# ATTP 4-02

# Army Health System

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**Headquarters, Department of the Army**

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# Army Health System

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# Preface

This publication provides the capstone doctrine for the Army Health System (AHS) in support of the modular force. The Army Health System is the overarching concept of support for providing timely medical support to the tactical commander. It discusses the current medical 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 and echelons above brigade units.

As the Army's capstone medical 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 Army Health System operations from the point of injury, illness, or wounding through successive roles of care within the theater 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 the modular force.

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 area of operations. Information in this publication is applicable to the full spectrum operations. It is compatible with the Army's sustainment and protection doctrine and is in consonance with Joint Publication (JP) 4-02.

This publication implements or is in consonance with the following North Atlantic Treaty Organization (NATO) Standardization Agreements (STANAGs), and American, British, Canadian, Australian, and New Zealand (ABCA) Standards and Quadripartite Advisory Publication 256.

| TITLE | STANAG | 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—AMedP-5(B) | 2131 | |
| Documentation Relative to Medical Evacuation, Treatment and Cause of Death of Patients | 2132 | 470 |
| Allied Joint Medical Support Doctrine | 2228 | |
| Morphia Dosage and Casualty Markings | 2350 | |
| Road Movements and Movement Control—AMovP-1(A) | 2454 | |
| Orders for the Camouflage of the Red Cross and the Red Crescent on Land in Tactical Operations | 2931 | |
| Minimum Requirements for Blood, Blood Donors and Associated Equipment | 2939 | |
| Aeromedical Evacuation | 3204 | |

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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.

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

# Chapter 1
# Army Health System Overview

The AHS is a component of the Department of Defense (DOD) Military Health System. It is responsible for the operational management of the health service support (HSS) and force health protection (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 Joint doctrine describes the capabilities of the Military Health System as a taxonomy of care, this description does not adequately address how the AMEDD must organize and equip its forces to successfully accomplish the health care delivery in the noncontiguous operational environment. Therefore, the AHS is in consonance with and supports the concept of the taxonomy of care, but AMEDD support is discussed in terms of capability packages specifically designed to support Army formations. Although the Military Health System is an interrelated system which may share medical services, capabilities, and specialties among the 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.

## SECTION I — OPERATIONAL ENVIRONMENT AND TRANSFORMATION

## OPERATIONAL ENVIRONMENT

1-1. The operational environment 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 an in-depth discussion of the operational environment refer to Field Manual (FM) 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 medical personnel while engaged in the humanitarian mission.

### GENERAL THREAT

1-3. There are four categories of threat which are defined. An adversary may use elements from within each of the threat groups to achieve an end. The four categories of threat are—

- **Traditional threats** emerge from states employing recognized military capabilities and forces in understood forms of military competition and conflict.

- **Irregular threats** are posed by an opponent employing unconventional methods and means to counter traditional US advantages, such as terrorist attacks, insurgency, and guerrilla warfare.
- **Catastrophic threats** involve the acquisition, possession, and use of chemical, biological, radiological, and nuclear (CBRN) weaponry, often referred to as weapons of mass destruction.
- **Disruptive threats** involve an enemy using new technologies that reduce US advantages in key operational domains.

1-4. Figure 1-1 provides a short discussion of each threat type and possible medical capabilities required to mitigate the health effects of enemy weapons systems and/or tactics.

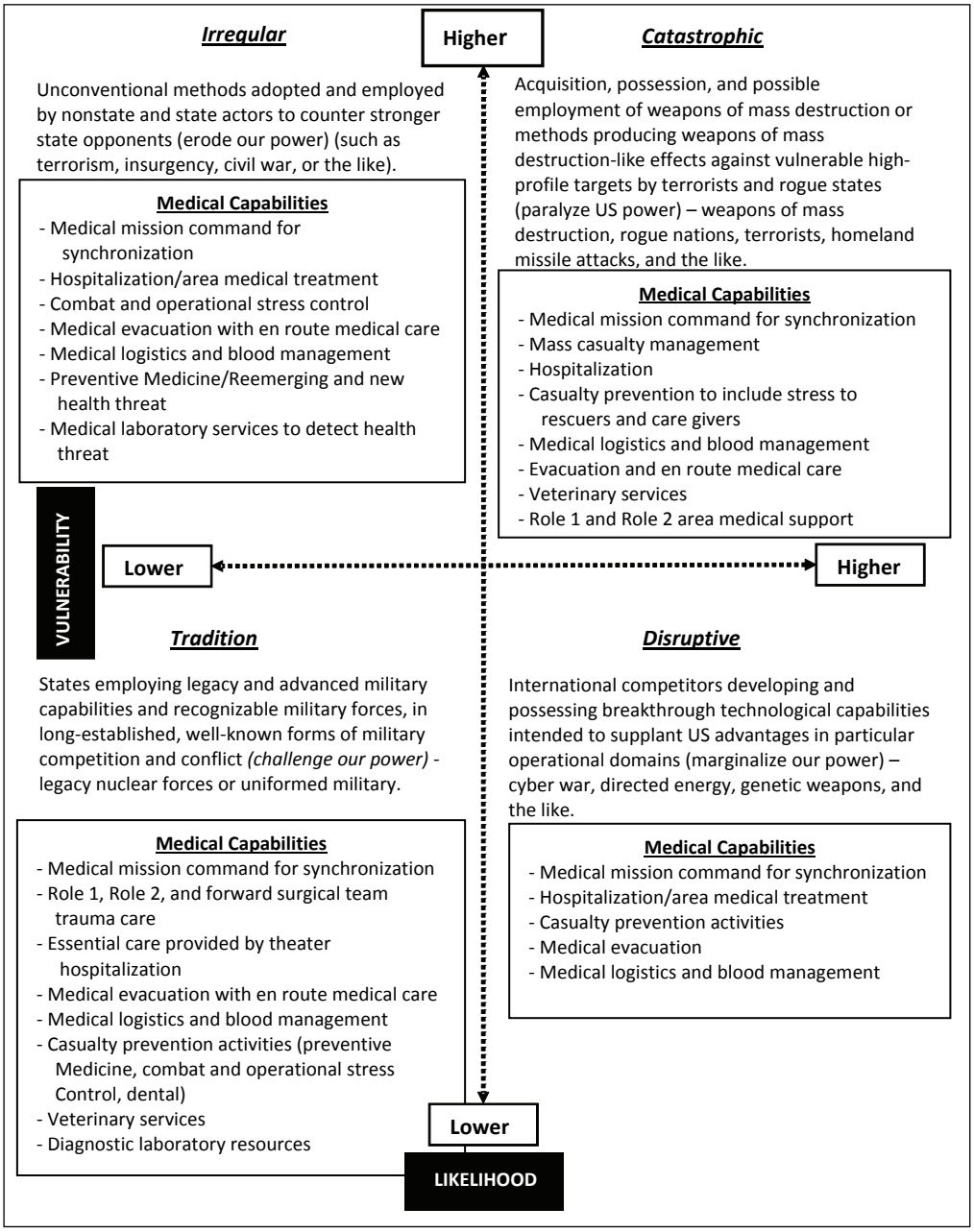


**Figure 1-1. General threats and medical considerations**

### HEALTH THREAT

1-5. The health threat faced by deployed US 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 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. The health threat**

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

## ARMY MEDICAL DEPARTMENT TRANSFORMATION

1-6. Following Operation Desert Storm, the AMEDD identified the need for lighter, more flexible, yet more capable units to reduce the medical footprint in theater. The solution was the Medical Reengineering Initiative unit redesign. By the end of fiscal year 2004, the AMEDD has completed approximately 42 percent of all Medical Reengineering Initiative unit activations and conversions. Army support in current and future Program Objective Memorandums is required to fully complete the reconfiguration. Building on the Medical Reengineering Initiative design, further structural refinement is now underway through modularization to create smaller, deployable increments within each Medical Reengineering Initiative medical unit. The end state will be modular medical units that are right-sized, require the least possible lift, and can provide optimal care to evolving troop concentrations. Army Medical Department modularization is the enabling tool that ensures Medical Reengineering Initiative units can support full spectrum operations.

1-7. Modularity (Figure 1-2) is at the core of AMEDD transformation. A myriad of medical missions exist, from humanitarian assistance and disaster relief, to the care of combat wounds, enemy prisoners of war, and detained and retained personnel in major combat operations. Initial operations, expanding operations, and high-end phases of theater operations all require different medical support packages. The medical time/distance conundrum demands effectiveness at the expense of efficiency during early

operational phases, in which we will doctrinally evacuate patients out of theater for definitive care. This is necessary due to limited early-entry medical capabilities and concerns about the quality of host-nation medical facilities, the qualifications of their providers, and the safety of their medical equipment, supplies, and it is essential to have the right mix of medical capabilities to accommodate changing missions as operations evolve and expand. Modularly configured units give medical planners a menu of modular medical units and capabilities in the medical force pool. From these modules they will be able to assemble, task organize, augment, and expand composite medical task forces, which have no fixed structure, but instead are tailored to the phase, intensity, and mission of the operation. Emerging capabilities and concepts will be fully integrated into AHS support planning and operations and will facilitate operational deployment of these medical capabilities.

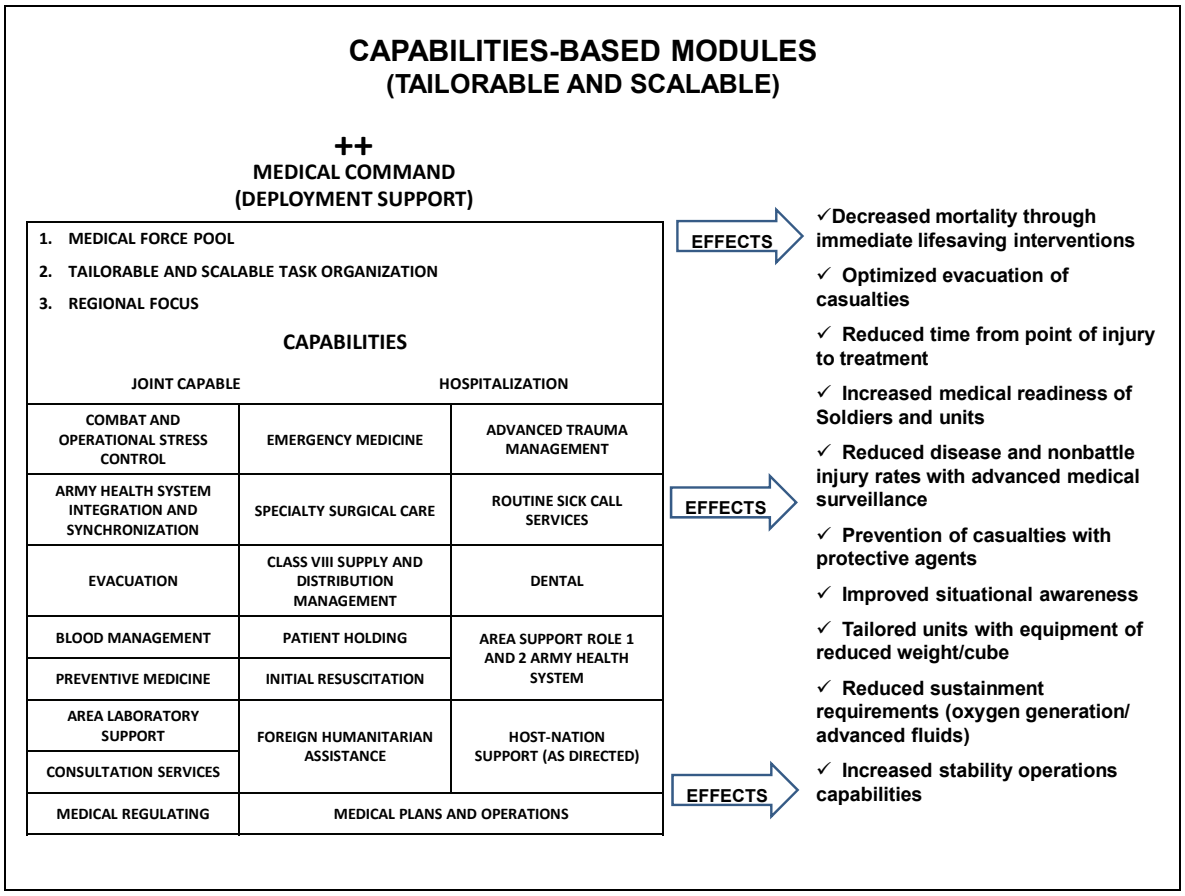


**Figure 1-2. Modular capabilities**

## SECTION II — MILITARY HEALTH SYSTEM

1-8. The Military Health System supports the military mission by fostering, protecting, sustaining, and restoring health. It also provides the direction, resources, health care providers, and other means necessary for promoting the health of the beneficiary population. These include developing and promoting health awareness issues to educate customers, discovering and resolving environmentally based health threats, providing health services (including preventive care and intervention services), and improving the means and methods for maintaining the health of the beneficiary population by constantly evaluating the performance of the health care services system.

# CAPABILITIES

1-9. The discussion of capabilities of the Military Health System is written to describe the system's capabilities rather than where they are provided in the operational area. As will be discussed in Section II below, the AHS discusses the capabilities based upon types of military formations and capability packages.

## POLICY AND RESOURCE ACQUISITION

1-10. All HSS capabilities are dependent on sound policy and sufficient resource acquisition. Policy provides the framework from which the HSS community derives the direction and identifies the requisite people, materiel, facilities, and information to promote, improve, conserve, or restore well-being. With policy as the guide, resource acquisition occurs through planning, programming, budgeting, and disbursement of money. This Title 10 US Code activity is foundational to the HSS community's capability to organize, train, and equip for sustainment of deployed forces.

## PREVENTION AND PROTECTION

1-11. Health service support can support the service member by applying prevention and protection capabilities. These capabilities are both wide-ranging and diverse, and match the complexity of human health needs. These capabilities are focused on the service member, while others are directed at the Family, organization, or force. Additionally, the Services will develop and enforce specific minimum standards. These standards will ensure service members are free of diseases or medical and dental conditions that are incompatible with military service.

- Force health protection includes all measures taken by commanders, leaders, individual service members, and the Military Health System to promote, improve, or conserve the behavioral 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.
- Members of the force have to be physically and behaviorally fit. This requirement demands programs that promote and improve the capacity of the personnel to perform military tasks at high levels under extreme conditions for extended periods of time. These preventive and protective capabilities include physical exercise, nutritional diets, dental hygiene and restorative treatment, combat and operational stress management, rest, recreation, and relaxation geared to the individual or organization.
- Methods to prevent disease are best applied synergistically. Sanitation practices, waste management, and pest and vector control are crucial to protection from disease. Regional spraying and the application of insect repellent to guard against hazardous flora and fauna are examples of prevention methods. Prophylactic measures can encompass human and animal immunizations, dental chemoprophylaxis and treatment, epidemiology, optometry, counseling on specific health threats, and issuance of protective clothing and equipment.
- Key to preventive and protective care is information—the capacity to anticipate the current and future health environment—and its proper delivery to the affected human population. Derived from robust health surveillance and medical intelligence, this information addresses occupational, local environmental, and enemy-induced threats: from industrial hazards; air and water pollution; endemic or epidemic disease; and CBRN, high-yield explosives, and directed energy devices/weapons to include high-powered microwaves, particle beams, and lasers. Health service support must be capable of acquiring, storing, moving, and providing information that is timely, relevant, accurate, concise, and applicable to the intended human user. In sum, this information capability is crucial to FHP.

## FIRST RESPONDER CARE

1-12. More than any other care or services, the first responder care is defined by its time requirements to provide timely and effective lifesaving interventions at or close to the point of injury or wounding. It is this phase of treatment that provides immediate clinical care and stabilization of the patient in preparation

for evacuation to the next role of medical care in the continuum of care and/or return to duty. This capability can offer primary care outpatient services, emergent care services, medical subspecialty services, and ancillary services.

- Primary care outpatient services often begin with the employment of basic first aid (self-aid and buddy aid) or enhanced first aid (combat lifesaver), normally followed by nonphysician medical care, and in some instances, physician primary care. Emergent care services offers basic emergency medical treatment to include initial resuscitative and fluid therapy and advanced trauma management. In addition to treating injuries, first responders treat patients for common acute minor illnesses.
- Medical subspecialty and ancillary services for some first responder activities consist of basic behavioral health, dental, and preventive medicine capabilities, as well as limited pharmacy, laboratory, and radiology capabilities.

## Tactical Combat Casualty Care

1-13. First responder capability can be usefully divided into the three phases called tactical combat casualty care. Tactical combat casualty care occurs during a combat mission and is the military counterpart to prehospital emergency medical treatment. Prehospital emergency medical treatment in the military is most commonly provided by enlisted personnel and includes self- and buddy aid (first aid), combat lifesaver (enhanced first aid), and enlisted combat medics in the Army, corpsmen in the US Navy, US Marine Corps, and US Coast Guard, and both medics and pararescuemen in the US Air Force. 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*

1-14. 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 life-saving interventions that must be performed immediately are undertaken during this phase.

### *Tactical Field Care*

1-15. During the tactical field care phase, medical personnel and their casualties are no longer under effective hostile fire and 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 also provide advanced trauma management.

### *Tactical Evacuation Phase*

1-16. In the tactical evacuation phase, casualties are being transported to a medical treatment facility by an aircraft or vehicle and there is an opportunity to provide additional medical personnel and equipment to maintain the interventions already performed, to further increase the level of care rendered to the casualty, 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 tactical combat casualty care initiative originated with US 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 FM 4-02.2 are not changed. However, during this phase of tactical combat casualty care 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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## FORWARD RESUSCITATIVE CARE

1-17. Forward resuscitative care capability is characterized by the capacity to perform emergency medical treatment as close to the point of injury as possible, to attain stabilization of the patient, and to achieve the most efficient use of life- and limb-saving medical treatment. The forward resuscitative care capability typically provides essential care for stabilization to ensure the patient can tolerate evacuation. This capability covers advanced emergency services, postsurgical inpatient services, surgical subspecialty services, and ancillary services.

- Advanced emergency services build on the first responder's capabilities by providing advanced trauma management, resuscitative care, emergency physician care, initial advanced burn management, and blood/fluid therapy. Available surgical services are normally comprised of trauma, general, thoracic, and orthopedic surgery capabilities. In turn, these surgical services are supported by surgical inpatient services: medical-surgical nursing care, postoperative care, critical care nursing, and temporary holding services. All of these capabilities are underpinned by sufficient pharmacy, laboratory, and radiology services.
- Such capabilities must be available to the trauma patient who might also be a CBRN casualty.

1-18. Damage control resuscitation is used for severely traumatized patients to optimize outcomes and consists of early identification of traumatized patients likely to require damage control resuscitation, hypotensive resuscitation, and interventions/treatments focused on the prevention of the lethal triad (hypothermia, acidosis, and coagulopathy), and rapid transfer to a surgeon capable of performing damage control surgery. The treatments and interventions required to prevent the lethal triad include early use of blood products, interventions to maximally manage airway, breathing, and circulation compromises; and effective warming strategies.

1-19. Damage control resuscitation consists of four major elements—

- Early identification and initiation of advanced trauma management protocols (first responder, combat medic, physician, and physician assistant at Roles 1 and 2 MTFs).
- Hypotensive resuscitation protocols (first responder, combat medic, physician, and physician assistant at Roles 1 and 2 MTFs).
- Simultaneous treatment of lethal triad (Role 2 with a forward surgical team and higher).
- Rapid transfer to a surgeon (Role 2 with a forward surgical team and higher).

## HOSPITALIZATION

1-20. This capability delivers HSS required to medically sustain forces in the area of operations. The HSS capability involves hospitals purposely positioned to provide support in the area of operations. Hospitalization capabilities in the area of operations deploy as modules or multiple individual capabilities that provide incrementally increased medical services in a progressively more robust area of operations. The hospitalization capability in the area of operations offers essential care to either return the patient to duty (within the theater patient movement policy) and/or stabilization to ensure the patient can tolerate evacuation to a definitive care facility outside the area of operations. In addition to the availability of substantial medical personnel skills, hospitalization capability in the area of operations has the facilities and materiel (equipment and consumable supplies) to render significant preventive and curative health care. These highly robust services encompass primary inpatient and outpatient care; emergent care; and enhanced medical, surgical, and ancillary capabilities. Hospitalization capabilities in the area of operations can vary according to the regional infrastructure, operational area, and tempo of operation. But, a robust capability in the area of operations would contain the following services not normally resident at the lower roles in the HSS continuum of care: advanced burn management; optometry and ophthalmology; pediatric, obstetric and gynecological; dental, preventive medicine, internal medicine and cardiology; eye surgery, maxillofacial surgery, and neurosurgery; intensive/critical care beds and nursing; blood banking service; pathology; infectious disease; medical nutrition therapy; behavioral health; occupational health; medical logistics; and other medical specialties.

## DEFINITIVE CARE

1-21. The definitive care capability includes care rendered to conclusively manage a patient's condition. This normally leads to rehabilitation, return to duty, or discharge from the Service. Definitive care capability includes the full spectrum of acute, convalescent, restorative, and rehabilitative care in the CONUS. Because this definitive care capability resides outside the operational area, the most advanced health care can be made available and accessible to the patient—in terms of mutually supporting resources: medical personnel, materiel, facilities, and information. Definitive care includes all the capabilities embedded in the Military Health System, plus extraordinary preventive, restorative, and rehabilitative capabilities not existent with lesser capabilities of care facilities. These additional capabilities give patients the maximum opportunity to enhance and sustain their performance, whether in recovery and rehabilitation, back on military duty, or as a civilian, medically retired or discharged.

## EN ROUTE CARE

1-22. The purpose of an en route capability is the continuation of care during movement (evacuation) without clinically compromising the patient's condition. Patient movement involves transitory medical care, patient holding, and staging capabilities during transport from the site of injury or onset of disease, through successive capabilities of medical care, to an MTF that can meet the needs of the patient. En route capability can take three forms.

### Casualty Evacuation

1-23. 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). 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

1-24. 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 US Air Force fixed-wing movement of regulated casualties, using organic and/or contracted mobility airframes, with an aeromedical evacuation aircrew trained explicitly for this mission.

1-25. 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 medical treatment facilities. Medical evacuation is an AMEDD function that supports and is an integral part of the AHS. 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 Movement

1-26. In today's operational environment, the reduced medical footprint forward, and the *evacuate and replace* philosophy place a high demand on en route care capabilities. Consequently, patient movement capabilities are even more critical than in the past and the US Army in coordination with the other Service medical elements must integrate with lift operations, as well as with the associated capabilities of multinational forces.

## MISSIONS DEFINED

1-27. Within the Military Health System the definitions for HSS and FHP vary slightly from those used in the AHS. This is due in part to slight differences in mission responsibilities and placement within the Army's warfighting functions (movement and maneuver, intelligence, fires, sustainment, mission command, and protection). The joint definitions provided below are specified in JP 1-02 and JP 4-02. The Army definitions are provided in paragraphs 1-31 and 1-32 below.

### HEALTH SERVICE SUPPORT

1-28. In the joint arena, HSS is defined as: 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 (COSC) and medical, dental, veterinary, laboratory, optometry, nutrition therapy, and medical intelligence services.

### FORCE HEALTH PROTECTION

1-29. In the joint arena, the definition for FHP is: 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.

# SECTION III — ARMY HEALTH SYSTEM

## SYSTEM OF SYSTEMS

1-30. The AHS is a component of the Military Health System that is responsible for 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. The AHS is a complex system of systems (Figure 1-3). 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 (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).

1-31. The AHS supports and is in consonance with joint doctrine as described in JP 4-02. However, rather than relying on broad terms to describe medical capabilities, the Army refers to capability packages which align the right mix of medical skills across the ten medical functions to the type of military formation where the support can be found. These descriptions provide the tactical commander with a composite sketch of what medical capabilities are available within his area of operations and what medical capabilities are available elsewhere in the operational environment. This graduated system of increasing levels of medical capabilities is referred to as the roles of medical care.

1-32. For an in-depth discussion of the ten medical functions refer to Chapter 2. For a discussion of the roles of medical care, refer to paragraphs 1-41 through 1-50.

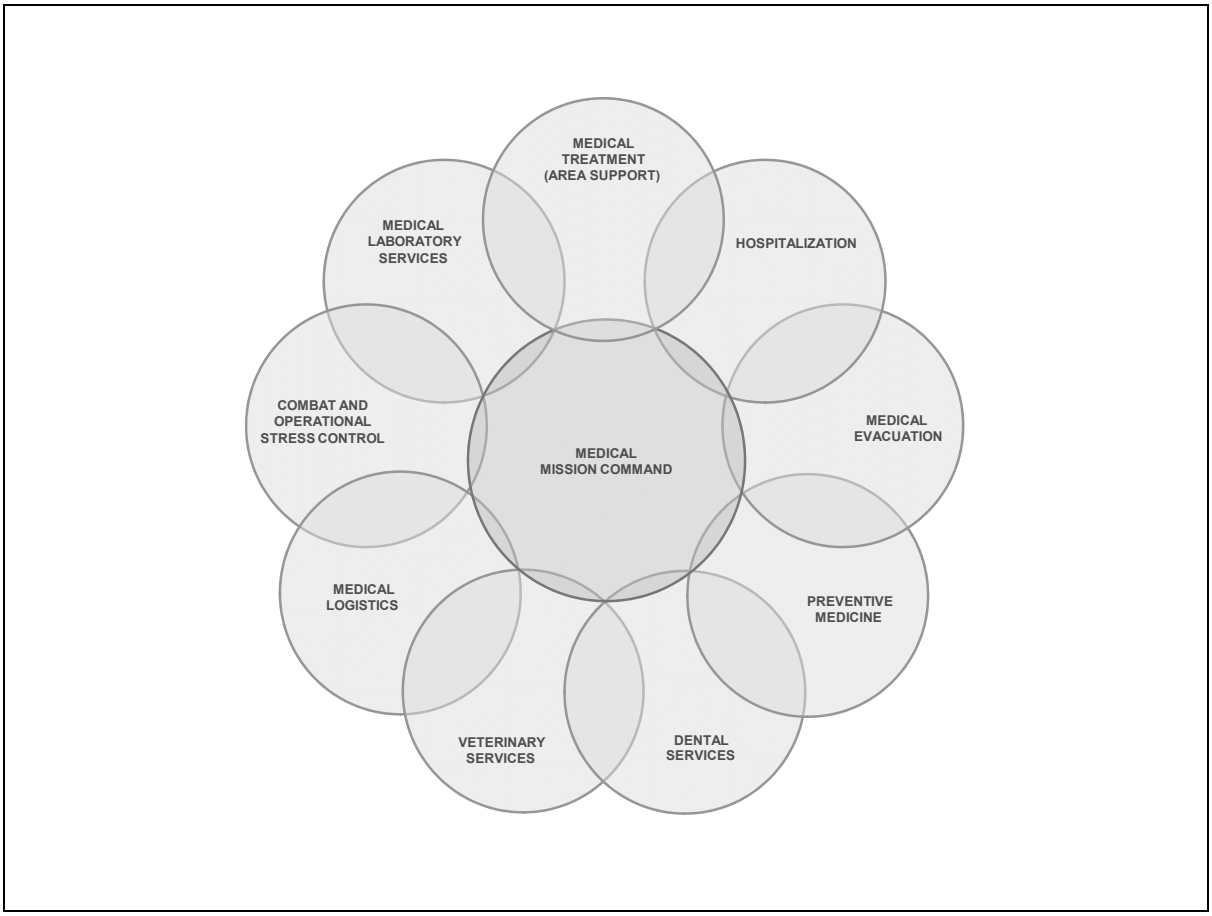


**Figure 1-3. System of systems**

1-33. The AHS supports two warfighting functions as described in FM 3-0. The HSS mission is included in the sustainment warfighting function, while the FHP mission comes under the protection warfighting function.

## HEALTH SERVICE SUPPORT MISSION

1-34. 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 mental 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/neuropsychiatric treatment, clinical laboratory services, and the treatment of CBRN patients), medical evacuation, and medical logistics.

### FORCE HEALTH PROTECTION MISSION

1-35. The Army FHP mission is defined as the measures to promote, improve, or conserve the mental 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 and includes the prevention aspects of a number of AMEDD functions (preventive medicine—including medical surveillance and occupational and environmental health surveillance—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 (area medical laboratory support).

## PRINCIPLES OF THE ARMY HEALTH SYSTEM AND THE ARMY MEDICAL DEPARTMENT BATTLEFIELD RULES

1-36. The principles of the AHS are the enduring tenets upon which the delivery of health care in a field environment is founded. The principles guide medical planners in developing operational plans which are effective, efficient, flexible, and executable. Army Health System plans are designed to support the tactical commander's scheme of maneuver while still retaining a Soldier-centric/patient-centric focus. When the AHS principles are combined with the AMEDD battlefield rules, the medical planner can prioritize activities to reduce morbidity and mortality, maximize patient outcomes, and potentially decrease long-term disability.

1-37. 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 1-4 depicts the AHS and the AMEDD battlefield rules.

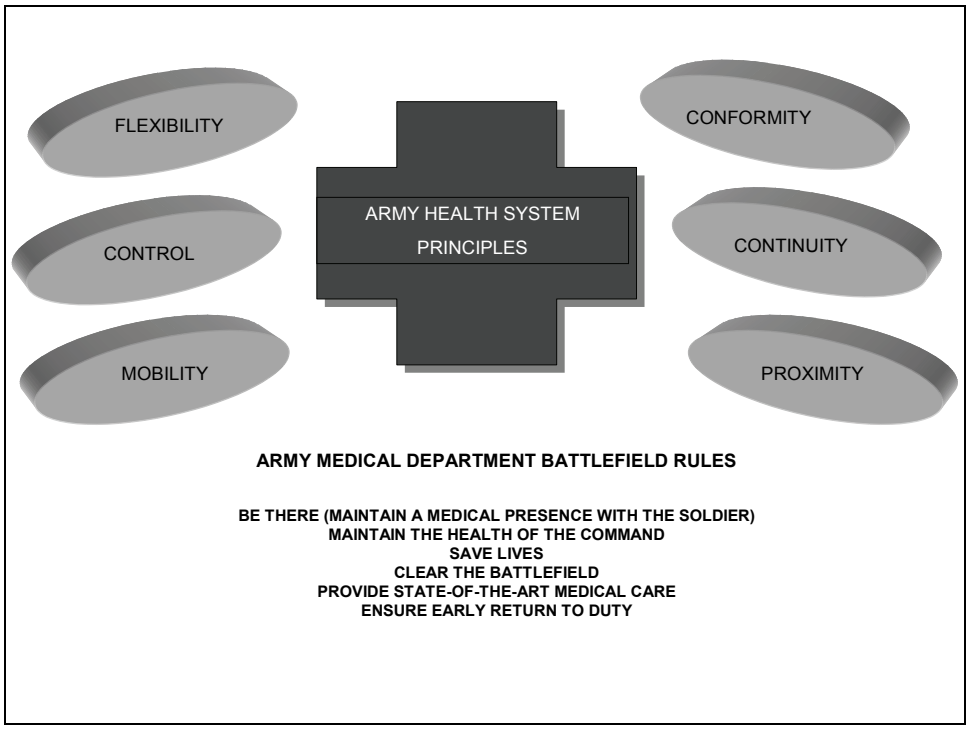


**Figure 1-4. Army Health System principles and Army Medical Department battlefield rules**

## CONFORMITY

1-38. *Conformity* with the tactical plan 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 tactical 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 stability operations, it is essential that AHS support operations are in consonance with the combatant commander's theater engagement strategy and have been thoroughly coordinated with the supporting assistant chief of staff, civil affairs. Army Health System plans in stability operations must be coordinated with all participating organizations and multinational forces.

## PROXIMITY

1-39. The principle of *proximity* is to provide AHS support to sick, injured, and wounded Soldiers at the right time 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 combat operations. As the battle rhythm of the medical commander is similar to the tactical commander's, it is essential that AHS assets are positioned to rapidly locate, acquire, stabilize, and evacuate combat casualties. Peak workloads for AHS resources occur during combat operations.

## FLEXIBILITY

1-40. *Flexibility* is being prepared to and empowered to shift AHS resources to meet changing requirements. Changes in tactical plans or operations make flexibility in AHS planning and execution essential. In addition to building flexibility into operation plans to support the tactical 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 spectrum of conflict. As the current era is one characterized by persistent conflict, the medical commander may be supporting simultaneous actions along the continuum from stable peace through general war. 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 area of operations. For example, there are insufficient numbers of forward surgical teams to permit the habitual assignment of these organizations to each brigade combat team. 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 brigade combat teams in contact with the enemy and where the highest rates of Soldiers will potentially receive traumatic wounds and injuries are anticipated. As the tactical situation changes within that brigade combat team area of operations, the command surgeon and medical commander monitor and execute resupply and/or reconstitute operations of that forward surgical team to prepare for follow-on operations which could be in another brigade combat team's area of operations. 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

1-41. The principle of *mobility* is to ensure that AHS assets remain in supporting distance to support maneuvering combat forces. The mobility, survivability (such as armor plating), and sustainability of medical units organic to maneuver elements must be equal to the forces being supported. Major AHS headquarters in echelons above brigade continually assess and forecast unit movement and redeployment. Army Health System support must be continually responsive to shifting medical requirements in the operational environment. 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 medical units is to evacuate all patients they are holding. Medical units anticipating an influx of patients must medically evacuate patients on hand prior to the start of the engagement.

### CONTINUITY

1-42. *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 situational variables often times enables a patient to be evacuated from the point of injury directly to the supporting combat support hospital. In more traditional combat 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

1-43. *Control* is required to ensure that scarce AHS resources are efficiently employed and support the tactical and strategic plan. It also ensures that the scope and quality of medical treatment meet professional standards, policies, and US and international law. As the AMEDD is comprised of 10 medical functions which are interdependent and interrelated, control of AHS support operations requires synchronization to ensure the complex interrelationships and interoperability of all medical assets remains in balance to optimize the effective functioning of the entire system. Within the theater, 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 theater. Due to specialization and the low density of some medical skills within the Military Health System force structure, the providers may only exist in one Service (for example, the US Army has the only Veterinary Corps officers in the Military Health System).

## ROLES OF MEDICAL CARE

1-44. A basic characteristic of organizing modern AHS 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 advanced trauma management and far forward resuscitative surgery prior to movement between MTFs (Roles 1 through 3).

### ROLE 1

1-45. 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 collecting 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.)

1-46. 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

1-47. 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.

### Combat Lifesaver

1-48. 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 assigned, attached, or in sustainment units. The senior medical person designated by the commander manages the training program.

### Medical Personnel

1-49. 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.

- Emergency medical treatment (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 who 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 tactical situation permits. Like elements provide this role of medical care at brigade and echelons above brigade.

## ROLE 2

1-50. At this role, care is rendered at the Role 2 MTF which is operated by the treatment platoon of medical companies/troops. 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 emergency medical treatment 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, dental support, COSC, and preventive medicine. 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 a forward surgical team collocated with a medical company/troop. (A discussion of the forward

surgical team is contained in FM 4-02.25.) 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.

1-51. Role 2 AHS assets are located in the—

- Medical company (brigade support battalion), assigned to modular brigades which include the heavy brigade combat team, infantry brigade combat team, the Stryker brigade combat team, and the medical troop in the armored cavalry regiment.
- Medical company (area support) which is an echelons above brigade asset that provides direct support to the modular division and support to echelons above brigade 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 US 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 forward surgical team may be referred to as a *light maneuver* Role 2 facility.

• An enhanced Role 2 MTF may be used in stability operations scenarios and consists of the medical company, forward surgical team, 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.

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## ROLE 3

1-52. 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 a MTF with the proper staff and equipment.
- Providing support on an area basis to units without organic medical assets.

## ROLE 4

1-53. Role 4 medical care is found in CONUS-base hospitals and other safe havens. Mobilization requires expansion of military hospital capacities and the inclusion of Department of Veterans Affairs and civilian hospital beds in the National Disaster Medical System to meet the increased demands created by the evacuation of patients from the area of operations. The support-base hospitals represent the most definitive medical care available within the AHS.

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# Chapter 2
# Medical Functions

The ten medical functions which comprise the AHS are discussed in this chapter. Although the ten functions are aligned with specific medical disciplines or support tasks, the execution of the individual functions are interrelated, interconnected, and interdependent and require close coordination and integration to facilitate the effective and efficient provision of AHS support.

## SECTION I — MEDICAL MISSION COMMAND

## MISSION COMMAND

2-1. The complexities of the operational environment, the myriad of medical functions and assets, and the requirement to provide health care across full spectrum operations to diverse populations (US, joint, multinational, host nation, and civilian) necessitates a medical command authority that is regionally focused and capable of utilizing the scarce medical resources available to their full potential and capacity. Each of the medical mission command organizations (medical command [deployment support], medical brigade, and medical battalion [multifunctional]) 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 theater matured and an Army and joint integrated health care infrastructure is established.

2-2. The medical mission command system provides a seamless state-of-the-art health care system across the spectrum of conflict. The medical mission command capability is flexible and versatile and is capable of providing reliable AHS support to the tactical commander in current and future operations. It is strategically, operationally, and tactically responsive to a broad range of worldwide requirements. The medical mission command capability integrates both vertically and horizontally with the tactical commander's mission command warfighting functions and enhances situational understanding.

## MEDICAL COMMUNICATIONS

2-3. The AHS uses Medical Communications for Combat Casualty Care System to integrate, field, and support a comprehensive medical information system enabling lifelong electronic medical records, streamlined medical logistics, and enhanced situational 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 occupational and environmental health 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 full spectrum 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 battlefield (locate, acquire, treat, and evacuate battlefield casualties).
- Conduct split-base operations on a continuous basis.
- Provide AHS staff virtual presence at all command levels.

- Provide a lead element with deploying forces and coordinate the arrival of medical assets into an area of operations.
- Support joint and multinational medical forces, as directed, across the full spectrum of conflict.
- Interface with Army systems, other Services, DOD, and Department of Veterans Affairs automated systems throughout the operational continuum.
- Allow transfer of images and videos from numerous sensors and platforms, with image compression and transmission technologies, enabling better AHS situational understanding in the theater.
- Document patient encounters and Soldiers exposures to health threats (such as CBRN warfare agents and toxic industrial materials) electronically.
- Enable three-dimensional presentation of imagery and graphics with multimedia technology to help commanders visualize their area of operations for more effective training, planning, rehearsal, and execution.

2-4. The AHS communications network has interconnectivity to Army and joint global automated architecture systems to access Army mission command systems and sustainment systems.

# PRIMARY TASKS

2-5. Table 2-1 discusses the primary tasks of the medical mission command function.

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

| ***Primary Task*** | ***Purpose*** |
|---|---|
| Mission command | • Plan, direct, execute, and synchronize Army Health System support across full spectrum operations.<br>• 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.<br>• Maximize the use of scarce medical resources. |
| Communications and computers | • Maintain situational awareness and understanding there Army battle command systems and the common operational picture.<br>• 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 Systems. |
| 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 medical 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.<br>• Provide consultation and support to subordinate medical units/elements.<br>• Provide a reachback capability to the continental United States-support base in the areas of the various medical disciplines and specialties. |
| Regional focus | • Support and facilitate the execution of the combatant commander's theater engagement strategy during stability operations. |

2-6. For a more detailed discussion on mission command, Army Regulation (AR) 600-20, FM 3-0, FM 4-02.12, FM 5-0, and FM 6-0.

## SECTION II — MEDICAL TREATMENT (ORGANIC AND AREA SUPPORT)

# ORGANIZATIONS AND PERSONNEL

2-7. The medical treatment function encompasses Roles 1 and 2 medical treatment support. These roles of care are provided by organic assets or on an area support basis from supporting medical companies or detachments. Within the brigade combat teams and echelons above brigade medical units, this support is provided by medical companies/troops of brigades or armored cavalry regiments, the medical company (brigade support battalion), and the area support medical company. In the corps and at the Army-level, it is also provided by the area support medical company. The area support function encompasses emergency medical treatment, 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.)

2-8. In operation, each medical company is assigned a specific geographical area to ensure all personnel receive adequate medical care. Within each company area of operations, the treatment platoon with its treatment, dental, x-ray, laboratory, and patient-holding capability forms the core of the company's support scheme. The 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/troop for further treatment or holding.

# PRIMARY TASKS

2-9. Table 2-2 discusses the primary tasks of the medical treatment (organic and area support) function.

**Table 2-2. Primary tasks and purposes of the medical treatment (organic and area support) function**

| *Primary Task* | *Purpose* |
|---|---|
| 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. |
| Emergency medical treatment | 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. |
| 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 is 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 and 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. |

2-10. For additional information on area medical support, refer to FM 4-02.4, FM 4-02.6, and FM 4-02.21.

## SECTION III — MEDICAL EVACUATION

# MEDICAL EVACUATION SYSTEM

2-11. 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.

2-12. Medical evacuation occurs at the tactical, operational, 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 US Transportation Command.

2-13. 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 joint operations area. At the tactical 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 where they are stabilized, prioritized, and prepared for further evacuation, if required, to an MTF capable of providing required essential care within the joint operations area.

2-14. The most recognized mission of Army medical evacuation assets is the evacuation and provision of en route medical care to combat wounded. However, the essential and vital functions of medical evacuation resources encompass many additional missions and tasks that support the Military Health System. Medical evacuation resources are used to transfer patients between MTFs within the joint operations area and from MTFs to US Air Force 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.

### THEATER EVACUATION POLICY

2-15. 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 geographic combatant commander. The policy establishes, in number of days, the maximum period of noneffectiveness (hospitalization and convalescence) that patients may be held within the theater for treatment. This policy does not mean that a patient is held in the area of operations 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 theater. This is done providing that the treating physician determines that such evacuation will not aggravate the patient's disabilities or medical condition. For example, a theater evacuation policy of seven days does not mean that a patient is held in the theater for seven days and then evacuated. Instead, it means that a patient is evacuated as soon as possible after the determination is made that he cannot be returned to duty within seven days following admission to a Role 3 hospital.

### EVACUATION PRECEDENCE

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

2-16. 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 precedence for the US 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 1 hour to save life, limb, or eyesight and to prevent complications of serious illness and to avoid permanent disability.
- Priority IA, URGENT-SURGICAL 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 4 hours. Additionally, 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, the precedence is assigned as a PRIORITY.
- Priority III, ROUTINE is assigned to sick and wounded personnel requiring evacuation but whose condition is not expected to deteriorate significantly. The sick and wounded in this category should be evacuated within 24 hours.
- Priority IV, CONVENIENCE is assigned to patients for whom evacuation by medical vehicle is a matter of medical convenience rather than necessity.

***Note.*** The NATO STANAG 3204 has deleted the category of Priority IV, CONVENIENCE. However, this category is still included in the US Army evacuation priorities as there is a requirement for it in the operational environment.

2-17. For additional information on the evacuation precedence and the use of air ambulances refer to AR 40-3 and FM 4-02.2.

### RESPONSIBILITIES

2-18. The Service component commander is responsible for medical evacuation at the tactical level and is responsible for executing the medical evacuation of his forces. Strategic aeromedical evacuation is the responsibility of the US Transportation Command.

2-19. 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 US Navy and US Marine Corps forces could also be available within the Army's support capabilities.

## MEDICAL REGULATING

2-20. Medical regulating is a casualty management system designed to coordinate the movement of patients from site of injury or onset of disease through successive roles of medical care to an appropriate MTF.

2-21. 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.

2-22. 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).

2-23. The theater patient movement requirements center is a joint agency normally located at or near the theater headquarters. The combatant command surgeon supervises the functions of this office. These functions include—

- Maintaining direct liaison with the Global Patient Movement Requirements Center, the medical regulating officer of component Services, and the transportation agencies which furnish the means for evacuation.
- Obtaining periodic reports of available beds from the Services medical regulating officers providing hospitalization.
- Selecting hospitals based on the reported bed availability to receive patients.

# ORGANIZATIONS

2-24. There are two types of medical evacuation units, ground and air.

### GROUND AMBULANCES

2-25. The maneuver battalions medical platoon ambulances provide ground ambulance evacuation support from the supported brigade combat team or from the point of injury to the supporting MTF.

2-26. The medical company provides ground medical evacuation direct support for brigade combat teams and theater units. Medical companies are located in the brigade support medical company and medical battalion (multifunctional).

### AIR AMBULANCES

2-27. The medical company (air ambulance) provides medical air evacuation for all categories of patients, consistent with evacuation precedence and other operational considerations. The medical company (air ambulance) falls under the general support aviation battalion, combat aviation brigade.

# PRIMARY TASKS

2-28. Table 2-3 discusses the primary tasks of the medical evacuation function.

**Table 2-3. Primary tasks and purposes of the medical evacuation function**

| *Primary Task* | *Purpose* |
|---|---|
| Acquire, locate, treat, stabilize, and evacuate | Clear the battlefield of casualties and 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 to 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 evacuation platforms in the medical company (ground ambulance) (medical command [deployment support]/medical brigade) and the medical company (air ambulance) (general support aviation battalion). |
| Emergency movement of medical personnel, equipment, and supplies | 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. |

2-29. Refer to JP 4-02, AR 40-3, FM 4-02.2, FM 4-02.4, FM 4-02.6, FM 4-02.21, and FM 8-10-6 for additional information on medical evacuation operations.

## SECTION IV — HOSPITALIZATION

# COMBAT SUPPORT HOSPITAL

2-30. In theater, hospitalization is provided by the combat support hospitals operating within the area of operations. The combat support hospital provides essential care within the theater 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 combat support hospital capabilities include triage/emergency care, outpatient services, inpatient care, pharmacy, clinical laboratory, blood banking, radiology, physical therapy, medical logistics, operational dental care (emergency and essential dental care), oral and maxillofacial surgery, nutrition care, and patient administration services.

# AUGMENTATION TEAMS

2-31. The combat support hospital 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 hospitals.
- *Forward surgical team* that is available to augment the surgical services of the combat support hospital with general surgery and orthopedic surgery capabilities when not deployed forward with medical companies to provide forward resuscitative surgical care and damage control surgery.
- *Hospital augmentation team (head and neck)* provides special surgical care for ear, nose, and throat surgery, neurosurgery, and eye surgery to support the combat support hospital, 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 stability operations.
- *Hospital augmentation team (pathology)* provides pathology support to the combat support hospital 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 medical 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

2-32. Table 2-4 discusses the primary tasks of the hospitalization function.

**Table 2-4. Primary tasks and purposes of the hospitalization function**

| *Primary Task* | *Purpose* |
|---|---|
| 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 theater 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; interpretation of x-ray films; and the final reading and interpretation of all films taken at the facility. |
| Pharmacy support | Provide general pharmaceutical support (to include all controlled substances); packaging and dispensing medication for patient evacuations and discharge to duty patients and/or other ambulatory patients; providing parenteral admixture services; generating intravenous-quality fluids in the theater; and providing parenteral nutritional solutions. |
| Nutritional care | Prepare special diets for hospitalized Soldiers 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; scheduling patient evacuation; collecting, safeguarding, and accounting for patient's funds and valuables; custodianship of inpatient and outpatient treatment records, redeployment of medical records; maintenance of medical records and files; collecting and reporting of medical statistical data; management of 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 lens, 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 provide community 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 stability operations. This unit provides—<br>• Pediatric inpatient, consultation, and nurse practitioner services.<br>• Obstetrics/gynecology and specialty nursing services.<br>• Preventive medicine services.<br>• Community health nursing services.<br>• Family physician services. |

**Table 2-4. Primary tasks and purposes of the hospitalization function (continued)**

| *Primary Task* | *Purpose* |
|---|---|
| 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 the disease, assures access to health services, and provides consultative services to the medical 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. |

2-33. Refer to FM 4-02.10 and FM 4-02.25 for additional information of theater hospitalization.

## SECTION V — DENTAL SERVICES

2-34. 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

2-35. There are three levels of dental support within the theater: 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

2-36. Unit-level dental care consists of those services provided by dental personnel organic to the supporting medical companies/troops of brigade combat teams, armored cavalry regiments, and Special Forces groups. This module provides emergency dental treatment to Soldiers during tactical operations.

### HOSPITAL-LEVEL DENTAL CARE

2-37. 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

2-38. Area dental support is provided for units that do not have organic dental assets. This coverage is provided by the—

- Medical company (dental services).
- Dental company (area support).

2-39. Both dental companies provide operational dental care and both have dental assets which can deploy when and where necessary to provide augmentation and or reinforcement to the area support squads.

# CATEGORIES OF DENTAL CARE

2-40. Within the theater, 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 US, 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

2-41. 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 tactical operations. Common examples of emergency treatments are simple extractions, providing antibiotics and pain medication, and temporary fillings.

### Essential Care

2-42. 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 tactical situation permits. Soldiers in dental Class 2 (untreated oral disease) should be provided essential care as the tactical situation and availability of dental resources permit. The scope of operational care includes definitive restoration, minor oral surgery, exodontic, periodontic, and prosthodontic procedures, as well as prophylaxis.

## COMPREHENSIVE DENTAL CARE

2-43. 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 theater. The scope of facilities needed to provide this level of dental support could equal that of Role 3 MTFs.

2-44. Table 2-5 discusses the primary tasks of the dental services function.

**Table 2-5. Primary tasks and purposes of the dental services function**

| ***Primary Task*** | ***Purpose*** |
|---|---|
| Comprehensive dental care | Restore an individual to optimal oral health, function, and esthetics. Normally provided in the continental United States-support base. |
| Operational care | Provide treatment in austere environments for Soldiers engaged in tactical operations. Operational care is provided in the theater 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 theater. |

2-45. Refer to FM 4-02.19 for additional information on dental services.

## SECTION VI — PREVENTIVE MEDICINE SERVICES

# MISSION

2-46. In past conflicts, disease and nonbattle injury rendered more Soldiers combat ineffective than combat action. 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

2-47. Preventive medicine falls under the warfighting function of protection and is concerned with both the enemy threat and the health threat. The enemy threat produces combat casualties. This threat depends on the types of weapons used, the will of the enemy to fight, and other operational concerns. To counter the health threat, comprehensive medical surveillance activities, occupational and environmental health 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

2-48. 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, enteric diseases, vectorborne disease, and other health threats. Echelons above brigade staff support consists of preventive medicine staff officers organic to the medical command (deployment support), medical brigade, medical battalion (multifunctional), and corps surgeon section. These staff officers serve as the commander's principal preventive medicine consultants and environmental sciences advisors.

# PRIMARY TASKS

2-49. Table 2-6 discusses the primary tasks of the preventive medicine function. For an in-depth discussion of preventive medicine activities refer to AR 40-5, Department of the Army Pamphlet (DA Pam) 40-11, FM 4-02.17, FM 4-25.12, and FM 21-10.

**Table 2-6. Primary tasks and purposes of the preventive medicine function**

| *Primary Task* | *Purpose* |
|---|---|
| Disease prevention and control | Prevent and control communicable diseases, 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/packaged water in a tactical environment. |
| Environmental health | Provide drinking water; recreational waters; ice manufacture; wastewater; pest and disease vector prevention and control; solid waste; hazardous waste; groundwater and subsurface release of hazardous constituents; regulated medical waste; waste disposal guidance; spill control; air quality; environmental noise; climatic injury prevention and control; and sanitation and hygiene. |
| 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 health, and health promotion | Provide Soldier health (to include Soldier medical and dental readiness), Family and community 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. |

## SECTION VII — COMBAT AND OPERATIONAL STRESS CONTROL

# FUNCTIONS

2-50. Combat and operational stress control are programs developed and actions taken by military leadership to prevent, identify, and manage adverse combat and operational stress reactions in units. This program 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 DOD Directive (DODD) 6490.02E, COSC activities include routine screening of individuals when recruited; continued surveillance throughout military service, especially before, during, and after deployment;

continual assessment and consultation with medical and other personnel from garrison to the battlefield, and the early identification of mild traumatic brain injury. Soldiers who are temporarily impaired or incapacitated with stress-related conditions are diagnosed as behavioral health 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,

# ORGANIZATIONS AND PERSONNEL

## BRIGADE COMBAT TEAMS

2-51. In the modular brigade combat teams, COSC support is provided by mental health sections assigned to the brigade support medical company of the brigade support battalion.

## AREA SUPPORT MEDICAL COMPANY

2-52. At echelons above brigade, MH sections are assigned to the area support medical companies that are normally assigned to the medical battalion (multifunctional).

## MEDICAL DETACHMENT, COMBAT AND OPERATIONAL STRESS CONTROL

2-53. Also at echelons above brigade, a medical detachment (combat stress and operational control) is usually assigned to the medical battalion (multifunctional) and provides direct support to the division or supporting at theater-level. The basis of allocation for the medical detachment (combat stress control) is 0.333 per brigade combat team; 1 per division; and 2 per theater. In support of a theater, this unit provides support on an area basis and provides additional support to the division/corps on orders. The medical detachment, (combat and operational stress control) consist 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 behavioral health team made up of social workers, clinical psychologist, psychiatrist, occupational therapists, psychiatric nurses, mental health specialists, and occupational therapy specialist. The forward support section consists of an 18-Soldier behavioral health team. Each behavioral health 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

2-54. Table 2-7 discusses the primary tasks of the COSC function.

**Table 2-7. Primary tasks and purposes of the combat and operational stress control function**

| *Primary Task* | *Purpose* |
|---|---|
| Implement combat and operational stress control plan/program | Prevent combat and operational stress reaction. |
| Perform combat and operational stress control unit needs assessment | Provide command with global assessment of the unit, with considerations of multiple variables that may affect leadership, performance, morale, and combat effectiveness of the organization. |
| Conduct traumatic events 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 health 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 postcombat and operational stress reactions. |
| 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. |

2-55. Refer to FM 4-02.51 and FM 6-22.5 for additional information on COSC.

## SECTION VIII — VETERINARY SERVICES

2-56. The US Army Veterinary Service is the executive agent for veterinary support to all Services with the exception of food inspection on US Air Force installations. Appropriate mixes of 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 veterinary unit 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 zoonotic (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 area of operations. 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 area of operations. Comprehensive veterinary medical and surgical programs are required to maintain the health of military working dogs. See DODD 6400.4 and FM 4-02.18 for additional information.

# ORGANIZATIONS

2-57. There are two types of veterinary units, the medical detachment (veterinary service) and the medical detachment (veterinary medicine).

### MEDICAL DETACHMENT (VETERINARY SERVICES)

2-58. The veterinary services detachment provides veterinary services to all branches of the Services throughout the area of operations in the areas of approving commercial food sources; food safety/security/sanitation; food service sanitation; military working dogs and other government-owned animals care; veterinary preventive medicine directed towards endemic zoonotic diseases and foreign

animal disease surveillance/mitigation; and stability operations in support of all branches of the Services throughout the area of operations. The veterinary services detachment is assigned to a MEDCOM [DS], a medical brigade, a medical battalion (multifunctional), or a joint/combined task force, or is functionally aligned to a security or logistics unit. In the event that there are no AMEDD units in the area of operations, the veterinary services detachment may be assigned under a task force surgeon to another Service medical organization. In the absence of a medical unit, the veterinary services detachment may be assigned to a functionally aligned security or logistics unit. This detachment may be deployed to provide veterinary service in an area of operations and provides food safety, security, and quality assurance of inspections audits as a primary means for preventing foodborne illnesses in US forces and Role 1 and Role 2 veterinary medical care to military working dogs.

### MEDICAL DETACHMENT (VETERINARY MEDICINE)

2-59. The veterinary medicine detachment establishes a centrally located veterinary hospital facility in proximity to the military working dog population supported along normal ground or aeromedical evacuation routes or other supported units as assigned. This location facilitates the receipt, treatment, and evacuation of injured military working dogs in the area of operations. The veterinary medicine detachment also has the capability for deploying a team into high animal casualty areas for short periods of time.

## PRIMARY TASKS

2-60. Table 2-8 discusses the primary tasks of the veterinary services function.

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

| *Primary Task* | *Purpose* |
|---|---|
| Animal medical care | Provide medical care for military working dogs and other government-owned animals. |
| Inspection of subsistence | Ensure the quality and safety of food sources for deployed forces. |
| Veterinary preventive medicine | Reduce the transmission of zoonotic diseases transmissible to man. |

2-61. Refer to FM 4-02.18 for additional information on veterinary services.

## VETERINARY ROLES OF MEDICAL CARE

2-62. The roles of veterinary medical care for government-owned animals is discussed in a similar fashion as are the roles of medical care are used to describe the successive and increasing capabilities to provide care to our injured and wounded Soldiers in the operational environment. The major difference is there are very few organic veterinary assets in the brigade combat team. The majority of veterinary assets in the theater is assigned to echelons above brigade veterinary units and must be projected forward to provide care in the brigade area.

### VETERINARY ROLE 1 MEDICAL CARE

2-63. This role of veterinary medical care is provided by an animal care specialist (military occupational specialty 68T) assisted in his duties by the military working dog, equestrian, livestock, and the Navy marine mammal handler who provides immediate first aid for his military working dog, horse, livestock, or marine mammals in the event of injury with or without a veterinarian (area of concentration 64A) present.

#### Animal Handler

2-64. Nonveterinary personnel, such as military working dog, equestrian, livestock, and/or Navy marine mammal handlers perform limited lifesaving and first aid procedures until an animal care specialist or a veterinarian is available.

## Animal Medical Specialist

2-65. Animal care specialists are organic to Army Engineer, Ranger, Navy, and medical detachment, (veterinary service) 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

2-66. 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 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 scraping, 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, feces) for further evaluation.
- Conducting minor sick call by the animal care specialist under the indirect supervision of a veterinarian (such as telemedicine or preauthorized protocol). Treatment may include restorating the airway by invasive procedures; use of intravenous fluids and medications; and applying of splints, bandages, and tourniquets.
- Preventing disease and nonbattle injury (such as heat/cold injuries, bloat, arthropod/reptile bites/stings, vomit/diarrhea, and the like).
- Performing routine preventive care for 18 to 24 dogs and emergency care up to 6 dogs and kennel inspection support for units in the supported area.

2-67. Veterinary Role 1 medical care is provided by the animal care specialist and veterinarian assigned individually to various Army, Air Force, Marine, or Navy 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 Navy 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 medical 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.

## VETERINARY ROLE 2 MEDICAL CARE

2-68. Veterinary Role 2 medical care is provided by forward deployed veterinary service support team veterinarian and an animal care specialist from the medical detachment (veterinary service) and includes veterinarian-directed resuscitation and stabilization and may include advanced trauma management, emergency medical procedures, and forward emergency resuscitative surgery to dogs, horses, livestock, and Navy 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).

2-69. 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 and civil support operations.
- Endemic zoonotic and foreign animal disease epidemiology surveillance and control by examination of local farm animals in the area, captured wildlife, and stray animals.

2-70. 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 service medical team can care for up to 50 dogs for up to 72 hours with significant degradation of other aspects of the veterinary mission.

***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 rider, livestock, or Navy marine mammal handler is also expected to stay with his animal.

## VETERINARY ROLE 3 MEDICAL CARE

2-71. This role of veterinary medical care is provided by the veterinary medical service team which consists of a clinical specialty veterinarian (area of concentration 64F) and three animal care specialists. The veterinary medical service team was designed to care for dogs only. No Veterinary Role 3 capability is available in theater for horses, livestock, or Navy marine mammals. If Veterinary Role 3 care is required, the horses, livestock, or Navy marine mammals would be transported/evacuated back to CONUS.

2-72. 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 medical service team per medical detachment (veterinary service).

2-73. 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.
- Theater-wide patient tracking of military working dogs to include evacuation.
- Established theater military working dog evacuation policy and standards of care.
- Training for veterinarians and animal care specialists.
- Development of theater 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.

2-74. The veterinary medical service 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

2-75. Veterinary Role 4 medical care is found in the CONUS at the Department of Defense Military Working Dog Center and outside the continental United States at the Dog Center, Europe and 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 IX — MEDICAL LOGISTICS

# MEDICAL LOGISTICS SYSTEM

2-76. The medical logistics 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.

2-77. The field medical logistics system consists of the following organizations:

- United States Army Medical Materiel Agency's medical logistics support team.
- Medical logistics management center.
- Medical logistics company.
- Blood support detachment.

# ORGANIZATIONS AND PERSONNEL

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

2-78. The medical logistics support team is a deployable table of distribution and allowances organization consisting of medical logistics personnel (military, DA civilians, and contractors) from the US Army Medical Materiel Agency. The mission of the medical logistics 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 medical logistics support team is normally under the operational control of the US Army Materiel Command's Army field support brigade. The medical logistics support team supports the reception, staging, onward movement, and integration of Army prepositioned stocks unit sets and sustainment stocks pre-positioned around the world. After completing the Army prepositioned stocks transfer or other assigned mission, the medical logistics support team redeploys to CONUS. At the end of the operation, the medical logistics support team may again deploy to the area of operations to support the redeployment of US forces and materiel from the area of operations to follow-on CONUS or outside the continental US locations.

## MEDICAL LOGISTICS MANAGEMENT CENTER

2-79. The medical logistics 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 Army Service component command surgeon's policy. The medical logistics management center operates in a split-based mode, with a medical logistics management center base organization and two forward support teams (early entry), and two forward support teams (follow-on). The medical logistics 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) combines 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 medical logistics management center, with the medical logistics company, serves as the single integrated medical logistics manager for joint operations. The medical logistics support team also provides technical guidance to medical contracting personnel within the area of operations.

## MEDICAL LOGISTICS COMPANY

2-80. The medical logistics company provides medical materiel, medical equipment maintenance, optical lens fabrication and repair, and patient movement items support to brigade combat teams and echelons above brigade medical units operating within the area of operations. The medical logistics company has no organic blood support capability. A cell from the blood support detachment collocates with the medical logistics company to provide blood support to the brigade combat teams and echelons above brigade medical units. The medical logistics company has the capability for limited self-sustainment during initial operations, meeting the requirement for early entry into the area of operations or as part of a task force organization. The company is normally under the mission command of the headquarters and headquarters detachment, medical battalion (multifunctional).

## BLOOD SUPPORT DETACHMENT

2-81. Theater blood support is provided to US military, and as directed, multinational military and indigenous civilian MTFs. The Army, US Navy, and US Air Force maintain individual blood programs to meet normal peacetime requirements. During contingency operations, a Joint Blood Program Office is established under the geographic combatant commander to provide blood support in theater. The program is theaterwide and interfaces with the CONUS blood banking system. One or more area joint blood program offices may be established to provide regional blood management in the theater. See JP 4-02 and FM 4-02.1 for more definitive information.

2-82. Theater blood support consists of CONUS-based resupply of blood components. In a developing theater, during the build-up period, immediate blood requirements may be provided by pre-positioned frozen blood components. These stocks are designed to meet initial blood requirements until the logistical system can deliver blood components to the theater. Liquid blood products enter the theater through US Air Force expeditionary blood transshipment centers for further shipment to Army blood support detachments.

2-83. Different levels of blood support exist at each role of care. No blood or blood products are provided at Role 1. Roles 2 and 3 MTFs acquire necessary blood products from the blood support detachments. Blood support for Role 2 MTFs (including forward surgical teams) consists of a limited number of Type O liquid red blood cells (15 percent of all blood distributed in theater should be Rh negative). Combat support hospitals at Role 3 have blood-banking capabilities that allow them to store blood products. The combat support hospital blood inventory management and resupply operations are coordinated directly with the supporting blood support detachments.

2-84. The blood support detachment serves as the Army's blood supply unit. The detachment provides collection, manufacturing, storage, and distribution of blood and blood products to echelons above brigade

medical units and to other operations (see FM 4-02.1). The detachment provides flexibility to shift personnel assets between collection and distribution missions as required. Blood and blood products are stored and distributed under rigid specifications and managed by standard information systems. Air movement is the preferred method for moving blood and blood products. Army blood support in the area of operations is the responsibility of the supporting blood support detachment. The blood support detachment collects, manufactures, receives, stores, and distributes blood and blood products on an area basis. The commander of the blood support detachment may also serve as the area joint blood program office as part of the theater Joint Blood Program. Primary blood support in the area of operations during a high operation tempo is based on resupply from the CONUS donor base. Commanders may task the Army blood support detachment to provide blood to other Services on an area basis.

# PRIMARY TASKS

2-85. Table 2-9 describes the primary tasks of the medical logistics function.

**Table 2-9. Primary tasks and purposes of the medical logistics function**

| *Primary Task* | *Purpose* |
|---|---|
| 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 full spectrum 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 medical units and other operations. |
| 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 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. |

2-86. Refer to JP 4-02, FM 4-02.1, Technical Manual (TM) 4-02.70, TM 8-227-3, TM 8-227-11, and TM 8-227-12.

## SECTION X — MEDICAL LABORATORY SERVICES

# OPERATIONAL

2-87. The area medical laboratory includes capabilities in the identification and field confirmation of suspect CBRN agents, endemic diseases, and occupational and environmental health hazards. Its focus is the total health environment of the theater, not individual patient care. Its facility conducts studies in pest identification, the efficacy of pesticides, frequency of infectious agents, monitoring immune response, and transmission of zoonotic diseases, and field confirmatory level of identification of suspect CBRN samples/specimens in theater. Its personnel also function as consultants to hospital clinical laboratory services within the theater. It may task-organize teams and employ them forward to troubleshoot a particular problem.

# CLINICAL

2-88. All Role 2 MTFs provide basic clinical laboratory services within the theater. They perform basic procedures in hematology, urinalysis, microbiology, and serology. Role 2 MTFs receive, maintain, and transfuse blood products.

2-89. The clinical laboratory in the combat support hospital performs procedures in biochemistry, hematology, urinalysis, microbiology, and serology in support of clinical activities. The combat support hospital also provides blood-banking services.

# PRIMARY TASKS

2-90. Table 2-10 discusses the primary tasks of the medical laboratory services function.

**Table 2-10. Primary tasks and purposes of the medical laboratory services function**

| ***Primary Task*** | ***Purpose*** |
|---|---|
| Analytical, investigation, and consultative capabilities | • Identify chemical, biological, radiological, and nuclear threat agents in biomedical specimens and other samples from the area of operations.<br>• 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 medical units, biological integrated detection system teams, and chemical company elements operating in the area of operations. |

2-91. Refer to FM 4-02.17 for additional information on area medical laboratory services and refer to FM 4-02.6 and FM 4-02.10 for additional information on clinical laboratory services.

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## Chapter 3

# Army Medical Department Operational Force and the Generating Force

The AMEDD has a long tradition of providing world-class medical care across global battlefields, operational environments, and under austere and challenging conditions. Wherever an injured or ill American Soldier is located, the US Army will project its resources to locate, acquire, treat, stabilize, and evacuate our wounded Warrior 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 theater. 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 operational environments to world-class fixed medical facilities 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 theater* 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.

## SECTION I — DEPLOYED FORCES

## MEDICAL COMMANDER

3-1. The medical commander exercises mission command (authority and direction) over his subordinate medical resources. As discussed in FM 3-0, the commander is the focus of mission command and uses two processes in decisionmaking. 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 decisionmaking 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. Only a commander is empowered to act immediately on an intuitive decision which reaches a conclusion that emphasizes pattern recognition based on knowledge, judgment, experience, education, intelligence, boldness, perception, and character. As commanders, they realize that, once executed, the effects of their decisions are frequently irreversible. Therefore, they anticipate actions that follow their decisions.

3-2. The leader-developed medical professional has been trained in critical thinking, assessing situations, determining requirements for follow-on services, and decisive decisionmaking 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. Without these skills, he would be unable to act decisively in the life and death situations he has faced throughout his career. 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 tactical commander and to successfully accomplish his Title 10 responsibilities for the care of his Soldiers.

3-3. 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, acting aggressively and independently to 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 medical command (deployment support) commander to retain a regional focus in support of the combatant commander's and Army Service component command commander's theater engagement plan, while still providing effective and timely direct support to the supported tactical commanders and providing general support on an area basis to theater forces at echelons above brigade (such as those conducting aerial ports of debarkation, seaports of debarkation, and tactical assembly areas operations or to other temporary or permanent troop concentrations). One consequence of the enduring regional focus of the Army Service component command is to drive specialization in its subordinate medical command (deployment support) 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

3-4. A command surgeon is designated at all levels of command. This AMEDD officer is a special staff officer charged with planning for and monitoring the execution of the AHS mission.

3-5. The command surgeon is responsible for ensuring that all AMEDD medical functions (Chapter 1) are considered and included in operation plans and operation orders. The command surgeon retains technical supervision of all medical operations. At the higher levels of command, the scope of duties and responsibilities expand to include all subordinate levels of command.

3-6. 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 injury rates may rise.

3-7. The duties and responsibilities of command surgeons may include, but are not limited to—

- Advising the commander on the health of the command.
- Ensuring early presence/arrival of preventive medicine resources into the area of operations.
- Developing and coordinating the HSS and FHP annexes of operation plans 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.
- Maintaining situational understanding by coordinating for current medical information with surgeons of the next higher, adjacent, and subordinate headquarters.
- Recommending task organization of medical units/elements to satisfy all mission requirements.
- Recommending policies concerning support of civil-military operations.
- Monitoring the availability of and recommending the assignment, reassignment, and utilization of AMEDD personnel within his area of operations.
- Evaluating and interpreting medical statistical data.
- Recommending policies and determining requirements and priorities for medical logistics (to include blood and blood products, medical supply/resupply, medical equipment maintenance and repair services, production of medical gases, optometric support, fabrication of single-and multivision optical lenses, spectacle fabrication and repair, and medical contracting support).
- Recommending medical evacuation policies and procedures.
- Monitoring medical regulating and patient tracking operations.
- Determining medical training policies and programs (to include combat lifesaver, unit field sanitation team, and combat medic/health care specialist) refresher training and training on the administration of pain medication.
- 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; standing operating procedures; applicable STANAGs and ABCA standards; memorandums of understanding or agreement; and Status of Forces Agreements.
- Ensuring the documentation of the individual health record and/or electronic medical records is maintained on each Soldier at the primary care MTF.
- Ensuring compliance with the theater blood bank service program.
- Ensuring a viable veterinary services program (to include inspection of subsistence and outside the continental US 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 of the use of suspect biological and chemical warfare agents by opposition forces. This also includes the capability for specimens/samples packaging and handling requirements and escort/chain of custody requirements. (Refer to FM 4-02.7, FM 4-02.17, FM 4-02.285, and FM 8-284 for additional information on medical laboratory capability.)
- Planning for and implementing preventive medicine operations (to include preventive medicine programs and initiating preventive medicine measures to counter the health threat). (Refer to paragraph 1-5, Appendix A, and FM 4-02.17 for additional information on the health threat.)
  - Planning for and ensuring pre- and postdeployment health assessments and reassessments are accomplished.
  - Establishing and executing a comprehensive health surveillance program (refer to DODD 6490.02E, DOD Instruction (DODI) 6490.03, AR 40-5, DA Pam 40-11, and FM 4-02.17 for an in-depth discussion).

  - Establishing and executing an occupational and environmental health surveillance program (FM 3-34.5) to include any associated health risk communication processes/analyzes/ programs.
  - Recommending COSC/behavioral health 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 (Provisional).
  - Centers for Disease Control and Prevention.
  - United States Public Health Services.
  - International organizations (United Nations, the World Health Organization, the Pan American Health Organization, and/or other nongovernmental organizations).
  - Information gathered from site visits to host-nation medical facilities.
- Providing medical technical supervision in detainee operations.
- Integrating Army medical civil support operations with the federal government.
- Ensuring that the general threat, health threat, and medical intelligence considerations are integrated into AHS plans and orders.
- Identifying the commander's critical information requirements that include priority intelligence requirements and friendly forces information requirements that pertain to the health threat and ensuring they are incorporated into the command's intelligence requirements.
- Coordinating for foreign humanitarian assistance, disaster relief, medical response to CBRN or terrorist incidents, and refugee support, when authorized and so directed.
- Advising commanders on medical CBRN defensive actions (such as immunizations and use of chemoprophylaxis, antidotes, pretreatments, and barrier creams).
- Ensuring that investigational new drug protocols are established and implemented. Refer to DODI 6200.02 and AR 40-7 for additional information on investigational new drugs.
- Assessing special equipment and procedures required to accomplish the medical 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 parkas, jungle boots, are some examples).
  - 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 the difficulty in traversing the terrain.
  - Having individual Soldiers carry additional medical items, such as bandages, tourniquets, and intravenous fluids.
  - Coordinating training on: pain management techniques; extrication of patients from armored vehicles; extraction from above, below, and at ground level, and from under rubble and debris; refresher or initial training for combat lifesavers; and other topics necessitated by the operational mission.
- 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 enemy prisoners of war, retained personnel, or detainees. (Refer to Chapter 4 for additional information on the Geneva Conventions.)

- Submitting to higher headquarters those recommendations on professional medical problems/conditions that require research and development.
- Coordinating and monitoring patient decontamination operations (FM 4-02.7) to include—
  - Layout and establishment of patient decontamination site.
  - Use of collective protection.
  - Use of nonmedical Soldiers (augmentees) to perform patient decontamination procedures under medical supervision.

**The following paragraph implements STANAGs 2132 and 2350 and ABCA Standard 470.**

3-8. 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.

- The command surgeon must ensure 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); and 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).

***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.

- The command surgeon 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.

## SECTION II — THE GENERATING FORCE

# MISSION FOCUS

3-9. The primary 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.

3-10. All elements of the Army, whether the generating force or operational Army, perform functions specified by law (Figure 3-1). 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 3-1 exhaustive.

| |
|---|
| Recruiting |
| Organizing |
| Supplying |
| Equipping (including research and development) |
| Training |
| Servicing |
| Mobilizing |
| Demobilizing |
| Administering (including the 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 3-1. Title 10 functions**

# SUPPORT TO THE TACTICAL COMMANDER

3-11. The generating force fulfills numerous critical roles with regards to supporting the Soldiers deployed in operational theaters. The US Army Medical Command tables of distribution and allowances organizations conduct combat 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 life styles 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

3-12. 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 USAMEDDCOM 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 theaters.

### TRAINING

3-13. All medical military occupational specialties require school training for award. 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 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 US Army Medical Command treatment facilities.

## SECTION III — THE ARMY MEDICAL DEPARTMENT TEAM

# SYNERGY

3-14. To ensure a seamless, continuum of care from the point of injury or wounding to the CONUS-support base exists, in order to decrease morbidity and mortality and to reduce disability, a synergistic effort is required between AMEDD table of organization and equipment (operational forces) and table of organization and equipment (the generating force) organizations and resources and those found in other areas of operation 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

3-15. 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.

3-16. 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 operational environments.

3-17. 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 FORCES

3-18. The deployed medical force ensures that the tactical 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

operational environment. Only a focused, responsive, dedicated medical effort can reduce morbidity and mortality and ensure that the tactical commander can maintain the health of the Soldiers and service members from the other Services entrusted to his care by our Nation.

### WITH OUR SOLDIERS AND THEIR FAMILIES

3-19. 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.

## CLINICAL AND OPERATIONAL FOCUS

3-20. The provision of the AHS in the operational environment is a complex process and requires continuous synchronization and comprehensive planning. The AMEDD has adopted a policy that the best qualified individual will be selected for leadership positions. Leaders who have trained with, have gained the confidence of, and have supported the movement and maneuver, fires, and sustainment units in an operational environment are more effective in planning for and executing real-world medical missions. The issue that requires continuous synchronization is the relationship of the operational aspects of the mission (normally represented by the Medical Service Corps officer) and the clinical aspects of the mission (normally represented by a Medical Corps officer, Army Nurse Corps officer, Dental Corps officer, physician assistant, or other health care provider).

### CLINICAL ASPECT

3-21. 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

3-22. 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 [Chapter 4]).

3-23. In most tables of organization and equipment 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 table of organization and equipment 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.

3-24. 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 operation. Likewise, a unit that can execute all of its military tasks is not successful if the patients entrusted to its care die or their conditions deteriorate because no consideration was given to their clinical needs during an operational relocation.

3-25. 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 a forward surgical team 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 forward surgical team cannot provide the required surgical care to stabilize patients for further evacuation and the unit cannot survive in the operational environment because it lacks a means for defense.

3-26. To enhance the delivery of health care in the operational environment 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

3-27. 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.

3-28. 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.

3-29. 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.

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## Chapter 4

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

## THE LAW OF LAND WARFARE

4-1. 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.

4-2. 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.

4-3. Refer to DODD 2311.01E, DA Pam 27-1, and FM 27-10 for additional information on the Land of Land Warfare.

## SOURCES OF THE LAW OF LAND WARFARE

4-4. The Law of Land Warfare is derived from two principal sources.

- Lawmaking treaties or conventions (such as The Hague and Geneva Conventions).
- Custom (practices which by common consent and long-established uniform adherence has taken on the force of law).

4-5. Under the US Constitution, treaties constitute part of the Supreme Law of the Land, and thus must be observed by both military and civilian personnel. The unwritten or customary Law of Land Warfare is also part of the US law. It is binding upon the US, citizens of the US, and other persons serving this country.

## SECTION I — GENEVA CONVENTIONS

4-6. The US 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 Ship-wrecked 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).

# PROTECTION OF THE WOUNDED AND SICK

4-7. 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

4-8. 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 lying 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 GC.
- 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 who 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

4-9. 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 US, will enjoy protection under both Conventions until his recovery. The GWS will take precedence over the GPW where the two overlap.
- Article 16 of the GWS requires the recording and forwarding of information regarding enemy wounded, sick, or dead. (See AR 190-8 and Field Manual Interim [FMI] 4-02.46 for disposition of an enemy prisoner of war after hospital care.)
- When intelligence indicates that large numbers of enemy prisoners of war/detainees may result from an operation, medical units may require reinforcement to support the anticipated additional enemy prisoner of war/detainee patient workload. Procedures for estimating the medical workload involved in the treatment and care of enemy prisoner of war patients are described in FM 8-55.

## SEARCH FOR AND COLLECTION OF CASUALTIES

4-10. 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

4-11. 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

4-12. Certain provisions of the GC 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 echelons above brigade 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

4-13. 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.

4-14. 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, after having cared for them until they are fit to travel. No sick or injured prisoner of war may be repatriated against his will during hostilities (Article 109, GPW).

4-15. The following shall be directly repatriated (Article 110, GPW):

- Incurably wounded and sick whose mental or physical fitness seem 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.

4-16. 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.

4-17. The conditions which prisoners of war accommodated in a neutral country must fulfill in order to permit their repatriation will be fixed, and will likewise their status, by agreement between the Powers concerned. In general, prisoners of war 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.

4-18. Upon the outbreak of hostilities, Mixed Medical Commissions will be appointed to examine sick and wounded prisoners of war and to make all appropriate decisions regarding them (Article 112, GPW). However, prisoners of war, 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

4-19. 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

4-20. 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 prisoners of war, 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 prisoners of war require." Article 25 personnel are prisoners of war, 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 prisoners of war is accomplished upon the cessation of hostilities.

## SPECIFIC CASES

4-21. 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 US 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 noncommissioned officers (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 brigade combat team 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 (an MS 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 US 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

4-22. 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 US armed services, DD Form 1934 [Geneva Conventions Identity Card for Medical and Religious Personnel Who Serve in or Accompany Armed Forces]). Article 25 personnel and medical personnel serving in positions that do not meet the exclusively engaged criteria of Article 24 are not entitled to carry the medical personnel identification card or wear the distinctive emblem armband. Such personnel carry a DOD Common Access Card, and under Article 25, may wear an armband bearing a miniature distinctive emblem when executing medical duties.

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

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

4-23. 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

4-24. 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 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 on the battlefield. 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 belligerents 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

4-25. 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 prisoners of war. A medical aircraft refusing a summons to land is a fair target.

## IDENTIFICATION

4-26. The GWS contains several provisions regarding the use of the Red Cross emblem on medical units, establishments, and transports. (The identification of medical personnel has been previously discussed.)

- Article 39 of the GWS reads as follows: "Under the direction of the competent military authority, the emblem shall be displayed on the flags, armlets and on all equipment employed in the Medical Service."
  - There is no obligation of a belligerent to mark his units with the emblem. Sometimes a commander (generally no lower than a brigade commander for US 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." (Paragraph 2, Article 42, GWS.) This provision makes it optional to fly the national flag with the Red Cross flag. It should be noted that on a battlefield, 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 tactical 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 tactical operations, the

camouflage of medical facilities may be ordered by a NATO commander of at least brigade level or equivalent. Such an order is to be temporary and local in nature and countermanded as soon as the circumstances permit. It is not envisaged that fixed, large, medical facilities would be camouflaged. The STANAG defines "medical facilities" as "medical units, medical vehicles, and medical aircraft on the ground."

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

4-27. 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

4-28. 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 ceasing such activity.

## ACTS HARMFUL TO THE ENEMY

4-29. The phrase "acts harmful to the enemy" is not defined in the Convention, but should be considered to include acts the purpose or effect of which is to harm the enemy, by facilitating or impeding military operations. Such harmful acts would include, for example, the use of a hospital as a shelter for able-bodied combatants, as an arms or ammunition dump, or as a military observation post. Another instance would be the deliberate sitting of a medical unit in a position where it would impede an enemy attack.

## WARNING AND TIME LIMIT

4-30. 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

4-31. 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 FM 4-02.2 for additional information on the use of smoke and obscurants for medical operations.

# CONDITIONS NOT DEPRIVING MEDICAL UNITS AND ESTABLISHMENTS OF PROTECTION

## CONDITIONS

4-32. 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

4-33. 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

4-34. 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-US Army Medical Command personnel in medical units are not required to train and qualify on crew-served weapons. However, US Army Medical Command 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 (AR 350-1).
- 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

4-35. 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 prisoners of war.

### Arms and Ammunition taken from the Wounded

4-36. 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

4-37. 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

4-38. 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

4-39. Amendments to the Geneva Conventions have been ratified by some of our allies and potential adversaries. The US representative to the diplomatic conference signed these amendments, but they have not been officially ratified by our government.

## COMPLIANCE WITH THE GENEVA CONVENTIONS

4-40. The US 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 prisoners of war 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).

4-41. Because even the perception of impropriety can be detrimental to the mission and US interests, medical commanders must ensure that they do not give the impression of impropriety in the conduct of medical operations. For example, if a multifunctional medical battalion commander included in the tactical standing operating procedure 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 tactical standing operating procedure 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

4-42. It is DOD policy that the US 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 US custody will receive medical care consistent with the standard of medical care that applies for US military personnel in the same geographic area. Refer to DODD 2310.01E, DODI

2310.08E, JP 3-63, JP 4-02, AR 40-400, AR 190-8, FM 3-39.40, FMI 4-02.46, FM 4-02-12, and FM 27-10 for additional information on medical care for retained and detained personnel.

## SECTION II — MEDICAL ETHICS

# ETHICAL CONSIDERATIONS FOR THE MEDICAL TREATMENT OF DETAINEES

4-43. 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 enemy prisoners of war, detainees, and civilians during conflict, will ensure the ethical treatment of all sick and wounded personnel.

4-44. 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 behavioral health 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 US law.
- Health care personnel charged with the medical care of detainees have a duty to protect detainees' physical and behavioral health 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 US 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 behavioral health.
- 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 behavioral health 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.

4-45. 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 US 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 emergency medical treatment, 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.

4-46. Detained personnel must have access to the same available standard of medical care as the US 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 US and multinational forces. During detainee operations, the patient administrator, the Criminal Investigation Division, 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.

4-47. Health care personnel shall safeguard patient confidences and privacy within the constraints of the law. Under US 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 US 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.

4-48. 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.

4-49. 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.

4-50. 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.

4-51. 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. Refer to FM 3-39.40 for additional information on internment facility operations.

4-52. 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.

4-53. 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./.

4-54. 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.

## Chapter 5

# Army Health System Operations

Army Health System support is provided across full spectrum operations and various types of mission support (traditional support to a deployed force, stability operations, and civil support operations) may be provided simultaneously in various locations throughout the area of operations. 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 operation to the next.

## SECTION I — ARMY HEALTH SYSTEM PLANNING

## OPERATIONAL THEMES

5-1. An operational theme describes the character of the dominant major operation being conducted at anytime within the land force commander's area of operations. The operational theme helps convey the nature of the major operation to the force to facilitate common understanding of how the commander broadly intends to operate. For an in-depth discussion of operational themes, refer to FM 3-0 and for medical considerations refer to FM 4-02.12.

5-2. As all major operations are joint in nature, the operational themes can be used to group similar types of activities under the predominant theme. Major operations normally are characterized by the offense and defense but may also include stability operations. Further, within the operational environment all three types of operations can be occurring simultaneously. There are five operational themes which span full spectrum operations—

- Major combat operations.
- Irregular warfare.
- Peace operations.
- Limited intervention.
- Peacetime military engagement.

## OPERATIONAL VARIABLES

5-3. As the operational environment is comprised of all of the factors, both military and civilian, that affect the conduct of military operations in an area of operations, 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 the operational environment that focus on the human aspects of the environment. Commanders and planners can use the memory aid *PMESII-PT* (**P**olitical, **M**ilitary, **E**conomic, **S**ocial, **I**nformation, **I**nfrastructure, **P**hysical environment, **T**ime) 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 medical planner to consider the medical aspects of an operation on a much broader scale than the immediate area of operations. The medical command (deployment support) provides this regional focus in support of the combatant commander's theater engagement strategy. For a detailed discussion of each of the PMESII-PT considerations, refer to FM 3-0.

5-4. Table 5-1 provides medical factors for consideration in relation to the operational variables. This table is not an all-inclusive listing but does provide the medical planner with some initial considerations.

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

| *Variable* | *Factors* | *Medical Aspects* |
|---|---|---|
| **P**olitical | • Legitimacy.<br>• Responsibility.<br>• Ideas.<br>• Beliefs.<br>• Actions.<br>• Control.<br>• National will. | • Health status of population.<br>• Public health issues.<br>• Accessibility to health care.<br>• Nutritional status of the population and/or subgroups of the population. |
| **M**ilitary | • Equipment.<br>• Manpower.<br>• Doctrine.<br>• Training levels.<br>• Resource constraints.<br>• Leadership.<br>• Organizational culture.<br>• History.<br>• Nature of civil-military relations. | • Development of military medical infrastructure.<br>• Trauma care capabilities.<br>• Medical evacuation.<br>• Forward surgical capabilities.<br>• Hospitalization capabilities.<br>• Disease and nonbattle injury rates.<br>• Blood supply and blood banking capabilities.<br>• Organic medical assets.<br>• Area medical support capabilities.<br>• Medical equipment and repair.<br>• Medical logistics system.<br>• Behavioral health and treatment of combat stress reactions capabilities.<br>• Rehabilitative and convalescent care capabilities. |
| **E**conomic | • Industrial organizations.<br>• Trade.<br>• Development (including foreign aid).<br>• Finance.<br>• Monetary policy and conditions.<br>• Institutional capabilities.<br>• Geography.<br>• Legal constraints. | • The economic base can affect health care for both the human and the animal populations in the nation.<br>• 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.<br>• The gross national product and the per capita income of the population affects the availability of resources for the government to expend on public health concerns and health care in general.<br>• When the medical 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. |

**Table 5-1. Medical aspects of the operational variables (continued)**

| *Variable* | *Factors* | *Medical Aspects* |
|---|---|---|
| **S**ocial | • Demographics.<br>• Religion.<br>• Migration trends.<br>• Urbanization.<br>• Standard of living.<br>• Literacy and nature of education.<br>• Cohesiveness and activity of cultural, religious, and ethnic groups. | • Age, gender, and genetics affect how individuals are affected by disease and existing environmental factors.<br>• Religion affects how people view medical intervention; it can affect how a person will comply with medical treatment regimes and whether they will accept recommended treatments (such as the use of blood transfusions).<br>• 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.<br>• Urbanization can increase the spread of infectious diseases due to inadequate living space, improper ventilation, poor sanitation practices, and lowered immunity.<br>• If public health and disease prevention programs are not instituted, the general health of the population or the affected subpopulation will decrease.<br>• 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.<br>• 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.<br>• Providers must be cautious in using graphic aids to communicate with their patients, as the explicit graphics may be considered offensive. |
| **I**nformation | • Collect, process, disseminate, or act on information used in decisionmaking.<br>▪ Conduct, inform, and influence.<br>▪ Mission command warfare.<br>▪ Operations security.<br>▪ Military deception. | • Availability of mass communications enablers for public health warnings, alerts, and information.<br>▪ Telephones.<br>▪ Televisions.<br>▪ Radios.<br>▪ Newspapers/periodicals.<br>▪ Computers/e-mail. |

**Table 5-1. Medical aspects of the operational variables (continued)**

| | | |
|---|---|---|
| **I**nfrastructure[1] | • Utilities.<br>• Sanitation and public health.<br>• Transportation. | • Availability of electricity and running water.<br>• Number of medical providers (by category).<br>• Numbers of primary, secondary, and tertiary medical treatment facilities.<br>• Status of waste disposal.<br>• Sanitation practices and standards (availability of toilets, showers, and bathing facilities).<br>• 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]). |
| **P**hysical environment | • Man-made structures (including urban areas).<br>• Climate and weather.<br>• Topography.<br>• Hydrology.<br>• Natural resources.<br>• Biological features and hazards.<br>• Other environmental conditions. | • Are brick and mortar structures available for use as medical treatment facilities?<br>• Climate and weather effects on—<br>▪ Disease vectors.<br>▪ Categories and types of injuries.<br>▪ Acclimatization issues pertaining to heat, cold, or altitude.<br>▪ Medical evacuation operations.<br>• Topography and hydrology considerations include—<br>▪ Character and types of injuries to be encountered.<br>▪ Natural barriers to medical evacuation.<br>▪ Lines of patient drift.<br>▪ Suitable for farming and for grazing animals.<br>• Natural resources to include the availability of medicinal herbs.<br>• Presence of toxic plants and animals and whether they pose a health hazard to deployed troops. |
| **T**ime | • Anticipated duration of operation. | • 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. |

1 For a more detailed listing of factors on the medical infrastructure, refer to Tables A-1 and A-2.

# TASK ORGANIZATION

5-5. Task organization is a tool used by commanders to tailor their forces to specific mission requirements. Task-organization is a temporary grouping of forces designed to accomplish a particular mission. Traditionally, task organization was accomplished by combining entire units; however with the advent of modularity, commanders are task organizing elements of the organization rather than the entire organization. This enables a commander to extract the individual capabilities required for a specific mission, to project the smallest footprint possible, yet still be able to effectively and efficiently accomplish the mission. Modularly designed units with deployable functional elements identified with a standard requirements code can be easily integrated into the time phased force deployment list process to ensure the rapid movement of both the unit's/element's personnel and equipment. Characteristics to examine when

task organizing the force include, but are not limited to: training, experience, equipage, sustainability, operating environment, enemy threat, and mobility. Additional considerations include constraints on manpower (troop ceilings), ability for a unit or element to be self-sufficient (for example, forward surgical team 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).

5-6. The medical battalion (multifunctional) is a versatile mission command organization which can serve as the parent unit when developing a medical task force. The medical battalion (multifunctional) 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 TACTICAL OPERATIONS

5-7. 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, medical resources must be arrayed in close proximity to the forces supported. This also permits the medical 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.

5-8. 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 operational environment, medical support plans must adhere to the AHS principles (paragraphs 1-35 through 1-42). Within noncontiguous operations, the linear array of medical units will not always occur and medical units must fully understand the various support relationships described in the operation orders to ensure that a seamless continuum of health care is established and can be maintained.

5-9. The tactical medical evacuation plan for the 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.

5-10. The primary tasks for offensive operations are depicted in Table 5-2 along with the key medical considerations for these types of operations.

**Table 5-2. Primary tasks, purposes, and key medical considerations for offensive operations**

| *Primary Tasks* | *Purposes* | *Key Medical Considerations* |
|---|---|---|
| • Movement to contact<br>• Attack<br>• Exploitation<br>• Pursuit | • Dislocate, isolate, disrupt, and destroy enemy forces.<br>• Seize key terrain.<br>• Deprive the enemy of resources.<br>• Develop intelligence.<br>• Deceive and divert the enemy.<br>• Create a secure environment for stability operations. | • All medical functions fully synchronized by medical mission command.<br>• 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.<br>• Trauma care, forward resuscitative care, and en route medical care to sustain the patient through medical evacuation to the appropriate role of care.<br>• Responsive medical logistics which facilitates and sustains the treatment of combat casualties during the fight.<br>• Theater hospitalization to provide essential care in theater to all categories of patients. |

5-11. Army Health System support operations in defensive operations are similar to those in offensive operations; however, normally the timeframe in which the operations must be conducted is normally compressed. The only means for increasing the mobility of medical units is to evacuate the patients they are holding. When it is anticipated that rapid shifts will occur in the operational environment, medical units must evacuate patients from the potentially affected units to ensure their agility and to enhance their capacity for newly arriving patients. Table 5-3 depicts the primary tasks and purposes of defensive operations and medical considerations when preparing for these types of operations.

**Table 5-3. Primary tasks, purposes, and key medical considerations for defensive operations**

| *Primary Tasks* | *Purposes* | *Key Medical Considerations* |
|---|---|---|
| • Mobile defense<br>• Area defense<br>• Retrograde | • Deter or defeat enemy offensive operations.<br>• Gain time.<br>• Achieve economy of force.<br>• Retain key terrain.<br>• Protect the populace, critical assets, and infrastructure.<br>• Develop intelligence. | • All medical functions fully synchronized by medical mission command.<br>• 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.<br>• Emphasis is placed on the rapid acquisition, stabilization, and evacuation of patients generated by units in contact. This enhances the mobility of supporting medical units and facilitates the Soldier's ability to exploit opportunities and leverage the momentum to mount a counterattack or perform other maneuvers.<br>• Responsive medical logistics which facilitates and sustains the treatment of combat casualties during the fight.<br>• Theater hospitalization to provide essential care in theater to all categories of patients. |

## SECTION III — SUPPORT TO STABILITY OPERATIONS

5-12. *Stability operations* encompass various military missions, tasks, and activities conducted outside the US in coordination with other instruments of national power to maintain or reestablish a safe and secure environment, provide essential governmental services, emergency infrastructure reconstruction, and humanitarian relief. Stability operations may be conducted alone or simultaneously with offensive and defensive operations.

5-13. The AMEDD has historically conducted humanitarian assistance operations when deployed in overseas areas. In some operations, 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 operations tasks to restore essential services and support to economic and infrastructure development, the assistant chief of staff, civil affairs is the responsible staff agency for developing and planning civil-military operations. This ensures that all stability activities conducted are in consonance with the combatant commander's theater engagement strategy.

5-14. The importance of stability operations in achieving US national goals and objectives is discussed in DODI 3000.05, DODI 6000.16, and FM 3-0. Stability operations considerations were included in the design of the medical command (deployment support) which has civil affairs officers assigned to the staff and the command maintains a regional focus on medical issues arising within the combatant commander's area of responsibility. For an in-depth discussion of AHS support during stability operations refer to FM 8-42 and FM 8-55.

5-15. Table 5-4 depicts the primary tasks and purposes of stability operations and the medical considerations when preparing for these types of operations.

**Table 5-4. Primary tasks, purposes, and key medical considerations for stability operations**

| *Primary Tasks* | *Purposes* | *Key Medical Considerations* |
|---|---|---|
| • Civil security<br>• Civil control<br>• Restore essential services<br>• Support to governance<br>• Support to economic and infrastructure development | • Provide a secure environment.<br>• Secure land areas.<br>• Meet the critical needs of the populace.<br>• Gain support for host-nation government.<br>• Shape the environment for interagency and host-nation success. | • Regionally focused medical mission command to promote unity of purpose of all engaged medical assets.<br>• Medical information management to provide health risk communications, coordinate multi-national force and interagency medical interoperability issues, and document health encounters.<br>• Traditional medical support to a deployed force engaged in these operations.<br>• Medical expertise and consultation to enhance medical capacity building in the public, private, and military health sectors of the host nation.<br>• Development of regional theater security cooperation plans aimed at mitigating or resolving the underlying causes of health issues prevalent within the region. |

## SECTION IV — SUPPORT TO CIVIL SUPPORT OPERATIONS

5-16. Civil support operations use Army forces to assist civil authorities, foreign and domestic, as they prepare to respond to crises and relieve suffering. In civil support operations, Army forces provide essential support, services, assets, or specialized resources to help civil authorities deal with situations beyond their capabilities. The purpose of civil support operations is to meet the immediate needs of designated groups for a limited time, until civil authorities can do so without Army assistance. In civil support operations, Army forces always support civil authorities—local, state, and federal. For additional

information on civil support operations refer to FM 3-0. Table 5-5 identifies the primary tasks, purposes, and key medical functions for civil support operations.

**Table 5-5. Primary tasks, purposes, and key medical functions for civil support operations**

| *Primary Tasks* | *Purposes* | *Key Medical Functions* |
|---|---|---|
| • Provide support in response to disaster or terrorist attack<br>• Support civil law enforcement<br>• Provide other support as required | • Save lives.<br>• Restore essential services.<br>• Maintain or restore law and order.<br>• Protect infrastructure and property.<br>• Maintain and restore local government.<br>• 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.<br>• Medical information management to facilitate medical regulating of victims to facilities outside of the disaster/incident site and to document medical treatment.<br>• Assist affected medical infrastructure in saving lives, reducing long-term disability, and alleviating human suffering.<br>• Assist the local government in conducting rescue operations and providing medical evacuation of victims to facilities capable of providing the required care.<br>• Preventive measures to respond to and resolve emerging health threats caused by the disaster/incident. |

5-17. Army Health System support to civil support operations will include both medical operating forces and the generating force. The US Army Medical Command is the mission command headquarters for all tables of distribution and allowances medical treatment facilities and medical research facilities within CONUS.

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

5-18. Theater opening, early entry, and expeditionary medical operations require the medical planner to develop flexible, agile, and comprehensive plans to provide effective and efficient medical support in an austere environment. Many of the medical forces deployed will be the organic medical assets of the maneuver forces conducting the operation; however, the medical command (deployment support) as the medical force pool provider will deploy sufficient medical resources.

5-19. Figure 5-1 provides an example of the types of medical activities which may be conducted in these types of operations.

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

**Figure 5-1. Example of medical activities which may be conducted in theater opening and expeditionary medical operations**

# THEATER OPENING AND EARLY ENTRY OPERATIONS

5-20. Theater opening operations involve two types of medical forces: those organic to the maneuver force and those medical organizations deployed to establish the initial medical infrastructure within the theater and to support theater opening forces during reception, staging, onward movement, and integration.

5-21. The organic medical resources of the maneuver units provide Roles 1 and 2 Army Health System support to their parent organizations. While these organizations are at the port of debarkation/embarkation, tactical assembly areas, or other in-transit locations, Army Health System support is provided on an area support basis by the medical organizations supporting port operations. Medical units accompanying the in-transit force normally do not unload and setup their medical equipment and supplies, but rather rely on area support to accomplish their immediate medical support mission.

5-22. The focus of medical support to theater opening operations is to establish a medical infrastructure which facilitates the smooth transition of incoming medical assets, provides real-time force health protection 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.

5-23. 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 Role 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

5-24. 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 area of operations. As the Army forces transform to an expeditionary force, Army medical units will also transform to a more modular flexible structure capable of providing health care across spectrum of conflict.

5-25. 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 forward surgical teams to coordinate directly with US Air Force aeromedical liaison teams and the supporting Theater Patient Movement Requirements Center for patient movement.

5-26. The array of medical 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.

5-27. One of the keys to success in expeditionary medical operations is to ensure that support relationships are clearly defined in the operation plan and operation order. The medical commander must be cognizant of the various types of support relationships defined in FM 3-0 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 VI — SUPPORT TO DETAINEE MEDICAL OPERATIONS

5-28. It is DOD policy that the US 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 US custody will receive medical care consistent with the standard of medical care that applies for US military personnel in the same geographic area. For additional information refer to DODD 2310.01E, DODD 2311.01E, DODI 2310.08E, JP 3-63, JP 4-02, AR 40-400, AR 190-8, FM 3-39.40, FMI 4-02.46, FM 4-02.12, and FM 27-10.

5-29. The focus of AHS support to detainee operations is depicted in Table 5-6.

**Table 5-6. Focus of Army Health System support to detainee operations**

| *Medical activity* | *Detainee Collection Point* | *Detainee Holding Area* | *Theater Internment Facility* | *Remarks* |
|---|---|---|---|---|
| Triage | Yes | Yes | Yes | |
| Emergency medical treatment | Yes | Yes | Yes | |
| Screening | Yes[2] | Yes[2] | Yes | Monthly weigh-in<br>Nutrition status<br>Vision |
| Medications | Yes[1] | Yes[1] | Yes[1] | If approved by medical personnel, detainees may retain emergency medicines such as fast acting inhalers or cardiac medicines. |
| Routine sick call | Yes[2] | Yes[2] | Yes | |
| Preventive medicine measures | Yes | Yes | Yes | Emphasis is on field hygiene and sanitation, disposal of waste, and personal hygiene practices. |
| Medical evacuation | Yes[3] | Yes[3] | Yes[3] | Nonmedical guards are required. |
| Hospitalization | No | No | Yes | Hospitalization is not available at collecting points or holding areas. Detainees requiring hospitalization are medically evacuated. |
| Medical specialty care | No | No | Yes | Augmentation of treatment assets may be required. |

1 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.
2 Dependent upon length of stay.
3 Detainees whose medical condition is such that they must moved to a medical treatment facility for medical care will be evacuated through medical channels. The echelon commander must provide guards for all detainee evacuated through medical channels

# MEDICAL PERSONNEL ORGANIC TO MILITARY POLICE UNITS

5-30. 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 area of operations, these medical personnel are under the technical guidance of the detainee operations medical director.

5-31. 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 emergency medical treatment and coordinate with the supporting medical units for Role 2 and above care. They maintain medical records, to include DA Form 2664-R (Weight Register). When the supporting

medical unit is collocated with the internment facility, the unit's scope of practice, schedule, and duty assignments are coordinated through the supporting medical unit.

# MEDICAL PERSONNEL ORGANIC TO MANEUVER UNITS

5-32. Medical personnel organic to maneuver units may be required to provide emergency medical treatment, area medical support, and medical evacuation at the point of contact 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 area of operations.

5-33. 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 (METT-TC). 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.

5-34. The detainee operations medical director is normally designated by the medical command (deployment support) commander to develop and provide technical guidance of the medical aspects of detainee operations conducted throughout the area of operations. 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, emergency medical treatment, 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, occupational and environmental health surveillance, hygiene and sanitation standards and practices, pest management activities, 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 US military MTFs which are not part of established internment facilities. This can include emergency medical treatment provided at battalion aid stations and Role 2 MTFs (medical companies) and forward resuscitative surgery provided by forward surgical teams 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).
- Procedural guides and standing operating procedures 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 standing operating procedures 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 area of operations that are established, inspected, and enforced (the standards used are the same as those for US 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.

## SECTION VII — WARRIORS IN TRANSITION

# ARMY MEDICAL ACTION PLAN

5-35. 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.

5-36. 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 5-2.
- 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 US Army.

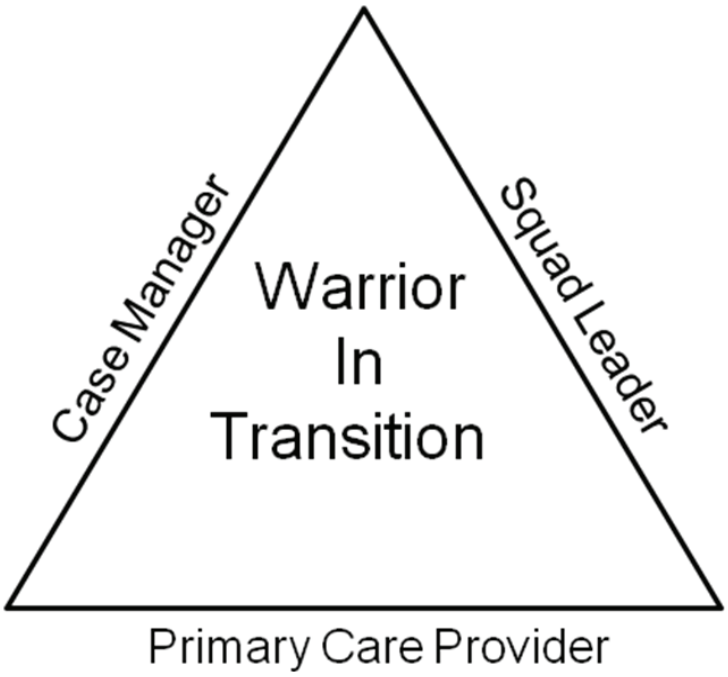


**Figure 5-2. Triad of Warrior Support**

## WARRIOR TRANSITION UNITS

5-37. 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 doctors 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.

5-38. The Warrior transition unit consists of command teams, a staff, and company or companies encompassing the Triad of Warrior Support care that consist of squad leaders, primary care managers, and nurse case managers—all dedicated to helping Warriors transition. The mission of the Warrior transition unit is to provide mission command, primary care, and case management to establish conditions for healing and to promote the timely return to the force or transition to civilian life. The Warrior transition unit also has a primary care clinic designed to—

- Enhance access to care for Warriors in Transition and their Families.
- Provide continuity of care for all their health care needs during the rehabilitative-care process.
- Facilitate medication and medical care reconciliation.
- Ensure seamless transfer across the health care continuum.
- Enhance expeditious movement throughout.

## Appendix A

# Medical Intelligence

## ASPECTS OF MEDICAL INTELLIGENCE

A-1. Medical intelligence is defined as that 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 treatment facilities, medical personnel, emergency and disaster responses, medical logistics, 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.

## SIGNIFICANCE OF MEDICAL INTELLIGENCE

A-2. 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.

A-3. At the operational level, the objective of medical intelligence is to support the development of medical strategies that—

- Identify the health threat. Refer to Table 1-1, FM 4-02.17, FM 4-25.12, and FM 21-10 for additional information on the health threat.
- Are responsive to the unique aspects of a particular theater.
- Enable the commander to accomplish his operation.
- Conserve the fighting strength of friendly forces.

## SOURCES OF MEDICAL INTELLIGENCE

A-4. 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 assessment. The medical 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.

A-5. An additional source of information on deployment occupational and environmental health hazards/threats is the US Army Public Health Command (Provisional). Information can be requested from the Global Threat Assessment Program (GTAP) office at commercial telephone (410) 436-3177 or Defense Switched Network 584-3177; e-mail address is: IPH-DHRM-GTAP (IP-RGT)@amedd.army.mil.

A-6. A supporting intelligence element should exist at some point in the medical 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

A-7. 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 enemies, environmental, and health threats in a specific area of operations. Determining the medical aspects of the intelligence preparation of the battlefield process is the first step in the mission analysis phase of the military decisionmaking 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 medical 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 the operational environment.
- Describe the operational effects on deployed forces and medical operations.
- Conduct threat integration (enemy and medical) and information consolidation.

A-8. Some of the categories may seem contrived when applying them to stability operations. The medical planner must, therefore, interpret the categories and apply the pertinent information or modify the category to fit the operational scenario. In some stability operations scenarios, there may not be a recognizable enemy. For example, in a discussion of opposition groups, it is conceivable that an organized opposition may not be apparent in a country where a medical program or disaster relief effort is being conducted. The medical planner should, therefore, consider those situations and factors which could foster an insurgency or the formation of opposition groups and focus the medical operations to proactively correct anticipated deficiencies, thereby eliminating the possible threat. Refer to FM 4-02.12 for a discussion of the regional focus of the medical command (deployment support). Refer to FM 8-42 for additional information and considerations for stability operations. Refer to FM 8-55 for additional information on medical planning considerations.

# DEFINE THE OPERATIONAL ENVIRONMENT

## IDENTIFY SIGNIFICANT CHARACTERISTICS OF THE ENVIRONMENT

A-9. The first task of the AHS planner is to define the operational environment. 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.

A-10. The significant characteristics of the environment include viewing them from both a military perspective and a civilian perspective. The medical planner must determine what aspects of the environment will impact the delivery of health care to US forces and conversely what impact military medical operations will have on the civilian population in the area of operations. 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 underdeveloped. As discussed in Chapter 5, the medical planner can use the memory aid PMESII-PT (normally used at the strategic level) or METT-TC factors (used at the tactical level) to frame the analysis of the operational environment. The civil aspects of METT-TC can also be thought of within the framework of the memory aid ASCOPE (**A**rea, **S**tructures, **C**apabilities, **O**rganizations, **P**eople, **E**vents). For the medical 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 medical 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 medical 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 area of operations.

### Geospatial Information

A-11. This includes hydrological data, elevation data, soil composition, and vegetation.

### Geography and Weather

A-12. This includes climate, weather, terrain (to include urban terrain), and altitude. It may also contain information on possible weather/environmental threats such as earthquakes, volcanoes, monsoons, or other such conditions.

### Climate and Weather Effects

A-13. Information contained here 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

A-14. 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 on projected combat action on terrain/mobility; and where potential sources of potable water are located.

### Altitude Effects

A-15. 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

A-16. The purpose of this phase of the intelligence preparation of the battlefield process is to analyze and integrate various factors of the battlefield environment. 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

A-17. The command area of operations is the geographic area where the commander is assigned the responsibility and authority to conduct military operations. The medical planner must identify the—

- Geographic area of operations 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 US and multinational forces, local civilian population, refugees, DOD and other US 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 US Army medical assets).
  - All supported US units which includes sister Services and elements from US governmental agencies and DOD contractors.
  - All supported allied, coalition, host nation, or other 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 US 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] area of operations); and the current level of health and dental fitness among the supported populations.

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

A-18. The area of influence and the area of interest is a geographic area from which information is required to facilitate planning. The area of influence and the area of interest usually falls outside the area of operations and may or may not be applicable to a particular operation. Army Health System support outside the area of operations:

- Army Health System support is being provided by organizations/elements outside of the area of operations. This can include organizations such as CONUS-support base or other safe haven hospitals, medical logistics support (Defense Logistics Agency or US 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 medical units/personnel within the area of operations must be established. This information can include discussions on units/elements in the CONUS-support base or adjacent theaters.
- Coordination and synchronization with mission command assets outside the area of operations assures the reach capability within the AHS and the ability to rapidly deploy medical specialty care resources as the need arises in the operational environment.
- Follow-on operations or operations being conducted simultaneously outside the area of operations can include full spectrum operations.
- 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; US Army Public Health Command (Provisional); 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.

***Note.*** Should 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.

## POLITICAL AND SOCIOECONOMIC SITUATION

### Population Demographics

A-19. Population demographics include the effect on the delivery of health care to supported forces; 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 refugees and the effects of cultural, religious, or language barriers on medical treatment. Other AHS population demographic concerns:

- Condition of the general population (and/or supported population) includes 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 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 medical support to deployed forces and other eligible beneficiaries?
- What affect/additional requirements will refugees, retained and detained personnel, and enemy prisoners of war 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, medical logistics 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

A-20. 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 refugees or displaced persons. Threat forces capabilities/effects encompass the following:

- The threat characteristics include the affects enemy doctrine has on deployed forces, to include medical personnel and units. This information facilitates forecasting what units/elements/ organizations are most likely to sustain heavy casualties.
- Enemy force structure and weapons systems includes 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 includes 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 includes 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.
- Psychological 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 medical assets/resources; and the effect unconventional warfare will have on the delivery of health care.)

## INFRASTRUCTURE

A-21. 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

A-22. Transportation systems include the effect of available transportation systems on timely medical evacuation and/or casualty evacuation, medical logistics supply/resupply operations; 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

A-23. Communication systems architecture includes the communications networks that are established in the area of operations; 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

A-24. 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

A-25. Industries 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

A-26. A checklist for assessing the foreign medical infrastructure is provided in Table A-1.

A-27. A checklist for assessing foreign MTF capabilities and services is provided in Table A-2.

**Table A-1. Checklist for assessing the foreign medical infrastructure**

| | |
|---|---|
| ***Public Health and Health Threat*** | • Number of public health personnel, facilities, and capabilities.<br>• Names and titles of key personnel within the public and private health care infrastructures.<br>• Leading causes of death of the general population or specified subpopulations.<br>• Prevalence of endemic and epidemic diseases in the area of operations.<br>• Prevalence of human immunodeficiency virus/acquired immunodeficiency syndrome.<br>• Environmental health risk (to include heat and cold injury, exposure to toxic industrial materials, and poisonous or toxic flora and fauna). |
| ***Hospitalization/Medical Clinics*** | • Nutritional status of the general population or specified subpopulations.<br>• Immunization level of general population or specified subpopulations.<br>• Infant mortality rate and other indices.<br>• Hospitals by type and location (such as general medical, psychiatric, or orthopedic).<br>• Number of hospital beds by type (such as surgical, intensive care, or general medicine).<br>• Number of operating room tables and table hours.<br>• Medical clinics (private or public), locations, and accessibility. |
| ***Services/Providers*** | • Number of physicians per population.<br>• Number of physicians by specialty.<br>• Ancillary services available (such as physical therapy, occupational therapy, orthotics capability, community/public health nurses, magnetic resonance imaging, computed tomography scan, or respiratory therapy).<br>• Number of nonphysician health care providers (such as physical therapists, occupational therapists, nurse practitioners, podiatrists, or optometrists) by type.<br>• Number of dental providers and types of dental care available (such as emergency and essential care and/or oral surgery).<br>• Number of behavioral/mental health clinics and available services.<br>• Number and types of behavioral/mental health personnel (such as psychologists, social workers, and the like).<br>• Veterinary medicine personnel, facilities, and capabilities. |
| ***Medical Evacuation*** | • Medical evacuation/casualty transport systems (public, private, and dedicated military ground and air ambulances or platforms of opportunity). |
| ***Medical Research/Education*** | • Number and types of medical research facilities.<br>• What toxic industrial materials does the facility use and/or produce (chemical, biological, and nuclear/radiation hazards).<br>• Number, types, and location of medical schools or medical training centers. |

**Table A-2. Checklist for assessing foreign medical treatment facility capabilities and services**

| *FOREIGN MEDICAL TREATMENT FACILITY CHECKLIST* |
|---|
| • 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 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 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 facility? |
| • Does the facility provide outpatient services? If so, what types of care? |
| • What is the standard of care provided at the facility? How does it compare to US facilities? |
| • How are medical professionals credentialed? What is their scope of practice? |
| • What is the nosocomial infection disease rate for the facility? |
| • Does the facility have the capability to isolate infectious disease patients? |
| • What is the patient accident/injury rate for the facility (such as falling out of bed, injury caused by faulty equipment, or the like)? |
| • What types of medical equipment are available in the 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 facility? If not, how are patients fed (such as by relatives)? |
| • Does the facility have an emergency room? Is it staffed and equipped to provide trauma care? |
| • What is the capacity of the 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 facility (days of supply)? |
| • How is the 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 facility have the capability to collect, test, and store blood? What diseases is the blood tested for? |
| • If the facility cannot collect and test blood, where do blood and blood products come from? Has it been tested? Does the facility have a refrigerated storage capability? What is the maximum number of units of blood which can be stored? |
| • Does the 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 hospital accredited by its parent nation and/or hospital organization (such as in the US by the Joint Commission on the Accreditation of Health Care Organizations)? |
| • Does the facility perform its own medical equipment maintenance or must be it sent out for repair? |
| • Does the facility have dependable electric service? Does it have a backup generator for power outages? |
| • Does the 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 facility have access to sterile water? |
| • Does the facility have an operational environmental control system? Heat? Air conditioning? |
| • What sanitation facilities are available in the facility? Restrooms for patients and staff? Bathtubs/showers for patients? Hand washing stations/capabilities in patient care areas? Disposal capabilities for general, medical, and human waste? Disposal capabilities for waste water? |
| • Does the 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 facility. Does it have floors, adequate ventilation, battle damage, or any other situation which would impact patient care? |
| • Other. Any other issues, concerns, or situations which affect the specific facility being evaluated. |

A-28. Analysis of local medical supply and equipment sources includes an analysis of local quantity, quality, and availability of local medical supplies and equipment; analysis of the availability of blood and blood products; availability of supplies for use for local populace, refugees, retained and detained persons, and enemy prisoners of war (to include donated supplies or those of a nongovernmental organization/international organization such as the United Nations); availability of supplies approved for use by US 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.

A-29. 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 medical treatment facilities; and, impact of military operations on local evacuation services.

A-30. Effects of disease and other occupational and environmental health threats includes the identification of disease and occupational and environmental health 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

A-31. 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 battlefield process will affect the health of the command, the employment of medical 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.

A-32. 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 operations). These categories are—

- What friendly courses of action are best supported from a medical standpoint? What friendly medical courses of action best support the mission?
- What probable enemy courses of action could affect friendly medical units/resources/services?
- Geographic-related threat issues include climatic/weather-related threats and their impact on the need for and delivery of medical and terrain-related issues that can best be depicted by creating a modified combined obstacle overlay.

## CONSOLIDATION

A-33. To facilitate understanding and consolidating additional elements of medical information/intelligence into concise formats assists the planner in future planning efforts or other possible contingencies. Databases are particularly useful for managing general information.

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## Appendix B

# Phases of Patient Treatment and Care

## INTRODUCTION

B-1. This appendix provides a description of the phases of patient treatment within the AHS. It describes and defines the skills and training required to provide medical treatment to patients from the point of injury, through successive roles of care, to the CONUS-support base.

B-2. Essential care is medical treatment and care within the area of operations which is METT-TC dependent. It includes first response, resuscitative care, and en route care, as well as care to either return the patient to duty within the theater evacuation policy, or to begin initial treatment required for optimization of outcome and/or to ensure the patient can tolerate further evacuation. Essential care includes—

- First response care—the initial essential stabilizing first aid and/or medical care rendered to ill or injured casualties at the point of initial wounding, illness, or injury.
- Resuscitative care—the aggressive management of life-, limb-, and eyesight-threatening injuries as they are identified. Interventions include protection/securing of the airway, ventilation and oxygenation, hemorrhage control, vigorous shock therapy, and protection from hypothermia, and can include damage control surgery (see paragraphs 1-15 and 1-16).
- En route care—the care required to maintain phased treatment initiated prior to evacuation and sustainment of the patient's medical condition during evacuation. The ability to provide en route medical care is dependent upon METT-TC and the availability of evacuation assets, medical equipment, and personnel.

## EMERGENCY MEDICAL TREATMENT (COMBAT MEDIC/HEALTH CARE SPECIALIST CARE)

B-3. Emergency medical treatment (also referred to as care provided by the combat medic/health care specialist) is the first medical treatment that a sick, injured, or wounded Soldier receives from a Soldier who holds a medically trained military occupational specialty. Any emergency or lifesaving measures required prior to emergency medical treatment must be performed by a Soldier trained in first aid (self-aid/buddy aid) or enhanced first aid (combat lifesaver). Combat medic/health care specialist capabilities entail the skillful application of examining techniques; performing emergency or lifesaving measures; and continuing observation and care to ensure that the airway remains open, that bleeding has been controlled, and that shock, infection, and further injury are prevented. It involves the effective use of medical supplies not available to the nonmedical Soldier and arrangement for evacuation by dedicated medical ground or air evacuation resources, as appropriate.

***Note.*** First aid (self-aid/buddy aid) and combat lifesaver are the emergency or lifesaving care given to sick, injured, or wounded persons when a medical military occupational specialty-trained Soldier (combat medic/health care specialist) is not available. Every Soldier is trained in applying lifesaving first aid measures. First aid is administered until the casualty can be treated by medically trained personnel (combat medic, health care specialist, physician assistant, or physician). Lifesaving measures are applied to maintain breathing and circulation, to control bleeding, and to prevent shock and infection. These procedures include first aid for chemical, biological, radiological, and nuclear casualties with particular emphasis on lifesaving tasks. First aid also entails—

- The application of measures to prevent a casualty's condition from deteriorating.
- The use of proper methods in moving a casualty to a relatively safe point to await evacuation and care by medically trained personnel. Refer to FM 4-02.2 and FM 8-10-6 for additional information on casualty evacuation.

B-4. Emergency medical treatment focuses on the initial stabilization of the patient and is initiated by medically trained (military occupational specialty-specific) personnel as far forward as feasible and as soon after wounding or onset of illness as feasible. Emergency medical treatment is within the capability of Role 1 care. This type of care includes—

- Maintenance of patient airway.
- Maintenance of circulation (stop the bleeding).
- Prevention of shock through vascular volume replacement (with intravenous fluids).
- Relief of pain.
- Application of dressings and splints (stabilize fractures).
- Protection from the elements.

## ADVANCED TRAUMA MANAGEMENT

B-5. The advanced trauma management or initial resuscitation and stabilization treatment phase is distinguished by the application of clinical judgment and skill of physicians or physician assistants at Role 1 and 2 MTFs. The physician and physician assistant at the battalion aid station provide this care. At Role 2, the medical company treatment teams are supported by a staff, basic laboratory and x-ray capabilities, a broad range of medical drugs, equipment and supplies, intravenous fluids, packed red blood cells (liquid), and a short-term holding capability where the necessary examinations, observations, and treatment can be accomplished in a deliberate manner. For those patients who must be evacuated for a more comprehensive, long-term scope of treatment, arrangements are made for evacuation by ground or air to a combat support hospital where the patient is treated and returned to duty or further stabilized for evacuation from the theater depending upon the theater evacuation policy.

## FORWARD RESUSCITATIVE SURGERY

B-6. The forward resuscitative surgery or stabilization treatment phase is for patients whose conditions require—

- Preoperative diagnostic procedures.
- Immediate preparation for surgery.
- Presence of a forward surgical team capability.
- Capability to administer general anesthesia.
- Provision for an adequately equipped operating room.
- Adequate postoperative recovery care environment.

B-7. The objective of this phase of treatment is to perform those emergency (urgent) surgical procedures without which death or loss of eyesight, limb, or body function is inevitable. Damage control surgery can be provided by a collocated forward surgical team with the Role 2 medical company.

## THEATER HOSPITALIZATION

B-8. The theater hospitalization phase provides essential care in theater. It embraces those endeavors that complete the recovery of the patient who can return to duty within the stated theater evacuation policy or prepares the patient for further evacuation the CONUS-support base rehabilitative and convalescent care.

## CONVALESCENT CARE

B-9. The convalescent care phase of health care entails guiding the patient from the acute phase of treatment, through recovery and rehabilitation to the phase of self-sufficiency. This phase involves clinical judgment as to the proper time for the patient to move to successively more intense reconditioning (in order that he is not challenged beyond the capabilities of his strength). Convalescent care is provided at Role 4 hospitals in CONUS or a safe haven.

B-10. The phases of patient care and treatment addressed in paragraphs B-3 through B-8 are in relation to combat wounds and injuries. The philosophy expressed also applies to patients who suffer from disease and nonbattle injury; however, the manner of providing treatment for disease-related conditions is somewhat different. For relatively minor conditions, virtually all of the phases can be accomplished at the lower operational roles. Deviations in the patient care and treatment phases may take place due to conditions beyond the control of the theater AHS.

B-11. Restorative treatment and rehabilitative treatment are normally not available in the theater. The medical assets to achieve this type of care are in the CONUS-support base.

## DEFINITIVE CARE

B-12. 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 prosthesis at a CONUS medical center or Department of Veterans Affairs hospital after a traumatic amputation. Doctrinally, definitive care is delivered at the lowest possible level. Definitive care is not a phase of patient treatment.

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## Appendix C

# Eligibility for Care Determination

C-1. During interagency and multinational operations, one of the most pressing questions is who is eligible for care in a US Army established MTF and the extent of care authorized. Numerous categories of personnel seek care in US 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 conjunction with the supporting staff judge advocate. Additionally, Department of State and other military staff sections (such as the assistant chief of staff, civil affairs) may also need to be involved in the determination process. Each operation is unique and the authorization for care is based on the appropriate US and international law, DODD and DODI, ARs, doctrine, and standing operating procedures. Other factors impacting on the determination of eligibility are command guidance, practical humanitarian and medical ethics considerations, availability of US 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 C-1 is just one approach to delineate and disseminate this information to MTF personnel and may not be all-inclusive based on specific scenarios.

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

## DOCUMENTATION

C-2. Basic documents required for determining eligibility of beneficiaries include AR 40-400; FM 27-10; relevant sections of Title 10, United States Code; relevant DODD and DODI; international standardization agreements; acquisition and cross-servicing agreements; orders from higher headquarters; interagency agreements (memorandums of understanding and memorandums of agreement); status of forces agreement; 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 a point of contact for the contracting company and a point of contact for the administration of the contract should be maintained. Finally, the political-military environment of the area of operations must be taken into account as the medical mission command headquarters and its higher headquarters develop the eligibility matrix.

C-3. The eligibility matrix should be as comprehensive as possible. If necessary, it should include eligibility determination by name (see example in Table C-1). 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 determination should be contacted immediately. Further, care will be provided in accordance with the standing operating procedure 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 US military to provide the full spectrum of medical care. Although it does obligate the MTF to provide immediate stabilization for life-, limb-, and eyesight-threatening medical conditions and to prepare the patient for evacuation to the appropriate civilian or national contingent MTF when the patient's medical condition permits.)

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

# KNOWLEDGE OF HEALTH CARE CAPABILITIES

C-4. The MTF staff must be familiar with the medical care available in the area of operations 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 US MTF and the patient can be transferred to another facility for continued care.

# DISSEMINATION OF ELIGIBILITY FOR CARE INFORMATION

C-5. 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 AHS operations, the AHS commander must ensure that this information is contained in appropriate operation plans and operation orders and briefed to the appropriate senior leadership of the command.

# SAMPLE ELIGIBILITY FOR CARE MATRIX

C-6. Table C-1 provides a sample of an eligibility for care matrix for treatment in a US Army MTF.

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

| ***ELIGIBILITY FOR MEDICAL/DENTAL CARE SUPPORT MATRIX (DATE) (THIS DOCUMENT IS SUBJECT TO FURTHER VERIFICATION AND/OR MODIFICATION)*** | | |
|---|---|---|
| ***CATEGORY*** | ***MEDICAL/DENTAL*** | ***INFORMATION/AUTHORITY**** |
| Allied military personnel | Yes[1] | The following nations have acquisition and cross-servicing agreements and ISAs with the US which are administered by (*combatant command*): *List nations.* |
| Coalition military personnel | Yes[1] | The following nations have acquisition and cross-servicing agreements and ISAs with the US which are administered by (*combatant command*): *List nations.* |
| DOD civilian employees | Yes | ITO. |
| US Government employees (non-DOD) | Yes[2] | ITO. |
| US Embassy personnel | Yes | US citizens on official business. |
| US Congressional personnel | Yes | US citizens on official business. |
| Army and Air Force Exchange Service US citizen employees | Yes | ITO. |
| Army and Air Force Exchange Service<br>Local national employees | Yes[3] | US law. |

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

| *CATEGORY* | *MEDICAL/DENTAL* | *INFORMATION/AUTHORITY** |
|---|---|---|
| Nonappropriated fund instrumentality morale, welfare, and recreation US employees | Yes | ITO. |
| Contracted college instructors | Yes | ITO. |
| United Nations personnel (includes all personnel employed by the United Nations and its agencies, such as the United Nations High Commissioner for Refugees) | Yes[3] | US law. |
| Contractor #2 all employees<br><br>POC: Mr. Franklin<br>(XXX) XXX-XXXX<br>ADMIN: Mr. Elliott<br>DSN XXX-XXXX | Yes[3]<br><br>No[5] | Contractor did not contract for the provision of medical care by military MTFs. Contractor stated in writing that they contracted with the host-nation medical infrastructure for the required care. **NOTE:** A separate determination may be required for individual cases, as the individual may be eligible for care under a different provision. Contact Mr. Bannon, DSN XXX-XXXX if additional information is required. |
| Contractor #4<br>Mr. Edward Lee<br>(company name classified)<br><br>POC: Ms. Hannah<br>(XXX) XXX-XXXX<br>ADMIN: Mr. Elliott<br>DSN XXX-XXXX | Yes | Per Mr. Bannon, Mr. Lee 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. Bannon, DSN XXX-XXXX, if additional information is required. |
| Contractor #5<br>Mr. Noah James<br>(company name classified)<br><br>POC: Ms. Hannah<br>(XXX) XXX-XXXX<br>ADMIN: Mr. Elliott<br>DSN XXX-XXXX | Yes[6] | Per Mr. Bannon, 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. Bannon, DSN XXX-XXXX, if additional information is required. |
| Dependents of US active duty or retired military personnel. | Yes[4] | Only if space is available and appropriate medical services/care are available in the operational setting. AR 40-400. Contact Mr. Bannon, DSN XXX-XXXX, if additional information is required. |
| Personnel in custody of US military forces | Yes | Enemy prisoner of war and retained or detained personnel. Extent of care rendered is the same as that provided to US military forces (ATTP 4-02, FMI 4-02.46, and FM 27-10). |

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

| *CATEGORY* | *MEDICAL/DENTAL* | *INFORMATION/AUTHORITY** |
|---|---|---|
| Individual injured as a result of military operations | Yes | US and international law (FM 27-10) and status of forces agreements. If the US military injures an individual (such as in an automobile accident involving a military vehicle), the US is responsible for providing immediate care (or paying for local care). Coordinate with Mr. Bannon, DSN XXX-XXXX and LTC Brian, supporting staff judge advocate, DSN XXX-XXXX. |

LEGEND:

* Illustrative in nature only.

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 US does not have both an acquisition and cross-servicing agreement and ISA. However, the acquisition and cross-servicing agreement and ISA requirements may be waived for those nations whom the commander, in conjunction with the supporting staff judge advocate, feels are supporting the missions of the command.
2 If not working for, contracted to, or on DOD ITO for logistical support, non-DOD US Government employees must pay for meals received at DOD dining facilities.
3 Emergency medical and dental care only. Emergency care is that care required to save life, limb, or eyesight.
4 Space available.
5 Routine.
6 Reimbursable.

| | |
|---|---|
| ADMIN administrator | ITO invitational travel order |
| DSN Defense Switched Network | LTC lieutenant colonel |
| ISA international standardization agreement | POC point of contact |

## Appendix D

# Army Medical Department Table of Distribution and Allowances Medical Organizations

Coordination with activities and organizations of the Office of The Surgeon General/US Army Medical Command provides the medical command (deployment support) with advice, consultation, and support of medical specialty expertise not resident in the theater.

## REGIONAL MEDICAL COMMANDS

D-1. To ensure that the health care delivery system is transparent and seamless, the medical command (deployment support) commander must have the ability to coordinate a Soldier's individual health care needs from the theater to the CONUS base. This reachback capability from the point of injury through the Army service component command AHS to the facilities providing definitive and rehabilitative care in the CONUS-support base is essential for the continuum of care. Additionally, regional medical centers and home station/mobilization site installation MTFs and/or other medical facilities are a crucial link in sustaining the longitudinal health record of each Soldier. This ensures the data from all medical encounters is captured and documented, that health assessments are accomplished prior to and after deployments, and that reassessments are accomplished as required all of which enhances the medical readiness of our force projection Army. The regional medical centers and home station/mobilization site installation MTFs also provide the Professional Filler System-base from which medical personnel are assigned to deploying forces.

## UNITED STATES ARMY MEDICAL DEPARTMENT CENTER AND SCHOOL

D-2. The USAMEDDC&S is a diverse organization that accomplishes the combat development mission by producing Army concepts, developing medical organizational structures, identifying materiel requirements, and developing doctrine which enables the AMEDD to deploy a modular, versatile, state-of-the-art medical capability to sustain the health of the geographic combatant commander's most valuable asset—the Soldiers and service members under his command. Additionally, the USAMEDDC&S trains medical Soldiers in the various medical functional specialties required in the operational environment to sustain the health of deployed forces. The USAMEDDC&S also develops future medical leaders and provides them the skills and knowledge needed to successfully and efficiently synchronize the complex and diverse functional responsibilities of the AMEDD with the other Services and with the joint, DOD, civilian, and international medical communities.

## UNITED STATES ARMY DENTAL COMMAND

D-3. The US Army Dental Command provides the requisite control and focus to promote dental health, to sustain and maintain dental operations, to enhance dental readiness, and to provide highly trained dental professionals to the deployed force through Professional Filler System.

## UNITED STATES ARMY VETERINARY COMMAND

D-4. The US Army Veterinary Command provides military veterinary services in support of US Army Medical Command and DOD missions in their area of responsibility. The US Army Veterinary Command assures the readiness of the command and deploys individual and unit Professional Filler System

personnel. The responsibilities of the US Army Veterinary Command include food safety and quality assurance, care of government-owned animals, and animal disease prevention and control. The US Army Veterinary Command supports over 300 installations including US Air Force, US Navy, and US Marine Corps units.

## UNITED STATES ARMY MEDICAL RESEARCH AND MATERIEL COMMAND

D-5. The US Army Medical Research and Materiel Command mission is to project and sustain a medically protected force and to enhance medical care to the deployed Soldier by leveraging medical solutions. The medical command (deployment support) commander and staff must be cognizant of the clinical and research capabilities encompassed by this diverse organization and its subordinate commands in order to gain insight into emerging technologies, medical materiel improvements, and innovations to include investigational new drugs.

## UNITED STATES ARMY PUBLIC HEALTH COMMAND (PROVISIONAL)

D-6. The US Army Public Health Command (Provisional) provides worldwide scientific expertise and services in clinical and field preventive medicine, occupational and environmental health, health promotion and wellness, health risk communications, epidemiology and disease surveillance, toxicology, and related laboratory sciences.

## UNITED STATES ARMY INSTITUTE OF SURGICAL RESEARCH

D-7. The US Army Institute of Surgical Research is dedicated to both laboratory and clinical trauma research. Its mission is to provide requirements-driven combat casualty care medical solutions and products for injured Soldiers from self-aid through definitive care across full spectrum operations and to provide state-of-the-art trauma, burn, and critical care to DOD beneficiaries around the world.

## UNITED STATES ARMY MEDICAL RESEARCH INSTITUTE FOR CHEMICAL DEFENSE

D-8. The US Army Medical Research Institute for Chemical Defense develops medical countermeasures to chemical warfare agents and trains medical personnel in the medical management of chemical casualties.

## UNITED STATES ARMY MEDICAL RESEARCH INSTITUTE FOR INFECTIOUS DISEASES

D-9. The US Army Medical Research Institute for Infectious Diseases conducts research to develop strategies, products, information, procedures, and training programs for medical defense against biological warfare agent threats and naturally occurring infectious diseases that require special containment. The Institute is the lead medical research laboratory for the US Biological Defense Research Program. The Institute plays a key role in national defense and in infectious disease research as the largest biocontainment laboratory in the DOD for the study of hazardous diseases.

## UNITED STATES ARMY AEROMEDICAL RESEARCH LABORATORY

D-10. The US Army Aeromedical Research Laboratory researchers enable our aviation Soldiers to fight better, longer, stronger, smarter, and safer. Researchers transform ideas and theories into practical applications to enhance the fighting ability, safety, and performance of Army aviators.

## UNITED STATES ARMY RESEARCH INSTITUTE OF ENVIRONMENTAL MEDICINE

D-11. The US Army Research Institute of Environmental Medicine conducts basic and applied research to determine how exposure to extreme heat, severe cold, high terrestrial elevations, occupational tasks, physical training, deployment operations, and nutritional factors affect the health and performance of military personnel.

## WALTER REED ARMY INSTITUTE OF RESEARCH

D-12. Walter Reed Army Institute of Research conducts research on a range of militarily relevant issues pertaining to naturally occurring infectious diseases, combat casualty care, operational health hazards, and medical defense against biological and chemical warfare agents. The Walter Reed Army Institute of Research scientists use their understanding of military operations and environments, including the stresses and exposures troops encounter and the performance requirements of a deployed military force to focus and refine their research efforts.

## UNITED STATES ARMY MEDICAL MATERIEL AGENCY

D-13. The US Army Medical Materiel Agency enhances medical readiness by providing medical logistics support for the full spectrum of DOD health care worldwide, by developing and implementing innovative logistics concepts and technologies, and by serving as the Army agent for medical materiel and sustainment programs.

## UNITED STATES ARMY MEDICAL MATERIEL CENTER-EUROPE

D-14. The US Army Medical Materiel Center-Europe provides the full spectrum of medical logistics support as the single integrated medical logistics manager for the European Command and out of area support to the Department of State Humanitarian Assistance Program, and the US Central Command in southwest Asia, Central Asia, and portions of Africa.

## UNITED STATES ARMY MEDICAL MATERIEL DEVELOPMENT AGENCY

D-15. The US Army Medical Materiel Development Agency is the designated Program Manager for Combat Medical Systems and develops and fields medical products for the US Armed Forces in conjunction with the USAMEDDC&S and US Army Medical Materiel Agency. The US Army Medical Materiel Development Agency assists in protecting and preserving Soldiers serving in the Nation's armed forces by providing new drugs, vaccines, and medical devices to enhance readiness, by ensuring the provision of the highest quality of medical care to the DOD, and by maximizing the survival rate for medical casualties on the battlefield.

## ARMY RESERVE MEDICAL COMMAND

D-16. Coordination with the Army Reserve Medical Command is required to achieve a high level of integration between the active Army and reserve component assets. Over 66 percent of the AMEDD's medical assets lie within the reserve component force structure. The distribution of future force capabilities between the active Army and reserve component must accommodate requirements for immediate strategic responsiveness, as well as the maintenance of strategic AHS reserves for extended operations and multiple global engagements. By and large, contingency response requires some reserve component forces with unique complementary capabilities maintained at the same level of readiness as the active Army. Simultaneously, the medical reserve component assets must include capabilities that mirror those of the active force for expansibility, but which may be afforded additional response time prior to commitment.

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## Appendix E

# Executive Agent

The Army Surgeon General exercises Executive Agency over a number of functions and/or health care organizations as directed by DOD directive. The Army Surgeon General provides direction and administrative and logistical support for these agencies that provide support not only to the US Army but to the sister Services or other government entities.

## JOINT MEDICAL EXECUTIVE SKILLS INSTITUTE

E-1. The Joint Medical Executive Skills Institute manages a Congressionally-mandated executive medical leader development program for prospective MTF commanders to ensure they have the required demonstrated professional administrative skills as required by the DOD Appropriations Act of 1992.

## ACCESSION MEDICAL STANDARDS ANALYSIS AND RESEARCH ACTIVITY

E-2. The Accession Medical Standards Analysis and Research Activity supports the development of evidenced-based standards by guiding the improvement of medical and administrative databases, conducting epidemiologic analysis, coordinating related research, and integrating into policy recommendations relevant operational, clinical, and economic considerations.

## ARMED FORCES PEST MANAGEMENT BOARD

E-3. The Armed Forces Pest Management Board recommends policy, provides guidance, and coordinates the exchange of information on all matters related to pest management (to include the technical requirements of the Federal Insecticide, Fungicide, and Rodenticide Act) throughout the DOD. The Armed Forces Pest Management Board mission is to ensure that environmentally sound and effective programs are present to prevent pests and disease vectors from adversely affecting DOD operations. Additionally, the Armed Forces Pest Management Board implements the DOD plan for certification of pesticide applicators and develops comprehensive training guidance for DOD pest management personnel.

## ARMED FORCES INSTITUTE OF PATHOLOGY

E-4. The Armed Forces Institute of Pathology is a tri-service DOD agency specializing in pathology consultation, education, and research and encompasses research in the basic sciences, environmental pathology and toxicology, geographic and infectious disease pathology, molecular diagnostics, and forensic science.

## ARMED FORCES EPIDEMIOLOGICAL BOARD

E-5. The Armed Forces Epidemiological Board provides timely scientific and professional advice concerning operational programs, policy development, and research needs for the prevention of disease and injury and the promotion of health.

## ARMED FORCES MEDICAL LIBRARY

E-6. The Armed Forces Medical Library is a specialized core of military medical materials pertaining to areas of management, hospital administration, and historical monographs. The Armed Forces Medical Library provides support to military medical personnel worldwide.

## ARMED SERVICES BLOOD PROGRAM OFFICE

E-7. The Armed Services Blood Program Office provides guidance and implements programs to ensure that the military services have a sustained, secure, and safe blood supply across the continuum and around the world.

## CIVILIAN EMPLOYEE OCCUPATIONAL AND MEDICAL SERVICES PROGRAM (PENTAGON)

E-8. The Civilian Employee Occupational and Medical Services Program falls directly under the DiLorenzo TRICARE Health Clinic. The mission of the Civilian Employee Occupational and Medical Services Program is to provide workplace health care for DOD civilian employees working in the Pentagon and 144 other Federal buildings in the Washington Headquarters Service network in the National Capital Area to ensure personnel are physically, mentally, and psychologically suited to their work. The Civilian Employee Occupational and Medical Services Program provides occupational and environmental services for active Army personnel, as specified in AR 40-5, to include hearing conservation, indoor air quality, repetitive strain injuries, workplace stress, workplace violence, worksite visits, and any health problem related to occupational hazards or exposures.

## COMBAT DENTAL RESEARCH PROGRAM

E-9. The US military dental science and technology research laboratories, the US Army Dental Research Detachment, and the Naval Dental Research Institute focus on research and development of new technologies that reduce lost duty time caused by dental disease or trauma in military populations. As mandated by the 1991 Base Realignment and Closure Act, the US Army Dental Research Detachment and Naval Dental Research Institute are collocated at Great Lakes, Illinois. Areas of research emphasis include methods to reduce disease-causing dental plaque in conjunction with military rations; epidemiology of dental disease and trauma; rapid diagnostic aids; field-expedient preventive technologies dental field equipment and sterilization; environment-insensitive dental materials; disposal of mercury contaminated water in deployed situations; and technologies to reduce morbidity and mortality of oral and maxillofacial trauma, especially through the use of lightweight personal armor.

## DEFENSE MEDICAL READINESS TRAINING INSTITUTE

E-10. The Defense Medical Readiness Training Institute coordinates, evaluates, and develops joint medical readiness training with a focus on evolving doctrine and joint operational requirements. It conducts or facilitates selected joint medical training programs to prepare DOD medical personnel for a wide range of military operations to include combat casualty care, joint operations medical managers, and homeland security medical executives.

## DILORENZO TRICARE HEALTH CLINIC

E-11. The mission of the DiLorenzo TRICARE Health Clinic is to provide access to good quality cost-effective health care for active duty, activated guard and reserve military members, and civilian employees of the Pentagon and surrounding areas.

## ARMED FORCES HEALTH SURVEILLANCE CENTER/ DEPARTMENT OF DEFENSE MEDICAL SURVEILLANCE SYSTEM

E-12. The main functions of the Armed Forces Health Surveillance Center (formerly referred to as the Army Medical Surveillance Activity) are to analyze, interpret, and disseminate information regarding the status, trends, and determinants of the health and fitness of America's Army and to identify and evaluate obstacles to medical readiness. The Army Medical Surveillance Activity is the central epidemiological resource for the Army providing regularly scheduled and customer-requested analyses and reports to policy makers, medical planners, and researchers. It identifies and evaluates obstacles to medical readiness by linking various databases that communicate information relevant to Soldiers' experience that has the potential to affect Soldiers' health. The Armed Forces Health Surveillance Center operates the DOD Medical Surveillance System, an executive information system whose database contains up-to-date and historical data on diseases and medical events (such as hospitalizations, ambulatory visits, reportable diseases, human immunodeficiency virus tests, acute respiratory diseases, and health risk appraisals) and longitudinal data on personnel and deployments. Through the DOD Medical Surveillance System, the Armed Forces Health Surveillance Center provides the sole link between the DOD Serum Repository and other databases.

## DEPARTMENT OF DEFENSE GLOBAL EMERGING INFECTIONS SURVEILLANCE AND RESPONSE SYSTEM

E-13. The DOD Global Emerging Infections Surveillance and Response System is designed to strengthen the prevention of, surveillance of, and response to infectious diseases that are a threat to military personnel and their Families, reduce medical readiness, or present a risk to US national security. The DOD Global Emerging Infections Surveillance and Response System enables the DOD to strengthen its global disease reduction efforts through—

- Centralized coordination.
- Improved preventive health programs and epidemiological capabilities.
- Enhanced involvement with MTFs and CONUS-based and overseas laboratories.

## DEPARTMENT OF DEFENSE LYME DISEASE PROGRAM

E-14. The mission of the DOD Lyme Disease Program is to maximize the ability for Army units and installations to protect the Soldier from the health threats posed by tickborne diseases.

## DEPARTMENT OF DEFENSE NUTRITION RESEARCH, TESTING, DEVELOPMENT, AND EVALUATION PROGRAM

E-15. The mission of the DOD Nutrition Research, Testing, Development, and Evaluation Program is to provide biomedical research, test, and evaluation support for ration developers and the DOD feeding program under the auspices of the Food and Nutrition Research Evaluation Board. This is a critical mission that was once thought to be expendable and the nutrition research mission was disbanded within the Army program. This required Deputy Chief of Staff, Logistics involvement to restore the program so that the new meals, ready-to-eat could be properly evaluated before widespread fielding. It was determined to be important enough for Deputy Chief of Staff, Logistics to provide 18 new personnel authorizations to recreate the biomedical capability at the US Army Research Institute of Environmental Medicine.

## DEPARTMENT OF DEFENSE PHARMAECONOMIC CENTER

E-16. The DOD Pharmaeconomic Center improves the clinical, economic, and humanistic outcomes of drug therapy in support of the readiness and managed health care missions of the Military Health System.

## DEPARTMENT OF DEFENSE SERUM REPOSITORY

E-17. The DOD Serum Repository receives and stores remaining serum specimens from human immunodeficiency virus testing programs within the DOD and receives and stores serum specimens related to operational deployments worldwide.

## DEPARTMENT OF DEFENSE AND DEPARTMENT OF VETERANS AFFAIRS CLINICAL GUIDELINES DEVELOPMENT

E-18. The purpose of the DOD/Department of Veterans Affairs clinical guidelines development is to utilize the evidence-based clinical approach to improve the health of the population across the Department of Veterans Affairs and the Military Health System.

## DEPARTMENT OF DEFENSE VETERINARY SERVICE ACTIVITY

E-19. The US Army, as the DOD Executive Agent for Veterinary Services, provides support to all Services in the areas of food safety and security, animal care, and the prevention of zoonotic diseases. This mission is accomplished by the Department of Defense Veterinary Service Activity.

## DEFENSE MEDICAL STANDARDIZATION BOARD

E-20. The Defense Medical Standardization Board standardizes medical military materiel for use by all military services for war readiness requirements and peacetime operations. They achieve maximum standardization of deployable medical systems within the military Services consistent with each Service's mission. Further, they provide clinical, technical, and logistical expertise to ensure quality medical materiel is available to the Services. This organization manages the joint deployment formulary.

## GULF WAR FORCE HEALTH PROTECTION RESEARCH PROGRAM

E-21. The mission of the Gulf War Force Health Protection Research Program targets solutions to problems identified in the Gulf War deployment, especially those most likely to be encountered in future deployments. It previously addressed the entire set of testable hypotheses concerning undiagnosed Gulf War illnesses, including studies mandated by Congress; it is now primarily focused on forward-looking research programs with specific research products/objectives to improve force medical protection. The Presidential Review Directive 5 and multiple high-level panels reviewing Gulf War health issues mandate that this research be conducted. This research will lead to understanding and health protection strategies that ensure individual readiness. This concerted effort also provides assurances that the military Services take care of their service members, including every effort to develop protection against avoidable long-term health risks (this affects future recruitment and the willingness of service members to deploy and to use protective drugs and other medical prophylaxis).

## GULF WAR ILLNESS TEAM REGISTRY

E-22. The mission of the Gulf War illness team is to determine the intensity and duration of exposure to the fumes of burning oil well fires and the subsequent risk to Gulf War veterans. Additionally, it investigates and documents other exposures that occurred in the Persian Gulf and cooperates with DOD, Department of Veterans Affairs, and university researchers studying Gulf War veterans' illnesses.

## HUMAN IMMUNODEFICIENCY VIRUS AND ACQUIRED IMMUNODEFICIENCY SYNDROME RESEARCH AND DEVELOPMENT PROGRAM

E-23. The mission of the Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome Research and Development Program is to conduct, for the DOD, a focused and responsive world-class disease research and development program to assess and mitigate the impact of human immunodeficiency virus/acquired immunodeficiency syndrome on the US military's readiness.

## INVESTIGATIONAL NEW DRUGS FOR FORCE HEALTH PROTECTION PROGRAM

E-24. The Investigational New Drugs for Force Health Protection Program is responsible for executing DOD policy pertaining to the preventive or therapeutic use during military operations of investigational drugs or biological products in those cases where no appropriate Food and Drug Administration-approved product is available. This includes development, in coordination with the Assistant Secretary of Defense (Health Affairs) and the involved combatant command, of a treatment protocol for use with the investigational product; the review of protocols by The Surgeon General's Human Subjects Research Review Board; and Congressional and public notification of the use of the investigational product. In addition, implementation plans for the use of investigational drugs are required to assist the combatant command in translating protocol-specific requirements into operational actions.

## MILITARY INFECTIOUS DISEASE RESEARCH PROGRAM

E-25. The Military Infectious Disease Research Program conducts a focused and responsive world-class infectious disease research and development program leading to the fielding of effective, improved means of protection and treatment to maintain maximal global operational capability with minimal morbidity and mortality. This research includes—

- Development of vaccines against militarily important diseases.
- Discovery and development of prophylactic and treatment drugs for parasitic infectious diseases.
- Development of techniques for rapid identification of disease organisms and diagnosis of infections.
- Collection and analysis of epidemiological data that aid in control of relevant infectious diseases.
- Conduct of studies of control measures against insect vectors of infectious diseases.

## MILITARY VACCINE AGENCY

E-26. The Military Vaccine Agency works to enhance military medical readiness and protect human health by synchronizing information, delivering education, enhancing scientific understanding, promoting quality, and coordinating military immunization programs worldwide.

## NATIONAL VACCINE HEALTH CARE CENTER

E-27. The National Vaccine Health Care Center, in collaboration with the Centers for Disease Control and Prevention, provides clinical support and leadership for immune readiness and develops programs to enhance vaccine safety, efficacy, and acceptability. This organization also conducts research and provides case management of complex adverse events for DOD beneficiaries.

## PEER REVIEWED MEDICAL RESEARCH PROGRAM

E-28. The Peer Reviewed Medical Research Program continues to fulfill Congressional intent by funding research of clear scientific merit with direct relevance to the Soldier, the military Family, and the American public. Through this effort, the Peer Reviewed Medical Research Program provides support for military health-related research of clear scientific merit that protects and supports the Soldier and his beneficiaries, and eradicates diseases that impact these populations.

## PENTAGON TRI-SERVICE DENTAL CLINIC

E-29. The mission of the Pentagon Tri-Service Dental Clinic is to provide access to cost-effective dental care to active Army and activated guard and reserve military members serving in the Pentagon and surrounding areas.

## DEPARTMENT OF DEFENSE PESTICIDE REGULATORY ACTION SYSTEM

E-30. The mission of the DOD Pesticide Regulatory Action System is to provide a DOD Pesticide Hotline service, prepare quarterly Pesticide Management Bulletins, and review/comment on proposed regulatory actions regarding the use and disposition of pesticides.

## REGIONAL TRI-SERVICE MEDICAL LOGISTICS SUPPORT PROGRAM

E-31. The overarching goal of the Regional Tri-Service Medical Logistics Support Program is to support the Military Health System with logistics processes that will provide the best value products and services at the lowest delivered cost. The primary objective for achieving this goal is to create regional programs that will drive down the costs of medical/surgical supplies and services and promote availability of high-quality products in support of best business and clinical practices. The second objective is to increase the use of DOD prime vendors as the primary acquisition source for pharmaceutical and medical surgical supplies, other Defense Supply Center Philadelphia acquisition strategies, and electronic commerce programs currently available.

## UNITED STATES MILITARY ENTRANCE PROCESSING COMMAND (MEDICAL)

E-32. The US Military Entrance Processing Command (Medical) ensures the quality of accessions during peacetime and mobilization according to standards. Obtaining the medical history and conducting the physical examination of prospective recruits is important to maintaining a fit and healthy force and in reducing the potential for injury during initial training and military service.

# Glossary

The glossary lists acronyms and terms with Army or joint definitions, and other selected terms. Where Army and joint definitions are different, (*Army*) or (*Joint*) follows the term. Terms for which this publication is the proponent manual (the authority) are marked with an asterisk (*). The proponent manual for other terms is listed in parentheses after the definition.

## SECTION I — ACRONYMS AND ABBREVIATIONS

| | |
|---|---|
| AABB | American Association of Blood Banks |
| ABCA | American, British, Canadian, Australian, and New Zealand |
| AFH | Air Force handbook |
| AFI | Air Force instructions |
| AFMAN | Air Force manual |
| AFTTP | Air Force tactics, techniques, and procedures |
| AHS | Army Health System |
| AJP | allied joint publication |
| AMEDD | Army Medical Department |
| AMedP | allied medical publication |
| AMovP | allied movement publication |
| AR | Army regulation |
| ASCOPE | area, structures, capabilities, organizations, people, events |
| ATTP | Army tactics, techniques, and procedures |
| CBRN | chemical, biological, radiological, and nuclear |
| CONUS | continental United States |
| COSC | combat and operational stress control |
| DA | Department of the Army |
| DD | Department of Defense |
| DOD | Department of Defense |
| DODD | Department of Defense directive |
| DODI | Department of Defense instruction |
| FHP | force health protection |
| FM | field manual |
| GC | Geneva Convention relative to the Protection of Civilian Persons in Time of War |
| GPW | Geneva Convention Relative to the Treatment of Prisoners of War |
| GWS | Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field |
| GWS SEA | Geneva Convention for the Amelioration of the Condition of the Wounded, Sick, and Shipwrecked members of the Armed Forces at Sea |
| HSS | health service support |
| JP | joint publication |
| MCO | Marine Corps order |
| MCRP | Marine Corps reference publication |
| MCWP | Marine Corps warfighting publication |

| | |
|---|---|
| METT-TC | mission, enemy, terrain and weather, troops and support available, time available, and civil considerations |
| MTF | medical treatment facility |
| NATO | North Atlantic Treaty Organization |
| NAVMED P | Naval medical publication |
| NAVSUPINST | Naval supplemental instruction |
| NTRP | Navy training reference publication |
| NWP | Navy warfighting publication |
| OPNAVINST | operational Naval instructions |
| PAM | pamphlet |
| PMESII-PT | political, military, economic, social, information, infrastructure, physical environment, time |
| STANAG | standardization agreement |
| TM | technical manual |
| US | United States |
| USAMEDDC&S | United States Army Medical Department Center and School |
| ZULU | Greenwich Mean Time |

## SECTION II — TERMS

***Army Health System** A component of the Military Health Systems 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.

***Force Health Protection** (1) 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) (2) 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]).

**Health Service Support** (1) 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) (2) 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. (FM 4-0)

**task organization** A temporary grouping of forces designed to accomplish a particular mission. (Army)

**task-organizing** The act of designing an operating force, support staff, or logistic package of specific size and composition to meet a unique task or mission. Characteristics to examine when task-organizing the force include, but are not limited to: training, experience, equipage, sustainability, operating environment, enemy threat, and mobility. For Army forces, it includes allocating available assets to subordinate commanders and establishing their command and support relationships. (Army)

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By Order of the Secretary of the Army:

**RAYMOND T. ODIERNO**
*General, United States Army*
*Chief of Staff*

Official:

**JOYCE E. MORROW**
*Administrative Assistant to the*
*Secretary of the Army*
1116101

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