



# **FM 4-02**

## **ARMY HEALTH SYSTEM**

**AUGUST 2013**

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# Army Health System

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## Preface

This publication 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 modernized under the Department of the Army (DA)-approved Medical Reengineering Initiative and the Modular Medical Force that is designed to support the brigade combat teams (BCTs) and echelons above brigade (EAB) units.

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

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

Part One, AHS, provides a holistic view of the entire AHS and the complexities and interdependence of each medical function in successfully accomplishing the AMEDD's mission to *conserve the fighting strength*. This part of the manual describes and provides operational guidance on the AHS's EAB mission command headquarters, as well as the medical aspects of the Law of Land Warfare.

Part Two, HSS, discusses the three mission sets of casualty care, medical evacuation, and medical logistics (MEDLOG). Casualty care encompasses all of the medical functions involved with direct patient care activities to include diagnostic medical laboratories, while medical evacuation and MEDLOG are separate medical functions.

Part Three, FHP, encompasses preventive medicine, veterinary services, all of the preventive aspects of combat and operational stress control (COSC) and dental services, and area medical laboratory (AML) including the testing of suspect biological and chemical warfare agent specimens and samples.

This publication is for use by commanders and their staffs and command surgeons. It is to be used as a guide in obtaining, as well as providing, AHS in an AO. 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 in agreement with Joint Publication (JP) 4-02.

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

- United States and international law.
- Policy guidance in the form of Army regulations (ARs) and Department of Defense (DOD) policy promulgated in the form of DOD directives (DODD) and instructions (DODI) and other documents.
- Medical standards established by civilian organizations (such as the Joint Commission on the Accreditation of Health Care Organizations).
- 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 the 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.

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 (Armies) (ABCA) Standards, and Quadripartite Advisory Publication 256, Coalition Health Interoperability Handbook.

TITLE	STANAG	ABCA STANDARDS
Blood Supply in the Area of Operations		815
Identification of Medical Material for Field Medical Installations	2060	
Emergency War Surgery	2068	
Medical Employment of Air Transport in the Forward Area	2087	
Multilingual Phrase Book for Use by the NATO Medical Services—Allied Medical Publication-5(B)	2131	
Documentation Relative to Medical Evacuation, Treatment and Cause of Death of Patients	2132	
Allied Joint Medical Support Doctrine—Allied Joint Publication 4-10(A)	2228	
Road Movements and Movement Control—Allied Movement Publication-1(A)	2454	
Orders for the Camouflage of Protective Medical Emblems on Land in Tactical Operations—Allied Tactical Publication-79	2931	
Minimum Requirements for Blood, Blood Donors and Associated Equipment	2939	
Aeromedical Evacuation	3204	

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Unless this publication states otherwise, masculine nouns and pronouns do not refer exclusively to men.

This publication uses joint terms where applicable. Terms for which this publication is the proponent publication are marked with an asterisk (\*) in the glossary.

This publication applies to the Active Army, the Army National Guard (ARNG)/Army National Guard of the United States (ARNGUS), and the United States Army Reserve (USAR), unless otherwise stated.

## PART ONE

# Army Health System

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, what it is comprised of, and the 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 AMEDD 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 or wounding and describes the system of phased and incrementally increasing capability which enables the wounded or ill Soldier to be stabilized and evacuated to the appropriate medical treatment capability to care for his specific medical condition and to restore him to health, limit long-term disability, and either return him to duty or to his civilian life as a productive member of that community.
  - 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 to 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 mission command organizations, their functions, and responsibilities. It also provides an in-depth discussion of the AMEDD team, the medical commander, the command surgeon, and the involvement required of the line commander.
  - Provides information on the role of the generating 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.
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## Chapter 1

# Army Health System Overview

The AHS is a component of the DOD Military Health System (MHS). It is responsible for the operational management of the HSS and FHP missions for training, predeployment, deployment, and postdeployment operations. The AHS includes all mission support services performed, provided, or arranged by the AMEDD to support HSS and FHP mission requirements for the Army and as directed, for joint, intergovernmental agencies, and multinational forces. Although the MHS is an interrelated system which may share medical services, capabilities, and specialties among the U.S. Service components, it is not a joint mission command 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 HSS refer to JP 4-02.

### SECTION I — OPERATIONAL ENVIRONMENT

1-1. The operational environment (OE) has evolved to an era of persistent conflict—a period of protracted confrontation among state, nonstate, and individual actors increasingly willing to use violence to achieve their political and ideological ends. For information on the OE see Army Doctrine Publication (ADP) 3-0.

1-2. The AMEDD views threats from two perspectives: the general threat and the health threat. Although the AMEDD'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

1-3. 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 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**

<b><i>Diseases</i></b>	Endemic and epidemic Foodborne Waterborne Arthropodborne Zoonotic Vectors and breeding grounds
<b><i>Occupational and Environmental Health Hazards</i></b>	Climatic (heat, cold, humidity, and significant elevations above sea level) Toxic industrial materials Accidental or deliberate dispersion of radiological and biological material Disruption of sanitation services/facilities (such as sewage and waste disposal) Disruption of industrial operations or industrial noise
<b><i>Poisonous or Toxic Flora and Fauna</i></b>	Toxic poisonous plants and bacteria Poisonous reptiles, amphibians, arthropods, and animals
<b><i>Medical Effects of Weapons</i></b>	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
<b><i>Physiologic and Psychological Stressors</i></b>	Continuous operations Combat and operational stress reactions Wear of mission-oriented protective posture ensemble Stability tasks Home front issues

**SECTION II — WARFIGHTING FUNCTIONS**

1-4. The AHS supports two warfighting functions as described in Army doctrine on unified land operations. The HSS mission is included in the sustainment warfighting function, while the FHP mission comes under the protection warfighting function.

**HEALTH SERVICE SUPPORT MISSION**

1-5. The Army HSS mission is defined as all support and services performed, provided, and arranged by the AMEDD to promote, improve, conserve, or restore the behavioral and physical well-being of personnel in the Army, and as directed in other Services, agencies, and organizations. This includes casualty care (encompassing a number of AMEDD functions—organic and area medical support, hospitalization, the treatment aspects of dental care, behavioral health [BH]/neuropsychiatric treatment, clinical laboratory services, and the treatment of CBRN patients), medical evacuation, and MEDLOG.

**FORCE HEALTH PROTECTION MISSION**

1-6. The Army FHP mission is defined as the measures to promote, improve, or conserve the behavioral and physical well-being of Soldiers. These measures enable a healthy and fit force, prevent injury and illness, and protect the force from health hazards. They also include the prevention aspects of a number of AMEDD functions (preventive medicine—including medical surveillance and occupational and environmental health [OEH] surveillance, and veterinary services—including the food inspection, animal care missions, and the prevention of zoonotic diseases transmissible to man), COSC, dental services (preventive dentistry), and laboratory services (AML support).

## SECTION III — TACTICAL COMBAT CASUALTY CARE

1-7. First responder capability can be usefully divided into the three phases called tactical combat casualty care (TC3). Tactical combat casualty care occurs during a combat mission and is the military counterpart to prehospital emergency medical treatment. Prehospital TC3 in the military is most commonly provided by enlisted personnel and includes self-aid/buddy aid (first aid), combat lifesaver (enhanced first aid), and enlisted combat medics in the Army, corpsmen in the U.S. Navy (USN), U.S. Marine Corps, and U.S. Coast Guard, and both medics and pararescuemen in the U.S. 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

1-8. 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

1-9. During the tactical field care phase, medical personnel and their casualties 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 advanced trauma management.

### TACTICAL EVACUATION PHASE

1-10. In the tactical evacuation phase, casualties are being transported to a medical treatment facility (MTF) by an aircraft or vehicle and there is an opportunity to provide additional medical personnel and equipment to maintain the interventions already performed and to be prepared to deal with the potential for the patient's condition to change during the tactical evacuation.

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*Note.* The TC3 initiative originated with U.S. Special Operations Command. Special operations forces do not have a dedicated, designed, and equipped medical evacuation capability. Therefore, they use nonmedical platforms augmented with medical personnel to perform the evacuation function. The conventional force doctrinal categories of medical evacuation and casualty evacuation as defined in Army doctrine on medical evacuation are not changed. However, during this phase of TC3 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.

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### CASUALTY EVACUATION

1-11. For the Army, casualty evacuation involves the unregulated movement of casualties using predesignated or opportune tactical or logistic aircraft and vehicles. These vehicles/rotary-wing aircraft are not staffed with medical personnel for en route care (unless augmentation is planned for in the operation plan [OPLAN]). These vehicles/aircraft do not have organic medical equipment. If the combat medic is not available to provide care en route, the combat lifesaver may accompany the casualties to monitor their condition.

**WARNING**

**Casualties transported in this manner may not receive proper en route medical care or be transported to the appropriate MTF to address the patient's medical condition. If the casualty's medical condition deteriorates during transport, or the casualty is not transported to the appropriate MTF, an adverse impact on his prognosis and long-term disability or death may result.**

**MEDICAL EVACUATION**

1-12. Medical evacuation refers to dedicated medical platforms staffed and equipped to provide en route medical care. Within the joint arena, aeromedical evacuation specifically refers to USAF fixed-wing movement of regulated casualties, using organic and/or contracted mobility airframes, with an aeromedical evacuation aircrew trained explicitly for this mission.

1-13. Within the Army arena, medical evacuation is performed by dedicated, standardized medical evacuation platforms, with medical professionals who provide the timely, efficient movement and en route care of the wounded, injured, or ill persons from the point of injury or wounding and/or other locations to MTFs. Medical evacuation is an AMEDD function that supports and is an integral part of the continuance of care. 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. Medical evacuation ground/air ambulance platforms are defined as: platforms designed especially for the medical evacuation mission with allocated medical equipment to provide en route care by trained medical personnel.

**PATIENT EVACUATION**

1-14. In today's OE, the reduced medical footprint forward and the evacuate and replace philosophy place a high demand on en route care capabilities. Consequently, patient evacuation capabilities are even more critical than in the past and the U.S. 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 OF THE ARMY HEALTH SYSTEM**

1-15. 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 OPLANs which are effective, efficient, flexible, and executable. Army Health System plans are designed to support the operational commander's scheme of maneuver while still retaining a focus on the delivery of health care.

1-16. The AHS principles apply across all medical functions and are synchronized through medical mission command and close coordination and synchronization of all deployed medical assets through medical technical channels. Figure 1-1 depicts the AHS principles.



**Figure 1-1. Army Health System principles**

### **CONFORMITY**

1-17. Conformity with the OPLAN 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 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 AO engagement strategy and have been thoroughly coordinated with the supporting assistant chief of staff, civil affairs (CA).

### **PROXIMITY**

1-18. 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. As the battle rhythm of the medical commander is similar to the operational commander's, 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 the conduct of operations.

### **FLEXIBILITY**

1-19. 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 transition from one level of violence to another across the range of military operations. As the current era is one characterized by persistent conflict, the medical commander may be supporting simultaneous actions characterized by different decisive actions, such as offensive, defensive, or stability tasks. The medical commander exercises his command authority to effectively manage his scarce medical resources so that they benefit the greatest number of Soldiers in the AO. For example, there are insufficient numbers of forward surgical teams (FSTs) to permit the habitual assignment of these organizations to each 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. As the operational situation changes within that BCT AO, the command surgeon and medical commander monitor and execute resupply and/or reconstitute operations of that FST to prepare for follow-on operations which could be in another BCT's AO. This ability to rapidly re-mission these special skills



maximizes the lifesaving capacity of these units, provides the highest standard of lifesaving medical interventions to the greatest number of our combat wounded, and enhances the effectiveness of the surgical care provided and the productivity of these teams.

## **MOBILITY**

1-20. 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 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, medical evacuation 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 on hand prior to the start of the engagement.

## **CONTINUITY**

1-21. Continuity in care and treatment is achieved by moving the patient through progressive, phased roles of care, extending from the point of injury or wounding to the CONUS-support base. Each type of AHS unit contributes a measured, logical increment in care appropriate to its location and capabilities. In current 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 point of injury directly to the supporting combat support hospital (CSH). In more traditional operations, higher casualty rates, extended distances, and patient condition may necessitate that a patient receive care at each role of care to maintain his physiologic status and enhance his chances of survival. The medical commander, with his depth of medical knowledge, his ability to anticipate follow-on medical treatment requirements, and his assessment of the availability of his specialized medical resources can adjust the patient flow to ensure each Soldier receives 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.

## **CONTROL**

1-22. 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 AMEDD is comprised of 10 medical functions (see paragraph 1-33) 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 AO, the most qualified individual to orchestrate this complex support is the medical commander due to his training, professional knowledge, education, and experience. In a joint and multinational environment it is essential that coordination be accomplished across all Services and multinational forces to leverage all of the specialized skills within the AO. 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**

1-23. 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. As a general rule, no role 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 TC3, advanced trauma management, and far forward resuscitative surgery is accomplished prior to movement between MTFs (Roles 1 through 3).

## **ROLE 1**

1-24. 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 prevention.
- Combat and operational stress preventive measures.
- Patient location and acquisition (collection).
- Medical evacuation from supported units (point of injury 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 patient to return to duty or to stabilize him and allow for his evacuation to the next role of care. These measures include maintaining the airway, stopping bleeding, preventing shock, protecting wounds, immobilizing fractures, and other emergency measures, as indicated.)

1-25. Nonmedical personnel performing first aid procedures assist the combat medic in his duties. First aid is administered by an individual (self-aid/buddy aid) and enhanced first aid is provided by the combat lifesavers.

### **Self-Aid and Buddy Aid**

1-26. 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.

### **Combat Lifesaver**

1-27. The combat lifesaver is a nonmedical Soldier selected by his 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 lifesaver is to provide enhanced first aid for injuries, based on his 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.

### **Medical Personnel**

1-28. Role 1 medical treatment is provided by the combat medic or by the physician, the physician assistant, or the health care specialist in the battalion aid station/Role 1 MTF. 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 advanced trauma management 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.

## ROLE 2

1-29. 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 patient is examined and his wounds and general medical condition are evaluated to determine his treatment and evacuation precedence, as a single patient among other patients. Advanced trauma management and TC3 including 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 has the capability to provide packed red blood cells (liquid), limited x-ray, clinical laboratory, operational dental support, COSC, preventive medicine, and when augmented, physical therapy and optometry services. 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. Patients who are nontransportable due to their medical condition may require resuscitative surgical care from an FST collocated with a medical company. (See Army doctrine on the FST.) This role of care provides medical evacuation from Role 1 MTFs and also provides Role 1 medical treatment on an area support basis for units without organic Role 1 resources.

1-30. Role 2 AHS assets are located in the—

- Medical company (brigade support battalion), 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.

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*Note.* The Role 2 definition used by NATO forces Allied Joint Publication-4.10(A) includes the following terms and descriptions not used by U.S. Army forces. 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 that a surgical capability is mandatory at this role. The NATO descriptions are—

- A medical company with a collocated FST may be referred to as a *light maneuver* Role 2 facility.
  - An enhanced Role 2 MTF may be used in operations with a preponderance of stability tasks scenarios and consists of the medical company, FST, and other specialty augmentation as deemed appropriate by the situation. Specialty augmentation is only provided when the situation has stabilized and it is not anticipated that the enhanced MTF will be required to relocate.
- 

## ROLE 3

1-31. 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—

- Evacuating patients from supported units.
- 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.

## ROLE 4

1-32. Role 4 medical care is found in CONUS-based hospitals and other safe havens. 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 AO. The support-based hospitals represent the most definitive medical care available within the AHS.

## SYSTEM OF SYSTEMS

1-33. The AHS is a complex system of systems (Figure 1-2). 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 mission command.
- Medical treatment (organic and area support).
- Hospitalization.
- Medical evacuation (to include medical regulating).
- Dental services.
- Preventive medicine services.
- Combat and operational stress control.
- Veterinary services.
- Medical logistics (to include blood management).
- Medical laboratory services (to include both clinical laboratories and area laboratories).

1-34. The AHS supports and is in consonance with joint doctrine, as described in JP 4-02.

## EXECUTIVE AGENT

1-35. The Army Surgeon General exercises Executive Agency over a number of functions and/or health care organizations as directed by the DOD. The Army Surgeon General provides direction and administrative and logistical support for these agencies that provide support not only to the U.S. Army but to the sister Services or other government entities. Refer to <http://www.armymedicine.mil/org/ea/ea.html> for a listing of these agencies.

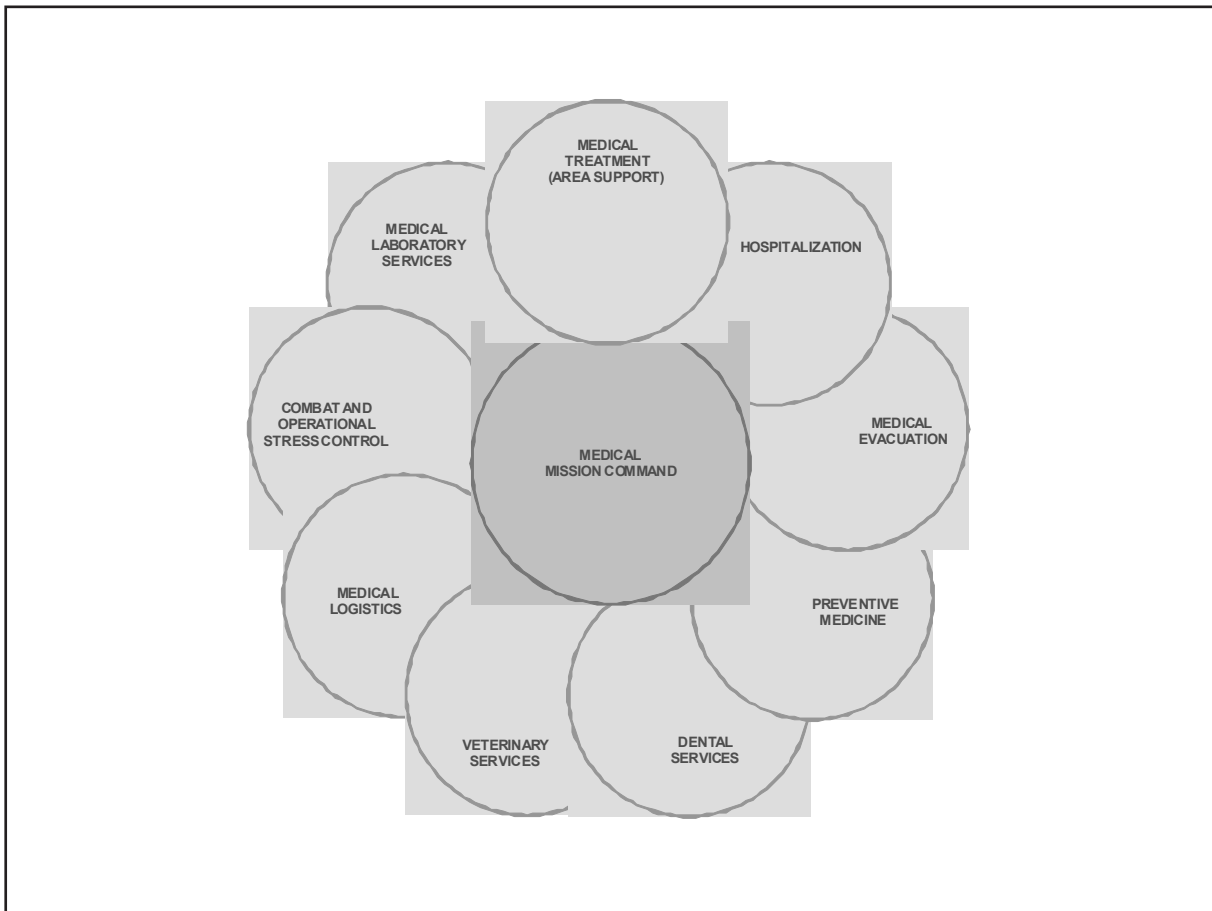


Figure 1-2. System of systems

## COMMUNICATIONS AND INFORMATION TECHNOLOGY

1-36. The AHS uses the Medical Communications for Combat Casualty Care System to integrate, field, and support a comprehensive medical information system enabling lifelong electronic medical records, streamlined MEDLOG, and enhanced medical awareness. The Medical Communications for Combat Casualty Care System employs automation and communications equipment to—

- Assist in conserving the fighting strength by integrating medical and OEH surveillance data and other health threat indicators. This assists in identifying disease and injury trends which facilitate the prevention of performance deterioration and casualties due to disease and nonbattle injury.
- Provide seamless state-of-the-art medical information management across the range of military operations.
- Ensure the capability of rapid strategic deployability in exercising the medical mission command *first-in, last-out* principle.
- Enhance the capability to promptly clear the AO (locate, acquire, treat, stabilize, and evacuate casualties).
- Conduct split-based operations on a continuous basis.
- Provide AHS staff virtual presence at all command levels.
- Support joint and multinational medical forces, as directed, across the range of military operations.

- Interface with Army systems, other Services, DOD, and Department of Veterans Affairs automated systems.
- Document patient encounters and Soldiers exposures to health threats (such as CBRN warfare agents and toxic industrial materials) electronically.

1-37. The AHS communications network has interconnectivity to Army and joint global automated architecture systems to access Army mission command systems and sustainment systems.

## ELIGIBILITY OF CARE DETERMINATION

1-38. During interagency and multinational operations, one of the most pressing questions is who is eligible for care in a U.S. 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 is just one approach to delineate and disseminate this information to MTF personnel and may not be all-inclusive based on specific scenarios.

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*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.

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## KNOWLEDGE OF HEALTH CARE CAPABILITIES

1-39. The MTF staff must be familiar with the medical care available in the AO from other sources. These sources could include multinational force military (tactical and strategic), nongovernmental organizations or international 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 U.S. Army MTF and the patient can be transferred to another facility for continued care.

## DISSEMINATION OF ELIGIBILITY FOR CARE INFORMATION

1-40. 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 concepts 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 operation orders (OPORDs) and briefed to the appropriate senior leadership of the command.

## DOCUMENTATION

1-41. Basic documents required for determining eligibility of beneficiaries include AR 40-400; Field Manual (FM) 27-10; 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 multinational force or international agency 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 AO must be taken into account as the medical mission command headquarters and its higher headquarters develop the eligibility matrix.

1-42. The eligibility matrix should be as comprehensive as possible. If necessary, it should include eligibility determination by name (see example in Table 1-2). 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 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.

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*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.

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## SAMPLE ELIGIBILITY FOR CARE MATRIX

1-43. Table 1-2 provides a sample of eligibility for care matrix for treatment in a U.S. Army MTF.

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

<b>ELIGIBILITY FOR MEDICAL/DENTAL CARE SUPPORT MATRIX (DATE) (THIS DOCUMENT IS SUBJECT TO FURTHER VERIFICATION AND/OR MODIFICATION)</b>		
<b>CATEGORY</b>	<b>MEDICAL/ DENTAL</b>	<b>INFORMATION/AUTHORITY*</b>
Allied military personnel	Yes <sup>1</sup>	The following nations have acquisition and cross-servicing agreements and multinational force compatibility agreements with the United States which are administered by ( <i>combatant command</i> ): <i>List nations.</i>
Coalition military personnel	Yes <sup>1</sup>	The following nations have acquisition and cross-servicing agreements and may have multinational force compatibility agreements with the United States which are administered by ( <i>combatant command</i> ): <i>List nations.</i>
Department of Defense civilian employees	Yes	Invitational travel order.
United States Government employees (non-Department of Defense)	Yes <sup>2</sup>	Invitational travel order.
United States Embassy personnel	Yes	United States citizens on official business.
United States Congressional personnel	Yes	United States citizens on official business.

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

<b>ELIGIBILITY FOR MEDICAL/DENTAL CARE SUPPORT MATRIX (DATE) (THIS DOCUMENT IS SUBJECT TO FURTHER VERIFICATION AND/OR MODIFICATION)</b>		
<b>CATEGORY</b>	<b>MEDICAL/ DENTAL</b>	<b>INFORMATION/AUTHORITY*</b>
Army and Air Force Exchange Service United States citizen employees	Yes	Invitational travel order.
Army and Air Force Exchange Service Local national employees	Yes <sup>3</sup>	United States law.
Nonappropriated fund instrumentality morale, welfare, and recreation United States 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 <sup>3</sup>	United States law.
Contractor #2 all employees  POC: Mr. Michaels (XXX) XXX-XXXX ADMIN: Mr. Johns DSN XXX-XXXX	Yes <sup>3</sup>  No <sup>5</sup>	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. <b>NOTE:</b> 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 <sup>6</sup>	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 United States active duty or retired military personnel	Yes <sup>4</sup>	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.



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

<b>ELIGIBILITY FOR MEDICAL/DENTAL CARE SUPPORT MATRIX (DATE) (THIS DOCUMENT IS SUBJECT TO FURTHER VERIFICATION AND/OR MODIFICATION)</b>		
<b>CATEGORY</b>	<b>MEDICAL/ DENTAL</b>	<b>INFORMATION/AUTHORITY*</b>
Personnel in custody of United States military forces	Yes	Enemy prisoner of war and retained or detained personnel. Extent of care rendered is the same as that provided to United States military forces within the geographical area. (Army Techniques Publication 4-02.46, and Field Manual 27-10).
Individual injured as a result of military operations	Yes	United States and international law (Field Manual 27-10) and status of forces agreements. If the United States military injures an individual (such as in an automobile accident involving a military vehicle), the United States 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.
<p>LEGEND:</p> <p>* Illustrative in nature only.</p> <p>1 Allied/coalition forces 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 multinational liaison. Logistical support is not permitted for those nations with whom the United States 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.</p> <p>2 If not working for, contracted to, or on Department of Defense multinational force compatibility agreement for logistical support, non-Department of Defense United States Government employees must pay for meals received at Department of Defense dining facilities.</p> <p>3 Emergency medical and dental care only. Emergency care is that care required to save life, limb, or eyesight.</p> <p>4 Space available.</p> <p>5 Routine.</p> <p>6 Reimbursable.</p>		

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## Chapter 2

# Army Health System Mission Command

The complexities of the range of military operations, 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 mission 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 mission 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 medical mission command modules for early entry and expeditionary operations which could be expanded and augmented as the AO matures and an Army and joint integrated health care infrastructure is established.

### SECTION I — THE ARMY MEDICAL DEPARTMENT TEAM

#### SYNERGY

2-1. To ensure a seamless continuum of care from the point of injury 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 AMEDD table of organization and equipment (TOE) (operational forces) and table of distribution and allowances (the generating 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 in theater and maximizes the utilization and employment of scarce medical resources.

#### PARTNERSHIPS

##### WITH OUR NATION

2-2. The advent of the war on terrorism has presented the AMEDD with a myriad of challenges in providing state-of-the-art care to both our deployed forces and their Family members and to be prepared to provide care to our Nation in the event of terrorist incidents and/or natural or man-made disasters.

2-3. The American public has high expectations of the quality and scope of health care that will be provided for our brave men and women who are wounded on the field of battle while protecting our Nation's freedom and way of life. That expectation includes that all measures that can be taken to protect our Soldiers and to prevent and to mitigate exposures to health threats in the deployed environment will be taken. It also includes an expectation that medical education and research will continue in order to enhance these protections in future OEs.

2-4. The AMEDD must synchronize the efforts of the deployed operational medical forces and the generating force medical resources to ensure a seamless system of health care from the point of injury or wounding through successive roles of medical care within the theater to definitive, rehabilitative, and convalescent care in CONUS.

### **WITH THE TACTICAL COMMANDER AND OPERATIONAL ARMY**

2-5. 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 his command by promoting health and fitness, preventing casualties from disease and nonbattle injury, 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 Service Members from the other Services entrusted to his care by our Nation.

### **WITH OUR MULTINATIONAL PARTNERS**

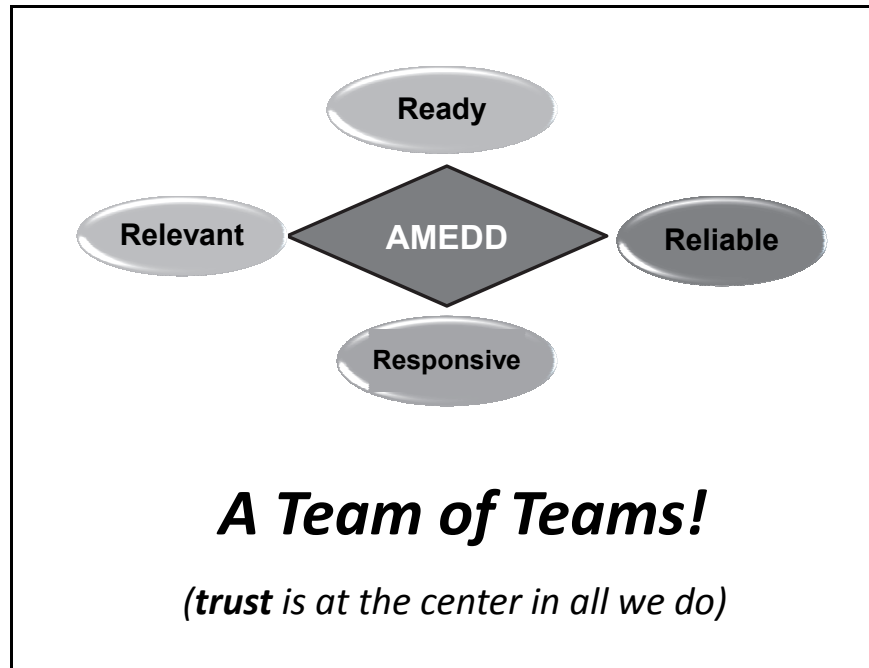
2-6. In the tactical environment, a unity of effort must be achieved by all participants and in many scenarios the AMEDD will provide responsive medical care to multinational partners within the operations determination of eligibility for care. Likewise, our multinational partners may provide first responder and health care services for U.S. troops engaged in multinational operations. The synchronization with our multinational partners of all health care delivery to U.S. Soldiers and allied and coalition forces is essential to ensure the appropriate medical resources are available when needed in the tactical environment.

### **WITH OUR SOLDIERS AND THEIR FAMILIES**

2-7. It is essential to the morale and combat 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 AMEDD 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 his Family is instrumental in reducing and mitigating some of the combat and operational stresses associated with lengthy deployments.

### **ARMY MEDICAL DEPARTMENT TEAM OF TEAMS**

2-8. Just as discussed in paragraph 1-33, the AHS is a system of systems (10 medical functions), the AMEDD team is comprised 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, and Air Force personnel 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 AMEDD team must be ready, reliable, responsive, and relevant (Figure 2-1).



**Figure 2-1. Army Medical Department—a team of teams**

**READY**

2-9. The AMEDD views readiness from two perspectives—medical personnel and the operational Army.

**Medical Personnel**

2-10. Internally, the AMEDD ensures that medical personnel receive the best training possible, not only in their professional skills but also in their Soldier skills. Medical personnel receive institutional training in their medical specialty, as well as sustainment training (to include medical continuing education requirements), refresher training and, depending upon the specific specialty requirements, predeployment training. Army Health System units (both generating force and operational Army) participate in training and exercises focused on reinforcing Soldier skills in the field environment. Medical training and education is a life-long pursuit to ensure medical personnel maintain currency in their medical discipline, use state-of-the-art medical equipment and supplies, and adopt evolving and improved clinical practice guidelines based on advances in technology and medical treatment protocols.

**Operational Army**

2-11. Externally, the AMEDD works 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, preventive medicine measures to include health risk communications and mitigation techniques, preventive dentistry, and COSC programs are all focused on maintaining the Soldier’s health both in garrison and when deployed.

**RELIABLE**

2-12. As discussed under partnerships, the Soldier, line commander, and Families must believe that the AMEDD 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 AMEDD 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 the Soldier knows that should his Family face a medical emergency while he is deployed, his Family member will receive state-of-the-art medical care. This in turn relieves some of the stressors the Soldier must manage during separation from his Family during deployments. The AMEDD 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**

2-13. Both the operational Army and the generating force must be responsive to the changing OE and the resulting medical implications.

### **Operational Army**

2-14. 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 AMEDD must leverage all available medical resources within a theater to optimize patient care to include medical capabilities of sister Services, U.S. governmental agencies, and multinational forces.

### **Generating Force**

2-15. The generating force (Chapter 4) is responsive to the health care needs of all Soldiers stationed throughout the world. Combat 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 AMEDD and the educational and industrial base within CONUS. It enables the AMEDD 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 USAMEDDC&S may develop additional predeployment training packages and assist U.S. 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 USAMEDDC&S were deployed to unit locations worldwide to facilitate the transition and use of this new shelter system.

2-16. The generating 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 tactical commander has a healthy and fit force.

2-17. The generating 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 generating force to meet theater-specific requirements. Additionally, the generating 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**

2-18. The AHS must provide relevant care based on current tactical, 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.

## **PERFORMANCE TRIAD AND THE ROLE OF ARMY MEDICINE**

2-19. For more than 237 years Army Medicine has been a critical partner in optimizing Soldier readiness with health being a primary performance enabler. Our mission is optimizing Soldier performance. Soldier performance translates to unit performance. Unit performance enables the military to mount a ready force at any time; the health of our Soldiers and force health is a matter of National security.

2-20. It is our duty to stand alongside the Soldier from point of injury through rehabilitation and recovery, fostering a spirit of resiliency. The AMEDD is dedicated to identifying and caring for those Soldiers who have sustained psychological and physical trauma associated with an Army engaged in a protracted war. A focus on wellness and prevention will ensure that our Soldiers are ready to heed the Nation's call.

2-21. The performance triad—activity, nutrition, and sleep—is a return to emphasizing the basics of Soldier health. Getting back to the basics of activity, nutrition, and sleep, as both leaders and health care providers, will be key in optimizing personal and unit performance and resiliency.

2-22. To achieve optimal Soldier health, a cooperative effort between the operational force (medical personnel and line commanders) and the generating force medical activities at all installations is required throughout the Army Force Generation Cycle.

### **Activity**

2-23. Physical activity encompasses more than just physical training at the gym, and it can improve health by reducing stress, strengthening the heart and lungs, increasing energy levels, and improving mood.

### **Nutrition**

2-24. Good nutrition promotes health and fuels individual stamina. There is a strong relationship between nutrition and quality of life that includes maintaining a healthy weight, preventing disease, and reducing stress.

### **Sleep**

2-25. Poor quality sleep can have serious short- and long-term consequences—from impairing daily function through reduced alertness and concentration to increasing risk for stroke, obesity, cardiovascular disease and depressed mood. Adequate sleep helps the body heal.

### **Clinical Aspects**

2-26. 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 disease and nonbattle injury 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 the patient is evacuated between roles of care, he receives en route medical care to sustain him, thus reducing the potential for his medical condition to deteriorate while in-transit.

### **Operational Aspects**

- 2-27. 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).
- Ensuring compliance with the Law of Land Warfare (to include the Geneva Conventions).

2-28. In most TOE units, when the unit is not deployed on an operation or exercise, the unit is staffed with administrative personnel and only limited clinical resources. When the unit is mobilized, the professional staff designated under the Professional Filler System is notified of the mobilization and is directed to report to the unit. The administrative staff that maintains the unit's readiness posture when the unit is not deployed are those individuals who have worked on a daily basis with supported maneuver units and commands. Although the TOE may indicate that an incoming officer be designated as the unit commander/platoon leader, the appointing authority may determine that the mission can best be accomplished by maintaining the same command structure that existed prior to mobilization.

2-29. To accomplish the AMEDD 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 battle. 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.

2-30. 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 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 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.

2-31. To enhance the delivery of health care in the OE and to provide a seamless medical system from the point of injury or wounding through progressive roles of care to the CONUS-support base, the AMEDD 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 AMEDD mission necessitates a cohesive unity of effort to provide the care our Soldiers deserve.

## **HEALTH CARE AND THE COMMAND SURGEON IN JOINT OPERATIONS**

2-32. 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.

2-33. 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, subunified 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.

2-34. Liaison must be established between the joint force surgeon and each Service component command surgeon to ensure that mutual understanding of technical medical and dental procedures, unity of purpose and action, and joint health care is maintained.



**SECTION II — PRIMARY TASKS**

2-35. All mission command headquarters perform the same basic military tasks (refer to FM 7-15). Specific medical mission command functions are addressed in Table 2-1.

**Table 2-1. Primary tasks and purposes of the mission command function**

<i>Primary Task</i>	<i>Purpose</i>
Mission command	Plan, direct, execute, and synchronize Army Health System support across the range of military operations. Facilitate and enhance a seamless continuum of health care from the point of injury or wounding to definitive care in the continental United States-support base, if required. Maximize the use of scarce medical resources. Provide subordinate units with administrative and logistical support.
Communications and computers	Maintain situational understanding of Army mission command systems and the common operational picture. Facilitate the transfer of medical information, to enhance the documentation of medical encounters and exposures to health hazards, and to ensure the compatibility and interoperability of medical communications for combat casualty care.
Task-organization	Provide a scalable and tailorable medical infrastructure which ensures the right mix of medical capabilities is available to execute the Army Health System mission. This capability is further enhanced through the modular design of Army Health System units.
Medical intelligence	Facilitate the identification, evaluation, and assessment of health hazards to the deployed force.
Technical supervision	Ensure medical standards are established, implemented, and monitored throughout the operational area. Provide consultation and support to subordinate Army Health System units/elements. Provide reachback capability to the continental United States-support base in the areas of various medical disciplines and specialties.
Regional focus	Support and facilitate the execution of the combatant commander's theater engagement strategy during the execution of stability tasks.

2-36. For a more detailed discussion on mission command, refer to ADRP 3-0, ADRP 5-0, and ADRP 6-0.

**SECTION III — MISSION COMMAND ORGANIZATIONS**

**MEDICAL COMMAND (DEPLOYMENT SUPPORT)**

2-37. The complexities of the OE, the myriad of medical functions and assets, and the requirement to provide AHS support across the range of military operations to diverse populations (U.S., joint, multinational, host nation, and civilian) necessitates a medical mission command authority that is regionally focused and capable of utilizing the scarce medical resources available to their full potential and capacity. The MEDCOM (DS) conserves the fighting strength of the tactical commander through synchronization of AHS operations and providing mission command of MEDBDE (SPT), MMBs, and/or other AHS units assigned/attached to the headquarters providing HSS/FHP to tactical commanders and AO forces while simultaneously conducting stability tasks.

**MISSION, ASSIGNMENT, AND BASIS OF ALLOCATION**

2-38. The MEDCOM (DS) serves as the medical force provider within the AO. As the medical force provider, the MEDCOM (DS) commander identifies and evaluates health care requirements throughout his

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.

2-39. The MEDCOM (DS) is composed of an operational command post and a main command post that can deploy autonomously into the AO. It possesses health to effectively and efficiently task-organize medical elements based on specific medical requirements in the AO. The MEDCOM (DS) serves as the medical force provider for the AO and focuses on AO medical OPLANs and medical contingency plans. It monitors threats within each AO, 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 establishes a command relationship with the theater Army and the combatant commander to influence and improve the delivery of health care and is linked to the theater sustainment command 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.

## **CAPABILITIES AND DEPENDENCIES**

2-40. The MEDCOM (DS) provides—

- Mission command of AHS units providing medical support within the AO.
- Subordinate medical organizations to operate under the MEDBDE (SPT) and/or the MMB and provide medical capabilities to the BCT.
- 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, preventive medicine, operational and strategic medical evacuation, 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.
- Support and planning for single integrated MEDLOG manager, when designated.
- Veterinary support for zoonotic disease control, investigation and inspection of subsistence, and animal medical care.
- Preventive medicine 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 coordinating with the headquarters unit ministry team for required religious support throughout the AO and providing consultation capability to subordinate MEDCOM (DS) unit ministry teams.
- Maintenance personnel that will augment the maintenance capability of the 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 theater sustainment command 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 requires 100 percent of its TOE and supplies to be transported in a single lift.

## REGIONAL FOCUS

2-43. The MEDCOM (DS) maintains a regional focus that encompasses all of the combatant commander's area of responsibility. 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.

2-44. 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 combatant commander with an effective tool to assist in shaping the security environment by alleviating the adverse health conditions that impact the development of strong social, economic, and political infrastructures. The combatant commander 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.

2-45. 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.

2-46. 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.

## STAFF ORGANIZATION

### Internal Staff and Operations

2-47. Section I of this chapter combines the mission command post and operational command post 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 ADRP 5-0.

## Coordinating Staff

2-48. Figure 2-2 graphically depicts the organization of the MEDCOM (DS) coordinating staff. 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.

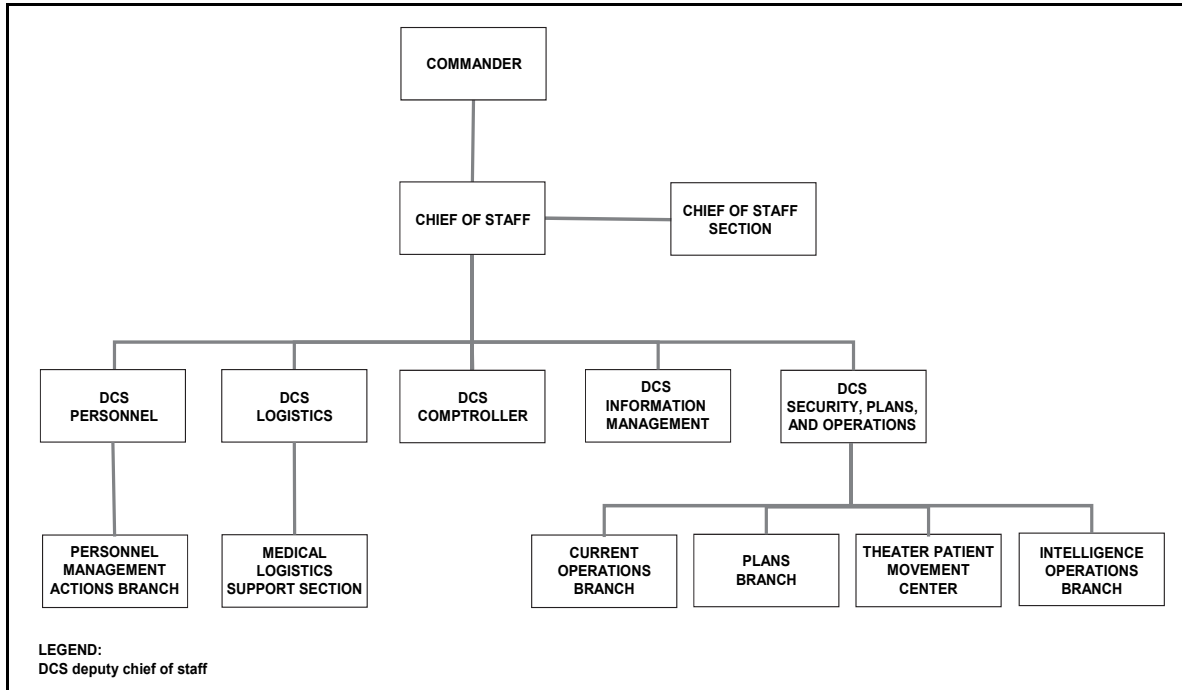


Figure 2-2. Medical command (deployment support) coordinating staff

## Special and Personal Staffs

2-49. The special staff depicted in Figure 2-3 helps the commander and other members of the staff in their professional and technical functional areas. Special staffs are organized according to functional areas.

2-50. The personal staff depicted in Figure 2-3 works under the commander's immediate control. They also serve as special staff officers as they coordinate actions and issues with other staff members.

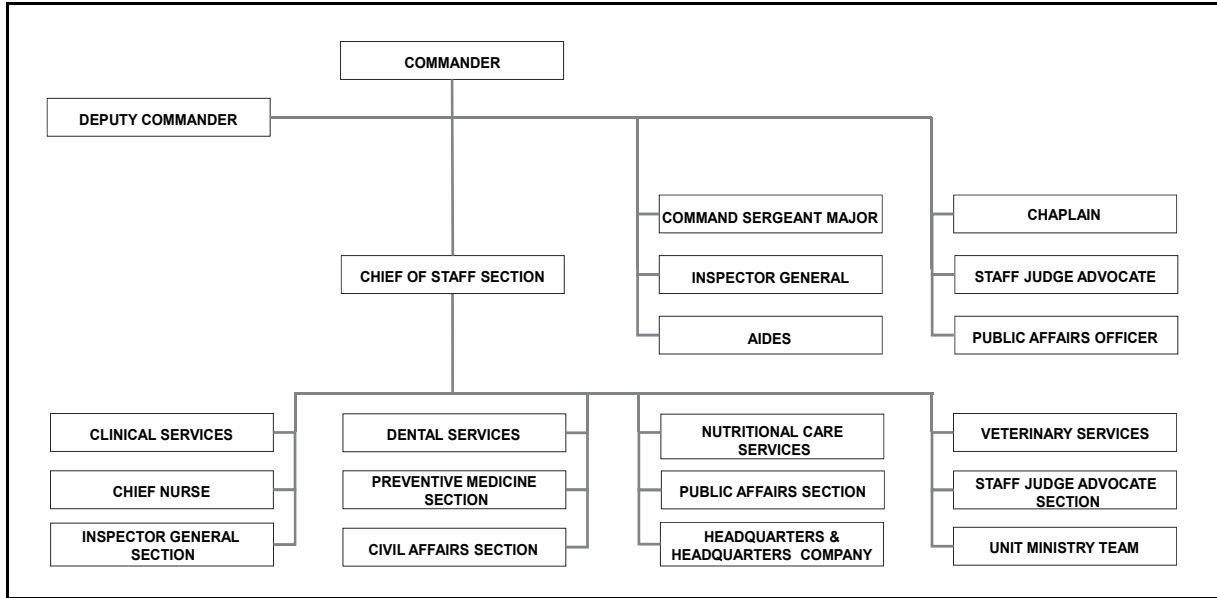
## STAFF FUNCTIONS

### Command Section

2-51. The command section provides mission command 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

2-52. 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.



**Figure 2-3. Medical command (deployment support) special and personal staffs**

### Deputy Chief of Staff, Personnel

2-53. The deputy chief of staff, personnel serves as the advisor to the commander on personnel issues and provides administrative services for the command. 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 security clearances, 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. This section monitors the Professional Filler System and the integration of Professional Filler System personnel into subordinate AHS units.

### *Personnel Management/Actions Branch*

2-54. Personnel management/actions branch develops personnel policies for promotions, appointments, demotions, classifications, assignments, reassignments, decorations, awards, separations, and rotations 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/Operations

2-55. Deputy chief of staff, security/plans/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 medical evacuation 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/operations branch, and the theater patient movement center.

### ***Current Operations Branch***

2-56. The current operations branch is responsible for all operational planning functions to include deployment, relocation, and redeployment of the MEDCOM (DS).

### ***Plans Branch***

2-57. 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***

2-58. 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 disease and nonbattle injury 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/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***

2-59. 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 AO 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 aeromedical evacuation when evacuation distances exceed the capabilities of U.S. Army rotary-wing aircraft. This section synchronizes intratheater evacuation plans with the intertheater evacuation plan to ensure a seamless transition between tactical 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 medical evacuation 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 medical records for deployed forces.

### ***Deputy Chief of Staff, Logistics***

2-60. 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 AO. This

section provides staff supervision and overall coordination for internal logistics support of MEDCOM (DS) units.

### ***Medical Logistics Support Section***

2-61. 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 AO. See paragraphs 9-15 through 9-16 for additional information on the single integrated MEDLOG manager and the theater lead agent for medical materiel missions. 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 FM 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.)

### **Civil Affairs Section**

2-62. The CA section integrates stability task planning within the MEDCOM (DS) AO and with the theater Army assistant chief of staff, CA. This section provides the regional focus of the combatant commander's area of responsibility. This section conducts 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 CA section facilitates and develops assessments of the host-nation medical infrastructure to assist the MEDCOM (DS) commander in planning and executing AHS support in the AO. This section develops cross-cultural communications to facilitate interpersonal relationships in a host-nation environment. This section 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.

### **Deputy Chief of Staff, Information Management**

2-63. 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 automation 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 interface of medical automation systems with other automated systems within the theater.

### **Deputy Chief of Staff, Comptroller**

2-64. 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

2-65. The clinical services personnel serve as the commander's principal consultants and technical advisors for the command in general medicine, surgical, neuropsychiatry, COSC, 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.

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**This paragraph implements STANAG 2068.**

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2-66. This staff section is responsible for—

- Neuropsychiatry, BH, and COSC to include establishing and monitoring policies, programs, and consultation services; advising on the medical evacuation 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 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 care of enemy prisoner of war (EPW) or personnel in U.S. custody (retained/detained); and recommending the designation of MTFs for specific situations or medical conditions (such as for EPW 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 and STANAG 2068. 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 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.

2-67. 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.

2-68. 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

2-69. 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 theater. It also advises the commander on the dental aspects of foreign humanitarian assistance operations, plans, and programs, as required. Refer to Tables 7-3 and 13-1 for the primary tasks and purposes of the dental services function.

### **Veterinary Services**

2-70. Veterinary services personnel serve as the commander's principal consultant and the command's technical advisor for veterinary activities and employment of veterinary assets. This section provides technical supervision of food inspection, animal medical care, and veterinary preventive medicine support. The U.S. Army is the Executive Agent for veterinary services for all Services (DODD 6400.4) (with the exception of food inspection operations on USAF installations). Refer to Table 11-1 for information on veterinary services primary tasks.

### **Nutrition Care Services**

2-71. 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 unit ministry team to ensure the availability of 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.

### **Chief Nurse**

2-72. 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**

2-73. The preventive medicine section serves as the commander's principal consultant and the command's preventive medicine and environmental sciences advisors. This section develops, plans, and implements preventive medicine policies and programs for the theater. 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 disease and nonbattle injury reports submitted by subordinate AHS units. It performs trend analysis which is used to identify shifts from the baseline of diseases within the AO (as a shift may indicate the use of biological warfare agents against the deployed force). It also evaluates host-nation capabilities and integrates preventive medicine 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 DA Pamphlet 40-11 for additional information on preventive medicine programs. This section provides advice and consultation on preventive medicine measures and issues arising in theater internment facilities.

2-74. This section, in conjunction with the chemical 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 preventive medicine refer to Table 10-1 of this publication.

### **Inspector General Section**

2-75. 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**

2-76. 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 AO. 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**

2-77. The functions of the staff judge advocate (SJA) are to provide legal advice and services to the commander, staff, subordinate commanders, Soldiers, and other authorized personnel. The SJA 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**

2-78. 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 defensive 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**

2-79. The unit ministry team provides religious support and pastoral care for assigned staff and subordinate organizations. This team develops, exercises staff supervision over, and implements the commander's religious support program; provides moral and spiritual leadership to the command and community; advises the commander and staff, in coordination with the CA officer, of the impact of faith and practice of indigenous religious groups in the AO; and provides liaison to indigenous religious leaders. This team coordinates with subordinate MEDCOM (DS) chaplains to ensure availability of rations within the theater for hospitalized patients with religion-based dietary restrictions.

### **Joint Augmentation**

2-80. 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 aeromedical evacuation liaison teams or other medical regulating personnel to enhance medical regulating and medical evacuation of MEDCOM (DS) patients by the USAF strategic aeromedical evacuation system.
- United States Navy personnel to expedite and deconflict shore-to-ship/ship-to-shore air medical evacuation operations conducted by U.S. Army rotary-wing medical evacuation aircraft and hospitalization of U.S. Army personnel in USN afloat facilities.
- United States Air Force and USN MEDLOG personnel when the U.S. 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)**

2-81. The MEDBDE (SPT) is a subordinate mission command organization of the MEDCOM (DS). It provides mission command of all assigned and attached AHS units. The focus of the MEDBDE (SPT) is mission, enemy, terrain and weather, troops and support available, time available, and civil considerations driven. One MEDBDE (SPT) may be providing direct support to a tactical commander, while another may be providing AHS support to an EAB sustainment force. These organizations may be providing simultaneous support to stability tasks occurring within their AO.

### **MISSION, ASSIGNMENT, AND BASIS OF ALLOCATION**

2-82. The mission of the headquarters and headquarters company, MEDBDE (SPT) is to organize, resource, train, sustain, deploys exercises mission command, and support assigned and attached health care capabilities to provide flexible, responsive, and effective HSS and FHP to supported forces conducting joint and simultaneous unified land operations. The MEDBDE (SPT) is assigned to the MEDCOM (DS).

2-83. The basis of allocation for the MEDBDE (SPT) is one per two to six subordinate battalions.

2-84. 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.)

### **Capabilities and Dependencies**

2-85. The MEDBDE (SPT) (Figure 2-4) is composed of three standard requirements code identified modules (the early entry, expansion, and campaign modules).

2-86. The MEDBDE (SPT) provides—

- Mission command of subordinate and attached units.
- Operational medical plugs 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 medical evacuation.
- Medical consultation services in the following areas—
  - Preventive medicine.
  - 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 combatant commander, serves as the single integrated MEDLOG manager.
- A joint capable mission command capability when augmented with appropriate joint assets.
- Support as the executive agent 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.

2-87. The MEDBDE (SPT) is dependent upon—

- The sustainment brigade to arrange religious, 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.

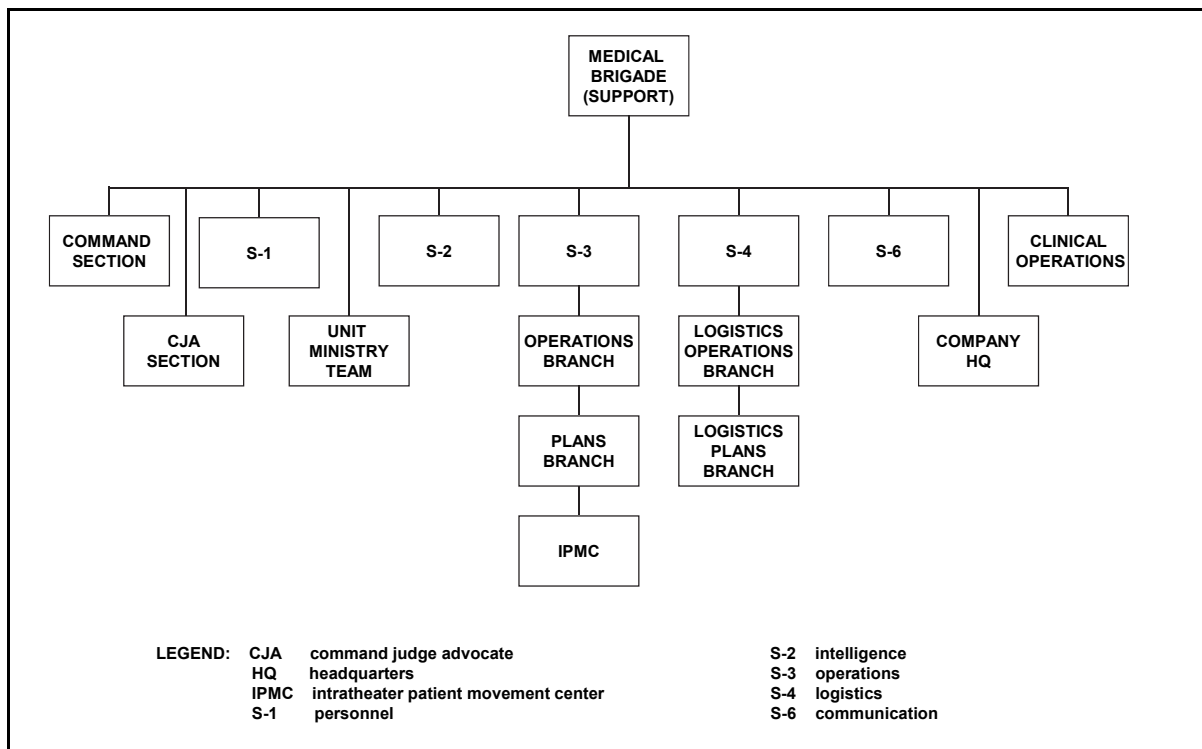


Figure 2-4. Medical brigade (support)

## STAFF FUNCTIONS

### Organization and Function

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.)

## **Internal Staff and Operations**

2-89. 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**

2-90. The MEDBDE (SPT) must coordinate with the MEDCOM (DS) and other headquarters within their AO. External coordination with the combat aviation brigade and general support aviation battalion for medical evacuation support by rotary-wing aircraft is critical.

## **Command Section**

2-91. The command section provides mission command 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.

## **S-1 Section**

2-92. 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.

## **S-2 Section**

2-93. The intelligence staff officer (S-2) section performs all source intelligence assessments and estimates for the command. It advises the commander and staff on nuclear/chemical surety and CBRN operations.

## **S-3 Section**

2-94. The operations staff officer (S-3) section is responsible for plans and operations, deployment, relocation and redeployment of the MEDBDE (SPT), and supervising medical evacuation operations for both air and ground.

### ***S-3 Operations Branch***

2-95. 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***

2-96. The S-3 plans branch is responsible for the current planning in the MEDBDE (SPT) AO, 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 ADRP 5-0 for additional information on the operations process.)

***Intratheater Patient Movement Center***

2-97. The intratheater patient movement center is responsible for maintaining 24-hour coordination and oversight for patient regulating and administration within the MEDBDE (SPT) AO.

**S-4 Section**

2-98. 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.

***S-4 Logistics Operations Branch***

2-99. The S-4 logistics operations branch monitors, coordinates, and facilitates MEDLOG operations within the command. The branch exercises staff responsibility for units engaged in medical supply, optical fabrication, medical maintenance, blood support, quality control operations and other medical logistical support. The branch plans and directs activities of personnel and units responsible for the receipt, storage, and issue of all Class VIII medical supply, optical fabrication support, blood support, and medical maintenance support. The branch provides command policy and monitors the collection, evacuation, and accountability for all MEDLOG items of supply classified as salvage, surplus, abandoned, or uneconomically repairable. The branch plans, directs, and implements the multifunctional areas of medical materiel management and their integration into the overall DOD logistics system, as well as the support interface between the deployed MEDLOG resources and reach to the wholesale logistics system and industry in the CONUS-support base. Further, he directs and/or exercises staff supervision of units engaged in the production, acquisition, receipt, storage and preservation, issue, and distribution of medical equipment, medical repair parts, and medical supplies. The branch serves as the focal point for medical property management and accountability procedures. As the materiel manager, the branch develops, coordinates, and supervises the supply support portion of an integrated logistics support plan

***S-4 Logistics Plans Branch***

2-100. 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.

**S-6 Section**

2-101. The signal staff officer (S-6) section provides for all aspects of automation and communications-electronics for the command. It determines mission command signal requirements, capabilities, and operations. It also provides advice and consultation on medical automation systems in use within the MEDBDE (SPT).

**Clinical Operations Section**

2-102. The clinical operations section serves as the commander's principal consultants and technical advisors for the command in general medicine, nursing services and activities, preventive medicine, 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

2-103. The command judge advocate section furnishes legal advice and services to the MEDBDE (SPT) in civil and criminal legal practice, including the fields of business, property, administration, and financial operations under the jurisdiction of the DA. This section provides defense counsel services for U.S. Army personnel whenever required by law or regulation and authorized by the Judge Advocate General or his designee. These services include representation at trials by courts-martial, administrative boards, and other criminal and adverse administrative actions. This section performs other defense-related duties as prescribed by the U.S. Army Trial Defense Service. 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 EPWs and detainees in subordinate CSHs and/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 his staff on the eligibility of care determinations, policies, and procedures.

### Company Headquarters

2-104. The company headquarters, MEDBDE (SPT), organizes, resources, trains, sustains, deploys, exercises mission command, and supports assigned and attached health care capabilities to provide flexible, responsive, and effective AHS to supported forces conducting joint and simultaneous unified land operations.

### Unit Ministry Team

2-105. The unit ministry team provides religious support and pastoral care ministry for assigned staff and subordinate organizations of the command.

## COORDINATION OF CLINICAL OPERATIONS

### Responsibilities

2-106. 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. He accomplishes this mission through the activities of his staff and coordinating and synchronizing clinical requirements with other MEDBDE (SPT) staff sections. He 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 AO, potential diseases present in the multinational force, and the health status of enemy forces who may become enemy EPWs or retained/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 AO 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 EPWs). 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 EPW and retained and/or 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**

2-107. The chief, professional services, exercises his technical supervision of all AHS clinical activities through his staff. He 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. He ensures that investigational new drug protocols are followed. He also monitors the use of chemoprophylaxis, pretreatments, immunizations, and barrier creams. He ensures credentialing policies are in place and are being adhered to. He 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. He monitors the medical evacuation/medical regulating activities to ensure necessary medical requirements and clearances for patients being evacuated are accomplished. Further, he develops patient preparation protocols for patients entering the USAF evacuation system, as required. He monitors the area support mission of assigned/attached Role 2 MTFs to ensure adequate AHS support to transient troop populations within the MEDBDE (SPT) AO. He 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. He identifies medical issues which require medical research and development. The duties and functions of his 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). He establishes nursing policies and reviews and monitors nursing practices. He 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. He 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. He ensures that documentation of medical treatment provided is appropriately documented in the individual health record using the prescribed forms and/or electronic media. He 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 medical treatment facilities. 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 noncommissioned officer (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 theater matures and the types of patient conditions being treated evolves from acute trauma to disease and nonbattle injuries, 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 preventive medicine activities and requirements of the command. The preventive medicine officer establishes reporting requirements and frequency of reports (such as the weekly disease and nonbattle injury report). He consolidates subordinate unit disease and nonbattle injury reports and analyzes the data submitted to identify trends and to compare incoming data with already established base-lines. 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 AO) and to OEH hazards. He receives, monitors, reviews, and forwards supporting laboratory analysis of CBRN samples/specimens and chain of custody documents for CBRN samples/specimens. He ensures that medical surveillance and OEH surveillance activities are developed and implemented for the health threat present in the AO. He 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 veterinary services technician, who are responsible for monitoring the implementation of programs for the inspection of food and food sources for procurement, quality assurance, security, food defense, and sanitation. He also monitors animal medical care activities and identifies MEDLOG shortfalls that will impact on animal medical care activities.
- 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. He 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. He coordinates policies, procedures, and protocols for the treatment of BH and neuropsychiatric disorders with the senior subordinate unit psychiatrist and provides consultation on the requirements for the medical evacuation of psychiatric patients. The psychiatrist also provides advice and guidance on any BH issues arising within the theater internment facility if located in the MEDBDE (SPT) AO.
- 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. He 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. He 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. He 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. He also serves as the command's dental surgeon.

2-108. 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. He 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. He 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 his 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 AML activities (including CBRN sample/specimen processing and chain of custody requirements) and MTF clinical laboratory practices. He advises the chief, professional services, on blood-banking and storage capabilities of Roles 2 and 3 MTFs within the command. He 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 science 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.

2-109. 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.

2-110. The clinical operations section coordinates with and provides consultation to the medical section of the theater internment facility and resettlement facilities established within the MEDBDE (SPT) AO for the treatment and hospitalization of EPW, retained, and detained personnel.

2-111. 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/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/weekly operations. The clinical operations section also receives medical situation reports from forward deployed FSTs to determine if reconstitution/replacement/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)

2-112. Force structure changes occurring within the modular Army necessitated a redesign of the functional medical battalions (area support, medical evacuation, and MEDLOG) into a multifunctional organization which can provide the requisite planning, synchronization, and coordination for modular medical companies, detachments, and teams/elements. Modularity has resulted in a smaller deployed medical footprint through enhancing the capability to rapidly task-organize scalable medical capabilities. The MMB headquarters is depicted in Figure 2-5.

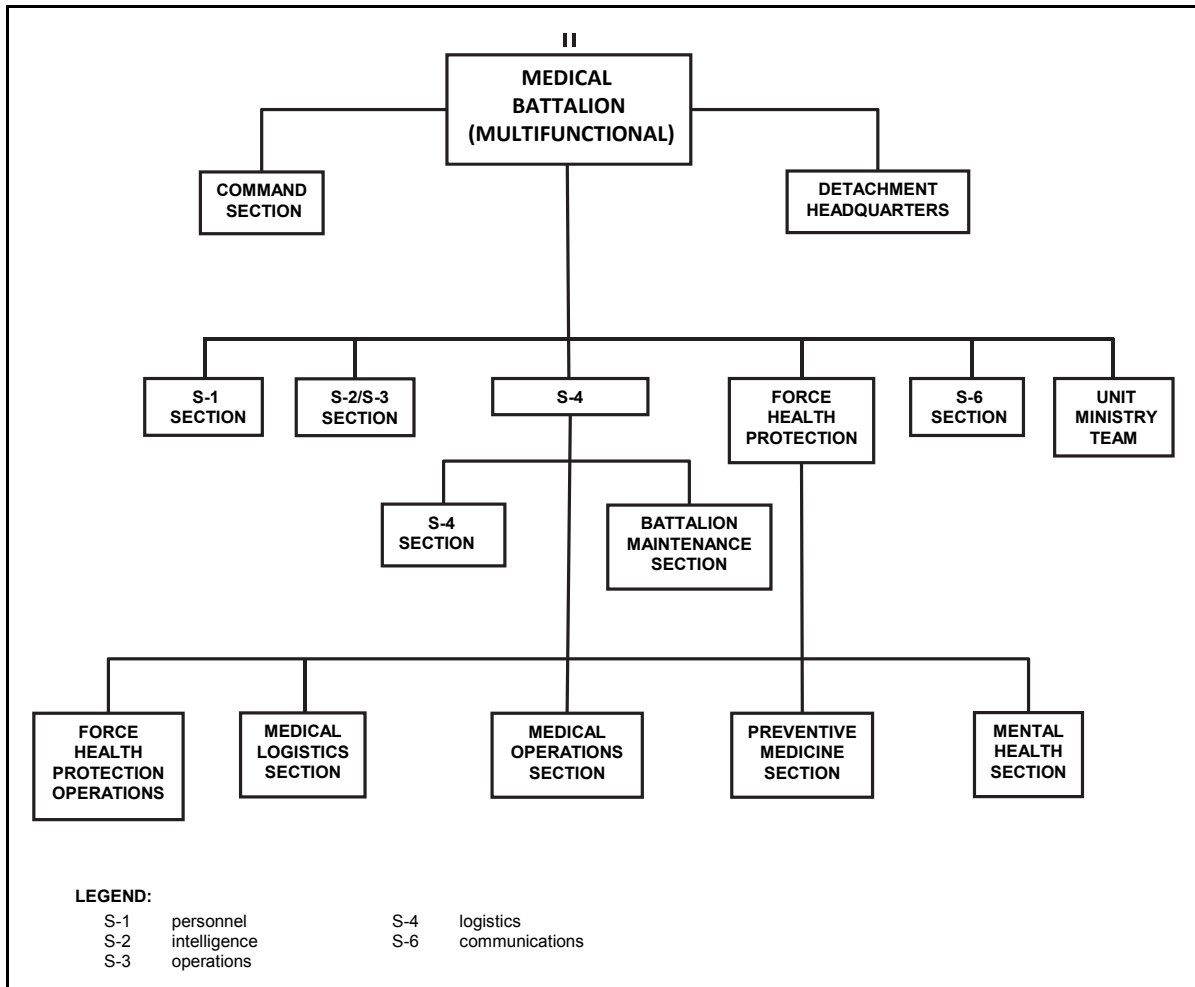


Figure 2-5. Medical battalion (multifunctional)

## MISSION, ASSIGNMENT, AND BASIS OF ALLOCATION

2-113. The mission of the MMB is to provide scalable, flexible, and modular medical mission command, 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.

2-114. This TOE will be assigned to the MEDBDE (SPT) or the MEDCOM (DS). One MMB is allocated as one MMB per combination of three to seven medical companies or ten to fifteen medical detachments or teams. 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.)

2-115. The MMB is the battalion-level medical headquarters in the AO. When fully manned, it provides—

- Medical mission command, staff planning, supervision of operations, medical and general logistics support as required, and administration of the assigned and attached units conducting medical operations in its supported 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 medical evacuation within the MMB AO. Coordinating requests with the supporting aviation unit for air medical evacuation support requirements and synchronization of the air medical evacuation plan into the overall medical evacuation plan.
- Guidance for facility site selection and area preparation.
- Consultation and technical advice on preventive medicine (medical entomology, medical and OEH surveillance, and sanitary engineering), 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.
- 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 casualties in subordinate MTFs in the MMB AO.

## CAPABILITIES AND DEPENDENCIES

2-116. The MMB is a multifunctional medical mission command organization. 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 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 mission command of the MEDBDE (SPT) and not directly attached to the BCT. Detachments/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.

## **STAFF ORGANIZATIONS AND FUNCTIONS**

### **Internal Staff and Operations**

2-117. 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***

2-118. The battalion command section provides mission command of assigned and attached medical companies and detachments.

#### ***S-1 Section***

2-119. 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. It is responsible for plans and operations, deployment, relocation, and deployment of the battalion and its assigned units. It prepares broad planning guidance, policies, and programs for command organizations, 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 AHS 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. It provides a 24-hour continuous operations capability.

#### ***S-2/S-3 Section***

2-120. The S-2/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 OEH surveillance data. This section provides a 24-hour continuous operations capability.

#### ***S-4 Section***

2-121. 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***

2-122. The FHP operations section coordinates and monitors the execution of area medical support, medical evacuation, 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.

2-123. The FHP operations section coordinates with the—

- S-1 on matters pertaining to personnel casualty estimates from which patient workload is derived and the priority of fill for subordinate AHS units.
- S-2/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 (EEFIs) 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 EPWs or retained/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 medical logistics 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 BW agents) not usually present in U.S. forces (such as for EPWs). 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***

2-124. 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***

2-125. 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***

2-126. The preventive medicine section is responsible for planning, coordination, and execution of the preventive medicine 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 disease and nonbattle injury reports from subordinate units to determine the development of trends or the possible use of BW agents on deployed forces. This section plans for and monitors veterinary inspection of Class I items, animal medical care operations, and veterinary preventive medicine activities pertaining to the transmission of zoonotic diseases to man.

***Mental Health Section***

2-127. 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***

2-128. The S-6 section is responsible for all aspects of information, management, automation, and communications-electronics support to assigned and attached units.

***Detachment Headquarters***

2-129. The detachment headquarters provides for billeting, field feeding, discipline, security, training, and administration for Soldiers assigned to the headquarters.

***Unit Ministry Team***

2-130. The unit ministry team provides religious support and pastoral ministry for assigned staff and patients. This team advises the commander on all matters in which religion impacts on command programs, personnel, policy, and procedures. This team also provides for the spiritual well-being and morale of headquarters personnel. The unit ministry team may also provide additional support to the subordinate COSC units, if required.

**External Coordination**

2-131. 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 medical evacuation. Coordinates and synchronizes the planning and execution of AHS actions.

2-132. 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 aeromedical evacuation aboard USAF resources. The MMB may be required to coordinate directly with CONUS for support services under control of DA, DOD, and Secretary of Defense. These include depots, arsenals, data banks, plants, research laboratories, and factories associated with the U.S. Army Medical Research and Materiel Command.

## SECTION IV — MEDICAL COMMANDER, COMMAND SURGEON, AND LINE COMMANDER

### MEDICAL COMMANDER

2-133. The medical commander exercises mission command (authority and direction) over his subordinate medical resources. As discussed in Army doctrine on unified land operations, the commander is the focus of mission command and uses two processes in the decision-making process. He 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.

2-134. 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 his professional career. These are essential and critical skills which have been taught, nurtured, and cultivated throughout his professional medical education and training. The medical commander's experience base cannot be viewed from a purely military perspective of when he entered the Army, but must be viewed holistically to encompass all of the training, education, and experience he received prior to and after his military career began. The military and leader development training, education, and experience coupled with his proven critical thinking skills and ability to take decisive action make him the most qualified commander to determine how medical assets will be employed in support of the operational commander and to successfully accomplish his Title 10 responsibilities for the care of his Soldiers.

2-135. 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 mission command 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. Within the medical mission command structure it enables the MEDCOM (DS) commander to retain a regional focus in support of the combatant commander and the AO 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

#### DUTIES AND RESPONSIBILITIES

2-136. At all levels of command, a command surgeon is designated. This AMEDD officer is a special staff officer charged with planning for and executing the AHS mission. At the lower levels of command, this officer may be dual-hatted as an AHS unit commander; further, he may have a small staff section to assist him in his planning, coordinating, and synchronizing the AHS effort within his AO.



2-137. The command surgeon is responsible for ensuring that all AMEDD 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.

2-138. 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. Sustainment unit commanders who previously commanded multifunctional battalions earlier in their careers may want to rely on that experience rather than the medical judgment and experience of a newly assigned command surgeon without realizing the complexities of managing the full array of medical specialty units and personnel. The effectiveness, responsiveness, and the efficiency of the deployed resources may be adversely impacted and Soldier survival rates may decrease and disease and nonbattle injuries rates may rise.

2-139. 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 TC3. Refer to paragraphs 1-7 though 1-10 for additional information on TC3.
- Developing and coordinating the HSS and FHP portion of OPLANs to support the combatant/tactical commander's decisions, planning guidance, and intent.
- Determining the medical workload requirements (patient estimates) based upon the casualty estimate developed by the assistant chief of staff, personnel and/or personnel staff officer (S-1).
- Determining, in conjunction with the SJA and the chain of command, the eligibility for medical care in a U.S. Army MTF.
- Maintaining situational understanding.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 AMEDD personnel within his 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 medical evacuation 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; standard operating procedures (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.
- 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 preventive medicine, and animal medical care) 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 preventive medicine operations and facilitating health risk communications (to include preventive medicine programs and initiating preventive medicine 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, Joint Chiefs of Staff Memorandum MCM 0028-07 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/unit. Pursuing other avenues to obtain medical intelligence and/or medical information such as the—
  - National Center for Medical Intelligence.
  - United States Army Public Health Command.
  - Centers for Disease Control and Prevention.
  - United States Public Health Services.
  - International organizations (such as the United Nations, the World Health Organization, or the Pan American Health Organization, and other nongovernmental organizations).
  - Information gathered from 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 to 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 EPWs and 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.

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**This paragraph implements STANAG 2132.**

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2-140. 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, 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 (Department of Defense [DD] Form 1380 (U.S. Field Medical Card) and/or DA Form 7656 (Tactical Combat Casualty Care Card), to include the marking of individuals who have received morphine sulfate).

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*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 and/or DA Form 7656. 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.

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- 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.

## LINE COMMANDER

2-141. Line 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.

## HEALTH PROMOTION

2-142. 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.

2-143. 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 interventions.
- Physical programs.
- Spiritual programs.
- Environmental and social programs.

2-144. Army health promotion involves—

- Identifying community health needs and setting priorities.
- Developing 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.

2-145. The health promotion process is similar to the risk management process described in FM 5–19.

## FIELD HYGIENE AND SANITATION

2-146. To counter the health threat, commanders and leaders must ensure that field hygiene and sanitation, preventive medicine 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.

## MILD TRAUMATIC BRAIN INJURY/CONCUSSION

2-147. Mild traumatic brain injury/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**

2-148. 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 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.

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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 four 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—

- Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field (GWS).
- Geneva Convention for the Amelioration of the Condition of the Wounded, Sick and Shipwrecked Members of the Armed Forces at Sea (GWS Sea).
- Geneva Convention Relative to the Treatment of Prisoners of War (GPW).
- Geneva Convention Relative to the Protection of Civilian Persons in Time of War (GC).

## SECTION I — THE LAW OF LAND WARFARE

3-1. The conduct of armed hostilities on land is regulated by the Law of Land Warfare. 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/enemy prisoners of war, 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 2311.01E, and FM 27-10 for additional information on the Law of Land Warfare.

## SECTION II — GENEVA CONVENTIONS

### PROTECTION OF THE WOUNDED AND SICK

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 his 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 for disposition of EPWs after hospital care.)
- When intelligence indicates that large numbers of EPWs/detainees may result from an operation, medical units may require reinforcement to support the anticipated additional EPW/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 his 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 the—
  - 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 internment 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 (Article 28 and 39, GWS).
- Seriously wounded and sick prisoners of war.

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 prisoners of war (POWs), after having cared for them until they are fit to travel. No sick or injured prisoner of war (POW) 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 Medical Department personnel and non-AMEDD personnel assigned to medical units fall into the category identified in Article 24 provided they meet the exclusively engaged criteria of that article. The U.S. 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 AMEDD 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 AMEDD officers serving as commanders of brigade support battalions with responsibility for base or base-cluster defense, as well as mission command of medical and nonmedical units.
  - The AMEDD 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 medical aviation unit to fly medical evacuation helicopters, 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 U.S. 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.

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

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### 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 AO. 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 only “. . . 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, armllets 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 AO 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 operational 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.”

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*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.

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3-24. For additional guidance on the marking of air ambulances, refer to AR 40-3 and TM 55-1500-345-23.

## 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 siting 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 medical evacuation 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 medical evacuation for additional information on the use of smoke and obscurants for medical operations.

## **CONDITIONS NOT DEPRIVING MEDICAL UNITS AND ESTABLISHMENTS OF PROTECTION**

### **CONDITIONS**

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 defence (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, AMEDD and non-U.S. Army Medical Command personnel in medical units are not required to train and qualify on crew-served weapons. However, U.S. Army Medical Command (USAMEDCOM) 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 the Veterinary Corps**

3-34. The presence of personnel and materiel of the Veterinary Corps 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 Geneva Conventions, 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 RETAINED AND 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 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. Refer to DODD 2310.01E, DODI 2310.08E, JP 3-63, JP 4-02, AR 40-400, and AR 190-8 for additional information on medical care for retained and detained personnel.

## SECTION III — MEDICAL ETHICS

### ETHICAL CONSIDERATIONS FOR THE MEDICAL TREATMENT OF DETAINEES

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 EPWs, detainees, and civilians during conflict will ensure the ethical treatment of all sick and wounded personnel.

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 U.S. 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 internment 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 U.S. 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 TC3, 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 multinational forces 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 U.S. 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, intelligence, 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 internment 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: <http://www.bordeninstitute.army.mil/>.

3-51. The provision of health care to detainees within MTFs or other facilities (such as dispensaries located within internment 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 an internment/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.

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## Chapter 4

# Generating Force Support to the Operational Army

The AMEDD has a long tradition of providing world-class medical care across global AOs, OEs, and under austere and challenging conditions. Wherever an injured or ill American Soldier is located, the U.S. Army will project its resources to locate, acquire, treat, stabilize, and evacuate our wounded Warriors to MTFs capable of providing world-class health care to enhance the Soldier's prognosis, mitigate disability, and empower him to lead a full and productive life.

Historically, the AMEDD 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). With the advent of technological innovations in transportation and medicine, 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 AO* 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

4-1. The mission of the generating force is to generate and sustain operational Army capabilities. The Army does not organize the generating force into standing organizations with a primary focus on specific operations. Rather, when the generating 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 generating force capabilities revert to their original function.

4-2. All elements of the Army, whether the generating force or operational Army, perform functions specified by U.S. law. The practical distinction is that the execution of these functions and others implied by law constitutes the primary purpose of the generating force organizations. Title 10 is not the only statute that governs the generating force, nor is the list of functions in Figure 4-1 exhaustive.

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.

**Figure 4-1. Title 10 functions**

4-3. The USAMEDCOM provides operational reach to the generating force to leverage the resources (personnel, infrastructure, and materiel) within the command and its subordinate research, educational, and training institutions and assets to ensure Soldiers receive the best possible health care possible regardless of their geographic location.

## **SUPPORT TO THE TACTICAL COMMANDER**

4-4. The generating force fulfills numerous critical roles with regards to supporting the Soldiers deployed in an AO. The USAMEDCOM 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. They also facilitate and enhance the medical readiness of all Soldiers through the promotion of fitness and healthy lifestyles, the performance triad (paragraphs 2-19 through 2-25), and the prevention of diseases and injuries. They 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 which exist in the deployment area). During deployments, they provide reachback support within all 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**

4-5. The educational requirements within the health care professions are significantly more complex than in other branches of the Army. Formal schooling is required for all fields within the AMEDD and this education is received in both 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 and these credentials are most often obtained from non-DOD affiliated civilian organizations. The health professions also require continuing education to maintain certification. The USAMEDCOM and the Office of The Surgeon General facilitate this process by providing opportunities to fulfill the continuing education requirements of all health care professionals including those in deployed AOs.

### **TRAINING**

4-6. All medical military occupational specialties require school training. Medical skills are considered perishable and require continual practice and refresher training. The USAMEDDC&S provides military occupational specialty-specific training for award of medical military occupational specialties and provides refresher training for some of the low-density medical specialties when Reserve Component forces and U.S. Army National Guard are mobilized. Additionally, the USAMEDDC&S develops and fields collective training materials and distance learning programs. In some medical specialty areas, the didactic

portion is completed at the USAMEDDC&S while the resident phase is provided at USAMEDCOM MTFs.

## WARRIOR TRANSITION UNITS

### ARMY MEDICAL ACTION PLAN

4-7. The Office of The Surgeon General established the Army Medical Action Plan Campaign Planning Group to develop an action plan to establish an integrated and comprehensive continuum of care and services for Warriors and their Families. These Warriors and their Families are being treated at DA MTFs in conjunction with DOD, Department of Veterans Affairs, and civilian medical facilities in order to provide world-class care and services that match the quality of service the Warriors and their Families provide the Nation. In support of this plan, the Army chief of staff approved the actions to be implemented to include—

- Establishing and institutionalizing a mission command structure for Warriors undergoing long-term definitive, rehabilitative, and convalescent care.
- Prioritizing mission support and creating ownership of actions and processes.
- Flexing housing policies and focusing on Family support issues.
- Developing training and doctrine to facilitate and ensure a system which provides timely and effective support.
- Creating full patient visibility throughout the process and facilitating the continuum of care.
- Improving the medical evaluation board process and eliminating delays in the process.

4-8. The intent of this action plan is for the Army to provide a continuum of integrated care and services from point of injury, 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—

- Establish Warrior transition units along with the *triad of Warrior support* consisting of a primary care manager, a nurse case manager, and a squad leader. See Figure 4-2.
- Streamline issues affecting Family care and disposition.
- Establish Soldier and Family Assistance Centers as entry points for Warriors in Transition.
- Restore the American people's confidence in the U.S. Army.

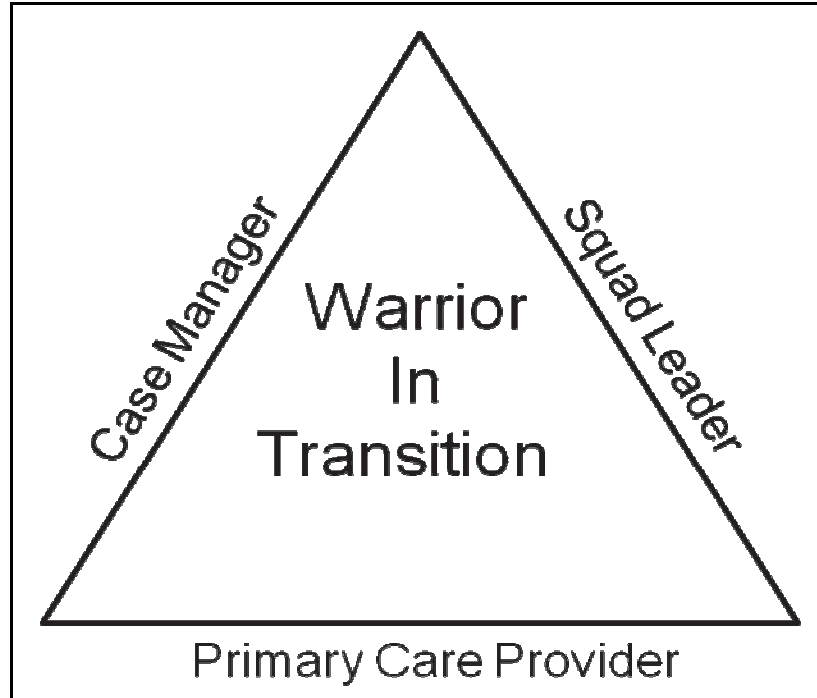


Figure 4-2. Triad of Warrior support

#### WARRIOR TRANSITION UNITS

4-9. The Warrior transition unit is a transition assistance unit aimed at overseeing the health, welfare, and morale of patients at an Army MTF. By design, the unit has a robust cadre, which allows physicians and nurses to focus on medical care, nurse case managers to manage medical care, and unit cadre to focus on meeting all mission command functions.

4-10. The Warrior transition unit consists of a triad of support, a triad of care, and a triad of leadership. The triad of support consists of a platoon sergeant/squad leader, case manager, and primary care manager. The triad of care consists of a primary care manager, a case manager, and a platoon sergeant/squad leader. The triad of leadership consists of senior commanders/command sergeants major, MTF commanders/command sergeants major, and Warrior transition unit commanders/command sergeants major/first sergeants. All work together to ensure advocacy for Warriors, continuity of care, and a seamless transition into the force or return to a productive civilian life.



## Chapter 5

# Medical Intelligence

Medical intelligence is defined as a component of all-source intelligence. 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. To develop medical intelligence, information is gathered, evaluated, and analyzed on the following subjects:

- Endemic and epidemic 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**

5-1. 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.

5-2. 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 his operation.
- Conserve the fighting strength of friendly forces.

## SOURCES OF MEDICAL INTELLIGENCE

5-3. Medical intelligence is provided to the AHS planner by intelligence organizations. The AHS planner must identify the intelligence requirements and provide that request to the supporting intelligence element within the command. In an emergency, up-to-date medical intelligence assessments can be obtained by contacting Director, Defense Intelligence Agency, ATTN: Director, National Center for Medical Intelligence, Fort Detrick, Maryland 21702-5000. The National Center for Medical Intelligence can provide health service assessments, infectious disease assessments, infectious disease alerts, environment health risk assessments, medical intelligence notes, medical intelligence imagery briefs, and foreign medical facility assessments. The AHS planner should use all available intelligence elements to obtain needed intelligence to support 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.

5-4. An additional source of information on deployment OEH hazards/threats is the U.S. Army Public Health Command. Information can be requested from the Global Threat Assessment Program Office at commercial telephone (410) 436-3177 or Defense Switched Network 584-3177, or e-mail address: [IPH-DHRM-GTAP \(IP-RGT\)@amedd.army.mil](mailto:IPH-DHRM-GTAP(IP-RGT)@amedd.army.mil).

5-5. A supporting intelligence element should exist at some point 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

5-6. Consideration of the medical aspects of the intelligence preparation of the battlefield 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 intelligence preparation of the battlefield process is 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 based on and specific to a country. The Phase I assessments that are part of the medical aspects of intelligence preparation of the battlefield 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. The Phase I assessments that are part of the medical aspects of intelligence preparation of the battlefield are to—

- Define an OE.
- Describe the operational effects on deployed forces and AHS operations.
- Conduct threat integration (enemy and health) and information consolidation.

## DEFINE THE OPERATIONAL ENVIRONMENT

### IDENTIFY SIGNIFICANT CHARACTERISTICS OF THE OPERATIONAL ENVIRONMENT

5-7. The first task of the AHS planner is to define an 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.

5-8. The significant characteristics of the OE include viewing them 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) (normally used at the strategic level) or mission, enemy, terrain and weather, troops and support available, time available, and civil considerations factors (used at the operational level) to frame the analysis of the OE. 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 combatant commander's 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**

5-9. Geospatial information includes hydrological data, elevation data, soil composition, and vegetation.

### **Geography and Weather**

5-10. 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**

5-11. 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 medical evacuation); 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**

5-12. Terrain analysis includes determining the effect on friendly/enemy maneuver capability; effect on friendly/enemy ability to sustain health care; effects on timely medical evacuation; natural lines of patient drift; impact 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 combat action on terrain/mobility; and where potential sources of potable water are located.

### **Altitude Effects**

5-13. Altitude effects include effect of high-altitude operations on force capability, rotary-wing medical evacuation assets, medical evacuation procedures and methods (higher incidence of litter evacuation and longer evacuation times for manual evacuation), and standard medical treatment protocols.

## **DESCRIBE THE BATTLEFIELD EFFECTS**

5-14. The purpose of this phase of the intelligence preparation of the battlefield process is to analyze and integrate various factors of the OE. Detailed analysis of these factors, to determine the military significant effects, results in intelligence upon which the commander can make informed decisions. The emphasis is on the medical aspects of the effects on friendly forces, as well as friendly and enemy actions.

## LIMITS OF COMMAND

5-15. The command 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 multinational forces, 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 U.S. Army medical assets [paragraphs 1-38 through 1-43]). 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.
  - All personnel in U.S. custody (EPWs and detainees).
- Others as directed.

## LIMITS OF THE AREA OF INFLUENCE AND THE AREA OF INTEREST

5-16. 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 U.S. Army Medical Materiel Agency), 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 mission command 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 operations.

5-17. Army Health System planners—

- Identify the level of detail required and the time available to conduct the medical aspects of the intelligence preparation of the battlefield.
- Evaluate existing information/intelligence of medical significance and identify intelligence gaps. (Sources include: National Center for Medical Intelligence; Defense Intelligence Agency; U.S. Army Public Health Command; 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; preventive medicine 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.

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*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.

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## POLITICAL AND SOCIOECONOMIC SITUATION

### Population Demographics

5-18. 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 affect 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 affect/additional requirements will dislocated persons, retained and detained personnel, and EPWs have on the AHS system? This is of particular importance for the preventive medicine arena as camps require sanitation, pest management, and potable water support. Other requirements include the provision of sick call services, outpatient treatment, hospitalization, medical evacuation, MEDLOG support (to include sorting, repackaging, inventorying, and disseminating donated medical supplies and equipment), and other functional concerns. Within the veterinary arena, this may include the types of domesticated and wild animals, as well as farm animals.

### Threat Forces Capabilities/Effects

5-19. 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/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/capabilities include the analysis of enemy medical doctrine and capabilities; priority and availability of medical care and medical evacuation; 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**

5-20. 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**

5-21. Transportation systems include the effect of available transportation systems on timely medical evacuation and/or casualty evacuation, 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**

5-22. Communication systems architecture includes the communications networks that are established in the AO; 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**

5-23. Utilities (water, electricity, and sanitation) include the analysis of water quality (potability) 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**

5-24. 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**

5-25. A checklist for assessing the foreign medical infrastructure is provided in Table 5-1.

5-26. A checklist for assessing foreign MTF capabilities and services is provided in Table 5-2 (page 5-8).

**Table 5-1. Checklist for assessing a foreign medical infrastructure**

<p><b><i>Public Health and Health Threat</i></b></p>	<p>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 in the area of operations.  Prevalence of human immunodeficiency virus/acquired immunodeficiency syndrome.  Environmental health risk (to include heat and cold injury, exposure to toxic industrial materials, and poisonous or toxic flora and fauna).</p>
<p><b><i>Hospitalization/ Medical Clinics</i></b></p>	<p>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.</p>
<p><b><i>Services/Providers</i></b></p>	<p>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/mental health clinics and available services.  Number and types of behavioral/mental health personnel (such as psychologists, social workers, and the like).  Veterinary medicine personnel, facilities, and capabilities.</p>
<p><b><i>Medical Evacuation</i></b></p>	<p>Medical evacuation/casualty transport systems (public, private, and dedicated military ground and air ambulances or platforms of opportunity).</p>
<p><b><i>Medical Research/ Education</i></b></p>	<p>Number and types of medical research facilities.  What toxic industrial materials does the facility use and/or produce (chemical, biological, and nuclear/radiation hazards).  Number, types, and location of medical schools or medical training centers.</p>

**Table 5-2. 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, 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/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?
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?



5-27. 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, retained and detained persons, and EPWs (to include donated supplies or those of a nongovernmental organization/international 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.

5-28. Analysis of medical evacuation services includes the analysis of local medical evacuation 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.

5-29. 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 preventive medicine measures which are required to counter the health threat; analysis of the effect of preventive medicine 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 international organizations.

## INTEGRATION

5-30. The object of threat integration is to relate how essential elements of information identified in analysis of the medical aspects of intelligence preparation of the operational area 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.

5-31. 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 a 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?
- Geographic-related threat issues 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

5-32. 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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## Chapter 6

# Army Health System Operations

Army Health System support is provided across the range of military operations 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 AO. 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.

### SECTION I — PLANNING FOR ARMY HEALTH SYSTEM SUPPORT

#### UNIFIED LAND OPERATIONS

- 6-1. Unified land operations describe the character of the dominant major operation being conducted at anytime within the land force commander's AO. The range of military operations 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 range of military operations. Further, refer to AHS doctrine for medical planning considerations.
- 6-2. Unified land operations are executed through decisive action by means of Army core competencies that are guided by mission command.
- 6-3. As all major operations are joint in nature, the range of military operations can be used to group similar types of activities under a predominant theme. Major operations normally are characterized by the offensive and defensive tasks, but may also include stability tasks. Further, within the OE all three types of tasks can be occurring simultaneously.

#### OPERATIONAL VARIABLES

- 6-4. As the OE is comprised of all of the factors, both military and civilian, that affect the conduct of military operations in an AO, 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, 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. The MEDCOM (DS) provides this regional focus in support of the combatant commander's 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 ADRP 5-0.

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**This paragraph implements NATO STANAG 2131.**

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6-5. Table 6-1 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 6-1. Medical aspects of the operational variables**

<b>Variable</b>	<b>Subvariables</b>	<b>Medical Aspects</b>
<b>Political</b>	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.
<b>Military</b>	Military forces. Government paramilitary forces. Nonstate paramilitary forces. Unarmed combatants. Nonmilitary armed combatants. Military functions. <ul style="list-style-type: none"> <li>• Command and control (mission command).</li> <li>• Maneuver.</li> <li>• Information warfare.</li> <li>• Reconnaissance, intelligence, and target acquisition.</li> <li>• Fire support.</li> <li>• Protection.</li> <li>• Logistics.</li> </ul>	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 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. Veterinary care for military working dogs and other government-owned animals and veterinary preventive medicine capabilities pertaining to zoonotic disease transmissible to man.

**Table 6-1. Medical aspects of the operational variables (continued)**

<b>Variable</b>	<b>Subvariables</b>	<b>Medical Aspects</b>
<b>Economic</b>	<p>Economic diversity.                      Employment status.                      Economic activity.                      Illegal economic activity.                      Banking and finance.</p>	<p>The economic base can affect health care for both the human and the animal populations in the nation.</p> <p>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.</p> <p>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.</p> <p>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.</p>
<b>Social</b>	<p>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.</p>	<p>Age, gender, and genetics affect how individuals are affected by disease and existing environmental factors.</p> <p>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).</p> <p>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.</p> <p>If public health and disease prevention programs are not instituted, the general health of the population or the affected subpopulation will decrease.</p> <p>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.</p> <p>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 gender is relevant in addressing women's health issues.</p> <p>Providers must be cautious in using graphic aids to communicate with their patients, as the explicit graphics may be considered offensive.</p>

Table 6-1. Medical aspects of the operational variables (continued)

<i>Variable</i>	<i>Subvariables</i>	<i>Medical Aspects</i>
Social (continued)		Medical personnel should develop a guide for asking medical questions in the local language dialect. North Atlantic Treaty Organization Standardization Agreement 2131 is a multilingual phrase book for medical questions in the various North Atlantic Treaty Organization languages. It should be adapted to include phrasing from the local language/dialect in the area of operations.
Information	Public communications media. Information warfare. <ul style="list-style-type: none"> <li>• Electronic warfare.</li> <li>• Computer warfare.</li> <li>• Information attack.</li> <li>• Deception.</li> <li>• Physical destruction.</li> <li>• Protection and security measures.</li> <li>• Perception management.</li> <li>• Intelligence.</li> <li>• Information management.</li> </ul>	Availability of mass communications enablers for public health warnings, alerts, and information. <ul style="list-style-type: none"> <li>• Telephones.</li> <li>• Televisions.</li> <li>• Radios.</li> <li>• Newspapers/periodicals.</li> <li>• Computers/e-mail.</li> </ul>
Infrastructure <sup>1</sup>	Construction pattern. Urban zones. Urbanized building density. Utilities present. Utility level. Transportation architecture.	Availability of electricity and running 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 <ul style="list-style-type: none"> <li>• *Observation and fields of fire.</li> <li>• *Avenues of approach.</li> <li>• *Key terrain.</li> <li>• *Obstacles.</li> <li>• *Cover and concealment.</li> <li>• Landforms.</li> <li>• Vegetation.</li> </ul>	Are brick and mortar structures available for use as medical treatment facilities? Climate and weather effects on— <ul style="list-style-type: none"> <li>• Disease vectors.</li> <li>• Categories and types of injuries.</li> <li>• Acclimatization issues pertaining to heat, cold, or altitude.</li> <li>• Medical evacuation operations.</li> </ul>

**Table 6-1. Medical aspects of the operational variables (continued)**

<b>Variable</b>	<b>Subvariables</b>	<b>Medical Aspects</b>
Physical environment (continued)	<ul style="list-style-type: none"> <li>• Terrain complexity.</li> <li>• Mobility classification.</li> </ul> Natural hazards. Climate. Weather. <ul style="list-style-type: none"> <li>• *Precipitation.</li> <li>• *High temperature—heat index.</li> <li>• *Low temperature—chill index.</li> <li>• *Wind.</li> <li>• *Visibility.</li> <li>• *Cloud cover.</li> <li>• *Relative humidity.</li> </ul>	Topography and hydrology considerations include— <ul style="list-style-type: none"> <li>• Character and types of injuries to be encountered.</li> <li>• Natural barriers to medical evacuation.</li> <li>• Lines of patient drift.</li> <li>• Suitable for farming and for grazing animals.</li> </ul> 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.
<p><b>NOTE:</b> 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.</p>		

## MISSION VARIABLES

6-6. Mission variables are used by AHS planners to determine the impact they will have on medical operations. Mission variables describe characteristics of the AO, focusing on how they might affect a mission. The mission variables are discussed below. In Table 6-1, 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 ADRP 5-0.

### MISSION

6-7. The mission refers to the overall mission of the tactical 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 tactical 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 tactical commander’s 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

6-8. The second variable the AHS planner must consider is the enemy. The elements of dispositions (including organization, strength, location, and tactical mobility), doctrine, equipment, capabilities, vulnerabilities, and probable courses of action are considered by the tactical 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, Operation New Dawn, 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 his 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**

6-9. The military aspects of terrain and weather are listed in Table 6-1. 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 point of injury or wounding through the theater AHS to definitive, restorative, and rehabilitative care in the CONUS-support base. The fully integrated ground and air medical evacuation 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 medical evacuation operations would result in a requirement for holding the injured or ill in place until medical evacuation 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**

6-10. 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 his traditional support plan, but he 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/gynecological, and geriatric patients, and patients with chronic medical conditions varies significantly from the items available in the medical equipment sets routinely carried by U.S. 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 U.S. AHS units.

## **TIME AVAILABLE**

6-11. 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 is to operate on a



seriously injured Soldier, the FST 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

6-12. Civil considerations are the influence of man-made infrastructure, civilian institutions, and activities of civilian leaders, populations, and organizations within the AO on the conduct of military operations. As discussed in paragraph 6-4, political, military, economic, social, information, infrastructure, physical environment, time is a model used at the strategic level to analyze the civil aspects of the area. Another model expressed in the memory aid area, structures, capabilities, organizations, people, and events is often used at the tactical level. Field Manual 3-24 provides an in-depth analysis of area, structures, capabilities, organizations, people, and events. 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 AO and adversely impact the health of U.S. forces.

## TASK-ORGANIZATION

6-13. 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, equipment, 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 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).

6-14. The MMB is a versatile mission command 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

6-15. 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.

6-16. 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 and ADRP 3-0 for additional information on decisive action.

6-17. The traditional and primary AMEDD mission is to *conserve the fighting strength* of the tactical commander. The AMEDD battle rhythm is that of the tactical 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 tactical commander's ability to quickly take advantage of opportunities which present themselves during the battle.

6-18. 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 combat forces being supported. To ensure effective and efficient AHS support within the OE, 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.

6-19. The medical evacuation 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 advanced trauma management performed by the physician assigned to the battalion aid station to further stabilize the patient before he is evacuated by air ambulance.

## OFFENSIVE TASKS

6-20. 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 6-2 along with key medical considerations for these types of tasks. For additional information on offensive tasks, refer to ADRP 3-0.

**Table 6-2. Offensive tasks, purposes, and key medical considerations**

<i>Offensive Tasks</i>	<i>Purposes</i>	<i>Key Medical Considerations</i>
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 by medical mission command. 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 tactical 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 combat casualties during the fight. Theater hospitalization to provide essential care in theater to all categories of patients.

## DEFENSIVE TASKS

6-21. 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.

6-22. 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 6-3 depicts the defensive tasks, purposes, and medical considerations when preparing for these types of tasks.

**Table 6-3. Defensive tasks, purposes, and key medical considerations**

<i>Defensive Tasks</i>	<i>Purposes</i>	<i>Key Medical Considerations</i>
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 by medical mission command.  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 combat casualties during the fight.  Theater hospitalization to provide essential care in theater to all categories of patients.

## STABILITY TASKS

6-23. 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.

6-24. The AMEDD has historically conducted humanitarian assistance operations when deployed in overseas areas. In some scenarios, medical forces may be deployed prior to the deployment of maneuver forces as the medical forces, due to the humanitarian nature of their activities, are more acceptable to a host nation than the deployment of combat forces. Although the medical commander can provide the combatant commander 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 combatant commander's theater engagement strategy.

6-25. The importance of stability tasks in achieving U.S. national goals and objectives is discussed in DODI 3000.05, DODI 6000.16, and ADPs and ADRPs 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 combatant commander's area of responsibility.

6-26. Table 6-4 depicts stability tasks, purposes, and medical considerations for the preparation for the conduct of these tasks.

**Table 6-4. Stability tasks, purposes, and key medical considerations**

<b><i>Stability Tasks</i></b>	<b><i>Purposes</i></b>	<b><i>Key Medical Considerations</i></b>
Establish civil security (including security force assistance) Establish civil control Restore essential services Support to governance Support to economic and infrastructure development	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 mission command 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

6-27. 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, U.S. 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 6-5 identifies defense support of civil authorities tasks, purposes, and medical considerations. For additional information on these types of tasks, refer to ADP 3-28, ADRP 3-0, and Graphic Training Aids (GTAs) 90-01-020 and 90-01-021.

**Table 6-5. Defense support of civil authorities tasks, purposes, and key medical considerations**

<b><i>Defense Support of Civil Authorities Task</i></b>	<b><i>Purposes</i></b>	<b><i>Key Medical Considerations</i></b>
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.	Medical mission command to 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.

6-28. Army Health System support to defense support of civil authorities tasks will include both AHS operational Army and the generating AHS forces. The USAMEDCOM is the mission command headquarters for all tables of distribution and allowances MTFs and medical research facilities within CONUS.

### **SECTION III — THEATER OPENING, EARLY ENTRY, AND EXPEDITIONARY MEDICAL OPERATIONS**

6-29. 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) as the medical force pool provider will deploy sufficient medical resources to provide the required support.

6-30. Figure 6-1 provides an example of the types of AHS activities which may be conducted in these types of operations.

### **THEATER OPENING AND EARLY ENTRY OPERATIONS**

6-31. 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 theater and to support theater opening forces during reception, staging, onward movement, and integration.

6-32. 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, tactical 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.

6-33. 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 occupational and environmental health surveillance), health risk communications, subsistence inspection programs, and integrates medical materiel (supplies, blood, and equipment) requisition, distribution, and maintenance.

6-34. Medical evacuation 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**

6-35. 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 which capitalize on the strengths of all units employed in the AO.

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

**Figure 6-1. Example of Army Health System activities which may be conducted in theater opening and expeditionary medical operations**

6-36. Army Medical Department 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 medical evacuation may necessitate Role 2 medical treatment facilities and FSTs to coordinate directly with USAF aeromedical liaison teams and the supporting Theater Patient Movement Requirements Center for patient movement.

6-37. 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 tactical commander is provided the most effective and efficient AHS support.

6-38. 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 ADRP 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 mission command and the technical supervision of ongoing clinical operations. Medical mission command 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

### FOCUS

6-39. 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 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 2311.01E, DODI 2310.08E, JP 3-63, JP 4-02, AR 40-400, AR 190-8, and FM 27-10.

6-40. The focus of AHS support to detainee operations is depicted in Table 6-6.

**Table 6-6. Focus of Army Health System support to detainee operations**

<i>Medical Activity</i>	<i>Detainee Collection Point</i>	<i>Detainee Holding Area</i>	<i>Theater Internment Facility</i>	<i>Remarks</i>
Triage	Yes	Yes	Yes	
Tactical combat casualty care	Yes	Yes	Yes	
Screening	Yes <sup>1</sup>	Yes <sup>1</sup>	Yes	Monthly weigh-in. Nutrition status. Vision.
Medications	Yes <sup>2</sup>	Yes <sup>2</sup>	Yes <sup>3</sup>	If approved by medical personnel, detainees may retain emergency medicines such as fast acting inhalers or cardiac medicines.
Routine sick call	Yes <sup>1</sup>	Yes <sup>1</sup>	Yes	
Preventive medicine measures	Yes	Yes	Yes	Emphasis is on field hygiene and sanitation, disposal of waste, and personal hygiene practices.

**Table 6-6. Focus of Army Health System support to detainee operations (continued)**

Medical evacuation	Yes <sup>3</sup>	Yes <sup>3</sup>	Yes <sup>3</sup>	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.
<p>1 Dependent upon length of stay.</p> <p>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.</p> <p>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.</p>				

## MEDICAL PERSONNEL ORGANIC TO MANUEVER UNITS

6-41. Medical personnel organic to maneuver units may be required to provide TC3, area medical support, and medical evacuation 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.

6-42. 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.

6-43. 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 AO. 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, TC3, preventive medicine measures (hygiene and sanitation), and medical evacuation 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 internment facility, to include—
  - Initial medical examinations.
  - Medical treatment (routine care, sick call, emergency services, hospitalization, medical consultation, and specialty care requirements).
  - Medical evacuation.
  - Preventive medicine (such as medical surveillance, OEH surveillance, hygiene and sanitation standards and practices, pest management activities, and inspection of water potability, dining facility and services hygiene, and food preparation practices).
  - Dental services.
  - Veterinary support (food inspection and quality assurance, veterinary preventive medicine, 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 internment facilities. This can include TC3 by combat medics and advanced trauma management provided at battalion aid stations and Role 2 MTFs (medical companies) and forward resuscitative surgery provided by FSTs to stabilize the patient for further evacuation and hospitalization.
- 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).

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

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- 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 internment facilities within the AO that are established, inspected, and enforced (the standards used are the same as those for U.S. 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

6-44. The internment/resettlement battalion has organic medical personnel to provide a limited Role 1 medical care capability and preventive medicine services within the internment 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.

6-45. The medical personnel assigned to the internment/resettlement battalion assist with inprocessing detainees by providing the initial medical examination. They provide routine sick call services and TC3 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 internment 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

6-46. The MEDCOM (DS) is the senior AHS mission command medical organization within the AO. The MEDCOM (DS) is responsible for ensuring that the medical care provided to EPWs and other personnel in U.S. custody (such as detained or retained personnel) 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 internment facilities located within its AO. The MEDBDE (SPT) coordinates medical issues related to

detainee operations being conducted by subordinate units with the MEDCOM (DS) detainee operations medical director.

6-47. The MEDCOM (DS) commander or his 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.

6-48. 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

# Health Service Support

With the development and emergence of the Army warfighting functions which replaced the battlefield operating systems and the publication of the 2008 edition of FM 3-0, *Operations*, the mission sets of the AMEDD (which historically had been shown under the combat service support battlefield operating system) were divided between the sustainment and protection warfighting functions. This change more closely aligned the AMEDD mission sets with the overall warfighting functions of the Army. The health service support mission set is discussed in Part Two of this publication, while the FHP mission set 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 as the medical functions (as discussed in Part One) are interrelated and interdependent.

Health service support pertains to the treatment and medical evacuation 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—casualty care, medical evacuation, and medical logistics.

This part of the publication discusses—

- Casualty care aspects of the AHS mission. It includes all of the treatment aspects of the medical functions to include medical treatment (organic and area support), hospitalization, the treatment aspects of dental services, treatment of BH/neuropsychiatric patients, clinical laboratory services and support, and the treatment of CBRN patients.
  - Medical evacuation, medical regulating, and the provision of en route care to patients being transported.
  - Medical logistics inclusive of all functional subcomponents and services.
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## Chapter 7

# Casualty Care

The mission set of casualty care comprises the medical functions of hospitalization, medical treatment (organic and area support), the treatment aspects of dental services and BH/neuropsychiatric treatment (COSC), clinical medical laboratory services, and 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)

### ORGANIZATION AND PERSONNEL

7-1. 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 battalion) and the medical company (area support). The area support function encompasses TC3, advanced trauma management, routine sick call, emergency dental care, preventive medicine, and COSC support. (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.)

7-2. 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 medical evacuation 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

7-3. Table 7-1 discusses the primary tasks of the medical treatment (organic and area support) function.

**Table 7-1. Primary tasks and purposes of the medical treatment (organic and area support) function**

<i>Primary Task</i>	<i>Purpose</i>
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.
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.
Advanced trauma management	Provide physician-directed trauma care to stabilize patients for evacuation to a higher role of care. This care is provided at the supporting Role 1 and/or Role 2 medical treatment facilities. A Role 2 medical treatment facility provides a greater resuscitative capability than is available at Role 1. At Role 2 medical treatment facilities, blood, x-ray, and medical laboratory support are available.
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.
Routine sick call	Provide primary care services as close to patient's unit as possible.
Patient holding	Provide a short-term holding capability (not to exceed 72 hours) for patients requiring minimal care prior to returning to duty.
Casualty prevention measures	Promote wellness and enhance Soldier medical readiness to decrease morbidity and mortality. There are no preventive medicine or combat and operational stress control assets at Role 1; however, they are available at Role 2.
Medical evacuation	Provide medical evacuation by ground ambulance on an area support basis and to provide en route medical treatment during transport.

**Table 7-1. Primary tasks and purposes of the medical treatment (organic and area support) function (continued)**

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.
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## SECTION II — HOSPITALIZATION

### COMBAT SUPPORT HOSPITAL

7-4. In the AO, hospitalization is provided by the CSHs operating within the AO. The CSH provides essential care within the AO to treat and return to duty those patients who can be treated within the theater evacuation policy and stabilize and evacuate those patients requiring definitive, convalescent, and rehabilitative care in CONUS or other safe haven. The CSH 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.

### AUGMENTATION TEAMS

7-5. The CSH 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 MTFs.
- *Forward surgical team* that is available to augment the surgical services of the CSH 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 CSH, plus specialty consultative services, as required. The hospital team (head and neck) is the only organization authorized a computerized tomography scanner.
- *Hospital augmentation team (special care)* provides the additional health care providers to support operations characterized predominantly with stability tasks.
- *Hospital augmentation team (pathology)* provides pathology support to the CSH clinical laboratory and specialty consultative services, as required.
- *Medical team (renal hemodialysis)* provides renal hemodialysis care for patients with acute renal failure and consultative services on an area basis.
- *Medical team (infectious disease)* provides infectious disease investigation, takes measures to control the spread of the disease, assures access to health services, and provides consultative services to the AHS unit to which attached. This team may include or partner with special care teams with a preventive medicine/public health nurse when public health measures are required.

### PRIMARY TASKS

7-6. Table 7-2 discusses the primary tasks of the hospitalization function.

Table 7-2. Primary tasks and purposes of the hospitalization function

<b>Primary Task</b>	<b>Purpose</b>
Hospitalization	Provide definitive medical care for Soldiers capable of being returned to duty and to provide essential care for patients who must be stabilized for medical evacuation out of the area of operations because they cannot recover within the time period established by the theater evacuation policy.
Forward resuscitative surgery	Provide initial emergency resuscitative surgery and damage control surgery to save life, limb, and eyesight.
Clinical laboratory services	Analyze body fluids and tissues or identify microorganisms as an adjunct in the diagnosis and treatment of patients and in the prevention of disease.
Blood bank	Manage the classification, collection, processing, storage, shipment, and use of blood and blood components.
Radiology services	Provide radiology support for acute care; interpret x-ray films; and provide the final reading and interpretation of all films taken at the facility.
Pharmacy support	Provide general pharmaceutical support (to include all controlled substances); package and dispense medication for patient evacuations and discharge-to-duty patients and/or other ambulatory patients; provide parenteral admixture services; generate intravenous-quality fluids in the area of operations; and provide parenteral nutritional solutions.
Nutritional care	Provide hospital food service support for patients and staff; prepare special diets for hospitalized Soldiers; provide support to command health promotion program; and provide nutrition counseling and advice to patients and staff.
Medical logistics	Provide medical supply operations, medical equipment maintenance and repair, optical fabrication and repair, contracting services, regulated medical or hazardous waste management and disposal, and production and distribution of medical gases.
Patient administration	Provide admission and disposition processing; schedule patient evacuation; collect, safeguard, and account for patient's funds and valuables; provide custodianship of inpatient and outpatient treatment records, redeployment of medical records, and maintenance of medical records and files; collect and report medical statistical data; manage casualty reporting and decedent affairs, line of duty investigations, and submission of special reports and other patient-related activities.
Respiratory care	Provide support for patients that require supplementation of oxygen, administration of aerosolized medicines, and general care of the patient with ventilatory compromise.
Optometry	Provide optometry support for glasses, contact lenses, or gas mask inserts, and ophthalmological support to perform surgical repair of eye and adnexal injuries.
Physical therapy	Provide services to injured Soldiers to develop, maintain, and restore maximum movement and functional ability thereby reducing morbidity.
Preventive medicine	Provide monitoring techniques necessary to investigate, prevent, and/or mitigate nosocomial infectious outbreaks within the hospital; and provide public health nursing.
Hospital augmentation team (head and neck)	Provide ear, nose, and throat surgery, neurosurgery, and eye surgery augmentation in support of theater hospitals and consultative services, as required.
Hospital augmentation team (special care)	Augment a medical treatment facility with the necessary health personnel and equipment to provide medical care during operations characterized predominantly by stability tasks. This unit provides— <ul style="list-style-type: none"> <li>• Pediatric inpatient, consultation, and nurse practitioner services.</li> <li>• Obstetrics/gynecology and specialty nursing services.</li> <li>• Preventive medicine services.</li> <li>• Public health nursing services.</li> <li>• Family physician services.</li> </ul>

**Table 7-2. Primary tasks and purposes of the hospitalization function (continued)**

Hospital augmentation team (pathology)	Provide pathology augmentation in support of theater hospitals and consultative services, as required.
Medical team (renal hemodialysis)	Provide medical augmentation to echelons above brigade hospitals. The medical team (renal hemodialysis) provides renal hemodialysis care for patients with acute renal failure and consultative services on an area basis.
Medical team (infectious disease)	Provide medical augmentation to echelons above brigade hospitals. This team provides infectious disease investigation, takes measures to control the spread of disease, assures access to health services, and provides consultative services to the Army Health System unit to which attached.
Medical detachment (minimal care)	Provide minimal care/convalescent care hospitalization, nursing, and rehabilitative services in support of echelons above brigade hospitalization. Provides oversight of holding and monitoring facilities for decontaminated biologic patients/communicable disease contacts.

## SECTION III — DENTAL SERVICES

### TREATMENT ASPECTS

7-7. 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 CARE

7-8. There are three levels of dental support within the AO: unit, hospital, and area. These levels are defined primarily by the relationship of the dental assets supporting the patient population within each level.

#### UNIT-LEVEL DENTAL CARE

7-9. Unit-level dental care consists of those services provided by dental personnel organic to the supporting medical companies of BCTs and Special Forces groups. This module provides emergency dental treatment to Soldiers during operations.

#### HOSPITAL-LEVEL DENTAL CARE

7-10. 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, which consists of emergency and essential dental support to all injured or wounded Soldiers, as well as the hospital staff.

#### AREA DENTAL SUPPORT

7-11. Area dental support is provided for units that do not have organic dental assets. This coverage is provided by the dental company (area support).

7-12. The dental company (area support) 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

7-13. Within the AO, dental service support assets provide operational care, which is comprised of emergency dental care and essential dental care. Another category, normally found only in fixed facilities

in the U.S., is comprehensive care. 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**

**Emergency Care**

7-14. Emergency care is provided to 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. It is the most austere type of care and is available to Soldiers engaged in operations. Common examples of emergency treatments are simple extractions, providing antibiotics and pain medication, and temporary fillings.

**Essential Care**

7-15. Essential care includes dental treatment necessary to intercept potential emergencies. This type of operational care is necessary for preventing lost duty time and preserving the fighting strength. Soldiers in dental Class 3 (potential dental emergencies) should be provided essential care as the operational situation permits. Soldiers in dental Class 2 (untreated oral disease) should be provided essential care as the operational situation and availability of dental resources permit. The scope of operational care includes definitive restorations, minor oral surgery, exodontic, periodontic, and prosthodontic procedures, as well as prophylaxis.

**Comprehensive Care**

7-16. Comprehensive care restores an individual’s optimal oral health, function, and aesthetics. This category of care is usually reserved for operations that anticipate an extensive period of reception and training in the AO. The scope of facilities needed to provide this level of dental support could equal that of Role 3 MTFs.

**PRIMARY TASKS**

7-17. Table 7-3 discusses the primary tasks of the dental services function.

**Table 7-3. Primary tasks and purposes of the dental services function**

<b>Primary Task</b>	<b>Purpose</b>
Comprehensive dental care	Restore an individual to optimal oral health, function, and aesthetics. Normally provided in continental United States-support base.
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.
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.
Essential dental care	Prevent potential dental emergencies and maintain the overall oral fitness of Soldiers at levels consistent with combat readiness.
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.



## SECTION IV — BEHAVIORAL HEALTH/NEUROPSYCHIATRIC TREATMENT

### TREATMENT ASPECTS

7-18. Behavioral health/neuropsychiatric treatment exists when there is an explicit therapist-patient or therapist-client relationship. 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, 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.

7-19. 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 disordered patients. 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.

7-20. 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 (<http://www.healthquality.va.gov>) offers clinicians evidence-based assessment and treatment algorithms for acute stress disorder, posttraumatic stress disorder, and many other behavioral/neuropsychiatric disorders.

### PRIMARY TASKS

7-21. Table 7-4 discusses the primary tasks of the BH/neuropsychiatric treatment. The remaining primary tasks of the COSC function are depicted in Table 12-1.

**Table 7-4. Primary tasks and purposes of behavioral health/neuropsychiatric treatment**

<i>Primary Task</i>	<i>Purpose</i>
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.

## SECTION V — CLINICAL LABORATORY SERVICES

### CLINICAL

7-22. 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.

7-23. The clinical laboratory in the CSH performs procedures in biochemistry, hematology, urinalysis, microbiology, and serology in support of clinical activities. The CSH also provides blood-banking services.

## PRIMARY TASKS

7-24. Table 7-5 discusses the primary tasks of the clinical laboratory services function. The primary tasks for the AML and/or operational medical laboratory services are discussed in Table 13-2.

**Table 7-5. Primary tasks and purposes of the clinical laboratory services**

<b><i>Primary Task</i></b>	<b><i>Purpose</i></b>
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.
Blood -banking services	Provide laboratory support to type and crossmatch blood specimens for transfusion services. Provide limited testing of blood products.

## Chapter 8

# Medical Evacuation

Medical evacuation encompasses both the evacuation of Soldiers from the point of injury 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

#### MEDICAL EVACUATION SYSTEM

8-1. 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.

8-2. Army medical evacuation 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 medical evacuation resources locate, acquire, treat, and evacuate Soldiers from the point of injury 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.

8-3. The mission of Army medical evacuation assets is the evacuation and provision of en route medical care to wounded. However, the essential and vital functions of medical evacuation 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 mobile aeromedical staging facilities or aeromedical staging facilities; emergency movement of Class VIII, blood and blood products, medical personnel and equipment; and serve as messengers in medical channels.

8-4. The appropriate level of 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

8-5. 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 combatant commander. The policy establishes, in number of days, the maximum period of noneffectiveness (hospitalization and convalescence) that patients may be held within the AO for treatment. This policy does not mean that a patient is held in the AO 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 AO. 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 AO 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

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**The following paragraph implements STANAG 2087 and 3204.**

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8-6. 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 evacuation based on their medical condition, assigned evacuation precedence, and availability of medical evacuation platforms. Patients may be evacuated from the point of injury or wounding to an MTF in closest proximity to the point of injury/wounding to ensure they are stabilized to withstand the rigors of evacuation over great distances. The evacuation precedences 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 who must receive far forward surgical intervention to save life 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 his medical condition could deteriorate to such a degree that he 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.

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*Note.* 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.

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## RESPONSIBILITIES

8-7. The Service component commander is responsible for medical evacuation at the operational level and is responsible for executing the medical evacuation of his forces. Strategic aeromedical evacuation is the responsibility of the U.S. Transportation Command.

8-8. Within Army support to other Services, Army resources may provide ship-to-shore medical evacuation on an area support basis. Medical evacuation from shore-to-ship for deployed USN and U.S. Marine Corps forces could also be available within the Army's support capabilities.

## ORGANIZATIONS

8-9. There are two types of U.S. Army medical evacuation platforms—air (rotary-wing) and ground. These platforms are dedicated and designed, equipped, and staffed to perform the medical evacuation mission.

**GROUND AMBULANCES**

8-10. Ground ambulances are organic to BCT maneuver battalion medical platoons and to both the brigade support medical company 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.

**Maneuver Battalion Medical Platoon**

8-11. The organic medical platoon ground ambulances provide medical evacuation support from the point of injury, company aid post, or casualty/patient collection point to the battalion aid station. In armor BCTs depending upon the mission, enemy, terrain and weather, troops and support available, time available, and civil considerations factors and the medical evacuation 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.

**Brigade Support and/or Area Support Medical Company Evacuation Platoon**

8-12. The medical company (brigade support) evacuation platoon provides medical evacuation 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.

8-13. The medical company (area support) provides supported EAB units with medical evacuation support on an area basis for those units that do not have organic medical evacuation resources.

**Medical Company (Ground Ambulance)**

8-14. 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**

8-15. The medical company (air ambulance) (HH-60) is assigned to the general support aviation battalion, combat aviation brigade. This unit provides air medical evacuation for all categories of patients consistent with evacuation precedence and other operational considerations within the AO. It evacuates patients from point of injury or Roles 1 and 2 MTFs to theater hospitals established in EAB. This unit has a single-lift capability of 72 litter patients or 84 ambulatory patients, or some combination thereof.

**PRIMARY TASKS**

8-16. Table 8-1 discusses the primary tasks of the medical evacuation function.

**Table 8-1. Primary tasks and purposes of the medical evacuation function**

<b>Primary Task</b>	<b>Purpose</b>
Acquire, locate, treat, stabilize, and evacuate	Clear the battlefield of casualties to facilitate and enhance the tactical commander's freedom of movement. This task is performed by the medical crew of the evacuation platform.
En route medical care	Maintain the patient's medical condition during transport and provide emergency medical intervention when required. This task is performed by the medical evacuation crew.
Area support	Provide medical evacuation for units without organic medical evacuation assets. This task is performed by medical evacuation platforms in Roles 1 and 2 and by medical evacuation platforms in the medical company (ground ambulance) and the medical company (air ambulance).

**Table 8-1. Primary tasks and purposes of the medical evacuation function (continued)**

<b>Primary Task</b>	<b>Purpose</b>
Emergency movement of medical personnel, supplies, and equipment	Provide a rapid response for the emergency movement of scarce medical resources throughout the operational environment when required by the tactical situation.
Transfer of patients between medical treatment facilities and mobile aeromedical staging facilities	Provide a capability to cross-level patients within the theater hospitals and to transport patients being evacuated out of the theater to staging facility prior to flight departure.
Medical property transfer	Provide a reciprocal procedure to exchange like medical property when patients are evacuated with equipment accompanying them.
Medical regulating support	Provide support to medical regulating activities to ensure vital linkup between tactical evacuation support and the scheduling of patients for evacuation out of theater by strategic aeromedical evacuation resources.

8-17. For additional information on medical evacuation and medical regulating, refer to JP 4-02 and AR 40-3.

## SECTION II — MEDICAL REGULATING

8-18. Medical regulating is the coordination and control of moving patients to MTFs which are best able to provide the required specialty care. This system is designed to ensure the efficient and safe movement of patients.

8-19. 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.

8-20. The factors that influence the scheduling of patient movement include—

- Patient's medical condition (stabilized to withstand evacuation).
- Tactical 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).

## SECTION III — STRATEGIC MEDICAL EVACUATION/PATIENT MOVEMENT

8-21. Medical evacuation occurs at the tactical and strategic levels and requires the synchronization and integration of Service component medical evacuation resources and procedures with the DOD worldwide evacuation system operated by the U.S. Transportation Command.

8-22. A comprehensive medical evacuation plan is essential to ensure effective, efficient, and responsive medical evacuation is provided to all wounded, injured, and ill Soldiers in the AO. The Army medical evacuation plan flows from the combatant commander's guidance and intent and incorporates all missions and tasks directed by the combatant commander 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.

8-23. When directed by the combatant commander, Army medical evacuation 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 combatant commander's OPLAN and OPORD. The theater Army surgeon, with the advice of the senior medical evacuation 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 9

# 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 range of military operations. Providing timely and effective AHS support is a team effort which integrates the clinical and operational aspects of the mission.

### SECTION I — MEDICAL LOGISTICS MANAGEMENT IN AN OPERATIONAL ENVIRONMENT

9-1. The MEDLOG system encompasses planning and executing all Class VIII supply support operations to include medical materiel procurement and distribution, medical equipment maintenance and repair, blood management, optical fabrication and repair, and the centralized management of patient movement items. It also includes contracting support, medical hazardous waste management and disposal, and production and distribution of medical gases. The appropriate command surgeon provides technical guidance. The system is anticipatory with select units capable of operating in a split-based mode.

### SECTION II — MEDICAL LOGISTICS MISSION COMMAND ORGANIZATIONS

#### MEDICAL LOGISTICS SYSTEM

9-2. The deployable MEDLOG system consists of the following organizations:

- Medical logistics management center.
- Medical logistics company.
- Medical detachment (blood support).
- Medical team (optometry).
- Medical mission command headquarters (to include the MEDCOM [DS], MEDBDE [SPT], and MMB).
- United States Army Medical Materiel Agency MEDLOG support team (reachback support for Army pre-positioned stocks).

#### MEDICAL LOGISTICS MANAGEMENT CENTER

9-3. 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 operates in a split-based mode, with a MEDLOG management center base organization and 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 mission command headquarters and collocates with the distribution management center of the theater sustainment command/expeditionary sustainment command. 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**

9-4. The MEDLOG company provides medical materiel, medical equipment maintenance, optical lens fabrication and repair, and patient movement items support to BCTs and EAB AHS units operating within the AO. 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 mission command of the headquarters and headquarters detachment, MMB.

## **MEDICAL DETACHMENT (BLOOD SUPPORT)**

9-5. 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 TEAM OPTOMETRY**

9-6. The medical team (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.

## **UNITED STATES ARMY MEDICAL MATERIEL AGENCY MEDICAL LOGISTICS SUPPORT TEAM**

9-7. The MEDLOG support team is a deployable table of distribution and allowances organization consisting of MEDLOG personnel (military, DA civilians, and contractors) from the U.S. Army Medical Materiel Agency. 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, the MEDLOG support team is normally under the operational control of the U.S. Army Materiel Command's Army field support brigade. The MEDLOG support team supports the reception, staging, onward movement, and integration of 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. At the end of the operation, the MEDLOG support team may again deploy to the AO to support the redeployment of U.S. forces and materiel to follow-on CONUS or outside the continental U.S. locations.

## **PRIMARY TASKS**

9-8. Table 9-1 describes the primary tasks of the medical logistics function.

**Table 9-1. Primary tasks and purposes of the medical logistics function**

<b>Primary Task</b>	<b>Purpose</b>
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.
Class VIII management and 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 range of military operations.
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.
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.
Blood management (distribution)	Provide collection, manufacturing, storage, and distribution of blood and blood products to echelons above brigade Army Health System units. Provide distribution of blood and blood products to Role 2 medical treatment facilities and forward surgical teams.
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.
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.
Medical contracting support	Ensure the establishment and monitoring of contracts for critical medical items and services.
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.
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.

9-9. Refer to JP 4-02, TM 4-02.70, TM 8-227-3, TM 8-227-11, TM 8-227-12, and FM 4-02.1.

### **SECTION III — MEDICAL LOGISTICS SUPPORT FOR ROLES 1 AND 2 MEDICAL TREATMENT FACILITIES**

9-10. The Class VIII supply functions for AHS units/elements operating Roles 1 and 2 MTFs are primarily the management of medical equipment sets and basic ordering for replenishment. The replenishment function within the BCT is performed by the brigade medical supply office of the brigade support medical company. See FM 4-02.1 for information on MEDLOG.

### **SECTION IV — MEDICAL LOGISTICS SUPPORT FOR ROLE 3 MEDICAL TREATMENT FACILITIES**

9-11. 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 and to the distribution plans and capabilities provided by sustainment organizations.

9-12. 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, integration of potency and dated items, refrigerated, and controlled substances with those assemblages. 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.

9-13. Class VIII sustainment of CSHs 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.

9-14. Theater hospitalization is provided by CSHs that operate Role 3 MTFs. Army CSHs are located at EAB. Forward surgical teams deployed from the CSH are dependent on their supporting medical company for Class VIII resupply, medical equipment maintenance and repair, and blood distribution support.

## **SECTION V — THEATER LEAD AGENT FOR MEDICAL MATERIEL AND THE SINGLE INTEGRATED MEDICAL LOGISTICS MANAGER**

9-15. The transformation of theater-level MEDLOG will continue through the joint implementation of DODD 5101.9 designating the Defense Logistics Agency as the executive agent for medical materiel. As the executive agent, the Defense Logistics Agency is designated as the DOD single point of contact to establish the strategic capabilities and systems integration necessary for effective and efficient Class VIII supply chain support to the combatant commander. The executive agent formalizes the roles and responsibilities necessary to leverage the strategic acquisition framework established by the Defense Logistics Agency that enables the Services to obtain materiel support from industry sources, rather than a national depot system. The executive agent will strengthen the combatant commander and Service collaboration for requirements planning and synchronize the Defense Logistics Agency and Army MEDLOG capabilities to improve end-to-end supply chain management support in support of joint HSS and FHP.

9-16. As part of the directive, Army MEDLOG units may be tasked to provide support to all Services and designated multinational partners (in accordance with applicable contracts and agreements) under the joint concept of the single integrated MEDLOG manager, as well as emerging concept of theater lead agent for medical materiel. The theater lead agent is designated by the combatant commander, in coordination with the Defense Logistics Agency, to provide the operational capability for medical supply chain management and distribution from strategic to operational levels. In a land AO, the Army will normally be designated as a theater lead agent for medical materiel, consistent with its traditional designation as a single integrated MEDLOG manager. Within the AO, these capabilities are provided by modular and scalable operational units that are task-organized under the control of the MEDCOM (DS).

## **PART THREE**

# **Force Health Protection**

The FHP mission set is a continuous process that begins with the entry of the Soldier into the military and is continuous throughout his 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 occupational and environmental health settings (in both deployed and garrison settings), the development and implementation of preventive medicine measures to reduce exposure to health hazards and to mitigate the effects of the adverse impact of health threats to military personnel.

Force health protection is comprised of a number of AMEDD functions and also includes the preventive aspects of some medical functions already discussed in Part Two of this publication. Force health protection encompasses preventive medicine, veterinary services, area medical laboratory services and support, and the preventive aspects of dental services and combat and operational stress control. Although nutrition plays a significant role in maintaining a healthy and fit force, nutrition is discussed under the casualty care aspects of health service support as an integral part of the hospitalization function.

This part of the publication discusses the preventive aspects of the medical functions and the preventive medicine programs and services designed to prevent health threats to our deployed forces.

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## **Chapter 10**

# **Preventive Medicine**

Preventive medicine is the anticipation, communication, prevention, education, and control of communicable diseases, illnesses, and exposure to endemic, occupational, and environmental threats. These threats (Table 1-1) include nonbattle injuries, OEH exposures, combat stress responses, weapons of mass destruction, and other threats to the health and readiness of the Soldier. Communicable diseases include arthropod-, vector-, food-, waste-, and waterborne diseases. Preventive medicine measures include health risk communication, education, field sanitation, medical surveillance, pest and vector control, disease risk assessment, environmental and occupational monitoring and health surveillance, preventive medicine measures, health threat controls for waste (human, hazardous, and medical) disposal, food safety inspection, and potable water surveillance.

## MISSION

10-1. In past conflicts, disease and nonbattle injury rendered more Soldiers operationally ineffective than actual battle wounds. Preventive medicine services to counter the health threat and prevent disease and nonbattle injury are the most effective, least expensive means of providing commanders with the maximum number of healthy Soldiers. Preventive medicine encompasses those measures to promote, improve, or conserve the behavioral and physical well-being of Soldiers. These measures enable a healthy and fit force, prevent disease and nonbattle injuries, and protect the force from health hazards.

## PROTECTION WARFIGHTING FUNCTION

10-2. Preventive medicine falls under the protection warfighting function and is concerned with both the enemy threat and the health threat. The enemy threat produces operational casualties. This threat 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, comprehensive medical surveillance activities, OEH surveillance activities, personal protective measures, preventive medicine measures, inspection of potable water and field feeding facilities, and field hygiene and sanitation are instituted and should receive command emphasis. Preventive medicine measures can include immunizations, pretreatments, chemoprophylaxis, and barrier creams. Field hygiene and sanitation combines with personal protective measures (to include correctly wearing the uniform and using insect repellent, sunscreen, and insect netting). Soldiers must practice these activities continuously during the force projection and postdeployment process.

## ORGANIZATIONS AND PERSONNEL

10-3. Preventive medicine support consists of preventive medicine units and staff officers. Preventive medicine detachments and teams provide preventive medicine support and consultation in the areas of disease and nonbattle injury prevention, field sanitation, entomology, sanitary engineering, and epidemiology to minimize the effects of environmental injuries, endemic diseases, vectorborne disease, and other health threats. 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 preventive medicine consultants and environmental sciences advisors.

## PRIMARY TASKS

10-4. Table 10-1 discusses the primary tasks of the preventive medicine function. See AR 40-5 and DA Pamphlet 40-11.

**Table 10-1. Primary tasks and purposes of the preventive medicine function**

<b>Primary Task</b>	<b>Purpose</b>
Disease prevention and control	Prevent and control communicable diseases and provide travel medicine, population health management, and hospital-acquired infection control.
Field preventive medicine	Provide field sanitation team, preventive medicine measures, individual Soldier personal protective measures, inspection of potable water and field feeding facilities, and ice and bottled/package water in an operational environment.
Environmental health	Provide the monitoring of environmental health-related data for the health of, or potential health hazard impact on, a population and on individual personnel; pest and disease vector prevention and control; health threat controls for waste disposal; identification of environmental health hazards and endemic diseases; incident-specific environmental monitoring; and climatic injury prevention and control.

**Table 10-1. Primary tasks and purposes of the preventive medicine function (continued)**

<b>Primary Task</b>	<b>Purpose</b>
Occupational health	Provide medical surveillance examinations and screenings; health hazard education; surety programs; hearing and vision conservation and readiness; workplace epidemiological investigations; ergonomics; radiation protection; industrial hygiene; work-related immunizations; Army aviation medicine; health hazard assessment of Army materiel and equipment; medical facility safety; and workplace violence prevention.
Health surveillance and epidemiology	Provide for the deployment of occupational and environmental health surveillance, Defense Occupational and Environmental Health Readiness System, medical surveillance, Medical Protection System, and epidemiology.
Soldier, Family, community (public) health, and health promotion	Provide Soldier health (to include Soldier medical and dental readiness), Family and community (public) health (to include childhood lead poisoning prevention and Family safety), and health promotion programs and services (to include tobacco use cessation, substance abuse prevention, and suicide prevention).
Preventive medicine toxicology	Provide toxicological assessments of potentially hazardous materials, toxicity clearances for Army chemicals and materiel, and toxicologically-based assessments of health risks.
Preventive medicine laboratory services	Provide laboratory certification and accreditation, quality control and quality management, and the Department of Defense Cholinesterase Monitoring Program.
Health risk assessment	Provide capabilities and activities necessary to identify and evaluate a health hazard and to determine the associated health risk (probability of occurrence and resulting outcome and severity) from potential exposure to the hazard.
Health risk communication	Provide capabilities and activities necessary to identify the personnel affected by potential or actual health and safety threats, to determine the interests and concerns that those personnel have about the threats, and to develop strategies for effectively communicating the complexities and uncertainties associated with their health risk.

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## Chapter 11

# Veterinary Services

The veterinary mission is to execute veterinary service support essential for FHP and to project and sustain a healthy and medically protected force; train, equip, and deploy the veterinary force; and promote the health of the Soldier.

### SECTION I — VETERINARY SERVICES

11-1. The U.S. Army Veterinary Service is the executive agent for veterinary support to all DOD Services with the exception of food inspection on USAF installations. Appropriate veterinary units provide this support. These units can be task-organized to support food safety and quality assurance and the medical care mission for military working dogs and other government-owned animals. Services include sanitary surveillance for food source and storage facilities, procurement, and surveillance and examination of foodstuffs for safety and quality assurance. The U.S. Army Veterinary Service is responsible for publishing a directory of approved food sources for the area of operations. Veterinary preventive medicine provides an effective combat multiplier through monitoring endemic (animal) disease threats of military significance. The animal medical care mission provides complete medical care for military working dogs and other government-owned animals located in the AO. The potential of foodborne disease, the threat of CBRN contamination of subsistence, the need to assess the zoonotic disease threat, and the need to provide animal medical care to military working dogs requires a veterinary presence throughout the entire AO. Comprehensive veterinary medical and surgical programs are required to maintain the health of military working dogs. See DODD 6400.4 for additional information.

### PRIMARY TASKS

11-2. Table 11-1 discusses the primary tasks and purposes of the veterinary services function.

**Table 11-1. Primary tasks and purposes of the veterinary services function**

<i>Primary Task</i>	<i>Purpose</i>
Animal medical care	Provide medical care for military working dogs and other government-owned animals.
Food protection	Ensure quality, food safety, and food defense of food sources for deployed forces.
Veterinary preventive medicine	Reduce transmission of zoonotic diseases transmissible to man.

### SECTION II — FOOD PROTECTION MISSION

11-3. The food inspection mission encompasses all services performed to include—

- Conducting sanitary audits of commercial food establishments to identify approved food sources for Class A rations.
- Conducting sanitation inspections audit of food processing facilities for either commercial or military food production/processing and storage facilities (including block and packaged ice, bottled water, baked goods, fresh fruits and vegetables, seafood, eggs, poultry, pork, red meat, and dairy products).
- 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 receipt and inspection at issue of operational and other government-owned subsistence intended for consumption or use by DOD personnel.
- Providing basic food microbiological and chemical surveillance of military food supply (to include performing rapid, presumptive laboratory testing [screening and surveillance] for microbial contaminants, pesticides and toxins, and other hidden contaminants [radioactive isotopes, polychlorinated biphenyls, petroleum by-products] in the food supply).
- Providing assessment and guidance on temperature-abused foods.
- Conducting periodic 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.

### **SECTION III — ANIMAL CARE MISSION**

11-4. The animal care mission for government-owned animals 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 Soldiers in an OE. The major difference is there are very few organic veterinary assets in the BCT. The majority of veterinary assets in the AO are assigned to EAB veterinary units and must be projected forward to provide care in the brigade area.

## **VETERINARY ROLE 1 MEDICAL CARE**

11-5. This role of veterinary medical care is provided by an animal care specialist.

### **ANIMAL HANDLER**

11-6. Nonveterinary personnel, such as military working dog, 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.

### **ANIMAL CARE SPECIALIST**

11-7. 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 diseases transmitted from animal to man and comprehensive care for government-owned animals.

### **CAPABILITIES**

11-8. Veterinary Role 1 medical care includes—

- Providing routine daily care for animals in veterinary treatment or research and development facilities or field units.
- Obtaining medical history from handlers and measuring and recording animal vital signs.
- Performing physical examinations to detect obvious abnormalities and reporting findings to the veterinarian.
- Positioning and restraining animals for examination and treatment.
- 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 treatment area (to include operating room and equipment).

- Assisting the veterinarian in surgical procedures and assisting in performing euthanasia when instructed by veterinarian. In the event a veterinarian is not present, an animal care specialist is trained to perform lifesaving measures to stabilize the patient for transport/evacuation and further care by a veterinarian. Lifesaving measures include maintaining the airway, controlling bleeding, preventing and controlling shock, and splinting or immobilizing fractures.
- Cleaning, debriding, and suturing superficial wounds.
- Collecting, preserving, and preparing blood, urine, feces, skin, and postmortem specimens for shipment and evaluation.
- Performing routine diagnostic laboratory tests such as fecal smears, urinalysis, blood counts, and chemistries and recording laboratory test results.
- Coordinating and stabilizing military working dogs, horses, livestock, and marine mammals for evacuation to veterinary field unit or treatment facility. Performing frequent monitoring of vital signs and collecting of fluids (blood, urine, saliva, and feces) for further evaluation.
- Conducting minor sick call by the animal care specialist 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 disease and nonbattle injury (such as heat/cold injuries, bloat, arthropod/reptile bites/stings, vomiting/diarrhea, and so forth).
- Performing routine preventive care for 18 to 24 dogs and emergency care for up to 6 dogs and kennel inspection support for units in the supported area.

11-9. Veterinary Role 1 medical care is provided by the animal care specialist and veterinarian assigned individually to various U.S. Army, USAF, U.S. Marine Corps, or USN field units or veterinary service support teams. Either the animal care specialist or veterinarian will respond to the emergency call of a military working dog, horse, livestock, 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 and treatment at either a forward-deployed veterinary Role 2 veterinary service support team, veterinary Role 3 medical care performed by a veterinary medicine and surgical team, or veterinary Role 4 medical 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 medical care at the point of injury/illness.

## VETERINARY ROLE 2 MEDICAL CARE

11-10. 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) and includes veterinarian-directed resuscitation and stabilization and may include advanced trauma management, emergency medical procedures, and forward emergency resuscitative surgery for dogs, horses, livestock, and USN marine mammals. This role provides care for up to ten military working dogs. There are five veterinary service support teams in a medical detachment (veterinary service support).

11-11. Veterinary Role 2 medical care includes—

- Basic veterinary laboratory: microscopic examination, packed cell volume, serum total protein, and urinalysis.
- Limited veterinary pharmacy.
- Limited temporary military working dog holding facilities for basic medical disease treatment.
- Sick call.
- Routine preventive care.
- Nonemergent surgical care.
- General anesthesia for emergency medical procedures (such as bloat).

- 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.

11-12. 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 patient holding capability is available for ten military working dogs and a veterinary medicine and surgical team can care for up to 50 dogs for up to 72 hours with significant degradation of other aspects of the veterinary mission.

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*Note.* There are no kennels at veterinary Role 2 or Role 3. The military working dog handler is expected to stay with his dog. Each military working dog handler has a crate for his dog. Dogs can sleep or rest in their crate on the ground. The horse, livestock, or USN marine mammal handler is also expected to stay with his animal.

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## VETERINARY ROLE 3 MEDICAL CARE

11-13. 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 AO for horses, livestock, 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.

11-14. Veterinary Role 3 medical care includes referral for veterinary diagnostic, therapeutic, and surgical procedures. Veterinary care administered at this veterinary role of care requires advanced clinical capabilities. At veterinary Role 3, capability exists to provide care for 50 to 200 military working dogs. There is one veterinary medicine and surgical team per medical detachment (veterinary service support).

11-15. 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 military working dog dental care to include endodontic procedures.
- Area of operations-wide patient tracking of military working dogs to include evacuation.
- Established AO military working dog evacuation policy and standards of care.
- Training for veterinarians and animal care specialists.
- Development of the AO policies for care of government-owned animals.
- Treatment, return to duty, or hospitalization of military working dogs for continued care or stabilization of military working dogs for transport/evacuation to veterinary Role 4 medical care.

11-16. The veterinary medicine and surgical team is staffed and equipped to hospitalize up to five military working dogs in accordance with the military working dog evacuation policy.

## VETERINARY ROLE 4 MEDICAL CARE

11-17. Veterinary Role 4 medical care is found in CONUS at the DOD Military Working Dog Center and outside CONUS at the Dog Center, Europe and the Dog Center, Pacific. 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 PREVENTIVE MEDICINE**

11-18. Veterinary preventive medicine includes the aspects of the prevention and mitigation of the effects of foodborne disease and the prevention of zoonotic diseases transmissible to man. It also provides guidance on decontamination for U.S.-owned equipment being retrograded to CONUS and on multinational forces to prevent the transmission of animal diseases, and advises the commander on foreign animal disease that may affect redeployment of military equipment back to the U.S. with the Department of Agriculture, other disease vectors, and other pathogens that pose a hazard to U.S. agriculture or present a hazard to humans. Specific services include—

- Support for prevention and control programs to protect Soldiers from foodborne diseases.
- Evaluation of zoonotic disease data collected in the AO and advice to preventive medicine elements and higher headquarters on potential hazards to humans.
- Establishment of animal disease prevention and control programs to protect Soldiers 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.
- Performance of investigations of unexplained animal deaths to include livestock and wildlife.

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## Chapter 12

# 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 — RESPONSIBILITIES

12-1. 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. 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.

### SECTION II — PROGRAM AND RESOURCES

## COMBAT AND OPERATIONAL STRESS CONTROL RESOURCES

### BRIGADE COMBAT TEAMS

12-2. 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)

12-3. 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

12-4. 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, 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

12-5. Table 12-1 discusses the primary tasks of the COSC function. Table 7-4 discusses the primary tasks of BH/neuropsychiatric treatment.

**Table 12-1. Primary tasks and purposes of the combat and operational stress control function**

<b>Primary Task</b>	<b>Purpose</b>
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 a Soldier's mental state renders him at risk to himself or others or may affect his ability to carry out his 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.



## Chapter 13

# Dental Services and Laboratory Services (Area Medical Laboratory Support)

Preventive dentistry incorporates primary, secondary, and tertiary preventive measures taken to reduce or eliminate conditions that may decrease a Soldier's fitness to perform his mission and which could result in the Soldier being removed from his unit for treatment. 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 AO, not individual patient care.

## SECTION I — DENTAL SERVICES

### PREVENTIVE DENTISTRY

13-1. 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. Preventive dentistry incorporates primary, secondary, and tertiary preventive measures.

13-2. See paragraphs 7-7 through 7-17 of this publication for information on the treatment aspects of dental services.

### PRIMARY TASKS

13-3. Table 13-1 discusses the primary tasks of preventive dentistry. Table 7-3 discusses the remaining primary tasks and purposes of the dental services function.

**Table 13-1. Primary tasks and purposes of preventive dentistry**

<b>Primary Task</b>	<b>Purpose</b>
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 — AREA MEDICAL LABORATORY

### SPECIALIZED THEATER LABORATORY

13-4. 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.

13-5. 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 public health Level 4 field 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) 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.

13-6. The AML is organized into three teams consisting of the following:

- The staff (headquarters) section provides mission command 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 agents analysis using multiple methodologies, provides identification of endemic disease agents, and supports animal pathology and endemic disease surveillance.
- The occupational and environmental health 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.

### PRIMARY TASKS

13-7. Table 13-2 discusses the primary tasks of the operational medical laboratory function performed by the area medical laboratory. The primary tasks of the clinical laboratory function are discussed in Table 7-5.

**Table 13-2. Primary tasks and purposes of the operational medical laboratory function performed by the area medical laboratory**

<b><i>Primary Task</i></b>	<b><i>Purpose</i></b>
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 occupational and environmental health hazards and endemic diseases.
Special environmental control and containment	Evaluate biomedical specimens for the presence of highly infectious or hazardous agents of operational concern.
Data and data analysis	Support medical analyses and operational decisions.
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.

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## Source Notes

This is the source used for historical purposes that is cited in this publication. It is listed by page number.

7-1 FM 3-0, Operations, (Washington, DC: Department of Defense, 27 February 2008).

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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 this publication 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

<b>ABCA</b>	American, British, Canadian, Australian, and New Zealand (Armies)
<b>ADP</b>	Army doctrine publication
<b>ADRP</b>	Army doctrine reference publication
<b>AHS</b>	Army Health System
<b>AMEDD</b>	Army Medical Department
<b>AML</b>	area medical laboratory
<b>AO</b>	area of operations
<b>AR</b>	Army regulation
<b>ATTN</b>	attention
<b>BCT</b>	brigade combat team
<b>BH</b>	behavioral health
<b>CA</b>	civil affairs
<b>CBRN</b>	chemical, biological, radiological, and nuclear
<b>CONUS</b>	continental United States
<b>COSC</b>	combat and operational stress control
<b>CSH</b>	combat support hospital
<b>DA</b>	Department of the Army
<b>DD</b>	Department of Defense
<b>DOD</b>	Department of Defense
<b>DODD</b>	Department of Defense directive
<b>DODI</b>	Department of Defense instruction
<b>EAB</b>	echelons above brigade
<b>EPW</b>	enemy prisoner of war
<b>FHP</b>	force health protection
<b>FM</b>	field manual
<b>FST</b>	forward surgical team
<b>GC</b>	Geneva Convention Relative to the Protection of Civilian Persons in Time of War

<b>GPW</b>	Geneva Convention Relative to the Treatment of Prisoners of War
<b>GTA</b>	graphic training aid
<b>GWS</b>	Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field
<b>GWS SEA</b>	Geneva Convention for the Amelioration of the Condition of the Wounded, Sick, and Ship-wrecked Members of the Armed Forces at Sea
<b>HSS</b>	health service support
<b>JP</b>	joint publication
<b>MEDBDE (SPT)</b>	medical brigade (support)
<b>MEDCOM (DS)</b>	medical command (deployment support)
<b>MEDLOG</b>	medical logistics
<b>MHS</b>	Military Health System
<b>MMB</b>	medical battalion (multifunctional)
<b>MTF</b>	medical treatment facility
<b>NATO</b>	North Atlantic Treaty Organization
<b>NCO</b>	noncommissioned officer
<b>OE</b>	operational environment
<b>OEH</b>	occupational and environmental health
<b>OPLAN</b>	operation plan
<b>OPORD</b>	operation order
<b>POW</b>	prisoner of war
<b>S-1</b>	personnel staff officer
<b>S-2</b>	intelligence staff officer
<b>S-3</b>	operations staff officer
<b>S-4</b>	logistics staff officer
<b>S-6</b>	signal staff officer
<b>SJA</b>	staff judge advocate
<b>SOP</b>	standard operating procedure
<b>STANAG</b>	standardization agreement
<b>TC3</b>	tactical combat casualty care
<b>TM</b>	technical manual
<b>TOE</b>	table of organization and equipment
<b>U.S.</b>	United States
<b>USAF</b>	United States Air Force



<b>USAMEDCOM</b>	United States Army Medical Command
<b>USAMEDDC&amp;S</b>	United States Army Medical Department Center and School
<b>USN</b>	United States Navy

## SECTION II — TERMS

### **\*advanced trauma management**

Resuscitative and stabilizing medical or surgical treatment provided to patients to save life or limb and to prepare them for further evacuation without jeopardizing their well-being or prolonging the state of their condition.

### **\*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. Army Health System includes all mission support services performed, provided, or arranged by the Army Medical Department 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**

Nonmedical units use this to refer to the movement of casualties aboard nonmedical vehicles or aircraft without en route medical care.

### **\*collection point(s) (patient or casualty)**

A specific location where casualties are assembled to be transported to a medical treatment facility. It is usually predesignated and may or may not be staffed.

### **\*combat and operational stress control**

A coordinated program for the prevention of and actions taken by military leadership to prevent, identify, and manage adverse combat and operational stress reactions in units.

### **\*combat lifesaver**

A nonmedical Soldier trained to provide enhanced first aid as a secondary mission. Normally, one member of each squad, team, or crew is trained.

### **\*continuity of care**

Attempt to maintain the role of care during movement between roles at least equal to the role of care at the originating role.

### **\*definitive care**

(1) That care which returns an ill or injured Soldier to full function, or the best possible function after a debilitating illness or injury. Definitive care 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 Dengue fever, to multiple surgeries and full rehabilitation with a prosthesis at a continental United States medical center or Department of Veterans Affairs hospital after a traumatic amputation.  
(2) That treatment required to return the Service member to health from a state of injury or illness. The Service member's disposition may range from return to duty to medical discharge from the military. It can be provided at any role depending on the extent of the Service member's injury or illness. It embraces those endeavors which complete the recovery of the patient.

### **\*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 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.

**\*essential care**

Medical care and treatment within the theater of operations and which is mission, enemy, terrain and weather, troops and support available, time available, and civil considerations-dependent. It includes first responder care, initial resuscitation and stabilization as well as treatment and hospitalization. Forward care may include stabilizing surgery to ensure the patient can tolerate further evacuation as well as en route care during evacuation. The objective is to either return the patient to duty within the theater evacuation policy, or to begin initial treatment required for optimization of outcome.

**\*first aid (self-aid/buddy aid)**

Urgent and immediate lifesaving and other measures which can be performed for casualties (or performed by the victim himself) by nonmedical personnel when medical personnel are not immediately available.

**\*force health protection**

(Joint) Measures to promote, improve, or conserve the mental and physical well-being of Service members. These measures enable a healthy and fit force, prevent injury and illness, and protect the force from health hazards. (JP 4-02) (Army) Force health protection encompasses measures to promote, improve, conserve or restore the mental or physical well-being of Soldiers. These measures enable a healthy and fit force, prevent injury and illness, and protect the force from health hazards. These measures also include the prevention aspects of a number of Army Medical Department functions (preventive medicine, including medical surveillance and occupational and environmental health surveillance; veterinary services, including the food inspection and animal care missions, and the prevention of zoonotic disease transmissible to man; combat and operational stress control; dental services [preventive dentistry]; and laboratory services [area medical laboratory support]).

**\*forward resuscitative surgery**

Urgent initial surgery required to render a patient transportable for further evacuation to a medical treatment facility staffed and equipped to provide for the patient's care.

**\*health service support**

(Joint) All services performed, provided, or arranged to promote, improve, conserve, or restore the mental or physical well-being of personnel. These services include, but are not limited to the management of health services resources, such as manpower, monies, and facilities; preventive and curative health measures; evacuation of the wounded, injured, or sick; selection of the medically fit and disposition of the medically unfit; blood management; medical supply, equipment, and maintenance thereof; combat and operational stress control and medical, dental, veterinary, laboratory, optometry, nutrition therapy, and medical intelligence services. (JP 4-02) (Army) Health service support encompasses all support and services performed, provided, and arranged by the Army Medical Department to promote, improve, conserve, or restore the mental and physical well-being of personnel in the Army. Additionally, as directed, provide support in other Services, agencies, and organizations. This includes casualty care (encompassing a number of Army Medical Department functions—organic and area medical support, hospitalization, the treatment aspects of dental care and behavioral/ neuropsychiatric treatment, clinical laboratory services, and treatment of chemical, biological, radiological, and nuclear patients), medical evacuation, and medical logistics.

**\*hospital**

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. A hospital may, in addition, discharge the functions of a clinic.

**\*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.

**\*lines of patient drift**

Natural routes along which wounded Soldiers may be expected to go back for medical care from a combat position.

**mass casualty**

Any large number of casualties produced in a relatively short period of time, usually as the result of a single incident such as a military aircraft accident, hurricane, flood, earthquake, or armed attack that exceeds local logistic support capabilities. (JP 4-02)

**\*medical evacuation**

The process of moving any person who is wounded, injured, or ill to and/or between medical treatment facilities while providing en route medical care.

**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) 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.

**\*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.

**\*patient**

A sick, injured or wounded Soldier who receives medical care or treatment from medically trained personnel.

**\*patient estimates**

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.

**\*patient movement**

The act of moving a sick, injured, wounded, or other person to obtain medical and/or dental care or treatment. Functions include medical regulating, patient evacuation, and en route medical care.

**\*preventive medicine**

The anticipation, prediction, identification, prevention, and control of communicable diseases (including vector-, food-, and waterborne diseases), illnesses, injuries, and diseases due to exposure to occupational and environmental threats, including nonbattle injury threats, combat stress responses, and other threats to the health and readiness of military personnel and military units.

**\*resuscitative care**

Advanced trauma management care and surgery limited to the minimum required to stabilize a patient for transportation to a higher role of care.

**\*return to duty**

A patient disposition which, after medical evaluation and treatment when necessary, returns a Soldier for duty in his unit.

**\*stabilized patient**

(1) Patient may require emergency intervention, but not surgery, within the next 24 hours. The patient's condition is characterized by a secure airway, control or absence of hemorrhage, shock adequately treated, vital signs stable, and major fractures immobilized. Stabilization is a precondition of extended duration evacuation (up to 24 hours). This includes, but is not limited to: (a) Ventilator. (b) Physiologic monitors. (c) Skull free of air or functioning drains in place. (d) Chest tube functional or x-ray free of pneumothorax. (e) Oxygen requirement is acceptable. (f) Functioning nasogastric tube or absence of ileus. (g) Bone fixator is acceptable. (h) Plaster bi-valved. (i) Pulses present after vascular repair. Despite these definitive example characteristics, there are patients who do not fit these descriptions, and yet may be considered stabilized—as always, this clinical decision is decided on between the originating and receiving physicians. (2) Patient whose condition may require emergency interventions within the next 24 hours. The patient's condition is characterized by a minimum of a secured airway, control or absence of hemorrhage, treated shock, and immobilized fractures. Stabilization is a necessary precondition for further evacuation. (3) A patient whose airway is secured, hemorrhage is controlled, shock is treated, and fractures are immobilized.

**strategic aeromedical evacuation**

That phrase of evacuation that provides airlift for patients from a theater to another theater or the continental United States. (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).

**\*theater evacuation policy**

A command decision indicating the length in days of the maximum period of noneffectiveness that patients may be held within the command for treatment. Patients that, in the opinion of a responsible medical officer, cannot be returned to duty status within the period prescribed are evacuated by the first available means, provided the travel involved will not aggravate their disabilities.

**\*triage**

The medical sorting of patients. The categories are: **MINIMAL (OR AMBULATORY)**—those who require limited treatment and can be returned to duty; **IMMEDIATE**—patients requiring immediate care to save life or limb; **DELAYED**—patients who, after emergency treatment, incur little additional risk by delay or further treatment; and **EXPECTANT**—patients so critically injured that only complicated and prolonged treatment will improve life expectancy.

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