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NATO SPECIAL OPERATIONS COORDINATION CENTRE



SOF MEDICAL STANDARDS AND TRAINING DIRECTIVE

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NATO SPECIAL OPERATIONS
COORDINATION CENTRE
SUPREME HEADQUARTERS
ALLIED POWERS EUROPE
B-7010 SHAPE BELGIUM



CENTRE DE COORDINATION
DES FORCES SPECIALES DE L'OTAN
GRAND QUARTIER GENERAL
DES PUISSANCES ALLIEES EN EUROPE
B-7010 SHAPE - BELGIQUE

NSCC-MED Directive 75-001

3 / October 2009

NSCC MEDICAL STANDARDS AND TRAINING DIRECTIVE

REFERENCES: A. AAP-3.0, NATO Policy for Standardization, defines common definitions of NATO Special Operations Forces (SOF) medical capability and to provide guidance to promote the highest quality, evidence-based, health care within NATO SOF.

- C. AJP-4.10A, Allied Joint Medical Support Doctrine, dated Mar 06
- D. MC 437/1, Special Operations Policy, dated 14 Jun 06
- E. AJP-3.5, Allied Joint Doctrine for Special Operations, dated 27 Jan 09
- F. AMedP-17, Training Requirements for Health Care Personnel in International Missions, dated 10 Mar 09
- G. NATO STANAG 2122, Medical Training in First-Aid, Basic Hygiene and Emergency Care (Edition 2), dated Dec 97

Status. This directive is a new publication; no previous version exists.

Purpose. The purpose of this directive is to establish common definitions of NATO Special Operations Forces (SOF) medical capability and to provide guidance to promote the highest quality, evidence-based, health care within NATO SOF.

Applicability. This directive is applicable to all nations contributing SOF to NATO operations, including all SOF assigned to conduct or participate in NATO missions and/or exercises.

Supplementation. Supplementation is authorized.

Publication Updates. This directive will be reviewed at least annually by the Office of primary responsibility (OPR)/proponent, and will be updated as and if needed. If, upon review, it is determined that no changes are required, the directive will be reissued with the date of the review and annotation of "no changes."

Proponent. The proponent for this directive is the Medical Director, NATO Special Operations Coordination Centre (NSCC) J4, SHAPE.


S P Mans
Brigadier, GBR A
Deputy Director

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INTRODUCTION

NATO Comprehensive Political Guidance forecasts a global environment of change: *“...it is and will be complex and global, and subject to unforeseeable developments.”*¹ The current and expected future global security environment presents a complex environment with irregular and unconventional threats that possess the potential to undermine international stability. Special Operations Forces (SOF) provide an inherently agile capability ideally suited to respond to this dynamic irregular environment.

Recent NATO operations have demonstrated the synergistic effects of integrated conventional forces and SOF at the strategic, operational and tactical levels across the operational continuum. Special operations differ from conventional operations in degree of physical and political risk, operational techniques and modalities of employment. SOF operations are often conducted independently or in conjunction with conventional forces. Political-military considerations often shape SOF operations requiring discreet, covert or low visibility techniques that may include operations with and through indigenous forces.

SOF elements by nature are small, agile, highly adaptable forces. SOF must be created over time; they cannot be mass produced or assimilated from scratch after a sentinel event. As a high readiness force, SOF personnel are specially selected, equipped and trained to achieve military strategic or operational objectives by unconventional military means in hostile, denied or politically sensitive areas. As such, these individuals must be physically strong and mentally resilient to conduct such complex operations.

Effective Health Service Support for NATO SOF operations is fundamental to our mission success. SOF Health Service Support is characterized by an austere structure and a limited number of personnel with enhanced medical skills. SOF Force Health Protection includes the prevention of disease, rapid treatment of the infirm, wounded or injured, medical evacuation and the eventual recovery and/or return to duty of NATO SOF's best. The provision of appropriate and visible medical support demonstrates military resolve.

Current NATO medical doctrine and policy do not address standardization and interoperability requirements of SOF medical providers, nor do they define the requirements of “enhanced medical skills.” The disciplines of military and civilian medicine are two of the most closely aligned areas of military-civilian interaction, particularly in the areas of medical law and clinical training. This relationship, and the highly specialised aspects of SOF military medicine, leads to the requirement for specialised SOF medical doctrine. SOF Health Service Support will operate within the framework of NATO combat service support structures and be compatible with NATO's logistic doctrine. However, at all levels, NATO SOF medical doctrine will derive from the specific medical principles and policies.

The purpose of this directive is to establish common definitions of NATO SOF medical capabilities and provide guidance to promote the highest quality evidence-based healthcare within NATO SOF.

¹ Endorsed by NATO Heads of State and Government, Riga, Latvia, 29 Nov 06.

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CHAPTER 1 – NATO SOF Medical Operational Requirements

“The preservation of a soldier’s health should be [the commander’s] first and greatest care.”

- George Washington

NATO SOF HEALTH SERVICE SUPPORT (HSS)

1-1. The priorities of HSS are to promote and sustain wellness, and to prevent or mitigate the effects of disease and injury by providing essential medical capabilities proximate to SOF. Effective HSS ensures NATO SOF’s ability to project military power to meet NATO’s global-political security requirements.

1-2. The standards of care applied to the battlefield have historically been based on civilian healthcare principles. These principles, while appropriate for the civilian community, often do not apply to care on the battlefield. This is compounded within NATO’s Alliance by differences in each nation’s civil medico-legal healthcare systems.

1-3. Role 1 is the primary means of HSS to NATO SOF; some nations possess critical Role 2 capabilities inherent to supporting SOF units. Reference C outlines and defines the requirements for Roles 1 through 4 within the Alliance. Current NATO doctrine defines Role 1 Medical Treatment Facilities (MTFs) as a national responsibility; as such, this has led to variance in manning, training and equipping which are essential to providing direct support to SOF operations.

1-4. SOF medical providers can include a wide range of medical and paramedical professions. Credentialed doctors/physicians and physician’s assistants (PAs) possessing emergency and primary care skill sets delivered outside of or in a pre-hospital setting are essential to providing adequate HSS. These critical capabilities continue to be a rate-limiting resource.

1-5. The feasibility of aligning dedicated credentialed medical providers to the Special Operations Task Units (SOTUs) or Groups (SOTGs) on operations is generally beyond national resourcing capabilities. Mid-level medical providers with “enhanced” medical skill sets are a solution to providing evidence-based, clinically relevant medical care across the operational continuum of NATO SOF.

NATO SOF OPERATIONAL ENVIRONMENT

1-6. NATO SOF missions and operational concepts are expeditionary in nature; they are conducted across the range of military operations from peacetime through conflict and in war, to include Article 5 collective defence or Non-Article 5 and Crisis Response Operations. NATO SOF often operate in denied areas and outside Role 1/2 supported areas without dedicated aero-medical evacuation platforms.

1-7. Special Operations medical providers and mid-level medics provide a first responder capability, extending the “Platinum 10 minutes.” SOTUs/SOTGs are specially manned, trained and equipped to adapted standard and non-standard

platforms for casualty evacuation to mitigate time-sensitive access to dedicated medical evacuation assets. NATO SOF mid-level medics at close proximity to point-of-injury enable SOF units operating in austere environments to triage, treat and evacuate casualties to the nearest host nation or Role 2/3 MTF. The time delay, transportation requirements and logistics footprint of tasking non-SOF medical units do not offer viable alternatives for SOF deploying rapidly where speed and low visibility are critical.

NATO SOF MEDICAL MISSION ESSENTIAL TASKS

1-8. NATO SOF medical essential tasks are based on NATO SOF Mission Essential Task List (METL). References D and E provide the authorization and approved definition for NATO SOF elements, and the missions they are authorized to conduct. NATO SOF METL tasks are based on the three principal tasks of SOF in the context of Allied joint operations:

- a. **Special Reconnaissance and Surveillance (SR).** SR complements national and Allied theatre intelligence collection assets and systems by obtaining specific, well-defined and time-sensitive information of strategic or operational significance. SR is a human intelligence function that places “eyes on target” in hostile, denied or politically sensitive territory.
- b. **Direct Action (DA).** DA complements NATO capabilities by attacking specific, well-defined targets of strategic and operational significance, or in the conduct of decisive tactical operations. SOF may conduct these tasks separately, supported by or in support of conventional forces.
- c. **Military Assistance (MA).** MA is a broad spectrum of measures in support of friendly or Allied forces in peace, crisis and conflict. MA can be conducted with or through friendly forces that are trained, equipped, supported or employed in varying degrees by SOF. The range of MA is thus considerable, and may vary from providing low-level military training or material assistance to the active employment of indigenous forces in the conduct of combat operations.

1-9. These METL tasks are the nexus for the subject areas and specified tasks that are essential medical skills required for SOF Soldiers, mid-level providers [Special Operations Combat Medics (SOCMs) and Special Operations Independent Duty Medics (SOIDMs)] and Special Forces medical providers. Annexes B through D outline the specified Critical Task Lists (CTLs) for SOF Soldiers and mid-level medics.

SCOPE

1-10. This directive will:

- a. Establish the baseline interoperable medical standard for training for NATO Special Operations Soldiers, SOCMs, SOIDMs, Special Operations

Credentialed Medical Providers and Senior Medical Advisors (SMAs)/SOF Command Surgeons.

b. Direct the implementation of NATO SOCM and SOIDM essential CTLs. These lists are the foundation for establishing standardization and interoperability of medical education and training requirements, validating requirements and clinical governance of the professional medical education of NATO SOF.

c. Provide the requirement and the authorization for SOCMs and SOIDMs to treat the life- and/or mission-threatening medical conditions outlined in the scope of practice (see Annexes C and D).

EXPLANATION OF TERMS

1-11. A glossary of acronyms and abbreviations used in this directive is at Annex A.

1-12. All references to masculine pronouns (e.g., “he, him, his”) in this directive refer to all service members, both male and female.

1-13. “Will”, “shall” and “must” indicate a mandatory requirement.

1-14. “Should” indicates a recommended procedure.

1-15. “May” indicates an acceptable or suggested means of accomplishment.

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CHAPTER 2 – NATO SOF Credentialed Medical Provider Standards and Training

“All living things contain a measure of madness that moves them in strange, sometimes inexplicable ways.”

*- Yann Martel
“Life of Pi”*

DEFINITION

2-1. Credentialed medical providers are subject matter experts who provide Special Operations units with the oversight and authority to develop, plan, mentor and train medical skills to SOF Soldiers, SOCMs and SOIDMs. SOF credentialed medical providers can include a wide range of medical and paramedical professions, including (but not limited to) doctors/physicians, general and sub-speciality surgeons, anaesthesiologists/anaesthetists, PAs, nurse practitioners, registered nurses, dentists, veterinarians, psychiatrists/psychologists and physical therapists.

COMPETENCIES

2-2. NATO SOF credentialed medical providers:

- a. Are designated non-combatants, as defined by the Geneva Convention.
- b. Are employed by or assigned to SOF units.
- c. Read on to operational security issues and understand operational requirements of SOF units.
- d. Must have a habitual relationship with SOF units.
- e. Must be within the SOF command structure and under operational control of SOF units.
- f. Must be operationally qualified to directly support SOF operations.
- g. Must maintain credentials and hold a current license, registration or certificate to practice medicine within their respective specialty.

(1) A license is a grant of permission to a medical professional by a recognized licensing agency of a nation or state to provide healthcare within the scope of practice for a specific healthcare discipline.

(2) In lieu of a license, when such is not available or offered, another mechanism, such as national certification or registration, serves as evidence to support practice within a specified discipline.

2-3. NATO SOF credentialed medical providers will:

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- a. Be trained as a joint medical planner and have working knowledge of SOF operational medical planning requirements.
- b. Be trained to evaluate, stabilize and evacuate expected and contingent patient populations across the SOF operational continuum.
- c. Maintain proficiency and ability to provide instruction to medical first responders, tactical combat casualty care (TCCC), preventative medicine, environmental/tropical medicine and primary and emergency care medicine.
- d. Meet all training and pre-deployment requirements outlined in Reference F, Modules 2 through 10, and Reference G. The perception of health or wellness, the delivery of care and the means of accessing care are tied to multiple complex parameters. An Area Study is essential to all pre-deployment and deployment training opportunities. A thorough review of language, culture, politics/power and religions is essential to understanding the population at risk.

2-4. NATO SOF credentialed medical providers should have additional training in:

- a. Joint Medical Operational Planning
- b. Aerospace/Flight Medicine
- c. Dive (Hyper/Hypobaric) Medicine
- d. Tropical/Environmental Medicine
- e. Survive, Evade, Resist and Escape (SERE) training

NATO SOF SENIOR MEDICAL ADVISOR/SOF COMMAND SURGEON

2-5. The SMA/SOF Command Surgeon is a special staff officer who provides medical subject matter expertise to the SOF commander. His duties, as they relate to medical standards and training, include:

- a. Planning, implementation, management and tracking of all medical training.
- b. Credentialing for all medical, dental and veterinary personnel within SOF.
- c. Management and validation of SOF medical skills sustainment training.
- d. Defining standards for medical training programs and procedures.
- e. Management of medical sustainment and proficiency training programs.

- f. Monitoring the conduct of medical training and regularly apprising SOF commander(s) of the status of the credentialing/certification progress of the medical personnel assigned to his unit.
- g. Participation in command inspection programs and assessments.
- h. Reviewing and revising annual requirements according to input from higher headquarters and subordinate units.

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CHAPTER 3 – NATO SOF Individual Medical Standards and Training

“The enemy always gets a vote.”

- Anonymous

INITIAL TRAINING REQUIREMENTS

3-1. Initial training requirements for all Soldiers assigned to or in direct support of NATO SOF will include:

- a. Requirements as outlined in Reference G (or most recent updates as they become available).
- b. Medical Training in First Aid, Basic Hygiene and Emergency Care and the SOF Individual Medical CTL (see Annex B).

3-2. It is imperative that all SOF Soldiers be cross trained as advanced medical first responders.

- a. A primary medical priority is eliminating preventable loss of life in the operational environment. The TCCC guidelines were developed to ensure SOF units suffering casualties are able to respond with actions that provide the best possible medical care consistent with the environment and good small unit tactics.
- b. TCCC guidelines are published in each edition of the Pre-Hospital Trauma Life Support (PHTLS) Manual and carry the endorsement of the American College of Surgeons Committee on Trauma and the National Association of Emergency Medical Technicians. Operational experience has validated TCCC to be highly successful in managing casualties on the battlefield.

COMPETENCIES

3-3. SOF Soldiers are:

- a. Designated combatants, as defined by the Geneva Convention.
- b. Assigned to NATO SOF and its subordinate units.
- c. Tactically trained, assessed, selected or qualified to a SOF combat standard.
- d. A graduate of SOF program of instruction, or equivalent.

3-4. SOF Soldiers will:

- a. Be proficient in SOF skill sets as defined by the NATO SOF METL, as defined within Reference E.

- b. Be proficient as an advanced first responder (see Annex B).

3-5. SOF Soldiers should complete NATO SOF advanced first responder training annually. TCCC refresher training is strongly recommended within 6 months of deployment.

NATO SOF COMMANDERS RESPONSIBILITIES

3-6. SOF commanders will ensure that all SOF Soldiers have currently prescribed individual first aid kit equipment and are trained in its use (see Annexes E and F).

CHAPTER 4 – NATO SOF Mid-level Medics Standards and Training

“The fate of the wounded rests in the hands of the one that applies the first dressing.”
- COL Nicholas Senn, MD
(1844-1908)

STANDARDS AND TRAINING

4-1. Management of medical emergencies is best accomplished by appropriately trained physicians in an emergency department setting. However, expeditionary operations are inherently in areas where modern standards of healthcare are nonexistent.

4-2. The establishment of a mid-level medical provider with an “enhanced” scope of practice, who can provide evidence-based, clinically relevant medical care across the NATO SOF operational continuum, has been identified as an operational requirement (see Reference C). The feasibility of aligning dedicated credentialed medical providers to the SOTUs/SOTGs on operations, however, is generally beyond national resourcing capabilities. As well, international variance in civil-medical health systems and medico-legal requirements for medics may not routinely authorize medics to treat non-traumatic emergencies.

4-3. Special Operations mid-level medics – SOCMs and SOIDMs – may often find themselves in austere tactical environments where evacuation of a casualty to an MTF for a medical emergency would entail either significant delays to treatment or compromise of the unit’s mission. In many SOF situations, training SOCMs and SOIDMs to treat specified medical emergencies within a scope of practice may result in both improved outcome for the individual and an improved probability of mission success.

4-4. Mid-level SOF medics provide the means of ensuring adequate HSS and Force Health Protection across the operational continuum of NATO SOF missions. The following descriptions are included to assist in understanding the capability of SOF mid-level SOF medics, to establish new NATO common definitions for “enhanced” mid-level SOF medics and to delineate the scope of practice for SOCMs and SOIDMs.

SOCM COMPETENCIES

4-5. A SOCM is a SOF medic who provides TCCC and advanced tactical medical support directly to SOF. They are credentialed to work under the direct supervision of a SOF credentialed medical provider in support of SOF operations within a scope of practice². The SOCM scope of practice is outlined in Annex C.

² A scope of practice is defined as the tasks and responsibilities associated with a profession. The scope of practice will outline sustainment training requirements, and the clinical practice of medicine to NATO beneficiaries (in deployed areas of operation and non-deployed settings), as defined by a NATO/Troop Contributing Nation (TCN) Memorandum of Understanding or Agreement (MOU/MOA).

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4-6. SOCMs are generally assigned to DA mission focused SOF units, and are able to provide MA medical mission profiles, such as Medical-Civil Action Programs (MEDCAPs) under the direct supervision of a credentialed medical provider. SOCMs are credentialed through and under the direct supervision of a SOF credentialed medical provider.

4-7. NATO SOCMs are:

- a. Designated combatant, as defined by the Geneva Convention.
- b. Trained in advanced tactical medicine as outlined in Annex C.
- c. Directly assigned or attached to SOF units, and provide direct HSS to SOTUs on operations.
- d. Trained to initially treat and sustain a casualty from point-of-injury for up to 36 hours before transfer of casualty for medical evacuation or non-standard MTF.

SOCM TRAINING

4-8. Initial training for SOCMs includes courses in:

- a. Basic human physiology
- b. Basic medical terminology
- c. Pharmacology calculations
- d. Basic math

4-9. SOCM medical skills encompass the requirements for Conventional Medics. SOCM Course content includes (but is not limited to):

- a. Basic trauma management
- b. Pre-hospital trauma management and care
- c. Basic life support
- d. Advanced cardiac life support (ACLS)
- e. Basic nursing skills
- f. Minor and invasive surgical procedures

4-10. SOCMs can directly support combat units, ambulance teams and Role 1 through 4 MTFs.

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4-11. The NATO SOCM will:

- a. Be proficient in advanced medic-level skills for trauma care and emergency cardiac care.
- b. Be proficient in TCCC.
- c. Be proficient in managing TMEs in accordance with the SOCM scope of practice in Annex C.
- d. Maintain the skill sets trained to medical first responders, advanced tactical provider, preventative medicine and environmental medicine.

4-12. In addition to Annex C, SOCMs may have an expanded scope of practice, to include additional medical skill sets as defined by the METL of the specific SOF unit to which they are assigned. SOF elements operate in a variety of environments, such as hypo/hyperbaric conditions, extremes of heat and cold, mountains or high altitude. SOTUs or SOTGs may have specific training needs and requirements based on differences in environment, location, equipment, dispersion and similar factors. The SOCM scope of practice should reflect the area of responsibility or mission specific training requirements to account for medically relevant and specific diagnosis and treatments. Examples of additional medical skill sets include (but are not limited to):

- a. Flight/aerospace medicine
- b. Combat search and rescue (CSAR)
- c. Mountaineering
- d. Dive (hypo/hyperbaric) medicine
- e. Arctic medicine
- f. Tropical medicine

NATO SOCM SUSTAINMENT TRAINING

4-13. Modern medicine is rapidly advancing. Medical diagnostics, treatments, invasive techniques/procedures and pharmacology continue to rapidly evolve. This, coupled with the perishable nature of medical knowledge and skills, sets the requirement for robust, realistic medical sustainment training programs.

4-14. Medical sustainment training programs should include a broad spectrum of primary and emergency medical care techniques. Preventative medicine, chemical, biological, radiological, nuclear and high yield explosives (CBRNE) trauma, advanced trauma, pharmacology and invasive surgical and anaesthesia techniques are also essential elements of medical sustainment training.

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4-15. NATO SOCM sustainment training should:

- a. Encompass requirements to maintain SOCM-level skills for trauma care and emergency cardiac care as defined within the scope of practice in Annex C.
- b. Encompass requirements to maintain proficiency in TCCC in (Annexes E and F).
- c. Encompass requirements to maintain proficiency in additional skill sets as defined by the METL for a specific SOF unit.
- d. Provide realistic casualty management. Scenarios from point-of-injury through first stabilization surgery should be exercised. Exercises should consume medical supplies, provide personnel reporting and accountability and use CIS systems in simulated environments.
- e. Be incorporated as a portion of all SOTU/SOTG training events.

NATO SOCM RECERTIFICATION

4-16. Recertification will be accomplished by completing all of the SOCM sustainment training requirements.

4-17. SOCMs should not exceed more than 2 years between completion of SOCM medical sustainment training requirements.

4-18. Each nation should develop standard operating procedures (SOPs) to address training intervals.

NATO SOIDM COMPETENCIES

4-19. The SOIDM is authorized by their national authority to provide medical care independent from the presence of a credentialed medical doctor/physician or dentist while deployed in an operational environment within the SOIDM scope of practice. The SOIDM's scope of practice is outlined in Annex D.

4-20. Within the SOIDM's scope of practice, a SOIDM is able to provide full mission support to SOF METLs (SR, DA and MA). SOIDMs are credentialed through and under the supervision of a SOF credentialed medical provider.

4-21. NATO SOIDMs are:

- a. Designated combatants, as defined by the Geneva Convention.
- b. Medical subject matter experts (SMEs) directly assigned to a SOTU or SOTG.

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- c. Tactically trained, assessed, selected or qualified to a SOF combat standard.
- d. A graduate of a SOIDM program of instruction or equivalent, who has passed a certification examination or equivalent, as outlined in Annex D.
- e. Trained to initially treat and sustain a casualty from point-of-injury for up to 72 hours before transfer of casualty for medical evacuation or non-standard MTF.

SOIDM TRAINING

4-22. Initial training for SOIDMs includes courses in:

- a. Basic human anatomy
- b. Basic human physiology
- c. Basic medical terminology
- d. Pharmacology calculations
- e. Basic math

4-23. SOIDMs' medical skills encompass what is required for SOCMs (Annex C). SOIDM course content usually includes (but is not limited to):

- a. Basic trauma management
- b. Pre-hospital trauma management and care
- c. ATLS
- d. Basic life support
- e. ACLS
- f. Tropical medicine
- g. Practical laboratory skills
- h. Inpatient/post-operative nursing skills
- i. Minor and invasive surgical procedures
- j. Didactics and clinical rotations in primary and emergency care medicine

4-24. SOIDMs can directly support conventional combat units, ambulance teams and Role 1 through 4 MTFs.

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4-25. The NATO SOIDM will:

- a. Hold enhanced medic-level skills for trauma care and emergency cardiac care.
- b. Be proficient in TCCC.
- c. Be proficient in managing tactical medical emergencies (TMEs) in accordance with the SOIDM's scope of practice in Annex D.
- d. Maintain the skill set trained to medical first responders, advanced tactical provider, preventative medicine, environmental/tropical medicine, primary and emergency care medicine.

4-26. The perception of health or wellness, the delivery of care and the means of accessing care are tied to multiple complex parameters. An area study is essential to all pre-deployment and deployment training opportunities. A thorough review of language, culture, politics/power and religions is essential to understanding the population at risk.

4-27. In addition to Annex D, NATO SOIDMs may have an expanded scope of practice, to include additional medical skill sets as defined by the METL of the specific SOF unit. SOF elements operate in a variety of environments, such as hypo/hyperbaric conditions, extremes of heat and cold, mountains or high altitude. SOTUs or SOTGs may have specific training needs and requirements based on differences in environment, location, equipment, dispersion and similar factors. The SOIDM scope of practice should reflect the area of responsibility or mission specific training requirements to account for medically relevant and specific diagnosis and treatments. Examples of additional medical skill sets include (but are not limited to):

- a. Flight/aerospace medicine
- b. CSAR
- c. Mountaineering
- d. Dive (hypo/hyperbaric) medicine
- e. Arctic medicine
- f. Tropical medicine

NATO SOIDM SUSTAINMENT TRAINING

4-28. Modern medicine is rapidly advancing. Medical diagnostics, treatments, invasive techniques/procedures and pharmacology continue to rapidly evolve. This, coupled with the perishable nature of medical knowledge and skills, sets the requirement for robust, realistic medical sustainment training programs.

4-29. Medical sustainment training programs should include a broad spectrum of primary and emergency medical care techniques, basic and ATLS, basic life support, ACLS, inpatient/post-operative nursing skills, minor and invasive surgical procedures. Preventative medicine, environmental/tropical medicine, practical laboratory skills, CBRNE, advanced trauma, pharmacology, invasive surgical and anaesthesia techniques and didactics and clinical rotations in primary and emergency care medicine are also essential elements of medical sustainment training to encompass the expanded scope of practice of the SOIDMs.

4-30. NATO SOIDM sustainment training should:

- a. Encompass requirements to maintain SOIDM-level skills for advanced trauma and emergency cardiac care, laboratory services and primary care as defined within the scope of practice in Annex D.
- b. Encompass requirements to maintain proficiency in TCCC (Annexes E and F).
- c. Encompass requirements to maintain proficiency in additional skill sets as defined by the METL for a specific SOF unit.
- d. Provide realistic casualty management. Scenarios from point-of-injury through first stabilization surgery should be exercised. Exercises should consume medical supplies, provide personnel reporting and accountability and use CIS systems in simulated environments.
- e. Be incorporated as a portion of all SOTU/SOTG training events.

NATO SOIDM RECERTIFICATION

4-31. Recertification will be accomplished by completing all of the requirements listed in SOIDM sustainment training requirements.

4-32. SOIDMs should not exceed more than 2 years between completion of SOIDM medical sustainment training requirements.

4-33. Each nation should develop SOPs to address training intervals.

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GLOSSARY

ACRONYM	DEFINITION
AAP	Allied Administrative Publication
ABO	Type A, B and O blood antigen sub-groups
ACO	Allied Command Operations
ACLS	Advanced Cardiac Life Support
ACT	Allied Command Transformation
AGE	Air-Gas Embolism
AIDS	Acquired Immune Deficiency Syndrome
AJP	Allied Joint Publication
AMedP	Allied Medical Publication
ATCN©	Advanced Trauma Care for Nurses
ATLS	Advanced Trauma Life Support
BLS	Basic Life Support
BLS-C	Basic Life Support for Health Care Providers
CBRNE	Chemical, Biological, Radiological, Nuclear and High Yield Explosives
CJFSOCC	Combined Joint Forces Special Operations Component Command
CIS	Communications and Information Systems
CoTCCC	Committee on Tactical Combat Casualty Care
CPR	Cardiopulmonary Resuscitation
CSAR	Combat Search and Rescue
CTL	Critical Task List
DA	Direct Action
DS	Direct Support
EMT	Emergency Medical Technician
EMT-P	Emergency Medical Technician - Paramedic
ER	Extended Release
FHP	Force Health Protection
JFC	Joint Force Command (e.g., JFC Brunssum or JFC Naples) Joint Force Commander
HCG	Human Chorionic Gonadotropin
HIV	Human Immunodeficiency Virus
HSS	Health Service Support
IFAK	Individual First Aid Kit
IO	Intraosseous
IM	Intramuscular
IV	Intravenous
LMA	Laryngeal Mask Airway
LR	Lactated Ringers
MA	Military Assistance
MACE	Military Acute Concussion Evaluation

ACRONYM	DEFINITION
MC	Military Committee
MEDAD	Medical Advisor/Surgeon
MEDCAP	Medical Civil Action Programs
MEDEVAC	Medical Evacuation
METL	Mission Essential Task List
mg	milligram
mL	millilitre
mmHG	Millimetres of Mercury
MROE	Medical Rules of Engagement
MTF	Medical Treatment Facility
NATO	North Atlantic Treaty Organization
NMR	National Military Representative
NSAID	Non-steroidal Anti-inflammatory Drug
NSCC	NATO Special Operations Coordination Centre
OPR	Office of Primary Responsibility
OTFC	Oral Trans-mucosal Fentanyl Citrate
PA	Physician's Assistant
PASG	Pneumatic Anti-shock Garment
PEPP	Paediatric Emergencies for Pre-Hospital Providers
PG	Package
PHTLS	Pre-Hospital Trauma Life Support
PMC	Preventive Medicine Countermeasures
PO	By mouth
POI	Program of Instruction
PRBC	Packed Red Blood Cells
RBC	Red Blood Cell
Rh	Rhesus blood group antigen
ROE	Rules of Engagement
RPR	Rapid Plasma Reagin
SHAPE	Supreme Headquarters Allied Powers Europe
SACEUR	Supreme Allied Commander Europe
SOIDM	Special Operations Independent Duty Medic
SMA	Senior Medical Advisor/Command Surgeon
SMO	Senior Medical Officer
SR	Special Reconnaissance and Surveillance
STRATEVAC	Strategic Evacuation
SO	Special Operations
SOAP	Subject, Objective, Assessment, Plan
SOCM	Special Operations Combat Medic
SOF	Special Operations Forces
SOTU	Special Operations Task Unit
SOTG	Special Operations Task Group
TACEVAC	Tactical Evacuation
TB	Tuberculosis
TBI	Traumatic Brain Injury
TCCC	Tactical Combat Casualty Care
TCN	Troop Contributing Nation

ACRONYM	DEFINITION
TME	Tactical Medical Emergencies
TMEP	Tactical Medical Emergency Protocols
TNCC©	Trauma Nursing Care Course
U/I	Unit of issue
WBC	White Blood Cell

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NATO SOF INDIVIDUAL MEDICAL CRITICAL TASK LIST

1. Immediate, far-forward first aid is essential on a widely dispersed and fluid battlefield to prevent Soldiers from dying of wounds. Medical personnel may not be able to reach Soldiers at all points on the battlefield in a timely manner. Due to the operational constraints of the Joint Special Operations Area (JSOA), all NATO SOF non-medical Soldiers should be trained to provide advanced first aid/lifesaving procedures beyond the level of self-aid or buddy aid.
2. This annex establishes the NATO SOF non-medical individual scope of practice for first aid and basic hygiene. The NATO SOF non-medical Soldier is not intended to take the place of medical personnel, but to slow deterioration of a wounded Soldier's condition until medical personnel arrive. NATO SOF Soldiers' function as an Advanced First Responder is a secondary mission undertaken only when the tactical situation permits.
3. The NATO SOF Advanced First Responder program of instruction (POI) is a combination of the current medical training standards outlined in STANAG 2122, and the (USA) Combat Life Saver Course (including current TCCC guidelines). This POI is a means of standardizing NATO SOF individual medical training. The program reflects the realities of combat casualty care under the austere battlefield conditions encountered within the JSOA. The management practices used during this program are an effort to apply a tested trauma training program to a unique operational situation.
4. The individual medical CTL is shown below:
 - a. Perform first aid to clear an object stuck in the throat of a conscious casualty.
 - b. Perform first aid to prevent or control shock.
 - c. Perform first aid for burns.
 - d. Perform first aid for heat injuries.
 - e. Perform first aid for cold injuries.
 - f. Perform first aid to restore breathing and/or pulse.
 - g. Perform first aid for an open abdominal wound.
 - h. Perform first aid for an open chest wound.
 - i. Perform first aid for a bleeding and/or severed extremity.

- j. Perform first aid for a closed/open head wound.
- k. Perform first aid for a suspected fracture.
- l. Perform first aid for nerve agent injury.
- m. Transport a casualty.
- n. Practice individual Preventive Medicine Countermeasures (PMCs):
 - (1) To protect against the cold.
 - (2) To protect against the heat.
 - (3) To protect against arthropod bites and arthropod-borne diseases.
 - (4) To protect against poisonous plants and animals.
 - (5) To protect against diseases from contaminated food and water.
 - (6) To protect against diseases from human waste.
 - (7) To protect against diseases from soil and common objects.
 - (8) Maintain personal hygiene on the move.
 - (9) Maintain the proper level of nutrition.
 - (10) Take measures to resist stress.
 - (11) To protect against sexually transmitted diseases.
 - (12) To protect against AIDS.
- o. **Clinical Skills**
 - (1) Communicate with the patient.
 - (2) Document patient care using Subject, Objective, Assessment, Plan (SOAP) format.
 - (3) Perform a primary and secondary survey.
 - (4) Initiate a field medical card.
 - (5) Vital signs:

- (a) Measure a patient's respirations.
 - (b) Measure a patient's pulse.
 - (c) Measure a patient's blood pressure.
 - (d) Measure a patient's temperature.
 - (e) Measure a patient's pulse oxygen saturation.
- (6) Perform airway management:
- (a) Maintain a patient's airway.
 - (b) Insert an oropharyngeal airway.
 - (c) Insert a nasopharyngeal airway.
 - (d) Perform pulse oximetry monitoring.
 - (e) Administer oxygen therapy.
 - (f) Ventilate a patient with a bag-valve-mask system.
- (8) Perform chest decompression using needle thoracentesis.
- (9) Perform haemorrhage control:
- (a) Using a tourniquet.
 - (b) Using haemostatic agents.
 - (c) Using pressure dressings.
 - (d) Initiate a saline lock.
 - (f) Initiate an intravenous infusion.
 - (g) Manage a patient with an intravenous infusion.
 - (h) Initiate intraosseous (IO) infusion device.

TCCC

5. Approximately 90 percent of combat deaths occur on the modern battlefield before the casualties reach a MTF. Most of these deaths are not preventable (e.g., massive head injury, massive trauma to the body). About 15 percent of the casualties that die before reaching a MTF may be saved if proper measures are taken.

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6. The focus of TCCC is:
 - a. Stopping severe bleeding (haemorrhage) by the application of pressure dressings and tourniquets to stop the bleeding.
 - b. The relief of tension pneumothorax by use of needle chest decompression and a chest seal.
 - c. Maintain/restoration of the airway by opening the airway with a chin-lift or jaw-thrust manoeuvre in unconscious and spontaneously breathing casualties, insertion of a nasopharyngeal airway and placing the casualty in the recovery position are the keys to reducing preventable death on the modern battlefield.
7. TCCC has been approved by the American College of Surgeons and National Association of Emergency Medical Technicians (EMTs) and is included in the PHTLS Manual (6th edition, dated 2006).
8. **Evaluate a Casualty.** TCCC can be divided into three phases:
 - a. Care under fire is the care rendered by the individual at the scene of the injury while he and the casualty are still under effective hostile fire. Available medical equipment is limited to that carried by the Soldier or the medic in his aid bag.
 - b. Tactical field care is the care rendered by the medic once he and the casualty are no longer under effective hostile fire. It also applies to situations in which an injury has occurred, but there has been no hostile fire. Available medical equipment is still limited to that carried into the field by medical personnel. Time to evacuation to a MTF may vary considerably.
 - c. Combat casualty evacuation care is the care rendered once the casualty has been picked up by an aircraft, vehicle or boat. Additional medical personnel and equipment may have been pre-staged and available at this stage of casualty management.
9. TCCC tasks:
 - a. Perform care under fire:
 - (1) Suppress enemy fire to keep the casualty from sustaining additional wounds.
 - (2) Encourage responsive casualties to protect themselves and perform self-aid, if able.
 - (3) Administer life-saving haemorrhage control.

- (4) Transport the casualties, weapons and mission essential equipment, when the tactical situation permits.
- b. Perform tactical field care:
- (1) Check for responsiveness.
 - (2) Position the casualty and open the airway.
 - (3) Assess for breathing and chest injuries.
 - (4) Identify and controlled bleeding.
 - (5) Check for fractures.
 - (6) Check for burns.
 - (7) Administer pain medications and antibiotics, if appropriate.
 - (8) Document the casualty's injuries and treatment given on the field medical card, if applicable.
 - (9). Transport the casualty to the site where evacuation is anticipated.
- c. Monitor an unconscious casualty's airway, breathing and bleeding during casualty evacuation.
- d. Perform all necessary steps in sequence.
- e. Identify all wounds and/or conditions.

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SOCM CRITICAL TASK LIST

1. Reference C, Annex B, Glossary of Terms and Definitions, defines a “paramedic” as a *non-credentialed* medical provider who provides specialized care and treatment to patients who are either acutely ill or injured *in the pre-hospital/hospital setting*. The paramedic can administer a range of drugs and carry out certain surgical techniques.
2. To date, this term has not been added to AAP-6, NATO Glossary of Terms and Definitions, 2008. “Paramedic” is a national civilian term used to refer to a specific civilian equivalent (Emergency Medicine Technician-Paramedic), and does not adequately represent the military medic. The term “medic” used within this document is used to define the base capability for non-credentialed “paramedical professionals” as used in AAP-6, 2008 and in Reference F.
3. A SOCM is a SOF Soldier who meets all the following standards:
 - a. A designated combatant, as defined by the Geneva Convention.
 - b. Tactically trained, assessed, selected, or qualified to a SOF combat standard.
 - c. Directly assigned or attached to SOF units, and provides direct HSS to SOTUs or SOTGs on operations.
 - d. Utilized in a Role 1 environment; may be utilized at Role 1 through 4 MTFs.
 - e. Successfully completed all elements of the SOCM POI listed within this document, and possesses a current grant of permission to provide medical care from their nation, delineated within a scope of practice.
4. A SOCM is a SOF medic who provides TCCC and advanced tactical medical support directly to SOF. SOCMs are credentialed to work under the supervision of a SOF credentialed medical provider in support of SOF operations within a scope of practice. SOCMs provide direct HSS to SOTUs on operations.
5. SOCMs are trained to initially treat and sustain a casualty from point-of-injury for up to 36 hours before transfer of casualty to medical evacuation or non-standard MTF. SOCMs’ medical skill sets are based on the types of patients expected in hostile, denied or politically sensitive areas. These mission requirements are the nexus for the following list of subject areas and specific tasks which are core medical skills to be initially trained and maintained through sustainment training for SOCMs.

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4. SOCMs are generally assigned to DA-focused SOF units, units who conduct SR missions or direct SOF Role 1/2 HSS elements. SOCMs are able to support MA medical mission profiles under the direct supervision of a credentialed medical provider. SOCMs would not be expected to support MEDCAPs or medical engagements independently.
5. SOCMs should maintain medical skills in:
 - a. Preventative medicine
 - b. Advanced tactical emergency medicine
 - c. Trauma and tactical casualty management
 - d. Advanced invasive lifesaving procedures
 - e. Tactical medical evacuation using standard and non-standard assets conducted across the full range of military operations, independently or in conjunction with conventional forces
6. SOCMs' medical sustainment training programs should include a broad range of primary and emergency medical care techniques. Preventative medicine, CBRNE, advanced trauma, pharmacology and invasive surgical and anaesthesia techniques are also essential elements of medical sustainment training.
7. This directive provides the requirement and the authorization for SOCMs to treat the life and/or mission threatening medical conditions listed as TMEs, with the following provisions:
 - a. Do so only when no MTFs or credentialed medical practitioners are available within an appropriate time.
 - b. Adhere to the approved protocols unless otherwise directed by a credentialed SOF medical provider or consulting physician.
 - c. Consult with a credentialed SOF medical provider as soon as feasible.
 - d. Follow the recommended guidelines for evacuation as tactically feasible.
 - e. Document the care provided in the patient's medical record upon completion of the mission.
8. The following subject areas and tasks highlight initial and sustainment training topics for SOF medical training programs. Modern technology and lessons learned should be used to further develop and amend this task list as required.

a. Basic Sciences

- (1) Understand common medical terminology.
- (2) Understand fundamentals of anatomy and physiology.
- (3) Understand medical math and pharmaceutical calculations.
- (4) Understand the pathophysiology of medical emergencies and traumatic injuries.

b. Pharmacology

- (1) Demonstrate knowledge and use of drugs.
- (2) Manage pain.
- (3) Understand concepts of fluid and electrolyte therapy.
- (4) Understand proper administration of medications.
- (5) Understand basic pharmacological concepts.
- (6) Understand how to properly dispense medications.

c. Joint Operational Medicine

- (1) Understand the fundamentals of diving and aerospace medicine.*
- (2) Identify, assess and treat CBRNE casualties.
- (3) Understand medical mission planning:
 - (a) Understand the principles of casualty evacuation transport.
 - (b) Understand the levels of care.
 - (c) Understand the principles of medical logistics support.
 - (d) Understand the resources available for medical intelligence.
- (4) Identify and employ preventive medicine measures:
 - (a) Vector control.

*Denotes task associated with Tactical Medical Emergency Protocols (TMEP).

- (b) Field sanitation.
- (c) Water treatment and procurement.
- d. **Environmental Injuries**
 - (1) Manage a heat casualty.*
 - (2) Manage insect bites and stings.
 - (3) Manage a snakebite casualty.
 - (4) Manage a near-drowning casualty.
 - (5) Manage injuries from electrical and lightning injuries.
 - (6) Manage cold injuries.*
 - (7) Manage allergic reactions.*
 - (8) Manage high altitude illnesses.*
- e. **Tactical Medicine**
 - (1) Initial assessment and management of trauma casualties.
 - (2) Triage casualties on the battlefield.
 - (3) Identify mechanisms of injury and common complications:
 - (a) Mechanisms and complications of penetrating injury.
 - (b) Mechanisms and complications of blunt injury.
 - (c) Mechanisms and complications of blast injury.
 - (d) Mechanisms and complications of burn injury.
 - (e) Mechanisms and complications of crush injury.
 - (4) Recognize and manage specific TMEs.*
 - (5) Recognize and manage common orthopaedic injuries.
 - (6) Recognize psychiatric illnesses.
 - (a) Recognize acute psychosis.

*Denotes task associated with Tactical Medical Emergency Protocols (TMEP).

- (b) Recognition of depression and suicidal ideation.
- (c) Recognition of combat stress reaction.
- (7) Recognize mild traumatic brain injury (TBI).
- (8) Emergency cardiac care.
 - (a) Perform Basic Life Support for Health Care Providers (BLS-C).
 - (b) Perform ACLS.
 - (c) Perform Paediatric Emergencies for Pre-Hospital Providers (PEPP).
 - (d) Perform TCCC.
 - (e) Perform PHTLS.

f. **Clinical Medicine**

- (1) Detailed physical exam.
- (2) Recognition of medical emergencies.
- (3) Manage common illnesses with over the counter medications.
- (4) Diagnosis and initial management of specific medical emergencies*.
- (5) Treatment of common illnesses with over-the-counter medications.
- (6) Treatment of common sports medicine injuries.
- (7) Triage casualties on a conventional battlefield.
- (8) Trauma system and mechanism of injury.
- (9) Perform rapid assessment of trauma.
- (10) Initial assessment and management of trauma.
- (11) Advanced airway management.
- (12) Manage haemorrhagic/hypovolemic shock.
- (13) Manage trauma of the genitourinary tract.

- (14) Manage a burned casualty.
- (15) Manage head and neck trauma.
- (16) Manage thoracic trauma.
- (17) Manage abdominal trauma.
- (18) Manage spinal trauma.
- (19) Manage extremity trauma:
 - (a) Recognition and emergency treatment of open and closed fractures.
 - (b) Recognition and emergency treatment of compartment syndrome.
 - (c) Management of common dislocations.
 - (d) Recognition and emergency treatment of pelvic trauma.
 - (e) Management of traumatic amputations.

g. Clinical Skills

- (1) Communicate with the patient.
- (2) Document patient care using SOAP format.
- (3) Perform a complete physical examination.
- (4) Initiate a field medical card.
- (5) Employ sterile technique:
 - (a) Perform surgical hand and arm scrub.
 - (b) Put on sterile gown and gloves.
 - (c) Establish a sterile field.
 - (d) Perform a sterile dressing change.
- (6) Perform airway management:
 - (a) Maintain a patient's airway.
 - (b) Perform pulse oximetry monitoring.

- (c) Administer oxygen therapy.
 - (d) Ventilate a patient with a bag-valve-mask system.
 - (e) Intubate a patient.
 - (f) Employ an oesophageal intubation detector.
 - (g) Perform exhaled carbon dioxide monitoring.
- (7) Perform chest decompression.
- (a) Perform needle thoracentesis.
 - (b) Perform tube thoracostomy.
- (8) Perform haemorrhage control.
- (a) Using a tourniquet.
 - (b) Using vessel ligation.
 - (c) Using haemostatic agents.
 - (d) Using pressure dressings.
 - (e) Obtain a blood specimen using a vacutainer.
 - (f) Initiate a saline lock.
 - (g) Initiate an intravenous infusion.
 - (h) Manage a patient with an intravenous infusion.
 - (i) Initiate IO infusion device.
 - (j) Initiate sternal IO infusion device.
- (9) Perform local and regional anaesthesia.
- (10) Perform suturing.
- (11) Drain abscesses.
- (12) Remove foreign body from external auditory canal.
- (13) Perform advanced nursing skills.
- (a) Wound care management.

- (b) Perform nasogastric intubation.
 - (c) Perform urinary catheterization.
 - (d) Perform urinary catheter care.
 - (e) Measure a patient's intake and output.
- (14) Determine death.
- i. **TMEP.** The specified medical conditions and emergencies listed should have protocols that include:
- (1) Disease specific medical considerations.
 - (2) Signs/symptoms for continued observation or urgent evacuation.
 - (3) Specific medical management.
 - (4) Pharmacology:
 - (a) Medication indications.
 - (b) Alternate drug treatment options.
 - (c) Dosing.
 - (d) Contraindications.
 - (e) Pregnancy category.
 - (f) Adverse side effects.
 - (g) Adverse reactions.
 - (h) Antidote use if applicable.
 - (5) Disposition of patient.
- j. **TMEP list:***
- (1) Abdominal pain.
 - (2) Abscess.
 - (3) Allergic rhinitis/hay fever/cold-like symptoms.

* Denotes task associated with Tactical Medical Emergency Protocols (TMEP).

- (4) Altitude illness.
- (5) Anaphylactic reaction.
- (6) Asthma (reactive airway disease).
- (7) Back pain.
- (8) Barotrauma and Air-Gas Embolism (AGE).
- (9) Behavioural changes (includes psychoses, depression, suicidal impulses).
- (10) Blast injury assessment.
- (11) Bronchitis/pneumonia.
- (12) Cellulitis/abscess.
- (13) Chest pain (includes pulmonary embolus).
- (14) Constipation/fecal impaction.
- (15) Contact dermatitis.
- (16) Corneal abrasion/corneal ulcer/conjunctivitis.
- (17) Cough.
- (18) Crush syndrome.
- (19) Deep venous thrombosis (DVT).
- (20) Dehydration.
- (21) Dental pain.
- (22) Determination of death/discontinuing resuscitation.
- (23) Ear infection (includes Otitis media and Otitis externa).
- (24) Envenomation.
- (25) Epistaxis.
- (26) Flank pain (includes renal colic, pyelonephritis, kidney stones).
- (27) Fungal skin infection.

- (28) Gastroenteritis.
- (29) Headache.
- (30) Head and neck infection (includes epiglottitis and peritonsillar abscess).
- (31) HIV post-exposure prophylaxis.
- (32) Hyperthermia.
- (33) Hypothermia.
- (34) Ingrown toenail.
- (35) Joint infection.
- (36) Loss of consciousness (without seizures).
- (37) Military Acute Concussion Evaluation (MACE).
- (38) Malaria.
- (39) Meningitis.
- (40) Nausea and vomiting.
- (41) Pain management.
- (42) Seizure.
- (43) Sepsis/septic shock.
- (44) Smoke inhalation.
- (45) Spontaneous pneumothorax.
- (46) Subungual hematoma.
- (47) Testicular pain.
- (48) Tuberculosis.
- (49) Typhus.
- (50) Urinary tract infection.

SOCM ADDITIONAL SPECIFIED MISSION ESSENTIAL TASKS

9. Additional medical skill sets as may be required to provide HSS as defined by the METL of the specific SOF unit. SOF elements operate in a variety of environments, such as hypo/hyperbaric conditions, extremes of heat and cold, mountains or high altitude. SOTUs or SOTGs may have specific training needs and requirements based on differences in environment, location, equipment, dispersion and similar factors. The SOCM scope of practice should reflect the area of responsibility or mission specific training requirements to account for medically relevant and specific diagnosis and treatments. Examples of additional medical skill sets include (but are not limited to):

- a. Flight/aerospace medicine.
- b. CSAR.
- c. Mountaineering.
- d. Dive (hypo/hyperbaric) medicine.
- e. Arctic (extreme cold weather) medicine.
- f. Tropical medicine.

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SOIDM CRITICAL TASK LIST

1. A SOIDM is a SOF Soldier who meets all the following standards:
 - a. A designated combatant, as defined by the Geneva Convention.
 - b. Medical SME directly assigned to a SOTU or SOTG.
 - c. Tactically trained, assessed, selected or qualified to a SOF combat standard.
 - d. Utilized in a Role 1 environment; may be utilized at Role 1 through 4 MTFs.
 - e. Successfully completed all elements of the SOIDM's POI listed within this document, and possesses a current grant of permission from their nation to provide medical care delineated within a scope of practice.

2. A SOIDM is a Soldier trained as an advanced tactical provider with skills in preventative medicine, environmental/tropical medicine and primary and emergency care medicine. The SOIDM is authorized by their national authority to provide medical care independent from the direct supervision of a current credentialed medical physician or dentist while deployed in an operational environment. He is the medical SME directly assigned to a SOTU or SOTG on operations. SOIDMs are trained to initially treat and sustain a casualty from point-of-injury for up to 72 hours before transfer of casualty for medical evacuation.

3. SOIDMs are Special Operations Soldiers with advanced medical training. They are an essential capability integral to SOTUs. SOIDMs' enhanced medical skills allow them to conduct CSAR, en route casualty care or augment Role 1 through 4 MTFs. These mission requirements are the nexus for the following list of subject areas and specific tasks that are core medical skills to be initially trained and maintained through sustainment training.

4. SOIDMs are trained and equipped to provide full spectrum HSS for NATO SOF operations, i.e., DA, SR and MA. SOIDMs should maintain medical skills in:
 - a. Preventative medicine.
 - b. Environmental extremes/wilderness medicine.
 - c. Trauma and tactical casualty management.
 - d. Advanced invasive life saving procedures.

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- e. Tactical medical evacuation using standard and non-standard assets conducted across the full range of military operations, independently or in conjunction with conventional forces.
5. SOIDMs' medical sustainment training programs should include a broad range of primary and emergency medical care techniques, pre-hospital trauma management and care, ATLS, basic life support, ACLS, inpatient/post-operative nursing skills and minor and invasive surgical procedures. Preventative medicine, environmental/tropical medicine, practical laboratory skills, CBRNE, advanced trauma, pharmacology, invasive surgical and anaesthesia techniques and didactics and clinical rotations in primary and emergency care medicine are also essential elements of medical sustainment training to encompass the expanded scope of practice of the SOIDMs.
6. This directive provides the requirement and the authorization for SOIDMs to treat the life and/or mission threatening medical conditions listed as TMEs with the following provisions:
- a. Do so only when no medical treatment facilities or credentialed medical practitioners are available within an appropriate time.
 - b. Adhere to the approved protocols unless otherwise directed by a credentialed SOF medical provider or consulting physician.
 - c. Consult with a credentialed SOF medical provider as soon as feasible.
 - d. Follow the recommended guidelines for evacuation as tactically feasible.
 - e. Document the care provided in the patient's medical record upon completion of the mission.
7. The following subject areas and tasks highlight initial and sustainment training topics for SOIDMs' medical training programs. Modern technology and lessons learned should be used to further develop and amend this task list as required.
- a. **Basic Sciences**
 - (1) Understand common medical terminology.
 - (2) Understand fundamentals of anatomy and physiology.
 - (3) Understand medical math and pharmaceutical calculations.
 - (4) Understand the pathophysiology of medical emergencies and traumatic injuries.

b. Pharmacology

- (1) Demonstrate knowledge and use of drugs from the Tactical Medical Emergency Protocols (TMEP).
- (2) Manage pain in accordance with the TMEP.
- (3) Understand concepts of fluid and electrolyte therapy.
- (4) Understand proper administration of medications.
- (5) Understand basic pharmacological concepts.
- (6) Understand how to properly dispense medications.

c. Joint Operational Medicine

- (1) Understand the fundamentals of diving and aerospace medicine.*
- (2) Identify, assess and treat CBRNE casualties.
- (3) Understand medical mission planning:
 - (a) Understand the principles of casualty evacuation transport.
 - (b) Understand the levels of care.
 - (c) Understand the principles of medical logistics support.
 - (d) Understand the resources available for medical intelligence.
- (4) Identify and employ preventive medicine measures.
 - (a) Vector control.
 - (b) Field sanitation.
 - (c) Water treatment and procurement.

d. Environmental Injuries

- (1) Manage a heat casualty*.
- (2) Manage insect bites and stings.

* Denotes task associated with TMEP.

- (3) Manage a snakebite casualty.
- (4) Manage a near-drowning casualty.
- (5) Manage injuries from electrical and lightning injuries.
- (6) Manage cold injuries*.
- (7) Manage allergic reactions*.
- (8) Manage high altitude illnesses*.
- (9) Manage endoparasitic diseases.
- (10) Manage vector-borne diseases.

e. **Tactical Medicine**

- (1) Initial assessment and management of trauma casualties.
- (2) Triage casualties on the battlefield.
- (3) Identify mechanisms of injury and common complications:
 - (a) Mechanisms and complications of penetrating injury.
 - (b) Mechanisms and complications of blunt injury.
 - (c) Mechanisms and complications of blast injury.
 - (d) Mechanisms and complications of burn injury.
 - (e) Mechanisms and complications of crush injury.
- (4) Recognize and manage specific TMEs below*.
- (5) Recognize and manage common orthopaedic injuries.
- (6) Recognize psychiatric illnesses:
 - (a) Recognize acute psychosis.
 - (b) Recognition of depression and suicidal ideation.
 - (c) Recognition of combat stress reaction.
- (7) Recognize mild TBI.

* Denotes task associated with TMEP.

- (8) Emergency cardiac care.
 - (a) Perform BLS-C.
 - (b) Perform ACLS.
 - (c) Perform PEPP.
 - (d) Perform TCCC.
 - (e) Perform PHTLS.
 - (f) Perform Trauma Nursing Care Course (TNCC©) or Advanced Trauma Care for Nurses (ATCN©),

f. **Clinical Medicine**

- (1) Detailed physical exam.
- (2) Recognition of TMEs*.
- (3) Manage common illnesses with over-the-counter medications.
- (4) Diagnosis and initial management of specific medical emergencies*.
- (5) Treatment of common illnesses with over-the-counter medications.
- (6) Treatment of common sports medicine injuries.
- (7) Triage casualties on a conventional battlefield.
- (8) Trauma system and mechanism of injury.
- (9) Perform rapid assessment of trauma.
- (10) Initial assessment and management of trauma.
- (11) Advanced airway management.
- (12) Manage haemorrhagic/hypovolemic shock.
- (13) Manage trauma of the genitourinary tract.
- (14) Manage a burned casualty.
- (15) Manage head and neck trauma.

* Denotes task associated with TMEP.

- (16) Manage thoracic trauma.
- (17) Manage abdominal trauma.
- (18) Manage spinal trauma.
- (19) Manage extremity trauma:
 - (a) Recognition and emergency treatment of open and closed fractures.
 - (b) Recognition and emergency treatment of compartment syndrome.
 - (c) Management of common dislocations.
 - (d) Recognition and emergency treatment of pelvic trauma.
 - (e) Management of traumatic amputations.

g. **Clinical Skills**

- (1) Communicate with the patient.
- (2) Document patient care using SOAP format.
- (3) Perform a complete physical examination.
- (4) Initiate a field medical card.
- (5) Employ sterile technique:
 - (a) Perform surgical hand and arm scrub.
 - (b) Put on sterile gown and gloves.
 - (c) Establish a sterile field.
 - (d) Perform a sterile dressing change.
- (6) Perform airway management:
 - (a) Maintain a patient's airway.
 - (b) Perform pulse oximetry monitoring.
 - (c) Administer oxygen therapy.
 - (d) Ventilate a patient with a bag-valve-mask system.

- (e) Intubate a patient.
- (f) Employ an oesophageal intubation detector.
- (g) Perform exhaled carbon dioxide monitoring.
- (7) Perform chest decompression:
 - (a) Perform needle thoracentesis.
 - (b) Perform tube thoracostomy.
- (8) Perform haemorrhage control:
 - (a) Using a tourniquet.
 - (b) Using vessel ligation.
 - (c) Using haemostatic agents.
 - (d) Using pressure dressings.
 - (e) Obtain a blood specimen using a vacutainer.
 - (f) Initiate a saline lock.
 - (g) Initiate an intravenous infusion.
 - (h) Manage a patient with an intravenous infusion.
 - (i) Initiate IO infusion device.
 - (j) Initiate sternal IO infusion device.
- (9) Perform local and regional anaesthesia.
- (10) Perform suturing.
- (11) Drain abscesses.
- (12) Remove foreign body from external auditory canal.
- (13) Perform advanced nursing skills:
 - (a) Wound care management.
 - (b) Perform nasogastric intubation.
 - (c) Perform urinary catheterization.

- (d) Perform urinary catheter care.
- (e) Measure a patient's intake and output.

(14) Determine death.

j. **Laboratory**

- (1) Perform ABO grouping and confirmation tests.
- (2) Perform a Rhesus blood group antigen (Rh) typing.
- (3) Perform a cross match procedure.
- (4) Perform a rapid test for HIV, rapid plasma reagin (RPR), malaria, tuberculosis (TB), leishmaniasis, filariasis, strep throat, mono-spot.
- (5) Perform a microhematocrit determination.
- (6) Perform a urinalysis.
- (7) Perform a macroscopic examination of feces and test for occult blood.
- (8) Perform a potassium (sodium) hydroxide preparation of skin scrapings.
- (9) Perform a Giemsa stain for the presence of blood parasites.
- (10) Perform a qualitative human chorionic gonadotropin (HCG) test.
- (11) Obtain a blood specimen using a vacutainer.

k. **TMEP.** The specified emergencies listed should have protocols that include:

- (1) Disease specific medical considerations.
- (2) Signs/symptoms for continued observation or urgent evacuation.
- (3) Specific medical management.
- (4) Pharmacology:
 - (a) Medication indications.
 - (b) Alternate drug treatment options.
 - (c) Dosing.

- (d) Contraindications.
 - (e) Pregnancy category.
 - (f) Adverse side effects.
 - (g) Adverse reactions.
 - (h) Antidote use if applicable.
- (5) Disposition of patient.

I. **TMEP list***

- (1) Abdominal pain.
- (2) Abscess.
- (3) Allergic rhinitis/hay fever/cold-like symptoms.
- (4) Altitude illness.
- (5) Anaphylactic reaction.
- (6) Asthma (reactive airway disease).
- (7) Back pain.
- (8) Barotrauma and AGE.
- (9) Behavioural changes (includes psychoses, depression, suicidal impulses).
- (10) Blast injury assessment.
- (11) Bronchitis/pneumonia.
- (12) Cellulitis/abscess.
- (13) Chest pain (includes pulmonary embolus).
- (14) Constipation/fecal impaction.
- (15) Contact dermatitis.
- (16) Corneal abrasion/corneal ulcer/conjunctivitis.

* Denotes task associated with TMEP.

- (17) Cough.
- (18) Crush syndrome.
- (19) DVT.
- (20) Dehydration.
- (21) Dental pain.
- (22) Determination of death/discontinuing resuscitation.
- (23) Ear infection (includes Otitis media and Otitis externa).
- (24) Envenomation.
- (25) Epistaxis.
- (26) Flank pain (includes renal colic, pyelonephritis, kidney stones).
- (27) Fungal skin infection.
- (28) Gastroenteritis.
- (29) Headache.
- (30) Head and neck infection (includes epiglottitis and peritonsillar abscess).
- (31) HIV post exposure prophylaxis.
- (32) Hyperthermia.
- (33) Hypothermia.
- (34) Ingrown toenail.
- (35) Joint infection.
- (36) Loss of consciousness (without seizures).
- (37) MACE.
- (38) Malaria.
- (39) Meningitis.
- (40) Nausea and vomiting.

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- (41) Pain management.
- (42) Seizure.
- (43) Sepsis/septic shock.
- (44) Smoke inhalation.
- (45) Spontaneous pneumothorax.
- (46) Subungual hematoma.
- (47) Testicular pain.
- (48) Tuberculosis.
- (49) Typhus.
- (50) Urinary tract infection.

SOIDM ADDITIONAL SPECIFIED MISSION ESSENTIAL TASKS

8. Additional medical skill sets as may be required to provide HSS as defined by the METL of the specific SOF unit. SOF elements operate in a variety of environments, such as hypo/hyperbaric conditions, extremes of heat and cold, mountains or high altitude. SOTUs or SOTGs may have specific training needs and requirements based on differences in environment, location, equipment, dispersion and similar factors. The SOIDM's scope of practice should reflect area of responsibility or mission specific training requirements to account for medically relevant and specific diagnosis and treatments. Examples of additional medical skill sets include (but are not limited to):

- a. Flight/aerospace medicine.
- b. CSAR.
- c. Mountaineering.
- d. Dive (hypo/hyperbaric) medicine.
- e. Arctic (extreme cold weather) medicine.
- f. Tropical medicine.

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TACTICAL COMBAT CASUALTY CARE GUIDELINES

1. The focus of TCCC is eliminating preventable loss of life on the battlefield. The TCCC guidelines were developed to ensure SOF units suffering casualties are able to respond with actions that provide the best possible medical care consistent with the battlefield environment and good small unit tactics. TCCC guidelines are published in each edition of the PHTLS Manual and carry the endorsement of the American College of Surgeons Committee on Trauma and the National Association of Emergency Medical Technicians.
2. Reports from both SOF and conventional units have shown TCCC to be highly successful in managing casualties on the battlefield. All members of SOF units will receive TCCC training prior to deployment. Commanders are also directed to ensure all unit combatants have currently prescribed TCCC equipment and are trained in its use. Current TCCC equipment requirements will be reviewed and updated as necessary.
3. **Basic Management Plan for Care Under Fire**
 - a. Return fire and take cover.
 - b. Direct or expect casualty to remain engaged as a combatant if appropriate.
 - c. Direct casualty to move to cover and apply self-aid if able.
 - d. Try to keep the casualty from sustaining additional wounds.
 - e. Airway management is generally best deferred until the Tactical Field Care phase.
 - f. Stop *life-threatening* external haemorrhage if tactically feasible:
 - (1) Direct casualty to control haemorrhage by self-aid if able.
 - (2) Use a Committee on TCCC (CoTCCC)-recommended tourniquet for haemorrhage that is anatomically amenable to tourniquet application.*
 - (3) Apply the tourniquet proximal to the bleeding site, over the uniform, tighten and move the casualty to cover.*

* Denotes changes from the TCCC guidelines published in the 2006 PHTLS Manual, Sixth Edition.

4. Basic Management Plan for Tactical Field Care

- a. Casualties with an altered mental status should be disarmed immediately.
- b. Airway Management
 - (1) Unconscious casualty without airway obstruction:
 - (a) Chin lift or jaw thrust manoeuvre.
 - (b) Nasopharyngeal airway.
 - (c) Place casualty in recovery position.
 - (2) Casualty with airway obstruction or impending airway obstruction:
 - (a) Chin lift or jaw thrust manoeuvre.
 - (b) Nasopharyngeal airway.
 - (c) Allow casualty to assume any position that best protects the airway, to include sitting up.
 - (d) Place unconscious casualty in recovery position.
 - (e) If previous measures unsuccessful, surgical cricothyroidotomy (with lidocaine if conscious).
- c. Breathing*
 - (1) In a casualty with progressive respiratory distress and known or suspected torso trauma, consider a tension pneumothorax and decompress the chest on the side of the injury with a 14-gauge, 3.25 inch needle/catheter unit inserted in the second intercostal space at the midclavicular line. Ensure that the needle entry into the chest is not medial to the nipple line and is not directed towards the heart.*
 - (2) All open and/or sucking chest wounds should be treated by immediately applying an occlusive material to cover the defect and securing it in place. Monitor the casualty for the potential development of a subsequent tension pneumothorax.*

* Denotes changes from the TCCC guidelines published in the 2006 PHTLS Manual, Sixth Edition.

d. Bleeding*

(1) Assess for unrecognized haemorrhage and control all sources of bleeding. If not already done, use a CoTCCC-recommended tourniquet to control life-threatening external haemorrhage that is anatomically amenable to tourniquet application or for any traumatic amputation.

Apply directly to the skin 2-3 inches above wound.*

(2) For compressible haemorrhage not amenable to tourniquet use or as an adjunct to tourniquet removal (if evacuation time is anticipated to be longer than 2 hours), use combat gauze as the haemostatic agent of choice with WoundStat as the backup (if the primary agent is not successful at controlling the haemorrhage or if the wound characteristics call for a granular agent). Both agents should be applied with at least 3 minutes of direct pressure. Before releasing any tourniquet on a casualty who has been resuscitated for haemorrhagic shock, ensure a positive response to resuscitation efforts (i.e., a peripheral pulse normal in character and normal mentation if there is no TBI).*

(3) Reassess prior tourniquet application. Expose wound and determine if tourniquet is needed. If so, move tourniquet from over uniform and apply directly to skin 2-3 inches above wound. If tourniquet is not needed, use other techniques to control bleeding.*

(4) When time and the tactical situation permit, a distal pulse check should be accomplished. If a distal pulse is still present, consider additional tightening of the tourniquet or the use of a second tourniquet, side by side and proximal to the first, to eliminate the distal pulse.*

(5) Expose and clearly mark all tourniquet sites with the time of tourniquet application. Use an indelible marker.*

c. Intravenous (IV) access

(1) Start an 18-gauge IV or saline lock if indicated.

(2) If resuscitation is required and IV access is not obtainable, use the IO route.

d. Fluid resuscitation

(1) Assess for haemorrhagic shock; altered mental status (in the absence of head injury) and weak or absent peripheral pulses are the best field indicators of shock.

* Denotes changes from the TCCC guidelines published in the 2006 PHTLS Manual, Sixth Edition.

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- (2) If not in shock:
 - (a) No IV fluids necessary.
 - (b) By mouth (PO) fluids permissible if conscious and can swallow.
 - (3) If in shock:
 - (a) Hextend, 500-mL IV bolus.
 - (b) Repeat once after 30 minutes if still in shock.
 - (c) No more than 1000 mL of Hextend.
 - (4) Continued efforts to resuscitate must be weighed against logistical and tactical considerations and the risk of incurring further casualties.
 - (5) If a casualty with TBI is unconscious and has no peripheral pulse, resuscitate to restore the radial pulse.
- g. Prevention of hypothermia:
- (1) Minimize casualty's exposure to the elements. Keep protective gear on or with the casualty if feasible.
 - (2) Replace wet clothing with dry if possible.
 - (3) Apply Ready-Heat Blanket to torso.
 - (4) Wrap in Blizzard Rescue Blanket.
 - (5) Put Thermo-Lite Hypothermia Prevention System Cap on the casualty's head, under the helmet.
 - (6) Apply additional interventions as needed and available.
 - (7) If mentioned gear is not available, use dry blankets, poncho liners, sleeping bags, body bags or anything that will retain heat and keep the casualty dry.
- h. Penetrating Eye Trauma.* If a penetrating eye injury is noted or suspected:
- (1) Perform a rapid field test of visual acuity.*

* Denotes changes from the TCCC guidelines published in the 2006 PHTLS Manual, Sixth Edition.

- (2) Cover the eye with a rigid eye shield (NOT a pressure patch.)*
- (3) Ensure that the 400 mg moxifloxacin tablet in the combat pill pack is taken if possible and that IV/IM antibiotics are given as outlined below if oral moxifloxacin cannot be taken.*
 - i. Monitoring pulse oximetry should be available as an adjunct to clinical monitoring. Readings may be misleading in the settings of shock or marked hypothermia.
 - j. Inspect and dress known wounds.
 - k. Check for additional wounds.
 - l. Provide analgesia as necessary:
 - (1) Able to fight (these medications should be carried by the combatant and self-administered as soon as possible after the wound is sustained)*:
 - (a) Mobic, 15 mg PO once a day
 - (b) Tylenol, 650-mg bilayer caplet, 2 PO every 8 hours
 - (2) Unable to fight (have naloxone readily available whenever administering opiates):
 - (a) Does not otherwise require IV/IO access.
 - (b) Oral transmucosal fentanyl citrate (OTFC), 800 ug transbuccally.
 - (c) Recommend taping lozenge-on-a-stick to casualty's finger as an added safety measure.
 - (d) Reassess in 15 minutes.
 - (e) Add second lozenge, in other cheek, as necessary to control severe pain.
 - (f) Monitor for respiratory depression.
 - (g) IV or IO access obtained:
 - 1/ Morphine sulfate, 5 mg IV/IO
 - 2/ Reassess in 10 minutes.

* Denotes changes from the TCCC guidelines published in the 2006 PHTLS Manual, Sixth Edition.

- 3/ Repeat dose every 10 minutes as necessary to control severe pain.
 - 4/ Monitor for respiratory depression
 - 5/ Promethazine, 25 mg IV/IM/IO every 6 hours as needed for nausea or for synergistic analgesic effect
- m. Splint fractures and recheck pulse.
- n. Antibiotics (recommended for all open combat wounds):
- (1) If able to take PO: Moxifloxacin, 400 mg PO one a day
 - (2) If unable to take PO (shock, unconsciousness):
 - (a) Cefotetan, 2 grams IV (slow push over 3-5 minutes) or IM every 12 hours *or*
 - (b) Ertapenem, 1 grams IV/IM once a day
- o. Communicate with the casualty if possible:
- (1) Encourage; reassure.
 - (2) Explain care.
- p. Cardiopulmonary resuscitation (CPR). Note: Resuscitation on the battlefield for victims of blast or penetrating trauma who have no pulse, no ventilations and no other signs of life will not be successful and should not be attempted.
- q. Documentation of Care. Document the clinical assessments, treatments rendered and changes in the casualty's status on a TCCC Casualty Card*. Forward this information with the casualty to the next level of care.

5. Basic Management Plan for Casualty Evacuation Care

- a. Airway Management:
- (1) Unconscious casualty without airway obstruction:
 - (a) Chin lift or jaw thrust manoeuvre.
 - (b) Nasopharyngeal airway.
 - (c) Place casualty in recovery position.

* Denotes changes from the TCCC guidelines published in the 2006 PHTLS Manual, Sixth Edition.

- (2) Casualty with airway obstruction or impending airway obstruction:
- (a) Chin lift or jaw thrust manoeuvre.
 - (b) Nasopharyngeal airway.
 - (c) Allow casualty to assume any position that best protects the airway, to include sitting up.
 - (d) Place unconscious casualty in recovery position.
 - (e) If above measures unsuccessful:
 - 1/ Laryngeal Mask Airway (LMA)/intubating LMA *or*
 - 2/ Combitube *or*
 - 3/ Endotracheal intubation *or*
 - 4/ Surgical cricothyroidotomy (with lidocaine if conscious)

(3) Spinal immobilization is not necessary for casualties with penetrating trauma.

b. Breathing:

- (1) In a casualty with progressive respiratory distress and known or suspected torso trauma, consider a tension pneumothorax and decompress the chest on the side of the injury with a 14-gauge, 3.25 inch needle/catheter unit inserted in the second intercostal space at the midclavicular line. Ensure that the needle entry into the chest is not medial to the nipple line and is not directed towards the heart.*
- (2) Consider chest tube insertion if no improvement and/or long transport is anticipated.
- (3) Most combat casualties do not require supplemental oxygen, but administration of oxygen may be of benefit for the following types of casualties:
- (a) Low oxygen saturation by pulse oximetry
 - (b) Injuries associated with impaired oxygenation
 - (c) Unconscious casualty

* Denotes changes from the TCCC guidelines published in the 2006 PHTLS Manual, Sixth Edition.

- (d) Casualty with TBI (maintain oxygen saturation > 90%)
 - (e) Casualty in shock
 - (f) Casualty at altitude
- (4) All open and/or sucking chest wounds should be treated by immediately applying an occlusive material to cover the defect and securing it in place. Monitor the casualty for the potential development of a subsequent tension pneumothorax.*
- c. Bleeding*
- (1) Assess for unrecognized haemorrhage and control all sources of bleeding. If not already done, use a CoTCCC-recommended tourniquet to control life-threatening external haemorrhage that is anatomically amenable to tourniquet application or for any traumatic amputation. Apply directly to the skin 2-3 inches above wound.*
 - (2) For compressible haemorrhage not amenable to tourniquet use or as an adjunct to tourniquet removal (if evacuation time is anticipated to be longer than two hours), use combat gauze as the haemostatic agent of choice with WoundStat© as the backup (if the primary agent is not successful at controlling the haemorrhage or if the wound characteristics call for a granular agent). Both agents should be applied with at least 3 minutes of direct pressure. Before releasing any tourniquet on a casualty who has been resuscitated for haemorrhagic shock, ensure a positive response to resuscitation efforts (i.e., a peripheral pulse normal in character and normal mentation if there is no TBI.)*
 - (3) Reassess prior tourniquet application. Expose wound and determine if tourniquet is needed. If so, move tourniquet from over uniform and apply directly to skin 2-3 inches above wound. If tourniquet is not needed, use other techniques to control bleeding.*
 - (4) When time and the tactical situation permit, a distal pulse check should be accomplished. If a distal pulse is still present, consider additional tightening of the tourniquet or the use of a second tourniquet, side by side and proximal to the first, to eliminate the distal pulse.*
 - (5) Expose and clearly mark all tourniquet sites with the time of tourniquet application. Use an indelible marker.*
- d. Intravenous (IV) access. Reassess need for IV access:
- (a) If indicated, start an 18-gauge IV or saline lock.

* Denotes changes from the TCCC guidelines published in the 2006 PHTLS Manual, Sixth Edition.

- (b) If resuscitation is required and IV access is not obtainable, use IO route.
- e. Fluid resuscitation. Reassess for haemorrhagic shock (altered mental status in the absence of brain injury and/or change in pulse character).
 - (1) If not in shock:
 - (a) No IV fluids necessary.
 - (b) PO fluids permissible if conscious and can swallow.
 - (2) If in shock:
 - (a) Hextend 500-mL IV bolus.
 - (b) Repeat once after 30 minutes if still in shock.
 - (c) No more than 1000 mL of Hextend.
 - (3) Continue resuscitation with packed red blood cells (PRBCs), Hextend, or Lactated Ringer's solution (LR) as indicated.
 - (4) If a casualty with TBI is unconscious and has a weak or absent peripheral pulse, resuscitate as necessary to maintain a systolic blood pressure of 90 mmHg or above.
- f. Prevention of hypothermia:
 - (1) Minimize casualty's exposure to the elements. Keep protective gear on or with the casualty if feasible.
 - (2) Continue Ready-Heat Blanket, Blizzard Rescue Wrap, and Thermo-Lite Cap.
 - (3) Apply additional interventions as needed.
 - (4) Use the Thermal Angel or other portable fluid warmer on all IV sites, if possible.
 - (5) Protect the casualty from wind if doors must be kept open.
- g. Penetrating Eye Trauma.* If a penetrating eye injury is noted or suspected:
 - (1) Perform a rapid field test of visual acuity.*

* Denotes changes from the TCCC guidelines published in the 2006 PHTLS Manual, Sixth Edition.

- (2) Cover the eye with a rigid eye shield (NOT a pressure patch).*
- (3) Ensure that the 400 mg moxifloxacin tablet in the combat pill pack is taken if possible and that IV/IM antibiotics are given as outlined below if oral moxifloxacin cannot be taken.*
- h. Monitoring. Institute pulse oximetry and other electronic monitoring of vital signs, if indicated.
- i. Inspect and dress known wounds if not already done.
- j. Check for additional wounds.
- k. Provide analgesia as necessary.
 - (1) Able to fight:
 - (a) Mobic, 15 mg PO once a day
 - (b) Tylenol, 650-mg bilayered caplet, 2 PO every 8 hours
 - (2) Unable to fight (have naloxone readily available whenever administering opiates):
 - (a) Does not otherwise require IV/IO access:
 - 1/ Oral transmucosal fentanyl citrate (OTFC) 800 ug transbuccally
 - 2/ Recommend taping lozenge-on-a-stick to casualty's finger as an added safety measure.
 - 3/ Reassess in 15 minutes.
 - 4/ Add second lozenge, in other cheek, as necessary to control severe pain.
 - 5/ Monitor for respiratory depression.
 - (b) IV or IO access obtained:
 - 1/ Morphine sulfate, 5 mg IV/IO
 - 2/ Reassess in 10 minutes
 - 3/ Repeat dose every 10 minutes as necessary to control severe pain.
 - 4/ Monitor for respiratory depression.

5/ Promethazine, 25 mg IV/IM/IO every 6 hours as needed for nausea or for synergistic analgesic effect.

- I. Reassess fractures and recheck pulses.
- m. Antibiotics (recommended for all open combat wounds):
 - (1) If able to take PO: Moxifloxacin, 400 mg PO once a day
 - (2) If unable to take PO (shock, unconsciousness):
 - (a) Cefotetan, 2 grams IV (slow push over 3-5 minutes) or IM every 12 hours *or*
 - (b) Ertapenem, 1 grams IV/IM once a day
- n. The Pneumatic Anti-shock Garment (PASG) may be useful for stabilizing pelvic fractures and controlling pelvic and abdominal bleeding. Application and extended use must be carefully monitored. The PASG is contraindicated for casualties with thoracic or brain injuries.
- o. Documentation of Care. Document clinical assessments, treatments rendered, and changes in casualty's status on a TCCC Casualty Card.* Forward this information with the casualty to the next level of care.

* Denotes changes from the TCCC guidelines published in the 2006 PHTLS Manual, Sixth Edition.

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TACTICAL COMBAT CASUALTY CARE EQUIPMENT**1. NATO SOF Individual First Aid Kit**

- a. 1 x Pouch Medical Aid SOF
NSN 6515-01-528-1702, Pouch Medical Aid SOF



- (1) Nations may substitute colour and type of pouch as needed. The pouch should have similar design and format due to lessons learned for packing and access during emergency situations.
- (2) Combat wound pill pack includes:
- (a) 1 x Broad spectrum antibiotic tablet
 - (b) 1 x COX-2 Non-steroidal Anti-inflammatory Drug (NSAID) tablet
 - (c) 1 x Acetaminophen Extended Release (ER) 650mg caplet tablet
- (3) Nations may substitute medications without limiting the broad range antibiotic or anti-inflammatory aspects of the medications listed. Caplets are more temperature stable and resist melting or becoming powder in packaging.
- b. 1 x Tourniquet, one-hand combat application
NSN 6515-01-521-7976, Tourniquet, One-Hand Combat Application



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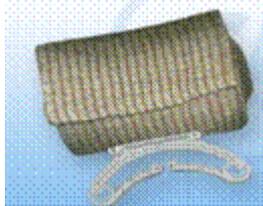
- c. 1 x Airway, Nasopharyngeal size 28 rubber
NSN 6515-01-518-8597, Airway, Nasopharyngeal Size 28 Rubber



- d. 1 x Lubricant Surgical 5 grams
NSN 6505-00-111-7829, Lubricant Surgical 5 Gram



- e. 1 x Pressure Dressing (Israeli)
NSN 6510-01-515-7528, Pressure Dressing (Israeli)



- f. 2 x Chest Seal
NSN 6515-01-532-8019, Combat Chest Seal



- g. 1 x Needle 14 gauge 8 cm (3.25 inches) (chest decompression)
NSN 6515-01-153-5373, Catheter-Needle 14GA 3.5 inches



- h. 1 x Bandage Haemorrhage Control (Combat gauze)
NSN 6510-01-562-3325, QuikClot Combat Gauze



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- h. 4 x Gloves, Patient Exam (Powder-free, Non-latex)
NSN 6515-01-519-9161, Glove, Patient Exam Large



2. **Advanced First Responder Bag.** Where the unit of issue (U/I) specifies a package (PG), the quantity column denotes the number taken from that PG for the assemblage. For example, there are 6 pads isopropyl alcohol from the PG in the Advanced First Responder bag.

NSN	Nomenclature	Unit of Issue/Quantity
6545015323674	Advanced First Responder Bag	1 each
6545009129870	Case Medical Instrument and Supply Set	1 each
6505009269083	Atropine Injection Aqueous Type 0.7ml Syringe with Needle	5 each
6505012740951	Diazepam Injection USP 5mg/mL 2mL Syringe-Needle Unit Auto Injector	5 each
6515015195778	Adapter Catheter to Luer Syringe Short Locking	5S Package/2 each
6510009268884	Adhesive Tape Surgical Porous Woven 3 Inches By 10 Yards	4S Package/1 roll
6515012331917	Airway Nasopharyngeal 28 fr Kink Resistant Smooth Round Edges	10S Package/1 each
6510002011755	Bandage Muslin Compressed Olive Drab 37x37x52" Triangular W/Safety Pins	3 each
6510009355823	Bandage Elastic Flesh Rolled Non-sterile 6"X 4.5 Yards	12S Package/1 each
6510015032117	Bandage Gauze Cotton 6 Ply White 4.5" Wide 4.1 Yards Long	2 rolls
6510014922275	Bandage Kit Elastic	2 each
6510005977469	Bandage Adh. 7.5x3" Flesh/Clear Sterile Dressing Affixed To Plastic Adhesive	100S Package/5 each
6515014841327	Catheter IV Introcan Safety 18 ga x1-1/4"Lg Winged Needle Teflon	200S Package/4 each
6515011535373	Catheter-Needle Unit IV 14 ga x 3.25" Luer Hub And Needle Guard	50S Package/2 each
6510002017425	Dressing First Aid Field Camouflaged 11.5-12" Wide by 11.5-12" Long	1 each
6510 15198421	Dressing Occlusive Adhesive Clear 4.75 X 4"	5S Package/2 each
6515014915719	Glove Patient Examining & Treatment Size 10 large Purple	10S Package/4 each
6505014988636	Hetastarch in Lactated Electrolyte Injection	500ML/2 each
6515014523445	Administration Set Infusion Pump Vented/Unvented	1 each
6505001117829	Lubricant Surgical 5 Gram	144S Package/2 each
6505011978809	Oral Rehydration Salts USP 27.9 gm Foil Packet	125S Package/2 each
6510007863736	Pad Isopropyl Alcohol Impregnated Non-woven Cotton/Rayon White	200S Package/6 each
6510010100307	Pad Povidone-Iodine Impregnated Sterile Cotton/Rayon 2x1.375" Brown	100S Package/6 each
6515009357138	Scissors Bandage 7.25" Large Angle To Handel 1.50" Cut Large Blunt	1 each

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NSN	Nomenclature	Unit of Issue/Quantity
6515014941951	Splint Universal Alum 36" O/A Large 4.25" Wide Gray & Olive Drab Reusable	1 each
6515015195872	Syringe and Needle Hypodermic Safety 3 mL 23ga Sterile Disposable	25S Package/1 each
6515011467794	Tourniquet Non-pneumatic Adult 14x1"	1 each
6515015217976	Tourniquet Combat Application One-Handed	1 each
6515015196764	Tube Drainage Surgical Penrose 1"X18" Rubber Sterile	6S Package/ 1 each

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