, staff, subordinate commanders, Soldiers, and other authorized personnel. The staff judge advocate section develops and executes plans and programs in the fields of criminal law and related military justice, administrative law, litigation, environmental law, regulatory law, intelligence activities law, labor and civilian personnel law, and medical jurisprudence. This section advises the commander on the legal aspects of determining eligibility for care in U.S. military MTFs. This section also advises the commander on any issues arising with the provisions of the Geneva Conventions and other international treaties or agreements.

Company Headquarters

2-82. The company headquarters is responsible for Soldiers assigned to the MEDCOM (DS) headquarters that are not assigned or attached to subordinate commands. Besides common staff responsibilities, the company headquarters is responsible for— developing the MEDCOM (DS) headquarters occupation plan; ensuring local headquarters security, to include constructing fighting and protective positions; arranging for and moving the headquarters; training; conducting morale, welfare, and recreation activities for headquarters personnel; obtaining or providing food service, quarters, medical support, field sanitation, and supply for headquarters personnel; receiving, accommodating, and orienting visitors and professional filler personnel; providing and prioritizing motor transportation support (organic to or allocated for use by the headquarters); and maintaining equipment organic to or allocated for use by the headquarters.

Unit Ministry Team

2-83. The unit ministry team serves as the advisor to the Commander and provides religious support and pastoral care ministry for assigned staff and subordinate organizations. It advises the commander, staff, and subordinate commanders on religion, morals, and morale within units, and ethical decision making of the command. The unit ministry team coordinates with the CA operations staff officer (S-9) to advise the command and staff concerning operational impact of religious belief and practice of local populations and leaders in the operational area, building relationships with and conducting Soldier Leader Engagements with local religious leaders as directed by the command. It coordinates with subordinate commands and their assigned unit ministry teams to ensure proper coordination of religious support throughout the area of operations, to include advising commanders and their logistics support personnel on the process for ordering appropriate available rations within the theater for hospitalized patients with religion-based dietary restrictions. This team coordinates with subordinate MEDCOM (DS) unit ministry teams to ensure similar advisement on availability of rations within the operational area for hospitalized patients with religion-based dietary restrictions. The unit ministry team assigned to medical units also coordinate with adjacent units for appropriate contingency plans for religious support in mass casualty incidents.

Joint Augmentation

2-84. The MEDCOM (DS) headquarters may be augmented by functional specialists from other Services based on mission, enemy, terrain and weather, troops and support available, time available, and civil considerations and availability of joint augmentation resources. Augmentation support to coordinate and facilitate interoperability in AHS support operations may include:

- United States Air Force AE liaison teams or other medical regulating personnel to enhance medical regulating and MEDEVAC of MEDCOM (DS) patients by the USAF strategic AE system.
- United States Navy personnel to expedite and deconflict shore-to-ship/ship-to-shore air medical evacuation operations conducted by United States Army rotary-wing MEDEVAC aircraft and hospitalization of United States Army personnel in USN afloat facilities.

- United States Air Force and USN MEDLOG personnel when the United States Army is designated as the single integrated MEDLOG manager to ensure responsive MEDLOG support, to include blood management for Service-unique MEDLOG requirements.
- United States Air Force and USN communications personnel to assure communications connectivity and interoperability of communications equipment and of the automated information system.

MEDICAL BRIGADE (SUPPORT)

2-85. The MEDBDE (SPT) is a subordinate command organization of the MEDCOM (DS). It serves as the headquarters for all assigned and attached AHS units. One MEDBDE (SPT) may be providing direct support to an operational commander, while another may be providing general AHS support to an EAB sustainment force. These organizations may be providing simultaneous support to stability tasks occurring within their operational area. The MEDBDE (SPT) may not always be subordinate to a MEDCOM (DS). In an operational area where the MEDCOM (DS) is not yet deployed, the MEDBDE (SPT) may be the senior medical command. Refer to Figure 2-7 for a notional deployed MEDBDE (SPT).

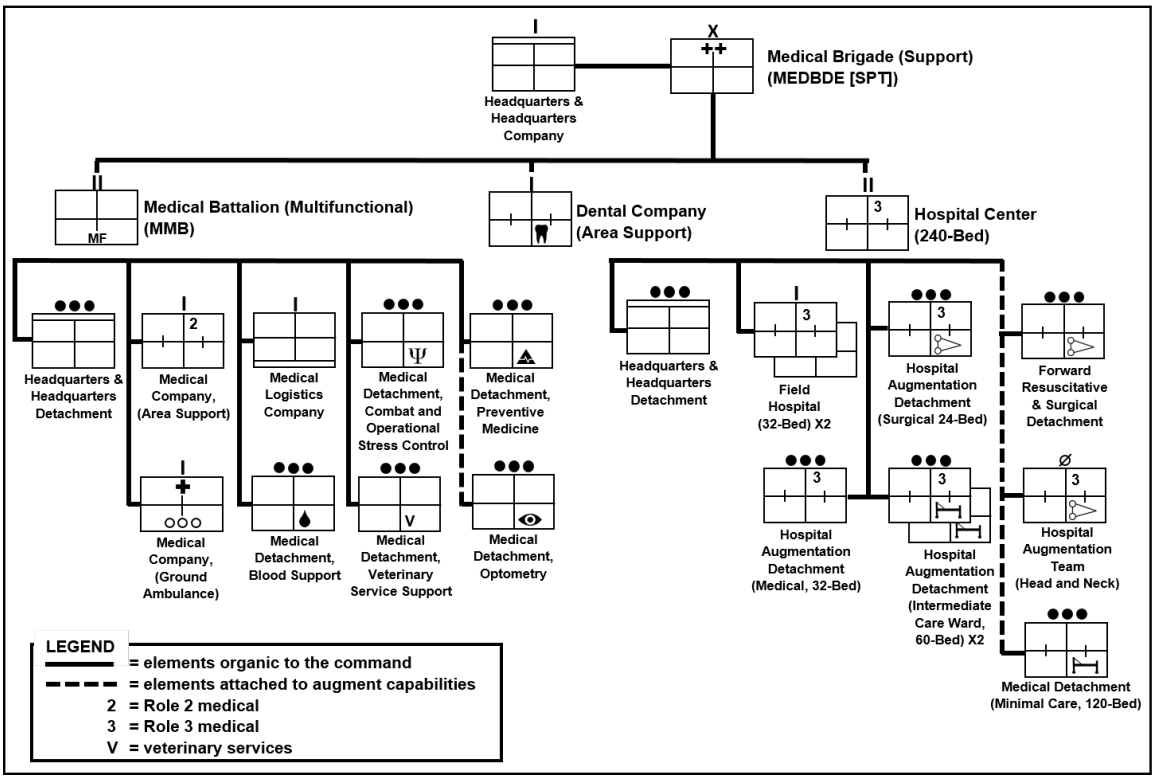

Figure 2-7. Notional deployed medical brigade (support)

Mission, Assignment, and Basis of Allocation

2-86. The mission of the headquarters and headquarters company, MEDBDE (SPT) is to organize, resource, train, sustain, deploy support assigned and attached health care capabilities to provide flexible, responsive, and effective HSS and FHP to supported force. The MEDBDE (SPT) is assigned to the MEDCOM (DS).

2-87. The basis of allocation for the MEDBDE (SPT) is one per two to six subordinate battalions.

2-88. Organizations and functions combine the early entry, campaign, and expansion modules of the MEDBDE (SPT) to provide a complete description of the composition and capabilities of the organization. This unit is designated a Category II unit. (For unit categories, see AR 71-32).

2-89. Refer to Figure 2-8 for MEDBDE (SPT) organizational structure.

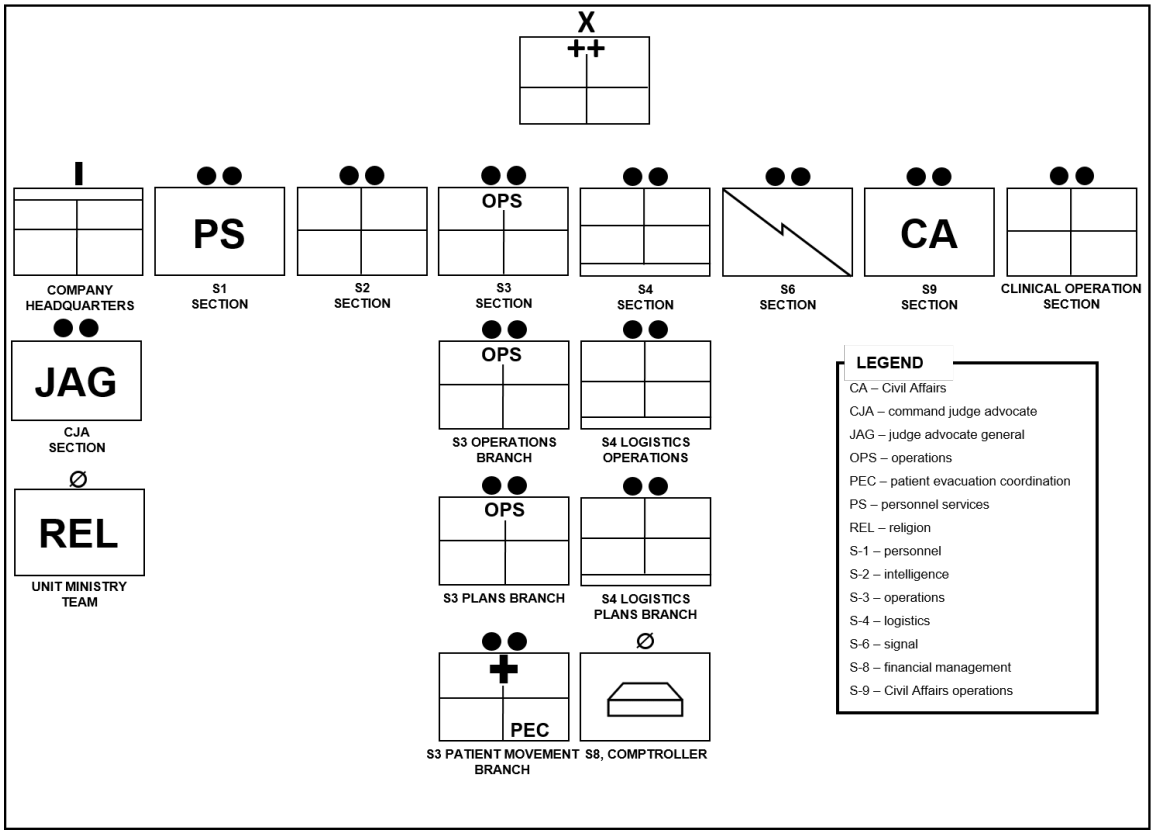

Figure 2-8. Medical brigade (support) organizational structure

Capabilities and Dependencies

2-90. The MEDBDE (SPT) is composed of three standard requirements code identified modules (the early entry, expansion, and campaign modules).

2-91. The MEDBDE (SPT) provides—

- Command and control of subordinate and attached units.
- Operational medical augmentation to Role 2 BCT medical companies.
- Advice to the commanders on the medical aspects of their operations.
- Medical staff planning, operational and technical supervision, and administrative assistance for subordinate or attached units.
- Coordination with the supporting patient movement requirements center for medical regulating and strategic MEDEVAC.
- Medical consultation and education services in the following areas:
  - Operational public health.
  - Behavioral health to include COSC and neuropsychiatric care.
  - Food services.
  - Advice and recommendations for the conduct of operations predominated by stability tasks.
  - Control and supervision of Class VIII supply and resupply to include blood management. When designated by the CCDR, serves as the single integrated MEDLOG manager.
  - A joint capable command and control capability when augmented with appropriate joint assets.

  - Support as the sole provider for veterinary services.
- Assistance in the coordinated defense of the unit's area.
- Field maintenance on all organic equipment, except communications-electronics and communications security.
- Religious support and pastoral care ministry.

2-92. The MEDBDE (SPT) is dependent upon—

- The combat aviation brigade to support the MEDEVAC plan with air ambulance assets.
- The sustainment brigade to arrange legal, administration, finance, human resources, transportation services, CBRN and decontamination assistance, and laundry and shower services.
- Class I ration support.
- Waste disposal and construction support.
- Supplemental transportation support requirements.

STAFF FUNCTIONS

2-93. This section discusses staff functions assigned to a MEDBDE (SPT).

2-94. Refer to Figure 2-9 on page 2-24 for MEDBDE (SPT) staff structure.

Organization and Function

2-95. Organizations and functions combine the early entry, campaign, and expansion modules of the MEDBDE (SPT) to provide a complete description of the composition and capabilities of the organization. This unit is designated a Category II unit. (For unit categories, see AR 71-32.)

Internal Staff and Operations

2-96. The MEDBDE (SPT) coordinating staff (S-staff) and special staff manage the command's internal operations through coordination with staffs of higher, lower, and adjacent units. The staff's efforts support the commander and subordinate units by providing accurate and timely information. It produces estimates, recommendations, plans and orders, and monitors execution. The staff streamlines cumbersome or time-consuming procedures by ensuring that all activities contribute to mission accomplishment. Within the MEDBDE (SPT) headquarters, staff sections coordinate their functional responsibilities with other headquarters staff sections as required.

External Coordination

2-97. The MEDBDE (SPT) must coordinate with the MEDCOM (DS) and other headquarters within their operational area. External coordination with the combat aviation brigade and general support aviation battalion for air ambulance support is critical.

Command Section

2-98. The command section provides command and control, and management for all MEDBDE (SPT) operations, activities, and services. The commander has overall responsibility for both the clinical and operational aspects of all activities and operations conducted within the MEDBDE (SPT). The chief, professional services is responsible to oversee the day-to-day clinical operations of the command.

Personnel (S-1) Section

2-99. The personnel staff officer (S-1) section provides overall administrative services for the command, to include personnel administration, and coordinates with elements of supporting agencies for finance, personnel, legal, and administrative services.

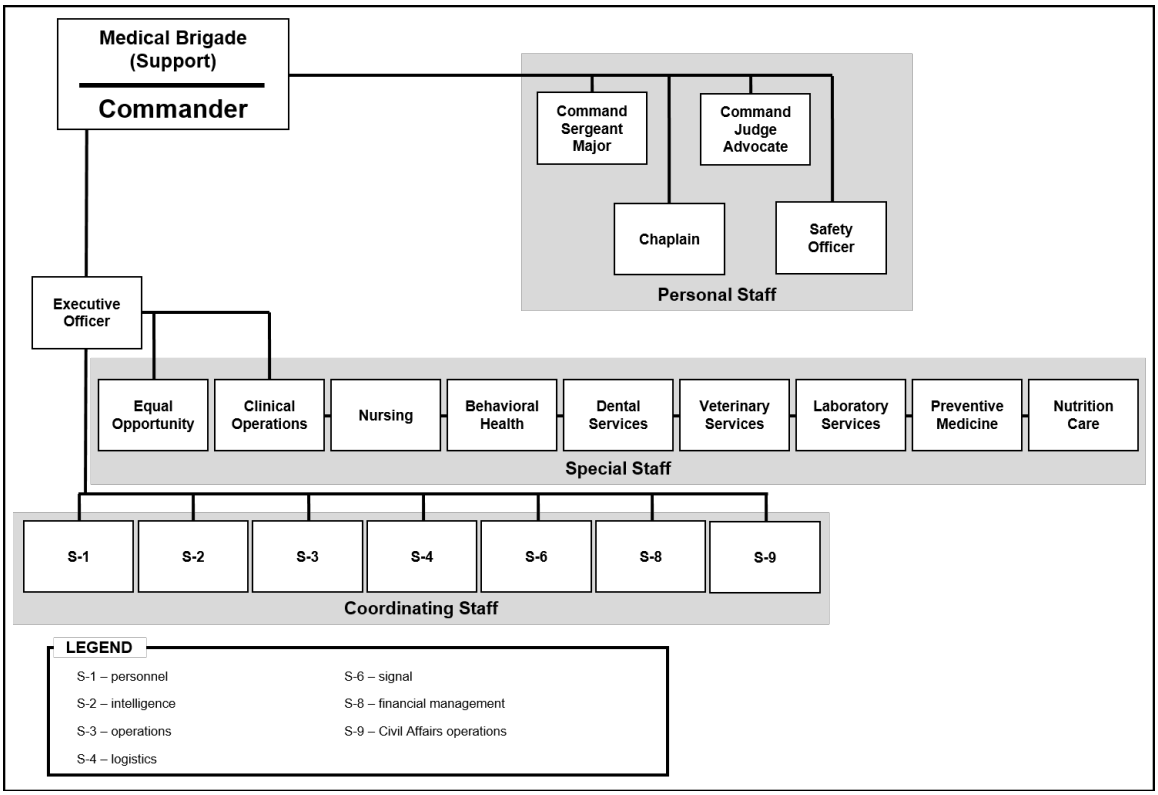

Figure 2-9. Medical brigade (support) staff structure

Intelligence (S-2) Section

2-100. The intelligence staff section (S-2) performs all-source intelligence assessments and estimates for the command. In coordination with the Chemical Officer/noncommissioned officer (NCO) in the S-3 section or the CBRN unit that supports the MEDBDE (SPT). It advises the commander and staff on nuclear/chemical surety and potential enemy use of CBRN weaponry and toxic industrial materials.

Operations (S-3) Section

2-101. The operations staff officer (S-3) section is responsible for plans and operations, deployment, relocation and redeployment of the MEDBDE (SPT), and supervising MEDEVAC operations for both air and ground.

S-3 Operations Branch

2-102. The S-3 operations branch is responsible for authenticating and publishing plans and orders. It exercises staff supervision over AHS activities and advises the commander and staff on nuclear/chemical surety and CBRN operations.

S-3 Plans Branch

2-103. The S-3 plans branch is responsible for the current planning in the MEDBDE (SPT) operational area, to include deliberate and crisis planning. Additionally, it plans for future operations in excess of 72 hours and prepares major regional contingency plans for the MEDBDE (SPT). Further, this branch prepares, authenticates, and publishes medical plans and OPLANs to include the integration of annexes and appendixes prepared by other staff sections. (Refer to ADP 5-0 for additional information on the operations process).

Patient Movement Branch

2-104. The patient movement branch is responsible for maintaining 24-hour coordination and oversight for patient regulating and administration within the MEDBDE (SPT) operational area.

Logistics (S-4) Section

2-105. The logistics staff officer (S-4) section plans, monitors, coordinates, and facilitates MEDLOG operations within the command. This includes Class VIII supply and resupply, blood management and distribution, medical equipment maintenance and repair, medical gases, optical lens fabrication, spectacle fabrication and repair, and contracting support. The section is responsible for ensuring service support functions and directs and supervises the collection, evacuation, and accountability for all classes of supply classified as salvage, surplus, abandoned, or uneconomically repairable. The section advises the commander of logistical matters and unit mission capabilities. The section serves as the focal point for property management and accountability procedures of all assigned or attached units. As a staff office, they advise the commander on matters regarding supply and services support and other logistical functions. As the materiel manager, they develop, coordinate, and supervise the supply support portion of an integrated logistics support plan.

2-106. In the Logistics (S-4) Section is the S-4 Logistics Plans Branch. The S-4 logistics plans branch completes the logistics staffing to monitor, coordinate, and facilitate MEDLOG operations within the MEDBDE (SPT). This includes Class VIII supply and resupply, blood management and distribution, medical equipment maintenance and repair, medical gases, and optical lens fabrication and repair.

Signal (S-6) Section

2-107. The S6 section is responsible for all aspects of automation and communications-electronics support within the MED BDE (SPT). This section establishes a medical automation office and is responsible for medical information system policy and guidance for all subordinate commands. This section identifies communications-electronics requirements for data transmission services and coordinates these requirements with the external signal organizations. This section provides advice and consultation on the integration of medical information systems in support of AHS and with other command and control systems within the operational area.

Civil Affairs Operations (S-9) Section

2-108. The civil affairs operations staff officer (S-9) is the principal staff officer responsible for all matters concerning civil affairs. The S-9 establishes the civil-military operations center, evaluates civil considerations during mission analysis, and prepares the groundwork for transitioning the area of operations from military to civilian control. The S-9 advises the commander on the military's effect on civilians in the area of operations, relative to the complex relationship of these people with the terrain and institutions over time. The S-9 is responsible for enhancing the relationship between Army forces and the civil authorities and people in the area of operations. The S-9 prepares Annex K (Civil Affairs Operations) to the operation order or operation plan. (See FM 3-57 for more detailed information on the S-9 duties and responsibilities).

Clinical Operations Section

2-109. The clinical operations section serves as the commander's principal consultants and technical advisors for the command in general medicine, nursing services and activities, operational public health, COSC and BH to include neuropsychiatric care and treatment, veterinary services, dental services, nutrition and hospital food service activities, and medical laboratory support.

Command Judge Advocate Section

2-110. The command judge advocate section advises the commander on ethical issues as they relate to health care operations. Further, it advises the commander and the MEDCOM (DS) detainee operations medical director on issues pertaining to the treatment of detainees in subordinate CSHs, hospital centers, or other MTFs. This section advises the commander on any issues related to the Geneva Conventions and the

protection of medical personnel, patients, facilities, supplies, and transports. The command judge advocate advises the commander and its staff on the eligibility of care determinations, policies, and procedures.

Company Headquarters

2-111. The company headquarters, MEDBDE (SPT) organizes, resources, trains, sustains, deploys, exercises command and control to supported forces.

Unit Ministry Team

2-112. The unit ministry team provides two capabilities: first, they provide religious support and pastoral care ministry for assigned or attached Service members, Family members, and authorized civilians, patients, and casualties. Second they advise on real and potential impacts of religion, morals, ethics, and morale in operations. Brigade unit ministry teams supervise and coordinate the provision of these religious support functions by subordinate unit ministry teams, and provide these capabilities directly for subordinate commands as needed.

Clinical Operations Responsibilities

2-113. The chief, professional services, has the responsibility to monitor the impact of all of the medical functions on the clinical services provided within the command. The chief, professional services accomplishes this mission through the activities of the staff and coordinating and synchronizing clinical requirements with other MEDBDE (SPT) staff sections. The chief, professional services coordinates with—

- The S-1 for all personnel matters relating to clinical staff personnel. The chief, professional services, recommends the priority of fill and assignment of all clinical personnel to subordinate MTFs. As required, he requests augmentation support for medical specialties not represented on the TOE.
- The S-2 for medical intelligence support. The clinical operations section develops, recommends, and submits priority intelligence requirements and essential elements of friendly information for information impacting clinical operations (to include the potential enemy use of CBRN weaponry and toxic industrial material releases). This includes health threats within the operational area, potential diseases present in the multinational force, and the health status of enemy forces who may become detained personnel (to include new or exotic diseases in enemy forces).
- The S-3 for operational planning and medical regulating support. The clinical operations section monitors current operations and assists in planning future operations by providing clinical input into the development of AHS estimates and plans. They must evaluate proposed courses of action for their impact on clinical capabilities and activities and recommend whether they are feasible from a clinical viewpoint. Further, the clinical operations section must closely monitor medical regulating activities, bed status, and/or operating room delays, if any, of subordinate hospitals, patient movement items requirements, delays in the timely evacuation of patients to and from MEDBDE (SPT) MTFs, and requirements for providing medical attendants for en route patient care on USAF evacuation assets, if critical care air transport team support is not available. The clinical operations section recommends clinical capabilities (task-organized) required to be deployed forward to support EAB personnel deployed in the operational area to provide direct support. The patient administration officer assigned to the intratheater patient movement center serves as a consultant to the clinical operations section when issues concerning medical record management arise.
- The S-4 for MEDLOG support of critical Class VIII items required for patient care, to include medical supplies, pharmaceuticals, medical equipment, and blood. The clinical operations section monitors the blood distribution and reporting processes (Technical Manual [TM] 8-227-12) to determine the impact on clinical operations of shortages and delays. Further, they monitor the status of medical supplies, medical equipment, and medical equipment maintenance and repair to ensure that sufficient quantities are on hand and/or on order to sustain patient care activities within the command. They also work closely with the S-4 in identifying and obtaining pharmaceuticals to treat diseases (to include biological warfare agents) not usually present in U.S. forces (such as for detainees). This section also advises the command on the management and disposition of

captured enemy medical supplies and equipment. The pharmacy officer assigned to the S-4 serves as a consultant to the clinical operations section on all issues pertaining to pharmaceuticals.

- The S-6 for information management, automated information system requirements, and communications-electronics support.
- The command judge advocate section for all medical-legal matters to include the determination of eligibility for medical care in U.S. MTFs. Further, the command judge advocate section provides guidance on the provisions of the Geneva Conventions as they affect medical personnel, equipment, evacuation platforms, and Class VIII supplies. He also provides guidance on any legal issues involving care to detained personnel.
- The unit ministry team on religious matters that affect AHS operations to include faith-based dietary restrictions and assistance in COSC programs and activities.

Technical Supervision

2-114. The chief, professional services exercises technical supervision of all AHS clinical activities through his staff. The chief, professional services develops policies, procedures, and protocols for clinical activities within subordinate MTFs. Treatment protocols implemented in the command are developed according to Defense Medical Materiel Program Office standards and requirements, ARs, appropriate doctrinal publications, and sound medical practice. The chief, professional services ensures that investigational new drug protocols are followed. The chief, professional services also monitors the use of chemoprophylaxis, pretreatments, immunizations, and barrier creams. The chief, professional services ensures credentialing policies are in place and are being adhered to. The chief, professional services further ensures that a quality assurance program is implemented within the command which encompasses patient safety, risk management, infection control, peer review, and quality assurance. The chief, professional services monitors the MEDEVAC and medical regulating activities to ensure necessary medical requirements and clearances for patients being evacuated are accomplished. Further, develops patient preparation protocols for patients entering the USAF evacuation system, as required. The chief, professional services monitors the area support mission of assigned/attached Role 2 MTFs to ensure adequate AHS support to transient troop populations within the MEDBDE (SPT) operational area. The chief, professional services compiles and analyzes wounded-in-action data to determine trends in wounding patterns, to forecast specialized care requirements, and to recommend protective measures as appropriate. The chief, professional services identifies medical issues which require medical research and development. The duties and functions of The chief, professional services' staff include the:

- Chief nurse, who is the senior nurse in the command and provides technical supervision of the MEDBDE (SPT) subordinate MTFs nursing personnel (officer and enlisted). This individual establishes nursing policies and reviews and monitors nursing practices. The chief nurse monitors staffing levels, personnel shortages, and advises the chief, professional services on the impact of nursing shortfalls on the capability to provide required patient care. The chief nurse recommends to the chief, professional services the priority of assignment for nursing care personnel. The chief nurse also ensures educational and training requirements are met and monitors in-service training activities of subordinate MTFs. The chief nurse monitors mass casualty planning of subordinate MTFs, provides consultation to subordinate MTF mass casualty coordinators during rehearsals of the mass casualty plan, and ensures that if training shortfalls are identified that appropriate refresher/sustainment training is provided. *Mass casualty* refers to any number of human casualties produced across a period of time that exceeds available medical support capabilities. (JP 4-02). This individual ensures that documentation of medical treatment provided is appropriately documented in the individual health record using the prescribed forms and/or electronic media. The chief nurse directs routine reporting requirements and establishes format and frequency of all formal nursing reports. The chief nurse monitors the quality assurance program through records and reports provided by the subordinate MTFs. Quality assurance programs are the responsibility of the subordinate MTF leadership and further delegated to the assistant chief nurse, public health nurses, or clinical nurse officer-in-charge or to a senior NCO. In early phases of operations, the focus of MTFs is on quality combat casualty care; it is essential that the major duties of all clinicians be directly related to the delivery of patient care, rather than administrative oversight. As the operational area matures and the types of patient conditions being

treated evolves from acute trauma to DNBIs, the delegated quality assurance officer can devote more time to administrative oversight of the quality assurance program.

- Preventive medicine officer, environmental science officer, and senior preventive medicine NCO, who monitor all public health activities and requirements of the command. The preventive medicine officer establishes reporting requirements and frequency of reports (such as the weekly DNBI report). This individual consolidates subordinate unit DNBI reports and analyzes the data submitted to identify trends and to compare incoming data with already established baselines. If trends are identified, he recommends and develops effective medical countermeasures and disseminates this information to all subordinate, adjacent, and higher headquarters. The preventive medicine officer and environmental science officer analyze the data for indicators of the potential exposure of U.S. forces to enemy employment of biological and chemical warfare agents (increases in endemic disease rates in one specific geographic location or the appearance of diseases which can be weaponized and are not endemic to the operational area) and to OEH hazards. The preventive medicine officer, environmental science officer, and senior preventive medicine NCO receives, monitors, reviews, and forwards supporting laboratory analysis of CBRN samples/specimens and chain of custody documents for CBRN samples/specimens. This individual ensures that medical surveillance and OEH surveillance activities are developed and implemented for the health threat present in the operational area. The preventive medicine officer, environmental science officer, and senior preventive medicine NCO monitors pest management, potable water inspection, and inspection of field feeding/dining facility sanitation activities, toxic industrial materials sources and hazards, and further ensures the procedures for the disposal of medical waste are being adhered to. The preventive medicine NCO ensures that field hygiene and sanitation training and unit field sanitation team training for subordinate units and personnel is current and adequate.
- Veterinary preventive medicine officer and the food safety officer, who are responsible for oversight of the implementation and conduct of programs for the inspection of food and food sources for procurement, quality assurance, food safety, food defense, and sanitation. The veterinary preventive medicine officer also oversees working animal medical care activities and identifies MEDLOG shortfalls that will impact on these activities. The veterinary preventive medicine officer provides technical consultation for implementation and conduct of public health programs such as feral animal risk mitigation, rabies advisory boards, and any zoonotic and/or endemic animal disease surveillance and mitigation efforts. The veterinary staff advises other staff elements on appropriate veterinary global health engagement activities and coordinates with veterinary staff elements at higher headquarters on these initiatives to ensure synchronization with Theater Campaign Plan priorities and objectives. The veterinary preventive medicine officer coordinates with the senior veterinarian in the theater and the supporting staff judge advocate to develop a veterinary eligibility for care determination and the extent of care authorized in accordance with applicable law and DOD and theater policy. Veterinary staff officers also identify the metrics and frequency of reporting requirements for the various aspects of the veterinary service support mission.
- Psychiatrist, behavioral science officer, and the BH NCO, who monitor all COSC activities and the treatment of BH and neuropsychiatric cases within subordinate MTFs. The psychiatrist ensures that all treatment programs for combat and operational stress are founded on proven principles of combat psychiatry and are established and administered in accordance with current doctrinal principles. The psychiatrist monitors the stress level of subordinate unit medical personnel and provides consultation on traumatic event management support to health care providers after mass casualty situations or other high stress events. The psychiatrist coordinates policies, procedures, and protocols for the treatment of BH and neuropsychiatric disorders with the senior subordinate unit psychiatrist or behavioral science officer and provides consultation on the requirements for the MEDEVAC of psychiatric patients. The psychiatrist also provides advice and guidance on any BH issues arising within the theater detention facility if located in the MEDBDE (SPT) operational area.
- Dietitian and senior nutrition NCO, who monitors the status of medical diet supplemental rations, hospital food service operations, and command health promotion program. The dietitian provides consultation to subordinate hospitals on special diet requirements and preparation. The dietitian

further coordinates with the unit ministry team on faith-based dietary restrictions. In foreign humanitarian assistance operations, he provides consultation and advice on refeeding operations for malnourished children and adults, dislocated person populations, and victims of man-made or natural disasters. The dietitian also provides consultation on special dietary requirements for patients being evacuated through the USAF evacuation system.

- The chief, dental services, who monitors dental activities for the command. The chief, dental services, receives reports from subordinate units and consolidates this data for forwarding to higher headquarters. The chief, dental services, establishes and coordinates policies, procedures, and protocols for the treatment of dental conditions and preventive dentistry programs. The chief also serves as the command's dental surgeon.

2-115. Not all functional specialties are fully represented on the MEDBDE (SPT) headquarters staff. Therefore the clinical operations section coordinates with subordinate AHS units for expertise in the following areas:

- The senior subordinate surgeon serves as the principal consultant to the chief, professional services, on all matters pertaining to surgical policy and employment of FSTs or FRSDs. The senior subordinate surgeon maintains visibility of the joint trauma system patient treatment issues, wounding patterns, and weapons effects in order to ensure subordinate MTFs are informed, equipped, and supplied to provide appropriate treatment. Additionally, the chief, professional services, can consult with the surgical consultant on the MEDCOM (DS) staff.
- The senior subordinate medical laboratory officer serves as the principal consultant to the chief, professional services, on all matters pertaining to clinical laboratory support. The senior subordinate medical laboratory officer advises the chief, professional services, on blood-banking and storage capabilities of Roles 2 and 3 MTFs within the command. The senior medical laboratory NCO on the MEDBDE (SPT) staff monitors the performance of MEDBDE (SPT) medical laboratories, identifies deficiencies, and recommends solutions. Issues arising that exceed the NCO skill set are referred to the senior subordinate medical laboratory officer for resolution. This officer monitors the performance of MEDBDE (SPT) medical laboratories, to include area medical laboratory (AML) activities (including CBRN sample/specimen processing and chain of custody requirements) and MTF clinical laboratory practices. The senior subordinate medical laboratory officer advises the chief, professional services, on blood-banking and storage capabilities of Roles 2 and 3 MTFs within the command. This officer monitors Class VIII support as it impacts on medical laboratory capabilities and advises the chief, professional services, of any shortfalls which adversely impact on the performance of laboratory procedures.
- The senior subordinate optometry officer serves as the principal consultant to the chief, professional services, on all matters pertaining to optometric support and optical laboratory support. If no optometry personnel are assigned to the command, the chief, professional services, coordinates with the optometry officer on the MEDCOM (DS) staff.
- The senior subordinate nuclear medicine officer serves as a consultant to the chief, professional services, on all nuclear medicine issues. If there are no nuclear medicine officers assigned to subordinate units, the chief, professional services, coordinates for this support with the MEDCOM (DS) staff.
- When required, the preventive medicine officer coordinates for support from subordinate preventive medicine units for entomology and environmental engineering support. If these preventive medicine specialties are not available in subordinate units, the preventive medicine officer coordinates with the MEDCOM (DS) preventive medicine section for this support.

2-116. The clinical operations section coordinates with the higher and, when appropriate, adjacent medical headquarters on any clinical issues which cannot be resolved at this level or that will adversely impact clinical operations in other adjacent or higher commands. The clinical operations section monitors medical specialty capabilities of subordinate hospitals and coordinates with its higher headquarters when medical specialty augmentation team support is required.

2-117. The clinical operations section coordinates with and provides consultation to the medical section of the theater detention facility and resettlement facilities established within the MEDBDE (SPT) operational area for the treatment and hospitalization of detained personnel.

2-118. To facilitate monitoring clinical operations of subordinate MTFs, the clinical operations section determines what reports are required, formats to be used, and at what frequency the reports will be submitted. The intratheater patient movement center receives bed status reports and requests for medical regulating and evacuation which should include the clinical operations section on distribution. The S-4 receives medical supply status from all subordinate facilities which the clinical operations section must review to determine if the medical supply status of subordinate facilities will adversely impact patient care. Additionally, he may develop a medical situation report for the clinical aspects of subordinate MTF operations to remain apprised of daily or weekly operations. The clinical operations section also receives medical situation reports from forward deployed FSTs or FRSDs to determine if reconstitution, replacement, and reinforcement of these assets is required. This report also provides information on the types of surgical cases that will require follow-on surgery at subordinate MEDBDE (SPT) hospitals.

MEDICAL BATTALION (MULTIFUNCTIONAL)

2-119. Force structure changes occurring within the modular Army necessitated a redesign of the functional medical battalions (area support, MEDEVAC, and MEDLOG) into a multifunctional organization. The medical battalion (multifunctional) is an EAB headquarters. This unit provides command and control, administrative assistance, logistical support, and technical supervision for assigned and attached medical functional organizations (companies, detachments, and teams) task-organized for support to deployed forces operating within the area of responsibility. Modularity has resulted in a smaller deployed medical footprint through enhancing the capability to rapidly task-organize scalable medical capabilities. The medical battalion (multifunctional) can be deployed to provide command and control of medical forces during early entry operations and facilitate the reception, staging, onward movement, and integration of theater medical forces. All EAB medical companies, detachments, and teams in theater may be assigned, attached, or placed under the OPCON of a medical battalion (multifunctional). The medical battalion (multifunctional) is a subordinate command and control of the MEDBDE (SPT) and/or MEDCOM (DS). Refer to Figure 2-10 (on page 2-31) for notional deployed MMB.

MISSION, ASSIGNMENT, AND BASIS OF ALLOCATION

2-120. The mission of the MMB is to provide scalable, flexible, and modular medical command and control, administrative assistance, logistical support, and technical supervision capability for assigned and attached medical functional organizations (companies, detachments, and teams) task-organized for support of deployed BCTs and EAB forces.

2-121. This TOE will be assigned to the MEDBDE (SPT) or the MEDCOM (DS). An MMB is allocated as one per combination of three to six subordinate medical companies/medical detachments size units. This basis of allocation is computed on the aggregate of total companies, detachments, and teams assigned or attached. This unit is designated a Category II unit. (For unit categories, see AR 71-32). Refer to Figure 2-11 (on page 2-32) for MMB organizational structure.

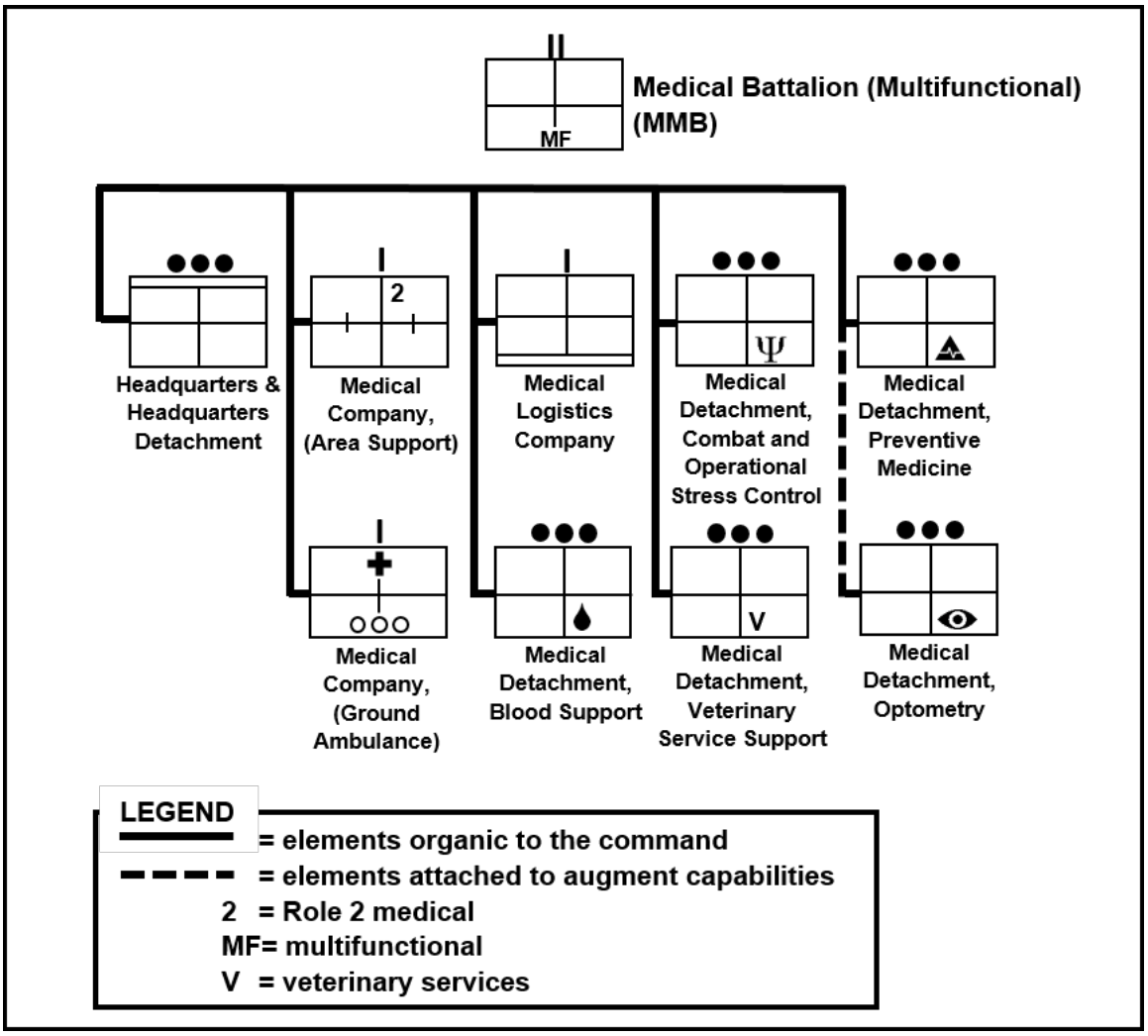

Figure 2-10. Notional deployed medical battalion (multifunctional)

2-122. The MMB is the battalion-level medical headquarters in the AO. When fully manned, it provides—

- Command and control staff planning supervision of operations medical and general logistics support as required, and administration of the assigned and attached units conducting medical operations in the support AO.
- Task organization of EAB health care assets to meet the projected patient workload.
- Advice to senior commanders in the AO on the health care aspects of their operations.
- Coordination of medical regulating and patient movement with the MEDBDE (SPT) intratheater patient movement center or the MEDCOM (DS) theater patient movement center, as required.
- Monitoring, planning, and coordinating of medical ground and air MEDEVAC within the MMB AO. Coordinating requests with the supporting aviation unit for air MEDEVAC support requirements and synchronization of air ambulances into the overall MEDEVAC plan.
- Guidance for facility site selection and area preparation.
- Consultation and technical advice on operational public health (medical entomology, and medical and OEH surveillance), pharmacy procedures, COSC and BH, medical records administration, veterinary services, nursing practices and procedures, and medical laboratory procedures to supported units. Monitors and provides advice and consultation on dental support activities within the MMB AO.

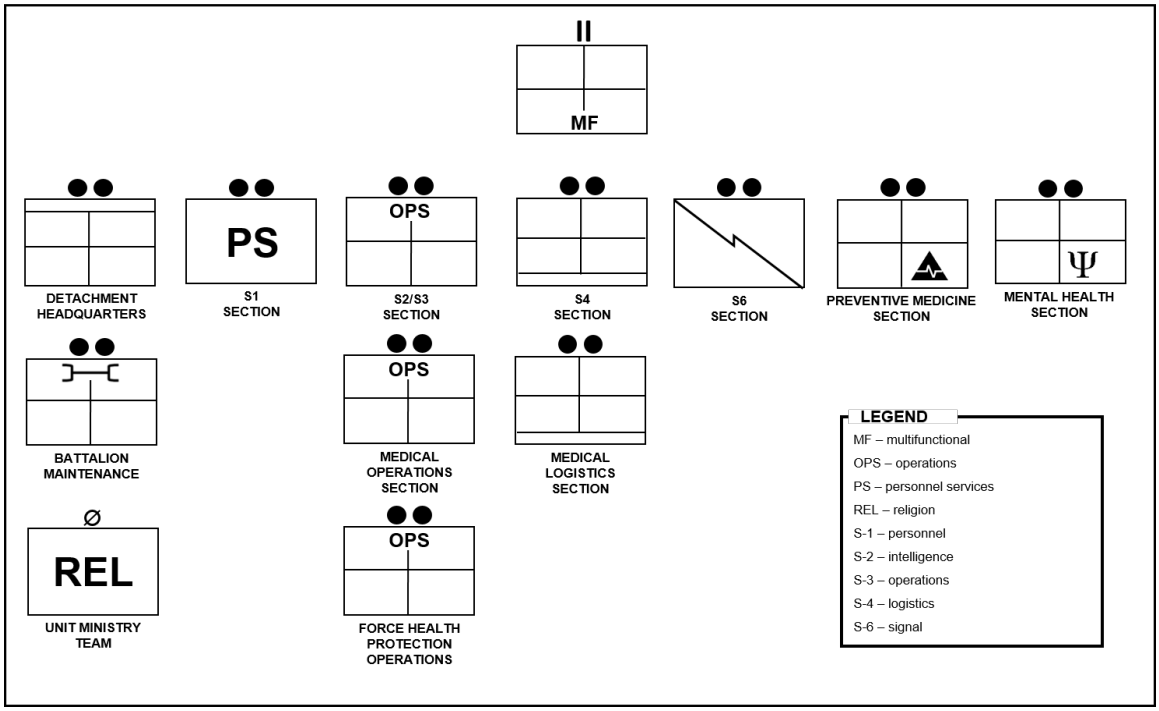

Figure 2-11. Medical battalion (multifunctional) organizational structure

- Monitoring and supervision of MEDLOG operations, to include Class VIII supply/resupply, medical equipment maintenance and repair support, optical fabrication and repair support, and blood management.
- Planning and coordination of Role 1 and Role 2 medical treatment, to include staff advice on an area support basis for EAB units without organic health care assets.
- Unit-level maintenance for wheeled vehicles and power generation equipment and wheeled vehicle recovery operations support to assigned or attached units.
- Organizational communications equipment maintenance support for the battalion.
- Food service support for staff and other medical elements dependent upon the battalion for food service.
- Maintenance of a consolidated property book for assigned units.
- Religious support for the battalion staff, unit personnel of assigned/attached medical elements, and patients in subordinate MTFs in the MMB AO.

CAPABILITIES AND DEPENDENCIES

2-123. The MMB headquarters is composed of two standard requirements code identified modules (the early entry element and the campaign support element) to facilitate the deployment and integration of the unit on the time-phased force deployment list. This headquarters conducts operational planning for assigned and attached medical functional companies, detachments, and teams. The early entry element can be deployed independently or task-organized with a CSH or hospital center as a medical multifunctional task force. The MMB headquarters should only be deployed as far forward as the division AO. Even in this circumstance, the MMB would remain under the direct command and control of the MEDBDE (SPT) and not directly attached to the BCT. Detachments and teams assigned or attached to the MMB may be further attached to the brigade support medical company to augment or reconstitute BCT medical elements. The array of health care units assigned and attached will vary depending upon mission, enemy, terrain and weather, troops and support available, time available, and civil considerations factors. The MMB staff structure is depicted in Figure 2-12.

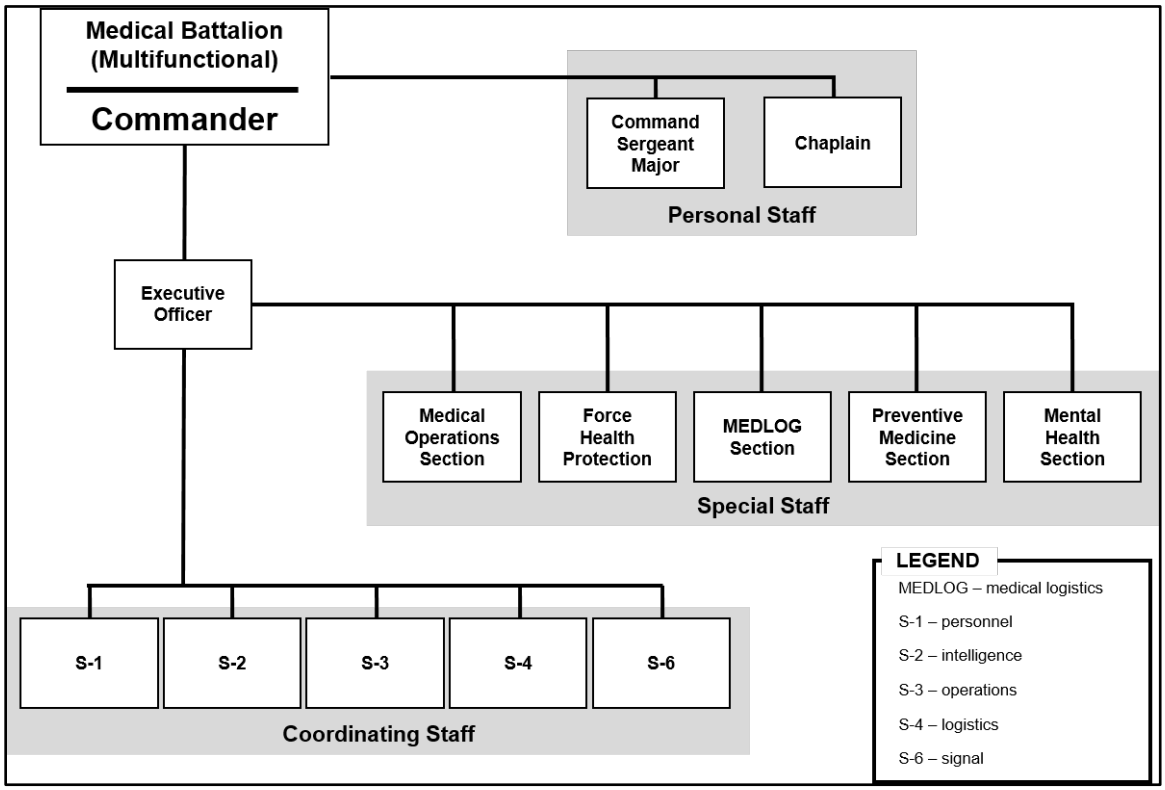

Figure 2-12. Medical battalion (multifunctional) staff structure

STAFF ORGANIZATIONS AND FUNCTIONS

2-124. This section discusses staff organizations and functions in MMB.

Internal Staff and Operations

2-125. The MMB's coordinating staff and special staff sections manage the command's internal operations through coordination with staffs of higher, lower, and adjacent units. The staff's efforts support the commander and subordinate units. The staff supports the commander by providing accurate and timely information. It produces estimates, recommendations, plans and orders, and monitors execution. The staff streamlines cumbersome or time-consuming procedures by ensuring that all activities contribute to mission accomplishment. Within the MMB headquarters, staff sections coordinate their areas of interest with other headquarters staff sections as required.

Battalion Command Section

2-126. The battalion command section provides command and control and administrative services for assigned and attached medical companies and detachments.

S-1 Section

2-127. The S-1 section provides overall administrative services for the command, to include personnel administration, and coordinates with elements of supporting agencies for finance, legal, and administrative services. This section maintains the unit status reports for each subordinate unit.

S-2 and S-3 Section

2-128. The intelligence staff officer/operations staff officer (S-2 and S-3) section is responsible for security, plans, and operations, deployment, relocation, and redeployment of the battalion and its assigned and attached units. It prepares broad planning guidance, policies, and programs for command organization, operations, and functions. This section assists the commander in developing and training the unit's mission essential task list. It identifies training requirements, based on FHP missions and the unit's training programs, directives, and orders. This section maintains the unit status reports for each subordinate unit. This section performs all-source intelligence assessments and estimates for the command. Further, it advises the commander and staff on nuclear/chemical surety and CBRN operations. It acquires, analyzes, and evaluates intelligence to include health threat information and medical and OEH surveillance data. This section provides a 24-hour continuous operations capability.

S-4 Section

2-129. The S-4 section coordinates issues pertaining to medical and general supply for MMB operations, hazardous waste disposal, contracting support with other staff sections and maintains consolidated property book for the battalion.

Force Health Protection Operations Section

2-130. The FHP operations section coordinates and monitors the execution of area medical support, MEDEVAC, and dental support within the MMB AO. The section is responsible for existing and future medical planning in the MMB AO, to include deliberate and crisis planning. Additionally, it plans future operations in excess of 72 hours and prepares major regional contingency plans for the MMB. Further, it prepares, authenticates, and publishes medical plans and OPLANs to include the integration of annexes and appendixes prepared by other staff sections. This section supervises the activities of the MEDLOG, medical operations, preventive medicine, and BH sections. The section coordinates with each internal staff organization planning activities and support requirements for subordinate medical functional companies, detachments, and teams assigned and attached to the MMB.

2-131. The FHP operations section coordinates with—

- S-1 on matters pertaining to personnel replacement and the priority of fill for subordinate AHS units.
- S-2 and S-3 on matters pertaining to—
  - Health threat and medical intelligence requirements. Develops, recommends, and submits priority information requests and essential elements of friendly information for information impacting clinical operations (to include the potential enemy use of CBRN weaponry and toxic industrial materials releases). This includes health threats and potential diseases present in the AO and the health status of enemy forces who may become detained personnel (to include new or exotic diseases in enemy forces).
  - Operational, planning, and medical regulating support. This section monitors current operations and assists in planning future operations by developing and coordinating estimates and plans. They must evaluate proposed courses of action for their impact on MMB capabilities and activities and recommend whether they are feasible. Further, they must closely monitor medical regulating activities delays in the timely evacuation of patients to and from MMB MTFs. The FHP operations section recommends clinical and operational capabilities (task-organized) required to be deployed forward to support MMB personnel deployed to the BCT or to areas within the EAB to provide direct support.
- S-4 for MEDLOG support of critical Class VIII items required for patient care, to include medical supplies, pharmaceuticals, medical equipment, and blood. The FHP operations section monitors the blood distribution and reporting processes (TM 8-227-12) to determine the impact on medical company (area support) clinical operations of shortages and delays. Further, they monitor the status of medical supplies, medical equipment, and medical equipment maintenance and repair to ensure that sufficient quantities are on hand and/or on order to sustain patient care activities within the command. They also work closely with the MEDCOM (DS) and MEDBDE (SPT) logistics in identifying and obtaining pharmaceuticals to treat diseases (to include biological warfare

agents) not usually present in U.S. forces (such as for detainees). This also includes medications and medical equipment required to treat nontraditional populations, such as U.S. government contractors, geriatric, pediatric, and obstetric patients. This section also advises the command on the management and disposition of captured enemy medical supplies and equipment.

- Battalion maintenance section on issues related to assigned wheeled vehicle maintenance, power-equipment maintenance, and wheeled vehicle.
- S-6 on matters pertaining to connectivity, information management, automation, and communications. Ensures automated systems for MEDLOG management are established and maintained and ensures connectivity to other medical information programs such as the U.S. Transportation Command Regulating and Command and Control Evacuation System, Theater Medical Information Program-Joint, and Medical Communications for Combat Casualty Care System. Additionally ensures connectivity of medical platforms deployed in supported BCT areas are adequately equipped with systems such as Force XXI battle command—brigade and below or blue force tracker.
- Detachment headquarters for logistical and administrative support requirements throughout the headquarters for unit members.

Medical Logistics Section

2-132. The MEDLOG section is responsible for the planning, coordination, and execution of the Class VIII mission within the MMB AO. This includes blood and medical maintenance management.

Medical Operations Section

2-133. The medical operations section is responsible for the planning, coordination, and execution of the medical area support mission within the MMB AO.

Preventive Medicine Section

2-134. The preventive medicine section is responsible for planning, coordination, and execution of the operational public health and veterinary services mission within the MMB AO. This includes the management of preventive medicine and veterinary assets. This section ensures medical and OEH surveillance programs are planned for, established, and implemented within the MMB AO. They monitor DNBI reports from subordinate units to determine the development of trends or the possible use of biological warfare agents on deployed forces. This section plans for and monitors veterinary food protection programs, animal medical care operations, and veterinary public health activities pertaining to the transmission of zoonotic and endemic animal diseases.

Mental Health Section

2-135. The mental health section is responsible for the planning, coordination, and execution of the COSC mission with the MMB AO. The section collects and records social and psychological data.

S-6 Section

2-136. The S6 section is responsible for all aspects of automation and communications-electronics support within the MMB. This section establishes a medical automation office and is responsible for medical information system policy and guidance for all subordinate commands. This section identifies communications-electronics requirements for data transmission services and coordinates these requirements with the external signal organizations. This section provides advice and consultation on the integration of medical information systems in support of AHS and with other command and control systems within the AO.

Detachment Headquarters

2-137. The detachment headquarters provides for billeting, filed feeding, discipline, security, training, and administration for Soldiers assigned to the headquarters.

Unit Ministry Team

2-138. The battalion unit ministry team provides two required capabilities to the command. First, religious support and pastoral ministry for assigned or attached Service members, authorized civilians, patients, and casualties. Second, they advise on religion, morals, and morale within units, and ethical decision making of the command. The unit ministry team also supports and advises subordinate commanders and COSC units, as required.

External Coordination

2-139. The MMB must coordinate externally with the MEDBDE (SPT)/MEDCOM (DS) and in early entry operations when a senior medical command headquarters is not present, with the sustainment brigade staff and other supported units to accomplish the medical mission. This coordination is conducted mainly through command surgeon channels for synchronization of the medical plan and external coordination with the combat aviation brigade for MEDEVAC. Coordinates and synchronizes the planning and execution of AHS actions.

2-140. In the performance of their AHS mission, the MMB staff may be required to coordinate with medical personnel/organizations of the other Services. For example, the USAF staff provides aeromedical liaison teams to facilitate AE aboard USAF resources. The MMB may be required to coordinate directly with CONUS for support services under control of Department of the Army (DA), DOD, and Secretary of Defense. These include depots, arsenals, data banks, plants, research laboratories, and factories associated with the United States Army Medical Research and Materiel Command.

SECTION III — MEDICAL COMMANDER, COMMAND SURGEON, AND LINE COMMANDER

2-141. The medical commander exercises command and control (authority and direction) over the subordinate medical resources.

MEDICAL COMMANDER

2-142. As discussed in Army doctrine on unified land operations, the medical commander is the focus of command and control and uses two processes in the decision-making process. The commander uses an analytic approach to evaluate information and data systematically, proposes courses of action, and determines which course of action will provide the optimal results. The commander also makes decisions intuitively. For the medical commander, the intuitive decision-making process is guided by professional judgment gained from experience, knowledge, education, intelligence, and intuition. Experienced staff members use their intuitive ability to recognize the key elements and implications of a particular problem or situation, reject the impractical, and select an adequate solution.

2-143. The leader-developed medical professional has been trained in critical thinking, assessing situations, determining requirements for follow-on services, and decisive decision-making skills since the beginning of leader's professional career. These are essential and critical skills which have been taught, nurtured, and cultivated throughout commander's professional medical education and training. The medical commander's experience base cannot be viewed from a purely military perspective of when the commander entered the Army, but must be viewed holistically to encompass all of the training, education, and experience this leader received. The military and leader development training, education, and experience coupled with proven critical thinking skills and ability to take decisive action make this officer the most qualified commander to determine how medical assets will be employed in support of the operational commander and to successfully accomplish Title 10 responsibilities for the care of assigned Soldiers.

2-144. The construct of mission command provides for centralized planning and decentralized execution and is driven by mission orders. Successful mission command demands that subordinate leaders at all echelons exercise disciplined initiative, aggressive action, and to independently accomplish the mission within the commander's intent. Mission command gives the subordinate leaders at all echelons the greatest possible freedom of action. While command and control restrains higher-level commanders from micromanaging subordinates, it does not remove them from the fight. Rather, mission command frees these

commanders to focus on accomplishing their higher commander's intent and on critical decisions only they can make. The medical command and control structure enables the MEDCOM (DS) commander to retain a regional focus in support of the CCDR and the operational area engagement plan, while still providing effective and timely direct support to the supported operational commanders and providing general support on an area basis to theater forces at EAB (such as those conducting aerial ports of debarkation, sea ports of debarkation, and operational assembly areas operations or to other temporary or permanent troop concentrations). One consequence of the enduring regional focus of the Army AO is to drive specialization in its subordinate MEDCOM (DS) since unique health threats, local needs and capabilities, other Service capabilities, and geographic factors are distinctly related to a particular region. This characteristic is in contrast to some other staff and subordinate unit functions that are performed in much the same ways regardless of region.

COMMAND SURGEON

2-145. At all levels of command, a command surgeon is designated. This Army Medicine officer is a member of the commander's personal and special staff charged with planning, coordinating, and ensuring the AHS mission is executed. At the lower levels of command, this officer may be dual-hatted as an AHS unit commander; further, the command surgeon may have a small staff section to assist in planning, coordinating, and synchronizing the AHS effort within the operational area. For detailed information regarding the surgeon and surgeon section at echelon, refer to Appendix C.

2-146. The command surgeon is responsible for ensuring that all Army Medicine functions are considered and included in running estimates, OPLANs, and OPORDs. The command surgeon retains technical supervision of all AHS operations. At the higher levels of command, the scope of duties and responsibilities expand to include all subordinate levels of command.

2-147. Through mission command, the command surgeon may be empowered to act somewhat independently; however, the nonmedical commander can retain the authority to make the decisions which he feels are critical. Mission command, to be successful, requires an environment of trust and mutual understanding which may be challenging to establish for newly assigned staff members who have not had a previous supporting relationship with the command.

2-148. The duties and responsibilities of command surgeons may include, but are not limited to:

- Advising the commander on the health of the command.
- Monitoring the three phases of TCCC.
- Developing and coordinating the HSS and FHP portion of OPLANs to support the CCDRs decisions, planning guidance, and intent.
- Preparing and developing the medical concept of support and medical common operating picture.
- Determining the medical workload requirements (patient estimates) in coordination with the assistant chief of staff, personnel (the assistant chief of staff, personnel's casualty estimate includes only those casualties that require replacements). A *patient estimate* refers to estimates derived from the casualty estimate prepared by the personnel staff officer/assistant chief of staff, personnel. The patient medical workload is determined by the Army Health System support planner. Patient estimate only encompasses medical casualty (ATP 4-02.55).
- Determining, in conjunction with the staff judge advocate and the chain of command, the eligibility for medical care in a U.S. Army MTF.
- Maintaining situational understanding. The AHS units/elements to satisfy all mission requirements.
- Recommending policies concerning support of stability tasks.
- Monitoring the availability of and recommending the assignment, reassignment, and utilization of Army Medicine personnel within the AO.
- Developing, coordinating, and synchronizing health consultation services.
- Evaluating and interpreting medical statistical data.
- Monitoring implementation of Army medical information programs.

- Recommending policies and determining requirements and priorities for MEDLOG (to include blood and blood products, medical supply/resupply, medical equipment maintenance and repair, production of medicinal gases, optometric support, and fabrication of single- and multivision optical lens spectacle fabrication and repair, and contract support).
- Recommending policies and determining requirements for medical information systems. The usage of these systems will enable theater-wide visibility in support of AHS functions and joint HSS.
- Recommending MEDEVAC policies and procedures.
- Monitoring medical regulating and patient tracking operations.
- Determining AHS training requirements.
- Developing policies, protocols, and procedures pertaining to the medical and dental treatment of sick, injured, and wounded personnel. These policies, protocols, and procedures will be in consonance with applicable regulations, directives, and instructions; higher headquarters policies; SOPs; applicable multinational force compatibility agreements; memorandums of understanding or agreement; and Status of Forces Agreements.
- Ensuring patient safety, quality assurance, infection control, and risk management programs are established and implemented.
- Ensuring field medical records and/or electronic medical records, when available, are maintained on each Soldier at the primary care MTF according to AR 40-66. This includes documentation of any radiological exposures and integration with U.S. Army Dosimetry Center and radiation safety officer as necessary.
- Ensuring compliance with the theater blood bank service program.
- Ensuring a viable veterinary program (to include inspection of subsistence and outside the continental U.S. food production and bottled water facilities, veterinary public health, and animal medical care [including establishing a military working dog (MWD) evacuation policy]) is established.
- Ensuring a medical laboratory capability or procedures for obtaining this support from out of theater resources are established for the identification and confirmation and/or theater validation of the use of suspect biological warfare and chemical warfare agents by opposition forces. This also includes the capability for collecting specimens/samples, packaging, and handling requirements and escort/chain of custody requirements. For additional information on AHS support in a CBRN environment refer to Army medical doctrine.
- Planning for and implementing public health operations and facilitating health risk communications (to include operational public health activities and initiating personnel protective measures to counter the health threat).
- Planning for and ensuring pre- and postdeployment health assessments are accomplished.
- Establishing and executing a medical surveillance program (refer to DODD 6490.02E, DODI 6490.03, and AR 40-66 for an in-depth discussion).
- Establishing and executing an OEH surveillance program.
- Recommending COSC, BH, and substance abuse control programs.
- Coordinating for medical intelligence with the supporting intelligence officer, section, and unit. Refer to Appendix D for more information on medical intelligence. Pursuing other avenues to obtain medical intelligence and/or medical information such as the—
  - National Center for Medical Intelligence.
  - Army Public Health Center.
  - Centers for Disease Control and Prevention.
  - United States Public Health Services.
  - The Office of The Surgeon General, Intelligence and Security Division.
  - Intergovernmental organizations (such as the United Nations, the World Health Organization, or the Pan American Health Organization, and other nongovernmental organizations).
  - Information gathered from MSAT, site visits to host-nation medical facilities.

- Identifying commander's critical information requirements, priority intelligence requirements, essential elements of friendly information, and friendly forces information requirements as they pertain to the health threat; ensuring they are incorporated into the command's intelligence requirements.
- Coordinating for foreign humanitarian assistance, disaster relief, and medical response to weapons of mass destruction or terrorist incidents, and defense support of civil authorities, when authorized.
- Advising commanders on AHS CBRN defensive actions (such as immunizations, use of chemoprophylaxis, pretreatments, and barrier creams).
- Ensuring individual informed consent is established before the administration of investigational new drugs as described in AR 40-7.
- Assessing special equipment and procedures required to accomplish the AHS mission in specific environments such as urban operations, mountainous terrain, extreme cold weather operations, jungles, and deserts. Requirements are varied, depending upon the scenario, and could include:
  - Obtaining pieces of equipment or clothing not usually carried (piton hammers, extreme cold weather parka, jungle boots, or the like).
  - Adapting medical equipment sets for a specific scenario to include adding items based on the forecasted types of injuries to be encountered (such as more crush injuries and fractures in urban operations or mountain operations). In certain scenarios (such as urban operations), some medical supplies and equipment may not be carried into the fight initially (such as sick call materials), but rather brought forward by follow-on forces. In mountain operations, bulky or heavy items (such as extra tentage) may not accompany the force because of the difficulty in traversing the terrain.
  - Having individual Soldiers carry additional medical items, such as bandages and intravenous fluids.
- Recommending disposition instructions for captured enemy medical supplies and equipment. Under the provisions of the Geneva Conventions, medical supplies and equipment are protected from intentional destruction and should be used to initially treat sick, injured, or wounded detainees. Refer to Chapter 3 for additional information on the Geneva Conventions.
- Submitting to higher headquarters those recommendations on medical problems/conditions that require research and development.
- Recommending theater policy for medically evacuating contaminated patients.
- Coordinating and monitoring patient decontamination operations to include:
  - Theater policies on patient decontamination operations.
  - Layout and establishment of patient decontamination site.
  - Use of collective protection.
  - Use of nonmedical Soldiers to perform patient decontamination procedures under medical supervision.

This paragraph implements STANAG 2132.

2-149. The command surgeon is responsible for the standard of care (scope of practice) which is provided to sick, injured, and wounded Soldiers by subordinate medical personnel, he—

- Ensures that standardized protocols for the alleviation of pain (to include the administration of pain relief medications by nonphysician health care providers) are established and disseminated. Further, he must ensure and certify that each military occupational specialty 68W Soldier (combat medic), working under the supervision of a physician, has received sufficient training to—
  - Recognize when pain management measures and medications are required.
  - Provide pain management measures (elevation, immobilization, and ice [when available]).
  - Select the appropriate medication (such as acetaminophen, ibuprofen, or morphine sulfate); determine the mode of administration (oral or parenteral); be knowledgeable of the possible side effects and how to treat them; and administer the appropriate medication.

- Document the treatment provided DD Form 1380 (Tactical Combat Casualty Care [TCCC] Card), to include the marking of individuals who have received morphine sulfate).

Note. When morphine is administered to a casualty in the field, the dose, Greenwich Mean Time (ZULU time), date, route of entry, and name of the drug must be entered onto the DD Form 1380. Additionally, the combat medic (or other health care provider) must mark the casualty with the letter "M" (for morphine) and the hour of injection (such as "M 0830") on the patient's forehead with a skin pencil or another semipermanent marking substance. The empty syrette, injection device, or its envelope should be attached to the patient's clothing.

- Is also responsible for ensuring that all controlled substances are stored, safeguarded, issued, and accounted for in accordance with the provisions of AR 40-3. The medical equipment set for the combat medic includes morphine sulfate. When the mission supported involves a high risk of trauma, the command surgeon may authorize the combat medic to carry morphine sulfate to alleviate severe pain caused by trauma or wounding. This medication must be accounted for when issued to the combat medic and upon mission completion.

TACTICAL COMMANDER AND OPERATIONAL ARMY

2-150. The deployed medical force ensures that the operational commander has the right mixture of medical professional (operational, technical, and clinical) expertise to synchronize the complex system of medical functions required to maintain the health of the command by promoting health and fitness, preventing casualties from DNBI, and promptly treating and evacuating those injured in the OE. Only a focused, responsive, dedicated medical effort can reduce morbidity and mortality and ensure that the operational commander can maintain the health of the Soldiers and uniformed members from the other Services entrusted to the commander's care by our Nation. According to ADP 1, an Army professional is a member of the Army Profession who meets the Army's certification criteria of competence, character, and commitment.

COMMANDER

2-151. Commanders and unit leaders must take an active role to counter the health threat to their deployed forces. Command emphasis and support is required in the areas of health promotion, field hygiene and sanitation, identification and treatment of Soldiers with potential mild traumatic brain injury, and in promoting the COSC programs to include suicide prevention.

2-152. According to FM 3-0, LSCO is intense, lethal, and brutal. Their conditions include complexity, chaos, fear, violence, fatigue, and uncertainty. Future battlefields will include noncombatants, and they will be crowded in and around large cities. Enemies will employ conventional tactics, terror, criminal activity, and information warfare to further complicate operations. Large-scale combat operations present the greatest challenge for Army forces. Army Health System support must maintain a balance between supporting the commander's scheme of maneuver during LSCO while still retaining the focus of patient care.

HEALTH PROMOTION

2-153. Health promotion is a leadership program that encompasses the assets of educational, environmental, and AHS support services that enable individuals to increase control over and improve their health in support of Army well-being. Commanders and leaders must raise the awareness of health promotion programs and informational sources and establish a command climate which encourages Soldiers to develop healthy habits and make the lifestyle changes required to maximize their personal health and fitness. Refer to ATP 6-22.5 for more information on health and fitness.

2-154. Army health promotion is defined as any combination of health education and related organizational, political, and economic interventions designed to facilitate behavioral and environmental changes conducive to the health and well-being of the Army community. It focuses on the integration of primary prevention and public health practices into community and organizational structure to ensure that health and well-being are part of the way the Army does business. Health is the product of many personal, environmental, and

behavioral factors. Health promotion programs must consider a broad range of health-related factors and should address the following areas:

- Health education and the health promotion process.
- Behavioral health programs.
- Physical programs.
- Spiritual programs.
- Environmental and social programs.

2-155. Army health promotion involves—

- Identifying community health needs and setting priorities.
- Developing, adjusting, and implementing health promotion programs to meet identified needs.
- Evaluating the effectiveness of these programs.
- Promoting resiliency.
- Promoting and enhancing quality of life.
- Promoting wellness along with well-being.

2-156. The health promotion process is similar to the risk management process described in ATP 5-19.

FIELD HYGIENE AND SANITATION

2-157. To counter the health threat, commanders and leaders must ensure that field hygiene and sanitation, , feral animal risk mitigation measures, inspection of potable water and field feeding facilities, sleep discipline (including work and rest schedules), and personal protective measures are instituted and receive command emphasis. Field hygiene and sanitation combines with personal protective measures, to include correctly wearing the uniform and using insect repellent, sunscreen, and insect netting. Leaders must ensure that Soldiers practice these activities continuously during the force projection through postdeployment cycles and processes. Guidance for establishing, training, and employing unit field sanitation teams can be found in ATP 4-25.12.

MILD TRAUMATIC BRAIN INJURY/CONCUSSION

2-158. Mild traumatic brain injury or concussion is a major health threat facing Soldiers and is recognized as a matter of significant military and operational concern. Concussive injuries are associated with explosions or blasts and blows to the head during training activities or contact sports. Leaders and Soldiers at all echelons must be aware of this invisible injury and receive mild traumatic brain injury/concussion education and training to help decrease stigma associated with seeking medical assistance. Commanders must also be aware of leader reporting requirements, mandatory medical evaluations, and medical reporting requirements. Leaders also have a responsibility to ensure their Soldiers receive a medical evaluation following a concussive event, no matter how mild. Prompt medical attention as soon as possible after an injury maximizes recovery, decreases risk of a subsequent concussion while the brain is healing, and ultimately preserves combat power. Education, training, treatment, and tracking of injured Soldiers are the keys to the Army's Traumatic Brain Injury Management Strategy.

COMBAT AND OPERATIONAL STRESS

2-159. Stress in response to threatening or uncertain situations is a reality in all types of military operations including major combat, stability, and defense support of civil authorities as well as during training exercises, in garrison, and issues related to Family and home life. Soldiers are exposed to various types of combat and operational stress throughout their military experience. ***Combat and operational stress control*** **refers to a coordinated program of actions taken by military leadership to prevent, identify, and manage reactions to traumatic events that may affect exposed organizations and individuals during unified land operations. Also called COSC.** Combat and operational stress control does not take away the experiences faced while engaged in such operations, but provides mechanisms to mitigate reactions to those experiences so that Soldiers remain combat effective and maintain the quality of life to which they are entitled.

SOLDIERS AND THEIR FAMILIES

2-160. It is essential to the morale and effectiveness of our Soldiers and their units that Soldiers recognize and believe they will receive the best and most effective medical care possible should they be wounded or injured. The AHS must ensure that it can provide responsive medical care to our injured or wounded Soldiers regardless of their physical location. Our Soldiers must also be confident that their Family members will receive the highest quality, responsive, and compassionate care at their home station while they are deployed. This confidence in the ability of the AHS to care for both the Soldier and the Soldier's Family is instrumental in reducing and mitigating some of the combat and operational stresses associated with lengthy deployments.

SECTION IV — ARMY HEALTH SYSTEM TEAM OF TEAMS

2-161. The AHS is a system of systems which is comprised of 10 medical functions. The AHS team is composed of a myriad of professional medical, scientific, research, operational, and administrative teams dedicated to the single purpose of providing the best medical care and treatment to our Nation's Soldiers, Sailors, Marines, Airmen and their Families, deployed DOD civilian employees and defense contractors, and to other eligible beneficiaries in their time of need. To achieve this aim, the AHS team must be ready, reliable, responsive, and relevant (Figure 2-13).

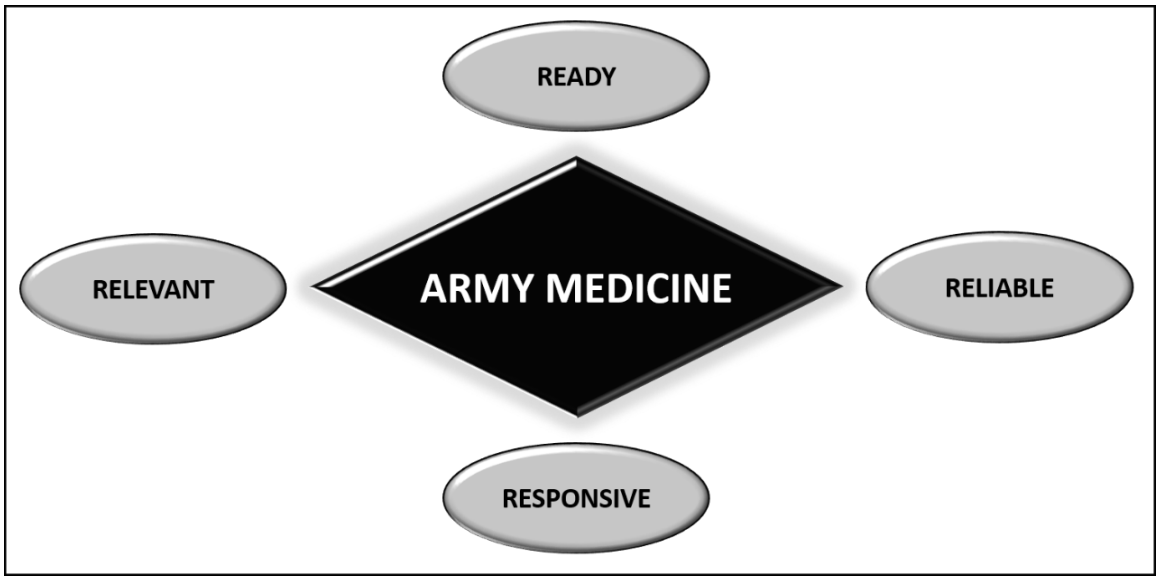

Figure 2-13. Army Health System—a team of teams

Ready

2-162. The AHS views readiness from two perspectives: medical personnel (ready medical force) and the operational Army (medically-ready force).

Medical Personnel

2-163. Medical personnel contribute to the success of military operations by applying medical skills and knowledge to problems on the battlefield. Medical personnel undergo institutional and organizational training to ensure they gain appropriate initial qualifications and maintain currency in their discipline. Ongoing training is essential to avoid skill and knowledge fade, and ensures practitioners adapt to evolving clinical practice guidelines, and advances in technology and treatment protocols. The training continuum comprises initial training in a specialty, sustainment training (including medical continuing education requirements), refresher training and pre-deployment training. AHS units (both in the institutional force and the operational Army) participate in realistic and rigorous training focused on reinforcing Soldier skills in the field and exercising the entire scope of battlefield medicine from point-of-injury, through the roles of

care, to evacuation from the operational area. Training must be integrated with combatant elements to ensure friction points are revealed and resolved before exposure to the added difficulties and uncertainty of actual combat operations. Mastery of the basics of battlefield medicine by all medical personnel is the pivotal component of supporting LSCO. To prepare for combat operations, medical personnel must also be afforded the opportunity to hone their skills and knowledge in demanding clinical environments (e.g., hospitals, emergency medical services and remote clinics).

Operational Army

2-164. The AHS collaborates with line commanders to ensure that Soldiers maintain a healthy lifestyle, are physically and mentally fit for deployments, and are medically screened to ensure they do not have on-going medical conditions which could be aggravated by conditions in the AO. Health promotion programs, nutrition programs and counseling, personnel protective measures to include health risk communications and mitigation techniques, preventive dentistry, and COSC programs all focus on maintaining the Soldier's health both in garrison and when deployed.

RELIABLE

2-165. As discussed under partnerships, the Soldier, commander, and Families have confidence that the AHS will always be prepared to provide the appropriate medical care whenever and wherever it may be required. This trust between the AHS and its beneficiaries is at the center of all that the AHS does. It is imperative to the fighting morale of our forces, that each Soldier believes that if injured, he will promptly be given medical care for those wounds and will be medically evacuated from the battlefield. It is also essential that should the Soldier's Family face a medical emergency while the Soldier is deployed, the Family member will receive state-of-the-art medical care. This in turn relieves some of the stressors the Soldier must manage during deployments and separation from the Soldier's Family. The AHS system of health is a proven system which has provided reliable health care throughout its history regardless of where needed on the battlefield or in garrison operations.

RESPONSIVE

2-166. Both the operational Army and the institutional force must be responsive to the changing OE and the resulting medical implications.

Operational Army

2-167. Army Health System planning must be flexible, scalable, and adaptable to optimize the full utilization and integration of scarce medical resources in the accomplishment of the health care delivery mission. The medical command and control organizations must leverage all available medical resources within an AO to optimize patient care to include medical capabilities of sister Services, U.S. governmental agencies, and multinational forces.

Institutional Force

2-168. The institutional force is responsive to the health care needs of all Soldiers stationed throughout the world. Combat capability developers use observations, insights, and lessons learned from on-going operations to identify requirements and gaps in order to develop TOE medical organizations which are more modular and adaptive to changes on the battlefield and to incorporate emerging technologies to enhance the effectiveness and efficiency of medical materiel. Medical research and development is a vital link between the Army Medicine and the educational and industrial base within CONUS. It enables the MEDCoE to capitalize on emerging technologies and treatment protocols to refine and enhance the state-of-the-art care provided to our Soldiers and other eligible beneficiaries. The military medical education provided within the AHS includes leadership training, enlisted military occupational specialty skills, refresher and sustainment training, medical continuing education, individual Soldier skills, and collective training. Further, if training deficiencies are identified during a deployment, the MEDCoE may develop additional predeployment training packages and assist United States Army Forces Command with predeployment certification of individual and unit skill sets. When appropriate, new equipment training teams provide collective training

to units located throughout the world to ensure the medical personnel are properly trained on how to deploy and employ the new equipment. For example, during the initial stages of Operation Enduring Freedom and Operation Iraqi Freedom, a new collective protection shelter system was fielded and training teams from the Army Medicine were deployed to unit locations worldwide to facilitate the transition and use of this new shelter system.

2-169. The institutional force provides a vital link in ensuring the medical readiness of forces to be deployed. Mobilization stations within CONUS ensure Soldiers are medically processed for overseas deployments to include immunizations, eyewear, dental care, medications, resiliency training, and individual patient records are initiated and/or maintained. This ensures the operational commander has a healthy and fit force. For more information, refer to Appendix E.

2-170. The institutional force provides the reachback capability for deployed forces. Requirements for medical specialty personnel generated during the conduct of operations are met by mobilizing and deploying medical resources in the institutional force to meet theater-specific requirements. Additionally, the institutional force provides definitive health care services; restorative, rehabilitative, and convalescent care to enhance and expand on the essential care provided to Soldiers in the deployment area.

RELEVANT

2-171. The AHS must provide relevant care based on current operational and strategic plans. The AHS must be adaptive and use innovative approaches and solutions for identified gaps and shortfalls, such as was done to establish the Wounded Warrior Program and to staff Warrior transition units to ensure that our Soldiers' medical, rehabilitative, and convalescent needs were effectively addressed, as well as providing the appropriate command climate and unit support to either return the Soldier to military duty or to transition back to civilian life as a productive member of society.

Clinical Aspects

2-172. The clinical aspects of the operation involve the provision of medical care to sick, injured, and wounded Soldiers (or other designated beneficiaries) and the prevention of DNBI by medically trained individuals. The care extends from the place of injury or wounding and is usually provided initially by the combat medic assigned to a movement and maneuver or fires unit or by a health care provider at the battalion aid station through the successive roles of care to the CONUS-support base, if the patient's medical condition so warrants. As patients are evacuated between roles of care, they receive en route medical care to sustain them, thus reducing the potential for their medical condition to deteriorate while in-transit.

Operational Aspects

2-173. The operational aspects of the mission include such military tasks as:

- Maintaining situational understanding of the ongoing and future operations.
- Providing timely support to the maneuver forces.
- Maintaining the unit's readiness posture.
- Ensuring the survivability of the unit (such as unit perimeter defense, hasty firing positions, and patient bunkers). See ATP 3-37.34 Survivability Operations for more information.
- Ensuring compliance with the law of land warfare (to include the Geneva Conventions).

2-174. To accomplish the Army Medicine mission, a synchronization of the clinical and operational aspects must be achieved. It accomplishes nothing for a unit to provide the best clinical care, if it cannot survive the operation. Likewise, a unit that can execute all of its military tasks is not successful if the patients entrusted to its care die or their conditions deteriorate because no consideration was given to their clinical needs during an operational relocation.

2-175. A balance must be achieved in prioritizing the requirements generated from both the operational and clinical aspects of the mission. Without synchronizing the response to the overall requirements, both operational and clinical, a shortfall in one sphere may have serious ramifications on mission success. A shortage of scalpel blades for an FST or FRSD adversely impacts the patient care mission as would a shortage of ammunition for use in perimeter defense which could lead to mission failure in an operational sense. If

neither item is available, the FST or FRSD cannot provide the required surgical care to stabilize patients for further evacuation and the unit cannot survive in the OE because it lacks a means for defense.

2-176. To enhance the delivery of health care in the OE and to provide a seamless medical system from the POI or wounding through progressive roles of care to the CONUS-support base, the Army Medicine team must integrate their special skills and knowledge, leverage technology, maximize the use of scarce resources, and synchronize their collective efforts. The accomplishment of the Army Medicine mission necessitates a cohesive unity of effort to provide the care our Soldiers deserve.

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Chapter 3

Army Health System and the Effects of the Law of Land Warfare and Medical Ethics

The U.S. is a party to numerous conventions and treaties pertinent to warfare on land. Collectively, these treaties are often referred to as The Hague and Geneva Conventions. Whereas the Hague Conventions concern the methods and means of warfare, the Geneva Conventions concern the victims of war or armed conflict. The Geneva Conventions are 4 separate international treaties, signed in 1949. The Conventions are very detailed and contain many provisions, which are tied directly to the medical mission. These Conventions are entitled—

- Convention (I) for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field.
- Convention (II) for the Amelioration of the Condition of Wounded, Sick and Shipwrecked Members of Armed Forces at Sea.
- Convention (III) relative to the Treatment of Prisoners of War.
- Convention (IV) relative to the Protection of Civilian Persons in Time of War.

SECTION I — THE LAW OF LAND WARFARE

3-1. The conduct of armed hostilities on land is regulated by the law of land warfare. Refer to FM 6-27 for more information. This body of law is inspired by the desire to diminish the evils of war by—

- Protecting both combatants and noncombatants from unnecessary suffering.
- Safeguarding certain fundamental human rights of persons who fall into the hands of the enemy, particularly detainees, the wounded and sick, and civilians.
- Facilitating the restoration of peace.

3-2. The law of land warfare places limits on the exercise of a belligerent's power in the interest of furthering that desire (diminishing the evils of war) and it requires that belligerents—

- Refrain from employing any kind or degree of violence which is not actually necessary for military purposes.
- Conduct hostilities with regard for the principles of humanity and chivalry.

3-3. Refer to DODD 2311.01 (DOD law of War Program) and FM 6-27/MCTP 11-10C (The Commander's Handbook on the Law of Land Warfare) for additional information on the law of land warfare.

SECTION II — GENEVA CONVENTIONS

3-4. The essential and dominant idea of the GWS is that the Soldier who has been wounded or who is sick, and for that reason is out of the combat in a disabled condition, is from that moment protected. Friend or foe must be tended with the same care. From this principle, numerous obligations are imposed upon parties to a conflict.

PROTECTION AND CARE

3-5. Article 12 of the GWS imposes several specific obligations regarding the protection and care of the wounded and sick.

- The first paragraph of Article 12, GWS, states: "Members of the armed forces and other persons mentioned in the following Article, who are wounded or sick, shall be respected and protected in all circumstances."
  - The word *respect* means "to spare, not to attack" and *protect* means "to come to someone's defense, to lend help and support." These words make it unlawful to attack, kill, ill-treat, or in any way harm a fallen and unarmed enemy soldier. At the same time, these words impose an obligation to come to aid and give him such care as his condition requires.
  - This obligation is applicable in all circumstances. The wounded and sick are to be respected just as much when they are with their own army or in no man's land as when they have fallen into the hands of the enemy.
  - Combatants, as well as noncombatants, are required to respect the wounded. The obligation also applies to civilians; Article 18, GWS, specifically states: "The civilian population shall respect these wounded and sick, and in particular abstain from offering them violence."
  - The GWS does not define what *wounded* or *sick* means, nor has there ever been any definition of the degree of severity of a wound or a sickness entitling the wounded or sick combatant to respect. Any definition would necessarily be restrictive in character and would thereby open the door to misinterpretation and abuse. The meaning of the words *wounded* and *sick* is thus a matter of common sense and good faith. It is the act of falling or laying down of arms because of a wound or sickness which constitutes the claim to protection. Only the soldier who is himself seeking to kill may be killed.
  - The benefits afforded the wounded and sick extend not only to members of the armed forces, but to other categories of persons as well, classes of whom are specified in Article 13, GWS. Even though a wounded person is not in one of the categories enumerated in the article, we must still respect and protect that person. There is a universal principle which says that any wounded or sick person is entitled to respect and humane treatment and the care which his condition requires. Wounded and sick civilians have the benefit of the safeguards of the Geneva Conventions.
- The second paragraph of Article 12, GWS, provides that the wounded and sick "…shall be treated humanely and cared for by the Party to the conflict in whose power they may be, without any adverse distinction founded on sex, race, nationality, religion, political opinions, or any other similar criteria."
  - All adverse distinctions are prohibited. Nothing can justify a belligerent in making any adverse distinction between wounded or sick that require his attention, whether they are friend or foe. Both are on equal footing in the matter of their claims to protection, respect, and care. The foregoing is not intended to prohibit concessions, particularly with respect to food, clothing, and shelter, which take into account the different national habits and backgrounds of the wounded and sick.
  - The wounded and sick shall not be made the subjects of biological, scientific, or medical experiments of any kind which are not justified on medical grounds and dictated by a desire to improve their condition.
  - The wounded and sick shall not willfully be left without medical assistance, nor shall conditions exposing them to contagion or infection be created.
- The *only* reasons which can justify priority in the order of treatment are reasons of *medical urgency*. This is the only justified exception to the principle of equality of treatment of the wounded.
- Paragraph 5 of Article 12, GWS, provides that if we must abandon wounded or sick, we have a *moral* obligation to, "as far as military considerations permit," leave medical supplies and personnel to assist in their care. This provision is in no way bound up with the absolute obligation imposed by paragraph 2 of Article 12 to care for the wounded. A belligerent can never refuse to care for enemy wounded on the pretext that his adversary has abandoned them without medical personnel and equipment.

ENEMY WOUNDED AND SICK

3-6. The protections accorded the wounded and sick apply to friend and foe alike without distinction. Certain provisions of the GWS; however, specifically concern enemy wounded and sick. There are also provisions in the GPW which, because they apply to prisoners of war generally, also apply to enemy wounded or sick.

- Article 14 of the GWS states that persons who are wounded and then captured have the status of prisoners of war, however, that wounded soldier is also a person who needs treatment. Therefore, a wounded soldier who falls into the hands of an enemy who is a Party to the GWS and the GPW, such as the U.S., will enjoy protection under both Conventions until his recovery. The GWS will take precedence over the GPW where the two overlap.
- Article 16 of the GWS requires the recording and forwarding of information regarding enemy wounded, sick, or dead. (See AR 190-8 and FM 3-63 for disposition of detainees after hospital care.)
- When intelligence indicates that large numbers of detainees may result from an operation, medical units may require reinforcement to support the anticipated additional detainee patient workload.

SEARCH FOR AND COLLECTION OF CASUALTIES

3-7. Article 15 of the GWS imposes a duty on combatants to search for and collect the dead and wounded and sick as soon as circumstances permit. It is left to the operational commander to judge what is possible and to decide to commit the commander's medical personnel to this effort. If circumstances permit, an armistice or suspension of fire should be arranged to permit this effort.

ASSISTANCE OF THE CIVILIAN POPULATION

3-8. Article 18, GWS, addresses the civilian population. It allows a belligerent to ask the civilians to collect and care for wounded or sick of whatever nationality. This provision does not relieve the military authorities of their responsibility to give both physical and moral care to the wounded and sick. The GWS also reminds the civilian population that they must respect the wounded and sick, and in particular, must not injure them.

ENEMY CIVILIAN WOUNDED AND SICK

3-9. Certain provisions of the Geneva Conventions are relevant to the medical mission.

- Article 16 of the GC provides that enemy civilians who are "…wounded and sick, as well as the infirm, and expectant mothers, shall be the object of particular protection and respect." The Article also requires that, "As far as military considerations allow, each Party to the conflict shall *facilitate* the steps taken to search for the killed and wounded [civilians], to assist…other persons exposed to grave danger, and to protect them against pillage and ill-treatment [emphasis added]."
  - The "protection and respect" to which wounded and sick enemy civilians are entitled is the same as that accorded to wounded and sick enemy military personnel.
  - While Article 15 of the GWS requires Parties to a conflict to search for and collect the dead, wounded, and sick members of the armed forces, Article 16 of the GC states that the Parties must "facilitate the steps taken" in regard to civilians. This recognizes the fact that saving civilians is the responsibility of the civilian authorities rather than of the military. The military is not required to provide injured civilians with medical care in a combat zone, however, if we start providing treatment, we are bound by the provisions of the GWS. Provisions for treating civilians (enemy or friendly) will be addressed in EAB regulations.
- In occupied territories, the Occupying Power must accord the inhabitants numerous protections as required by the GC. The provisions relevant to medical care include:
  - Requirement to bring in medical supplies for the population if the resources of the occupied territory are inadequate.
  - Prohibition on requisitioning medical supplies unless the requirements of the civilian population have been taken into account.

- Duty of ensuring and maintaining, with the cooperation of national and local authorities, the medical and hospital establishments and services, public health, and hygiene in the occupied territory.
- Requirement that medical personnel of all categories be allowed to carry out their duties.
- Prohibition on requisitioning civilian hospitals on other than a temporary basis and then only in cases of urgent necessity for the care of military wounded and sick and after suitable arrangements have been made for the civilian patients.
- Requirement to provide adequate medical treatment to detained persons.
- Requirement to provide adequate medical care in detention camps.

MEDICAL REPATRIATION

3-10. The Geneva Conventions provide for the repatriation of—

- Retained health care personnel once they are no longer needed to provide health care to members of their own forces (Articles 28 and 39, GWS).
- Seriously wounded and sick prisoners of war (POWs).

3-11. Parties to the conflict are bound to send back to their own country, regardless of number or rank, seriously wounded and seriously sick POWs, after having cared for them until they are fit to travel. No sick or injured prisoner of war may be repatriated against his will during hostilities (Article 109, GPW).

3-12. The following shall be directly repatriated (Article 110, GPW):

- Incurably wounded and sick whose mental or physical fitness seems to have been gravely diminished.
- Wounded and sick who, according to medical opinion, are not likely to recover within one year, whose condition requires treatment, and whose mental or physical fitness seems to have been gravely diminished.
- Wounded and sick who have recovered, but whose mental or physical fitness seems to have been gravely and permanently diminished.

3-13. The following may be accommodated in a neutral country (Article 110, GPW):

- Wounded and sick whose recovery may be expected within one year of the date of the wound or the beginning of the illness, if treatment in a neutral country might increase prospects of a more certain and speedy recovery.
- Prisoners of war whose behavioral or physical health, according to medical opinion, is seriously threatened by continued captivity.

3-14. The conditions which POWs accommodated in a neutral country must fulfill in order to permit their repatriation will be fixed, as shall likewise their status, by agreement between the Powers concerned. In general, POWs who have been accommodated in a neutral country, and who belong to the following categories, should be repatriated:

- Those whose state of health has deteriorated so as to fulfill the conditions laid down for direct repatriation.
- Those whose mental or physical powers remain, even after treatment, considerably impaired.

3-15. Upon the outbreak of hostilities, Mixed Medical Commissions will be appointed to examine sick and wounded POWs and to make all appropriate decisions regarding them (Article 112, GPW). However, POWs who, in the opinion of the medical authorities of the Detaining Power, are manifestly seriously injured or seriously sick, may be repatriated without having been examined by a Mixed Medical Commission.

PROTECTION AND IDENTIFICATION OF MEDICAL PERSONNEL

3-16. Article 24 of the GWS provides special protection for "Medical personnel exclusively engaged in the search for, or the collection, transport or treatment of the wounded or sick, or in the prevention of disease, [and] staff exclusively engaged in the administration of medical units and establishments . . . [emphasis added]." Article 25 provides limited protection for "Members of the armed forces specially trained for

employment, should the need arise, as hospital orderlies, nurses or auxiliary stretcher-bearers, in the search for or the collection, transport or treatment of the wounded and sick . . . if they are carrying out these duties at the time when they come into contact with the enemy or fall into his hands [emphasis added]."

PROTECTION

3-17. There are two separate and distinct forms of protection.

- The first is protection from intentional attack if medical personnel are identifiable as such by an enemy in a combat environment. Normally, this is facilitated by medical personnel wearing an armband bearing the distinctive emblem (a Red Cross or Red Crescent on a white background), or by their employment in a medical unit, establishment, or vehicle (including medical aircraft and hospital ships) that displays the distinctive emblem. Persons protected by Article 25 may wear an armband bearing a miniature distinctive emblem only while executing medical duties.
- The second protection provided by the GWS pertains to medical personnel who fall into the hands of the enemy. Article 24 personnel are entitled to "retained person" status. They are not deemed to be POWs, but otherwise benefit from the protections of the GPW. Article 28 of the GWS states they are authorized to carry out medical duties only, and ". . . shall be retained only in so far as the state of health . . . and the number of POWs require." Article 25 personnel are POWs, but shall be employed to perform medical duties in so far as the need arises. They may be required to perform other duties or labor, and they may be held until a general repatriation of POWs is accomplished upon the cessation of hostilities.

SPECIFIC CASES

3-18. Army Medicine personnel and non-Army Medicine personnel assigned to medical units fall into the category identified in Article 24 provided they meet the exclusively engaged criteria of that article. The United States Army does not have any personnel who officially fall into the category identified in Article 25. While it is not a violation of the GWS for Article 24 personnel to perform nonmedical duties, it should be understood; however, that Article 24 personnel lose their protected status under that article if they perform duties or tasks inconsistent with their noncombatant role. Should those personnel later take up their medical duties again, a reasonable argument might be made that they cannot regain Article 24 status since they have not been exclusively engaged in medical duties and that such switching of roles might at best cause such personnel to fall under the category identified in Article 25.

- While only Article 25 refers to nurses, nurses are Article 24 personnel if they meet the criteria of that article.
- The AHS officers and NCOs assigned to nonmedical positions in a brigade support battalion or a sustainment brigade are neither Article 24 nor Article 25 personnel. Such assignments place them in the role of a combatant. Examples of such personnel are—
  - The AHS officers serving as commanders of brigade support battalions with responsibility for base or base-cluster defense, as well as command and control of medical and nonmedical units.
  - The AHS officers and NCOs assigned to nonmedical staff positions with a brigade support battalion with responsibility for planning and supervising the sustainment support for a BCT or other combat unit.
- Article 24 personnel who might become Article 25 personnel by virtue of their switching roles could include the following:
  - A medical company commander, a physician, or the executive officer (a Medical Service Corps officer) detailed as convoy march unit commander with responsibility for medical and nonmedical unit routes of march, convoy control, defense, and repulsing attacks.
  - Helicopter pilots, who are permanently assigned to a dedicated air ambulance unit, but fly helicopters not bearing the Red Cross emblem on standard combat missions during other times.
- The GWS does not itself prohibit the use of Article 24 personnel in perimeter defense of nonmedical units such as areas or base clusters under overall security defense plans, but the policy

of the United States Army is that Article 24 personnel will not be used for this purpose. Adherence to this policy should avoid any issues regarding their status under the GWS due to a temporary change in their role from noncombatant to combatant. Medical personnel may guard their own unit without any concurrent loss of their protected status.

IDENTIFICATION CARDS AND ARMBANDS

3-19. Medical personnel who meet the exclusively engaged criteria of Article 24, GWS, are entitled to wear an armband bearing the distinctive emblem of the Red Cross and carry the medical personnel identification card authorized in Article 40, GWS (in the U.S. Armed Services, DD Form 1934 [*Geneva Conventions Identity Card for Medical and Religious Personnel Who Serve in or Accompany Armed Forces*]). Article 25 personnel and medical personnel serving in positions that do not meet the exclusively engaged criteria of Article 24 are not entitled to carry the medical personnel identification card or wear the distinctive emblem armband. Such personnel carry a DOD Common Access Card, and under Article 25, may wear an armband bearing a miniature distinctive emblem when executing medical duties.

The following paragraph implements STANAGs 2060, 2454, and 2931.

PROTECTION AND IDENTIFICATION OF MEDICAL UNITS, ESTABLISHMENTS, BUILDINGS, MATERIEL, AND MEDICAL TRANSPORTS

3-20. There are two separate and distinct forms of protection: protection from intentional attack and protection when falling into the hands of the enemy.

PROTECTION FROM INTENTIONAL ATTACK

3-21. The first is protection from intentional attack if medical units, establishments, or transports are identifiable as such by an enemy in a combat environment. Normally, this is facilitated by medical units or establishments flying a white flag with a Red Cross and by marking buildings and transport vehicles (aircraft or ground) with the distinctive emblem.

- It follows that if we cannot attack recognizable medical units, establishments, or transports, we should allow them to continue to give treatment to the wounded in their care as long as this is necessary.
- All vehicles employed exclusively on medical transport duty are protected in the operational area. Medical vehicles being used for both military and medical purposes, such as moving wounded personnel during an evacuation and carrying retreating belligerents, are not entitled to protection.
- Medical aircraft, like medical transports, are protected from intentional attack, but with a major difference—they are protected ". . . while flying at heights, times and on routes specifically agreed upon between the belligerents concerned." (Article 36, GWS.) Such agreements may be made for each specific case or may be of a general nature, concluded for the duration of hostilities. If there is no agreement, belligerents use medical aircraft at their own risk and peril.
- Article 37, GWS specifies that ". . . medical aircraft of Parties to the conflict may fly over the territory of neutral Powers, land on it in case of necessity, or use it as a port of call." The medical aircraft will ". . . give the neutral Powers previous notice of their passage over the said territory and obey all summons to alight, on land or water." The aircraft will be " . . . immune from attack only when flying on routes, at heights and at times specifically agreed upon between the Parties to the conflict and the neutral Power concerned." It further states that "The neutral Powers may, however, place conditions or restrictions on the passage or landing of medical aircraft on their territory."
- The second paragraph of Article 19 imposes an obligation upon those responsible to ". . . ensure that the said medical establishments and units are, as far as possible, situated in such a manner that attacks against military objectives cannot imperil their safety." Hospitals should be sited alone,

as far as possible from military objectives. The unintentional bombardment of a medical establishment or unit due to its presence among or in proximity to valid military objectives is not a violation of the GWS. Legal protection is certainly valuable, but it is more valuable when accompanied by practical safeguards.

PROTECTION WHEN FALLING INTO THE HANDS OF THE ENEMY

3-22. The second protection provided by the GWS pertains to medical units, establishments, materiel, and transports that fall into the hands of the enemy.

- Captured mobile medical unit materiel is to be used first to treat the patients in the captured unit. If there are no patients in the captured unit, or when those who were there have been moved, the materiel is to be used for the treatment of other wounded and sick persons.
- Generally, the buildings, materiel, and stores of fixed medical establishments will continue to be used to treat wounded and sick, however, after provision is made to care for remaining patients, operational commanders may make other use of them. All distinctive markings must be removed if the buildings are to be used for other than medical purposes.
- The materiel and stores of fixed establishments and mobile medical units are not to be intentionally destroyed, even to prevent them from falling into enemy hands. In certain extreme cases, buildings may have to be destroyed for operational reasons.
- Medical transports that fall into enemy hands may be used for any purpose once arrangement has been made for the medical care of the wounded and sick they contain. The distinctive markings must be removed if they are to be used for nonmedical purposes.
- A medical aircraft is supposed to obey a summons to land for inspection. If it is performing its medical mission, it is supposed to be released to continue its flight. If examination reveals that an act "harmful to the enemy" (for example, if the aircraft is carrying munitions) has been committed, it loses the protections of the Conventions and may be seized. If a medical aircraft makes an involuntary landing, all aboard, except the medical personnel, will be POWs. A medical aircraft refusing a summons to land is a fair target.

IDENTIFICATION

3-23. The GWS contains several provisions regarding the use of the Red Cross emblem on medical units, establishments, and transports. (The identification of medical personnel has been previously discussed.)

- Article 39 of the GWS reads as follows: "Under the direction of the competent military authority, the emblem shall be displayed on the flags, armlets and on all equipment employed in the Medical Service."
  - There is no obligation of a belligerent to mark his units with the emblem. Sometimes a commander (generally no lower than a brigade commander for NATO forces) may order the camouflage of his medical units in order to conceal the presence or real strength of his forces. The enemy must respect a medical unit if he knows of its presence, even one that is camouflaged or not marked. The absence of a visible Red Cross emblem, however, coupled with a lack of knowledge on the part of the enemy as to the unit's protected status, may render that unit's protection valueless.
  - The distinctive emblem is not a Red Cross alone; it is a Red Cross on a white background. Should there be some good reason, however, why an object protected by the Convention can only be marked with a Red Cross without a white background, belligerents may not make the fact that it is so marked a pretext for refusing to respect it.
  - Some countries use the Red Crescent on a white background in place of the Red Cross. This emblem is recognized as an authorized exception under Article 38, GWS. Additional Protocol III to the Geneva Conventions also recognizes the Red Crystal. The Red Crystal replaces the Red Star of David.
  - The initial phrase of Article 39 shows that it is the military commander who controls the emblem and can give or withhold permission to use it. He is at all times responsible for the

use made of the emblem and must see that it is not improperly used by the troops or by individuals.

- Article 42 of the GWS specifically addresses the marking of medical units and establishments.
  - "The distinctive flag of the Convention shall be hoisted only over such medical units and establishments as are entitled to be respected under the Convention, and only with the consent of the military authorities." (Paragraph 1, Article 42, GWS.) Although the Convention does not define "the distinctive flag of the Convention," what is meant is a white flag with a Red Cross in its center. Also, the word "flag" must be taken in its broadest sense. Hospitals are often marked by one or several Red Cross emblems painted on the roof. Finally, the military authority must consent to the use of the flag (see the above comments on Article 39) and must ensure that the flag is used only on buildings entitled to protection.
  - "In mobile units, as in fixed establishments, it [the distinctive flag] may be accompanied by the national flag of the Party to the conflict to which the unit or establishment belongs." (Article 42, GWS.) This provision makes it optional to fly the national flag with the Red Cross flag. It should be noted that in an operational area the national flag is a symbol of belligerency and is therefore likely to provoke attack.
  - In a NATO conflict, NATO STANAG 2931 provides for camouflage of the Geneva emblem on medical facilities where the lack of camouflage might compromise operations. Medical facilities on land, supporting forces of other nations, will display or camouflage the Geneva emblem in accordance with national regulations and procedures. When failure to camouflage would endanger or compromise operational operations, the camouflage of medical facilities may be ordered by a NATO commander of at least brigade level or equivalent. Such an order is to be temporary and local in nature and countermanded as soon as the circumstances permit. It is not envisaged that fixed, large, medical facilities would be camouflaged. The STANAG defines "medical facilities" as "medical units, medical vehicles, and medical aircraft on the ground."

Note. There is no such thing as a "camouflaged" Red Cross. When camouflaging a medical unit either cover up the Red Cross or take it down. A black cross on an olive drab or any other background is not a symbol recognized under the Geneva Conventions.

3-24. For additional guidance on the marking of air ambulances, refer to AR 40-3 and TM 1-1500-345-23. For more information on approved medical symbols, refer to Appendix F.

LOSS OF PROTECTION OF MEDICAL ESTABLISHMENTS AND UNITS

3-25. Medical assets lose their protected status by committing acts "harmful to the enemy." (Article 21, GWS.) A warning must be given to the offending unit and a reasonable amount of time allowed to cease such activity.

ACTS HARMFUL TO THE ENEMY

3-26. The phrase "acts harmful to the enemy" is not defined in the Convention, but should be considered to include acts the purpose or effect of which is to harm the enemy, by facilitating or impeding military operations. Such harmful acts would include, for example, the use of a hospital as a shelter for able-bodied combatants, as an arms or ammunition dump, or as a military observation post. Another instance would be the deliberate sitting of a medical unit in a position where it would impede an enemy attack.

WARNING AND TIME LIMIT

3-27. The enemy has to warn the unit to put an end to the harmful acts and must fix a time limit on the conclusion of which he may open fire or attack if the warning has not been complied with. The phrase in all appropriate cases recognizes that there might obviously be cases where no time limit could be allowed. A body of troops approaching a hospital and met by heavy fire from every window would return fire without delay.

USE OF SMOKE AND OBSCURANTS

3-28. The use of smoke and obscurants during MEDEVAC operations for signaling or marking landing zones does not constitute an act harmful to the enemy, however, employing such devices to obfuscate a medical element's position or location is tantamount to camouflaging; it would jeopardize its entitlement privilege status under the GWS. Refer to Army doctrine for MEDEVAC for additional information on the use of smoke and obscurants for medical operations.

CONDITIONS NOT DEPRIVING MEDICAL UNITS AND ESTABLISHMENTS OF PROTECTION

3-29. Article 22 of the GWS reads as follows: "The following conditions shall not be considered as depriving a medical unit or establishment of the protection guaranteed by Article 19: (1) That the personnel of the unit or establishment are armed, and that they use the arms in their own defense (sic), or in that of the wounded and sick in their charge. (2) That in the absence of armed orderlies, the unit or establishment is protected by a picket or by sentries or by an escort. (3) That small arms and ammunition taken from the wounded and sick and not yet handed to the proper service, are found in the unit or establishment. (4) That personnel and material (sic) of the veterinary service are found in the unit or establishment, without forming an integral part thereof. (5) That the humanitarian activities of medical units and establishments or of their personnel extend to the care of civilian wounded or sick."

ACTS

3-30. These five conditions are not to be regarded as acts harmful to the enemy. These are particular cases where a medical unit retains its character and its right to immunity, in spite of certain appearances which might lead to a contrary conclusion or, at least, create some doubt.

DEFENSE OF MEDICAL UNITS AND SELF-DEFENSE BY MEDICAL PERSONNEL

3-31. A medical unit is granted a privileged status under the law of land warfare. This status is based on the view that medical personnel are not combatants and that their role in the combat area is exclusively a humanitarian one. In recognition of the necessity of self-defense, however, medical personnel may be armed for their own defense or for the protection of the wounded and sick under their charge. To retain this privileged status, they must refrain from all aggressive action and may only employ their weapons if attacked in violation of the Conventions. They may not employ arms against enemy forces acting in conformity with the law of land warfare and may not use force to prevent the capture of their unit by the enemy (it is, on the other hand, perfectly legitimate for a medical unit to withdraw in the face of the enemy). Medical personnel who use their arms in circumstances not justified by the law of land warfare expose themselves to penalties for violation of the law of land warfare. Provided they have been given due warning to cease such acts, they may also forfeit the protection of the medical unit or establishment which they are protecting.

- Medical personnel are not authorized crew-served or offensive weapons. They may carry small arms, such as rifles, pistols, squad automatic weapons, or authorized substitutes in the defense of medical facilities, equipment, and personnel/patients without surrendering the protections afforded by the Geneva Conventions. Further, Army Medicine and non- Army Medicine personnel in medical units are not required to train and qualify on crew-served weapons, however, Army Medicine personnel attending training at Noncommissioned Officer Education System courses will receive weapons instruction that is part of the curriculum. This will ensure the successful completion of the course is not jeopardized by failure to attend the weapons training portion of the curriculum. (Refer to AR 350-1 for further information).
- The presence of machine guns, grenade launchers, booby traps, hand grenades, light antitank weapons, or mines (regardless of the method by which they are detonated) in or around a medical unit or establishment would seriously jeopardize its entitlement privilege status under the GWS. The *deliberate arming* of a medical unit with such items could constitute an act harmful to the enemy and cause the medical unit to lose its protection, regardless of the location of the medical unit.

Guarding Medical Units

3-32. As a rule, a medical unit is to be guarded by its own personnel, however, it will not lose its protected status if the guard is performed by a number of armed Soldiers. The military guard attached to a medical unit may use its weapons, just as armed medical personnel may, to ensure the protection of the unit. But, as in the case of medical personnel, the Soldiers may only act in a purely defensive manner and may not oppose the occupation or control of the unit by an enemy who is respecting the unit's privileged status. The status of such Soldiers is that of ordinary members of the armed forces. The mere fact of their presence with a medical unit will shelter them from attack. In case of capture, they will be POWs.

Arms and Ammunition taken from the Wounded

3-33. Wounded persons arriving in a medical unit may still be in possession of small arms and ammunition, which will be taken from them and handed to authorities outside the medical unit. Should a unit be captured by the enemy before it is able to get rid of these arms, their presence is not of itself cause for denying the protection to be accorded the medical unit under the GWS.

Personnel and Materiel of Veterinary Services

3-34. The presence of personnel and materiel of Veterinary Services with a medical unit is authorized, even where they do not form an integral part of such unit.

Care of Civilian Wounded and Sick

3-35. A medical unit or establishment protected by the GWS may take in civilians, as well as military wounded and sick, without jeopardizing its privileged status. This clause merely sanctions what is actually done in practice.

THE 1977 PROTOCOLS TO THE GENEVA CONVENTIONS

3-36. Amendments to the Geneva Conventions have been ratified by some of our allies and potential adversaries. The U.S. representative to the diplomatic conference signed these amendments, but they have not been officially ratified by our government.

COMPLIANCE WITH THE GENEVA CONVENTIONS

3-37. The U.S. is a party to the 1949 Geneva Conventions. Two of these Conventions afford protection for medical personnel, facilities, and evacuation platforms (to include aircraft on the ground). All medical personnel should thoroughly understand the provisions of the Geneva Conventions that apply to medical activities. Violation of these Conventions can result in the loss of the protection afforded by them. Medical personnel should inform the operational commander of the consequences of violating the provisions of these Conventions. The consequences can include the following:

- Medical evacuation assets subjected to attack and destruction by the enemy.
- Medical capability degraded. Captured medical personnel becoming POWs rather than retained persons. They may not be permitted to treat fellow prisoners.
- Loss of protected status for medical unit, personnel, or evacuation platforms (to include aircraft on the ground).

3-38. Because even the perception of impropriety can be detrimental to the mission and U.S. interests, medical commanders must ensure that they do not give the impression of impropriety in the conduct of medical operations. For example, the MMB commander included in the operational SOP rules governing the use of crew-served weapons, it would give the impression that the unit possessed and intended to use these types of weapons. Under the provisions of the GC, medical units are only authorized individual small arms and squad automatic weapons for use in the defense of the patients under their care and for themselves. Even though the unit did not possess these types of weapons, the entry in the operational SOP could be misinterpreted and a case made that the commander intended to use these weapons in violation of the Geneva Conventions.

MEDICAL CARE FOR DETAINED PERSONNEL

3-39. It is DOD policy that the U.S. military Services shall comply with the principles, spirit, and intent of the international law of war, both customary and codified, to include the GCs. As such, captured or detained personnel will be accorded an appropriate legal status under international law and conventions. Personnel in U.S. custody will receive medical care consistent with the standard of medical care that applies for U.S. military personnel in the same geographic area. Refer to DODD 2310.01E, DODI 2310.08E, JP 3-63, JP 4-02, AR 40-400, AR 190-8, and ATP 4-02.46 for additional information on medical care for detained personnel.

SECTION III — MEDICAL ETHICS

3-40. Health care personnel are well-trained in and guided by the ethics of their professional calling. This training and ethical principles, coupled with the requirements of international law as it pertains to the treatment of detainees, and civilians during conflict will ensure the ethical treatment of all sick and wounded personnel.

ETHICAL CONSIDERATIONS FOR THE MEDICAL TREATMENT OF DETAINEES

3-41. Health care personnel (particularly physicians) perform their duties consistent with the following basic principles:

- Health care personnel have a duty in all matters affecting the physical and BH of detainees to perform, encourage, and support, directly and indirectly, actions to uphold the humane treatment of detainees. They must ensure that no individual in the custody or under the physical control of the DOD, regardless of nationality or physical location, shall be subject to cruel, inhuman, or degrading treatment or punishment as defined in U.S. law.
- Health care personnel charged with the medical care of detainees have a duty to protect detainees' physical and BH and provide appropriate treatment for disease. To the extent practicable, treatment of detainees should be guided by professional judgments and standards similar to those applied to personnel of the United States Armed Forces.
- Health care personnel shall not be involved in any professional provider-patient treatment relationship with detainees the purpose of which is not solely to evaluate, protect, or improve their physical and BH.
- Health care personnel, whether or not in a professional provider-patient treatment relationship, shall not apply their knowledge and skills in a manner that is not applicable law or the standards set forth in DODD 2310.01E.
- Health care personnel shall not certify, or participate in the certification of, the fitness of detainees for any form of treatment or punishment that is not in consonance with applicable law, or participate in any way in the administration of any such treatment or punishment.
- Health care personnel shall not participate in any procedure for applying physical restraints to the person of a detainee unless such a procedure is determined to be necessary for the protection of the physical or BH or the safety of the detainee, or necessary for the protection of other detainees or those treating, guarding, or otherwise interacting with them. Such restraints, if used, shall be applied in a safe and professional manner.

3-42. Health care personnel engaged in a professional provider-patient treatment relationship with detainees shall not participate in detainee-related activities for purposes other than health care. Such health care personnel shall not actively solicit information from detainees for other than medical purposes. Health care personnel engaged in nontreatment activities, such as forensic psychology, behavioral science consultation, forensic pathology, or similar disciplines, shall not engage in any professional provider-patient treatment relationship with detainees (except in emergency circumstances in which no other health care providers can respond adequately to save life or prevent permanent impairment).

- During the initial screening of detainees any preexisting medical conditions, wounds, fractures, and bruises should be noted. Documentation of these injuries/conditions provides a baseline for

each detainee which facilitates the identification of injuries which may have occurred in the detention facility.

- Detainees who report for routine sick call should be visually examined to determine if any unusual or suspicious injuries are apparent. If present, the health care provider should determine from the detainee how the injuries occurred. Any injuries which cannot be explained or for which the detainee is providing evasive responses should be noted in the medical record and should be reported to the chain of command, technical medical channels, and United States Army Criminal Investigation Command.
- Health care personnel may enter the holding areas of the facility for a variety of reasons. These can include, but are not limited to, conducting sanitary inspections, providing TCCC, and dispensing medications. When in the holding areas of the facility, health care personnel must be observant. Should they observe anything suspicious which might indicate that detainees are being mistreated, they should report these suspicions immediately to the chain of command. Should they observe a detainee being mistreated, they should take immediate action to stop the abuse and then report the incident.

3-43. Detained personnel must have access to the same available standard of medical care as the U.S. and unified action partners to include respect for their dignity and privacy. In general, the security of detainees' medical records and confidentiality of medical information will be managed the same way as for the U.S. and multinational forces. During detainee operations, the patient administrator, the United States Army Criminal Investigation Command, the International Committee of the Red Cross, and the medical chain of command can have access to detainee medical records besides the treating health care personnel.

3-44. Health care personnel shall safeguard patient confidences and privacy within the constraints of the law. Under U.S. and international law and applicable medical practice standards, there is no absolute confidentiality of medical information for any person. Detainees shall not be given cause to have incorrect expectations of privacy or confidentiality regarding their medical records and communications, however, whenever patient-specific medical information concerning detainees is disclosed for purposes other than treatment, health care personnel shall record the details of such disclosure, including the specific information disclosed, the person to whom it was disclosed, the purpose of the disclosure, and the name of the medical unit commander (or other designated senior medical activity officer) approving the disclosure. Similar to legal standards applicable to U.S. citizens, permissible purposes include preventing harm to any person, maintaining public health and order in detention facilities, and any lawful law enforcement, or national security-related activity.

3-45. In any case in which the medical unit commander (or other designated senior medical activity officer) suspects that the medical information to be disclosed may be misused, he should seek a senior command determination that the use of the information will be consistent with the applicable standards.

3-46. The information disclosed to a physician during the course of the relationship between physician and patient is confidential to the greatest possible degree. The patient should feel free to make a full disclosure of information to the physician in order that the physician may most effectively provide needed services. The patient should be able to make this disclosure with the knowledge that the physician will respect the confidential nature of the communication. The physician should not reveal confidential communications or information without the express consent of the patient, unless required to do so by law. The obligation to safeguard patient confidences is subject to certain exceptions, which are ethically and legally justified because of overriding social considerations. Where a patient threatens to inflict serious bodily harm to another person or to himself and there is a reasonable probability that the patient may carry out the threat, the physician should take reasonable precautions for the protection of the intended victim, including notification of law enforcement authorities.

3-47. Patient consent for the release of medical records is not required. The MTF commander or commander's designee, usually the patient administrator, determines what information is appropriate for release. Only that specific medical information or medical record required to satisfy the terms of a legitimate request will be authorized for disclosure.

3-48. Because the chain of command is ultimately responsible for the care and treatment of detainees, the detention facility chain of command requires some medical information. For example, detainees suspected

of having infectious diseases such as tuberculosis should be separated from other detainees. Guards and other personnel who come into contact with such patients should be informed about their health risks and how to mitigate those risks.

3-49. Releasable medical information on internees includes that which is necessary to supervise the general state of health, nutrition, and cleanliness of internees and to detect contagious diseases. Such information should be used to provide health care; to ensure health and safety of internees, soldiers, employees, or others at the facility; to ensure law enforcement on the premises; and to ensure the administration and maintenance of the safety, security, and good order of the facility.

3-50. For additional information on medical ethics refer to the Textbooks of Military Medicine: Military Medical Ethics, Volumes I and II, and The Emergency War Surgery Handbook. Both of these publications are available electronically at the Borden Institute website.

3-51. The provision of health care to detainees within MTFs or other facilities (such as dispensaries located within detention or holding facilities) is a unique role within the military structure. This role is governed by rules and regulations designed to ensure the provision of health care while ensuring personal safety and maintenance of security, custody, and discipline in a detention/holding facility environment. Health care personnel must ensure that their actions, both on- and off-duty, do not undermine their ability to function effectively among detainees or compromise established health care, safety, security, and custody guidelines.

Note. The process of abiding by the principles of ethical treatment of personnel regardless of national/adversarial affiliation and navigating rules regarding employment of weapon systems, markings, and duties, can be challenging. Units are strongly encouraged to consult with their servicing Staff Judge Advocate and Unit Ministry Team for advisement.

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Chapter 4

Army Health System Operations

Army Health System support is provided across the competition continuum and various types of mission support (traditional support to a deployed force, operations predominantly characterized by stability tasks, and defense support of civil authorities) may be provided simultaneously in various locations throughout the operational area.

SECTION I — PLANNING FOR ARMY HEALTH SYSTEM SUPPORT

4-1. Army Health System planners must anticipate the types of support that may be required and develop flexible plans that can be rapidly adjusted to changes in the level of violence and operational tempo, as well as to transition from one type of task to the next.

UNIFIED LAND OPERATIONS

4-2. Unified land operations describe the character of the dominant major operation being conducted at any time within the land force commander's AO. The competition continuum helps convey the nature of the major operation to the force to facilitate common understanding of how the commander broadly intends to operate. See ADP 3-0 on unified land operations for an in-depth discussion of the competition continuum. Further, refer to AHS doctrine for medical planning considerations.

4-3. Unified land operations are executed through decisive action by means of Army core competencies that are guided by mission command. The Army's core competencies are combined arms maneuver and wide area security (ADP 1) with a number of enabling competencies. These enabling competencies include security cooperation, tailoring forces, entry operations, flexible command and control, the support we provide to the joint force.

4-4. As all major operations are joint in nature, the competition continuum can be used to group similar types of activities under a predominant theme. Unified land operations are simultaneous offensive, defensive, and stability or defense support of civil authorities' tasks to seize, retain, and exploit the initiative to shape OEs, prevent conflict, consolidate gains, and win our Nation's wars as part of unified action (ADP 3-0).

OPERATIONAL VARIABLES

4-5. As the OE is comprised of all of the factors, both military and civilian, that affect the conduct of military operations in an operational area, the medical commander must define how the different elements will impact on the concept of operations. The operational variables are a means for exploring and describing an OE that focuses on the human aspects of the environment. Commanders and planners can use political, military, economic, social, information, infrastructure, physical environment, and time (operational variables) to ensure all elements are considered. The operational variables are used by strategic planners in the development of plans and information may be broader than required for mission analysis at the tactical level, however, as medical issues often have a regional focus and may be the result of environmental, socioeconomic, political, and religious practices, it is essential for the AHS planner to consider the medical aspects of an operation on a much broader scale than the immediate AO. As the theater medical command, the MEDCOM (DS) provides this regional focus in support of the CCDRs theater engagement strategy. For a detailed discussion of each of the political, military, economic, social, information, infrastructure, physical environment, time (operational variables) considerations, refer to ADP 5-0.

4-6. Table 4-1 provides medical aspects for consideration in relation to the operational variables and subvariables. This table is not an all-inclusive listing but does provide the AHS planner with some initial considerations.

Table 4-1. Medical aspects of the operational variables

Variable	*Subvariables*	*Medical aspects*
Political	Attitude toward the United States. Centers of political power. Type of government. Government effectiveness and legitimacy. Influential political groups. International relationships.	Health status of population. Public health issues. Accessibility to health care. Nutritional status of the population and/or subgroups of the population.
Military	Military forces. Government paramilitary forces. Nonstate paramilitary forces. Unarmed combatants. Nonmilitary armed combatants. Military functions. • Command and control. • Maneuver. • Information operations. • Reconnaissance, security, and surveillance capabilities acquisition. • Fire capabilities. • Protection. • Sustainment. • Cyberspace operations and electronic warfare capabilities. • Special operations capabilities.	Development of military medical infrastructure. Level of education and training of military medical personnel. Trauma care capabilities. Medical evacuation (ground and air). Forward surgical/damage control surgical capabilities. Hospitalization capabilities. Disease and nonbattle injury rates. Identification and treatment of mild traumatic brain injuries and traumatic brain injuries. Dental care services. Blood supply and blood-banking capabilities. Organic medical assets. Area medical support capabilities. Availability of medical supplies and equipment. Medical equipment maintenance and repair. Medical logistics system to include medical gases and optical fabrication and repair. Behavioral health and treatment of combat and operational stress reaction capabilities. Rehabilitative and convalescent care capabilities to include prosthetics. Food inspection and laboratory analysis. Veterinary care for military working dogs and other government-owned animals and veterinary public health capabilities including zoonotic diseases and food protection infrastructure/programs.

✚ Table 4-1. Medical aspects of the operational variables (continued)

Variable	*Subvariables*	*Medical aspects*
Economic	Economic diversity. Employment status. Economic activity. Illegal economic activity. Banking and finance.	The economic base can affect health care for both the human and the animal populations in the nation. The types of injuries and health issues may vary significantly based upon whether it is an agricultural society or an industrialized nation and/or region. This affects the types of health care available including restorative and rehabilitative services and programs and the availability of health care to the populace. The gross national product and the per capita income of the population affect the availability of resources for the government to expend on public health concerns and health care in general. When the Army Health System planner examines the economic factors of a nation or region, it is important to determine what influence it has on how much money is expended in the health sector (both private and public) as this will affect health care, medical equipment, and pharmaceuticals availability.
Social	Demographic mix. Social volatility. Education level. Ethnic diversity. Religious diversity. Population movement. Common languages. Criminal activity. Human rights. Centers of social power. Basic cultural norms and values.	Age, sex, and genetics affect how individuals are affected by disease and existing environmental factors. Religion affects how people view medical intervention; it can affect how a person will comply with medical treatment regimens and whether they will accept recommended treatments (such as the use of blood transfusions). Persons who are uprooted may be more susceptible to disease because of lowered immunity status due to fatigue, restricted food intake, poor living conditions, inadequate shelters, and poor sanitation. If public health and disease prevention programs are not instituted, the general health of the population or the affected subpopulation will decrease. Populations where education and literacy are not widespread will often have a lower standard of living, less appreciation for public health and disease prevention practices, less skilled workers, and be more difficult to reach with public health alerts and programs. Cultural, ethnic, and religious beliefs often influence who will seek medical care and who will not. Privacy issues may require that consideration of the provider's sex is relevant in addressing women's health issues. Providers must be cautious in using graphic aids to communicate with their patients, as the explicit graphics may be considered offensive.

Table 4-1. Medical aspects of the operational variables (continued)

Variable	*Subvariables*	*Medical aspects*
Social (continued)		Medical personnel should develop a guide for asking medical questions in the local language dialect.
Information	Public communications media. • Telephone/cell phones. • Print Media. • Broadcast media (TV, radio). • Public Webpages.	Availability of mass communications enablers for public health warnings, alerts, and information. • Telephones. • Televisions. • Radios. • Newspapers/periodicals. • Computers/e-mail.
Infrastructure[1]	Construction pattern. Urban zones. Urbanized building density. Utilities present. Utility level. Transportation architecture.	Availability of electricity and potable water. Number of medical providers (by category). Numbers of primary, secondary, and tertiary medical treatment facilities. Status of waste disposal. Sanitation practices and standards (availability of toilets, showers, and bathing facilities). Urbanization can increase the spread of infectious diseases due to inadequate living space, improper ventilation, poor sanitation practices, and lowered immunity. Accessibility issues (roads [paved and unpaved], commercial transportation systems [buses, taxis, rail, and air], vehicles and/or pack animals, and natural barriers [mountains, streams, jungles, and deserts]). Availability of transportation assets for medical evacuation or other medical purposes in the event of natural or man-made disaster or other mass casualty situation.
Physical environment	Terrain • *Observation and fields of fire. • *Avenues of approach. • *Key terrain. • *Obstacles. • *Cover and concealment. • Landforms. • Vegetation.	Are brick and mortar structures available for use as medical treatment facilities? Climate and weather effects on— • Disease vectors. • Categories and types of injuries. • Acclimatization issues pertaining to heat, cold, or altitude. • Medical evacuation operations.

Table 4-1. Medical aspects of the operational variables (continued)

Variable	*Subvariables*	*Medical aspects*
Physical environment (continued)	• Terrain complexity. • Mobility classification. Natural hazards. Climate. Weather. • *Precipitation. • *High temperature—heat index. • *Low temperature—chill index. • *Wind. • *Visibility. • *Cloud cover. • *Relative humidity.	Topography and hydrology considerations include: • Character and types of injuries to be encountered. • Natural barriers to medical evacuation. • Lines of patient drift. • Suitable for farming and for grazing animals. Natural resources to include the availability of medicinal herbs. Presence of toxic plants and animals and whether they pose a health hazard to deployed troops.
Time	Cultural perception of time. Information offset. Tactical exploitation of time. Key dates, time periods, or events.	Time affects not only the provision of medical care, but also may affect the types of diseases and injuries which may occur. Short duration operations require emphasis on rapidly treating Soldiers with traumatic injuries, while longer duration operations require emphasis on disease prevention and the management of chronic medical conditions.
NOTE: Subvariables marked with an asterisk (*) are also the military aspects of terrain and weather used in analyzing mission, enemy, terrain and weather, troops and support available, time available, and civil considerations.		

MISSION VARIABLES

4-7. Mission variables are used by AHS planners to determine the impact they will have on medical operations. Mission variables describe characteristics of the operational area, focusing on how they might affect a mission. The mission variables are discussed below. In Table 4-1 above, the subvariables which are the same as mission variable considerations are marked with an asterisk (*). For an in-depth discussion of the mission variables, refer to ADP 5-0.

MISSION

4-8. The mission refers to the overall mission of the operational commander, as well as the specific mission of the supporting AHS unit. In order to develop a flexible and responsive support plan, the AHS planner must have a clear understanding of the operational mission, the purpose of that mission, and the tasks/actions to be performed and the rationale for accomplishing those actions. The AHS planner must be able to forecast where AHS support assets should be positioned to best support the CCDRs plan and also anticipate if augmentation of medical resources will be required and preplan, coordinate, and synchronize the employment of this augmentation support should the need arise.

ENEMY

4-9. The second variable the AHS planner must consider is the enemy. The elements of dispositions (including organization, strength, location, and operational mobility), doctrine, equipment, capabilities, vulnerabilities, and probable courses of action are considered by the operational planners and the important factors are normally reflected in the OPORD. The AHS planner must also analyze the potential impacts on the provision of AHS support to our forces. The enemy weapons systems will indicate the types of wounds which U.S. forces may experience (conventional weapons, blast, CBRN, or improvised weapons [such as punji sticks used in Vietnam that resulted in countless numbers of infected wounds and improvised explosive devices used in Operation Iraqi Freedom, and Operation Enduring Freedom]) and give an indication on the

types and quantities of medical supplies that will be required. If enemy forces have been issued any chemoprophylaxis, barrier creams, or pretreatments, it may indicate the types of CBRN weaponry available to them and their likelihood of using those types of weapons. The morale of the enemy and its likelihood of engaging in sustained combat is often dependent upon the nutritional status of the enemy and the availability of medical aid should they become injured. A malnourished enemy with little hope of being rescued and surviving the enemy's injuries will normally not have the will to continue the fight. Medical personnel must also be knowledgeable about the enemy doctrine in respect to whether it is likely to abide by the provisions of international law and the Geneva Conventions pertaining to the protection and respect of medical personnel. (Refer to Chapter 3 for a discussion of the Geneva Conventions).

TERRAIN AND WEATHER

4-10. The military aspects of terrain and weather are listed in Table 4-1. The AHS planner must continuously plan for changes in weather and terrain conditions when conducting AHS support operations. The AHS's effectiveness and efficiency are based on a system of progressively increasing the complexity of medical resources and services available from the POI or wounding through the operational area AHS to definitive, restorative, and rehabilitative care in the CONUS-support base. The fully integrated ground and air MEDEVAC system sustains the care provided at a lower role as the patient is evacuated to a role of care capable of providing the required support. This continuum of care is effective in reducing morbidity and mortality, mitigating long-term disability, and restoring a Soldier's health and fitness. Any factor that disrupts this continuum can have an adverse impact on a Soldier's prognosis and long-term disability. Therefore, the AHS planner must develop contingency plans for all types of weather scenarios, changes in topography due to weather (flooding, thawing, or freezing), trafficability/nontrafficability of evacuation routes, availability of resources (rotary-wing aircraft may be grounded due to visibility issues, sandstorms, or other weather phenomenon). The types of medical supplies required for an operation may vary depending upon the terrain/weather. Operations conducted in mountainous terrain may result in more crush injuries, while operations conducted in jungles may result in significantly higher rates of infection. The disruption or cessation of MEDEVAC operations would result in a requirement for holding the injured or ill in place; medical personnel would then be required to provide prolonged care until MEDEVAC operations could be resumed. This circumstance would require that the treatment elements be augmented with additional holding capability, more medical supplies, and possible increased surgical or other medical specialty capability. For an AHS planner, this type of contingency planning, coordinating, and synchronizing needs to occur prior to an operation, as the health of a patient is perishable and may not withstand delays in treatment and evacuation.

TROOPS AND SUPPORT AVAILABLE

4-11. The AHS planner must not only consider the traditional populations which require support (such as U.S. forces or multinational forces) but must also determine the population at risk in a more broad context. During each operation, the population at risk may vary due to political, social, economic, religious, and humanitarian considerations. The AHS planner must develop a traditional support plan, but must also develop a number of contingency plans in the event the population at risk and population support changes during the operation. If the AHS planner does not anticipate an increase in nontraditional populations supported, the diversion of AHS resources can adversely impact the delivery of health care to our U.S. forces. The support requirements (food, medicines, and medical supplies) for a civilian population who is malnourished, has pediatric, obstetrics and gynecological, and geriatric patients, and patients with chronic medical conditions varies significantly from the items available in the medical equipment sets routinely carried by United States Army AHS units. Prior planning, coordinating, and synchronization with CONUS-based organizations is required to ensure the appropriate mix of medical items can be deployed to rapidly augment United States Army AHS units.

TIME AVAILABLE

4-12. Military commanders assess the time available for planning, preparing, and executing tasks and operations. This includes the time required to assemble, deploy, and maneuver units in relationship to the enemy and conditions. Army Health System planners also view time in relationship to the continuum of care and timeframes required to treat and evacuate patients. For example, if an FST or FRSD is to operate on a seriously injured Soldier, the FST or FRSD will not be able to displace and move for at least six hours, as the

Soldier will require a period of time to become hemodynamically stable following surgery if he is to survive the rigors of evacuation.

CIVIL CONSIDERATIONS

4-13. Civil considerations are the influence of man-made infrastructure, civilian institutions, and activities of civilian leaders, populations, and organizations within the operational area on the conduct of military operations. The operational and mission variables are used to analyze to analyze the civil aspects of the area. Field Manual 3-24/MCWP 3-33.5 provides an in-depth analysis of this model. The AHS planner must always analyze the local and the regional medical aspects in any given AO. Although the immediate local considerations are important, in the medical arena the regional aspects may be just as important. Areas such as blood supply, type, species, and virulence of disease vectors may vary across the operational area and adversely impact the health of U.S. forces.

TASK-ORGANIZATION

4-14. Task-organization is a tool used by commanders to tailor their forces to specific mission requirements. Task-organization is a temporary grouping of forces designed to accomplish a particular mission. Traditionally, task-organization was accomplished by combining entire units; however with the advent of modularity, commanders are task-organizing elements of the organization rather than the entire organization. This enables a commander to extract the individual capabilities required for a specific mission, to project the smallest footprint possible, yet still be able to effectively and efficiently accomplish the mission. Modularly designed units with deployable functional elements identified with a standard requirements code can be easily integrated into the time phased force deployment list process to ensure the rapid movement of both the unit's/element's personnel and equipment. Characteristics to examine when task-organizing the force include, but are not limited to: training, experience, equipage, sustainability, OE, enemy threat, and mobility. Additional considerations include constraints on manpower (troop ceilings), ability for a unit or element to be self-sufficient (for example, FST or FRSD must be collocated with a medical company for power generation, x-ray, laboratory, and other services), and the population at risk (additional augmentation is required to support chronic medical conditions [present in the contractor and civilian employee force], pediatric, geriatric, and obstetric patients).

4-15. The MMB is a versatile organization which can serve as the parent unit when developing a medical task force. The MMB has a diverse staff which can provide the planning and administrative support for the medical functional elements assigned to the medical task force.

SECTION II — SUPPORT TO DECISIVE ACTION

4-16. Decisive action is the simultaneous combination of offense, defense, and stability or defense support of civil authority tasks. These tasks require versatile, adaptive medical support, and flexible leadership.

4-17. Operational experience demonstrates that AHS forces trained exclusively for offensive and defensive tasks are not as proficient at stability tasks. Effective medical training reflects a balance among the elements of decisive action that produces and sustains proficiency in all the tasks. See ADP 3-0 for additional information on decisive action.

4-18. The traditional and primary Army Medicine mission is to conserve the fighting strength of the tactical commander. The Army Medicine rhythm of military operations is that of the operational commander. Casualties begin to occur immediately upon engagement with the enemy. Due to the necessity to perform lifesaving interventions for Soldiers suffering combat trauma within minutes of wounding or injury, AHS resources must be arrayed in close proximity to the forces supported. This also permits the AHS assets to rapidly clear the battlefield of casualties and enhances the CCDRs ability to quickly take advantage of opportunities which present themselves during the operation.

4-19. Army Health System planners must be included early-on in the planning cycle for tactical operations and must fully participate in rehearsals conducted by the operational Army being supported. To ensure effective and efficient AHS support, AHS support plans must adhere to the AHS principles. Within noncontiguous operations, the linear array of AHS units will not always occur and AHS units must fully

understand the various support relationships described in the OPORDs to ensure that a seamless continuum of health care is established and can be maintained.

4-20. The MEDEVAC plan for the tactical operation includes both rotary-wing air ambulances and ground ambulances. The preferred means of evacuation is the air ambulance; however its availability can be affected by air superiority issues and environmental factors such as visibility, winds, and dust. The evacuation plan must address the use of ground ambulances when feasible and/or the simultaneous use of both platforms. For example, if a wounded Soldier cannot be evacuated by air ambulance for at least 1 hour, the combat medic may evacuate the patient first to the supporting Role 1 (or Role 2) MTF to arrive within 20 minutes for TCCC performed by the physician assigned to the battalion aid station to further stabilize the patient before he is evacuated by air ambulance.

OFFENSIVE TASKS

4-21. An offensive task is a task conducted to defeat and destroy enemy forces and seize terrain, resources, and population centers. The direct action offensive tasks are depicted in Table 4-2 along with key medical considerations for these types of tasks. For additional information on offensive tasks, refer to FM 3-0.

Table 4-2. Offensive tasks, purposes, and key medical considerations

Offensive tasks	*Purposes*	*Key medical considerations*
Movement to contact Attack Exploitation Pursuit	Dislocate, isolate, disrupt, and destroy enemy forces. Seize key terrain. Deprive the enemy of resources. Develop intelligence. Deceive and divert the enemy. Create a secure environment for stability tasks.	All medical functions fully synchronized. Medical information management to document health threat exposures and medical encounters, to report health surveillance data and information on the health of the command, and to accomplish medical regulating and patient tracking operations. Locate, acquire, stabilize, treat, and evacuate injured or ill Soldiers from the battlefield to facilitate the operational commander's ability to exploit opportunities on the battlefield. Trauma care, forward resuscitative care, and en route medical care to sustain the patient through medical evacuation to the appropriate role of care. Responsive medical logistics which facilitates and sustains the treatment of patients during the fight. Theater hospitalization to provide essential care in theater to all categories of patients.

DEFENSIVE TASKS

4-22. A defensive task is a task conducted to defeat an enemy attack, gain time, economize forces, and develop conditions favorable for offensive or stability tasks.

4-23. Army Health System support operations for defensive tasks are similar to those for offensive tasks; however, normally the timeframe in which the tasks must be conducted is compressed. The only means for increasing the mobility of AHS units is to evacuate the patients they are holding. When it is anticipated that rapid shifts will occur in the OE, AHS units must evacuate patients from the potentially affected units to ensure their agility and to enhance their capacity for newly arriving patients. Table 4-3 (on page 4-9) depicts the defensive tasks, purposes, and key medical considerations when preparing for these types of tasks.

Table 4-3. Defensive tasks, purposes, and key medical considerations

Defensive tasks	*Purposes*	*Key medical considerations*
Mobile defense Area defense Retrograde	Deter or defeat enemy offense. Gain time. Achieve economy of force. Retain key terrain. Protect the populace, critical assets, and infrastructure. Develop intelligence.	All medical functions fully synchronized. Medical information management to document health threat exposures and medical encounters, to report health surveillance data and information on the health of the command, and to accomplish medical regulating and patient tracking operations. Emphasis is placed on the rapid acquisition, stabilization, and evacuation of patients generated by units in contact. This enhances the mobility of supporting Army Health System units and facilitates the commander's ability to exploit opportunities and leverage the momentum to mount a counterattack or perform other maneuvers. Responsive medical logistics which facilitates and sustains the treatment of patients during the fight. Theater hospitalization to provide essential care in theater to all categories of patients.

STABILITY TASKS

4-24. Stability is an overarching term encompassing various military missions, tasks, and activities conducted outside the U.S. in coordination with other instruments of national power to maintain or reestablish a safe and secure environment, and provide essential governmental services, emergency infrastructure reconstruction, and humanitarian relief.

4-25. The Army Medicine has historically conducted foreign humanitarian assistance operations when deployed in overseas areas. In some scenarios, medical forces may be deployed prior to the deployment of maneuver forces due to the humanitarian nature of their activities and medical personnel are more acceptable to a host nation than the deployment of the operational Army forces.

4-26. Although the medical commander can provide the CCDR assistance in planning for the primary stability tasks to restore essential services and support to economic and infrastructure development, the assistant chief of staff, CA is the responsible staff agency for developing and planning CA operations. This ensures that all stability activities conducted are in consonance with the CCDRs theater engagement strategy.

4-27. The importance of stability tasks in achieving U.S. national goals and objectives is discussed in DODD 3000.05, ADPs 3-0 and 3-07. Stability task considerations were included in the design of the MEDCOM (DS) which has CA officers assigned to the staff. The command maintains a regional focus on medical issues arising within the CCDRs AOR.

4-28. Table 4-4 (on page 4-10) depicts stability tasks, purposes, and key medical considerations for the preparation for the conduct of these tasks.

Table 4-4. Stability tasks, purposes, and key medical considerations

Stability tasks	*Purposes*	*Key medical considerations*
Establish civil security (including security force assistance) Establish civil control Restore essential services Support to governance Support to economic and infrastructure development Conduct security cooperation	Provide a secure environment. Secure land areas. Meet the critical needs of the populace. Gain support for host-nation government. Shape the environment for interagency and host-nation success.	Regionally focused medical command and control to promote unity of purpose of all engaged medical assets. Medical information management to document health threat exposures and medical encounters, to report health surveillance data and information on the health of the command, and to accomplish medical regulating and patient tracking operations. Traditional medical support to a deployed force engaged in performing these tasks. Medical expertise and consultation to enhance building partnership capacity in public, private, and military health sectors of the host nation. Development of regional theater security cooperation plans aimed at mitigating or resolving the underlying causes of health issues prevalent within the region.

DEFENSE SUPPORT OF CIVIL AUTHORITIES

4-29. Defense support of civil authorities is support provided by U.S. Federal military forces, DOD civilians, DOD contract personnel, DOD component assets, and National Guard forces (when the Secretary of Defense, in coordination with the Governors of the affected States, elects and requests to use those forces in Title 32, United States Code, status). This support is in response to requests for assistance from civil authorities for domestic emergencies, law enforcement support, and other domestic activities, or from qualifying entities for special events. Defense support of civil authorities is a task that takes place only in the homeland, although some of its tasks are similar to stability tasks. Table 4-5 identifies defense support of civil authorities, tasks, purposes, and key medical considerations. For additional information on these types of tasks, refer to ADP 3-28.

Table 4-5. Defense support of civil authorities tasks, purposes, and key medical considerations

Defense support of civil authorities task	*Purposes*	*Key medical considerations*
Provide support for domestic disasters. Provide support for domestic chemical, biological, radiological, and nuclear incidents. Provide support for domestic civilian law enforcement agencies. Provide other designated support.	Save lives. Restore essential services. Maintain or restore law and order. Protect infrastructure and property. Maintain or restore local government. Shape the environment for interagency success.	Coordinate, integrate, and synchronize Army Health System resources into the interagency efforts. Further, providing medical expertise to identify and analyze critical needs emerging within the operational area. Medical information management to facilitate medical regulating of victims to facilities outside of the disaster/incident site and to document medical treatment. Assist affected medical infrastructure in saving lives, reducing long-term disability, and alleviating human suffering. Assist the local government in conducting rescue operations and providing medical evacuation of victims to facilities capable of providing the required care. Preventive measures to respond to and resolve emerging health threats caused by the disaster/incident.

4-30. Army Health System support to defense support of civil authorities tasks will include both AHS operational and the institutional AHS forces. The U.S. Army Medical Command retains command and control and provides both medical forces and medical capabilities in support of defense support of civil authorities tasks. As the Military Health System integrated combat support agency, the Defense Health Agency (DHA) enables the Services in providing this support.

SECTION III — SETTING THE THEATER, THEATER OPENING, EARLY ENTRY, AND EXPEDITIONARY MEDICAL OPERATIONS

4-31. As the theater medical command, the MEDCOM (DS) maintains a regional focus that encompasses the GCC's entire AOR and is critical for the successful provision of AHS support to set the theater. The medical commander's ability to assess host-nation medical capability/capacity and the presence of health threats prevalent in the AOR, facilitates the planning and execution of regional strategies for establishment of the theater joint trauma system and mitigation of identified threats.

4-32. The MEDCOM (DS) provides the GCC an effective tool to assist in maximizing the use of scarce medical resources, shaping the security environment by building partner medical capacity, and alleviating health conditions that not only impact U.S. military forces, but multinational partners and particular challenges faced by the host nation. Efforts must also be made to understand the roles and responsibilities of all agencies involved (to include the Department of State, World Health Organization, partner nations, and others) for integration and synchronization of all medical capabilities in the region.

4-33. The MEDCOM (DS) also provides AHS support to set the theater through coordination, integration, and synchronization of strategic medical capabilities from the U.S. sustaining base, global health engagements, establishment and maintenance of medical support agreements, deploying medical technical expertise for consultation services and other support, military medical training exercises, as well as the following:

- Executing AHS support to other Services when directed.
- Ensuring adherence to eligibility criteria for treatment in U.S. military MTFs.
- Recommending theater evacuation policy adjustments.
- Providing theater food protection support.
- Coordinating with USTRANSCOM for patient movement plans.
- Coordinating with the theater signal command to support command and control and medical information system capabilities.
- Establishing medical logistics capabilities necessary to support health services during early entry operations and ensure theater MEDLOG operations are connected to strategic enablers.
- Ensuring integration and interoperability of theater medical capabilities.
- Providing AHS support to foreign humanitarian assistance and disaster relief.
- Conducting medical preparation of the OE.
- Maximizing use of host-nation medical capabilities.
- Establishing and executing OEH surveillance programs and countermeasures.
- Coordinating with the National Center for Medical Intelligence, Centers for Disease Control and Prevention, and other strategic partners for identification and mitigation of regional health threats.
- Planning and coordination for AHS support to—
  - Noncombatant evacuation operations.
  - Detainee operations.
  - Reception, staging, onward movement and integration and theater opening.
  - Large-scale casualty events and prolonged care.
  - Other Services.

5-34. Theater opening, early entry, and expeditionary medical operations require the AHS planner to develop flexible, agile, and comprehensive plans to provide effective and efficient AHS support in an austere environment. Many of the AHS forces deployed will be the organic medical assets of the maneuver forces

conducting the operation; however, the MEDCOM (DS) (or other senior medical command in its absence such as the MEDBDE [SPT]), as the theater medical command will deploy sufficient medical resources to provide the required support.

4-35. Table 4-6 (page 4-13) provides an example of the types of AHS activities which may be conducted in these types of operations.

THEATER OPENING AND EARLY ENTRY OPERATIONS

4-36. Theater opening operations involve two types of AHS forces: those organic to the maneuver force and those AHS organizations deployed to establish the initial medical infrastructure within the AOR and to support theater opening forces during reception, staging, onward movement, and integration.

4-37. The organic medical resources of the maneuver units provide Roles 1 and 2 AHS support to their parent organizations. While these organizations are at the port of debarkation/embarkation, operational assembly areas, or other in-transit locations, AHS support is provided on an area support basis by the AHS organizations supporting port operations. Army Health System units accompanying the intransit force normally do not unload and setup their medical equipment and supplies, but rather rely on area support to accomplish their immediate AHS support mission.

4-38. The focus of AHS support to theater opening operations is to establish a medical infrastructure which facilitates the smooth transition of incoming AHS assets, provides real-time HSS and FHP data (medical and OEH surveillance), health risk communications, subsistence inspection programs, and integrates medical materiel (supplies, blood, and equipment) requisition, distribution, and maintenance.

4-39. Intertheater USAF AE during theater opening operations may be delayed during initial entry with patients being held in the operational area for evacuation out of theater on airframes of opportunity. Evacuation at Roles 1 and 2 will be accomplished by organic air and ground evacuation assets. Forward resuscitative surgery assets will be critical to stabilize nontransportable patients.

EXPEDITIONARY MEDICAL OPERATIONS

4-40. Expeditionary operations are operations that are inherently joint and require strategic reach. During crisis response, joint force commanders rely on contingency expeditionary forces to respond promptly. The Army provides ready forces able to operate in any environment- from urban areas to remote, rural regions. Health service support/FHP planning during expeditionary medical operations must remain flexible and coordinated, but it must also be adaptable to unique support arrangements (Table 4-6, page 4-13) which capitalize on the strengths of all units employed in the operational area.

4-41. Army Medicine personnel with an expeditionary and joint mindset have the confidence, skills, and knowledge to adapt and overcome unique medical challenges in providing a seamless continuum of care to our deployed forces. During expeditionary medical operations, units may be required to accomplish missions or coordinate support which they traditionally have not been required to accomplish. For example, the ability to project surgical resources into austere locations and the extended distances required to affect MEDEVAC may necessitate Role 2 MTFs and FSTs or FRSDs to coordinate directly with USAF aeromedical liaison teams and the supporting Theater Patient Movement Requirements Center for patient movement.

4-42. The array of AHS units in the current force was designed under three force design initiatives, Medical Force 2000, Medical Reengineering Initiative, and the Modular Force. Capabilities in like units under the three initiatives may vary, but the medical leadership can maximize and capitalize on the strengths of the various force designs, while minimizing the weaknesses to ensure the operational commander is provided the most effective and efficient AHS support.

Table 4-6. Example of Army Health System activities which may be conducted in theater opening and expeditionary medical operations

Early Entry Modules	***Theater-Level Capabilities***
Operational command post, medical command (deployment support), medical logistics management center team, medical logistics company (-), Roles 1 and 2 medical care, forward surgical team, combat support hospital (-), casualty prevention (operational public health, combat and operational stress control, and veterinary services), and medical evacuation.	Medical command (deployment support)/medical brigade, medical logistics management center team, medical logistics company, medical detachment (blood support) (-), Roles 1 and 2 medical care, operational dental support, forward surgical team, combat support hospital, casualty prevention (operational public health, combat and operational stress control, and veterinary services), medical evacuation (ground and air), and area medical laboratory services.
Theater Opening	***Expeditionary***
Army Health System support during reception, staging, onward movement, and integration. Provide Roles 1 and 2 medical treatment on an area support basis for units without organic medical resources and/or units entering theater and deploying to other areas within an operational environment. Medical evacuation and/or casualty evacuation from point of injury to medical treatment facility based on availability of medical evacuation platforms. Intra/Intertheater patient movement (between medical treatment facilities). Provide forward resuscitative surgery to stabilize nontransportable patients for evacuation out of theater. Emergency movement of Class VIII (to include blood), medical personnel, and medical equipment. Coordinate medical evacuation plan with the combat aviation brigade for air ambulance support. Coordinate with United States Air Force for strategic aeromedical evacuation and medical regulating. Manage patient movement items. Conduct medical and OEH surveillance. Conduct health risk assessment and communications. Provide Roles 1 and 2 veterinary treatment on an area support basis for military working dogs. Conduct subsistence inspections to ensure quality assurance, food safety, and food defense.	Force rotation (reception, staging, onward movement, and integration). Roles 1 and 2 medical treatment on an area basis. Provide forward resuscitative surgery to stabilize nontransportable patients for evacuation out of theater. Medical and/or casualty evacuation from point of injury to medical treatment facility based on availability of medical evacuation platforms. Patient evacuation (between medical treatment facilities). Sustainment of Army Health System support operations (possible nontraditional sources of support from other Services, multinational forces, or host nation without habitual support relationships). Primary care. Tactical combat casualty care. Medical specialty care. Increased emphasis on liaison and coordination with nontraditional sources. Training prior to deployment as there is decreased time for in-country training. Adjustment of distribution channels may be required depending on source of support. Unit reconstitution may be accomplished using modular teams. Manage patient movement items. Care for detainees (increased requirements for operational public health support, primary care, care of chronic diseases/conditions). Casualty prevention measures to include medical and OEH surveillance. Veterinary support for the inspection of subsistence and the treatment of military working dogs. Coordination with United States Air Force for strategic aeromedical evacuation and medical regulating.

4-43. One of the keys to success in expeditionary medical operations is to ensure that support relationships are clearly defined in the OPLAN and OPORD. The medical commander must be cognizant of the various types of support relationships defined in ADP 5-0 to facilitate the seamless provision of health care. Another

key to the successful accomplishment of the AHS mission is the synchronization of health care activities through medical command and control and the technical supervision of ongoing clinical operations. Medical command and control provides a conduit to obtain reachback medical technical support during early entry and expeditionary operations conducted in austere environments prior to deployment of some medical specialty care assets.

SECTION IV — SUPPORT TO DETAINEE OPERATIONS

4-44. It is DOD policy that the U.S. military Services shall comply with the principles, spirit, and intent of the international law of war, both customary and codified, to include the Geneva Conventions. As such, captured or detained personnel will be accorded an appropriate legal status under international law and conventions. Personnel in U.S. custody will receive medical care consistent with the standard of medical care that applies for U.S. military personnel in the same geographic area. See DODD 2310.01E, DODD 2311.01, DODI 2310.08E, JP 3-63, JP 4-02, AR 40-400, AR 190-8, and FM 6-27/MCTP 11-10C.

4-45. The focus of AHS support to detainee operations is depicted in Table 4-7.

Table 4-7. Focus of Army Health System support to detainee operations

Medical activity	*Detainee collection point*	*Detainee holding area*	*Theater detention facility*	*Remarks*
Triage	Yes	Yes	Yes	
Tactical combat casualty care	Yes	Yes	Yes	
Screening	Yes[1]	Yes[1]	Yes	Monthly weigh-in. Nutrition status. Vision.
Medications	Yes[2]	Yes[2]	Yes[3]	If approved by medical personnel, detainees may retain emergency medicines such as fast acting inhalers or cardiac medicines.
Routine sick call	Yes[1]	Yes[1]	Yes	
personnel protective measures	Yes	Yes	Yes	Emphasis is on field hygiene and sanitation, disposal of waste, and personal hygiene practices.
Medical evacuation	Yes[3]	Yes[3]	Yes[3]	Nonmedical guards are required.
Hospitalization	No	No	Yes	Hospitalization is not available at collecting points or holding areas. Detainees requiring hospitalization are medically evacuated.
Medical specialty care	No	No	Yes	Augmentation of treatment assets may be required.

1 Dependent upon length of stay.

2 Detainees may not have medications on their person. Any medications the detainee has when detained are collected, tagged, and identified and provided to medical personnel. Medications are dispensed by medical personnel.

3 Detainees whose medical condition is such that they must be moved to a medical treatment facility for medical care will be evacuated through medical channels. The echelon commander must provide guards for all detainees evacuated through medical channels.

MEDICAL PERSONNEL ORGANIC TO MANEUVER UNITS

4-46. Medical personnel organic to maneuver units may be required to provide TCCC, area medical support, and MEDEVAC at the point of contact/injury and to temporary concentrations of detainees at detainee collection points and detainee holding areas. In early-entry operations, the senior medical officer (brigade surgeon) serves as the detainee operations medical director until follow-on forces are deployed and a detainee operations medical director is designated for the AO.

4-47. The medical resources required to support detainee operations are task-organized based on mission, enemy, terrain and weather, troops and support available, time available, and civil considerations. The detainee operations medical director determines the medical support requirements and develops and provides technical guidance for all medical resources engaged in detainee medical operations. This guidance is directed to appropriate medical personnel through their technical channels.

4-48. The detainee operations medical director is normally designated by the MEDCOM (DS) commander to develop and provide technical guidance on the medical aspects of detainee operations conducted throughout the operational area. Technical guidance is exercised throughout all echelons of medical channels and affects all medical personnel and units delivering health care to detainee populations. Technical guidance encompasses—

- All medical services provided at detainee collection points and detainee holding areas, to include limited medical screening, TCCC, personnel protective measures (hygiene and sanitation), and MEDEVAC of seriously injured or ill detainees. The echelon commander must provide guards and/or escorts when detainees are evacuated through medical channels; medical personnel cannot perform guard functions.
- All medical services provided in the detention facility, to include:
  - Initial medical examinations.
  - Medical treatment (routine care, sick call, emergency services, hospitalization, medical consultation, and specialty care requirements).
  - Medical evacuation.
  - Operational public health (such as medical surveillance, OEH surveillance, hygiene and sanitation standards and practices, pest management activities, and inspection of water portability, dining facility and services hygiene, and food preparation practices).
  - Dental services.
  - Veterinary support (food inspection and quality assurance, veterinary public health, and animal medical care).
  - Behavioral health care.
  - Neuropsychiatric treatment and stress prevention, as required.
  - Medical logistics (such as medical supplies, pharmaceuticals, medical equipment and medical equipment maintenance and repair, blood management, and optical lens fabrication).
  - Medical laboratory support.
- All medical services provided in U.S. military MTFs which are not part of established detention facilities. This can include TCCC by combat medics and provided at battalion aid stations and Role 2 MTFs (medical companies) and forward resuscitative surgery provided by FSTs or FRSDs to stabilize the patient for further evacuation and hospitalization. *Resuscitative care* is tactical combat casualty care and surgery limited to the minimum required to stabilize a patient for transportation to a higher role of care while forward resuscitative surgery refers to urgent initial surgery required to render a patient transportable for further evacuation to a MTF staffed and equipped to provide for the patient's care.
- All medical administrative matters such as the establishment and maintenance of medical records, documentation of preexisting injuries (to include medical photography, if deemed appropriate), restrictions on activities based on medical conditions (similar to medical profiles), and documentation required for legal purposes (such as monthly height and weight records).

Note. All documentation pertaining to detainees must be identified with either the capture tag number or the detainee's internment serial number.

- Procedural guides and SOPs that are developed and disseminated for reporting suspected detainee abuse. Medical personnel are trained on procedures to identify injuries resulting from abuse and the ethical considerations of treating personnel with suspected abuse.
- Procedural guides and SOPs that are developed to standardize the credentialing of health care providers, to define the scope of practice of medical personnel, and to establish the scope of practice for retained medical personnel.
- Standards of medical care throughout detention facilities within the AO that are established, inspected, and enforced (the standards used are the same as those for United States Armed Forces).
- Procedures that are established and disseminated for identifying, reporting, and resolving medical ethics and other legal issues.
- Procedures that are established for ensuring medical proficiencies and competencies, identifying deficiencies, and providing required training to resolve deficiencies.
- Programs of instruction that are developed to ensure that all medical personnel engaged in detainee health care have appropriate orientation and training in the detainee's culture, language (and/or linguist support), social order, and religion.

MEDICAL PERSONNEL ORGANIC TO MILITARY POLICE UNITS

4-49. The military police detention battalion has organic medical personnel to provide a limited Role 1 medical care capability and operational public health services within the detention facility. When a detainee operations medical director has been designated within the AO, these medical personnel are under the technical guidance of the detainee operations medical director.

4-50. The medical personnel assigned to the military police detention battalion assist with in processing detainees by providing the initial medical examination. They provide routine sick call services and TCCC and coordinate with the supporting AHS units for Role 2 and above care. They maintain medical records, to include DA Form 2664-R (*Weight Register*). When the supporting AHS unit is collocated with the detention facility, the unit's scope of practice, schedule, and duty assignments are coordinated through the supporting AHS unit.

ARMY HEALTH SYSTEM UNITS IN SUPPORT OF DETAINEE OPERATIONS

4-51. The MEDCOM (DS) theater medical command and is the senior AHS medical command and control organization within the AOR. The MEDCOM (DS) is responsible for ensuring that the medical care provided to detainees and other personnel in U.S. custody is provided in compliance with international and U.S. law and military policies and regulatory guidance. The MEDCOM (DS) plans for and coordinates support for detention facilities located within CCDR's AOR. The MEDBDE (SPT) coordinates medical issues related to detainee operations being conducted by subordinate units with the MEDCOM (DS) detainee operations medical director.

4-52. The MEDCOM (DS) commander or the commander's designee (normally the deputy commander, professional services) serves as the detainee operations medical director and provides oversight, guidance, and policy on medical ethics issues, standards and availability of care, requirements for field hygiene and sanitation, nutrition and maintenance of weigh-in registers, and all other medical aspects of confinement health care.

4-53. The MEDBDE (SPT) coordinates medical issues related to detainee operations being conducted by subordinate units with the MEDCOM (DS) detainee operations medical director.

PART TWO

Force Health Protection

The mission sets of the Army Medicine (which historically had been shown under the combat service support battlefield operating system) are under two warfighting functions- the protection and sustainment warfighting functions. This change more closely aligned the Army Medicine mission sets with the overall warfighting functions of the Army. The FHP mission is discussed in Part Two of this publication, while the HSS mission is discussed in Part Three. Although Parts Two and Three discuss the mission sets as separate entities, the medical personnel and staffs that plan, coordinate, and synchronize these operations are responsible for the execution of both mission sets. These interrelated and interdependent medical functions are complex in nature and require medical command and control for synchronization and integration. This ensures the interrelationships and interoperability of all medical assets and optimizes the effective functioning of the entire AHS system.

Force Health Protection is a continuous process that begins with the Soldier's entry into the military and is continuous throughout the Soldier's military career. Force health protection includes establishing and sustaining a healthy and fit force, health promotion and nutrition programs, the identification of the health threat in all settings (in both deployed and garrison settings), the development and implementation of personnel protective measures to reduce exposure to health hazards and mitigating the adverse effects of the impact of health threats to military personnel.

Force health protection **are measures that promote, improve, or conserve the behavioral and physical well-being of Soldiers comprised of preventive and treatment aspects of medical functions that include: combat and operational stress control, dental services, veterinary services, operational public health, and laboratory services. Enabling a healthy and fit force, prevent injury and illness, and protect the force from health hazards.** Although nutrition plays a significant role in maintaining a healthy and fit force, nutrition is discussed as an integral part of the hospitalization function under the HSS mission.

Chapter 5

Operational Public Health

Public Health is the science and practice of promoting, protecting, improving, and, when necessary, restoring the health of individuals, specified groups, or the entire population. As applied in the operational setting it is the preservation, maintenance, and restoration of health in Army populations through the anticipation, prediction, identification, surveillance, evaluation, prevention, and control of DNBI. (AR 40-5) Public Health encompasses a wide range of capabilities, organizations, and professional disciplines operating in a systematic manner to effectively execute the 10

Essential Public Health Services. It is a major enabler for Army readiness and a major component of force health protection in its application throughout all Army activities. Levels of readiness and health in all Army populations are enhanced and sustained by applying the principles of public health to promote healthy behaviors and to prevent and minimize the impacts of diseases and injuries. According to the recent published AR 40-5 (May 2020), field preventive medicine is no longer a valid term. The term *operational public health* is now the term to describe the application of Public Health practices and conduct of Public Health-related activities within a geographic area where military operations are conducted by TOE units (AR 40-5). Examples of military operations include training and exercises conducted in field environments or locations outside of a permanent U.S. military installation, humanitarian support, contingency operations, and combat or stability operations. When emphasized by commanders and unit leaders, operational public health can effectively reduce and prevent DNBI and maximize the fighting strength of the force. For more information regarding Public Health Program and operational public health, refer to AR 40-5.

MISSION

5-1. The FHP mission set is a continuous process that begins with the entry of the Soldier into the military and is continuous throughout the Soldier's military career. Force health protection includes those measures designed to promote, improve, or conserve the behavioral and physical well-being of Army personnel across the full range of military activities and operations. The successful employment of FHP activities enables a healthy and fit force, prevents injury and illness, and protects the force from health hazards.

PROTECTION WARFIGHTING FUNCTION

5-2. Operational public health falls under the protection warfighting function and is concerned with both the enemy threat and the health threat. The enemy threat produces operational casualties. It depends on the types of weapons used, the will of the enemy to fight, and other operational concerns. The health threat consists of diseases, OEH hazards, poisonous or toxic flora and fauna, medical effects of weapons, and physiological and psychological stressors. To counter the health threat and sustain health readiness, the following garrison-based public health activities must be considered in an operational setting: health surveillance, OEH surveillance and OEH risk management, disease vectors and pest management, food protection, water management, waste management, operational hearing services, health promotion, and heat, cold, and altitude (climatic injury prevention).

5-3. The success of operational public health requires deliberate and consistent analysis and communication of health threats to inform individuals, and the implementation and enforcement of unit and individual countermeasures (for example, exposure controls, chemoprophylaxis, and immunizations) required to reduce associated health risks. Commanders and unit leaders must remain informed and proactively engaged to ensure the health of the Force; reduce health threats, stressors, and risks; and promote all available countermeasures.

ORGANIZATIONS AND PERSONNEL

5-4. Operational public health support is provided by preventive medicine units and staff officers. Preventive medicine detachments and teams provide operational public health support and consultation in the areas of health surveillance (inclusive of medical and DNBI surveillance), OEH surveillance (inclusive of OEH risk management and site assessments), disease vectors and pest management, water management, food protection, waste management, operational hearing services, and field hygiene and sanitation (inclusive of climatic injury prevention). Echelons above brigade staff support consists of preventive medicine staff officers organic to the MEDCOM (DS), MEDBDE (SPT), and MMB. These staff officers serve as the commander's principal public health consultants and environmental sciences and engineer advisors.

PRIMARY TASKS

5-5. Table 5-1 discusses the primary tasks and purposes of the operational public health function. See AR 40-5 and DA PAM 40-11, ATP 4-02.5, and ATP 4-02.8 for more information on Army public health.

Table 5-1. Primary tasks and purposes of the operational public health function

Primary task	*Purposes*
Conduct Health Surveillance and Epidemiology	- Collect, analyze, and interpret health-related data effectively on the health status of Army personnel throughout their time in service. - Identify populations at risk of disease, injury, behavioral, or social health conditions and the associated risk and protective factors.
Conduct Occupational Health	- Prevent injury and illness by identifying and evaluating occupational health hazards and preventing or limiting those exposures. - Optimize protection and readiness of Army personnel in all environments and protect the health of populations exposed to occupational hazards. - Provide occupational illness and injury prevention and mitigation.
Monitor environmental health	- Prevent injury and illness by identifying and evaluating environmental health hazards and limiting exposures. - Optimize Soldier protection and readiness in all environments and protect the health of personnel and other relevant populations exposed to environmental hazards. - Ensure compliance with environmental health standards.
Provide occupational and environmental medicine	- Provide consultative support, when requested, for— • health surveillance and epidemiology services • non-clinical occupational health services • environmental health services - Respond to accidental, intentional, and unintentional exposures to Army personnel.
Conduct operational public health	- Ensure healthy and ready forces, sustain health readiness, and provide technical consultation support on public health issues. - Identify and articulate force health protection recommendations, and direct, lead, and assess operational public health activities. - Establish baseline health conditions, capture data on occupational and environment health exposures, prescribe chemoprophylaxis as necessary, train field sanitation teams, and provide general Public Health support and consultation for unit leaders.
Conduct Health Risk Assessment	- Enable risk management in order to optimize Soldier protection. - Estimate risks posed by identified health hazards exposure.
Provide clinical public health	- Deliver preventive medicine services to promote protective factors and mitigate risk factors for disease and disability. - Provide consultation to other healthcare providers and decision makers on medical, behavioral, and environmental conditions of public health significance. - Provide services necessary for the prevention and control of communicable diseases.
Provide community-based prevention and health promotion	- Improve health readiness across the force. - Empower individuals and communities to engage in healthy behaviors. - Provide health promotion initiatives focused on the Performance Triad.

Table 5-1. Primary tasks and purposes of the operational public health functions (continue)

Primary tasks	*Purposes*
Perform public health toxicology	- Support Army medicine and acquisition, research, and development programs. - Provide toxicological assessments of all new and potentially hazardous materials.
Perform public health laboratory services	- Provide analytical services in support of Army personnel health readiness. - Participate in appropriate laboratory networks. - Provide specialized clinical testing's; radiochemistry and laboratory support for health physics; and analysis of diseases of military Public Health significance.
Deliver public health communication	- Enable the overall Army Public Health Program and supports services to inform, educate, and empower people about health issues.
Provide public health emergency management	- Provide synchronization ensuring seamless coordination between the installation and the local public health community during a public health emergency. - Ascertain the existence of cases suggesting a public health emergency and recommend implementation of control measures (to include declaration of a public health emergency) to the senior commander.

Chapter 6
Veterinary Services

The veterinary mission is to execute veterinary service support essential for FHP including maintaining the health and welfare for military working animals and other animals entitled to veterinary care by the United States Army; food protection and veterinary public health missions; and to train, equip, and deploy the veterinary force; in order to project and sustain a healthy and medically protected force and promote the health of the Service member.

SECTION I — VETERINARY RESPONSIBILITIES

6-1. The United States Army Veterinary Services under the direction of the Secretary of the Army and delegated to the United States Army Surgeon General, is the sole provider for veterinary services and retains responsibility to provide veterinary personnel for operational and tactical support to all DOD components.

6-2. According to DODD 6400.04E, the United States Army Surgeon General has also been delegated to act on behalf of the DOD EA for the DOD Veterinary Public and Animal Health Services to—

- Develop, support, and evaluate food protection measures (food safety and food defense) to ensure food ingredients and food products are safe, wholesome, meet quality standards, and are free from unintentional or intentional contamination and adulteration.
- Collaborate with the Military Services' public health and preventive medicine authorities to develop policies.
- Develop military sanitary standards for commercial food (including bottled water) plants providing products to the DOD Components.
- Maintain and publish approved lists of food suppliers used by all DOD Components.
- Maintain laboratories or contract the capability for laboratory examinations (organic or purchased) for wholesomeness and quality of food products and diagnosis of animal diseases.
- Inspect food products and provide food protection programs at all food procurement, operational ration assembly facilities, and subsistence and war reserve stocks storage facilities under the control of the Defense Logistics Agency.
- Inspect troop support food products on all installations under the control of the Departments of the Army and Navy.
- Provide food inspection and food protection and, in collaboration with Army and Navy Surgeons' General preventive medicine or public health authorities, provide food service sanitation programs at all Defense Commissary Agency and Exchange Service retail convenience stores (for example, shoppettes and mini-marts) associated with the Departments of the Army and Navy.
- In coordination with the Military Services' public health and preventive medicine authorities, develop and maintain the tri-Service Food Code used by all DOD Components.
- Coordinate with the Secretaries of the Navy and Air Force at joint bases to delineate Service responsibilities for installation food service sanitation and food protection programs.
- Provide clinical and regulatory veterinary services, through appropriated and nonappropriated funds.
- Operate facilities and establish equipment standards for and monitor standard of care at installation veterinary facilities.
- Operate the Veterinary Services Central Funds Supplemental Mission Nonappropriated Fund Instrumentality.

- Provide veterinary public health guidance, consultation, and clinical support regarding zoonotic diseases, including veterinarian participation in installation and command rabies advisory teams or boards, and in conducting the animal rabies control program.
- Advocate for and provide consultation for animal welfare on DOD installations.
- Provide advocacy, veterinary consultation, and support for DOD Human-Animal Bond Programs, DOD animal-assisted activity/therapy programs, and service/assistance animals owned by authorized beneficiaries.
- Provide veterinary coordination, manning, and support to plan and conduct agricultural, veterinary public health, and animal health activities across the competition continuum (DOD Stabilization; Defense Support to Civil Authorities; Global Health strategic goals to include cooperative threat reduction activities to counter weapons of mass destruction through Global Health Security Agenda initiatives and global health engagement). Refer to DODD 3000.05, DODD 3025.18, DODD 2060.02, and DODI 2000.30 for more information.
- Train and equip Army veterinary service personnel, including veterinarians and veterinary food safety officers with relevant specialty training, to enable food protection, animal health and welfare, veterinary public health, and, when required by the DOD Components, for research, development, test, and evaluation and training.
- Conduct Food and Water Risk Assessments on hotels, restaurants, caterers, host nation military dining facilities, and other food facilities being evaluated as a source of food or water for United States Forces.
- Identify requirements for veterinary services information systems.

6-3. The Secretary of the Air Force provides the food inspection program at Air Force bases and may develop locally approved lists of food suppliers from which food products are procured only for individual Air Force installations.

6-4. Appropriate veterinary units provide this support. These units can be task-organized to support food protection, food protection (food safety and food defense), quality assurance, and/or the medical care mission for military and contract working dogs, and other government-owned animals. The food protection mission includes food safety, food defense, and quality assurance inspection and surveillance activities associated with food sources, distribution, warehousing, bulk storage, food quality, food vulnerability, and food and water risk assessment. The United States Army Veterinary Service is responsible for publishing a directory of approved food sources for the AO. Veterinary public health reduces transmission of zoonotic diseases; monitors, assesses, and mitigates endemic animal disease threats to working animals and CONUS agricultural systems; monitors animals as sentinels of threats to humans or other animals by investigating unexplained animal deaths. It is an effective combat multiplier through monitoring endemic animal disease threats of military significance and zoonotic disease threats to Service members. The animal medical care mission provides comprehensive medical and surgical care for MWDs, other government-owned animals, contract working dogs, and other animals authorized care in the AO. The potential of foodborne disease, the threat of CBRN contamination of subsistence, the need to assess and mitigate the zoonotic and endemic animal disease threat, and the need to provide animal medical care to working dogs requires a veterinary presence throughout the entire operational area. Comprehensive veterinary medical and surgical programs are required to provide casualty care for and maintain the health of military and contract working dogs in order to optimize their detection and patrol capabilities to protect the Service members. Refer to Table 6-1 for primary tasks and purposes of veterinary services.

Table 6-1. Primary tasks and purposes of veterinary services

Primary task	*Purpose*
Provide animal medical care	− Provide veterinary medical care for military and contract working dogs and other government owned animals.
Conduct food protection activities	− Ensure quality, food safety, food defense of food sources and storage areas to ensure wholesome food supply for deployed forces.
Execute veterinary public health activities	− Reduce transmission of zoonotic disease threats to deployed forces and mitigate the impact of animal diseases of operational importance to working animals or continental U.S. agricultural systems.

SECTION II — FOOD PROTECTION MISSION

6-5. The food protection mission ensures quality, food safety, and food defense of food sources and food storage areas for deployed sources to minimize foodborne illness threats. It encompasses all services performed to include:

- Conducting food protection sanitation audits of commercial food establishments, including storage facilities for DOD procurement.
- Conducting military sanitary inspections at all food establishments on military installations.
- Conducting contingency CBRN surveillance of potentially contaminated subsistence, as directed/required and providing guidance on the disposition of CBRN-contaminated subsistence.
- Providing CBRN decontamination instructions for subsistence.
- Conducting surveillance and receipt inspections of operational rations and other government-owned subsistence intended for consumption or use by DOD personnel.
- Providing basic food microbiological and chemical surveillance of the military food supply (to include performing rapid, presumptive laboratory testing [screening and surveillance] for microbial contaminants, pesticides and toxins, and field confirmatory testing for microbial contaminants in the food supply).
- Providing assessment and guidance on temperature-abused foods.
- Conducting routine inspections of government food storage facilities.
- Participating in foreign humanitarian assistance and other stability tasks as directed.
- Providing food surveillance inspections of dining facilities for security and storage of food products.
- Assisting in foodborne illness investigations.
- Conducting food and water risk assessments.

SECTION III — ANIMAL CARE MISSION

6-6. The animal care mission provides comprehensive medical and surgical care for MWDs and for government-owned animals to optimize performance and protect Service members from enemy threats. It provides preventive and casualty care as authorized for other animals eligible for United States Army-provided veterinary care. The animal care mission is discussed in a similar fashion as are the roles of medical care used to describe the successive and increasing capabilities to provide care to our injured and wounded Service members. The major difference is there are no veterinary assets in the BCT. The majority of veterinary assets in the operational area are assigned to EAB veterinary units and must be projected forward to provide care in the brigade area.

Note. Non-veterinary health care providers should only perform medical or surgical procedures consistent with their medical training and necessary to manage problems for working animals that immediately threaten life, limb, or eyesight, and to prepare the working dog for evacuation to a facility that has a veterinary provider. Non-veterinary health care providers should refer to the Joint Trauma System clinical practice guidelines for MWDs (http://jts.amedd.army.mil/index.cfm/PI_CPGs/cpgs) and consult with their local military veterinary providers.

6-7. Veterinary treatment in a deployed environment consists of veterinary Roles 1 through 3 veterinary treatment support. Treatment is provided by supporting Medical Detachments (Veterinary Service Support) on an area support basis. No organic veterinary personnel are located in the BCT.

6-8. Table 6-2 on page 6-4 discusses the primary tasks and purposes of veterinary services treatment.

Table 6-2. Primary tasks and purposes of veterinary services treatment

Primary task	*Purpose*
Provide preventive care	Maintenance of health to optimize working dog detection and patrol capability to detect threats to Service members.
Conduct sick call	Treatment of routine DNBI and noncombat related emergencies as close to the working dog's unit as possible to minimize lost working days.
Perform K9 tactical combat casualty care	Provision of lifesaving stabilization and care as close to the working dog's point of injury as possible to maximize survival rates.
Perform resuscitation and emergency surgical stabilization	Provision of resuscitative surgical care on an area support basis to maximize survival rates.
Provide hospitalization services	Provision of short-term hospitalization capability (not to exceed 72 hours) for military and contract working dogs requiring direct veterinary care to reduce medical evacuation and maximize return to duty rates.
Support medical evacuation	In order to maximize survival rates of working dogs during medical evacuation to higher roles of care, veterinary personnel may be required to augment standard medical personnel and be allowed access to working dog patients en route.

VETERINARY ROLE 1 MEDICAL CARE

6-9. This role of veterinary medical care is provided by the animal's handler and the animal care specialist.

ANIMAL HANDLER

6-10. Non-veterinary personnel, such as MWD, equestrian, livestock, and/or USN marine mammal handlers perform limited lifesaving and first aid procedures until an animal care specialist or a veterinarian is available. This paragraph details handler-provided capabilities for MWDs since they are most likely to be encountered within the AHS. Qualified MWD handlers from all Services provide emergency medical care to their dogs in three specific areas of concentration: K9TCCC, noncombat emergency care, and preventive medical care. Tasks reflect current practices based on experience with MWDs injured in combat operations. Tasks reflect the most current scope of practice for medical care of MWDs by handlers, and focus on tasks that are most critical to preservation of life, limb, and eyesight of working dogs. Handlers are trained to provide the most effective immediate care to prevent further injury, reduce effects of trauma and illness, and stabilize the patient while coordinating rapid evacuation. In conjunction with the tasks and training focus, each handler has a MWD Handler First Aid Set, which is compartmentalized to ensure the exact medical supplies needed to perform every task are available. Following appropriate emergency veterinary medical training provided by a veterinarian, a MWD handler has the following capabilities:

- Perform rapid evaluation of a MWD and application of a muzzle for safety.
- Provide immediate control of hemorrhage.
- Manage the airway (airway obstruction, tracheal intubation, surgical tracheostomy).
- Manage breathing (airway obstruction, open chest wound and tension/closed pneumothorax).
- Manage circulation via intravenous access and fluid resuscitation for shock.
- Prevent and manage hypothermia.
- Bandage open wounds including abdominal wounds.
- Manage heat trauma.
- Manage eye trauma or irritation.
- Provide analgesia.
- Initiate infection control (wound lavage, antibiotic therapy).
- Manage burn injuries or wound.
- Splint distal extremity fracture.

- Perform cardiopulmonary resuscitation.

ANIMAL CARE SPECIALIST

6-11. Animal care specialists are organic to Army engineer, Ranger, USN, and Medical Detachment (Veterinary Service Support) units. The animal care specialist supervises or provides the care, management, treatment, and sanitary conditions for animals, with a primary responsibility for the prevention and control of zoonotic diseases and comprehensive care for government-owned animals.

6-12. Animal Care Specialists can perform the same tasks as the Animal Handler plus the following capabilities:

- Calculating doses and administering oral and topical medications as directed by the veterinarian or established protocol approved by a veterinarian.
- Maintaining sanitary conditions for all components of the veterinary facility.
- Cleaning, debriding, and suturing superficial wounds.
- Collecting, preserving, and preparing postmortem specimens (including rabies suspect specimens) for shipment and evaluation at the appropriate laboratory.
- Coordinating and stabilizing MWDs, equids, and marine mammals for evacuation to veterinary field unit or treatment facility.
- Performing serial monitoring of vital signs and reporting patient's clinical status to the veterinarian.
- Collecting laboratory specimens (blood, urine, feces, skin scraping) and performing routine diagnostics (chemistry, complete blood count, urinalysis); handling and shipping of samples to diagnostic laboratories.
- Conducting minor sick call or emergency procedures under the indirect supervision of a veterinarian (such as teleconsultation or preauthorized protocol). Treatment may include restoring the airway by invasive procedures; use of intravenous fluids and medications; and applying splints, bandages, and tourniquets.
- Preventing and managing DNBI (such as heat/cold injuries, gastric dilatation volvulus [bloat], arthropod/reptile bites/stings, vomiting/diarrhea, and so forth).
- Performing humane euthanasia when instructed by veterinarian.
- Performing advanced lifesaving measures to include triage, tracheotomy, burn and poison management, venous cutdown, insertion of stomach tubes, gastric trocharization, establishing and maintaining the airway, controlling hemorrhage, performing first aid for hypovolemic shock, and splinting or immobilizing fractures.
- Inducing and maintaining general anesthesia (under the supervision of a veterinarian), operating mechanical ventilators, and monitoring anesthetized patient status.
- Taking radiographs and reviewing images for proper positioning.
- Initiating and maintaining patient medical records.

6-13. Veterinary Role 1 care is provided by the animal care handler, animal care specialist, and veterinarian assigned individually to various United States Army, United States Air Force, United States Marine Corps, or United States Navy field units or Veterinary Service Support Teams. Either the animal care specialist or veterinarian will respond to the emergency call of a MWD, equid, or USN marine mammal handler. Depending on the type of emergency, the animal care specialist or veterinarian will evaluate the traumatized or ill animal to provide stabilization with basic first aid equipment or medications so that the patient can withstand further evacuation to and treatment by either a forward-deployed veterinary Role 2 Veterinary Service Support Team, veterinary Role 3 Veterinary Medical and Surgical Team, or veterinary Role 4 care at an Army veterinary hospital. An animal handler can be instructed to perform basic emergency aid procedures and prepare the animal for transport/evacuation to a higher role of veterinary medical care in the event the animal care specialist or veterinarian cannot provide veterinary Role 1 care at the POI/illness.

Note. Injured or ill MWDs may be evacuated on any transportation means available. The using unit is responsible for the evacuation of the animal. Use of dedicated MEDEVAC assets (air or ground ambulances) is authorized based on mission priority and availability. When possible, the handler should accompany the animal during the evacuation. Using units should include the location of veterinary treatment facility/support units on mission request. Refer to ATP 4-02.2 for more information.

VETERINARY ROLE 2 MEDICAL CARE

6-14. Veterinary Role 2 medical care is provided by a forward-deployed Veterinary Service Support Team veterinarian and an animal care specialist from the Medical Detachment (Veterinary Service Support). This level of care includes veterinarian-directed resuscitation and stabilization and may include K9TCCC, emergency medical procedures, and forward emergency resuscitative surgery for military or contract working dogs, other government owned animals such as equids and USN marine mammals. A Veterinary Service Support Team provides veterinary Role 2 support for up to 50 military or contract working dogs. There are five Veterinary Service Support Teams in a Medical Detachment (Veterinary Service Support), which are geographically dispersed throughout the operational area.

6-15. Veterinary Role 2 medical care includes:

- Basic veterinary clinical laboratory- microscopic examination, complete blood count, blood chemistry, and urinalysis.
- Limited veterinary pharmacy.
- Limited temporary MWD holding facilities for basic medical disease treatment.
- Sick call.
- Routine preventive care.
- Nonemergent surgical care.
- Emergency medical and limited emergency surgical procedures.
- Ultrasound.
- Limited care for large animals under certain conditions of government interest for stability tasks and defense support of civil authorities tasks.
- Endemic zoonotic and foreign animal disease epidemiology surveillance and control by examination of local farm animals in the area, captured wildlife, and stray animals.

6-16. Veterinary patients are treated and returned to duty or are stabilized for transport/evacuation to a higher veterinary role of medical care. At veterinary Role 2 no organic patient holding capability is available.

Note. There are no kennels at veterinary Role 2. The MWD handler is expected to stay with his dog. Each MWD handler has a crate for his dog. Dogs can sleep or rest in their crate on the ground. The horse or USN marine mammal handler is also expected to stay with his animal.

VETERINARY ROLE 3 MEDICAL CARE

6-17. This role of veterinary medical care is provided by the Veterinary Medical and Surgical Team which consists of a clinical and surgical team designed to care for dogs only. No veterinary Role 3 capability is available in the operational area for horses or USN marine mammals. If veterinary Role 3 care is required, the horses, livestock, or USN marine mammals may be transported/evacuated back to CONUS.

6-18. Veterinary Role 3 medical care includes referral for veterinary diagnostic, therapeutic, and surgical procedures, and requires advanced clinical capabilities. At veterinary Role 3, capability exists to provide veterinary Role 1 and 2 care for up to 50 military or contract working dogs, and veterinary Role 3 care for a catchment population of up to 300 military or contract working dogs provided five Veterinary Service Support Teams are deployed in support to provide veterinary Role 1 and 2 care. There is one Veterinary Medical and Surgical Team per Medical Detachment (Veterinary Service Support).

6-19. Veterinary Role 3 medical care capabilities include:

- Patient case consultation and acceptance of referrals.
- Comprehensive canine veterinary medical/surgical care (such as orthopedic and extensive soft tissue surgeries).
- Extensive veterinary laboratory capabilities- complete blood count, chemistry, and urinalysis.
- Robust veterinary pharmacy.
- Diagnostic imaging (radiographs and ultrasound).
- Definitive and restorative MWD dental care to include endodontic procedures.
- Area of operations-wide patient tracking of MWD to include evacuation.
- Established operational area MWD evacuation policy and standards of care.
- Training for unit veterinarians and animal care specialist as well as institutional veterinary training programs, ranging from university hospitals to local veterinary technician training, for stability tasks.
- Development of the detachment's policies for care of government-owned animals.
- Treatment, return to duty, or hospitalization of military or contract working dogs for continued care or stabilization of MWDs for transport/evacuation to veterinary Role 4 medical care.

6-20. The Veterinary Medical and Surgical Team is staffed and equipped to hospitalize up to five military or contract working dogs.

VETERINARY ROLE 4 MEDICAL CARE

6-21. Veterinary Role 4 medical care is found in CONUS at the DOD Military Working Dog Veterinary Service and outside CONUS at the Veterinary Medical Center Europe. Veterinary Role 4 medical care expands the capabilities available at veterinary Roles 1 through 3 and provides additional specialized veterinary medical and surgical care, rehabilitative therapy, and convalescent capability.

SECTION IV — VETERINARY PUBLIC HEALTH

6-22. Veterinary public health includes preventing and mitigating the effects of foodborne disease; reducing the transmission of zoonotic diseases; monitoring, assessing, and mitigating endemic animal disease threats to working animals and CONUS agricultural systems; and monitoring animals as sentinels of threats to humans or other animals by investigating unexplained animal deaths. Using the U.S. Department of Agriculture's regulations or the regulations for other countries (depending on the equipment's final destination), veterinary services also assists with decontamination guidance for U.S.-owned equipment being retrograded to CONUS and other nations to prevent the transmission of animal diseases as well as advises the commander on foreign animal disease that may affect redeployment of military equipment back to the U.S. Specific services include:

- Support for prevention and control programs to protect Service members from foodborne diseases.
- Evaluation of zoonotic disease data collected in the AO and advice to preventive medicine elements, patient treatment elements, and higher headquarters on potential hazards to humans.
- Establishment of animal disease prevention and control programs to protect Service members and other DOD and multinational personnel from zoonotic diseases.
- Assessment of the presence of animal diseases that may impact the CONUS agriculture system if contaminated equipment or personnel are allowed to redeploy.
- Investigation of unexplained animal deaths to include livestock and wildlife to detect any threats to Service members, working animals, or U.S. agricultural systems.
- Establishment of animal disease prevention and control programs to protect military working animals from infectious diseases.
- Technical consultation for zoonotic disease and pest control programs such as rabies advisory boards and feral animal risk mitigation. For more information on feral animal risk mitigation, see Armed Forces Pest Management Board Technical Guide No. 3, Feral Animal Risk Mitigation in Operational Areas.

6-23. For more information on Veterinary Services, refer to AR 40-3, AR 40-5, DA PAM 40-11, AR 40-905, ATP 4-02.8, and ATP 4-02.7.

Chapter 7

Combat and Operational Stress Control

Combat and operational stress control has always been a commander's program. To be successful, commanders must fully understand and appreciate the magnitude of a potentially traumatic event as it affects exposed organizations and individuals. It is a harsh reality that combat and operational stress affects everyone engaged in unified land operations. It should be viewed as a continuum of possible outcomes that each person will experience with a range from positive growth behaviors to negative and sometimes disruptive reactions. Effective leadership shapes the experience that they and their Soldiers go through in an effort to successfully transition units and individuals, build resilience and promote posttraumatic growth, or increased functioning and positive change after enduring trauma. Combat and operational stress control does not take away the experiences faced while engaged in military operations, it attempts to mitigate those experiences so that Soldiers and units remain combat-effective and ultimately provide the support and meaning that will allow Soldiers to maintain the quality of life to which they are entitled.

SECTION I — COMBAT AND OPERATIONAL STRESS CONTROL RESPONSIBILITIES

7-1. Combat and operational stress control is a program developed and actions taken by military leadership to prevent, identify, and manage adverse combat and operational stress reactions in units. This medical function optimizes mission performance; conserves the fighting strength; and prevents or minimizes adverse effects of combat and operational stress reaction on Soldiers and their physical, psychological, intellectual, and social health. Its goal is to return Soldiers to duty expeditiously.

SECTION II — PROGRAM AND RESOURCES

7-2. According to DODD 6490.02E, COSC activities include routine screening of individuals when recruited; continued surveillance throughout military service, especially before, during, and after deployment; and continual assessment and consultation with medical and other personnel from garrison to the battlefield. Soldiers who are temporarily impaired or incapacitated with stress-related conditions are diagnosed as BH disorders. Combat and operational stress control promotes Soldier and unit readiness by—

- Enhancing adaptive stress reactions.
- Preventing maladaptive stress reactions.
- Assisting Soldiers with controlling combat and operational stress reactions.
- Assisting Soldiers with behavioral disorders.
- Teaching warrior resiliency skills.

7-3. For more information on COSC, refer to ATP 4-02.5 and ATP 4-02.8.

BRIGADE COMBAT TEAMS

7-4. In the BCTs, COSC support is provided by mental health sections assigned to the brigade support medical company of the brigade support battalion. If required, these resources can receive direct support from the BH personnel assigned to the medical detachment (COSC), if augmentation is required.

MEDICAL COMPANY (AREA SUPPORT)

7-5. At EAB, mental health sections are assigned to the medical companies (area support) that are normally assigned to the MMB. If required, these resources can be augmented with BH personnel assigned to the medical detachment (COSC).

MEDICAL DETACHMENT, COMBAT AND OPERATIONAL STRESS CONTROL

7-6. A medical detachment (COSC) is usually assigned to the MMB and provides direct support to the EAB. In support of an AO, this unit provides support on an area basis and provides additional support to the BCT as required. The medical detachment (COSC) consists of a detachment headquarters, a main support section, a Unit Ministry Team, and a forward support section. The main support section consists of its headquarters and an 18-Soldier BH team made up of social workers, clinical psychologist, psychiatrist, occupational therapists, psychiatric nurses, BH specialists, and occupational therapy specialist. The forward support section consists of an 18-Soldier BH team. Each BH team is capable of breaking into six 3-person subteams, for battalion/company prevention and fitness support activities. This provides for a total of 12 subteams for each detachment, giving supported commanders more teams and more flexibility in the utilization of those teams.

PRIMARY TASKS

7-7. Table 7-1 discusses the primary tasks of the COSC function. Table 7-2 (on page 7-3) discusses the primary tasks and purposes of BH/neuropsychiatric treatment.

Table 7-1. Primary tasks and purposes of the combat and operational stress control function

Primary task	*Purpose*
Implement combat and operational stress control plan/program	Prevent combat and operational stress reaction.
Perform combat and operational stress control unit needs assessment	Provide command with global assessment of the unit, with considerations of multiple variables that may affect leadership, performance, morale, and operational effectiveness of the organization.
Conduct traumatic event management for potentially traumatic event	Assist in the transition of units and Soldiers who are exposed to potentially traumatic events by building resilience, promoting posttraumatic growth, and/or increasing functioning and positive changes in the unit.
Screen and evaluate Soldiers with maladaptive behaviors to rule out neuropsychiatric/behavioral health conditions	Provide diagnosis, treatment, and disposition for Soldiers with neuropsychiatric/behavioral problems.
Conduct combat and operational stress restoration and reconditioning programs to include warrior resiliency training	Provide Soldiers rest/restoration within or near their unit area for rapid return to duty and to prevent posttraumatic stress disorder.
Perform command-directed evaluation for Soldier's behavioral health status	Determine if Soldiers' mental state renders them at risk to themselves or others or may affect their ability to carry out their mission.
Screen patients with potential behavioral health issues for signs/symptoms of mild traumatic brain injury	Rule out mild traumatic brain injury for Soldiers seeking assistance with behavioral health issues. If appropriate, refer individuals for follow-up medical examination.

SECTION III — BEHAVIORAL HEALTH AND NEUROPSYCHIATRIC TREATMENT ASPECTS

7-8. Behavioral health/neuropsychiatric treatment exists when there is an explicit therapist-patient or therapist-client relationship.

TREATMENT PROVISION

7-9. Behavioral health/neuropsychiatric treatment is provided for Soldiers with behavioral disorders to sustain them on duty or to stabilize them for referral/transfer. This is usually a brief, time-limited treatment as dictated by the operational situation. Behavioral health/neuropsychiatric treatment includes counseling, psychotherapy, and behavior therapy, occupational therapy, and medication therapy. Treatment assumes an ongoing process of evaluation and may include assessment modalities such as psychometric testing, neuropsychological testing, laboratory and radiological examination, and COSC providers' discipline-specific evaluations.

7-10. Behavioral health/neuropsychiatric treatment is provided to Soldiers with diagnosed behavioral disorders and who require more intentions for their diagnoses. It is both inappropriate and detrimental to treat Soldiers with combat and operational stress reactions as if they are behavioral health disorder. A therapeutic relationship may promote dependency and foster the patient role. Likewise, medication therapy and the highly structured treatment modalities imply the patient role. Medication for transient symptom relief (insomnia or extreme anxiety) may not be detrimental if there is no expectation that medication will continue to be prescribed.

7-11. Treatment standards are the same in the deployed environment as in garrison. When operational requirements dictate that clinical standards of treatment/care are waived or relaxed, it must be approved by the AO COSC consultant. Treatment should be tailored to the anticipated availability of the Soldier and the COSC provider. Short-term interventions are more practical than long-term commitments. If longer-term treatment is necessary, design the intervention in time-limited modules. Under no circumstances should treatment diminish the Soldier's ability to provide self-care and to defend himself. Exceptions include emergency stabilization and preparation for evacuation. In addition, the Department of Veterans Affairs/DOD Clinical Practice Guidelines website offers clinicians evidence-based assessment and treatment algorithms for acute stress disorder, posttraumatic stress disorder, and many other behavioral/neuropsychiatric disorders.

PRIMARY TASKS

7-12. Table 7-2 discusses the primary tasks and purposes of BH/neuropsychiatric treatment.

Table 7-2. Primary tasks and purposes of behavioral health/neuropsychiatric treatment

Primary task	*Purpose*
Identify and diagnose behavioral health/neuropsychiatric disorder/ disease	– Identify and initiate treatment for patients with behavioral health/ neuropsychiatric disease processes.
Stabilize patient	– Stabilize behavioral health/neuropsychiatric patients for evacuation from the theater for treatment of disease process in the continental United States-support base.

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Chapter 8
Dental Services

The Soldier as the centerpiece of the United States Army is the basic guarantor of mission success. As such, the Soldier's health and physical fitness are vitally important. Equally important is the Soldier's oral and dental health, which if not properly maintained can result in becoming nondeployable, and if already deployed, can render this Soldier nonmission-capable.

SECTION I — DENTAL SERVICES PREVENTIVE DENTISTRY

8-1. Preventive dentistry incorporates primary, secondary, and tertiary preventive measures. For more information on dental services, refer to AR 40-35 and ATP 4-02.19.

PREVENTIVE MEASURES

8-2. Preventive dentistry measures can effectively prevent the development of tooth decay and oral disease. The application of fluoride and sealants combined with regular dental checkups and oral screenings can prevent tooth decay and identify oral disease at its most treatable stages. Therefore, Soldiers who incorporate good preventive dental hygiene practices are far less likely to become dental casualties due to disease while deployed.

PRIMARY TASKS

8-3. Table 8-1 discusses the primary tasks and purposes of preventive dentistry.

Table 8-1. Primary tasks and purposes of preventive dentistry

Primary task	*Purpose*
Conduct periodic examination of Soldiers' teeth, gums, and jaw	Identify dental deficiencies and recommend follow-up courses of action.
Classify Soldiers' dental conditions in the dental classification system and determine Soldiers' dental readiness status	Determine Soldiers dental classification and dental readiness status.
Provide training to Soldiers and units on measures to take to mitigate the adverse impact of dental threats	Provide training/education to Soldiers and unit leaders on identifying dental threats, taking preventive measures to mitigate or eliminate the dental threat, and ensuring Soldiers are practicing good oral hygiene.

SECTION II — DENTAL SERVICES TREATMENT ASPECTS

8-4. The mission of the dental service support system is to promote dental health; prevent and treat oral and dental disease; provide far forward dental treatment; provide early treatment of severe oral and maxillofacial injuries; and augment medical personnel (as necessary) during mass casualty operations.

LEVELS OF DENTAL SUPPORT

8-5. There are three levels of dental support, previously known as levels of dental care, within the AO. These levels are defined primarily by the relationship of the dental assets supporting the patient population within each level. These levels of dental support are exclusive and not synonymous with the medical roles of care. Reference paragraphs 1-32 through 1-47 for more discussion on the medical roles of care.

LEVEL 1 DENTAL SUPPORT

8-6. The first dental care a Soldier receives is provided by Level 1 dental support (previously known as unit-level dental care). This level of support consists of those services provided by dental personnel organic to the supporting medical companies and special forces groups (SFGs).

8-7. This level of support provides operational dental care to Soldiers during a range of military operations from dental assets in a direct support relationship to an area support task. Major emphasis is placed on those measures necessary for the patient to return to duty or to stabilize them and allow for their evacuation to the next role of medical care.

LEVEL 2 DENTAL SUPPORT

8-8. Level 2 dental support (previously known as hospital-level dental care) consists of those services provided by the hospital dental staff to minimize loss of life and disability resulting from oral and maxillofacial injuries and wounds. The hospital dental staff provides operational dental care and preventive dental care to all injured or wounded Soldiers, as well as the hospital staff. The hospital dental staff will not normally provide Level 1 dental support to organizations outside of the hospital, however they will direct patients to the Level 3 dental support activity.

8-9. Emphasis is placed on those measures necessary for the patient to return to duty or to stabilize them and allow for their evacuation to the next role of medical care. If needed the hospital dental staff can coordinate with the dental company (area support) (DCAS) for patient consultation and treatment.

LEVEL 3 DENTAL SUPPORT

8-10. Level 3 dental support (previously known as area dental support) is provided for units that do not have organic dental assets or those patients being referred by the Level 2 dental support. This level of support is provided by the DCAS.

8-11. The DCAS provides operational dental care and has dental assets which can deploy, when and where necessary, to provide augmentation and/or reinforcement to the area support squads.

CATEGORIES OF DENTAL CARE

8-12. Dental service planning must include the consideration of two categories of dental services in joint and multinational operations. Operational dental care is provided within the area of operations (AO), and comprehensive dental care is provided in the support base, normally found only in fixed facilities, out of theater such as in the joint security area or the strategic support area. These categories are not absolute in their limits; they are the general basis for defining the dental service capabilities available at the different AHS roles of care.

OPERATIONAL DENTAL CARE

8-13. *Operational dental care* is the dental care provided for deployed Soldiers in theater consisting of emergency dental care and essential dental care (ATP 4-02.19).

Emergency Care

8-14. *Emergency dental care* is the care given for the relief of oral pain; diagnosis and treatment of infections; control of life-threatening oral conditions (hemorrhage, cellulitis, or respiratory difficulties); and treatment of trauma to teeth, jaws (maxilla/mandible), and associated facial structures is considered emergency care

(ATP 4-02.19). It is the most austere form of dental care provided to deployed Soldiers who are engaged in tactical operations.

8-15. Common examples of emergency dental treatments include:

- Airway management.
- Hemorrhage control.
- Stabilization of maxillofacial injuries (fracture stabilization, soft tissue injury/lacerations repair).
- Simple extractions.
- Management of maxillofacial infection (antibiotics, incision, and drainage).
- Interim pulp therapy (pulpectomy).
- Pain medication.
- Temporary restorations.

Essential Dental Care

8-16. *Essential dental care* is the dental care necessary to intercept potential emergencies to prevent lost duty time and preserve fighting strength (ATP 4-02.19). Essential dental care is the highest category of operational dental care available in theater. It enhances the individual Soldier's combat readiness and can prevent lost duty time. It is for these reasons that essential dental care is made readily available. Soldiers who are categorized as Class 2 (untreated oral disease) or Class 3 (potential dental emergencies) should receive essential care as soon as the tactical situation and availability of dental assets permit.

8-17. Essential treatments performed by dental officers may include:

- Basic restorations.
- Extractions.
- Definitive pulp therapy (pulpectomy, obturation).
- Treatment of periodontal conditions.
- Simple prosthetic repairs.

Comprehensive Dental Care

8-18. *Comprehensive dental care* is the dental treatment to restore and/or maintain a Soldier's optimal oral health, function, and aesthetics (ATP 4-02.19).

8-19. This category of care is usually reserved for medical support plans that anticipate an extended period of reception and training in theater and is also included as a component of the theater hospitalization capability. The scope of facilities needed to provide this level of dental support should equal that of theater hospitalization medical treatment facility (MTF) capability.

PRIMARY TASKS

8-20. Table 8-2 discusses the primary tasks and purposes of the dental services function.

Table 8-2. Primary tasks and purposes of the dental services function

Primary task	*Purpose*
Provide comprehensive dental care	Restore an individual to optimal oral health, function, and aesthetics. Normally provided in continental United States-support base.
Provide operational dental care	Provide treatment in austere environments for Soldiers engaged in operations. Operational care is provided in the area of operations and consists of emergency dental care and essential dental care.

Table 8-2. Primary tasks and purposes of the dental services function (continued)

Primary task	*Purpose*
Conduct emergency dental care	Relieve oral pain, eliminate acute infection, control life-threatening oral conditions (hemorrhage, cellulitis, or respiratory difficulty) and treat trauma to teeth, jaws, and associated facial structures.
Conduct essential dental care	Prevent potential dental emergencies and maintain the overall oral fitness of Soldiers at levels consistent with combat readiness.
Perform oral maxillofacial surgery	Provide oral maxillofacial surgery capability to minimize loss of life and disability resulting from oral and maxillofacial injuries and wounds within the area of operations.

Chapter 9
Laboratory Services

This chapter discusses environmental and clinical medical laboratory services.

SECTION I — AREA MEDICAL LABORATORY SUPPORT

9-1. The AML includes capabilities in the identification and theater validation of suspect CBRN agents, endemic diseases, and OEH hazards. Its focus is the total health environment of the operational area, not individual patient care.

9-2. The AML is the Army's specialized theater laboratory that deploys worldwide as a unit or by task-organized teams to perform surveillance, analytical laboratory testing and health hazard assessments of environmental, occupational, endemic, and CBRN threats in support of Soldier protection and weapons of mass destruction missions.

FIELD ENVIRONMENTAL LABORATORY

9-3. The AML tests air, water, soil, food, waste, and vectors (insects, animals) for a broad range of microbiological, radiological, and/or chemical contaminants under two basic scenarios:

- As a field environmental laboratory (theater validation) in support of theater operations. The AML provides—
  - Theater validation level of identification to enable commanders and health care providers to make data-based decisions.
  - Support to multiple medical detachments (preventive medicine and veterinary services) with surveillance/surveillance oversight, sample collection/sample management, and rapid laboratory analysis and validation.
- In contingency operations (for example, after use of weapons of mass destruction), the AML provides—
  - Immediate hazard identification (presumptive or field confirmatory level of identification) in high risk environments with chemical or biological agent contamination, epidemic disease, or industrial contamination.
  - Rapid laboratory analysis and theater validation level of identification to assist commanders in making operational decisions.

9-4. The AML is organized into teams consisting of the following:

- The staff (headquarters) section provides command, control, and communications support for the unit and accomplishes all required administrative functions of the unit.
- The analytical chemistry (CBRN) section conducts analytical chemistry support by providing identification of chemical agents in the environment to include food, water, plants, soil, and explosives.
- The microbiology (endemic) section conducts biological agent analysis using multiple methodologies, provides identification of endemic disease agents, and supports animal pathology and endemic disease surveillance.
- The OEH surveillance (CBRN) section provides identification for environmental samples and clinical specimens using multiple methodologies. This section also provides diagnostic capability to identify outbreaks of regionally specific endemic diseases and serves as a resource of information for higher-level command medical personnel. This section also provides the

operational commander the immediate hazard identification (presumptive or field confirmatory level of identification) of CBRN.

9-5. For more information on the AML, refer to ATP 4-02.7/MCRP 4-11.1F/NTTP 4-02.7/AFTTP 3-42.3. Figure 9-1 depicts the four levels of identification where AML serves as a theater validation environmental laboratory.

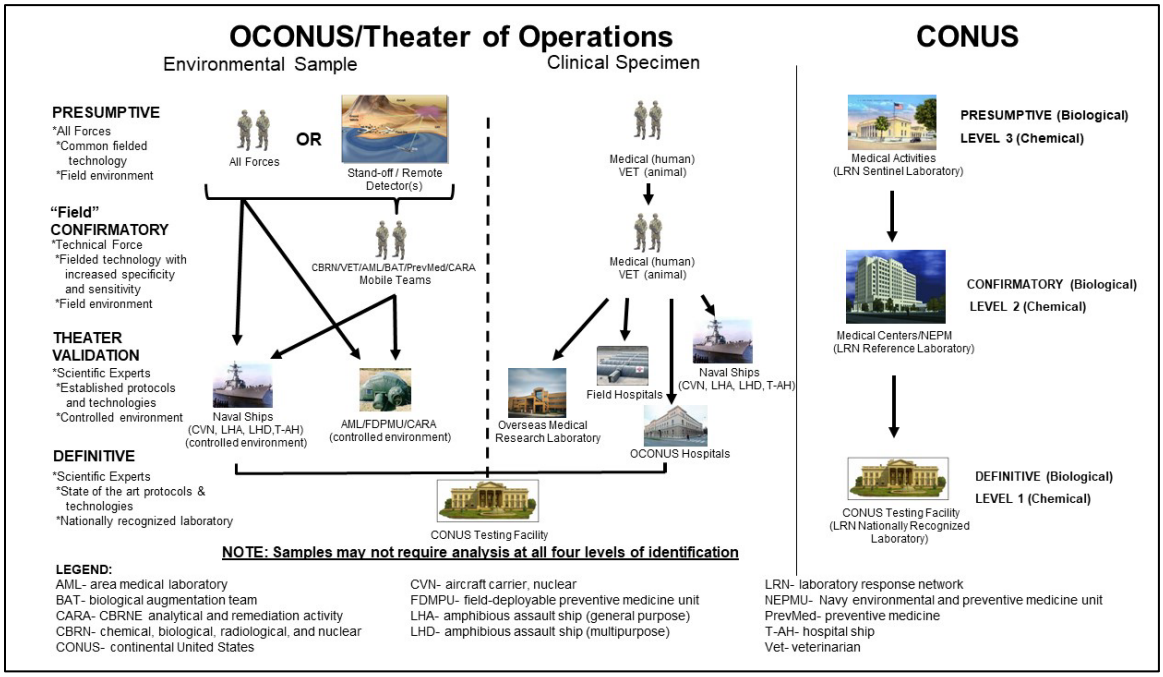

Figure 9-1. Four levels of identification

PRIMARY TASKS

9-6. Table 9-1 discusses the primary tasks and purposes of the operational medical laboratory function performed by the AML.

Table 9-1. Primary tasks and purposes of the operational medical laboratory function performed by the area medical laboratory

Primary task	*Purpose*
Provide analytical, investigational, and consultative capabilities	Identify chemical, biological, radiological, and nuclear threat agents in biomedical specimens and other samples from the area of operations. Assist in the identification of OEH hazards and endemic diseases.
Provide special environmental control and containment	Evaluate biomedical specimens for the presence of highly infectious or hazardous agents of operational concern.
Provide data and data analysis	Support medical analyses and operational decisions.
Conduct medical laboratory analysis	Support the diagnosis of zoonotic and significant animal diseases that impact on military operations.
Deploy modular sections or sectional teams	Interface with preventive medicine teams, veterinary teams, forward-deployed Army Health System units, biological integrated detection system teams, and chemical company elements operating in the area of operations.

SECTION II — CLINICAL LABORATORY SERVICES

9-7. All Role 2 MTFs provide basic clinical laboratory services within the AO. They perform basic procedures in hematology, urinalysis, microbiology, and serology. Role 2 MTFs receive, maintain, and transfuse blood products.

9-8. The clinical laboratory in the CSH/hospital center performs procedures in biochemistry, hematology, urinalysis, microbiology, and serology in support of clinical activities. The CSH/hospital center also provides blood-banking services.

CHEMICAL, BIOLOGICAL, RADIOLOGICAL, AND NUCLEAR CLINICAL LABORATORY SUPPORT

9-9. At Role 2, medical laboratory support may be very limited. Diagnostic testing for evidence of CBRN exposure or disease may be difficult unless technologies are present to ensure high levels of safety (for example, biological safety cabinets). Laboratory personnel prepare collected suspect CBRN specimens for submission to supporting medical laboratories while maintaining chain-of-custody.

9-10. At Role 3, medical laboratory support in a CSH or hospital center is intended for providing clinical laboratory support and is primarily in support of acute surgical cases, blood services, and immediate services required for intensive care operations. Microbiology services may also be available to include bacterial culture and antimicrobial sensitivity testing. A polymerase chain reaction technology has been fielded to most Role 3 MTF laboratories for initial field confirmation analysis of biological warfare agents. Patients with documented or suspected exposure to CBRN weapons/agents will be medically evaluated; specimens will be collected, packaged, and a chain-of-custody will be established and forwarded through technical channels to a supporting medical laboratory for further analysis. For more information, refer to ATP 4-02.7/MCRP 4-11.1F/NTTP 4-02.7/AFTTP 3-42.3.

PRIMARY TASKS

9-11. Table 9-2 discusses the primary tasks and purposes of the clinical laboratory services function.

Table 9-2. Primary tasks and purposes of the clinical laboratory services

Primary task	*Purpose*
Provide analysis of medical specimens	Provide for the identification, diagnosis, and treatment of diseases and pathogens. Provide blood-banking services to include capability to type and crossmatch blood samples and perform limited testing of whole blood.
Provide blood banking services	Provide laboratory support to type and crossmatch blood specimens for transfusion services. Provide limited testing of blood products.

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PART THREE

Health Service Support

Health service support pertains to the treatment and MEDEVAC of patients from the battlefield and the required Class VIII supplies, equipment, and services to necessary to sustain these operations. Health service support encompasses three components: direct patient care, MEDEVAC, and MEDLOG.

This part of the publication discusses—

- Direct patient care aspects of the AHS mission. It includes medical treatment (organic and area support) and hospitalization. Health Service Support includes the treatment of CBRN patients.
- Medical evacuation to include medical regulating, and the provision of en route care to patients being transported.
- Medical logistics inclusive of all functional subcomponents and services to include blood management.

Chapter 10

Direct Patient Care

The mission set of direct patient care comprises of the medical functions of medical treatment (organic and area support) and hospitalization. Health service support includes the treatment of CBRN casualties. Although these medical functions are aligned with specific tasks, the execution of the individual functions are interrelated, interconnected, and independent and require close coordination and integration to facilitate effective and efficient provision of AHS support.

SECTION I — MEDICAL TREATMENT (ORGANIC AND AREA SUPPORT)

10-1. The medical treatment function encompasses Roles 1 and 2 medical treatment support. These roles of care are provided by organic assets (medical platoons of maneuver forces and treatment teams assigned to sustainment units) or on an area support basis from supporting medical companies or detachments. Within the BCTs and EAB AHS units, this support is provided by the medical company (brigade support) and the medical company (area support). The area support function encompasses TCCC, routine sick call, emergency dental care, operational public health, and COSC support.

MEDICAL COMPANY

10-2. At Role 2 MTFs, in addition to the Role 1 capabilities, these additional services are available- x-ray, medical laboratory, essential dental care, and patient holding capability. Medical companies may also be augmented with physical therapy services and optometry services and collocated with an FST or FRSD.

10-3. During operations, each medical company is assigned a specific AO to ensure all personnel receive adequate medical care. Within each company AO, the treatment platoon with its medical treatment squads, area support treatment squad (dental, x-ray, laboratory, and patient-holding capability) forms the core of the company's support scheme. The medical treatment squads are employed geographically to best support the troop population. Company ambulances are collocated with medical elements to provide a ground MEDEVAC capability or to evacuate patients to the Role 2 MTF established by the area support section of the medical company for further treatment or holding.

PRIMARY TASKS

10-4. Table 10-1 discusses the primary tasks and purposes of the medical treatment (organic and area support) function.

Table 10-1. Primary tasks and purposes of the medical treatment (organic and area support) function

Primary task	*Purpose*
Provide first aid	Decrease killed-in-action rate. This task is performed by nonmedical Soldiers performing self-aid, buddy aid, and/or combat lifesaver support prior to arrival of the combat medic and/or other health care personnel.
Provide tactical combat casualty care	Provide lifesaving intervention at the point of injury or wounding. This task is performed by the combat medic who locates, acquires, stabilizes, and evacuates patients with combat trauma. At echelons above brigade, this task is referred to as emergency medical treatment in noncombat operations.
Provide forward resuscitative surgery	Provide a damage control surgery capability close to the point of injury or wounding. This care is provided by a forward surgical team collocated with a Role 2 medical treatment facility.
Conduct routine sick call	Provide primary care services as close to patient's unit as possible.
Provide patient holding	Provide a short-term holding capability (not to exceed 72 hours) for patients requiring minimal care prior to returning to duty.
Promote casualty prevention measures	Promote wellness and enhance Soldier medical readiness to decrease morbidity and mortality. There are no operational public health or combat and operational stress control assets at Role 1; however, they are available at Role 2.
Provide medical evacuation	Provide medical evacuation by ground ambulance on an area support basis and to provide en route medical treatment during transport.
Provide physical therapy	Role 2 medical treatment facilities may be augmented with a physical therapy team to provide assistance in strengthening the Soldier's physical resiliency, assistance in the prevention of neuromusculoskeletal injuries, and treatment of Soldiers with neuromusculoskeletal injuries allowing them to return to duty as soon as possible.

SECTION II — THEATER HOSPITALIZATION

10-5. Theater hospitalization provides essential care within the theater evacuation policy to either return a patient to duty or stabilize a patient for evacuation to a definitive care facility outside the AO. A hospital is a medical treatment facility capable of providing inpatient care. It is appropriately staffed and equipped to provide diagnostic and therapeutic services, as well as the necessary supporting services required to perform its assigned mission and functions. In addition, a hospital may discharge the functions of a clinic. Often, the terms hospital and MTF are misused interchangeably. While a Role 3 MTF provides hospitalization, and is therefore a hospital, Role 1 and 2 MTFs do not provide all of the capabilities included in hospitalization.

Thus, Role 1 and 2 MTFs are not hospitals. The Army Medicine provides Role 3 medical capabilities with two organizations, the currently fielded CSH and the recently designed and Army approved hospital center. Both hospital's assigned medical personnel, facilities, equipment, and materials provide the requisite capabilities to render significant preventive and curative health care. These highly robust services encompass primary inpatient and outpatient care; emergent care; and enhanced medical, surgical, and ancillary capabilities. *Inpatient* refers to a person admitted to and treated within a Role 3 and 4 hospital and who cannot be returned to duty within the same calendar day (ATP 4-02.10). While *outpatient* is a person receiving medical/dental examination and/or treatment from medical personnel and in a status other than being admitted to a hospital. Included in this category is the person who is treated and retained (held) in a medical treatment facility (such as a Role 2 facility) other than a hospital (ATP 4-02.10). The modular design of the hospital provides the capability to tailor and deploy capabilities as modules or multiple individual capabilities that provide incrementally increased medical services. The theater hospitals may be augmented by one or more medical detachments, hospital augmentation teams, or medical teams designed to enhance the hospital's capabilities to provide HSS to the AO.

10-6. Theater hospital capabilities include triage/emergency care, outpatient services, inpatient care, pharmacy, clinical laboratory, blood banking, radiology, physical therapy, MEDLOG, operational dental care (emergency and essential dental care), oral and maxillofacial surgery, nutrition care, and patient administration services. ***Triage* is the process of sorting casualties based on need for treatment, evacuation, and available resources.** Triage consists of the immediate sorting of patients according to type and seriousness of injury, and likelihood of survival, and the establishment of priority for treatment and evacuation to assure medical care of the greatest benefit to the largest number. The categories of triage are: MINIMAL (OR AMBULATORY) - those who require limited treatment and can be rapidly returned to duty; IMMEDIATE- patients requiring immediate care to save life, limb or eyesight; DELAYED- patients who, after emergency treatment, incur little additional risk by delaying further treatment; and EXPECTANT- patients so critically injured that only complicated and prolonged treatment will improve the chances of survival.

PRIMARY TASKS

10-7. Table 10-2 on page 10-4 discusses the primary tasks and purposes of theater hospitalization function.

COMBAT SUPPORT HOSPITALS

10-8. The CSH provides hospitalization and outpatient care for all classes of patients within the AO. It is comprised of a headquarters and headquarters detachment and two hospital companies (one 84-bed and one 164-bed company)

10-9. The CSH provides hospitalization for up to 248 patients and treatment for all classes of patients.

10-10. Surgical capacity is based on six operating room tables staffed for 96 operating table hours per day. The six operating room tables are contained in three operating room shelters. Surgical capabilities include general, orthopedic, thoracic, urological, gynecological, and oral maxillofacial.

10-11. Other capabilities include:

- Medical command and control of organic and attached elements include AHS planning, policies, and support operations with the hospital AO.
- Emergency treatment to receive, triage, and resuscitate casualties to include civilians and enemy prisoners of war, as required.
- Consultation services for inpatient and outpatient support.
- Pastoral care for staff and patients, as well as ethical advisement on bioethics or end of life issues.
- Pharmacy, psychiatry, public health nursing, clinical laboratory, blood banking, radiology, physical therapy, and nutrition care services.
- Medical administrative and logistical services.
- Operational dental care treatment.
- Medical logistics support to the FST/FRST, when attached.

- Reconstitution of the FST/FRST as directed by higher headquarters or the operation plan.

10-12. For maximum use of the CSH, the entire organization should deploy together, however, due to its limited mobility and the availability of transportation support, it may be necessary to deploy by modules/echelons.

Table 10-2. Primary tasks and purposes of theater hospitalization function

Primary task	*Purpose*
Provide essential care	– Includes first responder care, initial resuscitation and stabilization as well as treatment and hospitalization in order to either return the patient to duty within the theater evacuation policy, or to begin initial treatment required for optimization of outcome.
Perform triage and emergency care	– Provides for the receiving of incoming patients to assess their medical condition, provide emergency medical treatment, and transfer them to the appropriate functional area within the hospital.
Provide outpatient services	– Provides patient care and family medicine consultation services, evaluation and treatment of dermatological and gynecological diseases, injuries, disorders, orthopedic and physical therapy services; sick call operations and comprehensive routine medical care to include electrocardiographs in the medical services clinic.
Manage inpatient care	– Provides nursing and medical services in intermediate and intermediate care wards in order to prepare patients for surgery, manage postoperative recovery, monitor patients, and prepare them for further evacuation.
Perform clinical Laboratory and blood banking	– Performs analytical procedures in hematology, urinalysis, chemistry, blood banking, and microbiology screening. Includes all routine blood grouping and typing, abbreviated cross-matching procedures, emergency blood collection, and storage/issuing liquid blood components and fresh frozen plasma.
Provide radiology services	– Provides radiological services to all areas of the hospital and operates on a 24-hour basis to include computed tomography in the newly designed field hospitals.
Conduct physical therapy	– Provides a physical-occupational clinic to evaluate and treat neuromusculoskeletal injuries, minor soft tissue wounds to include burn wound treatment, behavioral health, injury prevention, and human performance optimization.
Provide medical logistics	– Provides Class VIII management, requisitioning, and resupply as well as maintenance on medical equipment. Coordinates with supporting medical logistics company and medical detachment (blood support) for required external medical logistics support.
Provide emergency and essential dental care	– Provides emergency and essential dental services and consultation for patients and staff in order treat urgent dental cases or prevent dental emergencies.
Perform general and specialty surgery	– Perform initial surgery for battle and nonbattle injuries and follow-on surgery for patients received from other medical treatment facilities to include general, orthopedic, and obstetrics-gynecological surgical services in order to return patients to duty or stabilize them for further evacuation.
Provide anesthesia services	– Provides anesthesia and respiratory services for the hospital that includes respiratory therapy by specifically trained technicians and the ability to provide mechanical respiratory assistance in intensive care units and the operating rooms.
Provide pharmacy support	– Operates a fully functioning pharmacy and exercises appropriate control, accountability, and distribution of medications and controlled substances to both inpatients and outpatients as prescribed by medical staff.
Manage nutrition care	– Provides food service management, meal preparation, modified diet food preparation, and distribution of foods to patients and staff.
Provide behavioral health services	– Provides outpatient psychiatry and inpatient neuropsychiatric consultation and education services.

Table 10-2. Primary tasks and purposes of theater hospitalization function

Primary task	*Purpose*
Provide patient administration services	– Admission and disposition of patients, maintaining patient records, security of patient valuables, statistical reporting, patient privacy policies, and coordination for patient evacuation out of theater.
Provide consultation support	– Provide specialty medical consultation to Role 1 and 2 medical providers to enhance the care given in forward areas, potentially eliminating the need to evacuate some patients rearward.

HOSPITAL CENTER

10-13. The hospital center is a modular MTF designed to provide Role 3 medical capability in a tailored organizational structure to support the Army's varied unified operations missions. The organization was designed to support the Army's requirement to conduct a mix of offensive, defensive and stability and support of civil authorities' tasks simultaneously in a variety of scenarios. Depending on the mission, supported population, patient at risks, surgical and medical care providing a surgical and medical organizations. The hospital center provides essential care within the theater evacuation policy to either return the patient to duty and/or stabilize the patient for evacuation to a definitive care facility outside the AO. The hospital's assigned medical personnel, facilities, equipment, and materials provide the requisite capabilities to render significant preventive and curative health care. These highly robust services encompass primary inpatient and outpatient care; emergent care; and enhanced medical, surgical, and ancillary capabilities. The modular design of the hospital provides the capability to tailor and deploy capabilities as modules or multiple individual capabilities that provide incrementally increased medical services. The field hospital (32 bed) may be augmented by one or more medical detachments, hospital augmentation teams, or medical teams designed to enhance the hospital's capabilities to provide HSS to the AO.

10-14. The enhanced organizational design replaces the current CSH providing a more agile, deployable, versatile and medically capable hospital.

10-15. The headquarters and headquarters detachment (HHD), hospital center and field hospital (32 bed) are the core and lowest denominator of the hospital organization. The field hospital (32 bed) represents the smallest unit that can provide the complete clinical capabilities of a Role 3 MTF. This hospital is deliberately designed to be self-supporting while remaining light, highly mobile, and expandable. The HHD, hospital center and field hospital (32 bed) are designed as the first increment to be deployed in support of an expeditionary force. The HHD, hospital center and field hospital (32 bed) can be expanded incrementally to a maximum 240 bed hospitalization capability. The HHD hospital center can command one to two field hospitals (32 bed) in separate locations without augmentation. Combinations of the modular units within the hospitalization capability would be suitable to support across the competition continuum and fully integrating operations with joint, interagency, and multinational partners.

10-16. Increases in overall clinical functions of the hospitalization capability include:

- Computed Tomography services.
- Microbiology laboratory services.
- Critical care physicians, (intensivists), to manage patients in the intensive care unit.
- Internal medicine physicians, (hospitalists), to manage patients in the intermediate care ward.
- Emergency room physician assistants in the triage/pre-operative care and emergency medical treatment section.
- Psychiatry and inpatient neuropsychiatric consultation services.
- Minimal psychiatry inpatient capabilities.
- Increased capacity of intensive care beds.
- Improvements in versatility and agility.
- Command and communications capability to conduct split base operations indefinitely without augmentation.

- Augmentation detachments with specific clinical specialties can be adapted to better support the mission.
- The hospitalization capability can be built up or scaled down based on the tactical situation.

10-17. Deployability and adaptability:

- The initial hospital capability is a 100 percent mobile field hospital (32 bed) and is dependent on the HHD, hospital center for transportation support.
- Each element and hospital augmentation detachment has a separate TOE.
- Each hospital augmentation detachment is designed to expand the capabilities and increase the capacities of the field hospital (32 bed).
- Commanders can tailor the medical forces to support unified land operations, matching the anticipated mix of capabilities and medical specialties to the population supported and the clinical challenges they present.

HOSPITAL CENTER COMPONENTS AND EMPLOYMENT

10-18. This section will be discussing hospital center employment.

HEADQUARTERS AND HEADQUARTERS DETACHMENT, HOSPITAL CENTER

10-19. The HHD, hospital center provides command and control, consultation services, for up to two functioning, dual-based, field hospitals (32 bed) and requisite augmentation detachments, with a combined maximum of 240 beds. Medical command and control for hospitalization in more than one location presents unique HSS support planning requirements. The distance between hospital elements as well as requisite surgical and bed requirements for each location have a significant impact on the planning and employment process. Medical planners may want to consider employing two HHD, hospital centers if the operations do not allow adequate command and control, senior medical consultation, and adequate transportation to transport the hospital center during deployment or moves.

10-20. The HHD, hospital center is dependent on the field hospital (32 bed) for administrative support, feeding, unit level maintenance, security, power and classes of supply.

FIELD HOSPITAL (32 BED)

10-21. The field hospital (32 bed) is the corner stone of the deployed hospital. It represents the smallest hospital element with complete requisite clinical capabilities of a Role 3 MTF. This hospital is deliberately designed to be self-supporting while remaining light, highly mobile, and expandable. Combinations of the modular units within the hospitalization capability would be suitable to support peacetime military engagements, limited intervention, peace operations and irregular warfare.

10-22. Capable of providing complete Role 3 hospitalization under the command and control of the HHD, hospital center with a 72-hour basic load of medical and nonmedical supplies. Hospitalization for up to 32 patients consisting of one ward providing intensive care nursing for up to twelve patients (ten beds are fully equipped for patients requiring the most intensive monitoring/care) and one ward providing intermediate care nursing for up to twenty patients. Provides emergency treatment to receive, triage, and prepare incoming patients for surgery. Surgical capability consisting of general, orthopedic, obstetrical/gynecological surgery based on two operating tables staffed for 36 operating table hours per day. Provides pharmacy and clinical laboratory services to include: limited basic microbiology screening, blood banking, computed tomography and radiology services. The field hospital (32 bed) provides personnel administration, patient administration, logistical, nutrition care services, and a hospital ministry team for hospital staff and patients.

10-23. The field hospital (32 bed), as an individual unit, was not designed to perform split based operations for a sustained period of time. If the capabilities of the field hospital (32 bed) are required in a two locations then two field hospitals and requisite hospital augmentation detachments will be required to support the medical plan.

HOSPITAL AUGMENTATION DETACHMENTS

10-24. Hospital augmentation detachments that may be attached to the field hospital (32 bed) to increase its bed, surgical and staffing and medical specialty capabilities. The hospital augmentation detachments consists of a surgical (24 bed) detachment, medical (32 bed) detachment, and an intermediate care ward (60 bed) detachment.

10-25. The hospital augmentation detachment (surgical 24 bed) augments the field hospital (32 bed) with thoracic, urology, oral maxillofacial surgical capabilities, 24 additional intensive care beds, outpatient service and microbiology.

10-26. The hospital augmentation detachment (medical 32 bed) augments the field hospital (32 bed) with operational dental care, one additional intensive care unit, one intermediate care ward, additional microbiology capabilities and outpatient services for all classes of patients within the Theater.

10-27. The hospital augmentation detachment (intermediate care ward 60 bed) augments the capabilities of the hospital center as required with three additional intermediate care wards providing intermediate nursing care and additional personnel to support nutrition and patient administration capabilities.

HOSPITAL CENTER CONFIGURATIONS

10-28. The hospital center has the capability of being deployed in multiple configurations to provide requisite care to any military or humanitarian operation. The hospital center has the capability of to perform split-based operations within an AO. Split-based operation limitations include the 240 maximum number of beds per hospital center and command and control limitations. The HHD, hospital center has the capability to provide medical command and control and support for up to a 240 bed hospital center when employed in one or two locations. Table 10-3 (on page 10-8) depicts the bed types and numbers as well as surgical capabilities available to per hospital center modules.

10-29. The initial entry piece of the hospital will be the HHD, Hospital Center collocated with one field hospital (32 Bed). With the addition of a second field hospital (32 Bed) and/or the surgical, medical or intermediate care ward augmentation detachments as many as 240 beds can be deployed in one or two locations to support a LSCL.

10-30. The field hospital (32 bed) and augmentation detachments are dependent on transportation support from the HHD, hospital center and may require additional transportation support based on employment criteria. Refer to dependencies in section one of this document for support.

10-31. Refer to the Table 10-3 on page 10-8 for examples of hospital center configurations that would support there completion continuum. Table 10-4 on page 10-9 depicts a sample configuration of the hospital center designed to support a high surgical and intensive care and intermediate care planning scenario during combat operations. Table 10-5 on page 10-9 depicts a sample configuration emphasizing a treat and return capability in support of foreign humanitarian assistance or stability operations.

AUGMENTATION TEAMS

10-32. Theater hospitals may be augmented by one or more medical detachments, hospital augmentation teams, or medical teams. These may include:

- *Medical detachment (minimal care*) that is capable of providing minimal/convalescent care, nursing, and rehabilitative services in support of Role 3 MTF's.
- *Forward surgical team/forward resuscitative surgical teams* augment the surgical services of the hospital with general surgery and orthopedic surgery capabilities when not deployed forward with medical companies to provide forward resuscitative surgical care and damage control surgery.
- *Hospital augmentation team (head and neck)* provides special surgical care for ear, nose, and throat surgery, neurosurgery, and eye surgery to support the hospital, plus specialty consultative services, as required.

Table 10-3. Hospital center and hospital augmentation detachment bed and surgical hour capabilities

Organization	*Intensive care beds*	*Intermediate care beds*	*Minimal care beds*	*Surgical tables*	*Surgical hours per 24 hours*
Headquarters and Headquarters Detachment, Hospital Center	0	0	0	0	0
Field Hospital, (32 Bed)	12	20	0	2	24
Hospital Augmentation Detachment, (Surgical 24 bed)	24	0	0	2	36
Hospital Augmentation Detachment, (Medical 32 bed)	12	20	0	0	0
Hospital Augmentation Detachment, (Intermediate Care Ward 60 bed)	0	60	0	0	0

- Medical detachment (minimal care) provides minimal and convalescent care, nursing, and rehabilitative services in support of theater hospitalization.

10-33. All Role 2 MTF's provide basic clinical laboratory services within the AO. They perform basic procedures in hematology, urinalysis, microbiology, and serology. Role 2 MTF's receive, maintain, and transfuse blood products.

10-34. The clinical laboratory in the hospital center performs procedures in biochemistry, hematology, urinalysis, microbiology, and serology in support of clinical activities. The hospital center also provides blood-banking services. For more information regarding Role 3 MTF's primary tasks clinical laboratory services, refer to Chapter 9.

Table 10-4. Example hospital center configuration (maximum 240 beds) in support of full range military operations

Hospital units	*Intensive care beds*	*Intermediate care beds*	*Minimal care beds*	*Surgical tables*	*Surgical hours per 24 hours*
Field Hospital, (32 Bed)	12	20	0	2	36
Field Hospital, (32 Bed)	12	20	0	2	36
Hospital Augmentation Detachment, (Surgical 24 bed)	24	0	0	2	36
Hospital Augmentation Detachment, (Medical 32 bed)	12	20	0	0	0
Hospital Augmentation Detachment, (Intermediate Care Ward 60 bed)	0	60	0	0	0
Hospital Augmentation Detachment, (Intermediate Care Ward 60 bed)	0	60	0	0	0
TOTALS	60	180	0	6	108

Table 10-5. Example hospital center configuration (maximum 240 beds) in support of foreign humanitarian assistance or stability operations

Hospital units	*Intensive care beds*	*Intermediate care beds*	*Minimal care beds*	*Surgical tables*	*Surgical hours per 24 hours*
Field Hospital, (32 Bed)	12	20	0	2	36
Hospital Augmentation Detachment, (Surgical 24 bed)	24	0	0	2	36
Hospital Augmentation Detachment, (Medical 32 bed)	12	20	0	0	0
Hospital Augmentation Detachment, Minimal Care	0	0	120	0	0
TOTALS	48	40	120	4	72

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Chapter 11
Medical Evacuation

Medical evacuation encompasses both the evacuation of Soldiers from the POI or wounding to an MTF staffed and equipped to provide essential care in the AO and further evacuation from the AO to provide definitive, rehabilitative, and convalescent care in CONUS.

SECTION I — INTEGRATED MEDICAL EVACUATION SYSTEM

11-1. Medical evacuation is the system which provides the vital linkage between the roles of care necessary to sustain the patient during transport. This is accomplished by providing en route medical care and emergency medical intervention, if required, which enhances the individual's prognosis and reduces long-term disability.

11-2. Army MEDEVAC is a multifaceted mission accomplished by a combination of dedicated ground and air evacuation platforms synchronized to provide direct support, general support, and area support within the AO. At the operational level, organic or direct support MEDEVAC resources locate, acquire, treat, and evacuate Soldiers from the POI or wounding to an appropriate MTF. Soldiers are then stabilized, prioritized, and prepared for further evacuation, if required, to an MTF capable of providing required essential care within the AO. ***Essential care*** **refers to the absolutely necessary initial, en route, resuscitative, and surgical care provided to save, stabilize, and return as many Soldiers to duty as quickly as possible.** Essential care is medical care provided by medical providers at all roles of care that focuses on saving life, limb, and eyesight, and returning as many Soldiers to duty as quickly as possible within the theater evacuation policy or begin initial treatment required for optimization of outcome and/or stabilization to ensure the patient can endure evacuation.

11-3. The mission of Army MEDEVAC assets is the evacuation and provision of en route medical care, however, the essential and vital functions of MEDEVAC resources encompass many additional missions and tasks that support the AHS. Medical evacuation resources/assets are used to transfer patients between MTFs within the AO and from MTFs to USAF en route patient staging system; emergency movement of Class VIII, blood and blood products, medical personnel and equipment; and serve as messengers in medical channels.

11-4. The appropriate roles of medical care must be maintained throughout the continuum of care. A patient who has received complex care such as damage control resuscitation or damage control surgery requires continuous maintenance of the critical care support that was initiated at the forward MTF. To avoid the risk that these patients will deteriorate during transport, the level of care should not be decremented during en route care. Based on the appropriate level of care, the medical personnel providing en route care may be paramedics, nurses, or other properly trained medical specialists. When possible, this en route care should be used as far forward as mission, enemy, terrain and weather, troops and support available, time available, and civil considerations allows.

THEATER EVACUATION POLICY

11-5. The theater evacuation policy is established by the Secretary of Defense, with the advice of the Joint Chiefs of Staff, and upon the recommendation of the CCDR. *Theater evacuation policy* is a command decision indicating the length in days of the maximum period of non-effectiveness that patients may be held within the command for treatment, and the medical determination of patients that cannot return to duty status within the period prescribed requiring evacuation by the first available means, provided the travel involved will not aggravate their disabilities or medical condition. (ATP 4-02.2).

11-6. The medical commander may recommend changes in the theater evacuation policy to adjust patient flow within the deployed setting to include skip policy and surge capacity when necessary. The policy establishes, in number of days, the maximum period of noneffectiveness (hospitalization and convalescence) that patients may be held within the theater for treatment. This policy does not mean that a patient is held in the theater for the entire period of noneffectiveness. A patient who is not expected to be ready to return to duty within the number of days established by the theater evacuation policy is treated, stabilized, and then evacuated out of the theater. This is done providing that the treating physician determines that such evacuation will not aggravate the patient's disabilities or medical condition. For example, a theater evacuation policy of seven days does not mean that a patient is held in the theater for seven days and then evacuated. Instead, it means that a patient is evacuated as soon as possible after the determination is made that he cannot be returned to duty within seven days following admission to a Role 3 MTF.

EVACUATION PRECEDENCE

11-7. The initial decision for evacuation priorities is made by the treatment element or the senior nonmedical person at the scene. Soldiers are evacuated by the most expeditious means of MEDEVAC based on their medical condition, assigned evacuation precedence, and availability of MEDEVAC platforms. Patients are evacuated from the POI or wounding to the appropriate MTF. The evacuation precedence for the Army operations at Roles 1 through 3 are:

- Priority I, URGENT is assigned to emergency cases that should be evacuated as soon as possible and within a maximum of one hour to save life, limb, or eyesight and to prevent complications of serious illness and to avoid permanent disability.
- Priority IA, URGENT-SURG is assigned to patients that should be evacuated as soon as possible and within a maximum of one hour who must receive far forward surgical intervention to save life, limb, or eyesight and stabilize for further evacuation.
- Priority II, PRIORITY is assigned to sick and wounded personnel requiring prompt medical care. This precedence is used when the individual should be evacuated within four hours or if the personnel's medical condition could deteriorate to such a degree that this person will become an URGENT precedence, or whose requirements for special treatment are not available locally, or who will suffer unnecessary pain or disability.
- Priority III, ROUTINE is assigned to sick and wounded personnel requiring evacuation but whose condition is not expected to deteriorate significantly. The sick and wounded in this category should be evacuated within 24 hours.
- Priority IV, CONVENIENCE is assigned to patients for whom evacuation by medical vehicle is a matter of medical convenience rather than necessity.

Note 1. The NATO STANAG 3204 has deleted the category of Priority IV, CONVENIENCE. However, this category is still included in the U.S. Army evacuation priorities as there is a requirement for it in an OE.

Note 2. The Army has implemented the AE standard of a one-hour mission completion time for *urgent and urgent surgical missions* (time from mission request to delivery of the patient to the appropriate medical care). If appropriate medical care for urgent and urgent surgical missions can be reached within the one-hour standard by other transportation conveyances, the one-hour evacuation standard is met.

RESPONSIBILITIES

11-8. The Service component commander is responsible for evacuation at the operational level and is responsible for executing the evacuation of casualties. The Army is the only Service with dedicated MEDEVAC assets and is specifically tasked by DOD to provide intratheater AE. Strategic AE is the responsibility of the U.S. Transportation Command.

11-9. Within Army support to other Services, Army resources may provide ship-to-shore MEDEVAC on an area support basis. Medical evacuation from shore-to-ship for deployed USN and United States Marine Corps, as well as direct and general support to United States Marine Corps forces (when tactically operating on land as a maneuver force) forces could also be available within the Army's support capabilities.

ORGANIZATIONS

11-10. There are two types of United States Army MEDEVAC platforms- air (rotary-wing) and ground. These platforms are dedicated and designed, equipped, and staffed to perform the MEDEVAC mission.

MANEUVER BATTALION MEDICAL PLATOON

11-11. The organic medical platoon ground ambulances provide MEDEVAC support from the POI, company aid post, or casualty collection point to the battalion aid station. A *casualty collection point* is a location that may or may not be staffed, where casualties are assembled for evacuation to a medical treatment facility. (ATP 4-02.2). It is usually predesignated. In armored BCTs depending upon the mission, enemy, terrain and weather, troops and support available, time available, and civil considerations factors and the MEDEVAC plan, the tracked ambulances may evacuate the patient to an ambulance exchange point and transfer the patient to a wheeled ambulance for further movement to an MTF. This enables the tracked ambulance to keep pace with the maneuvering force.

GROUND AMBULANCES

11-12. Ground ambulances are organic to BCT maneuver battalion medical platoons and to both the medical company (brigade support) and the medical company (area support). In the maneuver battalion medical platoons, the actual vehicle platform (wheeled or tracked) varies with the type of parent unit. Both the brigade support medical company and the medical company (area support) have wheeled vehicles.

Brigade Support and/or Area Support Medical Company Evacuation Platoon

11-13. The medical company (brigade support) evacuation platoon provides MEDEVAC support on an area basis to units within its assigned AO. Additionally, it provides direct support to evacuate patients from the supported battalion aid stations to the medical company Role 2 MTF.

11-14. The medical company (area support) provides supported EAB units with MEDEVAC support on an area basis for those units that do not have organic MEDEVAC resources.

Medical Company (Ground Ambulance)

11-15. The mission of the medical company (ground ambulance) is to provide ground evacuation within the theater. This unit provides direct support to BCTs and is employed in the EAB to provide area support. It is tactically located where it can best control its assets and execute its patient evacuation mission. This unit has a single-lift capability for evacuation of 96 litter patients or 192 ambulatory patients.

AIR AMBULANCES

11-16. The medical company (air ambulance) provides MEDEVAC for all categories of patients with evacuation precedence and other considerations within the AO on an area and direct support basis. The single lift evacuation capacity varies among the three different air ambulance companies. See ATP 4-02.2 Medical Evacuation, for more information.

PRIMARY TASKS

11-17. Table 11-1 discusses the primary tasks and purposes of the MEDEVAC function.

Table 11-1. Primary tasks and purposes of the medical evacuation function

Primary task	*Purpose*
Acquire and locate	Provide a rapid response to acquire wounded, injured, and ill personnel. Clear the battlefield of casualties and facilitate and enhance the tactical commander's freedom of movement and maneuver. This task is performed by the medical evacuation crew of the evacuation platform.
Treat and Stabilize	Maintain or improve the patient's medical condition during transport and provide en route care as required. This task is performed by medical evacuation crewmembers and providers when necessary.
Provide intra-Theater Medical Evacuation	Provide rapid evacuation utilizing dedicated assets to the most appropriate role of care. Provide a capability to cross-level patients within the theater hospitals and to transport patients being evacuated out of theater to staging facility prior to departure. This task is performed by the evacuation platforms in the medical company (ground ambulance) and medical company (air ambulance).
Provide emergency movement of medical personnel, equipment, and supplies	Provide a rapid response for the emergency movement of scarce medical resources throughout an operational environment.

11-18. For additional information on MEDEVAC and medical regulating, refer to JP 4-02, AR 40-3 and ATP 4-02.2.

SECTION II — MEDICAL REGULATING

11-19. *Medical regulating* refers to the actions and coordination necessary to arrange for the movement of patients through the roles of care and to match patients with a medical treatment facility that has the necessary health service support capabilities and available bed space. (JP 4-02). This system is designed to ensure the efficient and safe movement of patients.

11-20. Medical regulating entails identifying the patients awaiting evacuation, locating the available beds, and coordinating the transportation means for movement. Careful control of patient evacuation to appropriate hospitals is necessary to—

- Effect an even distribution of cases.
- Ensure adequate beds are available for current and anticipated needs.
- Route patients requiring specialized treatment to the appropriate MTF.

11-21. The factors that influence the scheduling of patient movement include:

- Patient's medical condition (stabilized to withstand evacuation).
- Operational situation.
- Availability of evacuation means.
- Locations of MTFs with special capabilities or resources.
- Current bed status of MTFs.
- Surgical backlogs.
- Number and location of patients by diagnostic category.
- Location of airfields, seaports, and other transportation hubs.
- Communications capabilities (to include radio silence procedures).

11-22. For more information on medical regulating, refer to ATP 4-02.2.

SECTION III — STRATEGIC MEDICAL EVACUATION AND PATIENT MOVEMENT

11-23. Medical evacuation occurs at the tactical, operational, and strategic levels and requires the synchronization and integration of Service component MEDEVAC resources and procedures with the DOD worldwide evacuation system operated by the U.S. Transportation Command.

11-24. A comprehensive MEDEVAC plan is essential to ensure effective, efficient, and responsive MEDEVAC is provided to all wounded, injured, and ill Soldiers in the AO. The Army MEDEVAC plan flows from the CCDRs guidance and intent and incorporates all missions and tasks directed by the CCDR to be accomplished and is synchronized with supporting and supported units. In some scenarios, Army air and ground evacuation resources may be directed to provide support to sister Services, multinational partners, and host-nation forces.

11-25. When directed by the CCDR, Army MEDEVAC assets may be tasked to support other than Army forces engaged in the execution of the joint mission. These additional support missions will be clearly articulated in the CCDRs OPLAN and OPORD. The theater army surgeon, with the advice of the senior MEDEVAC planner, will coordinate and synchronize these support operations with the combatant command surgeon, joint task force surgeon, and the other Services and/or multinational partners as required ensuring that a comprehensive and effective, efficient, and responsive plan is developed and implemented.

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Chapter 12
Medical Logistics

The Army's MEDLOG system (including blood management) is an integral part of the AHS in that it provides intensive management of medical products and services that are used almost exclusively by the AHS and are critical to its success. Also key to this success is the delivery of a MEDLOG capability that anticipates the needs of the customer and is tailored to continuously provide end-to-end sustainment of the AHS mission throughout the competition continuum. Providing timely and effective AHS support is a team effort which integrates the clinical and operational aspects of the mission. This chapter provides an overview of the medical logistics function. Refer to ATP 4-02.1 for a more detailed description of the Army MEDLOG system.

SECTION I — MEDICAL LOGISTICS MANAGEMENT IN AN OPERATIONAL ENVIRONMENT

12-1. The MEDLOG system encompasses planning and executing all Class VIII supply support operations to include management of the following functions: medical materiel (Class VIIIA), medical equipment maintenance and repair, patient movement items, medical gases, blood (Class VIIIB) storage and distribution, regulated medical waste (including hazardous material), health facilities planning and management, and medical contracting.

SECTION II — MEDICAL LOGISTICS SYSTEM

12-2. The theater MEDLOG system consists of the following organizations:

- Medical logistics management center.
- Medical Logistics Company.
- Medical detachment (blood support).
- Medical team (optometry).
- Medical command and control headquarters (to include the MEDCOM [DS], MEDBDE [SPT], and MMB).

MEDICAL LOGISTICS MANAGEMENT CENTER

12-3. The MEDLOG management center provides theater-level centralized management of critical Class VIII commodities, patient movement items, medical contracting support, and medical equipment maintenance in accordance with the theater surgeon's policy. The MEDLOG management center provides two forward support teams (early entry) and two forward support teams (follow-on). The MEDLOG management center is capable of deploying these teams, while maintaining base operations in CONUS. One forward support team (early entry) and one forward support team (follow-on) combine to make one complete forward support team. The forward support teams (follow-on) are not meant to deploy independently of the forward support team (early entry). One team is deployed per theater. When deployed, the forward support team is subordinate to the MEDCOM (DS) or senior medical headquarters (such as the MEDBDE [SPT]) and collocates with the distribution management center of the TSC/ESC. When so designated, the MEDLOG management center, with the MEDLOG Company, serves as the single integrated MEDLOG manager for joint operations. The MEDLOG management center also provides technical guidance to medical contracting personnel within the AO.

MEDICAL LOGISTICS COMPANY

12-4. The MEDLOG company provides medical materiel, field and limited sustainment medical equipment maintenance and repair, optical lens fabrication and repair, and patient movement items support to BCTs and EAB AHS units operating within the AO. One MEDLOG company is deployed per 13 short tons of Class VIII supplies per day and provides 220 hours of field-level maintenance per day. The MEDLOG Company can deploy one early entry team, three contact repair teams, and three forward distribution teams. The MEDLOG Company has no organic blood support capability. The MEDLOG Company has the capability for limited self-sustainment during initial operations, meeting the requirement for early entry into the AO or as part of a task force organization. The company is normally under the command of the headquarters and headquarters detachment, MMB.

MEDICAL DETACHMENT (BLOOD SUPPORT)

12-5. The medical detachment (blood support) provides collection, manufacturing, storage, and distribution of blood and blood products for brigade and EAB AHS units and other Services as required. The detachment receives and stores up to 5,100 refrigerated and/or frozen blood products from CONUS or other U.S. MTFs and further distributes these products to supported MTFs and AHS units. This unit also coordinates the movement of blood and blood products and tracks shipments to ensure proper delivery. The detachment is assigned to the MMB.

MEDICAL DETACHMENT OPTOMETRY

12-6. The medical detachment (optometry) provides optometry care and optical fabrication and repair support for brigade and EAB units on an area basis. The detachment consists of six personnel that can be divided into two teams. Each team is capable of providing optometry support to include routine eye examinations, refractions, optical fabrication, frame assembly, and repair services. The optometry detachment is assigned to the MEDCOM (DS) or MEDBDE (SPT) with further attachment to an MMB or BCT.

PRIMARY TASKS

12-7. Table 12-1 (on page 12-3) describes the primary tasks and purposes of the medical logistics function.

12-8. Refer to JP 4-02, TM 4-02.70, TM 8-227-3, TM 8-227-11, TM 8-227-12, and ATP 4-02.1.

SECTION III — STRATEGIC MEDICAL LOGISTICS SUPPORT

12-9. Strategic logistics functions are performed in CONUS and within each within each of the combatant commands. Medical logistics activities at the strategic level include:

- Determination of materiel requirements.
- Acquisition, assembly, and fielding of medical supplies and equipment.
- Management of strategic programs for medical force modernization and materiel readiness.

12-10. Strategic medical logistics capabilities also include planning and executing the release or acquisition of Class VIII materiel to complete the outfitting of medical units at the time of deployment and coordination for movement into the theater and staging areas. Strategic medical logistics support is provided by a number of organization to include the Defense Logistics Agency, U.S. Army medical Research and Development Command, and Army Materiel Command. These organizations use multiple sources for support to operating force to include: commercial supplier networks Defense Logistics Agency stocks, Army pre-positioned stocks, operational project stocks, and other materiel readiness programs as well as the following:

Table 12-1. Primary tasks and purposes of the medical logistics function

Primary task	*Purpose*
Execute medical materiel procurement	Program funding, develop, acquire, and field the most cost-effective and efficient medical materiel support to satisfy materiel requirements generated by doctrinal and organizational revisions to tables of organization and equipment, as well as user-generated requirements, state-of-the-art advancements, and initiatives to enhance materiel readiness.
Conduct Class VIII management and coordinate distribution	Provide intensive management and coordinated distribution of specialized medical products and services required to operate an integrated Army Health System anywhere in the world in peace and throughout the competition continuum.
Perform medical equipment maintenance and repair	Perform appropriate maintenance checks, services, repairs, and tests on medical equipment set component equipment items as specified in applicable technical manuals or manufacturer operating instructions.
Conduct optical fabrication and repair	Fabricate and repair prescription eyewear that includes spectacles, protective mask inserts, and similar ocular devices for eligible personnel in accordance with applicable Army policies and regulations.
Provide blood management (and coordination for distribution)	Provide collection, manufacturing, storage, and distribution of blood and blood products to echelons above brigade Army Health System units. Provide coordination for distribution of blood and blood products to Role 2 medical treatment facilities and forward surgical teams.
Perform centralized management of patient movement items	Support in-transit patients, exchange in-kind patient movement items without degrading medical capabilities, and provide prompt recycling of patient movement items from initial movement to the patient's final destination.
Conduct health facilities planning and management	Provide a reliable inventory of facilities that meet specific codes and standards, maintains accreditation, and affords the best possible health care environment for the Soldiers, Family members, and retired beneficiaries.
Provide medical contracting support	Ensure the establishment and monitoring of contracts for critical medical items and services.
Ensure hazardous medical waste management and disposal	Ensure the proper collection, control, transportation, and disposal of regulated medical waste in accordance with applicable Army and host-nation policies and regulations.
Ensure production and distribution of medical gases	Ensure the production, receipt, storage, use, inspection, transportation, and handling of medical gases and their cylinders in accordance with all applicable regulations.

- The Defense Logistics Agency, as the DOD executive agent for medical materiel, coordinates medical prime vendor and other strategic acquisition programs to enable operational and strategic level MEDLOG organizations to order and receive materiel directly from commercial suppliers. The Defense Logistics Agency also coordinates these programs with the United States Transportation Command to enable direct delivery to Army medical materiel centers in theater without intermediate government inventory or handling.
- The U.S. Army Medical Research and Development Command is the Army's medical materiel developer, with responsibility for medical research, development, and acquisition. The U.S. Army Medical Research and Development Command manages and executes research in military infectious diseases, combat casualty care, military operational medicine, chemical biological defense, and clinical and rehabilitative medicine. The command's product line includes vaccines, pharmaceuticals, medical devices, medical equipment, and information technology. They work

closely with Army Materiel Command's Army Medical Logistics Command to ensure timely procurement and fielding of lifesaving products to the deployed force.

- The U. S. Army Materiel Command is the Army's materiel integrator providing national-level sustainment, acquisition integration support, contracting support, and selected logistics support to Army forces. Army Materiel Command provides related common support to other Services, multinational, and interagency partners. Army Materiel Command's capabilities are diverse and are accomplished through its various major subordinate commands which include the Army Medical Logistics Command for strategic-level medical logistics support. Refer to FM 4-0 for additional information.

12-11. The U.S. Army Medical Logistics Command is the life cycle management command for MEDLOG. The Army Medical Logistics Command manages and sustains medical programs for operational forces in the Total Army and delivers/fields medical solutions (on behalf of the Army Medical Program Executive Office). The command manages strategic-level medical materiel and logistics services required to generate and deploy ready medical forces and sustain Army and Joint health services. The Army Medical Logistics Command's core competencies include management of medical supply (Class VIIIA), MEDLOG operations that include theater-level medical logistics support, medical equipment maintenance and recapitalization, optical fabrication, and the Army's globally employed centralized medical materiel readiness programs. The Army Medical Logistics Command's subordinate organizations include the:

- U.S. Army Medical Materiel Agency
- U.S. Army Medical Materiel Center-Europe
- U.S. Army Medical Materiel Center-Korea

12-12. The U.S. Army Medical Materiel Agency's mission is to develop, tailor, deliver and sustain medical materiel capabilities and provide worldwide operational MEDLOG support. The Agency has a wide range of strategic roles including materiel fielding, centrally managed MEDLOG programs, Army supply cataloging and set assembly, and medical equipment maintenance and repair. The U.S. Army Medical Materiel Agency has two deployable teams: the MEDLOG Support Team and the Forward Repair Activity-Medical Team.

- The MEDLOG support team is a deployable table of distribution and allowances organization consisting of MEDLOG personnel military, DA Civilians, and contractors. The mission of the MEDLOG support team is to deploy to–designated locations worldwide, to provide medical materiel and medical equipment maintenance capabilities and solutions in support of Army strategic and contingency programs. Upon initial deployment for hand-off of Army Pre-positioned Stock, the MEDLOG support team is normally under the operational control of the United States Army Materiel Command's Army field support brigade. The primary role of the MEDLOG support team is the issue of medical Army pre-positioned stocks, unit sets, and sustainment stocks pre-positioned around the world. After completing the Army Pre-positioned Stocks transfer or other assigned mission, the MEDLOG support team redeploys to CONUS. Refer to ATP 4-02.1 for additional information.
- The Forward Repair Activity-Medical Team provides sustainment-level medical equipment maintenance support and technical expertise to deployed medical units in theater. The team is operated as a deployable section with the U.S. Army Medical Materiel Agency depot-level maintenance activities to extend sustainment maintenance capabilities to augment theater intermediate-level organizations as required. The members of the Forward Repair Activity-Medical Team are technical experts in one of five commodities including laboratory equipment, pulmonary, oxygen generation, anesthesia equipment, or medical imaging systems. The team may deploy as part of the MEDLOG support team for issue of medical Army Pre-positioned Stock. Upon completion of the Army Pre-positioned Stock transfer, the team may redeploy to CONUS or remain to augment theater medical equipment maintenance capabilities under the operational control of the theater medical materiel center.

12-13. The U.S. Army Medical Materiel Center-Europe provides and projects MEDLOG support across the competition continuum to the U.S. European Command, U.S. Central Command, U.S. Africa Command, and the U.S. Department of State.

12-14. The U.S. Army Medical Materiel Center-Korea serves as U.S. Forces Korea's theater lead agent for medical materiel and is responsible for ensuring that tactical units are integrated into the medical supply chain. The Medical Materiel Center also assists the CCDR in MEDLOG support planning and contributes to the Eighth Army's medical readiness by managing and fielding countermeasures used to protect and treat Soldiers in the event of a CBRN attack.

SECTION IV — MEDICAL LOGISTICS SUPPORT FOR ROLES 1 AND 2 MEDICAL TREATMENT FACILITIES

12-15. The Class VIII supply functions for AHS units/elements operating Roles 1 and 2 MTFs are primarily the management of medical equipment sets, basic ordering for replenishment, and field-level medical equipment maintenance and repair support. Within the BCT, these functions are performed by the brigade medical supply office of the brigade support medical company and the MEDLOG Company operating at echelons above brigade. Refer to ATP 4-02.1 for information on MEDLOG.

SECTION V — MEDICAL LOGISTICS SUPPORT FOR ROLE 3 MEDICAL TREATMENT FACILITIES

12-16. Theater hospitalization is provided by Army Role 3 CSHs and hospital centers operating at EAB. Class VIII support for Role 3 MTFs is a vital part of its mission and includes management of a commodity that must be adapted to specific theater health care requirements distribution plans and capabilities provided by sustainment organizations.

12-17. During port operations and reception, staging, onward movement, and integration these AHS units must be capable of operations immediately upon initial entry of forces. Therefore, MEDLOG support must be included in planning for port opening and early entry operations. Port operations may also include the issue of AHS unit sets from Army Pre-positioned Stocks as well as integration of potency and dated items, refrigerated, and controlled substances. In almost every operation, lessons learned reflect that theater MEDLOG units must also provide Class VIII materiel for unit shortages that were not filled prior to unit deployment.

12-18. Class VIII sustainment of CSHs and hospital centers present the most complex medical materiel requirements and may consume materiel at a tremendous rate when providing trauma care in support of operations. Specialty care for burn injuries, orthopedic injuries and surgeries, and neurosurgery often require materiel and equipment that is not standard and may not have been anticipated or stocked in sufficient quantities prior to deployment. Combat support hospitals are typically made direct customers of a MEDLOG company/element that is capable of meeting the unit's mission requirements.

12-19. Theater hospitalization is provided by CSHs and hospital centers that operate Role 3 MTFs. Army CSHs and hospital centers are located at EAB. Role 3 MTF and forward surgical teams/forward resuscitative surgical detachments deployed from the CSH or hospital center are dependent on their supporting MEDLOG Company for Class VIII resupply and medical equipment maintenance and repair, and the medical detachment (blood support) for distribution of blood and blood products.

SECTION VI — MEDICAL LOGISTICS SUPPORT TO JOINT HEALTH SERVICES

12-20. Theater lead agent for medical materiel is an organization or unit designated to serve as a major theater medical distribution node and provide the customer support interface for MEDLOG and supply chain management. The designation of a Service organization to serve as the theater lead agent for medical material (TLAMM) is a critical element of the Defense Logistics Agency's implementation of the Executive Agent for Medical Materiel. A TLAMM operates in the DOD medical supply chain using business processes and systems developed and standardized by the Defense Logistics Agency and Military Health System to promote effectiveness and efficiency. According to DODI 5101.15, the Defense Logistics Agency Director, in coordination with the CCDR, Chairman of the Joint Chiefs of Staff, and the Secretaries of the Military

Departments, recommend the designation of a TLAMM as necessary to ensure effective and efficient medical supply chain support to the CCDR. Once designated, the unit serving as the TLAMM remains within the chain of command of their parent organization (such as the parent combatant command, DOD component, or other headquarters element). As designated TLAMMs, the Army's theater medical materiel centers use DOD standard business processes and systems to provide theater-level Class VIIIA supply support to joint forces operating in their supported area of responsibility.

12-21. Title 10, United States Code requires that each Service provide its own logistics support, which makes MEDLOG support a Service responsibility. However, in joint operations, a CCDR may assign specific common user logistics functions, to include both planning and execution, to a lead Service. The Army is typically the predominant provider of forces in unified land operations and owns the preponderance of MEDLOG capability. Therefore, CCDRs often assign the ASCC (or Army component of a joint task force) responsibility to plan and execute MEDLOG support to all Services and multinational partners (when directed) operating in the theater. This function is known as SIMLM support. When assigning SIMLM responsibility, the CCDR specifies the scope and duration of MEDLOG support to be provided (such as medical supply, medical equipment maintenance, or optical fabrication). The performance of SIMLM responsibilities requires close coordination with the ASCC surgeon, MEDCOM (DS), and medical elements of the supported Services to ensure mutual understanding of requirements, expectations, and processes for MEDLOG support. Refer to ATP 4-02.1 and JP 4-02 for additional information.

Appendix A

Army Health System Support to the Army's Strategic Roles

The Army's primary mission is to organize, train, and equip its forces to conduct prompt and sustained land combat to defeat enemy ground forces and seize, occupy, and defend land areas. The Army accomplishes its mission by supporting the joint force in four strategic roles: shape OEs, prevent conflict, conduct large-scale ground combat operations, and consolidate gains. For more information on the Army's strategic roles, refer to FM 3-0.

SHAPE OPERATIONAL ENVIRONMENTS

A-1. Shaping activities are continuous within an area of responsibility. The CCDR (command authority) uses them to improve security within partner nations, enhance international legitimacy, gain multinational cooperation, and influence adversary decision making. This cooperation includes information exchange and intelligence sharing, obtaining access for U.S. forces in peacetime and crisis, and mitigating conditions that could lead to a crisis.

A-2. Army forces conduct operations to shape OEs with various unified action partners through careful coordination and synchronization facilitated by the theater army through the GCC, and when authorized, directly with the partner nation's military forces. Army forces provide security cooperation capabilities area of responsibility-wide, including building defense and security relationships and partner military capacity through exercises and engagements, gaining or maintaining access to populations, supporting infrastructure through assistance visits, and fulfilling EA responsibilities. Military-to-military contacts and exchanges, joint and combined exercises, various long-term persistent military engagements, and other security cooperation activities provide the foundation of the GCC's theater campaign plan. Key medical considerations in support of operations to shape include:

- Regionally focused medical command and control to promote unity of purpose of all engaged medical assets.
- Medical information management to document health threat exposures and medical encounters, to report health surveillance data and information on the health of the command, and to accomplish medical regulating and patient tracking operations.
- Traditional medical support to a deployed force engaged in performing these tasks.
- Medical expertise and consultation to enhance building partnership capacity in public, private, and military health sectors of the host nation.
- Development of regional theater security cooperation plans aimed at mitigating or resolving the underlying causes of health issues prevalent within the region.
- Army Health System support for maintenance and execution of medical support agreements.
- Home station medical readiness and training activities, and tailored force generation of medical combat power.
- Army medical support to other Services and unified action partners, as well as assessment and release of theater Army prepositioned stocks and other medical logistics support.
- Capability gaps and determine mitigation plan.
- Theater evacuation policy adjustments.
- Coordination with USTRANSCOM for patient movement plans.
- Integration and interoperability of theater medical capabilities.
- Army Health System support to foreign humanitarian assistance and disaster relief.
- Medical preparation of the OE.

A-3. See Figure A-1 for an example depiction of AHS support during operations to shape.

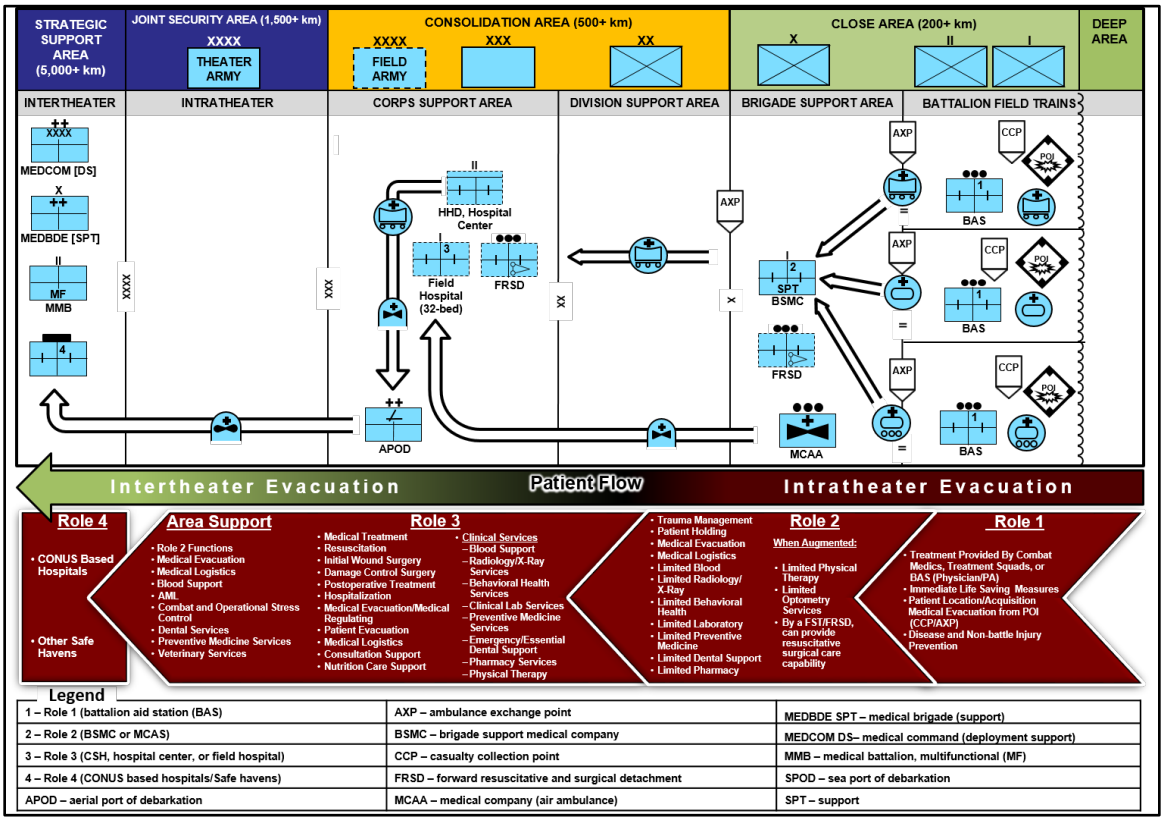

Figure A-1. Army Health System support during operations to shape

PREVENT CONFLICT

A-4. The intent of operations to prevent is to deter adversary actions and stop further deterioration of a particular situation. Prevent activities enable the joint force to gain positions of relative advantage prior to future combat operations. Operations to prevent are characterized by actions to protect friendly forces and indicate the intent to execute subsequent phases of a planned operation. With the shift from shaping to deterrence, the theater army shifts to refining contingency plans and preparing estimates for land power based on GCC's guidance. The theater army and subordinate Army forces perform the following major activities during operations to prevent:

- Execute flexible deterrent options and flexible response options.
- Set the theater.
- Tailor Army forces.
- Project the force.

A-5. The AHS support during operations to prevent includes coordination, integration, and synchronization of strategic medical capabilities from the U.S. sustaining base, global health engagements, establishment and maintenance of medical support agreements, as well as the following:

- Executing AHS support to other Services when directed.
- Recommending theater evacuation policy adjustments.
- Providing theater food protection support.
- Coordinating with USTRANSCOM for patient movement plans.
- Ensuring integration and interoperability of theater medical capabilities.
- Conducting medical preparation of the OE.

- Maximizing use of host-nation medical capabilities.
- Establishing and executing OEH surveillance programs and countermeasures.
- Coordinating with the National Center for Medical Intelligence, Centers for Disease Control and Prevention, and other strategic partners for identification and mitigation of regional health threats.
- Planning and coordination for AHS support to—
  - Noncombatant evacuation operations.
  - Detainee operations.
  - Reception, staging, onward movement, and integration, and theater opening.
  - Large-scale casualty events and prolonged care.
  - Other Services.

A-6. See Figure A-2 for an example depiction of AHS support during operations to prevent.

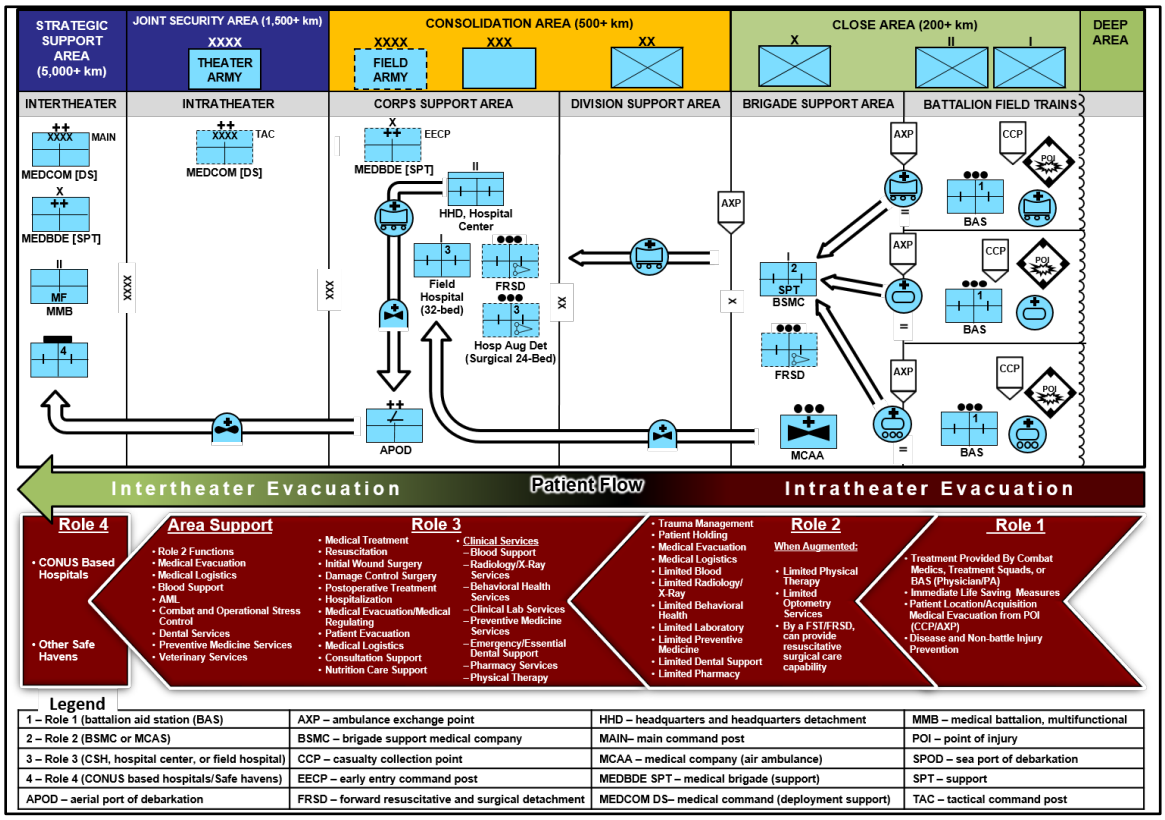

Figure A-2. Army Health System support during operations to prevent

CONDUCT LARGE SCALE GROUND COMBAT OPERATIONS

A-7. During large-scale ground combat operations, Army forces defeat the enemy. Defeat of enemy forces in close-combat operations is normally required to achieve campaign objectives and national strategic goals after the commencement of hostilities. Planning for sequels to consolidate gains at higher levels should be informed by combat operations and vice versa. However, the demands of large-scale ground combat operations consume all available staff capability at the tactical level.

A-8. In large-scale ground combat operations against a peer threat, commanders conduct decisive action to seize, retain, and exploit the initiative. This involves the orchestration of many simultaneous unit actions in the most demanding of operational environments. Large-scale ground combat operations introduce levels of complexity, lethality, ambiguity, and speed to military activities not common in other operations. Large-

scale ground combat operations require the execution of multiple tasks synchronized and converged across multiple domains to create opportunities to destroy, dislocate, disintegrate, and isolate enemy forces.

A-9. Army forces defeat enemy organizations, control terrain, protect populations, and preserve joint force and unified action partner freedom of movement and action in the land and other domains. Commanders are directly concerned with those enemy forces and capabilities that can affect their current and future operations. Medical command and control gives subordinate medical units at all echelons the freedom to provide a rapid response to acquire wounded, injured, and ill personnel clearing the battlefield of casualties and facilitating and enhancing the tactical commander's freedom of movement and maneuver.

A-10. Large-scale ground combat operations place a significant burden on medical resources due to the magnitude and lethality of the forces involved. Medical units must anticipate large numbers of casualties in a short period of time due to the capabilities of modern conventional weapons and the possible employment of weapons of mass destruction. These mass casualty situations can rapidly exceed the capabilities of medical assets. Careful planning and coordination is necessary to minimize the extent to which medical capabilities are overwhelmed. Casualty evacuation must occur concurrently with operations. Units that cease aggressive maneuver to evacuate casualties while in enemy contact are likely to both suffer additional casualties while stationary and fail their mission. Effective management of mass casualty situations depends on established and rehearsed unit-level mass casualty plans. There are a number of other variables which can ensure the success of a unit's mass casualty response. These include, but are not limited to:

- Coordination of additional medical support and augmentation of- medical evacuation support, forward resuscitative and surgical detachments, combat support and field hospitals, casualty collection points, ambulance exchange points, and established Class VIII resupply.
- Rapid clearance of casualties from the battlefield (independent of MEDEVAC).
- Providing effective tactical combat casualty care for the injured.
- Continuous flow of casualties to the MTFs at the next higher role of care.
- Use of alternative assets when the number of casualties overwhelms the capacity of available medical evacuation systems.

A-11. The AHS support during large-scale ground combat operations include but not limited to:

- Provide organic Roles 1 and 2 medical treatment and on an area basis.
- Provide Role 3 medical treatment.
- Medical evacuation and/or CASEVAC from POI to MTF.
- Intra/Intertheater patient movement (between medical treatment facilities).
- Provide forward resuscitative surgery to stabilize nontransportable patients for evacuation out of theater.
- Emergency movement of Class VIII (to include blood), medical personnel, and medical equipment.
- Coordinate medical evacuation plan with the combat aviation brigade for air ambulance support.
- Coordinate with United States Air Force for strategic aeromedical evacuation and medical regulating.
- Manage patient movement items.
- Conduct medical and OEH surveillance.
- Conduct health risk assessment and communications.
- Provide veterinary medical treatment for MWDs and government-owned animals.
- Force rotation (reception, staging, onward movement, and integration).
- Sustainment of AHS support operations (possible nontraditional sources of support from other Services, multinational forces, or host nation without habitual support relationships).
- Unit reconstitution may be accomplished using modular teams.
- Care for detainees (increased requirements for public health support, primary care, care of chronic diseases/conditions).

A-12. See Figure A-3 for an example depiction of AHS support during large-scale ground combat operations.

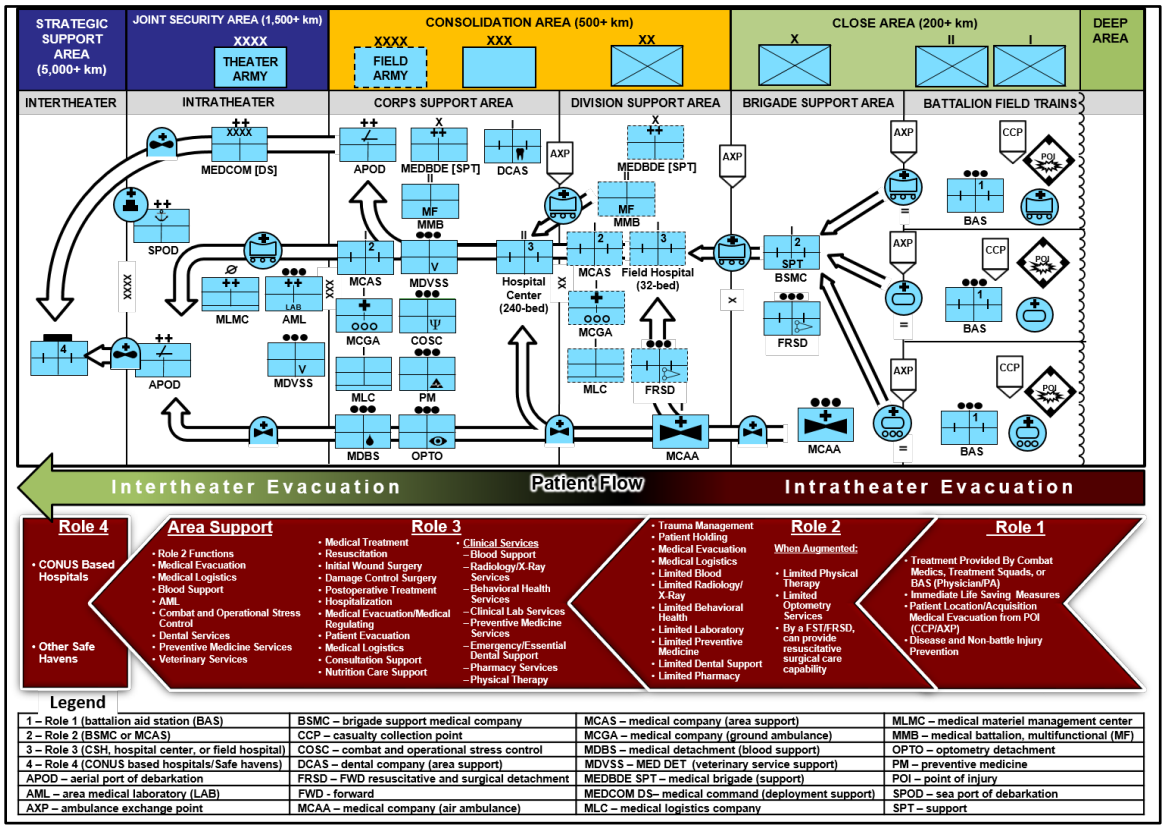

Figure A-3. Army Health System support during large-scale ground combat operations

CONSOLIDATE GAINS

A-13. Army forces provide the joint force commander the ability to capitalize on operational success by consolidating gains. Consolidate gains is an integral part of winning armed conflict and achieving success across the competition continuum. It is essential to retaining the initiative over determined enemies and adversaries. Army forces reinforce and integrate the efforts of all unified action partners when they consolidate gains.

A-14. Army forces consolidate gains in support of a host nation and its civilian population, or as part of the pacification of a hostile state. These gains may include the establishment of public security temporarily by using the military as a transitional force, the relocation of displaced civilians, reestablishment of law and order, performance of humanitarian assistance, and restoration of key infrastructure. Concurrently, corps and divisions must be able to accomplish these activities while sustaining, repositioning, and reorganizing subordinate units to continue operations in the close area. Refer to ATP 3-91 and ATP 3-92 for more information.

A-15. Upon successful termination of large-scale ground combat operations, Army forces in the close area transition rapidly to the conduct of consolidation of gains activities. Alternatively, they may be relieved in place by another unit. Consolidation of gains activities may encompass a lengthy period of post conflict operations prior to redeployment. This transition to consolidation of gains may occur even if large-scale ground combat operations are occurring in other parts of an AO in order to exploit tactical success. Anticipation and early planning for activities after large-scale ground combat operations ease the transition process.

A-16. The joint force commander defines the conditions to which an AO is to be stabilized. The theater army is normally the overseer of the orderly transition of authority to appropriate U.S., international, interagency, or host-nation agencies. The theater army and subordinate commanders emphasize those activities that

reduce post-conflict or post-crisis turmoil and help stabilize a situation. Commanders address the decontamination, disposal, and destruction of war materiel. They address the removal and destruction of unexploded ordnance and the responsibility for demining operations.

A-17. The consolidation of friendly and available enemy mine field reports is critical to this mission. Additionally, the theater army must be prepared to provide AHS support, emergency restoration of utilities, support to social needs of the indigenous population, and other humanitarian activities as required. (See ADP 3-07 and FM 3-07 for more information on the performance of stability tasks). Army Health System support during operations to consolidate gains includes but not limited to:

- Coordinate, integrate, and synchronize AHS resources into the interagency efforts. Provide medical expertise to identify and analyze critical needs emerging within the operational area.
- Manage medical information to facilitate medical regulating of victims to facilities outside of the operational area and to document medical treatment.
- Assist affected host nation medical infrastructure in saving lives, reducing long-term disability, and alleviating human suffering.
- Assist the local government in conducting rescue operations and providing medical evacuation of victims to facilities capable of providing the required care.
- Advise local animal, agricultural, and veterinary industry personnel; assess damage of veterinary and animal infrastructure; and provide animal medical care to local animals.
- Conduct preventive measures to respond to and resolve emerging health threats caused by the LSCO.
- Conduct health risk assessment and communications.
- Assist host nation to reestablish its own ability to provide medical services for its population to a reasonable level it possessed prior to hostilities and to support the legitimacy of the host nation.
- Continue to assess running estimates and be prepared to provide all aspects of roles of medical care while reducing capacities in support of redeployment operations and downsizing the footprint in theater (for example, reducing the number of intensive care unit and intermediate care ward beds).

A-18. See Figure A-4 (on page A-7) for an example depiction of AHS support during operations to consolidate gains.

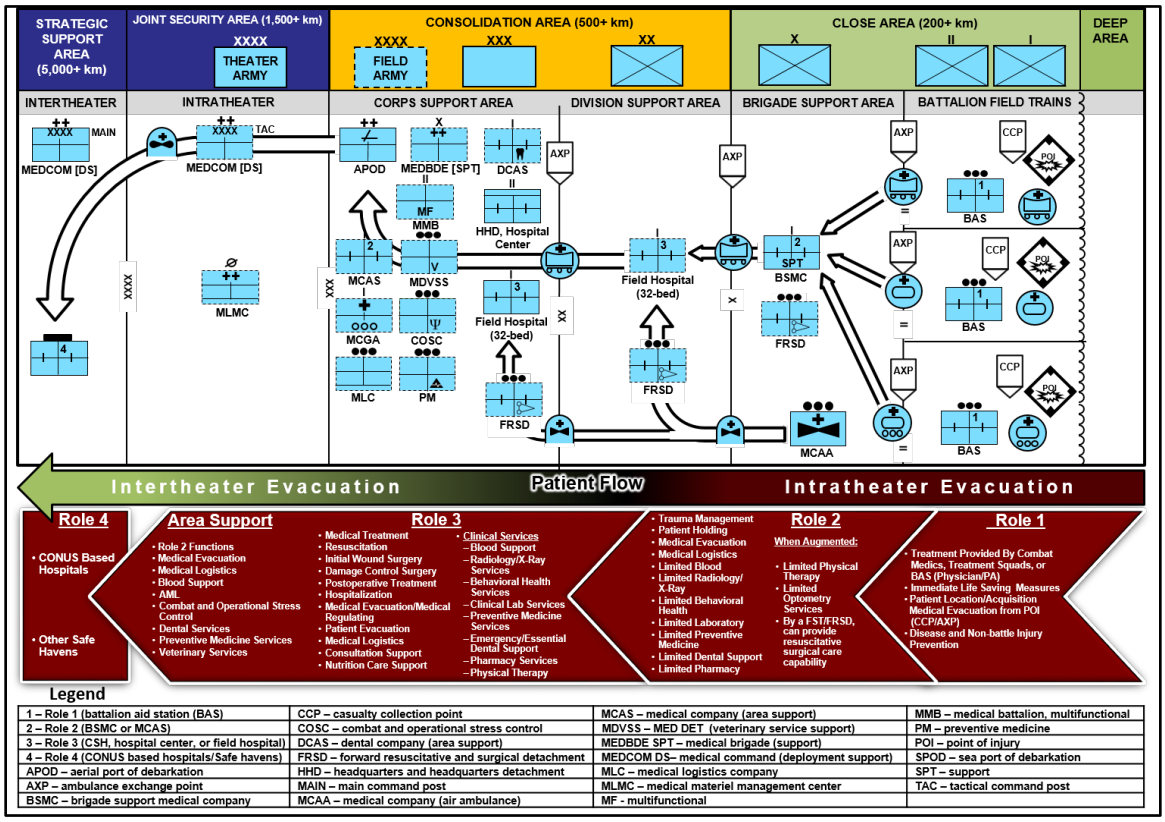

Figure A-4. Army Health System support during operations to consolidate gains

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Appendix B

Command and Support Relationship

This appendix is derived from FM 3-0. It discusses command and support relationships for joint and Army forces. This appendix delineates the four types of joint command relationships, Army command relationships, and Army command support relationships. Command and support relationships provide the basis for unity of command and unity of effort in operations.

FUNDAMENTAL CONSIDERATIONS

B-1. Establishing clear command and support relationships is a key aspect of any operation. Large-scale combat operations present unique and complex challenges that demand well-defined command and support relationships among units. These relationships establish responsibilities and authorities between subordinate and supporting units. Some command and support relationships limit the commander's authority to prescribe additional relationships. Knowing the inherent responsibilities of each command and support relationship allows commanders to effectively organize their forces and helps supporting commanders understand their unit's role in the organizational structure.

JOINT COMMAND RELATIONSHIPS

B-2. As part of a joint force, Army commanders and staffs must understand joint command relationships. JP 1 specifies and details four types of joint command relationships:

- Combatant command (command authority).
- Operational control (OPCON).
- Tactical control (TACON).
- Support.

COMBATANT COMMAND (COMMAND AUTHORITY)

B-3. Combatant command is a unified or specified command with a broad continuing mission under a single commander established and so designated by the President, through the Secretary of Defense and with the advice and assistance of the Chairman of the Joint Chiefs of Staff (JP 1). Title 10, United States Code, section 164 specifies this authority in law. Normally, the CCDR exercises this authority through subordinate JFCs, Service component commanders, and functional component commanders.

OPERATIONAL CONTROL

B-4. Operational control is the authority to perform those functions of command over subordinate forces involving organizing and employing commands and forces, assigning tasks, designating objectives, and giving authoritative direction necessary to accomplish the mission (JP 1). Operational control normally includes authority over all aspects of operations and joint training necessary to accomplish missions. It does not include directive authority for logistics or matters of administration, discipline, internal organization, or unit training. The CCDR must specifically delegate these elements of COCOM. Operational control does include the authority to delineate functional responsibilities and operational areas of subordinate JFCs. In two instances, the Secretary of Defense may specify adjustments to accommodate authorities beyond OPCON in an establishing directive- when transferring forces between CCDRs or when transferring members or organizations from the military departments to a combatant command. Adjustments will be coordinated with the participating CCDRs.

TACTICAL CONTROL

B-5. Tactical control is the authority over forces that is limited to the detailed direction and control of movements or maneuvers within the operational area necessary to accomplish missions or tasks assigned (JP 1). Tactical control is inherent in OPCON. It may be delegated to and exercised by commanders at any echelon at or below the level of combatant command. Tactical control provides sufficient authority for controlling and directing the application of force or tactical use of combat support assets within the assigned mission or task. Tactical control does not provide organizational authority or authoritative direction for administrative and logistic support; the commander of the parent unit continues to exercise these authorities unless otherwise specified in the establishing directive.

SUPPORT

B-6. Support is the action of a force that aids, protects, complements, or sustains another force in accordance with a directive requiring such action (JP 1). Support is a command authority in joint doctrine. A supported and supporting relationship is established by a superior commander between subordinate commanders when one organization should aid, protect, complement, or sustain another force. Designating supporting relationships is important. It conveys priorities to commanders and staffs planning or executing joint operations. Designating a support relationship does not provide authority to organize and employ commands and forces, nor does it include authoritative direction for administrative and logistic support. Joint doctrine divides support into the categories listed in Table B-1 (page B-3).

ARMY COMMAND AND SUPPORT RELATIONSHIPS

B-7. As discussed in Chapter 2, Army command relationships include:

- Organic.
- Assigned.
- Attached.
- OPCON.
- TACON.

B-8. See Table B-1 (on page B-3) for an illustration of Army command relationships.

ORGANIC

B-9. Organic forces are those assigned to and forming an essential part of a military organization as listed in its table of organization for the Army, Air Force, and Marine Corps, and are assigned to the operating forces for the Navy (JP 1). Joint command relationships do not include organic because a JFC is not responsible for the organizational structure of units. That is a Service responsibility.

B-10. The Army establishes organic command relationships through organizational documents such as tables of organization and equipment and tables of distribution and allowances. If temporarily task-organized with another headquarters, organic units return to the control of their organic headquarters after completing the mission. To illustrate, within a BCT, all subordinate battalions are included on the BCT table of organization and equipment. In contrast, within most functional and multifunctional brigades, there is a *base* of organic battalions and companies and a variable mix of assigned and attached battalions and companies.

ASSIGNED

B-11. Assign is to place units or personnel in an organization where such placement is relatively permanent, and/or where such organization controls and administers the units or personnel for the primary function, or greater portion of the functions, of the unit or personnel (JP 3-0). Unless specifically stated, this relationship includes administrative control (ADCON).

Table B-1. Army command relationships

If relation-ship is—	Then inherent responsibilities							
	Have command relation-ship with—	May be task organized by—	Unless modified, ADCON responsi-bility goes through—	Are assigned position or AO by—	Provide liaison to—	Establish and maintain communi-cations with—	Have priorities establish-ed by—	Can impose on gained unit further command or support relationship of—
Organic	All organic forces organized with the HQ	Organic HQ	Army HQ specified in organizin g document	Organic HQ	N/A	N/A	Organic HQ	Attached; OPCON; TACON; GS; GSR; R; DS
Assigned	Gaining unit	Gaining HQ	Gaining Army HQ	OPCON chain of comman d	As require d by OPCO N	As required by OPCON	ASCC or Service-assigned HQ	As required by OPCON HQ
Attached	Gaining unit	Gaining unit	Gaining Army HQ	Gaining unit	As require d by gaining unit	Unit to which attached	Gaining unit	Attached; OPCON; TACON; GS; GSR; R; DS
OPCON	Gaining unit	Parent unit and gaining unit; gaining unit may pass OPCON to lower HQ[1]	Parent unit	Gaining unit	As require d by gaining unit	As required by gaining unit and parent unit	Gaining unit	OPCON; TACON; GS; GSR; R; DS
TACON	Gaining unit	Parent unit	Parent unit	Gaining unit	As require d by gaining unit	As required by gaining unit and parent unit	Gaining unit	TACON; GS; GSR; R; DS

Note. [1]In NATO, the gaining unit may not task-organize a multinational force. (See TACON.)

ADCON	administrative control	HQ	headquarters
AO	area of operations	N/A	not applicable
ASCC	Army Service component command	NATO	North Atlantic Treaty Organization
DS	direct support	OPCON	operation control
GS	general support	R	reinforcing
GSR	general support-reinforcing	TACON	tactical control

ATTACHED

B-12. Attach is the placement of units or personnel in an organization where such placement is relatively temporary (JP 3-0). A unit may be temporarily placed into an organization for the purpose of conducting a specific operation of short duration. Attached units return to their parent headquarters (assigned or organic) when the reason for the attachment ends. The Army headquarters that receives another Army unit through assignment or attachment assumes responsibility for the ADCON requirements, and particularly sustainment, that normally extend down to that echelon, unless modified by directives.

OPERATIONAL AND TACTICAL CONTROL

B-13. For discussion on OPCON and TACON, refer to joint command relationship above.

ARMY SUPPORT RELATIONSHIPS

B-14. Table B-2 (page B-5) lists Army support relationships. As discussed in Chapter 2, the Army support relationships are-

- Direct support.
- General support.
- Reinforcing.
- General support-reinforcing.

B-15. Commanders assign a support relationship for several reasons. They include when-

- The support is more effective if a commander with the requisite technical and tactical expertise controls the supporting unit rather than the supported commander.
- The echelon of the supporting unit is the same as or higher than that of the supported unit. For example, the supporting unit may be a brigade, and the supported unit may be a battalion. It would be inappropriate for the brigade to be subordinated to the battalion; hence, the echelon uses an Army support relationship.
- The supporting unit supports several units simultaneously. The requirement to set support priorities to allocate resources to supported units exists. Assigning support relationships is one aspect of mission command.

B-16. Army support relationships allow supporting commanders to employ their units' capabilities to achieve results required by supported commanders. Support relationships are graduated from an exclusive supported and supporting relationship between two units-as in direct support-to a broad level of support extended to all units under the control of the higher headquarters-as in general support. Support relationships do not alter administrative control. Commanders specify and change support relationships through task organization.

B-17. Direct support is a support relationship requiring a force to support another specific force and authorizing it to answer directly to the supported force's request for assistance. A unit assigned a direct support relationship retains its command relationship with its parent unit, but it is positioned by and has priorities of support established by the supported unit. (Joint doctrine considers direct support a mission rather than a support relationship.) A field artillery unit in direct support of a maneuver unit is concerned primarily with the fire support needs of only that unit. The fires cell of the supported maneuver unit plans and coordinates fires to support the maneuver commander's intent. The commander of a unit in direct support recommends position areas and coordinates for movement clearances where the unit can best support the maneuver commander's concept of the operation.

B-18. General support is that support which is given to the supported force as a whole. It is not given to any particular subdivision of the force. Units assigned a general support relationship are positioned and have priorities established by their parent unit. A field artillery unit assigned in general support of a force has all of its fires under the immediate control of the supported commander or the designated force field artillery headquarters.

B-19. Reinforcing is a support relationship requiring a force to support another supporting unit. Only like units (for example, artillery to artillery) can be given a reinforcing mission. A unit assigned a reinforcing support relationship retains its command relationship with its parent unit, but it is positioned by the reinforced unit. A unit that is reinforcing has priorities of support established by the reinforced unit, then the parent unit. For example, when a direct support field artillery battalion requires more fires to meet maneuver force requirements, another field artillery battalion may be directed to reinforce the direct support battalion.

Table B-2. Army support relationships

If relation-ship is—	Then inherent responsibilities							
	Have command relation-ship with—	May be task-organized by—	Receive sustain-ment from—	Are assigned position or an area of operations by—	Provide liaison to—	Establish and maintain communi-cations with—	Have priorities establish-ed by—	Can impose on gained unit further command or support relationship of—
Direct support1	Parent unit	Parent unit	Parent unit	Supported unit	Supported unit	Parent unit; supported unit	Supported unit	See note1
Reinforcing	Parent unit	Parent unit	Parent unit	Reinforced unit	Reinforced unit	Parent unit; reinforce unit	Reinforced unit; then parent unit	Not applicable
General support-reinforcing	Parent unit	Parent unit	Parent unit	Parent unit	Reinforced unit and as required by parent unit	Reinforced unit and as required by parent unit	Parent unit; then reinforced unit	Not applicable
General support	Parent unit	Parent unit	Parent unit	Parent unit	As required by parent unit	As required by parent unit	Parent unit	Not applicable

Note. [1]Commanders of units in direct support may further assign support relationships between their subordinate units and elements of the supported unit after coordination with the supported commander.

B-20. General support-reinforcing is a support relationship assigned to a unit to support the force as a whole and to reinforce another similar-type unit. A unit assigned a general support-reinforcing support relationship is positioned and has its priorities established by its parent unit and secondly by the reinforced unit. For example, an artillery unit that has a general-support-reinforcing relationship supports the force as a whole and provides reinforcing fires for other artillery units.

ADMINISTRATIVE CONTROL

B-21. Administrative control is direction or exercise of authority over subordinate or other organizations in respect to administration and support (JP 1). ADCON is not a command or support relationship; it is a Service authority. It is exercised under the authority of and is delegated by the Secretary of the Army. ADCON is synonymous with the Army's Title 10 authorities and responsibilities.

B-22. ADCON responsibilities of Army forces involve the entire Army, and they are distributed between the Army institutional force and the operating forces. The institutional force consists of those Army organizations whose primary mission is to generate and sustain the operating force's capabilities for employment by JFCs. Operating forces consist of those forces whose primary missions are to participate in combat and the integral supporting elements thereof. Often, commanders in the operating force and commanders in the institutional force subdivide specific responsibilities. Army institutional force capabilities and organizations are linked to operating forces through co-location and reachback.

B-23. The ASCC is always the senior Army headquarters assigned to a CCDR. Its commander exercises command authorities as assigned by the CCDR and ADCON as delegated by the Secretary of the Army.

ADCON is the Army's authority to administer and support Army forces even while in a combatant command area of responsibility. The COCOM is the basic authority for command and control of the same Army forces. The Army is obligated to meet the CCDR's requirements for the operating forces. Essentially, ADCON directs the Army's support of operating force requirements.

B-24. Unless modified by the Secretary of the Army, administrative responsibilities normally flow from the Department of the Army through the ASCC to those Army forces assigned or attached to that combatant command. ASCCs usually "share" ADCON for at least some administrative or support functions. "Shared ADCON" refers to the internal allocation of Title 10, U.S. Code, section 3013(b) responsibilities and functions. This is especially true for Reserve Component forces. Certain administrative functions, such as pay, stay with the Reserve Component headquarters, even after unit mobilization. Shared ADCON also applies to direct reporting units of the Army that typically perform single or unique functions. The direct reporting unit, rather than the ASCC, typically manages individual and unit training for these units. The Secretary of the Army directs shared ADCON.

Appendix C

Surgeon and Surgeon Section

Organizations from battalion through ASCC level are authorized a surgeon. Army Medicine leverages the chain of surgeon's cells (staff channels) and medical command and control channels (MEDCOM [(DS], MEDBDE [SPT], and [MMB]) to provide AHS support to the deployed force. Integration of these two channels and other warfighting function elements occur at command headquarters (HQs) at different echelons.

The surgeon is a member of the commander's personal and special staff. Through medical command and control, the surgeon coordinates and synchronizes the medical functions within the protection and sustainment warfighting functions and serves as a link between these varied commands and staffs.

Surgeons at the ASCC/theater, corps, division, and brigade level are authorized a surgeon staff. The surgeon's staff is considered special staff and executes the actions required of the surgeon.

The surgeon and the surgeon sections at each echelon work with their commands and staffs to conduct planning, coordination, synchronization, and integration of AHS support. This ensures the consideration of all ten medical functions is included in the command's running estimates, OPLANs, and OPORDs.

SURGEON

C-1. The surgeon is a Medical Corps officer and member of the commander's personal and special staff. The surgeon normally work under the staff supervision of the chief of staff/executive officer. The surgeon is responsible for coordinating health assets and operations within the command. This officer provides and oversees medical care to Soldiers, civilians, and detainees. The surgeon prepares Appendix 9 (Force Health Protection) of Annex E (Protection) and Appendix 3 (Health Service Support) of Annex F (Sustainment) to the operation order or operation plan. If operating in a joint headquarters (Theater/Corps), they have the responsibility of writing Annex Q (Medical Services) to the joint operation order or operation plan (Refer to JP 4-02, Joint Health Services). The surgeon advises the commander and their staff on all medical or medical-related issues. The surgeon's responsibilities include, but are not limited to:

- Advises the commander on the health of the command.
- Responsible for the creation of or contribution to the medical common operating picture and medical concept of support.
- Provides medical treatment (to include CBRN).
- Provides status of the wounded.
- Coordinates MEDEVAC including Army dedicated MEDEVAC platforms (air and ground).
- Determines requirements for the requisition, procurement, storage, maintenance, distribution management, and documentation of Class VIII supplies within the organization.
- Plans for and implements operational public health (including initiating measures to counter the health threat, and establishing medical and OEH surveillance).
- Advises on the effects of the health threat on personnel, rations, and water.

- Advises on health threat requirements including the examination, processing of captured medical supplies, and recommending use of captured medical supplies in support of detainees and other recipients.
- Coordinates dental services.
- Coordinates COSC.
- Ensures the establishment of a viable veterinary services program (including inspection of subsistence and outside the continental U.S. food production and bottled water facilities, veterinary preventive medicine, and animal medical care).
- Ensures an area medical laboratory capability or procedures for obtaining this support from out of theater resources are established for the identification and confirmation of the use of suspect biological and chemical warfare agents by opposition forces. This includes the capability for specimens and samples, packaging and establishing handling requirements, and escort and chain of custody requirements.
- Coordinates clinical laboratory capabilities, including blood banking.
- Advises how operations affect the public health of personnel and the indigenous populations.
- Provides recommendations on allocation, redistribution, determining requirements, and assignment of medical personnel.
- Coordinates with medical unit commanders (to include leaders of medical platoons and sections) for continuous AHS support.
- Provides consultation, mentoring, and technical supervision of subordinate surgeons, physicians, and physician assistants.
- Submits to higher HQs those recommendations on professional medical problems that require research and development.
- Determines AHS training requirements and provides health education and training.
- Ensures field medical records and/or electronic medical records, when available, are maintained on each Solder at the primary MTF according to AR 40-66.
- Assessing special equipment and procedures required to accomplish the AHS mission in specific environments such as urban operations, mountainous terrain, extreme cold weather operations, jungles, and deserts, requirements varies depending upon the scenario, and could include:
  - Obtaining pieces of equipment of clothing not usually carries (piton hammers, extreme cold weather parka, jungle boots, or the like)
  - Adapting medical equipment sets for a specific scenario to include adding items based on the forecasted types of injuries to be encountered (such as more crushing injuries and fractures in urban operations or mountain operations). In certain scenarios (such as urban operations), some medical supplies and equipment may not be carried into the fight initially (such as sick call materials), but rather brought forward by follow-on forces. In mountain operations, bulky or heavy items (such as extra tentage) may not accompany the force because of the difficulty in traversing the terrain.
  - Having individual Soldiers carry additional medical items, such as bandages and intravenous fluids.

C-2. Through medical command and control, the surgeon coordinates and synchronizes the medical functions within the protection and sustainment warfighting functions and serves as a link between these varied commands and staffs (See Figure C-1; on page C-3).

C-3. Although AHS is broken down into two components; FHP which falls in the protection warfighting function and HSS which resides within the sustainment warfighting function, the AHS is functionally aligned with other warfighting fighting functions. Figure C-2 (on page C-3) below builds on Figure C-1 (on page C3) and depicts the 10 medical functions and how they are aligned within three warfighting functions.

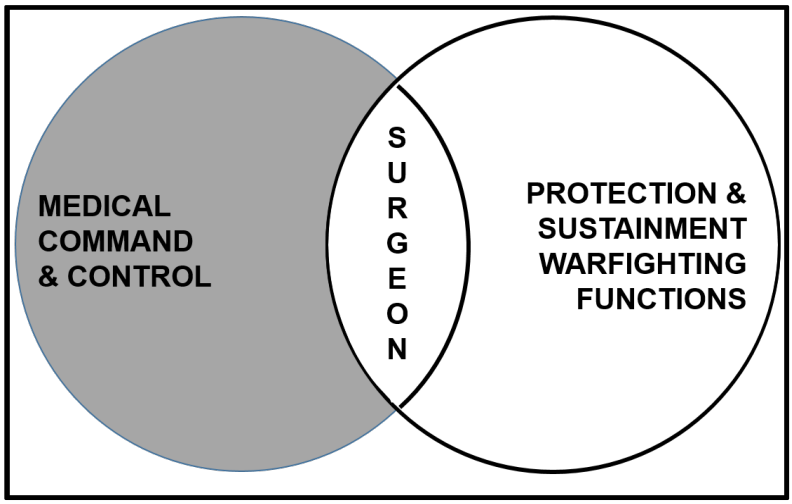

Figure C-1. Surgeon link to medical and warfighting functions

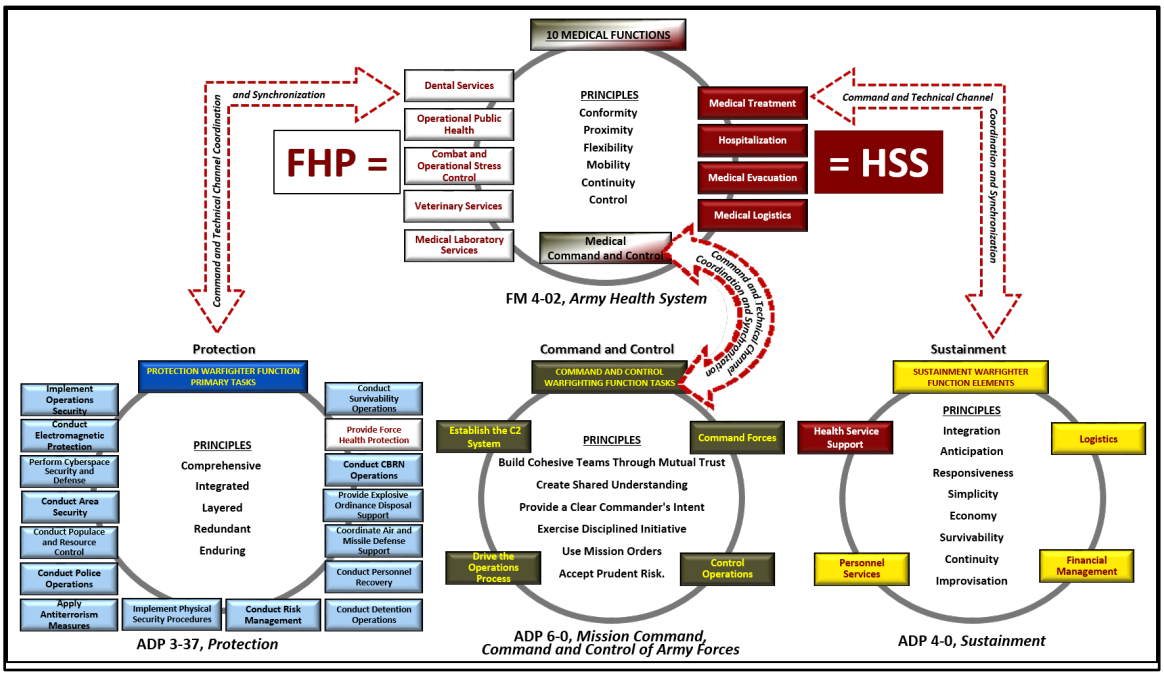

Figure C-2. Ten medical functions aligned with warfighting functions

SURGEON SECTION

C-4. The surgeon section works with many personal, special, and coordinating staffs. At different echelons, they work closely with two functional cells, protection and sustainment. At the theater, corps, and division level, there are chiefs of protection and sustainment. At the brigade and battalion level, the S-3 is responsible for protection and the S-4 is responsible for sustainment. Force health protection falls within the chief of protection/S-3's functional area. Health service support falls within the chief of sustainment's/S-4 functional area. The responsibility of the entire AHS support structure, which includes both FHP and HSS medical functions, rests with the surgeon. Figure C-3 on page C-4 depicts the coordination and synchronization relationship shared between the surgeon, their staffs, and the chief of the protection/S-3 and chief of sustainment/S-4 cells.

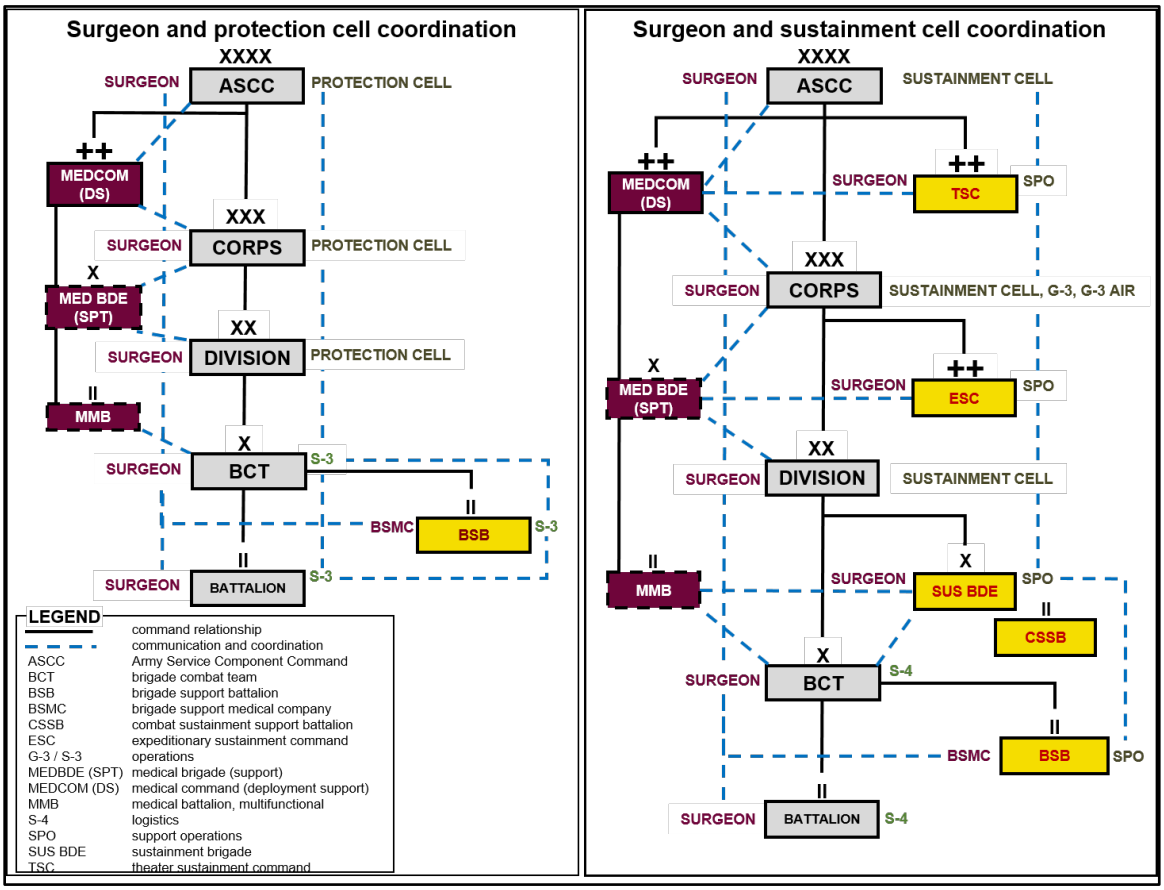

Figure C-3. Surgeon and protection/sustainment cell coordination and synchronization matrix

C-5. The staff of the surgeon is considered special staff and resides in the sustainment cells within corps, divisions, and brigades HQs. The surgeon staff varies in size depending on the echelon (See Table C-1; page C-5). It assists the surgeon in planning and conducting AHS support operations. Functionally, the surgeon's staff section "advises the commander" on medical capabilities and capacities necessary to support plans, and interfaces with operations, intelligence, protection cells, civil affairs, sustainment cells, and host nation authorities to coordinate AHS support across the warfighting functions. Specific functions of the surgeon staff include, but are not limited to:

- Plans and ensures Roles 1 thru 3 medical support for the command is provided in a timely and efficient manner.
- Recommends, develops, and maintains medical troop basis, revises as required, to ensure task organization for mission accomplishment.
- Plans and coordinates AHS support operations for the command and attached/OPCON medical assets. This includes reinforcement and reconstitution.
- Prepares and presents, as directed by the surgeon, the AHS support portion of the command and operational briefings.
- Coordinates with the G-1 (S-1) for tracking critical medical areas of concentration and military occupational specialties.
- Assists the G-1 (S-1) in casualty operations and estimates.
- Collects and disseminates health threat information and coordinates medical intelligence requirements with the G-2 (S-2).
- Facilitates functional integration between AHS and military intelligence staff elements within the command. This supports the G-2/S-2's intelligence preparation of the battlefield.

- Coordinates with the G-3 (S-3) for prioritizing the reallocation of organic and attached/OPCON medical augmentation assets as required by the tactical situation.
- Oversees command tactical standard operating procedures (TSOPs), plans, policies, and procedures for AHS support as prescribed by the surgeon.
- Oversees individual and collective medical training and provides information to the surgeon and commander.
- Coordinates with the G-3 (S-3), G-4 (S-4), and command chemical officer for nonmedical assets for assisting with mass casualties and patient decontamination operations.
- Coordinates with the G-3 (S-3) for additional evacuation assets, as required.
- Coordinates and prioritizes patient evacuation or movement within the command.
- Coordinates patient evacuation from organic MTFs to higher-level roles of medical care.
- Coordinates the MEDEVAC of all detainee casualties.
- Monitors medical regulating and patient tracking operations.
- Coordinates and prioritizes MEDLOG and blood management requirements for the command.
- Coordinates and manages the disposition of captured medical materiel.
- Coordinates, plans, and prioritizes public health missions.
- Monitors disease trends within the command.
- Coordinates dental support when the tactical situation permits.
- Coordinates with the supporting veterinary element pertaining to subsistence and animal disease surveillance.
- Develops and publishes the medical reporting schedule for Force XXI Battle Command Brigade and Below in accordance with FM 6-99 and the commander's guidance. Initiates other reports as necessary (see Table C-2 on page C-6).
- Maintains situational understanding by coordinating for current AHS information with surgeons of the next higher, adjacent, and subordinate headquarters.
- Coordinates, monitors, and synchronizes the execution of AHS support for the command for each war-gamed course of action to ensure a fit and healthy force.
- The surgeon and their sections are responsible for coordinating with many personal, special, and coordinating staffs. This list is not limited to Table C-3 (on page C-7). These tasks and responsibilities are outlined in FM 3-94 and ATPs 3-91, 3-92, and 3-94. For more information, refer to these doctrinal publications.

Table C-1. Surgeon section by echelon

Surgeon Echelon	*Personnel required*
ASCC surgeon section	6-15 personnel required (dependent on type of HQs assigned)
Corps surgeon section	12 personnel required
Division surgeon section	12 personnel required
Brigade surgeon section	3-11 personnel required (dependent on type of brigade assigned)

Table C-2. Medical reports

Report Title	*Report Acronym*
Bed Availability and Element Status	BEDAVAIL
Bed Designations	BEDDESIG
Bed Request	BEDREQ
Blood Shipment Report	BLDSHIPREP
Casualty Report	CASREP
Daily Blood Report	DBLDREP
Medical Evacuation Request	MEDEVAC
Medical Situation Report	MEDSITREP
Medical Spot Report	MEDSPTREP
Medical Status Report	MEDSTAT

THEATER ARMY SURGEON

C-6. The ASCC surgeon is a theater level officer and member of the commander's personal and special staff. The ASCC surgeon is charged with leading the planning and coordination of the AHS support mission within the theater. The ASCC surgeon is the theater army staff proponent responsible for (in coordination with the MEDCOM [DS] commander) the provision of AHS support within the AOR. The ASCC surgeon has staff responsibility for medical planning, coordination, and policy development for AHS support to deployed forces.

C-7. Through medical command and control, the theater army surgeon coordinates and synchronizes the ten medical functions split between the protection and sustainment warfighting functions and serves as a link between these varied commands and staffs.

SURGEON HEADQUARTERS SECTION

C-8. Specific functions of the surgeon HQs section include, but are not limited to:

- Advises the theater army commander on the health of the command and the occupied or friendly territory within the theater AO.
- Determines the health threat and provides advice concerning the medical effects of the environment and of CBRN weapons and personnel, military and contract working dogs, rations, and water. Develops and manages programs to identify health threats, apply risk management, and mitigate such risks.
- Maintains situational understanding by coordinating for current AHS information with the medical operations staffs of subordinate HQs.
- As a member of a joint staff, provides Annex Q (Medical Services) to all operation plans and orders.
- Participates in the sustainment cell working group to integrate and synchronize HSS tasks. Prepares a portion of Annex F (Sustainment) to the operation orders and plans.
- Participates in the protection cell-working group to integrate and synchronize FHP tasks and systems for each phase or transition of an operation or major activity. Prepares a portion of Annex E (Protection) to the operation orders and plans.
- Coordinates with the surgeon general for AHS information and resources.
- Provides for health services in the AOR.
- Monitors execution of AHS support to ensure it supports the CCDR's decisions and intent.

Table C-3. Coordinations between surgeon/surgeon section and staff elements

Coordinating Staff Supported	*Surgeon/Surgeon Section Responsibilities*
Commander/Staff Judge Advocate	As part of a joint HQs, coordinates with the staff judge advocate and chain of command to determine eligibility for medical care in a military MTF.
MEDCOM (DS) / MEDBDE (SPT)	Ensure that the division current and future operations and plans are coordinated with the MEDCOM (DS) and the supporting MEDBDE (SPT).
Assistant Chief of Staff, G-1 (S-1), Personnel	Coordinates and assists with all casualty and DNBI estimates and reporting related issues (casualty operations).
Assistant Chief of Staff, G-2 (S-2), Intelligence	Coordinates on all medical information of a potential intelligence value or medical intelligence related issues.
Assistant Chief of Staff, G-3 (S-3), Operations	Coordinates to establish environmental vulnerability protection levels.
Assistant Chief of Staff, G-3 (S-3), Operations	Coordinates for medical support requests.
Assistant Chief of Staff, G-3 (S-3), Operations	Coordinates for the task organization of corps support medical elements.
Assistant Chief of Staff, G-3 (S-3), Operations	Coordinates for medical contingency operations.
Assistant Chief of Staff, G-3 (S-3), Operations	Coordinates in regards to ground MEDEVAC within the command.
G-3 (S-3) Air	Coordinates in regards to aeromedical and nonstandard air platform evacuation within the command.
Assistant Chief of Staff, J-3, Operations	As part of a joint HQs, develops Annex Q (Medical Services)
Assistant Chief of Staff, G-4 (S-4), Logistics (Chief of Sustainment)	Participates in the sustainment cell-working group. Provides the chief of sustainment with HSS input for Annex F (Sustainment) Appendix 3 (HSS).
Assistant Chief of Staff, G-4 (S-4), Logistics (Chief of Sustainment)	Provides forecasts of the division's MEDLOG requirements during the defense.
Assistant Chief of Staff, G-4 (S-4), Logistics (Chief of Sustainment)	Refer to ATP 3-91, para 5-80 for list of medical coordinations required for a mobile defense.
Assistant Chief of Staff, G-4 (S-4), Logistics (Chief of Sustainment)	Coordinates for food and water inspections.
Assistant Chief of Staff, G-9 (S-9), Civil Affairs Operations	Provides a member to the civil affairs operations working group. Coordinates on the military use of civilian MTFs, medical materiels, and supplies.
Chief of Protection	Participates in the protection cell working group. Provides the chief of protection with FHP input for Annex E (Protection), Appendix 9 (FHP).
CBRN Officer	Coordinates AHS support requirements for CBRN operations. (Annex E (Protection, Appendix 10).
Chaplain	Coordinates the employment of COSC teams with the chaplain to best meet the needs of division Soldiers for stress control.
Detainee operations	Provides a member to the detention operations staff battle drill.
Senior, adjacent, and subordinate command surgeons	Provides the current AHS support plan/MEDCOP to the surgeons/medical operations staffs of senior, adjacent, and subordinate HQs to maintain medical situational awareness.

Table C-3. Coordinations between surgeon/surgeon section and staff elements (continued)

Coordinating Staff Supported	*Surgeon/Surgeon Section Responsibilities*
MTF Liaison	As part of a division staff, establishes a division liaison with the MTFs through which sick, injured, or wounded Soldiers move as they are evacuated outside the division AO.
Host nation local authorities	Coordinates with local authorities concerning environmental and health concerns.
Unified action partners	Works with civil affairs staff and other unified action partners to obtain up-to-date medical intelligence for a projected area of operations.

LEGEND:

AHS – Army Health System	DS – Direct Support	MEDCOP – Medical Common Operating Picture
AO – Area of Operations	FHP – Force Health Protection	MEDEVAC – Medical Evacuation
ATP – Army Technique Publication	HQ – Headquarters	MEDLOG – Medical Logistics
CBRN – Chemical, Biological, Radiological, Nuclear	HSS – Health Service Support	MTF – Medical Treatment Facility
COSC - Combat and Operational Stress Control	MEDBDE – Medical Brigade	SPT – Support
DNBI – Disease Nonbattle Injury	MEDCOM – Medical Command	

- Synchronizes AOR medical resources to ensure effective and consistent treatment of wounded, injured, or sick personnel as to return to full duty or evacuate from the AOR.
- Provides staff oversight for all ten AHS medical functions.
- Coordinates AHS support (including, but not limited to, operational public health, inpatient/outpatient care, ancillary support, medical logistics, patient evacuation, hospitalization, dental support, return to duty, and veterinary services) in preparing and sustaining theater forces.
- Coordinates with the staff judge advocate and chain of command to determine eligibility for medical care in an MTF.
- Determines the policy for the requisition, procurement, storage, maintenance, distribution management, and documentation of Class VIII material, blood and blood products, and special designation of a TLAMM and the assignment of missions for the single integrated MEDLOG manager (SIMLM)
- Recommends changes to the theater evacuation policy and provides input and personnel to the theater patient movement requirements center, as required.
- Recommends theater policy for medically evacuating contaminated patients.

SURGEON MEDICAL OPERATIONS ELEMENT

C-9. Specific functions of the surgeon medical operations element include, but are not limited to:

- Coordinates patient evacuation from theater.
- Manages movement of patients within and from theater.
- Manages flow of casualties within the AOR.
- Monitors the flow of patients to MTFs within the combatant command AOR or for inter-theater evacuation.
- Communicates with the theater patient movement requirements center and the global patient movement requirement center.
- Develops mass casualty plans and determines the medical workload requirements based upon the casualty estimate.
- Recommends medical evacuation policies and procedures, changes to the theater evacuation policy, and provides input to the theater patient movement requirements center.
- Monitors medical regulating and patient tracking operations.

SURGEON SUPPORT OPERATIONS ELEMENT

C-10. Specific functions of the surgeon support operations element include, but are not limited to:

- Manages health services resources in the AO to provide effective and consistent treatment of wounded, injured, or sick personnel as to return to full duty or evacuate from the theater.
- Monitors policies, protocols, and procedures pertaining to the medical and dental treatment of sick, injured and wounded personnel.
- Determines requirements and priorities for medical logistics.
- Evaluates and interprets medical statistical data.

MEDICAL COMMAND (DEPLOYMENT SUPPORT) ROLE

C-11. The MEDCOM (DS) commander is responsible for maintaining a regional focus in support of the GCC and ASCC theater engagement plan, while providing effective and timely direct FHP and HSS to tactical commanders and general support (GS) (on an area basis) to theater forces at EAB. The enduring regional focus of the ASCC drives organizational specialization in the supporting MEDCOM (DS) to address unique health threats, specific needs of the local populace, availability of other Service medical capabilities, and geographic factors that are distinctly related to a particular region. The MEDCOM (DS) coordinates with the ASCC surgeon (as the staff proponent with execution through G-3 channels under the authority of the ASCC commander) to provide AHS support within the AOR.

C-12. As the theater medical command, the MEDCOM (DS) integrates, synchronizes, and provides command and control of MEDBDE (SPT), MMB, and other AHS units providing FHP and HSS to tactical commanders. The MEDCOM (DS) employs an operational CP and a main CP that can deploy autonomously into an operational area and employ based on the size and complexity of operations or the support required. Refer to Figure 2-3 on page 2-6 for an overview of a theater medical structure. Key tasks of a MEDCOM (DS) in support of the ASCC include:

- Providing command and control of MEDBDE (SPT) and subordinate medical units.
- Task-organizing medical elements based on specific medical requirements.
- Monitoring health threats within each operational area and ensuring the availability of required medical capabilities to mitigate those threats.

CORPS SURGEON

C-13. The corps surgeon is a corps level officer and member of the commander's personal and special staff. They normally work under the staff supervision of the corps chief of staff. The corps surgeon is charged with leading the planning and coordination of the AHS support mission within the corps. However, as personal staff, the corps surgeon is the principal advisor to the commander on the health status of the corps and has direct access to the corps commander on all AHS support or medical-related issues. The corps surgeon is responsible for the technical oversight of all medical activities in the command. The corps surgeon oversee and coordinate AHS support activities through the corps surgeon section. The corps surgeon also monitor, prioritize, synchronize, and assess AHS support; serve as medical contract officer for the corps; and provides an analysis of the health threat.

C-14. Through medical command and control, the corps surgeon coordinates and synchronizes the ten medical functions split between the protection and sustainment warfighting functions and serves as a link between these varied commands and staffs.

SURGEON ELEMENT

C-15. The corps surgeon resides in the tactical command post within the surgeon element. This element is responsible for, but not limited to:

- Oversees, monitors, and coordinates AHS support operations.
- Provides current information on the corps AHS support plan/medical common operating picture (MEDCOP) to surgeons/medical operations staffs of the next higher, adjacent, and subordinate HQs to maintain medical situational awareness.

- As a member of a joint staff, provides Annex Q (Medical Services) to all operation plans and orders.
- Participates in the sustainment cell-working group to integrate and synchronize HSS tasks. Prepares a portion of Annex F (Sustainment) to the operation orders and plans.
- Participates in the protection cell-working group to integrate and synchronize FHP tasks and systems for each phase or transition of an operation or major activity. Prepares a portion of Annex E (Protection) to the operation orders and plans.
- Provides recommendations on allocation and redistribution of medical personnel and Class VIII items.
- Oversees MEDLOG for the command.
- Provides patient disposition and reports.
- Evaluates and interprets AHS statistical data.
- Monitors and coordinates FHP operations.
- Develops health consultation services within the corps.
- Provides technical advice to the Corps Commander for occupational, environmental health, and medical surveillances, sanitary inspections, and potential CBRN contamination.
- When operating as a joint headquarters, coordinates with the staff judge advocate and chain of command to determine eligibility for medical care in an MTF.
- When operating as a joint headquarters, recommends theater policy for medically evacuating contaminated patients.
- Determines corps AHS training policies and programs as required.
- Initiate operational public health programs (to include medical surveillance, and OEH surveillance) within the corps.

SURGEON SECTION

C-16. The surgeon section in the corps resides in the MCP. The surgeon section is normally functionally organized under the sustainment warfighting function, but may be directly under the corps chief of staff depending on the desires of the corps commander. This section is responsible for, but not limited to:

- Provides reachback capability for the forward deployed surgeon in the tactical command post.
- Reviews all Corps OPLANs and contingency plans to identify potential health threats associated with geographical locations and climatic conditions.
- Assists tactical command post in monitoring and coordinating AHS support operations.
- Ensures AHS support is provided across the conflict continuum. Various types of mission support (traditional support to a deployed force, operations predominantly characterized by stability tasks, and defense support of civil authorities) are provided simultaneously in various locations throughout the corps area of operations. AHS planners anticipate the types of support required and develop flexible plans that are rapidly adjusted to changes in the level of violence and tempo, as well as to transition from one type of task to the next.
- Coordinates access to intelligence of medical interest with the Assistant Chief of Staff, G-2, Intelligence and ensures that the health threat, medical intelligence, and intelligence of medical interest are integrated into AHS OPLANS and OPORDS.
- Coordinates HSS, including the treatment and MEDEVAC of patients from the battlefield and the required Class VIII supplies, equipment, and services necessary to sustain these operations.
- Coordinates FHP to include, operational public health, veterinary services, AML services and support, dental services and COSC.
- Develops, in conjunction with higher headquarters, corps evacuation policy.

DIVISION SURGEON

C-17. The division surgeon is a division level officer and member of the commander's personal and special staff. The division surgeon normally work under the staff supervision of the division chief of staff. The division surgeon is the principal advisor to the commander on the health status of the division and advise the

division commander and their staffs on all medical or medical-related issues. The division surgeon operating from within the section coordinates EAB medical support and ensures information is integrated into the commander's ground tactical plan. As the chief of the division surgeon section, the division surgeon is able to contribute to the division's warfighting capability by providing timely and effective AHS support planning (to include developing patient estimates) for inclusion in the division planning process and the conduct of conducting LSCO. They are also responsible for the technical oversight of all medical activities in the command. The division surgeon ensure that the division's current and future operations and plans are coordinated with the MEDCOM (DS) and the supporting MEDBDE (SPT).

C-18. Through medical command and control, the division surgeon coordinates and synchronizes the ten medical functions split between the protection and sustainment warfighting functions and serves as a link between these varied commands and staffs.

SURGEON ELEMENT

- The division surgeon position is in the tactical command post surgeon element. They oversee and coordinate AHS support activities through the division surgeon section. This element is responsible for, but not limited to:
- Advises the commander on the health of the command.
- Oversees, monitors, and coordinates divisional AHS support operations to include both FHP and HSS activities.
- Ensure that the division current and future operations and plans are coordinated with the MEDCOM (DS) and the supporting MEDBDE (SPT).
- Oversees, monitors, and coordinates medical treatment (to include CBRN) provided to personnel in the division AO.
- Provides status of the wounded.
- Coordinate MEDEVAC including Army dedicated MEDEVAC platforms (air and ground).
- Provides recommendations on allocation and redistribution of medical personnel and Class VIII items.
- Oversees all MEDLOG for the command.
- Monitors and coordinates dental services within the division.
- Monitors and coordinates COSC.
- Monitors and coordinates veterinary services within the division.
- Provides patient disposition and reports.
- Monitors and coordinates public health operations.
- Oversees medical civil-military operations.
- Provides technical advice to the Division Commander for OEH surveillance, health threat analysis, medical surveillance, facility sanitation inspections, and potential CBRN contamination.
- Participates in the sustainment cell working group to integrate and synchronize HSS
- tasks. Prepares a portion of Annex F (Sustainment) to the OPORD or OPLAN.
- Participates in the protection cell working group to integrate and synchronize FHP tasks and systems for each phase or transition of an operation or major activity. Prepares a portion of annex E (Protection) to the operation order or operation plan.
- Refines the division's FHP medical support plan during the preparatory phase of defensive tasks.
- Identifies additional medical resources needed to support additional divisional attachments received in the joint operations area and those elements of the civilian population whose needs are not meet by civilian medical assets.
- Coordinates for Role 4 CONUS-support based MTF support.
- Oversees medical training for division medical personnel.

SURGEON SECTION

C-19. The division surgeon section resides in the MCP. Its mission is to plan, coordinate, and synchronize the division's AHS support under the supervision of the division surgeon. The division AHS support planning also involves the division's staff and the division's projected supporting MEDBDE (SPT) and next higher echelon Army or joint surgeon's staff section. This coordination focuses on how the medical command's plans impact the provision of AHS support within the division. A series of planning, in-progress reviews, coordination meetings, and rehearsals are required to tailor an AHS support plan to sustain the division's anticipated operations. This section is responsible for, but not limited to:

- Provides reachback capability for the forward deployed surgeon in the tactical command post.
- Reviews all division OPLANs and contingency plans to identify potential health threats associated with geographical locations and climatic conditions.
- Oversees division TSOPs, plans, policies, and procedures for AHS support as prescribed by the division surgeon.
- Assists tactical command post in monitoring and coordinating AHS support operations.
- Provides current information on the division AHS support plan/MEDCOP to surgeons/medical operations staffs of the next higher, adjacent, and subordinate HQs to maintain medical situational awareness.
- Plans and ensures Roles 1 and 2 AHS support for the division is provided in a timely and efficient manner.
- Establishes links from the medical brigade supporting the division to the medical platoons and teams in its brigades as each brigade completes its deployment. Division medical support includes both air and ground ambulance platforms and embedded forward surgical, COSC, and preventive medicine detachments and teams.
- Utilizes casualty and DNBI estimates and forecasts evacuation, treatment, and Class VIII requirements. Commanders pre-position medical treatment and evacuation capabilities forward to efficiently evacuate casualties to where they can receive the appropriate medical care. When developing the AHS support plan, the surgeon section planner considers many factors (Refer to ATP 4-02.55). The forms of maneuver, as well as the threat's capabilities, influence the character of the patient workload and its time and space distribution. The analysis of this workload determines the allocation of medical resources and the location or relocation of MTFs.
- Establishes links to the theater MEDLOG infrastructure to begin the Class VIII resupply process once deployed. The division surgeon section anticipates customer Class VIII unit requisitions. They identify and store adequate Class VIII stocks in medical brigade Role 3 MTFs supporting the division to reduce the resupply turnaround times for forward surgical detachments in the brigades.
- Determines situationally appropriate medication resupply protocols for cold packages, birth control, and sexually transmitted diseases.
- Tracks the expenditures of prophylaxis means, such as anthrax and smallpox vaccinations.
- Coordinates relationships of organic medical units and medical units/elements under OPCON or attached to the division for GS or direct support (DS).
- Coordinates for both air and ground ambulance support beyond the capabilities of BCT medical companies with the division's supporting medical unit(s) and combat aviation brigade.
- Coordinates the prompt evacuation of casualties from the division's Role 1 and 2 MTFs to supporting Role 3 MTFs provided by the division's supporting medical unit.
- Coordinates with G-1/S-1 casualty operation personnel to ensure patient tracking is performed.
- Ensures medical supplies are available to division medical personnel.
- Develops and maintains the medical troop basis, revising as required, to ensure task organization for mission accomplishment.
- Plans and coordinates AHS support operations for division and attached/OPCON corps medical assets. This includes reinforcement and reconstitution.
- Prepares and presents, as directed by the division surgeon, routine AHS support portion of the division briefings.

- Coordinates with the G-3 for prioritizing the reallocation of organic and corps medical augmentation assets as required by the tactical situation.
- Works with the protection cell to provide staff supervision of the implementation of FHP actions by the division's subordinate units. Medical personnel monitor the division's area of operations for disease; conducts preventive services such as: immunizations and prophylaxes; and help when Soldiers are exposed to hazards. Medical personnel establish medical, occupational, and environmental health screening as required. Through field sanitation team training and water assessments, medical personnel educate Soldiers and noncombatants on disease and nonbattle injury prevention.
- Coordinates for prophylactic medical treatment for the division's projected AO and with projected supporting medical organizations to ensure they can support the division's projected operations and resupply divisional medical units and combat lifesavers with Class VIII (medical materiel).
- Works with the theater army surgeon, civil affairs staff, and other unified action partners to obtain up-to-date health threat analysis on the division's projected area of operations. Pre-deployment behavioral health surveys should be conducted as part of deployment processing.

BRIGADE SURGEON

C-20. The brigade surgeon is a member of the commander's personal and special staff. The brigade surgeon is assigned to the headquarters and Headquarters Company of a brigade, and normally work under the staff supervision of the brigade executive officer. The brigade surgeon plans and coordinates the brigade AHS support activities with the brigade's personal, special, and coordinating staffs. The brigade surgeon is responsible for the technical control of all medical activities in the command. The brigade surgeon oversees and coordinates AHS support activities through the brigade surgeon section and the brigade S-3. The brigade surgeon keeps the brigade commander informed on the status of AHS support for brigade operations and the health of the command. The brigade surgeon provides input and obtains information to facilitate medical planning. The brigade surgeon's specific duties in this area include, but are not limited to:

- Ensures implementation of the AHS support section of the brigade TSOP.
- Participates in the S-4's sustainment cell working group to integrate and synchronize HSS tasks. Prepares a portion of Annex F (Sustainment) to the operation orders and plans.
- Participates in the S-3's protection cell working group to integrate and synchronize FHP tasks and systems for each phase or transition of an operation or major activity. Prepares a portion of Annex E (Protection) to the operation orders and plans.
- Determines the allocation of medical resources within the brigade.
- Supervises technical training of medical personnel and the combat lifesaver program within the brigade.
- Determines procedures, techniques, and limitations in the conduct of routine medical care, emergency medical treatment, and trauma management.
- Monitors aeromedical and ground ambulance evacuation.
- Monitors the implementation of automated medical systems.
- Informs the division surgeon on the brigade's AHS support situation.
- Monitors the health of the command and advises the commander on measures to counter disease and injury threats.
- Exercises technical supervision of subordinate battalion surgeons and physician assistants.
- Provides consultation and mentoring for subordinate battalion surgeons, physicians, and physician assistants.
- Provides the medical estimate and health threat for inclusion in the commander's estimate.

C-21. The brigade surgeon utilizes medical command and control to coordinate and synchronize the ten medical functions split between the protection and sustainment warfighting functions and serve as a link between these varied commands and staffs.

SURGEON SECTION

C-22. The brigade surgeon section is assigned to the headquarters and Headquarters Company of the brigade and operates out of the brigade tactical operations center. This section is an integral part of the brigade's main CP and the staff of the brigade surgeon is intimately involved with the S-3 and their staff in the planning process. The section, in coordination with the brigade S-4, the brigade support medical company commander, and battalion surgeons, is responsible for the development of the medical portion of the brigade OPLAN/OPORD and takes part in the brigade operations process. This section is responsible to the brigade commander for staff supervision of AHS support within the brigade. The brigade surgeon section is also responsible for coordinating GS and DS relationships of organic medical units and medical units/elements whether OPCON or attached to the brigade. This section updates the brigade commander as required on the status of AHS support in the brigade. The staff of the brigade surgeon section assists the brigade surgeon in planning and conducting brigade AHS support operations. Specific functions include, but are not limited to:

- Provides current information on the brigade AHS support plan/MEDCOP to surgeons/medical operations staffs of the next higher, adjacent, and subordinate HQs to maintain medical situational awareness.
- Plans and ensures the timely and efficient establishment of Roles 1 and 2 AHS support for the brigade.
- Plans and coordinates AHS support operations for brigade medical assets, attached, or OPCON EAB assets. This includes reinforcement and reconstitution.
- Coordinates with the division surgeon section for prioritizing the reallocation of organic and corps medical augmentation assets as required by the tactical situation.
- Ensures that the medical annex of the brigade TSOPs, plans, policies, and procedures for AHS support, prescribed by the brigade surgeon, are prepared and executed.
- Oversees medical training and provides information to the brigade surgeon and brigade commander.
- Coordinates and prioritizes MEDLOG and blood management requirements for the brigade.
- Collects health threat information and coordinates medical intelligence requirements with the brigade S-2.
- Coordinates and directs patient evacuation from forward areas to supporting MTFs.
- Coordinates the MEDEVAC of all detainee casualties from the brigade AO.
- Coordinates the disposition of captured medical materiel.
- Coordinates, plans, and prioritizes operational public health missions.
- Coordinates with the supporting veterinary element for subsistence and animal disease surveillance.
- Coordinates and monitors patient decontamination operations to include:
  - Layout and establishment of patient decontamination site.
  - Use of collective protection.
  - Use of nonmedical Soldiers to perform patient decontamination procedures under medical supervision.

BATTALION SURGEON

C-23. The battalion surgeon/medical officer is a member of the commander's personal and special staff. The battalion surgeon also serve as the medical advisor to the battalion commander and the staff. In this role, the battalion surgeon advises the battalion commander on the employment of the medical platoon and on the health of the battalion. The battalion surgeon are also the supervising physician (medical officer/field surgeon) of the medical platoon's treatment squad. This officer is responsible for all AHS support provided by the platoon. The brigade support medical company commander, with consultation by the senior physician, performs many related responsibilities mentioned below within the brigade support battalion. Units not assigned a battalion surgeon will utilize their assigned senior medical Service member in order to accomplish the below listed responsibilities. Responsibilities include, but are not limited to:

- Advises the commander on the health of the battalion.

- Provides current information on the battalion AHS support plan/MEDCOP to surgeons/medical operations staffs of the next higher and adjacent HQs to maintain medical situational awareness.
- Advises the battalion commander and their staff on AHS support operations and the health threat.
- Advises the commander on the effects of the Geneva Conventions on AHS support.
- Plans and directs Role 1 AHS support for the battalion or within the brigade support area.
- Supervises the health, welfare, organizational training, administration, discipline, and maintenance of equipment, supply functions, and employment of medical platoon or company personnel.
- Supervises and oversees all medical treatment provided by platoon or company personnel.
- Examines, diagnoses, treats, and prescribes courses of treatment for patients, to include DNBI, TCCC, and trauma management.
- Supervises the battalion COSC program to include training troop leaders in the preventive aspect of stress on Soldiers.
- Supports humanitarian assistance programs, when directed.
- Provides operational public health support for the battalion.
- Requests operational public health support from the brigade for requirements beyond their (battalion surgeon) capabilities.
- Plans and oversees public health training for battalion personnel.
- Monitors the command operational public health program to include health risk assessment and medical surveillance.
- Oversees the Army warrior task training, continuing medical education, and clinical training of subordinate medical personnel.
- Oversees the training of combat lifesavers.
- Oversees the training of unit field sanitation teams.
- Ensures that field health records are maintained.
- Coordinates and monitors patient decontamination operations to include:
  - Layout and establishment of patient decontamination site.
  - Use of collective protection.
  - Coordinates the establishment and training of nonmedical personnel for patient decontamination teams.
  - Use of nonmedical Soldiers to perform patient decontamination procedures under medical supervision.

C-24. Only when a battalion surgeon is assigned does the overall responsibility for the medical platoon belong to someone other than the medical services corps officer. Based upon command discretion, the medical operations officer may be designated as the medical platoon leader. They work with both the battalion surgeon and physician assistant to ensure medical treatment and AHS support requirements are met for the battalion. This officer is the principal assistant to the battalion surgeon and the primary leader for medical platoon operations, administration, and logistics.

Note. In the absence of a battalion surgeon, the physician assistant is the principal advisor to the battalion commander and their staff in the area of health and medical readiness.

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Appendix D
Medical Intelligence

Medical intelligence is developed through the leveraging of all-sourced intelligence assessments and products. Medical intelligence results from collection, evaluation, analysis, and interpretation of foreign medical, bioscientific, and environmental information that is of interest to strategic planning and to military medical planning. This information is pertinent to operations for the conservation of the fighting strength of friendly forces and the formation of assessments of foreign medical capabilities in both military and civilian sectors. Military intelligence includes only finished intelligence products produced by an authorized agency. Military Intelligence Soldiers and other intelligence professionals, through the intelligence warfighting function, collect, process and exploit, analyze, disseminate, and evaluate information collected from a variety of sources to generate intelligence. Medical elements require intelligence support in order to not lose the medical personnel's protected status under Article 24 of the1949 Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the field by performing tasks that are inconsistent with their noncombatant role such as intelligence collection. To develop medical intelligence, information is gathered, evaluated, and analyzed on the following subjects:

- Endemic, emerging, epidemic and pandemic diseases, public health standards and capabilities, and the quality and availability of medical services.
- Foreign military and civilian medical capabilities, including MTFs, medical personnel, emergency and disaster responses, MEDLOG (to include blood processing), and medical pharmaceutical industries.
- Integrated databases on all medical treatment, training, pharmaceutical, and research and production facilities.
- Environmental risks that can degrade force health or effectiveness including: chemical and microbial contamination of the environment, toxic industrial materials and radiation accidents, and environmental terrorism.
- Impact of foreign environmental health issues and trends on environmental security and national policy.
- Infectious disease risks that can degrade mission effectiveness of deployed forces.
- Foreign and applied biomedical and biotechnological developments of military medical importance.
- Foreign scientific and technological medical advances for defense against CBRN warfare agents.

SIGNIFICANCE OF MEDICAL INTELLIGENCE

D-1. At the strategic level, the objective of medical intelligence is to contribute to the formulation of national-based policy. The policy will be based in part on assessments of foreign military and civilian capabilities of the medical or bioscientific community.

D-2. At the operational level, the objective of medical intelligence is to support the development of AHS strategies that—

- Identify the health threat.
- Are responsive to the unique aspects of a particular AO.

- Enable the commander to accomplish the operation.
- Conserve the fighting strength of friendly forces.

SOURCES OF MEDICAL INTELLIGENCE

D-3. Medical intelligence is provided to the AHS planner by intelligence organizations. The AHS planner must identify the medical intelligence requirements and provide a request for information and or updated commander's critical information requirements and other requirements to the supporting intelligence element within the command. Up-to-date medical intelligence assessments can be obtained by contacting Director, Defense Intelligence Agency, Attention: Director, National Center for Medical Intelligence, Fort Detrick, Maryland 21702-5000 or via the contact information listed at: https://www.ncmi.detrick.army.mil. The National Center for Medical Intelligence can provide finished all-source intelligence products that assess foreign medical facilities and capabilities; infectious disease/chemical/radiological health threats in the operational environment; foreign CBRN medical countermeasures; and emerging and disruptive biotechnology with military applications. The AHS planner should use all available intelligence elements to obtain information and intelligence which supports the military operation. The National Center for Medical Intelligence 24-hour service request for information telephone number is commercial (301) 619-7574 or Defense Switched Network 343-7574. Refer to DODI 6420.01 for more information.

D-4. A supporting intelligence element exists in the AHS unit's chain of command. This element will be the primary source for the AHS planner to access the necessary intelligence for the execution of AHS support operations.

MEDICAL ASPECTS OF INTELLIGENCE PREPARATION OF THE BATTLEFIELD

D-5. Consideration of the medical aspects of the IPB is a systematic process that is designed to aid AHS planners in analyzing various enemy, environmental, and health threats in a specific AO. Determining the medical aspects of the IPB process occurs during the first step in the mission analysis phase of the military decision-making process. The information derived from conducting a proper assessment of the medical aspects of the intelligence is specific to the geographic region where the AO is located. The Phase I assessments that are part of the medical aspects of IPB are the cornerstone to developing detailed and effective AHS estimates and plans. Some portions of the template will be more or less applicable depending on the assigned mission. For more information on IPB, see ATP 2-01.3/MCRP 2-3A, Intelligence Preparation of the Battlefield/Battlespace.

D-6. The Phase I assessments that are part of the medical aspects of IPB are to—

- Define the OE.
- Describe the operational effects on deployed forces and AHS operations.
- Conduct threat integration (enemy, environment, and health) and information consolidation.

IDENTIFY SIGNIFICANT CHARACTERISTICS OF THE OPERATIONAL ENVIRONMENT

D-7. The first task of the AHS planner is to define the OE. The AHS planner identifies and describes the significant characteristics of the environment to be able to assess the impact on AHS support operations and the health of the command.

D-8. The significant characteristics of the OE must be evaluated from both a military perspective and a civilian perspective. The AHS planner must determine what aspects of the OE will impact the delivery of health care to U.S. forces and conversely what impact military medical operations will have on the civilian population in the AO. As the provision of medical care is a humanitarian activity, the patient workload of deployed forces can be affected when forces are deployed in medically underserved areas or in areas where the civilian medical infrastructure has been disrupted or is underdeveloped. The AHS planner can use the memory aid political, military, economic, social, information, infrastructure, physical environment, time (operational variables) or mission, enemy, terrain and weather, troops and support available, time available, and civil considerations factors (mission variables) to frame the analysis of the OE based on the situation.

For the AHS planner, the civil considerations must be thoroughly explored and analyzed, even if the immediate mission does not recognize a requirement for the provision of health services to a host-nation population. The AHS planner must be prepared to provide support or have a plan in place in the event a civilian medical emergency should arise and the military forces are directed to provide support. Without prior planning, the diversion of military medical assets to support civilian medical emergencies will adversely impact the AHS support provided to deployed forces and could potentially overwhelm available medical resources. The AHS plan must not only conform to the tactical commander's concept of operation and scheme of maneuver, it must also be in consonance with the CCDRs theater engagement strategy so that any humanitarian activities conducted are not done haphazardly and are part of the regional strategy for the AO.

GEOSPATIAL INFORMATION

D-9. Geospatial information includes hydrological data, elevation data, soil composition, and vegetation.

GEOGRAPHY AND WEATHER

D-10. The geography and weather factors include climate, weather, terrain (to include urban terrain), and altitude. They may also contain information on possible weather/environmental threats such as earthquakes, volcanoes, monsoons, or other such conditions.

CLIMATE AND WEATHER EFFECTS

D-11. Information contained in the climate and weather effects includes the effects of extreme heat/cold/humidity; effects of the predominant weather patterns (such as monsoons) on AHS operations (such as MEDEVAC effects of heavy rains or snow; the phase of the moon and its effect on operations (such as fullness/brightness when military forces are infiltrating an area); how the weather may affect enemy biological and chemical warfare agents use; and climatic effects on medical supplies and equipment.

TERRAIN ANALYSIS

D-12. Terrain analysis includes determining the effect on friendly/enemy maneuver capability; effect on friendly/enemy ability to sustain health care; effects on timely MEDEVAC; and natural lines of patient drift. *Lines of patient drift* refers to natural routes along which wounded Soldiers may be expected to go back for medical care from a combat position. (ATP 4-02.2). Terrain analysis also impacts on MTF site selection factors; where the mobility corridors are located and their effects on friendly/enemy actions; effects of weather conditions on terrain/mobility; effect of overhead cover (canopy) and vegetation; effect of projected action on terrain/mobility; and where potential sources of potable water are located.

ALTITUDE EFFECTS

D-13. Altitude effects include effect of high-altitude operations on force capability, rotary-wing MEDEVAC assets, MEDEVAC procedures and methods (higher incidence of litter evacuation and longer evacuation times for manual evacuation), and standard medical treatment protocols.

DESCRIBE THE BATTLEFIELD EFFECTS

D-14. The purpose of this phase of the IPB process is to analyze and integrate various factors of the OE. Conducting a detailed analysis of these factors helps commanders and planners understand how the significant characteristics the OE can affect friendly and threat operations. The AHS planner will focus on identifying the medical aspects of battlefield effects on friendly and threat forces and operations.

LIMITS OF COMMAND

D-15. The AO is the geographic area where the commander is assigned the responsibility and authority to conduct military operations. The AHS planner must identify the—

- Geographic AO that may include the macroview or the microview depending upon the level of command and the size of the geographic area.

- Total population at risk which includes all U.S. and unified action partners, local civilian population, dislocated persons, DOD and other U.S. governmental employees and or contractors, and nongovernmental organizations personnel. In addition to identifying the total population at risk, the planner must also determine what the supported population at risk is (those individuals/groups deemed as eligible beneficiaries for health care provided by United States Army medical assets. The supported population includes:
  - All supported U.S. units which include sister Services and elements from U.S. governmental agencies and DOD contractors.
  - All supported multinational units/elements. This paragraph should discuss unit troop strengths, locations, and missions. It may also include organic medical resources and capabilities; multinational medical assets (military, paramilitary, and civilian) which are approved for use for U.S. personnel; identification of multinational (military, paramilitary, and civilian) requirements; identification of unique medical support requirements (such as endemic diseases in the multinational force that are not present in the deployment [host nation] AO); and the current level of health and dental fitness among the supported populations. For veterinary services, the number of military working and contract dogs and other government owned animals that will be used by the multinational force also need to be identified and included in planning.
  - All personnel in U.S. custody (detainees).
- Others as directed.

LIMITS OF THE AREA OF INFLUENCE AND THE AREA OF INTEREST

D-16. The area of influence and the area of interest are geographic areas from which information is required to facilitate planning. The area of influence and the area of interest usually fall outside the AO and may or may not be applicable to a particular operation. Army Health System support outside the AO includes:

- Army Health System support provided by organizations/elements outside of the AO. This can include organizations such as CONUS-support base or other safe haven hospitals, MEDLOG support (Defense Logistics Agency or Army Materiel Command), and global patient regulating support (such as the Global Patient Movement Requirements Center).
- Location and time/distance factors for medical resources that could be used for augmenting/ reinforcing/reconstituting AHS units/personnel within the AO. This information can include discussions on units/elements in the CONUS-support base or adjacent AOs.
- Coordination and synchronization with command and control assets outside the AO which assures the reach capability within the AHS and the ability to rapidly deploy medical specialty care resources as the need arises in the AO.
- Follow-on operations or operations being conducted simultaneously outside the AO which can include a range of military activities.

D-17. Army Health System planners—

- Identify the level of detail required and the time available to conduct the medical aspects of the IPB process.
- Evaluate existing information/intelligence of medical significance and identify intelligence gaps. (Sources include: National Center for Medical Intelligence; Defense Intelligence Agency; the Army Public Health Center; The Office of The Surgeon General, Intelligence and Security Division (division or higher staff for intelligence); country studies; supporting intelligence staff officer/assistant chief of staff, intelligence or military intelligence unit; Central Intelligence Agency World Fact Book; open source information system; tourist maps and brochures; public health resources; World Health Organization; Pan American Health Organization; Department of State; and internet, libraries, and other informational sources).
- Identify and submit collection requirements to the supporting intelligence staff section/element/unit.
- Collect required information to fill gaps.

Note. If medical personnel gain information of potential intelligence value through casual observation of activities in plain view while in the performance of their humanitarian duties, they are required to report it to their supporting intelligence staff officer/assistant chief of staff, intelligence.

Population Demographics

D-18. Population demographics include the effect on the delivery of health care to supported forces and the effect on the AHS if required to support the local populace and nongovernmental organizations. It also includes the political effects of providing care/not providing care to the host-nation populace, nongovernmental organizations, and dislocated persons and the effects of cultural, religious, or language barriers on medical treatment. Other AHS population demographic concerns include:

- Condition of the general population (and or supported population) to include an analysis of the health of the general population and the impact of it on deployed forces; analysis of the infant mortality rate as this serves as an indicator of the overall health of the population; leading causes of death; identification of the status of nutrition; and state of advancement of the medical infrastructure.
- What effect will clans, tribes, gangs, opposition groups, or paramilitary organizations/groups and organized crime have on the ability to provide AHS support to deployed forces and other eligible beneficiaries?
- What effect/additional requirements will dislocated persons and detained personnel have on the AHS system? This is of particular importance for the operational public health arena as camps require sanitation, pest management, and potable water support. Other requirements include the provision of sick call services, outpatient treatment, hospitalization, MEDEVAC, veterinary technical consultation and support, MEDLOG support (to include sorting, repackaging, inventorying, and disseminating donated medical supplies and equipment), and other functional concerns.

Threat Forces Capabilities/Effects

D-19. The effects of enemy ideology, goals, and missions includes an analysis of the enemy's will to fight; what they are trying to accomplish and why (military objectives); compliance with the Geneva Conventions (to include respect and protection of medical personnel, units, and transports); type of enemy forces (such as paramilitary, conventional, special operations, and or terrorists); philosophy concerning collateral damage, civilian casualties, disruption of utilities (sewage, waste disposal, sanitation, water, electricity, and gas), and generating dislocated persons. Threat forces capabilities or effects encompass the following:

- The threat characteristics include the affects enemy doctrine has on deployed forces, to include AHS personnel and units. This information facilitates forecasting what units/elements/ organizations are most likely to sustain heavy casualties.
- Enemy force structure and weapons systems include the analysis of the accuracy and range of enemy weapons systems; analysis of the size and composition of the enemy force; and what types of friendly wounds will be generated by enemy weapons systems (such as piercing, blast injuries, concussion, blunt trauma, burns, or combined injuries).
- Enemy medical doctrine and capabilities include the analysis of enemy medical doctrine and capabilities; priority and availability of medical care and MEDEVAC; status of the medical infrastructure and training to accomplish the medical mission; and the potential for the enemy to treat their own casualties or to leave them in the care of friendly forces.
- Effects of enemy CBRN weapons to include an analysis of enemy CBRN capabilities; effect of enemy CBRN use on friendly forces; the likelihood of its use; whether the enemy can continue the mission in a CBRN environment; and whether the enemy's delivery systems are accurate, reliable, and effective.
- Military information support operations and unconventional warfare capabilities and effects include an analysis of the probable impact of psychological operations on friendly forces; analysis

of unconventional warfare capabilities; probability of unconventional warfare forces targeting friendly areas and AHS assets/resources; and the effect unconventional warfare will have on the delivery of health care.

INFRASTRUCTURE

D-20. The infrastructure includes transportation systems (land, sea, and air); communications systems (telephone, cellular, digital, mass media, and electronic means); and, utilities (water, electricity, and sanitation).

TRANSPORTATION

D-21. Transportation systems include the effect of available transportation systems on timely MEDEVAC or CASEVAC, MEDLOG supply/resupply operations (to include time-sensitive blood distribution and other perishable and dated pharmaceuticals; analysis of likely avenues of approach; effect of the transportation system on mobility and military operations; effect of military operations on the transportation system; and impact of transportation networks on enemy/friendly courses of action).

COMMUNICATIONS SYSTEMS

D-22. Communication systems architecture includes the communications networks that are established in the operational area; the level of technology for these systems; and the level of access of the communications infrastructure by the population (for example, if the civilian population does not have telephones, radios, televisions, or computers, other methods for disseminating public health information and health risk communications information must be established).

Utilities

D-23. Utilities (water, electricity, and sanitation) include the analysis of water quality (portability) and distributions systems; analysis of the reliability of electrical power generation; effectiveness and efficiency of sanitation systems; effects of enemy/friendly military actions on the utilities infrastructure; and the impact a disruption of utilities would have on the health of the general population and/or deployed forces.

Industry

D-24. Industry includes the types of industry present, their effect on the economy, and the potential threat from toxic industrial materials either used in the manufacturing process or as an end product.

Medical Infrastructure

D-25. A checklist for assessing the foreign medical infrastructure is provided in Table D-1 (on page D-7).

D-26. A checklist for assessing foreign MTF capabilities and services is provided in Table D-2 (on page D-8).

D-27. Analysis of local medical supply and equipment sources includes an analysis of local quantity, quality, and availability of medical supplies and equipment; analysis of the availability of blood and blood products; availability of supplies for use for local populace, dislocated persons, and detained persons (to include donated supplies or those of a nongovernmental organization/intergovernmental organization such as the United Nations); availability of supplies approved for use by U.S. forces; analysis of local medical supply production facilities; impact of military operations on the local medical supply infrastructure; and availability and quality of medical gases.

Table D-1. Checklist for assessing a foreign medical infrastructure

Public health and health threat	Number of public health personnel, facilities, and capabilities. Names and titles of key personnel within the public and private health care infrastructures. Leading causes of death of the general population or specified subpopulations. Prevalence of endemic and epidemic diseases (both human and animal) in the area of operations. Prevalence of human immunodeficiency virus/acquired immunodeficiency syndrome. Status of host nation's food safety/defense program. Environmental health risk (to include heat and cold injury, exposure to toxic industrial materials, and poisonous or toxic flora and fauna).
Hospitalization/ medical clinics	Nutritional status of the general population or specified subpopulations. Immunization level of general population or specified subpopulations. Infant mortality rate and other indices. Hospitals by type and location (such as general medical, psychiatric, or orthopedic). Number of hospital beds by type (such as surgical, intensive care, or general medicine). Number of operating room tables and table hours. Medical clinics (private or public), locations, and accessibility.
Services and providers	Number of physicians per population. Number of physicians by specialty. Ancillary services available (such as physical therapy, occupational therapy, orthotics capability, community/public health nurses, magnetic resonance imaging, computed tomography scan, or respiratory therapy). Number of nonphysician health care providers (such as physician assistants, physical therapists, occupational therapists, nurse practitioners, podiatrists, or optometrists) by type. Number of dental providers and types of dental care available (such as emergency and essential care and or oral surgery). Number of behavioral health clinics and available services. Number and types of behavioral health personnel (such as psychologists, social workers, and the like). Veterinary medical personnel, facilities, and capabilities.
Medical evacuation	Medical evacuation/casualty transport systems (public, private, and dedicated military ground and air ambulances or platforms of opportunity).
Medical research/ education	Number and types of medical research facilities. What toxic industrial materials does the facility use and or produce (chemical, biological, and nuclear and radiation hazards). Number, types, and location of medical schools or medical training centers.

D-28. Analysis of MEDEVAC services includes the analysis of local MEDEVAC services and capabilities; training and education level of medical attendants; coordination and synchronization of local evacuation services/resources to evacuate civilian patients; availability of and quality of local MTFs; and impact of military operations on local evacuation services.

D-29. Effects of disease and other OEH threats include the identification of disease and OEH threats that affect friendly forces and the delivery of medical support; identification of personnel protective measures which are required to counter the health threat; analysis of the effect of protective measures on friendly forces; analysis of the impact that disease and environmental threats have on enemy actions; and the identification of additional disease and environmental health hazards which may be created and/or aggravated

by military operations and the analysis of services provided by nongovernmental organizations and other intergovernmental organizations.

Table D-2. Checklist for assessing foreign medical treatment facility capabilities and services

Is the medical treatment facility a private, public, or military institution?
Is the medical treatment facility a hospital, clinic (such as outpatient, emergency, or substance abuse), doctor's office, or long-term/rehabilitative care facility?
Where is the medical treatment facility located? How accessible is it (such as on a major thoroughfare, on side streets, or accessible by air)?
What type of care does the medical treatment facility provide (such as emergency and general medicine, surgical, orthopedic, maternity/obstetrics, and psychiatric, pediatric, rehabilitative, or long-term care)?
What are the number and types of beds (such as surgical, intensive care, intermediate care, minimal care, or general medicine)?
What ancillary services are available (such as physical therapy, occupational therapy, respiratory therapy, diagnostic x-ray, nuclear medicine, pharmacy services, or diagnostic laboratory services)?
What is the staffing level of the medical treatment facility?
Does the medical treatment facility provide outpatient services? If so, what types of care?
What is the standard of care provided at the medical treatment facility? How does it compare to U.S. facilities?
How are medical professionals credentialed? What is their scope of practice?
What is the nosocomial infection disease rate for the medical treatment facility?
Does the medical treatment facility have the capability to isolate infectious disease patients?
What is the patient accident or injury rate for the medical treatment facility (such as falling out of bed, injury caused by faulty equipment, or the like)?
What types of medical equipment are available in the medical treatment facility (such as diagnostic computed tomography scan or magnetic resonance imaging, rehabilitative, or patient care [ventilators, respirators, or orthopedic])?
What types of support services are available (such as laundry, housekeeping, or food service)? Are these services shared services with another medical treatment facility? If not, how are patients fed (such as by relatives)?
Does the medical treatment facility have an emergency room? Is it staffed and equipped to provide trauma care?
What is the capacity of the medical treatment facility to respond to a mass casualty situation (resulting from urban operations, terrorist incidents, man-made or natural disasters, or employment of CBRN weapons)?
What is the level of medical supplies maintained within the medical treatment facility (days of supply)?
How is the medical treatment facility resupplied with expendable and nonexpendable medical supplies? Are medicines readily available or must they be obtained on an individual case basis? Is local vegetation collected and used for medical purposes?
Does the medical treatment facility have the capability to collect, test, and store blood? What diseases is the blood tested for?
If the medical treatment facility cannot collect and test blood, where do blood and blood products come from? Has it been tested? Does the medical treatment facility have a refrigerated storage capability? What is the maximum number of units of blood which can be stored?
Does the medical treatment facility have its own ambulances (number and type [air and ground]) or is this a service which is provided by another agency/business?
Is the medical treatment facility accredited by its parent nation and or hospital organization (such as in the U.S. by the Joint Commission on the Accreditation of Health Care Organizations)?
Does the medical treatment facility perform its own medical equipment maintenance or must it be sent out for repair?
Does the medical treatment facility have dependable electric service? Does it have a backup generator for power outages?

Table D-2. Checklist for assessing foreign medical treatment facility capabilities and services (continued)

Does the medical treatment facility have running water? If not, from what source does the staff obtain water? Is it potable or does it require treatment before use? Does the medical treatment facility have access to sterile water?
Does the medical treatment facility have a working environmental control system? Heat? Air conditioning?
What sanitation facilities are available in the medical treatment facility? Restrooms for patients and staff? Bathtubs/showers for patients? Handwashing stations/capabilities in patient care areas? Disposal capabilities for general, medical, and human waste? Disposal capabilities for waste water?
Does the medical treatment facility have a pest management problem (rats, ants, flies, lice, and/or other animals and insects)?
Does the hospital have its own oxygen generation capability? If not, how are medical gases supplied?
Describe the physical plan of the medical treatment facility. Does it have flooring materials or dirt floors, adequate ventilation, operational damage, or any other situation which would impact patient care?
Other. Any other issues, concerns, or situations which affect the specific medical treatment facility being evaluated?

INTEGRATION

D-30. The object of threat integration is to relate how essential elements of information identified in analysis of the medical aspects of IPB process will affect the health of the command, the employment of AHS resources, as well as enemy/friendly courses of action as they pertain to medical issues. Further, information that is gathered relating to resources and background information should be consolidated in a usable format for use as the need arises. Some useful formats for managing information and medical intelligence include overlays, spreadsheets, matrices, and databases.

D-31. Threat integration can be broken down into three major categories. It is important to note that in each category the threat relates only to the health of the command or medical issues. Similarly, the type of threat can vary greatly with the type of mission or operation (offensive, defensive, and stability tasks). These categories are—

- What friendly courses of action are best supported from an AHS standpoint? What friendly AHS courses of action best support the mission?
- What probable enemy courses of action could affect friendly AHS units/resources/services?
- What geographic-related threat issues impact AHS support? Geographic-related threats include climatic/weather-related threats and their impact on the need for and delivery of AHS and terrain-related issues that can best be depicted by creating a modified combined obstacle overlay.

CONSOLIDATION

D-32. Understanding and consolidating additional elements of medical information/intelligence into concise formats assists the planner in future planning efforts or other possible contingencies. Databases are particularly useful for managing general information.

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Appendix E

Institutional Force Support to the Operational Army

E-1. The Army Medicine has a long tradition of providing world-class medical care across global operational areas, OEs, and under austere and challenging conditions to the joint force. Wherever an injured or ill Service member is located, the United States Army will project its resources to locate, acquire, treat, stabilize, and evacuate our wounded Service members to MTFs capable of providing world-class health care to enhance the prognosis, mitigate disability, and empower them to lead full and productive lives.

E-2. Historically, Army Medicine has provided acute trauma care, curative, restorative, rehabilitative, and convalescent care within the AO. Soldiers were not evacuated for care in the CONUS-support base unless their recovery time exceeded the theater evacuation policy (in some cases up to 60 days).

E-3. With the advent of technological innovations in transportation and medicine the last few years, Soldiers can be stabilized and rapidly evacuated from austere OEs to world-class fixed MTFs in CONUS or other safe havens in a matter of hours to days from the time of injury or wounding. These advancements have—

- Enabled the essential care in the operational area concept to be implemented.
- Reduced the medical footprint present in a deployed setting without reducing the quality of medical care provided to our Soldiers.
- Optimized the use of scarce medical resources.
- Enabled wounded and ill Soldiers to more rapidly be reunited with their Families and personal support structures to facilitate and enhance the healing process.

MISSION FOCUS

E-4. The mission of the institutional force is to generate and sustain operational Army capabilities. The Army does not organize the institutional force into standing organizations with a primary focus on specific operations. Rather, when the institutional force capabilities perform specific functions or missions in support of and at the direction of joint force commanders, it is for a limited period of time. Upon completion of the mission, the elements and assets of those institutional force capabilities revert to their original function.

E-5. All elements of the Army, whether the institutional force or operational Army, perform functions specified by U.S. law. The Army executes Title 10 and Title 32 USC directives, to include organizing, equipping and training forces for the conduct of prompt and sustained combat operations on land; accomplishing missions assigned by the President of the United States, Secretary of Defense and CCDRs; and changing the force to meet current and future demands. Below is the list of USC Title 10, Armed Forces, Subtitle B, Army functions:

- Recruiting.
- Organizing.
- Supplying.
- Equipping (including research and development).
- Training.
- Servicing.
- Mobilizing.
- Demobilizing.
- Administering (including morale and welfare of personnel).
- Maintaining.
- Constructing, maintaining, repairing buildings structures, utilities, and acquiring real property and interests in real property necessary to carry out the responsibilities specified in this section.

E-6. The Army Medicine serves as a critical link between medical formations in the operational and institutional force to leverage capability and capacity across the Total Army. The Army Medicine and joint force medical formations Service members receive the best health care anywhere in the world.

THE SURGEON GENERAL

E-7. According to General Order 2020-01, para 37, The Surgeon General is the principal military adviser to the Secretary of the Army and the Chief of Staff of the Army on the health and medical aspects of manning, training, and equipping the Army and serves as the principal military adviser to the Assistant Secretary of the Army (Manpower and Reserves Affairs) for health affairs.

E-8. The Surgeon General is responsible for—

- Assisting the Assistant Secretary of the Army (Manpower and Reserves Affairs) in developing policies and programs for the Army system for health and planning and supervising the execution of those policies and programs.
- Representing Army health policies and military health readiness requirements to DOD, executive departments, Congress, and nongovernmental organizations.
- Providing technical advice and assistance to the Secretariat and Army Staff for matters on public health, readiness of the force, warrior transition care, medical force structure and equipping, force development, medical materiel and research and development, medical training and education, medical evacuation, and medical military construction.
- Developing and directing the Army's Planning, Programming, Budgeting, and Execution process for the Defense Health Program.
- Assessing Assistant Secretary of Defense for Health Affairs and DHA health affairs policies and programs.

DEFENSE HEALTH AGENCY

E-9. The DHA is a Tri-Service, integrated combat support agency that enables the United States Army, Navy, and Air Force to provide a medically ready force and ready medical forces to the combatant commands in support competition continuum. The DHA supports the delivery of integrated, affordable, and high quality health services to beneficiaries of the Military Health System and is responsible for driving greater integration of clinical and business processes across the Military Health System. The DHA leads the Military Health System's integrated system of readiness and health to deliver increased readiness, better health, and lower cost. In support of a cohesive, globally integrated, affordable, and high quality Military Health System, the DHA directs the execution of ten joint directorates and manages and administers the following Enterprise Support Activities:

- TRICARE Health Plan.
- Pharmacy Programs.
- Health Information Technology.
- Education and Training.
- Public Health.
- Medical Logistics.
- Facility Management.
- Budget and Resource Management.
- Research, Development, and Acquisition.
- Procurement and Contracting.

E-10. The DHA's administration of the TRICARE Health Plan provides worldwide medical, dental, and pharmacy programs for over 9.4 million members of the uniformed Services, retirees, and Family members.

SUPPORT TO THE TACTICAL COMMANDER

E-11. The institutional force fulfills numerous critical roles with regards to supporting the Soldiers deployed in an operational area. Army Medicine organizations conduct operational development activities and medical

research and development to discover and field advanced technologies to mitigate the health threat faced by our deployed forces. Army Medicine institutional forces facilitate and enhance medical readiness of Soldiers through the promotion of fitness and healthy lifestyles, the Performance Triad, and the prevention of diseases and injuries. Army Medicine institutional forces provide mobilization and predeployment support to ensure that Soldiers are mentally and physically ready to be deployed (immunizations, predeployment health assessments, dental, vision, and hearing readiness testing and treatment, and health risk communications on health hazards in the operational environment. During deployments, they provide reach back support through medical specialty areas and can deploy teams comprised of physicians, scientists, technicians, and other health care providers to provide solutions to unique health threats or medical conditions and issues occurring during the deployment.

EDUCATION

E-12. Educational requirements within the health care professions are significantly more complex than in other branches of the Army. Formal accredited schooling is required for fields within Army Medicine and professional education is received in civilian educational and DOD medical organizations. Medical education is a lengthy process, which is often accomplished in phases (such as, medical school, internship, and residency). Medical professionals require credentialing and licensure before they can practice medicine. Credentials are most often obtained from non-DOD affiliated civilian organizations. Health professions also require continuing education to maintain certification. Headquarters, Department of the Army, Office of The Office of The Surgeon General facilitates this process by providing global opportunities to fulfill the continuing education requirements health care professionals across the Total Army.

TRAINING

E-13. All medical military occupational specialties require school training. Medical skills are perishable and require continual practice and refresher training. The MEDCoE provides military occupational specialty-specific training for award of medical military occupational specialties and provides refresher training for some low-density for Reserve Component forces and United States Army National Guard when mobilized. Additionally, the MEDCoE develops and fields collective training materials and distance learning programs. In some medical specialty areas, the didactic portion is completed at the MEDCoE while the resident phase is conducted at Role 4 MTFs.

ARMY MEDICAL ACTION PLAN

E-14. Military personnel are treated at DOD MTFs in conjunction with the Department of Veterans Affairs, and civilian medical facilities to provide world-class health care and services for their dedication and sacrifices to the nation. In support of this plan, the Chief of Staff of the Army approved the actions to be implemented to include:

- Establish and institutionalize a command and control structure for Service members undergoing long-term definitive, rehabilitative, and convalescent care.
- Prioritize mission support and create ownership of actions and processes.
- Flex housing policies and focus on Family support issues.
- Develop training and doctrine to facilitate and ensure a system which provides timely and effective support.
- Create full patient visibility throughout the Army and Military Health Systems continuum of care and facilitate medical information sharing across agencies to improve patient outcomes.
- Improve the medical evaluation board process and eliminate delays in the process.

E-15. The intent of this action plan is for the Army to provide a continuum of integrated care and services from POI or wounding, illness, or disease to return to duty or transition from active duty. It is vital that the Army coordinates execution of the necessary changes at the strategic, operational, and tactical level to ensure a simultaneous transformation of care and services over all lines of operations to achieve the desired end state.

THE ARMY RECOVERY CARE PROGRAM

E-16. The Army Recovery Care Program (ARCP) (formerly the Warrior Care and Transition Program) serves as the proponent for the case management and transition of the Army's seriously wounded, ill, and injured Soldiers. The program provides oversight, guidance, and advocacy for wounded, ill, and injured Soldiers, Veterans, and Families through a comprehensive recovery plan aimed at successful reintegration back into the force or into the community with dignity, respect, and self-determination. The ARCP includes an oversight and policy headquarters (a staff directorate of the U.S. Army Medical Command) and 14 Soldier Recovery Units.

E-17. The Soldier Recovery Units (see Figure E-1) are strategically postured at 14 installations aligned to division and corps headquarters with the capacity to manage care for 2,800 active, U.S. Army Reserve and Army National Guard Soldiers. The ARCP provides a total force solution for wounded, ill, and injured Soldiers and the program utilizes multi-component cadre designed to meet the needs of the population. More than 80,000 Soldiers have entered the ARCP, with a population peak of nearly 12,500 Soldiers in 2008. The program's motto, "Recover and Overcome," helps inspire Soldiers that their condition does not define them or their legacy. The health, humanity, dignity and respect of each individual Soldier remains paramount as the program remains scalable to meet future Army requirements. The foundation of the program includes:

- Single entry criteria for all components concentrating medical and administrative resources on Soldiers with complex case management requirements.
- Program and policy that supports goals and requirements based on individual Soldier requirements and point of recovery.
- Advocacy and non-clinical case management through transition to Veteran status and beyond.
- A comprehensive recovery plan supported by an interdisciplinary team including military leaders, transition coordinators, adaptive reconditioning specialists, and behavioral health professionals to help Soldiers realize their transition or career goals.

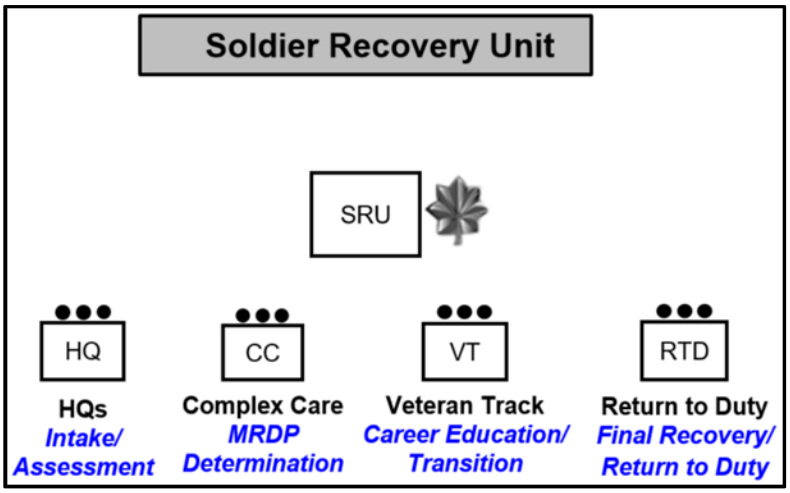

Figure E-1. The Soldier Recovery Unit

SOLDIER RECOVERY UNITS

E-18. The Soldier Recovery Unit is a total force solution open to Soldiers, regardless of mechanism of injury (in the line of duty), who meet the single entry criteria. The Soldier Recovery Unit is comprised of four platoons: Headquarters platoon, Complex Care platoon, Veteran Track platoon, and Return to Duty platoon. Each platoon is designed to meet the case management requirements of Soldier Recovery Unit Soldiers, and Soldiers are assigned to platoons depending on the primary stage of their recovery. This organization enables the Soldier Recovery Unit to concentrate personnel and services in accordance with each Soldier's individual recovery requirements. Two critical components of the Soldier Recovery Unit are the Triad of Leadership (TOL) and Triad of Care.

E-19. The TOL consists of senior commanders/command sergeants major, MTF commander/MTF ASCCs commanders/command sergeants major, and Soldier Recovery Unit commanders/command sergeants major. Soldier Recovery Unit entry packets are reviewed by the TOL but the senior commander on a Soldier Recovery Unit installation is the final decision authority for Soldier Recovery Unit entry.

E-20. The triad of care consists of the Soldier Recovery Unit Medical Provider, nurse case manager, and platoon sergeant/squad leader. The TOL and Triad of Care work together in conjunction with the interdisciplinary team to ensure advocacy for Warriors, continuity of care, and a seamless transition into the force or return to a productive civilian life.

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Appendix F

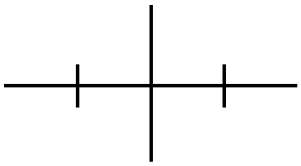
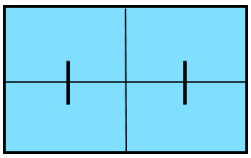
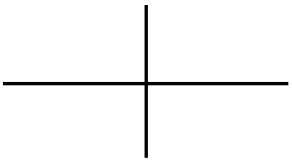
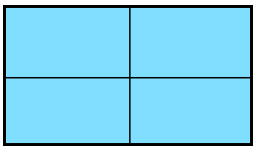
Army Health System Symbols

This appendix depicts and describes a variety of symbols and control measures related to AHS tactical mission tasks. The appendix does not attempt to produce all conceivable combinations for AHS symbols or control measures, but rather, it shows several examples of each type as a starting point. Readers should refer to MIL-STD 2525D and ADP 1-02 for more information about military symbols.

F-1. Military symbols are governed by the rules in MIL-STD 2525D. Army Doctrine Publication 1-02 is the Army proponent publication for all military symbols and complies with MIL-STD 2525D.

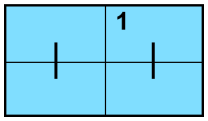
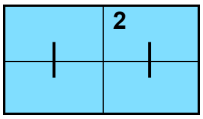
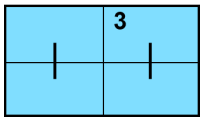
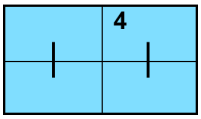
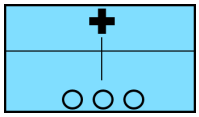
F-2. Army Doctrine Publication 1-02 provides a single standard for developing and depicting hand drawn and computer-generated military symbols for situation maps, overlays, and annotated aerial photographs for all types of military operations. A military symbol is a graphic representation of a unit, equipment, installation, activity, control measure, or tactical task relevant to military operations that is used for planning or to represent the common operational picture on a map, display, or overlay. Chapters 4–7 of ADP 1-02 also provide an extensive number of icons and modifiers for building a variety of framed symbols. Refer to Table F-1 for medical main icons.

Table F-1. Medical main icons

Function	***Icon*** ***Note. The icon has been enlarged for better visibility and is not proportional to the orientation or example***	***Example***
Hospital (medical treatment facility)		
Medical (Geneva cross)		

F-3. Sector 1 modifiers depict unit capabilities. These modifiers show the specific functions that the unit is organized and equipped to perform. Refer to Table F-2 (on page F-2) for medical sector 1 modifiers.

Table F-2. Medical sector 1 modifier

Function	*Icon* *Note. The icon has been enlarged for better visibility and is not proportional to the orientation or example*	*Example*
NATO medical role 1	**1**	
NATO medical role 2	**2**	
NATO medical role 3	**3**	
NATO medical role 4	**4**	
Medical evacuation	**✚**	

F-4. Sector 2 icons. Sector 2 modifiers reflect the mobility; size, range, or altitude of unit equipment; or additional capability of units. Refer to Table F-3 for medical sector 2 modifiers.

Note. Modifiers for medical units are offset to the right to avoid overlapping with the main icon.

Table F-3. Medical sector 2 modifiers

Function	*Icon* ***Note. The icon has been enlarged for better visibility and is not proportional to the orientation or example***	*Example*
Blood		
COSC	Ψ	Ψ
Dental		
Medical bed		
Medical laboratory	LAB	LAB
Optometry		
Patient evacuation coordination	PEC	PEC
Preventive medicine		
Surgical		
Veterinary	V	V

F-5. Activities symbols are applicable across the competition continuum, but they normally focus on stability activities and defense support of civil authorities' activities. Activities can affect military operations. Activities represented by icons can include acts of terrorism, sabotage, organized crime, a disruption of the flow of vital resources, and the uncontrolled movement of large numbers of people. Many of these icons represent emergency first response activities used in the civilian community. Icons in the main sector reflect the main function of the symbol. Refer to Table F-4 for medical main icons for activities; refer to Table F-5 for medical sector 1 modifiers for activities and Table F-6 for medical CBRN control measures.

Table F-4. Medical main icons for activities

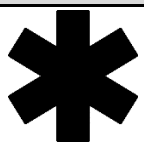
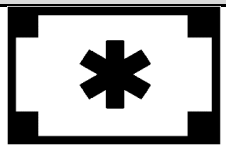
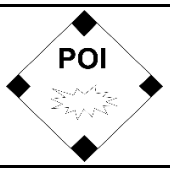
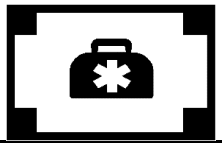
Function	*Icon* *Note. The icon has been enlarged for better visibility and is not proportional to the orientation or example*	*Example*
Emergency medical operations		
Point of injury	POI	
Triage		

Table F-5. Medical sector 1 modifiers for activities

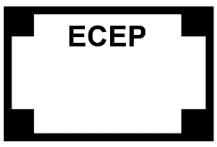
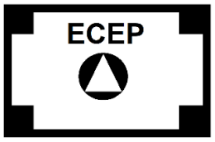
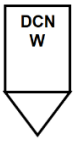
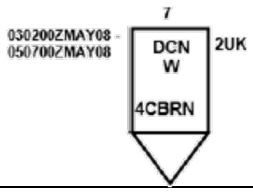
Function	*Icon*	*Example*
Emergency collection evacuation point	ECEP	 

Table F-6. Medical CBRN control measures

Control Measure	*Template*	*Example*
Decontamination site Wounded personnel		

LEGEND:

CBRN – Chemical, Biological, Radiological, Nuclear
UK – United Kingdom
DCN - Decontamination
W - Wounded

F-6. A control measure symbol is a graphic used on maps and displays to regulate forces and warfighting functions. Control measure symbols (refer to Table F-7) are organized by the six warfighting functions: command and control, movement and maneuver, fires, protection, sustainment, and intelligence. Control measure symbols generally fall into one of three categories: points, lines, or areas. The coloring and labeling of control measure symbols are almost identical to framed symbols

Table F-7. Medical sustainment control measures

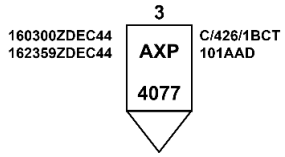
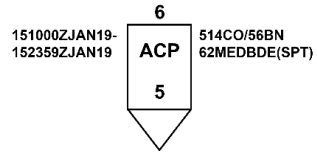
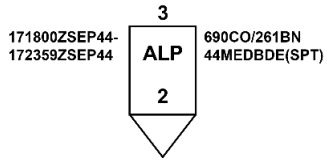
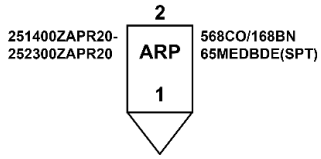
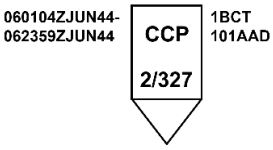
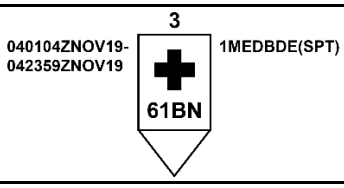
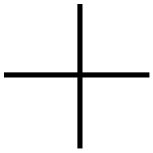
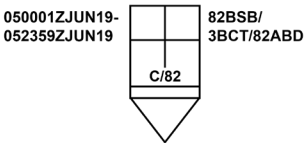
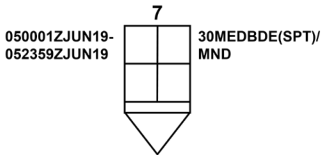
Control Measure	*Main Icon (Field A)*	*Construct example and symbol translation*
Ambulance exchange point A location where a patient is transferred from one ambulance to another en route to a medical treatment facility.	**AXP**	
Ambulance control point A point where ambulances may take one of two or more directions to reach loading points.	**ACP**	
Ambulance load point A point where one or more ambulances are stationed ready to receive patients for evacuation.	**ALP**	
Ambulance relay point A point where one or more empty ambulances are stationed.	**ARP**	
Casualty collection point A specific location where casualties are assembled to be transported to an MTF, for example, a company aid post.	**CCP**	
Medical evacuation pickup point		

Table F-7. Medical sustainment control measures (continued)

Control Measure	*Main Icon (Field A)*	*Construct example and symbol translation*
U.S. Class VIII A sustainment distribution point control measures symbol for medical supply		 

LEGEND:

AAD – Air Assault Division	BCT – Brigade Combat Team	MND – Multinational Division
ABD – Airborne Division	BDE – Brigade	SPT – Support
BN – Battalion	MED – Medical	

F-7. The symbols below (Table F-8) portray the different types of AHS units and elements. This table also depict how to use modifiers and amplifiers, affording the opportunity to show additional information about the main icon and display specific equipment such as medical beds.

Table F-8. AHS unit or element symbols

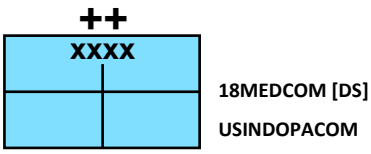
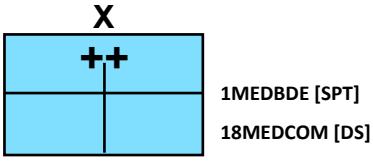
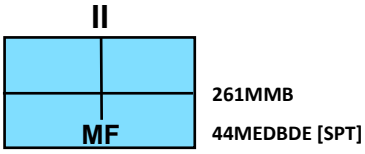
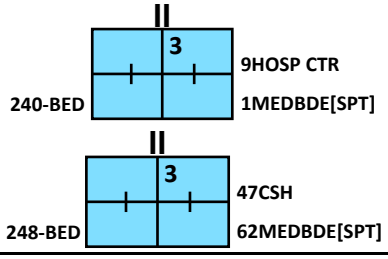
Title	*Symbol*	*Amplifier Definition*
Medical Command (Deployment Support)		18th Medical Command (Deployment Support); United States Indo-Pacific Command
Medical Brigade (Support)		1st Medical Brigade (Support); 18th Medical Command (Deployment Support)
Medical Battalion (Multifunctional)		261st Medical Battalion, Multifunctional; 44th Medical Brigade (Support)
Hospital Center (240-bed) Combat Support Hospital (248-bed)		9th Hospital Center; 1st Medical Brigade (Support) w/ 240-Bed Capability 47th Combat Support Hospital; 62nd Medical Brigade (Support), w/ 248-Bed Capability

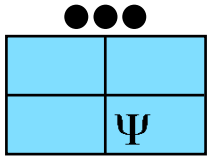
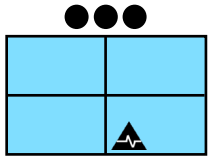
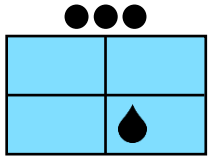
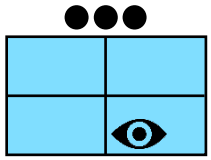
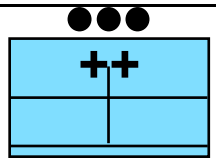
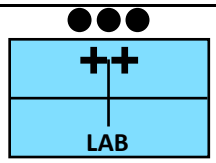
Table F-8. AHS unit or element symbols (continue)

Title	*Symbol*	*Amplifier Definition*
Field Hospital (32-bed)	3 586FLD HOSP 32-BED 531HOSP CTR	32-Bed, 586th Field Hospital; 531st Hospital Center, w/ 32-Bed Capability
Hospital Augmentation Detachment (Surgical, 24-bed)	3 534SURGICAL 24-BED 627HOSP CTR	24-Bed, 534th Hospital Augmentation Detachment, Surgical; 627th Hospital Center, w/ 24-Bed Capability
Hospital Augmentation Detachment (Medical, 32-bed)	3 433MEDICAL 32-BED 32HOSP CTR	32-Bed, 433rd Hospital Augmentation Detachment, Medical; 32nd Hospital Center, w/ 32-Bed Capability
Hospital Augmentation Detachment (ICW, 60-bed)	3 431ICW 60-BED 16HOSP CTR	60-Bed, 431st Hospital Augmentation Detachment, ICW; 16th Hospital Center, w/ 60-Bed Capability
Forward Resuscitative and Surgical Detachment (FRSD) Forward Surgical Team (FST)	250FRSD 62MEDBDE [SPT]	250th FRSD; 62nd Medical Brigade (Support)
Medical Detachment (Minimal Care, 120-bed)	319MINIMAL CARE 120-BED 531HOSP CTR	120-Bed, 319th Medical Detachment, Minimal Care; 531st Hospital Center, w/ 12-Bed Capability
Hospital Augmentation Team (Head and Neck)	3 499HEAD NECK 1MEDBDE [SPT]	499th Medical Detachment, Head & Neck; 1st Medical Brigade (Support)
Medical Company (Area Support)	2 575MCAS 40-BED 56MMB	575th Medical Company, Area Support; 56th Medical Battalion, Multifunctional, w/ 40-Bed capability
Brigade Support Medical Company (Airborne)	2 82BSB 505ABB 20-BED 82ABD	20-Bed, C Company, 82nd Brigade Support Battalion; 505th Parachute Infantry Regiment; 82nd Airborne Division, w/ 20-Bed Capability

Table F-8. AHS unit or element symbols (continue)

Title	*Symbol*	*Amplifier Definition*
Brigade Support Medical Company (Armor)	2 20-BED 47BSB 2BDE 1AD	C Company, 47th Brigade Support Battalion; 2nd Brigade Combat Team; 1st Armored Division, w/ 20-Bed Capability
Brigade Support Medical Company (Infantry)	2 20-BED SPT 101BSB 1BDE 1ID	C Company, 101st Brigade Support Battalion; 2nd Brigade Combat Team; 1st Infantry Division, w/ 20-Bed Capability
Brigade Support Medical Company (Stryker)	2 20-BED 296BSB 1SBCT 7ID	C Company, 296th Brigade Support Battalion; 1st Stryker Brigade Combat Team; 7th Infantry Division, w/ 20-Bed Capability
Medical Company (Air Ambulance)	6 GSAB 101CAB 101AAD	C Company, 6th General Support Aviation Battalion; 101st Combat Aviation Brigade; 101st Airborne Division (Air Assault)
Medical Company (Ground Ambulance)	24 M997 560MCGA 168MMB	560th Medical Company, Ground Ambulance; 168th Medical Battalion, Multifunctional, w/ 24 M997 Capability
Dental Company (Area Support)	464DCAS 421MMB 30MEDBDE [SPT]	464th Dental Company, Area Support; 421st Medical Battalion, Multifunctional; 30th Medical Brigade (Support)
Medical Logistics Company	582MLC 61MMB 1MEDBDE (SPT)	582nd Medical Logistics Company; 61st Medical Battalion, Multifunctional; 1st Medical Brigade (Support)
Medical Detachment (Veterinary Service Support)	V 248MDVSS 261MMB 44MEDBDE (SPT)	248th Medical Detachment, Veterinary Service Support; 261st Medical Battalion, Multifunctional; 1st Medical Brigade (Support)

Table F-8. AHS unit or element symbols (continue)

Title	*Symbol*	*Amplifier Definition*
Medical Detachment (Combat and Operational Stress Control)	 85COSC 61MMB	85th Medical Detachment, Combat and Operational Stress Control; 61st Medical Battalion, Multifunctional
Medical Detachment (Preventive Medicine)	 255PM 56MMB	255th Medical Detachment, Preventive Medicine; 56th Medical Battalion, Multifunctional
Medical Detachment (Blood Support)	 95BLOOD 168MMB 65MEDBDE (SPT)	95th Medical Detachment, Blood Support; 168th Medical Battalion, Multifunctional; 65th Medical Brigade (Support)
Medical Detachment (Optometry)	 24OPTO 261MMB	24th Medical Detachment, Optometry; 261st Medical Battalion, Multifunctional
Medical Logistics Management Center	 6MLMC 18MEDCOM (DS)	6th Medical Logistics Management Center; 18th Medical Command (Deployment Support)
Area Medical Laboratory	 1AML 18MEDCOM (DS)	1st Area Medical Laboratory; 18th Medical Command (Deployment Support)

F-8. The symbols below (Table F-9 on page F-10) portray the different vehicle and ship types. It also depicts how to use modifiers and amplifiers, affording the opportunity to show additional information about the main icon and display specific equipment and vehicle types (M997, M113, M1133).

Table F-9. AHS vehicle symbols

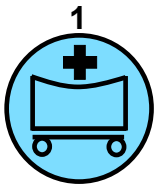
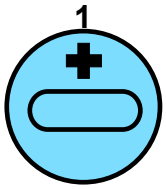
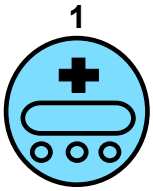
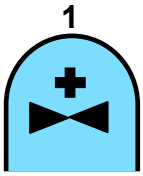
Title	*Symbol*	*Amplifier Definition*
Wheeled Vehicle Ambulance (M997) (High Mobility (Cross Country)	M997 4-LITTER GRND AMB MES 2/327 101AAD	(1) 4-Litter, M997; Equipped with a ground ambulance Medical Equipment Set (MES); Assigned to 2nd Battalion, 327th Infantry Battalion, 101st Airborne Division (Air Assault)
Wheeled Vehicle Ambulance (Limited Cross Country)	 M997 2-LITTER PARAMEDIC	(1) 2-Litter, Wheeled Vehicle Ambulance (Civilian); Paramedic on board
Armored Personnel Carrier Ambulance (M113) Armored Multi-Purpose Vehicle (Medical Evacuation)	 M113 4-LITTER GRND AMB MES 1/37 1AD	(1) 4-Litter, M113; Equipped with a ground ambulance MES; Assigned to 1st Battalion, 37th Armor Regiment 1st Armored Division
Armored Wheeled Ambulance (M1133) (High Mobility (Cross Country)	 M1133 4-LITTER GRND AMB MES 1/17SBCT 7ID	(1) 4-Litter, M1133; Equipped with a ground ambulance MES; Assigned to 1st Battalion 17th Stryker Infantry Battalion; 2nd Stryker Brigade Combat Team; 7th Infantry Division

Table F-9. AHS vehicle symbols (continue)

Title	*Symbol*	*Amplifier Definition*
Rotary wing, in flight	 HH-60M 4-LITTER AIR AMB MES 3/25GSAB	One (1) 4-Litter, HH-60M MEDEVAC helicopter; Equipped with an air ambulance MES; Assigned to 3rd General Support Aviation Battalion (GSAB), 25th Combat Aviation Brigade (CAB)
Rotary wing, on ground	HH-60M 2-LITTER AIR AMB MES 2/227GSAB	One(1) 2-Litter, HH-60M MEDEVAC helicopter; Equipped with an air ambulance MES; Assigned to 2nd GSAB, 227th CAB
Fixed wing, in flight	C130 74-LITTER AEROMED EVAC EQUIP USAF	One (1) 73-Litter, C-130; Equipped with an aeromedical evacuation equipment kit; Assigned to USAF

Fixed wing, on ground	1 C17 36L / 54A AEROMED EVAC EQUIP USAF	One (1) 36-Litter, 54 ambulatory, C-17; Equipped with an aeromedical evacuation equipment kit; Assigned to USAF
Military Noncombatant (Hospital Vessel)	1 USS COMFORT 500-BED USN	One (1) 500-Bed, USN Hospital Ship (USS Comfort); Assigned to the USN
	1 AH USS MERCY 500-BED USN	One (1) 500-Bed, USN Hospital Ship (USS Mercy); Assigned to the USN
Civilian/Merchant (Hospital Ship)	2 MERCY SHIP 80-BED CIVILIAN	Two (2) 80-Bed, Civilian operated hospital ships

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Glossary

This glossary lists acronyms and terms with Army or joint definitions. Where Army and joint definitions differ, (Army) precedes the definition. Terms for which FM 4-02 is the proponent are marked with an asterisk (*). The proponent publication for other terms is listed in parentheses after the definition.

SECTION I – ACRONYMS AND ABBREVIATIONS

ABCANZ	American, British, canadian, Australian, and New Zealand (Armies)
ADCON	adminstrative control
AE	aeromedical evacuation
AHLTA-T	Armed Forces Health Longitudinal Technology Application-Theater
AHS	Army Health System
AML	area medical laboratory
AO	area of operations
AOR	area of responsibility
AR	Army regulation
ARCP	Army Recovery Care Program
ASCC	Army Service Component Command
BCT	brigade combat team
BH	behavioral health
CA	civil affairs
CASEVAC	casualty evacuation
CBRN	chemical, biological, radiological, and nuclear
CCDR	combatant commander
COCOM	combatant command (command authority)
CONUS	continental United States
COSC	combat and operational stress control
CP	command post
CSH	combat support hospital
DA	Department of the Army
DA Pam	Department of the Army pamphlet
DD	Department of Defense
DHA	Defense Health Agency
DMC	distribution management center
DMLSS	Defense Medical Logistics Standard Support
DNBI	disease and nonbattle injury
DOD	Department of Defense
DODD	Department of Defense directive

DODI	Department of Defense instruction
EA	executive agent
EAB	echelons above brigade
ESC	expeditionary sustainment command
FHP	force health protection
FM	field manual
FRSD	forward resuscitative surgical detachment
FST	forward surgical team
GC	Geneva Convention Relative to the Protection of Civilian Persons in Time of War
GCC	geographic combatant command
GPW	Geneva convention Relative to the Treatment of Prisoners of War
GWS	Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field
HHD	headquarters and headquarters detachment
HQ	headquarters
HSS	health service support
IPB	intelligence prepartion of the battlefield
JFC	joint force commander
JOMIS	Joint Operational Medicine Information System
JP	joint publication
LSCO	large-scale combat operations
MCC	Mobile Computing Capability
MCP	main command post
MEDBDE (SPT)	medical brigade (support)
MEDCoE	Medical Center of Excellence
MEDCOM (DS)	medical command (deployment support)
MEDEVAC	medical evacuation
MEDLOG	medical logistics
MHS	Military Health System
MLMC	medical logistics management center
MMB	medical battaliion (multifunctional)
MSAT	Medical Situational Awareness in the Theater
MTF	medical treatment facility
MWD	military working dog
NATO	North Atlantic Teaty Organization
NCO	noncommissioned officer
OCP	operational command post
OE	operational environment
OEH	occupational and environmental health
OPCON	operational control
OPLAN	operation plan

OPORD	operation order
POI	point of injury
POW	prisioner of war
S-1	battalion or brigade personnel staff officer
S-2	battalion or brigade intelligence staff officer
S-3	battalion or brigade operation staff officer
S-4	battalion or brigade logistics staff officer
S-6	battalion or brigade signal staff officer
S-9	battalion or brigade civil affairs operations staff officer
SIMLM	single integrated medical logistics manager
SOP	standard operating procedure
STANAG	standardization agreement
TACON	tactial control
TC2	Theater Composite Health Care System Cache
TCCC	tactical combat casualty care
TLAMM	theater lead agent formedical material
TM	technical manual
TMDS	Theater Medical Data Store
TOE	table of organization and equipment
TOL	Triad of Leadership
TRAC2ES	Transporation Command Regulating and Command Control Evacuation System
TSC	theater sustainment command
TSOP	tactical standard operating procedures
U.S.	United States
USAF	United States air Force
USAMEDCOM	United States Army Medical Command
USN	United States Navy

SECTION II – TERMS

***Army Health System**

A component of the Military Health System that is responsible for operational management of the health service support and force health protection missions for training, predeployment, deployment, and postdeployment operations. The Army Health System includes all mission support services performed, provided, or arranged by the Army Medicine to support health service support and force health protection mission requirements for the Army and as directed, for joint, intergovernmental agencies, coalition, and multinational forces.

***casualty evacuation**

The movement of casualties aboard nonmedical vehicles or aircraft without en route medical care. Also called CASEVAC

casualty collection point

A location that may or may not be staffed, where casualties are assembed for evacuation to a medical treatment facility. (ATP 4-02.2)

***combat and operational stress control**

A coordinated program of actions taken by military leadership to prevent, identify, and manage reactions to traumatic events that may affect exposed organizations and individuals during unified land operations. Also called COSC.

***combat lifesaver**

A nonmedical Soldier of a unit trained to provide enhanced first aid as a secondary mission.

comprehensive dental care

The dental treatment to restore and/or maintain a Soldier's optimal oral health, function, and aesthetics (ATP 4-02.19).

***continuity of care**

Attempt to maintain the role of care during movement at least equal to the care provided at the preceding facility.

***definitive care**

Care or treatment which returns an ill or injured Soldier achieving maximum medical improvement.

***definitive treatment**

The final role of comprehensive care provided to return the patient to the highest degree of mental and physical health possible. It is not associated with a specific role or location in the continuum of care; it may occur in different roles depending upon the nature of the injury or illness.

emergency dental care

The care given for the relief of oral pain; diagnosis and treatment of infections; control of life-threatening oral conditions (hemorrhage, cellulitis, or respiratory difficulties); and treatment of trauma to teeth, jaws (maxilla/mandible), and associated facial structures is considered emergency care (ATP 4-02.19).

***emergency medical treatment**

The immediate application of medical procedures to the wounded, injured, or sick by specially trained medical personnel.

en route care

The care required to maintain the phased treatment initiated prior to evacuation and the sustainment of the patient's medical condition during evacuation. (ATP 4-02.2)

***essential care**

The absolutely necessary initial, en route, resuscitative, and surgical care provided to save, stabilize, and return as many Soldiers to duty as quickly as possible.

essential dental care

The dental care necessary to intercept potential emergencies to prevent lost duty time and preserve fighting strength (ATP 4-02.19).

***first aid (self-aid/buddy aid)**

Urgent and immediate lifesaving and other measures which can be performed for casualties (or performed by the victim themself) by nonmedical personnel when medical personnel are not immediately available.

***force health protection**

(Joint) Measures to promote, improve, or conserve the behavioral and physical well-being of Service members to enable a healthy and fit force, prevent injury and illness, and protect the force from health hazards. Also called FHP. (JP 4-02) (Army) Force health protection are measures that promote, improve, or conserve the behavioral and physical well-being of Soldiers comprised of preventive and treatment aspects of medical functions that include: combat and operational stress control, dental services, veterinary services, operational public health, and laboratory services. Enabling a healthy and fit force, prevent injury and illness, and protect the force from health hazards.

***health service support**

(Joint) All services performed, provided, or arranged to promote, improve,conserve, or restore the mental or physical well-being of personnel. Also called HSS. (JP 4-02) (Army) Health service support is support and services performed, provided, and arranged by the Army Medicine to promote, improve, conserve, or restore the behavioral and physical well-being of personnel by providing direct patient care that include medical treatment (organic and area support) and hospitalization, medical evacuation to include medical regulating, and medical logistics to include blood management.

inpatient

A person admitted to and treated within a Role 3 and 4 hospital and who cannot be returned to duty within the same calendar day. (ATP 4-02.10)

lines of patient drift

Natural routes along which wounded Soldiers may be expected to go back for medical care from a combat position. (ATP 4-02.2)

mass casualty

Any number of human casualties produced across a period of time that exceeds available medical support capabilities. (JP 4-02)

medical evacuation

The timely and effective movement of the wounded, injured, or ill to and between medical treatment facilities on dedicated and properly marked medical platforms with en route care provided by medical personnel. Also called MEDEVAC. (ATP 4-02.2)

medical regulating

The actions and coordination necessary to arrange for the movement of patients through the roles of care and to match patients with a medical treatment facility that has the necessary health service support capabilities, and available bed space. (JP 4-02)

***medical treatment facility**

(Joint) A facility established for the purpose of furnishing medical and/or dental care to eligible individuals. (JP 4-02) (Army) Medical treatment facility refers to any facility established for the purpose of providing medical treatment. This includes battalion aid stations, Role 2 facilities, dispensaries, clinics, and hospitals.

nontransportable patient

A patient whose medical condition is such that he could not survive further evacuation to the rear without surgical intervention to stabilize his medical condition. (ATP 4-02.2)

operational dental care

The dental care provided for deployed Soldiers in theater consisting of emergency dental care and essential dental care (ATP 4-02.19)

operational public health

The application of public health practices and conduct of public health-related activities within a geographic area where military operations are conducted by TOE units. (AR 40-5)

outpatient

A person receiving medical/dental examination and/or treatment from medical personnel and in a status other than being admitted to a hospital. Included in this category is the person who is treated and retained (held) in a medical treatment facility (such as a Role 2 facility) other than a hospital. (ATP 4-02.10)

***patient**

A sick, injured or wounded individual who receives medical care or treatment from medically trained personnel.

patient estimate

Estimates derived from the casualty estimate prepared by the personnel staff officer/assistant chief of staff, personnel. The patient medical workload is determined by the Army Health System support planner. Patient estimate only encompasses medical casualty. (ATP 4-02.55)

patient movement

The act of moving a sick, injured, wounded, or other person to obtain medical and/or dental treatment. (ATP 4-02.2)

public health

The science and practice of promoting, protecting, improving, and, when necessary, restoring the health of individuals, specified groups, or the entire population. As applied in the operational setting it is the preservation, maintenance, and restoration of health in Army populations through the anticipation, prediction, identification, surveillance, evaluation, prevention, and control of DNBI. (AR 40-5)

***return to duty**

A patient disposition which, after medical evaluation and treatment when necessary, returns a Soldier for duty in his unit.

stabilized patient

A Patient whose airway is secured, hemorrhage is controlled, shock treated, and fractures are immobilized. (JP 4-02)

***tailgate medical support**

An economy of force device employed primarily to retain maximum mobility during movement halts or to avoid the time and effort required to set up a formal, operational treatment facility (for example, during rapid advance and retrograde operations). (Currently the proponent is FM 4-02 but will be moved to ATP 4-02.3 when revised).

theater evacuation policy

A command decision indicating the length in days of the maximum period of non-effectiveness that patients may be held within the command for treatment, and the medical determination of patients that cannot return to duty status within the period prescribed requiring evacuation by the first available means, provided the travel involved will not aggravate their disabilities or medical condition. (ATP 4-02.2).

***triage**

The process of sorting casualties based on need for treatment, evacuation, and available resources.

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RECOMMENDED READINGS

None.

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