FIELD MANUAL
NO. 8-10

*FM 8-10
HEADQUARTERS
DEPARTMENT OF THE ARMY
Washington, DC, 1 March 1991

# HEALTH SERVICE SUPPORT IN A THEATER OF OPERATIONS

## TABLE OF CONTENTS



DISTRIBUTION RESTRICTION: **Approved for public release; distribution is unlimited.**

*This manual supersedes FM 8-10, 2 October 1978.

# PREFACE

This manual explains the purpose of health service support (HSS) in a theater of operations. It discusses the current HSS force structure and the modernization initiative known as Medical Force 2000. This modernization initiative is to be completed by the year 2000.

As the keystone manual of the Army Medical Department (AMEDD), Field Manual (FM) 8-10 is for the use of nonmedical unit commanders and their staff, command surgeons, and medical unit commanders and their staff. It is to be used as a guide in obtaining as well as providing HSS in a theater of operations. Information in this publication is applicable across the operational continuum. It is compatible with the Army's combat service support (CSS) doctrine in support of the AirLand Battle (ALB). Readers should have a fundamental understanding of FM 100-5, FM 100-10, FM 100-15, FM 100-20, and FM 101-5.

A series of field manuals currently under development will provide techniques and procedures for specific HSS organizations and activities in the theater of operations. These manuals will be published over the next several years.

This publication implements the following North Atlantic Treaty Organization (NATO) and American, British, Canadian, and Australian (ABCA) International and Quadripartite Standardization Agreements (STANAGs and QSTAGs, respectively).

| NATO STANAG | ABCA QSTAG | TITLE |
|---|---|---|
| | 248 | Identification of Medical Materiel to Meet Urgent Needs |
| | 815 | Blood Supply in the Area of Operations |
| 2027 | | Marking of Military Vehicles |
| 2060 | | Identification of Medical Materiel for Field Medical Installations |
| 2068 | | Emergency War Surgery |
| 2105 | | NATO Table of Medical Equivalents—AMedP-1(D) |
| 2135 | | Procedures for Emergency Logistic Assistance |
| 2931 | | Camouflage of the Geneva Emblem on Medical Facilities on Land |
| 2939 | | Medical Requirements for Blood, Blood Donors and Associated Equipment |

The proponent of this publication is the Academy of Health Sciences. Send comments and recommendations on Department of the Army (DA) Form 2028 directly to **Commandant, Academy of Health Sciences, US Army, ATTN: HSHA-TD, Fort Sam Houston, Texas 78234-6100.**

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

# CHAPTER 1

# HEALTH SERVICE SUPPORT IN THE AIRLAND BATTLE

## Section I. THE MISSION

### 1-1. The AirLand Battle Doctrine

The Army's keystone doctrinal manual, FM 100-5, explains how the Army plans and operates with other Services and allied forces, While emphasizing conventional military operations, FM 100-5 recognizes that Army forces must be capable of operating effectively in any battlefield environment.

### 1-2. The Mission of the Army Medical Department

*a.* Armies that are winners of battles and campaigns have the following common qualities:

- They are physically fit.
- They are emotionally well.
- They are capable of concentrating superior combat power at decisive times.

*b.* The AMEDD plays a key role in developing and maintaining combat power. Its mission is to maintain the health of the Army to conserve its fighting strength (trained manpower), Commanders need to retain acclimated and experienced personnel to perform their particular mission. In retaining such personnel, the load on the replacement system is diminished, and the requirements for patient evacuation are decreased. On the other hand, accumulation of patients within any combat unit restricts its movements. It may also reduce the soldier's willingness to take necessary risks because of a perceived lack of HSS.

## Section II. THE BATTLEFIELD OPERATIONAL ENVIRONMENT

### 1-3. The Operational Continuum

The strategic environment within each theater consists of a variety of conditions—political, economic, and military. It also consists of a range of threats that result in a wide range of operations that can correspondingly occur in response to those conditions and threats. These operations are conducted within a continuum consisting of three general states—peacetime competition, conflict, and war. The operational continuum discussed below suggests the types of operations conducted during the three general states. The operational continuum is intended to assist in the articulation of the strategic situations within a theater. Although the following discussion of the states within the continuum describes each in distinct terms, in actual circumstances there may be no precise distinctions where a particular state ends and another begins. In any case, the ability to describe strategic situations in clear terms will assist commanders in chief (CINC) in defining needs, devising strategies, and projecting resources.

*a. Peacetime Competition.* Peacetime competition is a state wherein political, economic, informational, and military measures, short of combat operations or active support to warring parties, are employed to achieve national objectives. Within this state, US forces may conduct joint training exercises to—

- Demonstrate resolve.
- Conduct peacekeeping operations.
- Participate in nation-building activities.
- Conduct disaster relief and humanitarian assistance.
- Provide security assistance to friends and allies.
- Execute shows of force,

Some operations, such as support to interagency counternarcotic operations, have dimensions that may span peacetime competition and conflict. These examples are illustrative, not inclusive. When confrontations and tensions occur involving the clear threat or the use of armed force, a situation exists that is a potential point of transition to a state of conflict.

*b. Conflict.*

(1) Conflict is an armed struggle or clash between organized parties within a nation or between nations to achieve limited political or military objectives. While regular forces are often involved, irregular forces frequently predominate. Conflict is often protracted, confined to a restricted geographic area, and constrained in weaponry and level of violence. Within this state, military power in response to threats may be exercised in an indirect manner while supporting other elements of national power. Limited objectives may be achieved by the short, focused, and direct application of force. Conflict also describes situations where continuing clashes or crises occur over—

- Boundary disputes.
- Land and water territorial claims.
- Conditions in which opposing political factions engage in military actions to gain control of political leadership within a nation.

(2) In the future, potential exists for crises and clashes in space.

(3) As the amount of forces, frequency of battle, number of nations, and levels of violence increase and are sustained over an extended period of time, and when the sovereignty of a nation is threatened, conflict approaches the threshold of a state of war.

*c. War.* War is sustained use of armed force between nations or organized groups within a nation involving regular and irregular forces in a series of connected battles and campaigns to achieve vital national objectives. War may be limited, with some self-imposed restraints on resources or objectives; or, it may be general with the total resources of a nation or nations employed and the national survival of a belligerent at stake.

## 1-4. The Medical Threat

The medical threat is the composite of all ongoing or potential enemy actions and environmental conditions that reduce the performance effectiveness of the soldier. The soldier's reduced effectiveness results from sustained wounds, injuries, or diseases. Examples of significant threats to the medical mission area are—

- Those weapons or environmental conditions that generate wounded, injured, and sick soldiers beyond the capability of the HSS system to provide timely medical care.
- Those weapons or environmental conditions that produce qualitatively different wound or disease processes.

## 1-5. Enemy Combat Operations

A threat to the medical mission results from enemy combat operationst that–

- Disrupt HSS operations.
- Threaten the survival of HSS.

*b.* This threat, however, is NOT considered to be a medical threat.

## 1-6. Elements of the Medical Threat

*a. Naturally Occurring Infectious Diseases.* Naturally occurring infectious diseases, also referred to as endemic diseases, represent a significant threat to US armed forces deployed outside continental United States (OCONUS). Historically, infectious diseases have been responsible for more lost foxhole days than battle injuries. Many naturally occurring infectious diseases have short incubation periods. They may cause significant numbers of casualties within the first 48 hours to 2 weeks of a deployment. Some examples of the more militarily significant, naturally occurring, infectious disease threats are as follows:

(1) Acute diarrhea.

(2) Acute respiratory diseases.

(3) Malaria.

(4)Arbovirus infections.

(5) Sexually transmitted diseases.

(6) Japanese encephalitis.

(7) Hemorrhagic fever with renal syndrome.

(8) Schistosomiasis.

(9) Leishmaniasis.

(10) Leptospirosis.

(11) Viral hepatitis.

(12) Scrub typhus.

*b. Environmental Extremes.*

(1) The following environmental conditions pose significant health hazards to an unacclimated, unprepared, and ill-conditioned military force:

- Heat.
- Cold.
- High humidity
- High terrestrial altitude.

(2) Projection of US armed forces into areas of the world where the above conditions exist without adequate opportunity for acclimatization may contribute to mission failure from the soldier's performance degradation. Many regions of the world where the US has vital national interests have areas of high altitude, humidity, and extremes in temperature. These areas include–

- Countries with year-round tropical climates and extended rainy seasons such as Panama and the Philippines.
- Countries with harsh, cold winters such as Korea and Northern Europe.
- Countries with large deserts and hot, dry climates such as Saudi Arabia and Kuwait.

*c. Battle Injuries–Kinetic Energy and Fragmentation Antipersonnel Ordnance/Munitions.* Conventional warfare munitions include small arms, high velocity weapons, rockets, bombs, artillery, as well as bayonets and other wounding devices used or employed by a single individual or a crew. This threat will be encountered in all geographic areas and will be employed by adversary forces throughout the operational continuum. Research and development in "smart munitions" and extended range artillery, coupled with more powerful high explosives, will increase the threat from this type weapons in mid- and high-intensity conflicts. In low- and mid-intensity conflicts, wounds from booby traps, mines, and nontraditional weapons (homemade explosives, crossbows, and "pungie sticks") will be encountered.

*d. Biological Warfare.*

(1) Biological warfare (BW) is defined as the intentional use of disease-causing organisms (pathogens), toxins, or other agents of biological origin (ABO) to–

- Incapacitate, injure, or kill humans and animals.
- Destroy crops.
- Weaken resistance to attack.
- Reduce the will to wage war.

(2) Historically, BW has primarily involved the use of pathogens as sabotage agents of food and water supplies to spread contagious disease among target populations. For purposes of medical threat risk assessment, only those biological warfare agents that incapacitate, injure, or kill humans or animals are considered. The BW agents and ABOs generally fall into one of the following categories:

- Naturally occurring, unmodified, infectious agents (pathogens).
- Toxins, venoms, and their biologically active fractions.
- Modified infectious agents.
- Bioregulators/physiologically active compounds.

(3) The causative agents for anthrax, tularemia, plague, and cholera, as well as *botulinum* toxin, staphylococcus enterotoxin, and mycotoxins are believed to have been developed as BW agents by potential adversaries of the US. Many governments recognize the virtually limitless potential of biotechnology as a tool for the production of biological warfare agents. Naturally occurring infectious organisms can be made more virulent, antibiotic-resistant, and manipulated to render protective vaccines ineffective. Such developments would greatly complicate the ability to detect and identify B W agents and operate in areas contaminated by such biological agents.

*e. Third World Chemical Warfare.* Since World War I, the popular opinion within western political and military circles has been that it is politically dangerous, morally wrong, or militarily unnecessary to prepare for *or* conduct offensive chemical warfare (CW). Events during the last 50 years have called into question the universality of this repulsion. The confirmed use of CW agents by Iraq against Iranian forces; the probable use of CW agents by the Soviets in Afghanistan; and the reported use of chemical agents and toxins in Southeast Asia indicate a heightened interest in CW as the underdeveloped country's force equalizer to counter advanced weapons technology in the world political arena. Nerve and blister agents appear to be the most probable types of CW agents available to developing countries.

*f. Soviet Chemical Warfare.* The Soviet Union has the most extensive CW capability in the world. The Soviets can deliver chemical agents with almost all conventional weapons systems from mortars to long-range tactical missiles available to ground, air, and naval forces. By their own admission, the Soviets have over 50,000 tons of poisonous compounds stockpiled for use in warfare. Agents believed to be available in the Soviet inventory include nerve agents (VX, thickened VX, GB [sarin], thickend GD [soman]; vesicants (thickened lewisite and a mustard-lewisite mixture); choking agents (phosgene); and riot control agents (CS).

*g. Directed-Energy Weapons.* Directed-energy weapons generate and illumuinate a target with coherent radiation to induce electronic upset, thermal damage, or structural damage and thereby cause mission failure. The radiation is of three types: radio frequency, laser (coherent light), and charged particle beam. There have been numerous reports of personnel using optic devices sustaining eye damage after exposure to a bright flashing light emanating from warships and other sources. These reports suggest an increasing threat from already fielded lasers to both air and ground forces.

*h. Blast-Effect Weapons.* Primary blast injury has been a rarity in the history of US military medicine. Battlefield employment of blast-effect weapons may represent an emerging medical-threat in the form of primary blast wounded. Gas-filled bodily organs such as the ears, lungs, and digestive tract are most susceptible to primary blast injury. This emerging threat may be reflected in terms of lower lethality; however it will result in a greater number of primary blast wounded and significantly increased medical work load.

*i. Combat Stress and Continuous Operations.* Global mobility of US armed forces is a major element of US political and military strategy. Alert forces may be required to operate without rest for extended periods of time during mobilization, staging, airborne transportation, and combat insertion into hostile areas. Modern combat will stress soldiers to the limits of their endurance. Some of the causes of stress to the soldiers are–

- The increased lethality of weapons.
- Technological skill requirements.
- Exposure to the horror of nuclear, biological, and chemical (NBC) weapons.
- Day/night all-weather operations.

Under these mobiliztion and combat conditions, stress, as well as physical and emotional fatigue, becomes a major contributor to the number of casualties seen by the HSS system.

*j. Flame and Incendiary Weapons.* Flame and incendiary systems will continue to be effective as antipersonnel and antimaterial weapons on the AirLand battlefield. Early generation weapons and munitions are still to be found in the armies of developed nations. Two examples include napalm and white phosporous fill for aerial delivered

bombs. New generation weapons and flame/incendiary agents are being fielded. Examples of some of the newer systems include the Soviet rocket-propelled flame projectors (Models RPO and RPO-A) currently in use by the Soviet Army. Possible uses of flame and incendiary weapons include the clearing of difficult defensive positions such as—

- Caves during combat operations in mountainous terrain.
- Bunkers and buildings during combat operations in urban areas.
- Soft shelter and vehicular targets.

Flame has also been used quite effectively in previous conflicts in an antitank role.

*k. Nuclear Warfare.* Currently, the primary nuclear warfare threat is from the Soviet Union. Open source information suggests that countries in the Middle East, Asia, and Africa may develop nuclear weapons capability within the next decade. On a European battlefield (NATO versus Warsaw Pact), likely nuclear targets include nuclear delivery systems, command, control, and communications systems, special ammunition supply points, troop concentrations, and prepared defenses. Planners can expect a minimum of 10 to 20 percent casualties within a division-sized force that has experienced a nuclear strike. This estimate may be understated as the proximity to ground zero is the critical factor in determining the effect of the weapon on the force. In addition to casualties, a nuclear weapon detonation can generate an electromagnetic pulse that will result in catastrophic failure of electronic equipment components.

## 1-7. The Medical Threat in High-Intensity Combat Operations

Commanders should anticipate increased casualty densities during high-intensity combat operations over those experienced in previous conflicts. The elements of medical threat of greatest potential for force degradation during high-intensity combat operations are—

- Battle injuries due to artillery, small arms, and fragmentation munitions.
- Casualties due to combat stress.
- Nuclear, biological, chemical, and combined casualties.

## 1-8. The Threat to Health Service Support Operations in a High-Intensity Combat Environment

*a.* Significant increases in casualty densities will cause local or general overload of the HSS system.

*b.* Premeditated attack upon medical organizations, personnel, or Class VIII stores is not anticipated, but it cannot be completely ruled out. The degree of adherence to the laws of land warfare are adversary dependent. A steady erosion of battlefield medical resources will result from the–

- Ever-increasing range of indirect fire weapons.
- Enhanced wounding capacity and destructiveness of munitions.
- Collateral effects of conventional, chemical, or nuclear weapons.
- Blindness of “smart,” nonline of sight munitions to the red cross.

*c.* Enemy combat operations in friendly rear areas will interdict lines of communication and disrupt necessary logistics activities. This will produce a serious negative effect on our ability to retrieve and evacuate wounded, sick, and injured soldiers and deliver medical care. Lack of air superiority will seriously reduce our use of aeromedical evacuation in the forward combat zone (CZ).

*d.* Prolonged periods of intense, continuous operations will tax combat medics to the limit of their physiological and emotional endurance. This stress and fatigue will cause a quantitative and qualitative degradation in the ability of the HSS system to deliver medical care at a sustained level.

*e.* Health service support organizations are not expected to be the primary target for biological or chemical strikes. However, logistics base

complexes WILL be primary targets. As elements of logistics complexes, medical organizations must anticipate collateral contamination from attacks on adjacent facilities. Divisional HSS assets have an even higher probability of being required to operate in or in proximity to areas contaminated from NBC strikes.

### 1-9 The Medical Threat in Mid-Intensity Combat Operations

*a.* The medical threat associated with mid-intensity combat closely parallels the medical threat associated with high-intensity conflict. The greatest difference between medical threat at these two levels of conflict is in the expected number of casualties. The primary reason is the reduced number of soldiers exposed to the destructive effects of enemy weapons. The second important difference is the expected increase in the impact of environmental extremes and naturally occurring infectious disease.

*b.* The most significant contributors to force degradation during mid-intensity combat operations are as follows:

- Battle injuries due to artillery, small arms, and fragmentation munitions.
- Casualties due to combat stress.
- Casualties from environmental extremes and endemic disease.
- Chemical and biological warfare and combined casualties.

### 1-10. The Threat to Health Service Support Operations in Mid-Intensity Combat Operations

The nature of the threat to HSS operations during mid- and high-intensity combat operations is very similar. However, the HSS infrastructure in a mid-intensity combat environment will be much more austere than in a high-intensity conflict. Hospitalization and evacuation resources backing up Echelon II HSS units will initially be limited in most mid-intensity combat scenarios. (The echelons of medical care are discussed in Chapter 3.) This situation will require–

- A greater reliance on and early deployment of preventive medicine assets.
- Far forward surgical and resuscitative capability.
- United States Air Force (USAF) strategic aeromedical evacuation.

Austere health service resources within the area of operations will significantly degrade the capability of the HHS commander to reconstitute or replace his depleted or destroyed units from within theater assets.

### 1-11. The Medical Threat in Military Operations Short of War

*a.* The medical threat is traditionally evaluated for its impact on US forces alone. However, when preparing for and conducting military operations short of war, the impact of these elements of medical threat on the indigenous population as a contributing factor to social, political, and economic instability must be considered. The general environment in which these types of operations are conducted can be varied. These environments range from peaceful developing countries with no apparent internal or external instabilities, to countries with limited resources and poorly-fed populations beset by disease and dependent on humanitarian assistance. Moreover, many of these countries may have active insurgent movements striving to displace the government using the general population for logistical support and cover.

*b.* During military operations short of war, the primary focus is on nation assistance, disaster relief, and humanitarian assistance. In this scenario, the most significant elements of the medical threat confronting US forces and mission planners are–

- Naturally occurring infectious disease.
- Environmental extremes.

*c.* There is a broad range of viable scenarios under which US forces could be employed in nation assistance, disaster relief, and humanitarian assistance missions involving an equally diverse list

of countries in the Third World. In general, areas where assistance teams and units may be employed will likely have very low standards of living and high levels of naturally occurring infectious disease. Many of these diseases could be considered "exotic" to most US health service personnel. United States forces entering these areas will have very little, if any, natural immunity to many of the endemic diseases. The degree of cultural and social interaction required to support the mission, as well as the sharing of food, quarters, and recreation with local nationals, will also increase the exposure of US personnel to diseases endemic to the host country. For the most part, assistance operations will last for an extended period of time (beyond 30 days), once again increasing the exposure to and raising the risk of endemic disease.

*d.* There is an increased potential for performance degradation and illness for unacclimatized personnel. These are caused by environmental extremes in many of the regions where US involvement in low-intensity conflict (LIC) is likely. In general, US assistance forces could be employed in regions where climate ranges from desert to tropical and lowlands to high terrestrial altitude. The US assistance forces must be acclimatized, both physiologically and psychologically. This will enable them to cope with environmental extremes associated with living and working during extended periods of high humidity, rain, or prolonged dry seasons.

*e.* Medical threat associated with peacetime contingency operations will, under certain combat scenarios, be the same as medical threat described for the mid-intensity conflict environment. Battle-type injuries will increase as the level of violence in the LIC environment escalates with increased insurgent and terrorist activities against US targets and the indigenous population. The spread of technology to the Third World carries with it the potential for eventual acquisition and use of nuclear devices and chemical and biological warfare agents by terrorist and insurgent groups.

### 1-12. The Medical Threat to Health Service Support Operations in Military Operations Short of War

*a.* In an LIC environment, the protection afforded to medical treatment facilities (MTFs) and medical personnel by the Geneva Convention may be nonexistent. In fact, HHS activities may be perceived as lucrative targets by insurgent or terrorist groups. This is true especially if these facilities are seen as making a major contribution to the host-nation government. Medical facilities will also be vulnerable to theft and raids on Class VIII supplies by insurgents or terrorists for their own support or to support black-market activities.

*b.* In most LIC environments, the in-country components of the US logistical system in support of US assistance forces will be austere. This is also the case with the HSS structure. The US assistance forces will place increased reliance on local food and water sources and host-nation sanitation, public health, medical treatment, and health industry resources. There will also be increased reliance on USAF for strategic medical evacuation resources in LIC scenarios. These circumstances will demand solid HSS planning. This planning must be based on current, accurate medical intelligence. It must include the total involvement of the country team in the HSS planning effort prior to the execution of operations.

## Section III. PROTECTION AND SUSTAINMENT

### 1-13. AirLand Battle Tenets

To enhance the maneuver commander's chance of success, medical commanders must apply the ALB tenets to their mission.

*a. Initiative.* The tactical operation must not be affected by a lapse in HSS. The HSS units must move rapidly to provide the continuity needed to protect and sustain the force; thereby, preserving the initiative of the force.

*b. Depth.* From the HSS perspective, applying depth means that HSS commanders and staffs must understand the maneuver commander's plan. This enables them to picture the battlefield in depth and width to–

- Determine the medical threat.

- Anticipate future events and HSS requirements as operations develop.

- Ensure that HSS elements retain the flexibility to respond quickly to change.

*c. Agility.* Like all supporting operations, HSS must be capable of rapid adjustment to changes in the tactical situation. Success in sustaining the force depends on a well-developed, responsive HSS system. The medical commander must retain the ability to shift medical resources to provide HSS to areas of large patient concentration. Responsive HSS is important to the soldier's morale and hastens his early return to duty (RTD).

*d. Synchronization.* With unity of purpose throughout the force, every resource is used where and when it will make the greatest contribution to success. With synchronization, nothing is wasted or overlooked. The hallmark of HSS is improvisation. The HSS commanders must seek innovative solutions to HSS problems. Every action must flow from understanding the higher commander's concept of the operation. The HSS requirements must be integrated in operational planning to increase the capability of medical units at all echelons to provide effective support.

## 1-14. General Principles Applied to Health Service Support Objectives

*a.* The objectives of the AMEDD are to–

- Save lives.

- Evacuate casualties from the battlefield. This allows the combat commander to continue his mission.

- Reduce the incidence of disease and nonbattle injury(DNBI) through preventive medicine programs.

- Examine, treat, and return soldiers to duty as far forward as possible.

- Provide the utmost benefit to the maximum number of personnel by synchronizing HSS resources.

*b.* The six general principles that must be applied to HSS objectives are conformity, proximity, flexibility, mobility, continuity, and control.

(1) Conformity with the tactical plan is the most basic element for effectively providing HSS. By taking part in the development of the commander's plan of operation, the HSS planner can–

- Determine requirements.

- Plan the support needed to conform to tactical operations.

(2) The objective of proximity is to provide HSS to sick, injured, and wounded soldiers at the right time and to keep morbidity and mortality to the minimum. The HSS resources are employed as close to the area of combat operations as the time and distance factors and the tactical situation permit. Patients are evacuated to the MTF or the MTF is moved to the area where the patient population is the greatest. However, medical commanders and staffs, through continuous coordination, ensure that treatment elements or MTFs are not placed in areas that interfere with combat operations.

(3) The objective of flexibility is to be prepared to shift HSS resources to meet changing requirements. Changes in tactical plans or operations make flexibility in HSS essential. Since all HSS units are used somewhere within the theater and none are held in reserve, the commander makes alternate plans for redistribution of HSS resources as required.

(4) The objective of mobility is to ensure HSS assets remain close enough to support maneuvering combat forces. The mobility of medical units organic to maneuver elements should be equal to the forces being supported. Major HSS headquarters in the theater of operations continually assess and forecast unit movement and redeployment. Through the use of organic and nonorganic transportation resources, commanders can rapidly move HSS units to best support combat operations. For example, if one unit is immobilized, a similar unit may be leapfrogged past it. An immobilized unit may be given priority in

evacuating its patients as they become stabilized, and its resources may be moved forward by echelon.

(5) The objective of continuity is to–

- Implement preventive medicine programs.

- Provide optimum care and treatment to the sick, injured, and wounded in an uninterrupted manner.

Continuity in care and treatment is achieved by moving the patient through a progressive, phased HSS system, extending from the forward area of the CZ to the area as far rearward as the patient's condition requires, possibly to the continental United States (CONUS). Each type of HSS unit contributes a measured, logical increment appropriate to its location and capabilities.

(6) The objective of control is to ensure that scarce HSS 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 and policies. To ensure that the scarce HSS resources are efficiently employed and support the tactical plan, medical assets are under the control of a single medical commander.

### 1-15. The Focus of Health Service Support in the AirLand Battle

*a.* Field Manual 100-10 provides the basis for subordinate CSS doctrine, materiel, training, and organizational development. It describes the principles upon which the Army's CCS system operates and the ways in which the system is organized.

*b.* As a function of CSS, HSS focuses on conserving the human and animal components of the combat commander's weapons system.Far forward care describes the character that HSS must assume. Applying ALB tenets to the delivery of HSS will ensure that the objectives of the AMEDD are met and that its mission to conserve the fighting strength is fulfilled.

# CHAPTER 2

# ORGANIZATIONAL RELATIONSHIPS

## 2-1. Theater of Operations

A theater of operations is that area of land, sea, and air required to support and perform military operations against the enemy. United States forces deployed to the theater may range from a relatively small task force, to a full array of large land, sea, and air forces. The theater is organized into a CZ and a communications zone (COMMZ). (See Figure 2-l.)

*a.* The CZ is the territory forward of the corps rear boundary. It is that area required by tactical forces for the conduct of operations. The depth of the CZ depends onthe–

- Forces involved.
- Nature of planned operations.
- Lines of communications.
- Terrain and enemy capabilities.

Normally, the CZ is divided into corps areas and division areas.

*b.* The COMMZ is the rear part of a theater of operations (behind but not necessarily contiguous to the CZ). It contains the–

- Lines of communications.
- Establishments for supply and evacuation.
- Other agencies required for the immediate support and maintenance of the field forces.

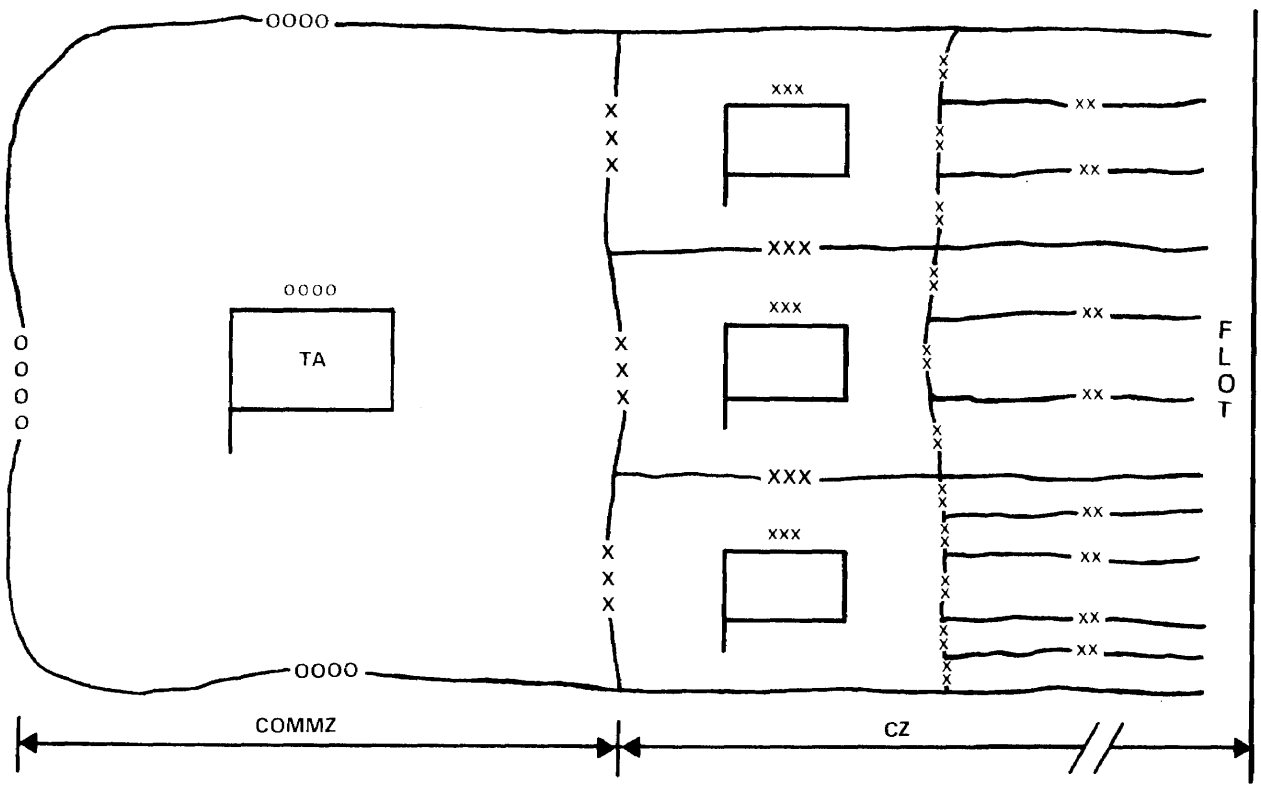



*Figure 2-1. Theater zones.*

## 2-2. Theater Army

*a. Army Service Component.* The theater army (TA is normally the Army service component command in a unified command. Third US Army, Seventh US Army, and Eighth US Army are examples of theater armies. The TA as the service component has both operational and support responsibilities. Its exact tasks are assigned by the theater CINC. These tasks may be exclusively operational missions, solely logistics tasks, or a combination of both types of responsibility.

*b. Assigned Forces.* The TA commander is responsible to the unified commander for recommending how assigned US Army forces should be allocated and employed. The TA commander's support responsibilities include the requirements to organize, equip, train, and maintain Army forces in the theater.

*c. Organization.* The organization of a TA is not standard. It varies between theaters according to the size of the US Army component in a force. It also varies with the factors of mission, enemy, terrain, troops, and time available (METT-T). Other levels of command can also perform TA functions. For example, a corps staff could perform the TA function if only a single corps were committed to a contingency area. On the other hand, a larger separate staff may be necessary to handle the administrative, legal, logistics, personnel, intelligence, operations, and communications tasks of a large force deployed overseas. Liaison between a TA and another headquarters employing its forces must be performed whenever theater armies release operational control of their units.

## 2-3. Theater Army Commander

*a.* The TA commander has two types of support organizations with which to accomplish the mission. They are–

- Area-oriented organizations with geographic responsibilities (theater army area commands [TAACOMs] and area support groups [ASGs]).
- Mission-oriented organizations with functional responsibilities (such as a personnel command, an engineer command, and a medical command [MEDCOM]).

*b.* Responsibility for the COMMZ is assigned to the TA commander whose primary responsibility in time of war is CSS of assigned forces.

## 2-4. Health Service Support for the Army Component

Health service support for the Army component in a theater of operations is the responsibility of the TA commander. On the commander's special staff is a TA surgeon.

## 2-5. Theater Army Surgeon

Normally, the MEDCOM commander or the senior medical commander in the COMMZ functions as the TA surgeon. As TA surgeon, he provides information, recommendations, and professional medical advice to the TA commander and to the general and special staffs. He also maintains current data regarding the status, capabilities, and requirements for the HSS of the TA. As the medical staff adviser, he is responsible to the TA commander for staff planning, coordinating, and developing policies for the HSS of TA forces. The TA surgeon–

- Determines the medical threat.
- Provides advice concerning the health services of the command and the occupied or friendly territory within the TA commander's area of responsibility.
- Provides advice concerning the medical effects of the environment and of NBC weapons on personnel, military working dogs, rations, and water.
- Recommends changes to the theater evacuation policy.
- Provides advice concerning the combat stress threat and its interaction with–
  - The medical and environmental threats.

- Other stress factors in the theater and home front.

- Determines requirements for the requisition, procurement, storage, maintenance, distribution, management, and documentation of Class VIII materiel and special hospital-peculiar items of subsistence.

- Develops and supervises a mass casualty plan. (See Chapter 14 for a discussion on the mass casualty plan.)

- Recommends priority of fills for all AMEDD officer and warrant officer vacancies and makes recommendations concerning the assignment of enlisted personnel with AMEDD specialties within the TA.

- Plans and coordinates medical training in the command.

- Coordinates with medical brigade commander(s) and corps surgeon(s) for continuous HSS.

- Monitors continuously the following HSS areas of interest:

  - The system of treatment and patient evacuation, including aeromedical evacuation (AE ) by Army air ambulance units, air movement of patients by Air Force evacuation units, and evacuation by Navy ships.

  - Dental service.

  - Veterinary food inspection, animal care, and veterinary preventive medicine activities. (See FMs 8-27 and 8~30.)

  - Medical food service.

  - Professional medical support in subordinate units.

  - Preventive medicine and, as required, preventive medicine in public health activities in coordination with the assistant chief of staff (civil affairs) (G5).

  - Medical laboratory service.

  - Blood services.

  - Optical service.

  - Medical supply, optical, maintenance, and repair facilities, including technical inspection and reporting of status.

  - Medical intelligence, including the examination of captured medical supplies and equipment.

  - Technical inspection of medical materiel.

  - The equipment status reporting system within his area of responsibility.

  - Medical civic action programs coordination with the G5.

  - Health service support aspects rear operations.

**NOTE**

As a result of ALB doctrine, the term rear operations supersedes the terms rear area protection and rear area combat operations. (See FMs 71-100, 90-23, and 100-15 for doctrine pertaining to rear operations.)

  - Consolidation of medical reports and other hospital administrative records of injured, sick, and wounded personnel.

  - Mental health/combat stress control services. These services include prevention and treatment programs for battle fatigue, misconduct combat stress reactions, and substance abuse.

  - Required automatic data processing support for appropriate medical agencies within the command.

  - Collection and analysis of operational data for the purpose of on-the-spot adjustments in the theater medical support structure and for use in combat materiel development studies.

• Reconstitution to include reorganization and regeneration. (See Section V, Chapter 3.)

### 2-6. Theater Army Surgeon's Section

The size and composition of the TA surgeon's section, which is a part of the MEDCOM headquarters, will vary in accordance with the strength of the Army forces in the theater, the nature of the military operations to be conducted, and the specific responsibilities assigned. The section may perform administrative, intelligence, operational, training, and logistical functions.

### 2-7. Consultants to Theater Army Surgeon

Professional consultants in various services and specialties assist the TA surgeon. These services and specialties may include entomology, environmental engineering, medicine, nuclear medicine, neuropsychiatry and social work (combat stress control), nursing, preventive medicine, surgery, dietary, optometry, pharmacy, dentistry, veterinary, and medical intelligence. The Armed Forces Medical Intelligence Center (AFMIC) should be considered as a source for consultation for medical intelligence. When time and manpower permit, intelligence exchanges should take place between this strategic asset and senior tactical medical authorities; however, this is done only with the advice and consent of organic intelligence sources. Consultants to the TA surgeon–

• Make recommendations which aid in establishing patient management policies for the command.

• Assist in personnel management decisions governing clinical specialists.

• Monitor quality of clinical performance and adherence to established policy through staff visits and reviews of records and reports.

• Recommend clinical investigations to solve critical patient-care problems. (When required, and depending upon the particular table(s) of organization and equipment (TOE), individuals in medical specialties at various subordinate or lower echelon medical headquarters and units also act as consultants.)

• Provide professional and technical consultation in functional areas.

### 2-8. Theater Army Area Command

The TAACOM accomplishes its support mission of supply, maintenance, and personnel services through subordinate units known as ASGs. The number of ASGs depends upon the size of the COMMZ and the number of troops supported. The senior medical unit commander located within the geographical boundaries of an ASG will normally provide medical staff advice for the ASG commander. Standing operating procedures (SOP) will normally be developed by the MEDCOM and the ASG to govern the relationship between each ASG commander and the senior medical unit commander in his area. Health service support is provided to the ASG on an area basis. Medical units are not subordinate to the ASG but do provide HSS on an area basis.

### 2-9. Theater Army Medical Command, TOE 08-111H200

*a.* The mission of the MEDCOM is to provide command and control and supervision of assigned and attached units in the TA COMMZ.

*b.* The MEDCOM is assigned on the basis of one per TA.

*c.* The capabilities of the MEDCOM are–

• Command and control, staff planning, supervision of operations, training, and administration of hospital centers and medical groups engaged in providing COMMZ health services.

• Medical services to include–

• Keeping the TA commander and his staff informed on the health of the command and on medical aspects of matters affecting CSS.

• Providing current information concerning the medical aspects of the CSS situation to the surgeons of higher headquarters.

- Coordinating HSS operations of the COMMZ.

- Providing advice to the commanders of personnel command, transportation command, and civil affairs units on medical matters.

- Centralized control and coordination of all medical regulating functions for evacuation of patients from the CZ to and within the COMMZ as well as centralized coordination of all medical regulating functions for further evacuation out of the theater.

- Professional specialty consultation service.

- Policy and guidance for management of medical materiel and medical equipment maintenance.

- Coordination and direction of medical scientific and technical intelligence and medical technical intelligence activities within the COMMZ.

d. The number and type of HSS units assigned to the MEDCOM depend on various factors. Some examples are—

- Size, composition, and location of forces to be supported.

- Type of operations conducted.

- Anticipated work load.

- Theater evacuation policy. (See Chapter 4 for a discussion on evacuation policy.)

*e.* A signal operating company is attached, less operational control, to the MEDCOM to provide internal headquarters communications. This signal unit interrelates with the MEDCOM headquarters company in supporting internal operations of the MEDCOM.

*f.* The MEDCOM will be tailored to adjust to theTA mission and retain flexibility. This will permit the MEDCOM to respond rapidly to changing HSS requirements. The organization of a MEDCOM headquarters and an example of overall task organization of MEDCOM (current structure) are illustrated on the following pages. (See Figures 2-2 and 2-3.)

*g.* Since all HSS units in the COMMZ are assigned to the ME DCOM, units of other major commands such as the TAACOM, personnel command, or transportation command must receive HSS from MEDCOM units. This support is most efficiently and economically provided on an area basis. Area HSS, to include outpatient care, is provided by area dispensaries operated by separate medical companies (clearing) and dispensary detachments of various sizes. Patient evacuation, hospitalization, preventive medicine services, optometry services, dental services, and health service logistics are also provided on an area basis. The various HSS units required for this support are allocated on the basis of troop strength supported and are established where troop concentrations dictate.

## 2-10. Command and Staff Relationships

*a. Command.* The M EDCOM commander reports directly to the TA commander. The coordination of MEDCOM staff matters with the TA staff is normally conducted through command channels. However, health service professional matters are coordinated through technical channels directly with the TA headquarters surgeon's section. The TA headquarters provides policy, direction, and broad guidance on HSS planning. The MEDCOM coordinates with other TA commands on mutual support requirements. To ensure that adequate HSS is provided throughout the COMMZ, close coordination between the MEDCOM and the major commands in the COMMZ is necessary. The MEDCOM commander must know the extent and location of troop concentrations to be supported. Supported unit commanders must know where their supporting MTFs are located and what type of support is available.

*b. Staff.* Staff elements of theMEDCOM headquarters conduct normal staff relationships (both command and technical) with the staffs of assigned subordinate medical headquarters. In the absence of command and control teams, the dental surgeon, preventive medicine staff officer, and veterinary staff officer may be delegated operational control, in their respective areas, of subordinate units.

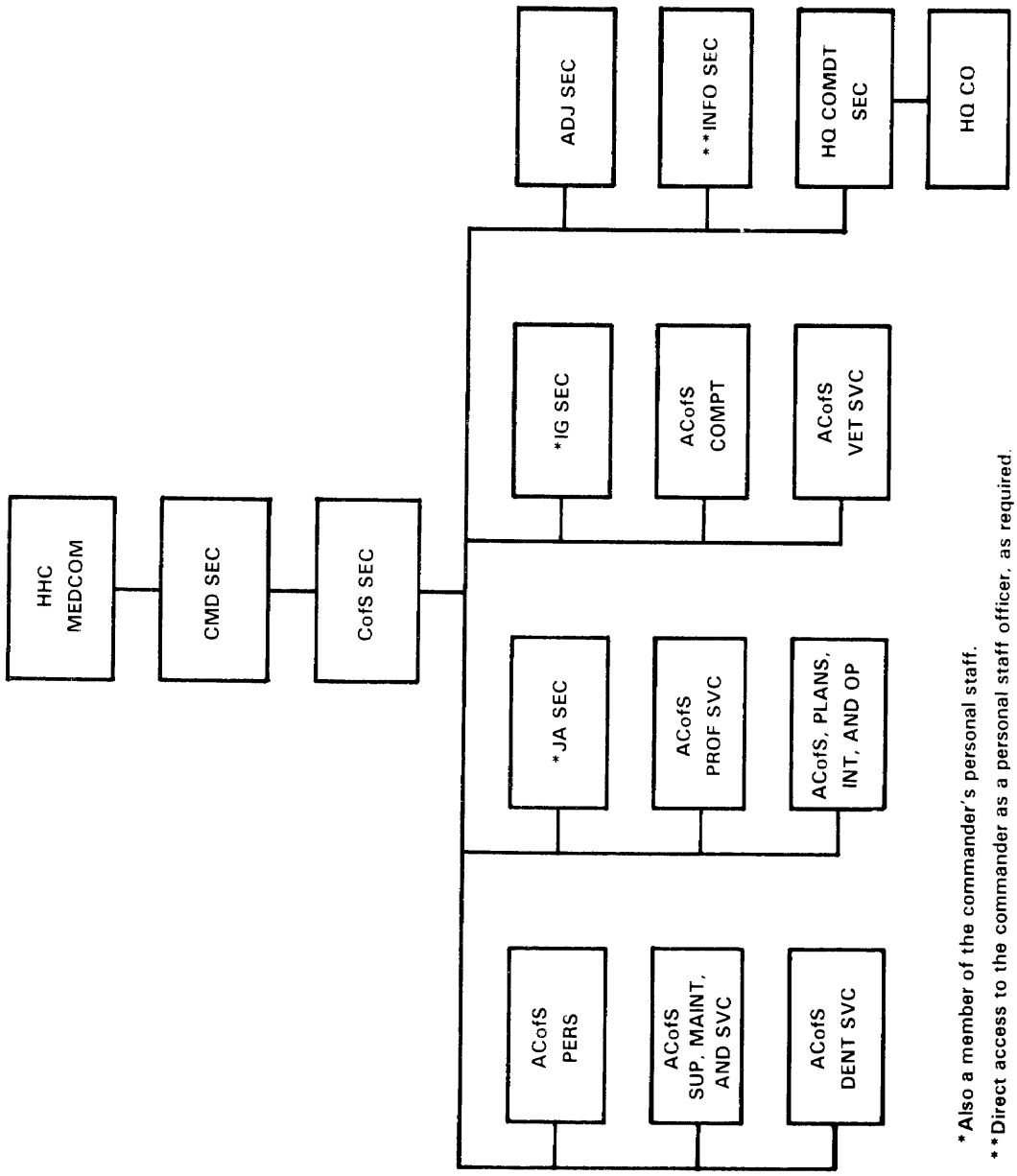
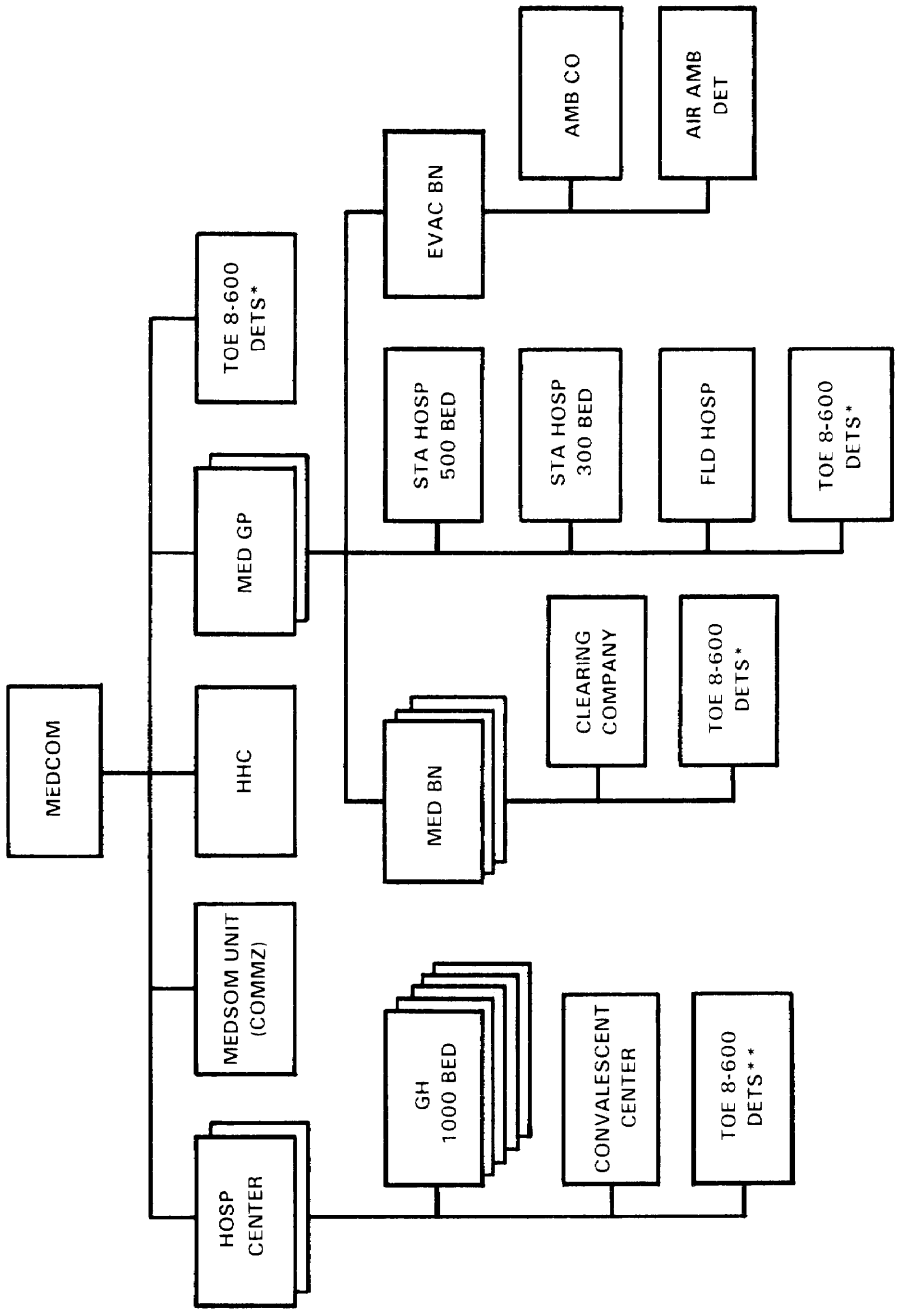



*Figure 2-2. Headquarters, medical command.*




*Includes preventive medicine, dental, psychiatry (combat stress control), veterinary, dispensary, laboratory, and professional specialty teams.

**Includes air and ground evacuation, preventive medicine, dental, psychiatry (combat stress control), veterinary, dispensary, laboratory, and professional specialty teams.

NOTE: This figure illustrates a *type* MEDCOM. The number and type units assigned in any given theater will depend on the mission and the composition of the supported force.

*Figure 2-3. Example of task organization of MEDCOM (current structure).*

*c. Liaison with CZ.* Liaison with the major medical headquarters within the corps is maintained for evacuation of patients from the CZ and for required reinforcement to the corps. Direct coordination concerning technical matters is also authorized between the MEDCOM and the major medical headquarters in each corps area (medical brigade or group). This coordination ensures that the respective corps surgeon is kept advised.

## 2-11. Command and Control

The MEDCOM headquarters commands and controls all assigned and attached units. Its major subordinate command and control units are hospital center headquarters, medical group headquarters, nondivisional medical battalion headquarters, and evacuation medical battalion headquarters.

*a. Headquarters and Headquarters Detachment, Hospital Center, TOE 08-5O2H1OO.*

*(1) Mission.* The mission of this unit is to command and control general hospitals and other health service units.

*(2) Assignment and basis of allocation.* This unit is assigned to the MEDCOM on the basis of one per two to eight general hospitals or their equivalent in a combination of general hospitals and other health service units (maximum of 8,000 fixed beds).

*(3) Capabilities.* In addition to providing command and control for attached general hospitals, the hospital center provides medical regulating and professional specialty consultation service.

*(4) Concept of operations.*

*(a) Location.* Hospital centers are located only in the COMMZ. Since a hospital center headquarters, including its assigned hospitals, requires not only extensive ground areas but certain adjuncts (water, power, and sewage disposal facilities) for its operations, ideal sites are seldom encountered. However, so far as possible, the center's location should conform to established principles regarding the location of medicaI installations. These basic principles include the adaptability of existing physical plant structures to the center's requirements.

*(b) Centralized functions.* The hospital center commander and staff, using their centralized facilities, correlate and coordinate the overhead activities of assigned hospitals. They assist the attached hospital's staffs by coordinating and consolidating a major portion of the administrative details associated with such services as supply and maintenance, transportation, utilities, and similar essential services. These actions result in the economical use of personnel and equipment. The hospital center commander exercises control over the movement of patients to and from attached hospitals. Certain hospitals operating under the command and control of the hospital center may be staffed and equipped to provide specialized treatment. Thus, the hospital center affords the opportunity for increased specialization in certain fields of medicine. Such a procedure ensures the additional advantage of fully utilizing the skills possessed by highly qualified professional personnel.

*b. Headquarters and Headquarters Detachment, Medical Group, TOE 08-122H200.*

*(1) Mission and assignment.* This unit provides command and control and administrative supervision of assigned or attached medical units. It is assigned to the TA MEDCOM in the COMMZ based on the general support requirements of the corps forces supported.

*(2) Concept of operations.* Medical units are assigned or attached to the group headquarters by the TA MEDCOM. The nature of the COMMZ requires that medical groups be employed to perform mission responsibilities consisting of HSS to forces in the COMMZ. Medical groups located in the COMMZ provide support on an area basis. This support consists of units furnishing station-type hospitalization, short-haul patient evacuation, patient holding, and other support. Assets from COMMZ medical groups may be used to replace ineffective units in the CZ. Medical groups may contain such medical attachments as dispensary, preventive medicine, dental, and veterinary units. Units are readily reallocated between groups by action of the MEDCOM to accomplish shifts in work loads.

*c. Headquarters and Headquarters Detachment, Medical Battalion, TOE 08-126H300.*

*(1) Mission and assignment.* This unit provides command and control and planning for a medical battalion (nondivisional) to include supply and organizational maintenance support. It is assigned to the TA MEDCOM, TOE 08-11lH200, or medical brigade, TOE 08-112H600, on the basis of one per three to seven nondivisional medical companies or equivalent-size units. The unit may operate directly under the MEDCOM, but it is often attached to a medical group, TOE 08-122H200. The number and types of companies or detachments attached to the medical battalion will depend upon the mission.

(2) *Employment.* The medical companies of the nondivisional medical battalion have essentially the same roles in the COMMZ as they do in the corps support area.

*d. Headquarters and Headquarters Detachment, Medical Battalion (Evacuation), TOE 08-446LOOO.*

(1) *Mission.* This unit provides command and control and planning of air and ground medical evacuation units within the theater of operations.

(2) *Assignment.* The medical battalion (evacuation) is assigned to the MEDCOM, TOE 08-111H200, in the COMMZ, or the medical brigade, TOE 08-112H600, in the corps.

(3) *Capabilities.* This unit provides–

- Command and control, supervision of operations, training, and administration of a combination of three to seven assigned or attached medical companies (air ambulances), TOE 08-447L100, and medical companies (ground ambulances), TOE 08-449 L000, medical detachments, TOE 08-660H0, and medical air ambulance company, TOE 08-137H200.
- Staff and technical supervision of aviation operations, safety, and aviation maintenance (AVUM) within attached ambulance companies.
- Coordination of medical evacuation operations and communications functions on a 24-hour, two-shift basis.
- Medical supply support to attached units.
- Echelon I HSS.

(4) *Basis of allocation.* One per combination of the following units:

- Three to four medical companies, air ambulance.
- Three to four medical companies, ground ambulance.

**2-12. The Corps**

*a. The Largest Tactical Unit.* Corps are the largest tactical units in the US Army, the instruments by which higher echelons of command conduct maneuvers at the operational level. Corps are tailored for the theater and the mission for which they are deployed. Once tailored, however, they contain all the combat, combat support (CS), and CSS capabilities required to sustain operations for a considerable period.

*b. Flexible Organization.* Corps may be assigned divisions of any type required by the theater and the mission. They possess support commands and are assigned combat and CS organizations based on their needs for a specific operation. Armored cavalry regiments, corps artillery brigades, engineer brigades, air defense artillery brigades, and aviation brigades are the nondivisional units commonly available to the corps to weight its main effort and to perform special combat functions. Separate infantry or armored brigades may also be assigned to corps. Signal, military intelligence, military police, and chemical brigades are the usual CS organizations present in a corps. Civil affairs and psychological operations units are often used to augment the CS role; however, they are not normally present within the corps. Other special operations forces may support corps combat operations as required, particularly when the corps is conducting an independent operation. The CSS organization of the corps is the

corps support command (COSCOM). The COSCOM provides supply, field services, transportation, maintenance, and HSS to the divisions and nondivisional units of the corps. Within the corps, corps support groups provide supply (less Class V and VIII), maintenance, and field service to division and nondivisional units. Transportation, ammunition supply, and medical support are provided by functional commands.

*c. Headquarters.* The corps headquarters is a tactical headquarters with responsibility for providing administrative and logistical support for its subordinate units. (See FM 100-15 for further discussion on corps operations.)

## 2-13. Health Service Support in the Corps

Generally, the mission of Echelon III (Level III) HSS is to provide the divisions and troops in the corps area with hospitalization and other HSS for continued care and treatment of their sick, injured, and wounded. Functions included in the mission are described in subsequent chapters.

## 2-14. The Corps Surgeon

*a. Special Staff Officer.* The corps surgeon is a special staff officer in the corps headquarters. This officer has a small staff section to assist in completing the mission. The corps surgeon has direct access to the corps commander on HSS matters. He keeps the commander and his staff informed concerning the health of the command and the health service aspects of combat operations and effectiveness. As the principal medical staff officer, he advises the corps commander and staff on all HSS matters related to personnel, intelligence, operations, logistics, and civil-military operations. He does not command medical troops unless assigned the responsibility by the corps commander. The corps surgeon exercises staff supervision over HSS in the COSCOM, divisions, and other subordinate corps units. The surgeon normally functions under the coordinating staff supervision of the assistant chief of staff (personnel) (G1) or directly under the corps chief of staff depending on the desires of the corps commander. Coordination with surgeons and medical commanders of higher, subordinate, and adjacent headquarters is through command channels, except for technical matters which may be coordinated through technical channels.

*b. Duties.* The corps surgeon and his staff perform the following duties:

- Develop and coordinate the HSS portion of corps plans to support the commander's decisions according to information provided by the senior medical headquarters of the corps (medical brigade or group).
- Provide current information on the corps health service situation to surgeons of the next higher, adjacent, and subordinate headquarters.
- Recommend policies concerning support of civil affairs and civic actions.
- Monitor the availability of and recommend the assignment, reassignment, and utilization of AMEDD personnel within the corps (to include critical occupational specialty personnel).
- Coordinate health consultation services within the corps.
- Evaluate and interpret health service statistical data.
- Recommend policies and determine requirements and priorities for medical supply, blood products, and medical equipment maintenance services according to information provided by the senior medical headquarters of the corps.
- Recommend and coordinate corps patient evacuation policies.
- Determine corps health service training policies and programs as required.
- Develop policies pertaining to the treatment of the sick, injured, and wounded personnel in coordination with the senior medical headquarters of the corps and the TA surgeon.
- Ensure compliance with the TA blood bank service program.

- Initiate preventive medicine programs and procedures within the corps.

- Recommend combat stress control, mental health, and substance abuse control programs and procedures within the corps.

- Coordinate access to intelligence of medical interest with the assistant chief of staff, (intelligence) (G2); ensure that medical threat, medical intelligence, and intelligence of medical interest are integrated into HSS plans and orders.

## 2-15. Corps Surgeon's Staff Relationships

The surgeon and his staff section interrelate with other members of the corps general and special staffs, as well as with surgeons of other commands. The corps surgeon exercises medical technical control over the HSS system of the entire corps.

*a. Assistant Chief of Staff for Personnel (G1) Staff Supervision.* The G1 exercises general staff supervision over the surgeon. The surgeon is responsible for the management of health services and must be professionally and technically qualified to assume this responsibility. On medical and technical matters affecting the health of the command and HSS of combat operations, the surgeon has direct access to the corps commander.

*b. Relationship with The Assistant Chief of Staff for Intelligence (G2).* The G2 has medical intelligence responsibilities in support of health services. He and the surgeons coordinate medical intelligence requirements. When appropriate, the staff surgeon may also assist the G2 with the integration of significant elements of medical threat, medical intelligence, and intelligence of medical interest into the intelligence preparation of the battlefield process.

*c. Relationship with the Assistant Chief of Staff for Logistics (G4).* The G4 has logistics responsibilities in support of health services. He reviews the surgeon's medical plans to determine logistics support requirements. In addition, he provides staff guidance and coordinates with the surgeon and the G1 concerning possible adjustments due to logistics considerations. He reviews the locations of medical units and installations to preclude any conflict with locations of logistical units. He advises and makes recommendations concerning logistics aspects of the command medical evacuation plan.

*d. Relationship with COSCOM Surgeon/ Senior Medical Headquarters Commander.* The corps surgeon coordinates with the COSCOM surgeon/senior medical headquarters commander and develops the health service portions of corps plans to support the commander's decisions.

*e. Relationship with Division Surgeon.* The relationship of the corps surgeon to the surgeons of lower commands depends in part on the policies of the corps commander. The corps surgeon, however, exercises staff supervision of all HSS for which his commander is responsible and is normally delegated full authority over the technical aspects of health services. The corps surgeon's relationship to the division surgeons is primarily technical. He exercises no command or operational control or authority over the divisional HSS system. The corps surgeon influences HSS in the division through the policies and directives of the corps commander. The division surgeons keep the corps surgeon apprised of the health service situation within the division.

*f. Relationship with the TA Surgeon.* The relationship between the corps surgeon and the TA surgeon is similar to that existing between the division surgeon and the corps surgeon. Except for direct coordination of technical matters, coordination with the TA surgeon is through command channels.

## 2-16. The Corps Support Command

The COSCOM is the principal logistics organization in the corps. It provides supply, field services, transportation (mode operations and movement control), maintenance, and HSS to the divisions and nondivisional units of the corps. Within the COSCOM, corps support groups provide supply (less Class V and VIII), maintenance, and field service to divisions and nondivisional units. Transportation, ammunition supply, and HSS are provided by functional commands. Depending upon the size of the corps, the senior medical organization may be a medical brigade or a medical group.

### 2-17. The Corps Support Command Surgeon

The COSCOM does not have an organic surgeon or surgeon's section. While the COSCOM surgeon's section is organic to the headquarters and headquarters company (HHC) medical brigade (TOE 08-112 H600), it may be collocated with the COSCOM headquarters upon deployment. The medical brigade commander within the COSCOM also serves as the COSCOM surgeon (or director of health services when the COSCOM is configured for a contingency-oriented corps). (This staff role is subordinate to the command role.) If the medical group headquarters is the highest medical headquarters, the senior medical corps officer assigned serves as the COSCOM surgeon. The COSCOM surgeon is a special staff officer of the COSCOM commander. He keeps the commander and his staff informed of the health of the command and of the medical aspects of CSS to the corps. He functions under the general staff supervision of the COSCOM G1 only in his role as COSCOM surgeon. He coordinates medical matters with other members of the staff. He provides advice to the commander and staff and assistance to supported and subordinate unit commanders on HSS matters. The surgeon is authorized direct access to the COSCOM commander and staff on the health of the command or the medical aspects of CSS operations. In conjunction with the corps surgeon, the COSCOM Assistant Chief of Staff (ACofS), Security, Operations, Training, and Intelligence (SOTI), and the COSCOM surgeon develop policies, plans, and programs for HSS of the corps. The COSCOM surgeon also assists the ACofS, SOTI, in HSS planning for rear operations. The surgeon's functions include–

- Developing, preparing, and coordinating the HSS policies of the command and the HSS portion of COSCOM plans.
- Providing current information on the HSS aspects of the CSS situation to the surgeons of higher and lower headquarters.
- Coordinating HSS operations of the corps.
- Providing the planning and coordinating aspects of medical supply arid medical maintenance.
- Maintaining liaison with the G5 on HSS.

### 2-18. Tailoring of Health Service Support in the Corps

*a. The Mission, Composition of Forces, and Geographic Area.* Health service support is tailored to the mission, composition of the force, and geographical area of operations. All nondivisional medical units located in the corps area are assigned to the major medical headquarters within the corps.

*b. Medical Brigade.*

(1) A medical brigade consists of a HHC and those subordinate medical units necessary for providing Echelon III HSS. It is assigned to a corps and is normally attached to the COSCOM. Like the corps itself, the medical brigade is a flexible organization, having no fixed composition. Its mission is to provide Echelon III HSS within a corps area.

(2) The number and types of units assigned and attached to the brigade will depend upon the mission, strength, and tactical disposition of the corps. The brigade is responsible for—

- Planning for HSS of the corps. The corps surgeon makes long-range plans (96 hours and beyond) for HSS. The commander of the medical brigade or group converts these plans into day-to-day operations for the fulfillment of the health service mission.
- Direction of subordinate medical unit operations.
- Implementation of hospitalization and evacuation policies, which includes medical regulating activities. (See Chapter 4 for a discussion on patient regulating.)
- Preparation of medical records and reports.
- Adjusting the priorities of Echelon III HSS as required.
- Modifying plans for future action.

*c. Health Service Support by Function.* Health service support is provided in functional areas by units specifically organized to provide the following functions:

- Evacuation.
- Treatment and hospitalization.
- Health service logistics.
- Medical laboratory services.
- Blood management.
- Veterinary services.
- Preventive medicine.
- Dental services.
- Combat stress control.
- Command and control.

Included in these functions are reconstitution of forward elements and HSS of enemy prisoners of war (EPW) and indigenous civilians.

*d. Centralized Control of Decentralized Operations.* The HSS mission is accomplished through centralized control of decentralized operations. Policies are provided for the effective integration of health service activities in the corps and are coordinated with supported units. The major subordinate command and control elements of the medical brigade in a corps are the headquarters of the medical groups and/or separate medical battalions. The major subordinate command and control elements of the medical group in a corps are normally the headquarters of separate medical battalions.

### 2-19. Medical Brigade or Group Commander

The commander of the major medical subordinate command (medical brigade or group) of the COSCOM is directly responsible to the COSCOM commander for the accomplishment of the HSS mission. He does not serve as the corps surgeon. He is both the director and the operator of the corps HSS system. As stated previously, the medical brigade commander is also the COSCOM surgeon. In addition to his other duties, he coordinates health service command and staff matters with the corps commander, corps surgeon, and other members of the corps staff. However, health service technical matters are coordinated with the corps surgeon. The corps medical brigade or group commander, in conjunction with the corps surgeon, coordinates directly with the TA MEDCOM for required reinforcements to the corps and for professional health service matters. His command and staff duties include the following:

*a. Command and Control.* He commands and controls all medical units assigned and attached to the corps.

*b. Plans.* He develops, refines, adjusts, coordinates, and implements HSS plans in consonance with the assigned mission.

*c. Policy.* He develops HSS policy in consonance with policies of higher headquarters and implements procedures to assure adherence to established policy in his jurisdiction.

*d. Area HSS.* He controls and directs the area HSS operations.

*e. Reporting on Health of the Command.* He furnishes current information to the COSCOM commander and staff concerning the health of the command and the command aspects of medical matters affecting combat effectiveness, combat operations, and CSS operations.

*f. Liaison and Coordination.* He maintains medical liaison and coordinates technical matters with the surgeons of higher, lateral, and subordinate headquarters.

### 2-20. Command and Staff Relationships

*a. Relationship to Higher Commands.* The medical brigade commander reports directly to the COSCOM commander. The coordination of staff matters with the corps commander and staff is normally through command channels, except that technical matters are coordinated with the corps surgeon.

*b. Relationship to Lower Commands.* The staff elements of the medical brigade headquarters have normal staff relationships with respect to subordinate elements. The dental and veterinary staff officers of the brigade headquarters may be delegated operational control of subordinate dental and veterinary units.

*c. Relationship to Division.* Coordination with division headquarters is through normal command channels, except that technical matters may be coordinated directly with the division surgeons.

*d. Relationship to the MEDCOM.* Direct coordination between the medical brigade and the TA MEDCOM is desirable concerning health service technical matters.

### 2-21. Other Corps Units

Separate brigades may be assigned to the corps. Brigades may be used as a force, as part of the TA reserve, or to augment the combat power of a corps. The brigade, with its attached battalions, may be assigned to a rear area or flank security mission, be employed as a corps reserve, or be assigned or attached to a division. Maneuver battalions may be attached or detached for specific missions as required.

### 2-22. Separate Brigade and Regimental Surgeons

The separate brigade or regimental surgeon's primary responsibility is to ensure that HSS is available and adequate to support the mission of the brigade or armored cavalry regiment (ACR). The separate brigade/regimental surgeon is the commander of the medical company/ troop assigned to provide HSS. The surgeon provides the commander with information regarding the medical aspects of combat effectiveness within the brigade or ACR and performs staff functions similar to those of the division surgeon. In addition, this surgeon–

- Ensures the implementation of the health service section of the division or corps SOP.
- Recommends the allocation of medical resources within the brigade or ACR.
- Exercises direct supervision over the technical training of medical personnel assigned to brigade or ACR units and manages the combat lifesaver program.
- Determines procedures, techniques, and limitations in the conduct of routine medical care, emergency medical treatment, and advanced trauma management (ATM) procedures.
- Monitors the health of the command and advises the commander on measures to counter the medical threat.
- Monitors requests for AE originating in units subordinate to the brigade.
- Ensures, through coordination with appropriate headquarters, that the brigade and its subordinate units receive adequate HSS for their assigned missions.
- Provides the COSCOM surgeon, in the case of a separate brigade or ACR, with information concerning the separate brigade's or ACR'S plans and operations for HSS of attached units.
- Assumes operational control (when directed) of augmentation medical units.
- Supervises activities of subordinate battalion or squadron surgeons.
- Assumes technical supervision of physician assistants (PAs) organic to subordinate units in the absence of their assigned physician.
- Advises PAs of artillery and engineer battalions as required.
- Advises on and oversees the plans of the battalions or squadrons for preventing and managing stress and battle fatigue casualties. Coordinates technical supervision of enlisted mental health personnel in the medical company by mental health officers of other commands.

### 2-23. The Division

*a.* The division is the basic unit of maneuver at the tactical level and performs major tactical operations for the corps. The division is a fixed,

combined arms organization capable of performing a tactical mission and is largely self-sustaining. The division can conduct large-scale ground combat operations because it contains combat, CS, and CSS units capable of sustaining it.

*b.* The mission of the division is twofold:

- To destroy enemy military forces.
- To control land areas including populations and resources. Each type of division has its own unique capabilities and limitations.

**2-24. Types of Divisions**

Army divisions are classified as either heavy or light. Division subcategories are heavy (armored and mechanized infantry) and light (airborne, infantry, light infantry, and air assault). (See FM 71-100 for further discussion on these divisions.)

**2-25. Major Commands in the Division**

The division has six major subordinate commands: three combat brigades, an aviation brigade, a division artillery, and a division support command (DISCOM).

**2-26. The Division Base**

The US Army division has a fixed nucleus called the division base. It consists of the command and control, combat, CS, and CSS units necessary to support the maneuver elements of the division. Various combinations of maneuver (combat) battalions are attached to the division base.

**2-27. The Combat Support Elements of a Division**

The CS elements of a division are the division artillery, an air defense artillery battalion, an engineer battalion, a signal battalion, an aviation brigade, a military intelligence battalion, a military police company, an NBC defense company, and a division band.

**2-28. Combat Element of the Division Base**

The combat element of the division base consists of a cavalry squadron and an attack helicopter battalion in heavy divisions and a reconnaissance squadron in the light divisions.

**2-29. Division Surgeon**

The division surgeon is a special staff officer of the division commander. He normally functions under the general staff supervision of the division's G1. (In the light division, the commander of the medical battalion also functions as the division surgeon and is the medical staff officer of the D ISCOM.) His duties as division surgeon generally are administrative. The division commander normally charges him with responsibility for staff supervision to include technical supervision of all HSS activities in the command. He has direct access to the division commander and staff on HSS matters. As a special staff officer, he advises the division commander on all medical matters. In conjunction with the division medical operations center (DMOC) in the heavy division or the medical battalion intelligence officer (S2)/operations and training officer (S3) in the light division, the surgeon also–

- Prepares the HSS annex to the division SOP and the division HSS plan.
- Provides plans and current information pertaining to the medical situation and combat operations to the Echelon III medical units operating within the division area.
- Informs the G2 of medical information or intelligence requirements. Also assists in the examination and processing of captured medical supplies. (See FM 8-10-8 for a complete discussion on medical intelligence.)
- Plans and coordinates the following HSS operations:
  - Treatment and patient evacuation.
  - Dental services.
  - Preventive medicine services.
  - Combat stress control and mental health services, assisted by the division mental health section.
  - Medical laboratory services.

- Blood services.
- Optical support.
- Medical supply and medical maintenance support.
- Medical personnel assignments.
- Medical reporting.
- Collection and analysis of operational data.
- Submits to higher headquarters those recommendations on technical problems which require research and development.
- Plans for and requests Echelon III HSS assets and support of division operations.

### 2-30. Division Support Command of the Heavy or the Light Division

To achieve and maintain readiness, division commanders need the right supplies, equipment, and personnel at the right place, at the right time, and in the right quantity. The DISCOM is responsible for monitoring this readiness and ensuring that the force is manned, armed, fueled, fixed, and transported. The DISCOM is organized to provide logistics, Echelons I and II HSS, maintenance, and administrative services to all organic and attached elements in the division area.

*a.* The DISCOM of the heavy division includes the HHC and the division materiel management center (DMMC), an aviation intermediate maintenance (AVIM) company, three forward support battalions (FSBs), and a main support battalion (MSB).

*b.* The DISCOM of the light division includes an HHC, a maintenance battalion, a supply and transport (S&T) battalion, a medical battalion, and an AVIM company (battalion for the air assault division).

*c.* The organization of the DISCOM headquarters is structurally the same for all divisions. Each DISCOM uses a functional-type staff including an executive officer; a chief, division medical operations officer (heavy division); a personnel staff officer; a security, plans, and operations officer; and a command logistics officer. The DISCOM commander is also assisted by a chemical staff officer, a communications-electronics officer, an automatic data processing officer, an ammunition officer, a chaplain, a movement control officer, and three forward area support coordinators FASCOs) in the light division. The medical battalion commander, as the division surgeon in the light division, is a staff officer of the DISCOM.

### 2-31. The Division Medical Operations Center (Heavy Division)

The DMOC staff is responsible to the DISCOM commander for staff supervision of HSS within the DISCOM. The division surgeon exercises technical control of all medical activities within the division. The DMOC coordinates HSS according to technical parameters established by the division surgeon. All HSS issues and requirements are coordinated with the DISCOM units, division staff, and division surgeon prior to committing any HSS resources. The DMOC staff assists the division surgeon in planning and accomplishing division HSS operations. The DMOC consists of a medical operations branch, medical materiel management branch, a patient disposition and reports branch, and a medical communication branch. (See FM 8-10-3.) The DMOC staff–

- Plans and ensures that Echelons I and II HSS for the division is provided.
- Plans and monitors HSS operations of DISCOM organic medical assets and attached corps assets to include reinforcement and reconstitution.
- Monitors medical training and provides information to division surgeon.
- Monitors health service logistics and logistical aspects of blood management for the division.
- Monitors and recommends medical personnel assignments and replacements in coordination with the division surgeon and the DISCOM S1.

- Plans, coordinates, and directs patient evacuation from Echelon I MTFs to Echelon III MTFs through the medical brigade or group medical regulating office.

- Plans, monitors, and allocates preventive medicine resources and programs in coordination with the division surgeon.

- Plans, monitors, and coordinates the division mental health/combat stress resources and programs in coordination with the division surgeon and the division psychiatrist/mental health section.

- Monitors medical equipment maintenance programs for the division.

- Monitors medical threat, coordinates health service intelligence requirements, and facilitates functional integration between health service support and military intelligence staff elements within the division in support of intelligence preparation of the battlefield. (See FM 8-10-8 for a complete discussion on this subject.)

- Coordinates HSS planning in rear operations.

- Monitors reporting aspects of HSS.

- Ensures that division SOPs, plans, policies, and procedures for HSS are prepared and executed.

- Coordinates for guards in the movement of EPW casualties.

- Coordinates the identification, exploitation, and disposition of captured medical material with appropriate staff elements. (See FM 8-10-8, FM 34-54, and 101-5 for discussions on this subject.)

- In coordination with the DISCOM S3, prioritizes the reallocation of organic and corps medical augmentation assets to the division as required by the tactical situation.

- Monitors blood product management.

- Integrates intelligence into Echelon II HSS operations planning and execution.

### 2-32. The Division Support Command Surgeon

The DISCOM surgeon assigned to the DMOC provides medical staff advice to the DISCOM commander, the DISCOM adjutant (S1), and the chief, DMOC. This individual provides technical medical advice to the Echelon II medical assets within the DISCOM and maintains and manages priorities throughout the DISCOM.

### 2-33. Communications in the Division Medical Operations Center

To facilitate prompt patient management and evacuation, all divisional medical elements are in contact by radio. This radio net includes the medical operations center, the DI SCOM S3, the respective medical companies, the division surgeon, and the corps senior medical headquarters. Patients requiring evacuation out of the division are reported to the corps medical group or brigade through the DMOC. The DMOC–

- Continuously monitors evacuation requests from medical companies and other elements throughout the division.

- Determines resource allocations.

- Provides coordination when necessary or requested.

### 2-34. Command and Control of the Medical Company (Heavy Division)

A medical company is assigned to each FSB and the MSB of the heavy division. These companies are under the command and control of the respective battalion commander.

### 2-35. The Forward Area Support Coordinators (Light Division)

*a.* Each of the three FASCOs in the light infantry division is assigned to coordinate support to an infantry brigade. The FASCOs operate in the brigade support area, and they report to the DISCOM commander. Their primary responsibility is to ensure that forward area support team (FAST) elements provide the required support to the

infantry brigade. The FASCOs coordinate support missions between the brigades and other units operating in the brigade support area and the supporting DISCOM elements. A FAST usually includes the forward area support coordination office, a forward supply company of the S&T battalion, a forward maintenance company of the maintenance battalion, a forward support medical company (FSMC) of the medical battalion, and a unit maintenance team from the headquarters and light maintenance company. It may also include support elements from corps.

*b.* As he does with other FAST elements, the FASCO coordinates with the brigade S3/supply officer (S4) to ensure geographical space for elements of the FSMC and oversees the movement and security of the company. In addition, the FASCO keeps the medical company commander informed of the tactical plans of the brigade to enable the commander to plan for support on the basis of projected requirements.

### 2-36. Medical Battalion (Light Division)

*a.* The medical battalion is under the overall command and control of the DISCOM commander. The medical battalion commander also functions as the division surgeon and is also the primary medical staff officer for the DISCOM. The battalion S2/S3 section assumes the planning and operations functions that have traditionally been associated with the division surgeon's section. The medical battalion commander, his staff, and subordinate medical commanders employ direct channels of communications on technical matters.

*b.* The medical battalion is organized to provide Echelon II HSS for the entire division. The battalion also provides Echelon I HSS on an area basis for assigned and attached units operating within the division's area of operations. The medical battalion is modular in design and consists of a headquarters and support company (HSC) and three forward medical companies.

**NOTE**

The HSC has the same capabilities as the medical company, MSB, and the forward medical company has the same capabilities as the medical company, FSB, in the heavy division.

*c.* The support company, medical battalion, DISCOM, airborne division, contains two surgical squads which are not found in other light forces.

*d.* The medical battalion, air assault division, also provides the following capabilities:

- Air crash rescue.
- Patient evacuation by organic AE helicopters.
- Supplemental patient evacuation by ground transportation. These capabilities are required because of the air assault division's–
  - Use of organic rotary-wing aircraft.
  - Requirement for the medical support element to be capable of flexible employment and quick response to unpredictable situations.

### 2-37. Command and Control of the Medical Company (Light Division)

The medical companies are assigned to the medical battalion. They are under the command and control of the battalion commander.

### 2-38. Communications in the Light Division

The commander, medical battalion, has the capability to communicate by amplitude modulated (AM)/frequency modulated (FM) voice and data link communications, together with automatic data processing, to the maximum extent available. All of these systems assist in the effective control of medical units, patient evacuation, and medical regulating. He communicates with the DISCOM S3, the respective medical companies, and the corps senior medical headquarters. Patients being evacuated out of the division are reported to the medical group or brigade through the commander, medical battalion. He is continually advised as to the corps hospital of choice by the medical group or the medical brigade medical regulating officer. The commander, medical

battalion, then relays information to the medical companies. Medical platoons of the maneuver elements coordinate evacuation directly with the FSMCs. The division surgeon monitors evacuation requests, establishes priorities, determines resource allocations, and provides coordination when necessary or required.

### 2-39. Division Artillery Surgeon

The medical officer in the division artillery (D IVARTY) headquarters is the surgeon for his unit. His duties are similar to those described for the brigade surgeon. The DIVARTY surgeon operates the battalion aid station (BAS) within HHC, DIVARTY.

### 2-40. Staff Flight Surgeon

The medical officer in the combat aviation brigade is the flight surgeon for his unit. His duties are similar to those of the brigade surgeon. In addition, the aviation brigade medical officer is trained in aviation medicine. The flight surgeon of the combat aviation brigade serves as special staff officer to the division surgeon for aviation medicine planning and programs.

### 2-41. Brigade Surgeon

Each brigade has a medical officer who is dual-hatted as the brigade surgeon and commander of the FSMC, FSB (heavy division), or commander of a forward medical company of the medical battalion (light division). The staff role is subordinate to the command role. The brigade surgeon exercises staff supervision and technical control over the medical elements of the command. He serves under the general staff supervision of the brigade executive officer. The brigade surgeon's primary responsibility is to ensure that adequate HSS is available to the brigade. He provides the brigade commander with information regarding the HSS aspects of combat effectiveness within the brigade and performs staff functions similar to those of the division surgeon. He is responsible for supervising the professional activities of the battalion surgeons who function in the medical platoons of the combat battalions attached to his brigade. The brigade surgeon–

- Ensures the implementation of the division HSS SOP.
- Recommends the allocation of HSS resources within the brigade.
- Supervises technical training of medical personnel and the combat lifesaver programs in the brigade area.
- Determines procedures, techniques, and limitations in the conduct of routine patient care, emergency medical treatment, and ATM.
- Monitors requests for AE from supported units.
- Ensures implementation of automated medical systems.
- Informs the division surgeon and chief, DMOC, on the brigade's HSS situation.
- Monitors the health of the command and advises the commander on measures to counter the medical threat.
- Assumes operational control of augmentation medical units when directed.
- Exercises technical supervision of subordinate battalion surgeons.
- Advises PAs of artillery and engineer battalions as required.
- Assumes technical supervision of PAs organic to subordinate units in the absence of their assigned physician.

### 2-42. Battalion and Squadron Surgeons

The duties of the battalion and squadron surgeons are similar to those of the brigade and regimental surgeons. The medical officer is also the battalion/squadron medical platoon leader. (The staff role is subordinate to the command role.)

### 2-43. Medical Platoon Leader

The platoon leader of the medical platoon in the combat battalions and certain CS battalions serves in the dual capacity of medical platoon leader and medical adviser to the battalion commander. (See FM 8-10-4 for a complete discussion.) In the absence of a Medical Corps officer, a Medical Service Corps lieutenant serves as the medical platoon leader. The responsibilities and functions of the battalion medical platoon leader include–

- Providing input to operations orders, administrative/logistics orders, overlays, and SOPs.
- Assisting the S3 in planning and supervising individual and unit training of the battalion medical platoon or section.
- Providing the battalion commander and staff with current data on the health of the command.
- Supervising the administration, maintenance, discipline, organization, training, and employment of the platoon or section.
- Regulating patient evacuation from combat/CS companies/batteries/troops to the aid station.
- Providing technical guidance for medical training of the nonmedical personnel within the battalion.

### 2-44. Physician Assistant

The PA is a highly skilled individual who is not a physician, but who by experience and formal training has become well qualified to perform certain patient treatment procedures formerly undertaken only by a physician. He is either assigned to the medical platoon of a combat battalion or squadron, where he functions as the treatment team leader under the command and administrative supervision of the medical platoon leader, or he is assigned to the medical section of a CS battalion as section leader. In either case, his technical treatment duties are supervised by the first Medical Corps officer in his chain of command. Under the direction of the medical platoon leader and the technical supervision of the brigade surgeon, the PA is responsible for–

- Conducting and supervising training of battalion nonmedical personnel in first aid, field sanitation, personal hygiene, patient evacuation procedures, and medical aspects of injury (accident) prevention.
- Arranging for the conduct of the battalion preventive psychiatry (combat stress control) program, with technical assistance from the division psychiatrist, to include training of battalion troop leaders in methods of preventing battle fatigue, substance abuse, and psychiatric disorders, especially combat exhaustion.
- Establishing and operating an aid station/treatment squad.
- Treating, within his medical capabilities and limitations, those patients reporting on sick call. Patients who require additional treatment beyond the capability of the PAs are referred to the medical company (division treatment station). He will advise the platoon leader as to whether a patient should be treated and returned to duty or stabilized and evacuated.
- Providing emergency medical treatment to wounded and injured personnel, to include–
  - Establishing and maintaining an airway.
  - Controlling bleeding.
  - Preventing and treating shock.
  - Protecting wounds.
  - Immobilizing fractures.
  - Other emergency measures, as indicated.

### 2-45. Cellular Teams, TOE 08-600 Edition

a. The mission of AMEDD cellular units or teams is to–

- Perform HSS functions where units of less than company size are required.

- Increase the capabilities of fixed-strength units where increments of less than company size are needed.

*b.* Cellular units or teams may be attached or assigned, as required, to fixed-strength units or may be organized into HSS composite units to perform HSS functions under varying conditions.

*c.* The capabilities of units organized under the TOE 08-600 edition vary with the size and grouping of the teams used. Teams are organized to provide command and control; medical supply; ambulance support; preventive medicine; veterinary service; and medical, surgical, dental, and blood services. Unless specifically provided for in the basic organization, these teams must be furnished food service, administration, and motor maintenance support.

*d.* A brief description of some of the cellular teams in the TOE 08-600 edition are discussed in subsequent paragraphs and in specific functional area chapters throughout this manual.

### 2-46. Medical Command, Control, and Staff Section Teams, TOE 08-600H0

*a.* Team AC, company headquarters, commands and controls two or more medical detachments or equivalent not to exceed 150 individuals. This unit is more often allocated to a corps medical brigade/group or task force than to a TA MEDCOM. Basis of allocation is one per two or more medical detachments not otherwise provided command and control.

*b.* Team AE, headquarters, receiving center, provides administrative support and control of nondivisional medical units withdrawn for reorganization or those arriving from the zone of interior and awaiting assignment to sites where the mission of the unit will be performed. This unit normally requires the attachment of postal, finance, adjutant general, engineer, military police, supply, and maintenance elements for performance of those functions.

*c.* Team AJ, headquarters, blood bank service, provides command and control for blood bank service teams. It is allocated to TA MEDCOM on the basis of one per 10 blood bank service teams.

*d.* Team AM, headquarters, preventive medicine service, provides command and control for two or more preventive medicine detachments, TOE 08-620. It also provides consultants in epidemiology, preventive medicine, entomology, and preventive medicine aspects of veterinary medicine.

### 2-47. Special Operations

*a.* Special operations are military operations conducted by forces of the Department of Defense (DOD) in pursuit of US national objectives. These forces are specially trained, equipped, and organized to accomplish strategic, operational, and tactical missions.

*b.* Special operations may be conducted during periods of peace or hostility. They may support conventional operations, or they may be prosecuted independently when the use of conventional forces is either infeasible or inappropriate.

### 2-48. Special Operations Forces Within the Department of the Army

The following are the five component elements of Special Operations Forces within the Department of the Army :

- Special Forces.
- Rangers.
- Psychological operations.
- Civil affairs.
- Special operations aviation.

### 2-49. Command and Control of Special Operations Forces

*a.* Special Operations Forces (SOF) are theater-level assets. Operational- and tactical-level commanders request SOF through the unified commander. An SOF command and control element is established at any headquarters, combined or US, employing SOF. This ensures that unique mission requirements and employment procedures are met.

*b.* The CINC directs theater special operations and the employment of SOF through his subordinate special operations command (SOC). The theater SOC is a joint command that controls Army, Navy, and Air Force SOF. As strategic assets, SOF elements are deployed to the theater of operations and placed under SOC operational control.

*c.* Special Operations Forces units do not have an organic combined arms capability and are not designed for sustained combat operations. These units require the support or attachment of other combat, CS, and CSS assets. The SOF units are entirely dependent upon the resources of the TA to support and sustain their operations.

## 2-50. Health Service Support Capability of Special Operations Forces Units

The organic HSS capability of SOF units is extremely austere. Consequently, SOF are dependent upon the conventional HSS structure for HSS in theater. Special Operations Forces missions require organic assets to perform Echelon I (Level I) and Echelon II (Level II) medical care. Echelon III (Level III) and Echelon IV (Level IV) medical care must be provided to the force.

*a. Special Forces.*

(1) The Special Forces group is a unique combat arms organization capable of planning, conducting, and supporting special operations activities in all operational environments and across the strategic continuum. Special Forces units are characterized by the quality, motivation, training, and individual skill of their members.

*(a)* The Special Forces group consists of a group HHC, a group support company, and three Special Forces battalions. The group can operate as a single unit, but normally the battalions plan and conduct operations from widely separated locations.

*(b)* The Special Forces company consists of a company headquarters ("B" detachment) and six operational detachments ("A" detachments or ODAs). The "A" detachment (twelve-man team) is the basic Special Forces unit and is specifically designed to conduct special operations activities in remote areas and intolerable environments. This unit can operate for extended periods with a minimum of external direction and support. The high-grade structure and experience level of the "A" detachment is required to permit it to develop, organize, equip, train, and advise or direct indigenous military and paramilitary organizations of up to battalion size. For other special operations activities that do not require its full capabilities, the "A" detachment serves as a manpower pool from which Special Forces commanders organize tailored Special Forces teams to execute specific missions.

(2) The Special Forces group has the ability to perform Echelon I and limited Echelon II medical care. Individual care consists of self-aid and buddy aid, combat lifesaver, and aidman (Special Forces medic) care. There are two Special Forces medics assigned each ODA. The Special Forces medic is often the sole source of medical care for his ODA and the indigenous personnel (and their families) with whom his ODA interfaces. Medical assets with the Special Forces group can provide limited support in the following areas:

- Preventive medicine.
- Medical information.
- Veterinary and dental medicine.
- Laboratory support for clinical diagnosis.
- Minor surgery.
- Short-term trauma management.
- Medical resupply.

(3) A flight surgeon and PA are assigned to each Special Forces battalion. At the battalion forward operating base, the flight surgeon and PA can perform ATM procedures and provide limited resuscitative care. However, medical evacuation to the forward operating base is unlikely due to the considerable distances that may separate the ODAs from the forward operating base.

Additionally, the battalion's forward operating base has a preventive medicine noncommissioned officer (NCO) capable of providing medical threat evaluation and limited direct preventive medicine support.

(4) The Special Forces operating base, normally established in the COMMZ, has a flight surgeon, dental officer, veterinary officer, medical operations officer, medical logistics officer, and an environmental science officer assigned. At this level, the medical officers perform primarily as staff advisers to the group commander and provide medical staff assistance to the deployed Special Forces battalions/forward operating bases.

*b. Rangers.*

(1) The Ranger regiment is a unique light infantry unit capable of planning, conducting, and supporting special operations activities. The Ranger regiment provides the National Command Authority with the capability to deploy a credible military force quickly to any region of the world. The primary Ranger mission in special operations is to conduct direct action operations best accomplished by conventional light infantry forces using special techniques. Ranger direct action operations may support or may be supported by other special operations activities, or they may be conducted independently or in conjunction with conventional military operations.

(2) The Ranger regiment has the capability to perform Echelon I and limited Echelon II care. Echelon III care must be provided to the force. Rangers have organic HSS similar to conventional light infantry battalions; however, they do not have an aid station/treatment squad capability. A general medical officer and PA are assigned to each Ranger battalion. The Ranger companies are assigned Career Management Fields 91A and 91B medics.

*c. Psychological Operations.*

(1) Psychological operations are planned operations to convey selected information and indicators to foreign audiences to influence their emotions, motives, and objective reasoning. These operations ultimately influence the behavior of foreign governments, organizations, groups, and individuals. Army psychological operations units may be employed by the National Command Authority in pursuit of national security objectives. These psychological operations may be designed to–

- Maintain the support of groups and nations friendly to the United States.
- Gain support and cooperation of neutral countries.
- Strengthen or alter alliances.
- Deter a nation from aggression.
- Induce the surrender of hostile forces.

(2) Psychological operations units have no organic HSS. They are dependent on area HSS from the theater medical command. These units also require timely and accurate information on all public health and host-nation support initiatives to accomplish their mission.

*d. Civil Affairs.*

(1) The civil affairs foreign internal defense and unconventional warfare battalion is a specialized unit that plans and conducts civil-military operations in support of SOF. This battalion employs specialized, regionally oriented, and language-qualified teams. The teams train, advise, and/or assist US and indigenous forces in the conduct of civil-military operations that support both foreign internal defense and unconventional warfare missions.

(2) Civil affairs units have no organic HSS. They are dependent on area HSS from the theater MEDCOM.

*e. Special Operations Aviation.*

(1) The special operations aviation regiment is a unique Army aviation unit that provides dedicated combat aviation support to Army and other SOF. This support is provided in all operational environments and across the strategic continuum. Because of current force structure and

contingency requirements, the regiment does not operate as a single unit. Instead, it tailors special operations aviation battalion or company task forces to perform specific missions. The primary mission of special operations aviation assets is to clandestinely penetrate hostile and sensitive airspace to conduct and support special operations activities.

(2) The special operations aviation has a flight surgeon and a psychiatrist assigned at group level. This unit is dependent on area HSS from units it is supporting (typically the Special Forces operating base). It does not have specifically designated medical aircraft with a primary mission of medical evacuation.

# CHAPTER 3

# THE HEALTH SERVICE SUPPORT CONTINUUM OF CARE

## Section I. DEVELOPING THE CONTINUUM

### 3-1. Single Integrated System

The HSS system is a single integrated system. It begins at the forward line of own troops (FLOT) and ends in the CONUS. This system entails the effective medical regulation of sick, injured, and wounded patients in the shortest possible time to the MTFs that can provide the required treatment. All sick, injured, and wounded patients are regulated and evacuated without regard to lateral or rear boundaries. Health service support involves delineation of support responsibility by geographical area. The effectiveness of the system is measured by its abilit y to return soldiers to duty.

### 3-2. Medical Assistance to Nonmilitary Personnel

As specified in Army Regulation (AR) 40-3, nonmilitary personnel who accompany combat forces or who function within a theater of operations are authorized both treatment in military MTFs and evacuation. Medical assistance to other civilians is provided within the limits of available health service resources. The civil affairs organizations are responsible for working with and through civilian health agencies. The civil-military operations (CMO) officer, associated civil-military units, and the appropriate command surgeon coordinate required support.

### 3-3. Transportation for Return-to-Duty Personnel

Under provisions of Geneva Conventions, medical units are prohibited from transporting soldiers discharged from MTFs to their units. The prompt and timely performance of this function by nonmedical units prevents possible adverse impact on the operational effectiveness of MTFs. (See paragraph 3-19a(1)(b).)

### 3-4. Considerations in Developing Health Service Support

*a.* A number of considerations affect the organization and operation of HSS in a theater of operations. The organization of the system is prescribed to a great extent by the–

- Tactical and strategic mission.
- Requirements of troop commanders.
- Medical threat.

*b.* Commanders and HSS planners must know the medical threat. Obtaining the required medical intelligence to know the medical threat assists commanders in developing HSS which is responsive to the unique aspects of a theater of operations. (See FM 8-10-8.)

*c.* Medical intelligence is that product resulting from the collection, evaluation, analysis, and interpretation of *foreign* medical, bio-technological, and environmental information. It includes intelligence on–

- Endemic and epidemic diseases, public health standards and capabilities, and the quality and availability of health services.
- Medical supplies, medical services, health service facilities, and the number of trained HSS personnel.
- Environmental conditions.
- Foreign animal and plant diseases, especially those diseases transmissible to humans.
- Health problems relating to the use of local food supplies.
- Medical effects of and prophylaxis for chemical and biological agents and radiation.
- The impact of newly developed *foreign* weapons systems as they relate to casualty production.

*d.* In the normal course of duty, medical personnel at all echelons gain information of medical intelligence value. Such information should be

reported on a timely basis to the supporting intelligence elements according to FM 8-10-8.

*e.* Requests for medical intelligence and requirements for military intelligence of medical interest should be accomplished through the command's supporting intelligence staff element, or the military intelligence analytical elements. (Some of these elements are the echelons above corps intelligence center (EACIC) and the tactical operations center support element.)

*f.* There is no medical intelligence or health service intelligence analytical and production capability within the theater. Possible exceptions to this are–

- The NBC and medical intelligence platoon of the military intelligence company (technical intelligence).

- The analyst company, technical intelligence battalion, military intelligence brigade (echelons above corps [EAC]).

However, the primary focus of the above organizations is the exploitation of weapons, equipment, and other materiel found, captured, or acquired within the theater. The focus is not on analyzing combat information and raw intelligence reports to support tactical- and operational-level intelligence preparation of the battlefield and HSS operations planning and execution. Medical intelligence officers and NCOs at medical command, medical brigade, and medical group level will be required to fill this void in the absence of additional health service intelligence analytical resources. A special health service intelligence analytical cell may be established within the theater at MEDCOM, medical brigade, and/or EACIC.

*g.* Military intelligence staff elements (G2, J2 [Intelligence]) and units maintain current intelligence reference materials which can include medical intelligence data, if requested.

**This paragraph implements NATO STANAG 2068**

## 3-5. Organization of Health Service Support System

The Army's HSS system in a theater of operations is organized into unit, division, corps, and EAC levels of care which extend throughout the theater. *Echelon of care* is a term used in NATO STANAG 2068 which can be used interchangeably with the term *level of care.*

*a.* Each higher echelon of care possesses the same treatment capabilities as those echelons forward of it. Each echelon adds a new increment of treatment capability which distinguishes it from the lower echelons of care. The echelons of care are referred to as Echelons (or Levels) I through IV. Zone of interior (ZI) is Level V.

*b.* The organization for all aspects of HSS is designed to be flexible. It is influenced principally by–

- The mission.
- The enemy.
- The terrain (and weather).
- The troops.
- The time available.
- Such constraints as the availability of specific types of HSS units, depending on different tactical situations and operational environments.

Although a COMMZ may not be required in the theater, HSS may include CZ and COMMZ units.

*c.* Health service support includes providing support to organizations that do not possess an organic medical capability. The HSS units required for this support are allocated based on troop strength and anticipated work load. The units are established where and when requirements indicate.

## Section II. THE ECHELONS OF MEDICAL CARE

### 3-6. Echelon I (Level I)

*a.* The first medical care a soldier receives is provided at this echelon. This echelon of care includes the following:

(1) Immediate lifesaving measures.

(2) Disease and nonbattle injury prevention.

(3) Combat stress control preventive measures.

(4) Casualty collection.

(5) Evacuation from supported units to supporting medical treatment.

(6) Treatment provided by designated individuals or treatment squad (BAS). Major emphasis is placed on those measures necessary to stabilize and allow for the evacuation of the patient to the next echelon of care. These measures include: maintain the airway, stop bleeding, prevent shock, protect wounds, immobilize fractures, and other emergency measures, as indicated.

*b.* Those patients not requiring a higher level of care are returned to duty.

*c.* Medical care is provided by an individual (self-aid, buddy aid, combat lifesaver, or combat medic) or by personnel in a treatment squad.

(1) Immediate far forward care consists of those lifesaving steps that do not require the knowledge and skill of a physician. The following three different skill levels of personnel provide the care required in the forward area.

*(a) Self-aid/buddy aid.* Each individual soldier is trained to be proficient 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 immediate care to alleviate a life-threatening situation.

*(b) Combat lifesaver.* The combat lifesaver is a member of a nonmedical unit selected by the unit commander for additional training beyond basic first aid procedures. A minimum of one individual per squad, crew, team, or equivalent-sized unit should be trained. The primary duty of this individual does not change. The additional duties of the combat lifesaver are performed when the situation permits. The combat lifesaver assists the combat medic by providing immediate care for injuries. The training is normally provided by medical personnel assigned to, attached to, or supporting the unit. The training program is managed by the senior medical person designated by the commander.

*(c) Combat medic (aidman).* This is the first individual in the HSS chain who makes medically-substantiated decisions based on medical military occupational specialty (MOS) specific training. The combat medic is trained to emergency medical technician (EMT) level. The combat medic is assigned to the medical platoon or section of the headquarters and headquarters company, the headquarters and support company, or the troop of the appropriate combat or CS battalion. (See paragraph 3-12 *a* for an explanation of this phase of care.)

(2) The physician and the PA in a treatment squad (aid station) are trained and equipped to provide ATM or trauma treatment to the battlefield casualty. This element also conducts routine sick call when the situation permits. Like elements provide this echelon of care in division, corps, and COMMZ units. (See paragraph 3-12 *b* for an explanation of this phase of care.)

*d.* Ammunition and individual weapons belonging to patients to be evacuated from the BAS are disposed of as directed by brigade (DIVARTY, battalion, or squadron) or division policy. Patients evacuated to the rear retain individual equipment as prescribed by division SOP. All excess equipment is collected at the BAS and disposed of by the battalion S4 or as directed by command SOP.

**NOTE**

Patients entering the HSS system will retain their protective mask.

*e.* Echelon I HSS is provided by the medical platoons/sections of combat and CS battalions, by divisional medical companies, by corps area support medical companies, and by other corps medical units.

**3-7. Echelon II (Level II)**

*a.* This echelon of care includes the following:

(1) Evacuating patients from Echelon I.

(2) Providing care at the clearing station (division) which is operated by the area support section of the treatment platoon of the medical company. (The area support section consists of a treatment squad, an area support squad, and a patient holding squad. When these squads are collocated, they form a clearing station capable of holding up to 40 patients.) At this echelon of care, the casualty is examined; his wounds and general status are evaluated; and he is treated and returned to duty or his priority for continued evacuation is determined. The area support section (clearing station) provides HSS on an area basis to all forces within a geographical area of responsibility. The area support section normally operates in the brigade support area (BSA), the division support area (DSA), and areas of high concentration of troops in the corps support area (CSA) and COMMZ. The area support and patient holding squads are incapable of independent operations.

*b.* This echelon of support duplicates Echelon I (see paragraph 3-6) and expands services available by adding dental, laboratory, x-ray, and patient holding capabilities. Emergency care, including beginning resuscitation procedures, is continued. (No general anesthesia is available.) If necessary, additional emergency measures are instituted; however, they do not go beyond the measures dictated by the immediate need. Those patients who can RTD within 24 to 72 hours are held for treatment.

*c.* The above functions are performed by medical companies organic to–

- Support battalions of separate maneuver brigades.
- Support squadrons of ACRs.
- Support battalions of DISCOMs (heavy division).
- Medical battalions of DISCOMs (airborne and air assault divisions).
- Nondivisional medical battalions (corps and COMMZ).

**3-8. Echelon III (Level III)**

*a.* This echelon of care includes the following:

(1) Evacuating patients from supported units.

(2) Providing care for all categories of casualties in an MTF with the proper staff and equipment.

(3) Providing support on an area basis to units without organic medical units.

*b.* This echelon of care expands the support provided at Echelon II (division level). Casualties who are unable to tolerate and survive movement over long distances will receive surgical care in a hospital as close to the division rear boundary as the tactical situation will allow. Echelon III characterizes the care that is provided by units such as mobile army surgical hospitals (MASH), combat support hospitals (CSH), and evacuation hospitals. Tactical situations or lack of suitable terrain availability may require that these Echelon III units locate in offshore support facilities, third country support bases, or in the COMMZ. Those whose injuries permit additional transportation without detriment receive surgical care in a hospital farther to the rear. Those patients who are expected to RTD are regulated to an RTD-type facility. (See paragraph 3-12 *d*, *e*, and *f* for an explanation of this phase of care. Also see Chapter 5 for a discussion on hospital units.)

**3-9. Echelon IV (Level IV)**

This echelon of care includes the following:

*a*. Treating the casualty in a general hospital (GH) and other COMMZ-level facilities staffed and equipped for general and specialized medical and surgical care. This echelon of care provides further treatment to stabilize those patients requiring evacuation to CONUS. See paragraph 3-12e for an explanation of this phase of care.

*b.* Providing area HSS to soldiers within the COMMZ.

### 3-10. Zone of Interior (Level V)

In ZI HSS, the casualty is treated in ZI hospitals staffed and equipped for the most definitive care available within the AMEDD HSS system. Hospitals in the CONUS base represent the final level of HSS.

### 3-11. Tailoring Health Service Support to the Battlefield Situation

Health service support is tailored to the constantly changing battlefield situation. In this adjustment process, the methods of employment of medical TOE units must not be confused with their basis of allocation. The staff planners of HSS develop the medical troop list for a theater, using primarily the basis of allocation for the various medical units selected; whereas HSS operators in the various medical command and control headquarters deploy these units on the basis of need which results from shifting patient densities and/or the METT-T. For example, evacuation hospitals are normally allocated to the TA on the basis of two per division. However, the two evacuation hospitals will not always be found in tandem with each division, and the same two evacuation hospitals will not remain associated exclusively with the same division throughout a campaign. An erroneous belief that the basis of allocation controls the methods of employment for a unit could cause misunderstandings between medical unit commanders and supported commanders and could result in noneffective use of a valuable battlefield health care delivery tool. (See FM 8-55 for a discussion on medical force planning.)

## Section III. PATIENT CARE, TREATMENT, AND REPORTING

### 3-12. Phases of Patient Care and Treatment in Health Service Support

*a. Combat Medic (Aidman) Care.* Combat medic care is the first medical care that a sick, injured, or wounded soldier receives from a soldier who holds a medical MOS. If emergency or lifesaving measures are required prior to aidman care, they must be performed by a soldier trained in first aid (self-aid/buddy aid) or by a combat lifesaver. (See NOTE below.) Aidman care entails the skillful application of examining techniques; performance of emergency or lifesaving measures; and continual observation and care to ensure that the airway remains open, that bleeding has ceased, and that shock, infection, and further injury are prevented. It involves the effective utilization of medical supplies not available to the nonmedical soldier and arrangement for evacuation by air or ground ambulance, as appropriate.

**NOTE**

*FIRST AID* is the emergency or lifesaving care given to a sick, injured, or wounded person when a soldier with a medical MOS is not immediately available. Every soldier is expected to know and apply lifesaving first aid measures; otherwise, the casualty may not live until he can receive care from the combat medic. Lifesaving measures are applied to restore breathing and heartbeat, to stop bleeding, and to prevent shock and infection. These procedures include aid for chemical casualties with particular emphasis on lifesaving tasks. First aid also entails–

(1) The application of measures to prevent a casualt y's condition from becoming worse.

(2) The use of proper methods in moving a victim to a relatively safe point to await evacuation and care by medically trained personnel. (See FM 21-11.)

*b. Emergency Medical Treatment.* In the emergency medical treatment phase, medical skill and judgment of a higher degree are applied. The medical treatment is provided in a relatively safe environment with time to accomplish a more complete examination and start an adequate plan of treatment. Treatment includes the use of intravenous fluids and antibiotics; the preservation of the patient's airway by surgical procedures, if necessary; and the application of more secure splints and bandages. These comprehensive elements of medical management make it possible for the patient to be transported to the level of treatment demanded by the nature of his condition. For those patients who cannot be returned to duty, the final step is to arrange for the proper means of evacuation. This phase of treatment is characteristic of an aid station's capabilities and has no holding capacity.

*c. Initial Resuscitative Treatment.* The initial resuscitative treatment phase is distinguished by the application of clinical judgment and skill of a team of physicians and a dentist. This team is supported by a staff, basic laboratory capability, a broad range of medicinal drugs, equipment and supplies, intravenous fluids to include whole blood, and a holding ward capability where the necessary examinations and observations can be accomplished in a deliberate manner. For those patients who must be evacuated for a more comprehensive scope of treatment, arrangements are made for evacuation by ground or air to the particular CZ hospital which can provide the required treatment. This phase of care is characteristic of a clearing station's capabilities.

*d. Resuscitative Surgery or Care.* The resuscitative treatment phase is for patients whose conditions require comprehensive, preoperative diagnostic procedures, intensive preparation for surgery, the presence of qualified surgical teams, the capability to administer general anesthesia, provision for properly equipped operating rooms, and an adequate postoperative intensive-care environment. The objective of this phase of treatment is to perform those emergency surgical procedures which, in themselves, constitute resuscitation and without which death or loss of limb or body function is inevitable. Performance of such procedures requires no less than the clinical capability described in *c* above; therefore, this phase of treatment is normally provided only in a hospital.

*e. Definitive Treatment.* The definitive treatment phase is particularly adapted to the precise condition of the patient. It embraces those endeavors which complete the recovery of the patient. Specific procedures are executed by specialists. Definitive treatment, not hampered by the crisis aspect as in resuscitative care, proceeds with a greater degree of deliberation and preparation. Definitive treatment is provided at hospitals located in the rear of the CZ and at GHs in the COMMZ. Its completion represents the maximum of recovery and preservation of limb and function. For the majority of patients, definitive treatment constitutes all that is needed for them to return to full and useful duty. This scope of treatment requires the type of clinical capability found only in a hospital that is properly staffed and equipped and located in an environment with a low level of threat from enemy action.

*f. Convalescent Care.* The convalescent-care phase of HSS entails guiding the patient from the time when it can be said that he has recovered from his injury or disease to the time when it can be determined that he has achieved a state of physical strength and stamina commensurate with the job to which he will be subsequently assigned. This phase involves clinical judgment as to the proper time for the patient to move to successively more intense reconditioning so that he is not challenged beyond the capabilities of his strength.

*g. Restorative and Rehabilitative Treatment.*

(1) The phases of patient care and treatment have been addressed (*a* through *f,* above) in relation to combat wounds and injuries. The philosophy expressed also applies to patients who suffer illness or nonbattle injuries; 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 levels. Deviations in the patient care and treatment phases may take place due to conditions beyond the control of the theater HSS system.

(2) Restorative treatment and rehabilitative treatment are available in the theater of

operations at the station, field, and general hospitals. Further convalescence is available beyond the theater of operations as required. In the Medical Force 2000 structure, the majority of physical therapy staff assets to provide these phases of care will be found in the field hospital and the medical company (holding). Minimal physical therapy staff assets to provide this care will also be found in the CSH and the GH.

### 3-13. Reporting Aspect of Health Service Support

Individuals entering the HSS system must be accounted for at all times. Prompt reporting of patients and their health status to the next higher headquarters is necessary to track patients for casualty reporting and personnel strength accounting. Correct and timely reports and reporting procedures are also necessary to determine the availability of HSS. However, the reports required must be limited to those absolutely necessary for ensuring HSS provisions in a theater of operations. This minimizes the administrative burden on health service units and the theater communications system. The AR 40 series, FM 8 series, and local command SOPs govern various HSS reports, including command health, patient admissions and disposition, medical summaries, and dental service. The Theater Army Medical Management Information System (TAMMIS) assists in this aspect through the medical patient accounting and reporting (MEDPAR) subsystem. (See Chapter 13 for a discussion on this subsystem.)

## Section IV. THE EFFECTS OF THE LAWS OF LAND WARFARE ON HEALTH SERVICE SUPPORT

### 3-14. The Law of War

*a.* The conduct of armed hostilities on land is regulated by the law of land warfare. (See DA Pam 27-1 and FM 27-10.) 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 prisoners of war, the wounded and sick, and civilians.
- Facilitating the restoration of peace.

*b.* The law of war places limits on the exercise of a belligerent's power in the interest of furthering that desire (diminishing the evils of war), and it requires that belligerents–

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

### 3-15. Sources of the Law of War

*a.* The law of war is derived from two principal sources.

(1) Treaties (or conventions) such as the Hague and Geneva Conventions.

(2) Custom–practices which by common consent and long-established uniform adherence have taken on the force of law.

*b.* Under the Constitution of the United States, 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 war is also part of the law of the United States. It is binding upon the United States, citizens of the United States, and other persons serving this country.

### 3-16. The Geneva Conventions

The United States 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, and are respectively entitled:

*a.* "Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field" (GWS).

*b.* "Geneva Convention for the Amelioration of the Condition of Wounded, Sick, and Shipwrecked Members of Armed Forces at Sea" (GWS Sea).

*c.* "Geneva Convention Relative to the Treatment of Prisoners of War" (GPW).

*d.* "*Geneva* Convention Relative to the Protection of Civilian Persons in Time of War" (GC).

The Conventions are very detailed and contain many provisions which are tied directly to the HSS mission.

### 3-17. Protection of the Sick and Wounded

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.

*a. Protection and Care.* Article 12 of the GWS imposes several specific obligations regarding the protection and care of the wounded and sick.

(1) 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."

*(a)* 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.

*(b)* 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.

*(c)* Combatants as well as noncombatants are required to respect the wounded. The obligation also applies to civilians, in regard to whom Article 18 specifically states: "The civilian population shall respect these wounded and sick, and in particular abstain from offering them violence."

*(d)* The GWS does not define what is meant by "wounded or sick," nor has there ever been any definition of the degree of severity of a wound or a sickness entitling the wounded or sick combatant to respect. Any definition would necessarily be restrictive in character and would thereby open the door to misinterpretation and abuse. The meaning of the words "wounded and sick" is thus a matter of common sense and good faith. It is the act of falling or laying down of arms because of a wound or sickness which constitutes the claim to protection. Only the soldier who is himself seeking to kill may be killed.

*(e)* 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 still must 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.

(2) 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 found on sex, race, nationality, religion, political opinions, or other similar criteria. . . ."

*(a)* 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 be 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.

*(b)* 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.

*(c)* The wounded and sick shall not willfully be left without medical assistance, nor shall conditions exposing them to contagion or infection be created.

(3) 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.

(4) 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 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.

*b. Enemy Wounded and Sick.* 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.

(1) Article 14 of the G WS 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 United States, will enjoy protection under both Conventions until his recovery. The GWS will take precedence over the GPW where the two overlap.

(2) Article 16 of the GWS requires the recording and forwarding of information regarding enemy wounded, sick, or dead. (See AR 190-8 for disposition of an EPW after hospital care.)

(3) When intelligence indicates that large numbers of EPWs may result from an operation, medical units may require reinforcement to support the anticipated additional EPW patient work load. Procedures for estimating the medical work load involved in the treatment and care of EPW patients are described in FM 8-55.

*c. Search for and Collection of Casualties.* 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 tactical 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.

*d. Assistance of the Civilian Population.* 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.

*e. Enemy Civilian Wounded and Sick.* Certain provisions of the GC are relevant to the HSS mission.

(1) 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]."

*(a)* 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.

*(b)* While Article 15 of the GWS requires Parties to a conflict to search for and collect the dead and 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 CZ. 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 COMMZ regulations.

(2) 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.

- A prohibition on requisitioning medical supplies unless the requirements of the civilian population have been taken into account.

- The responsibility 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.

- The requirement that medical personnel of all categories be allowed to carry out their duties.

- A 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.

- The requirement to provide adequate medical treatment to detained persons.

- The requirement to provide adequate medical care in internment camps.

### 3-18. Protection and Identification of Medical Personnel

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 those duties at the time when they come into contact with the enemy or fall into his hands* [emphasis added]."

*a. Protection.* There are two separate and distinct forms of protection.

(1) 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 arm band 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 arm band bearing a miniature Distinctive Emblem only while executing medical duties.

(2) 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. 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 on their 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.

*b. Specific Cases.* The AMEDD 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.

(1) While only Article 25 refers to nurses, nurses are Article 24 personnel if they meet the *exclusively engaged* criteria of that article.

(2) The AMEDD officers and NCOs assigned to nonmedical positions in an FSB, MSB, or DISCOM are neither Article 24 nor Article 25 personnel. Such assignments place them in the role of a combatant. Examples of such personnel are–

*(a)* The AMEDD officers serving as commanders of FSBs or MSBs with responsibility for base or base cluster defense as well as command and control of medical and nonmedical units.

*(b)* The AMEDD officers and NCOs assigned to nonmedical staff positions with an FSB or MSB with responsibility for planning and supervising the logistics support for a combat maneuver brigade or other combat unit.

(3) Article 24 personnel who might become Article 25 personnel by virtue of their switching roles could include the following:

*(a)* A medical company commander, a physician, or the executive officer, an MSC officer, detailed as convoy march unit commander with responsibility for medical and nonmedical unit routes of march, convoy control, defense, and repulsing attacks.

*(b)* 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 emblems on standard combat missions during other times.

(4) The GWS does not itself prohibit the use of Article 24 personnel in perimeter defense of Nonmedical units such as unit trains logistics 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.

*c. Identification Cards and Arm Bands.* Medical personnel who meet the *exclusively engaged* criteria of Article 24, GWS, are entitled to wear an arm band 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, Department of Defense (DD) Form 1934), 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 a standard military identification card or wear the Distinctive Emblem arm band. Such personnel carry a standard military identification card (DD Form 2A) and, under Article 25, may wear an arm band bearing a miniature Distinctive Emblem when executing medical duties. (For a discussion of ID cards, see AR 640-3.)

**This paragraph implements STANAGs 2931, 2027, 2060, and QSTAG 248.**

### 3-19. Protection and Identification of Medical Units and Establishments, Buildings and Materiel, and Medical Transports

*a. Protection.* There are two separate and distinct forms of protection.

(1) 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 red cross emblem.

*(a)* 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.

*(b)* All vehicles employed exclusively on medical transport duty are protected on the field of battle. Medical vehicles being used for both military and medical purposes such as moving wounded personnel during an evacuation and carrying retreating belligerents as well are not entitled to protection.

*(c)* 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.

*(d)* 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 still when accompanied by practical safeguards.

(2) The second protection provided by the GWS pertains to medical units, establishments, materiel, and transports which fall into the hands of the enemy.

*(a)* 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. (See Chapter 6 for additional information on captured enemy equipment.)

*(b)* 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, tactical 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.

*(c)* 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. The actual buildings may in certain extreme cases have to be destroyed for tactical reasons.

*(d)* Medical transports which fall into enemy hands may be used for any purpose once arrangements have 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.

*(e)* 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" (that is if the aircraft is carrying munitions, for example) has been committed, it loses the protections of the Convention 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.

*b. Identification.* 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).

(1) 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."

*(a)* There is no obligation on 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 which 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.

*(b)* 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.

*(c)* 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. Although not specifically authorized as a symbol in lieu of the red cross, enemies of Israel in past wars have recognized the red Star of David and have afforded it the same respect as the red cross. This showed compliance with the general rule that the wounded and sick must be respected and protected when they are recognized as such, even when not properly marked.

*(d)* 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.

(2) Article 42 of the GWS specifically addresses the marking of medical units and establishments.

*(a)* "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.

*(b)* "In mobile units, as in fixed establishments, [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.

(3) 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 Standardization Agreement

defines "medical facilities" as "medical units, medical vehicles, and medical aircraft on the ground." (For information on camouflage painting, see AR 750-1.)

**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 background is not a symbol recognized under the Geneva Conventions.

(4) Medical evacuation vehicles and medical materiel containers will, unless ordered otherwise, be marked with the Distinctive Emblem (red cross on a white background) and other distinguishing insignia and color markings when required by international STANAGs. (See STANAGs 2027 and 2060 and QSTAG 248.)

### 3-20. Loss of Protection of Medical Establishments and Units

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

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

*b. Warning and Time Limit.* 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.

*c. Use of Smoke and Obscurants.* The use of smoke and obscurants during medical evacuation operations does not differ from the use of camouflage and does not constitute an act harmful to the enemy.

### 3-21. Conditions Not Depriving Medical Units and Establishments of Protection

*a.* Article 22 of the GWS reads as follows: "The following conditions shall not be considered as depriving a medical unit or establishment of the protection guaranteed by Article 19:

"(1) That the personnel of the unit or establishment are armed, and that they use the arms in their own defense, 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 materiel 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."

*b.* 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 as such, and its right to immunity, in spite of certain appearances which might have led to the contrary conclusion or, at least, created some doubt.

*(1) Defense of medical units and self-defense by medical personnel.* A medical unit is granted a privileged status under the laws of war. 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 Convention. They may not employ arms against enemy forces acting in conformity with the law of war 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 war expose themselves to penalties for violation of the law of war and, provided they have been given due warning to cease such acts, may also forfeit the protection of the medical unit or establishment which they are protecting.

*(a)* Medical personnel may carry only small arms, such as rifles or pistols or authorized substitutes. Army Regulation 71-13 provides the policy that governs the small arms medical personnel are authorized to carry. Army Regulation 350-41 also supports this policy. It states "AMEDD personnel and non-AMEDD personnel in medical units will not be required to train or qualify with weapons other than individual or small arms weapons. However, AMEDD personnel attending training at NCOES [noncommissioned officer education system] courses will receive weapons instruction that is part of the curriculum. This will ensure that successful completion of the course is not jeopardized by failure to attend the weapons training portion of the curriculum."

*(b)* 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 to privileged 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. See the previous discussion of loss of protection of medical units and establishments.

(2) *Guarding of medical units.* 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.

(3) *Arms and ammunition taken from the wounded.* Wounded 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. (See paragraph *3-6d.)* 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.

(4) *Personnel and materiel of the veterinary corps.* 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.

*(5) Care of civilian wounded or sick.* 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.

### 3-22. 1977 Protocols to the Geneva Conventions

Amendments to the Geneva Conventions have been ratified by some of our allies and potential

adversaries. The United States representative to the diplomatic conference signed these amendments, but they have not been officially ratified by our government.

## Section V. RECONSTITUTION OF UNITS AND PERSONNEL

### 3-23. Reconstitution

*a.* Reconstitution is focused action to restore ineffective units to the level of effectiveness required by the mission. Reconstitution may include—

- Reestablishing or reinforcing command and control.
- Cross-leveling or replacing personnel, supplies, and equipment.
- Conducting mission-essential training.
- Reestablishing unit cohesion.

*b.* Reconstitution—

- May be required for combat, CS, or CSS units and may be required at any level of command.
- Uses organic systems and resources.
- Must be an integral part of the estimate process.

(See FMs 100-5 and 100-10 for discussion on reconstitution in the ALB.)

### 3-24. Reconstitution Options

Commanders have two options available for reconstituting units: reorganization and regeneration.

*a.* Reorganization consists of measures such as internal redistribution of equipment and personnel and the formation of composite units. The AMEDD commanders use reorganization to shift resources within an attrited unit to improve its ability to provide HSS.

*b.* Regeneration consists of incremental or whole-unit generation. Both involve the rebuilding of a unit.

*c.* Regeneration of entire medical units accomplishes the goal of reconstitution more rapidly. Whole-unit regeneration is the keystone of the modular medical system. The advantage of whole-unit regeneration is that the replacement unit will be able to immediately perform the HSS mission. A possible disadvantage of whole-unit regeneration is that some otherwise usable assets will be evacuated along with the noneffective portions of the replaced unit.

*d.* Reorganization and regeneration can be used separately or in combination. Their application depends upon current and anticipated situations, as well as resources and time available.

*e.* Health service support for Echelons I and II is provided by a modular medical system. The modular design enables the medical resource manager to rapidly tailor, augment, reinforce, or reconstitute modular units that have become ineffective. These modules were designed to acquire, receive, and sort casualties and to provide emergency medical treatment to personnel in divisions. The modular system is built around six modules: combat medic, treatment squad, ambulance squad, area support squad, patient holding squad, and surgical squad. The system is oriented to forward casualty assessment, collection, evacuation, treatment, and initial emergency surgery.

*f.* As stated earlier, Appendixes A through J describe HSS units designed to provide medical care on the battlefield of the future. The modular concept is used in many of these units.

### 3-25. Health Service Support in Personnel Reconstitution

*a.* Personnel for reconstitution of units operating forward are partially obtained by maximizing the RTD rate of combat soldiers. Maximizing the RTD of combat soldiers provides a pool of personnel for reconstituting units operating forward.

*b.* Injuries categorized as minimal during the triage process (see Chapter 14) are treated as soon after injury as possible to rapidly return the soldier to duty. However, under some circumstances there may be a period of time that ambulatory patients will be expected to participate in reorganization activities after receiving first aid and will continue to fight prior to more definitive treatment.

*c.* Soldiers incapacitated by combat stress will receive immediate treatment as close to their units as possible in a nonhospital military setting. This treatment practice is designed to quickly return the soldiers to duty with their unit and allow medical units to concentrate on patients with life-threatening injuries. To assist in this effort, combat stress control teams are echeloned far forward, perform assessments, and advise commanders on matters relating to combat stress, reaction capabilities, and the "will to fight." These teams deploy to units which are withdrawn from action for reconstitution along with other CSS teams as part of the reconstitution support package. There they assist command in assuring sleep, nutrition, and hygiene. They then foster the reintegration of surviving veteran and new replacements into cohesive units. They treat battle fatigued soldiers in the unit without labeling them as casualties. (See Chapter 12 for a discussion on combat stress control units.)

*d.* The reassignment of RTD personnel is the responsibility of personnel organizations. Patient treatment and disposition information is provided to lateral personnel organizations to assist in accurate personnel casualty reporting and replacement operations. The replacement companies maintain liaison with medical facilities to arrange for transportation from the MTF to the unit of assignment, to the weapons system replacement operation for crew training on a weapons system, or to a unit being reorganized.

### 3-26. Commander's Decision

*a.* Sustained combat, heavy casualties, and massive destruction of equipment will require commanders to *reorganize* (rebuild) or *regenerate* units during operations. When the commander determines that a unit is not sufficiently effective to meet operational requirements, reorganization or regeneration of that unit should begin.

*b.* The commander's decision to reorganize or regenerate a unit is normally based on the—

- Unit's personnel losses, including MOS shortages or shortages in leadership structure.
- Unit's equipment status including shortages of mission-essential items, low operational ready rates of major items, or lack of maintenance and repair parts.
- Unit's psychological condition including its internal cohesion and the physical and mental condition of its members.
- Impact of reIeasing the unit on the operations of the supported and supporting forces, including the time and resources available to reconstitute it.

*c.* Based on an analysis of these considerations and any others which may be relevant, the staff determines a unit's level of effectiveness and recommends to the commander measures to correct problems. No single report will provide the commander and staff with the necessary level of detail to determine relative effectiveness. Commanders must determine their unit's capabilities, taking into consideration both objective and subjective effectiveness indicators. Objective indicators include a comparison of personnel and equipment authorizations with on-hand strengths. Subjective indicators include evaluations of the levels of leadership, cohesion, training, and morale.

### 3-27. Responsibilities in Reconstitution

*a.* Responsibilities of commanders at all levels include–

- Conducting assessments before, during, and after battle, and conducting necessary planning.
- Establishing reconstitution priorities that are aligned with operational or tactical objectives.

- Determining reconstitution method, location, and unit combat effectiveness goals.

- Developing and executing training programs for units undergoing reconstitution.

*b*. Responsibilities of surgeons' include–

- Providing recommendations on allocation and redistribution of AMEDD personnel, health service logistics, and HSS units during the reconstitution process.

- Advising commanders about preventive medicine aspects of reconstitution and availability and use of combat stress control teams.

- Advising commanders on the effects of accumulated radiation exposure and possible delayed effects from exposure to chemical or biological agents.

- Advising commanders on disposition of personnel exposed to lethal but not immediately life-threatening doses of radiation or chemical and biological agents.

*c*. Responsibilities of MTF and medical supply units include–

- Returning a maximum number of personnel to duty.

- Coordinating requirements (on-site support) for health service logistics.

- Assisting the unit being reconstituted in acquiring the necessary medical equipment.

*d*. Responsibilities of MEDCOM and medical brigades are to ensure appropriate HSS is provided to units being reconstituted in corps and division areas.

## Section VI. TRAINING

### 3-28. Commanders' Responsibilities

*a*. Training is a key element of success. It is a full-time duty for commanders in peacetime, and it continues in wartime as well. Personnel and units will perform as well or as poorly as they were trained prior to the day of the battle. Forward deployed medical units may have to react on a few hours notice. Other components of the AMEDD may have only days or weeks to make final preparations for supporting combat operations. Commanders must have exceptionally effective plans in concept and execution for those important days or weeks. (See FM 8-55.) They must train their units for the specific missions they anticipate. They must ensure that each person in their unit is prepared and equipped to perform his job in completing the overall HSS mission. Field Manual 25-100 provides the necessary guidelines on how to plan, execute, and assess training at all levels.)

*b*. Health service support leaders at all echelons of care are responsible for training of subordinates. The requirement to train HSS personnel is discussed in Chapter 2. Chapter 14 also discusses the role HSS personnel play in mass casualty situations and the importance of regularly exercising mass casualty plans.

### 3-29. Unit Training

Personnel receive important training in their units under conditions that approximate HSS to combat units in a theater of operations. There they can-

- Familiarize themselves with their units.
- Train as individuals.
- Train as members of teams.
- Use actual field medical equipment.

# CHAPTER 4

# PATIENT EVACUATION AND MEDICAL REGULATING

## 4-1. Patient Evacuation

*a.* Patient evacuation is the timely, efficient movement of wounded, injured, or ill persons from the battlefield and other locations to MTFs. En route medical care is provided by medical personnel during patient evacuation. Precisely planned evacuation plays an important role in the carefully designed treatment sequence from the FLOT rearward. As the echelons of care become more sophisticated from front to rear, so do the means of patient evacuation.

*b*. The evacuation process continues for each person until he can be returned to duty or discharged from the Service. In keeping with the AMEDD mission, every effort is made, consistent with the evacuation policy, to rehabilitate patients and return them to duty at the lowest practicable echelon of care.

*c*. Evacuation of patients is the responsibility of the echelon of care to which patients are evacuated.

(1) Casualty collection evacuation from the point of injury or illness to the BAS is a unit responsibility.

(2) Evacuation from a BAS to a clearing station (division) is the responsibility of the forward support medical company. For those divisions not under the FSB/MSB design, separate brigades, and ACRs, evacuation is the responsibility of the supporting medical company.

(3) Evacuation from a clearing station to a MASH, CSH, or evacuation hospital is the responsibility of the corps medical brigade/group.

(4) Evacuation to a field, station, or general hospital in the COMMZ from a CZ hospital or from another MTF within the COMMZ is the responsibility of the TA MEDCOM in conjunction with the US Transportation Command (USTRANSCOM).

(5) Evacuation from the COMMZ to the ZI is the responsibility of the USTRANSCOM. (See paragraph 4-7c.)

## 4-2. Theater Evacuation Policy

*a.* Plans to provide theater evacuation must consider the theater evacuation policy. This policy is established by the Secretary of Defense, with the advice of the Joint Chiefs of Staff, and upon the recommendation of the theater 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 will be held in the theater for the entire period of noneffectiveness. A patient who is not expected to be ready for RTD within the number of days established in the theater evacuation policy is evacuated to CONUS or some other safe haven. This is done providing that the treating physicians determine that such evacuation will not aggravate the patient's disabilities or medical condition. For example, a theater evacuation policy of 60 days does not mean that a patient is held in the theater for 59 days and then evacuated. Instead, it means that a patient will be evacuated as soon as possible after a determination is made that the patient is not projected to be returned to duty within 60 days following admission.

*b.* When unforeseen increases in the number of patients occur (due perhaps to an epidemic or heavy combat casualties), a temporary reduction in the policy may be necessary to adjust the volume of patients in the theater hospital system. A reduction in the evacuation policy increases the number of patients requiring evacuation out-of-theater, and it increases the requirement for evacuation assets. This action is necessary to relieve the congestion caused by the increased number of patients.

*c.* The time period established in the theater evacuation policy starts on the date the patient is admitted to the first hospital (CZ or COMMZ). The total time a patient is hospitalized in the theater, including transit time between MTFs, for a single uninterrupted episode of illness or injury should not exceed the number of days stated in the theater evacuation policy. Although convalescent centers are not hospitals, the time a patient spends in one is included in the calculation of the duration of his hospital stay. Though guided by the evacuation policy, the actual selection of a patient for

evacuation will be based on clinical judgment as to the patient's ability to tolerate and survive the movement to the next level of hospitalization.

### 4-3. Intratheater Evacuation Policy

*a.* Subordinate commands may establish intratheater patient evacuation policies within the limits of the theater patient evacuation policy and subject to approval by the theater commander. For example, a short evacuation policy may be established for corps hospitals to maintain their mobility and their capability to accommodate surges of patients. The intratheater evacuation policy, usually stated in days at the corps level, represents the maximum period of allowable hospitalization in corps hospitals. Any patient who can be expected to RTD within the stated policy is retained by a corps hospital for definitive care and subsequent RTD. Any patient who cannot be expected to be returned to duty within the stated policy is evacuated to the COMMZ as soon as his condition and transportation resources permit. Intratheater patient evacuation policies must be flexible and changed as dictated by the tactical situation. (These policies may be adjusted in the early days of a contingency operation as the availability of treatment facilities and evacuation means permit. ) Intratheater evacuation policies may differ among hospitals depending on their location, facilities, staff, and the numbers and types of patients received.

*b.* When patients are received at a constant rate, the evacuation policy at a specific echelon may be adjusted to retain and subsequently RTD those patients who do not require specialized treatment in COMMZ GHs. However, when increased patient loads are anticipated, the intratheater evacuation policy must be adjusted downward to make additional beds available for current and anticipated needs. As a result, a larger proportion of patients admitted to hospitals in the CZ are evacuated to the COMMZ.

### 4-4. Acceptable Percentage of Fill for Available Hospital Beds

*a.* Another management tool available to the HSS planner is to establish a percentage limiting the number of beds that may be occupied within a command at any given time.

*b.* This percentage, as a tool, is smaller in scope but more immediate in impact than adjusting the evacuation policy. The use of this factor within the overall limitations of the intratheater evacuation policy allows the planner to respond immediately to the course of action selected by the tactical commander. For example: A corps commander has been assigned a mission requiring offensive action. The senior medical headquarters commander (COSCOM surgeon) in coordination with the corps surgeon anticipates increased casualties as a result of this action. During the previous defensive operations, a 15-day evacuation policy, coupled with a 75 percent bed-fill level, was in effect. The corps commander anticipates initiating action within 48 hours. In this scenario the adjustment of the evacuation policy would not provide for that immediate flexibility necessary to support the operation. However, by reducing the percentage of bed-fill level within the command (after coordination with the TA surgeon), the brigade/group commander can rapidly achieve the availability of the beds necessary to meet casualty needs.

*c.* This adjustment of the percentage of fill factor is dependent on many support assets and may not be done without extensive coordination. Adequate evacuation capability must exist to support any adjustment.

### 4-5. Medical Regulating

*a.* Medical regulating is a system for coordinating and controlling the movement of patients through the various echelons of care. The system ensures the timely, efficient, and safe movement of patients, often over great distances, to the destination MTF. Medical regulating is executed in such a manner that the welfare of the patient is second only to the success of the tactical mission. The system entails identifying patients to be evacuated, locating available beds, and coordinating evacuation means so that each patient is moved to the proper MTF with the least possible delay.

*b.* Careful control of patient evacuation to hospitals is necessary to–

- Effect an even distribution of cases.
- Assure adequate beds for current and anticipated needs.
- Route patients requiring specialized treatment to the proper MTFs.

*c.* Rigid control is maintained over the evacuation of patients needing surgery to prevent surgical backlog in MTFs. Surgical backlog is the time, generally measured in hours, between the time a patient is delivered to a facility and the time that patient enters an operating room. Obviously, with a fixed number of operating tables in a hospital, if patients arrive at a facility faster than surgery can be completed on them, surgical backlog will increase. Supporting MTFs should express surgical backlog in terms of total patient operating hours divided by the number of operating tables in use.

*d.* Factors which influence the scheduling of patient movement include the–

- Tactical situation.
- Availability of transportation means.
- Locations of MTFs with special capabilities or resources.
- Current bed status of MTFs.
- Surgical backlog.
- Number and location of patients by diagnostic category.
- Locations of airfields (or seaports).
- Condition of each patient (Is the patient sufficiently stabilized to withstand travel?).

*e.* With a responsive communication system, the receipt of medical evacuation mission requests and the issuance of mission assignments are expedited.

## 4-6. Bypassing Triage and Medical Care

Routinely bypassing available triage and care will not be practiced. To do so risks further injury to the patient and negates the effective use of medical resources. Routinely bypassing an echelon of care will also–

- Cause overevacuation of less critically injured soldiers which results in delaying their RTD.
- Remove the evacuation asset from its supporting position for longer periods of time.
- Cause more wear and tear of evacuation assets therefore requiring more maintenance on aircraft and vehicles.

## 4-7. Means of Evacuation

*a.* Within a theater of operations, patients may be evacuated by manual carries, litter teams, ground and air ambulances, other nonmedical ground and air transportation assets, watercraft, or any combination thereof. From the theater of operations to the ZI, patients are normally evacuated by aircraft, but surface means will be used when USAF transportation is not available or advisable. Regardless of the means used, patient evacuation under most battlefield conditions is a difficult, hazardous task. It becomes even more complex with problems created by bad weather, high altitude, inaccessibility to available roads, broken or rough terrain, NBC contamination of roads and vehicles, movement of other friendly elements, and enemy actions. Coordination of evacuation plans with those involving the flow of tactical and logistical traffic to and from the main battle area is essential to sound patient evacuation operations.

*b.* Army ground and air ambulances will be used in the CZ for the evacuation of patients.

*c.* The preferred means of evacuation from the CZ to the COMMZ is by USAF aircraft. These resources are controlled by USTRANSCOM. Aeromedical evacuation requirements are coordinated by the medical regulating officer assigned to the senior medical command in the CZ. If adequate air evacuation is not available, the medical regulating officer will coordinate for the use of ground transportation. In exceptional circumstances, Army ground or air ambulances may

be used. Evacuation of patients from the COMMZ to the ZI will normally be accomplished by the USAF.

*d*. The medical unit commander is responsible for coordinating additional emergency nonmedical transportation when requirements exceed the medical evacuation assets available. For example, the medical group coordinates with the area support group for additional resources.

*e*. The system of medical command and control headquarters, through their medical regulating (patient movement control) sections, provides the planning and coordination necessary for a successful patient evacuation system. This includes both air and ground ambulances. When there is an interruption in USAF AE from the CZ, movement of large numbers of patients to and from USAF mobile aeromedical staging facilities (MASFs) or aeromedical staging facilities (ASFs) and bet ween hospitals and convalescent centers may be done by ambulance buses, ambulance trains, or tactical helicopters (CH-47) with medical attendants. These buses, trains, and helicopters with medical attendants have been modified to accommodate ambulatory and litter patients and are acceptable substitutes for unavailable USAF tactical aircraft normally used for patient evacuation.

## 4-8. Sorting of Patients for Evacuation

*a*. Sorting for evacuation is the methodical process of examining patients and identifying those who—

- Can receive the required treatment without evacuation.
- Must be evacuated to a higher level for needed treatment.

Patients are also sorted to route them to the proper element within a MTF. Sorting for these purposes must not be confused with the sorting of mass casualties into priority treatment and evacuation categories (Chapter 14).

*b*. Proper sorting is essential for effective patient management in the evacuation system. Improper sorting can jeopardize the success of combat operations by creating the following unnecessary burdens:

(1) The patient's unit must go short-handed until the soldier is returned to duty or replaced.

(2) The replacement system must procure and deliver additional personnel unnecessarily.

(3) Medical treatment facilities in the rear will be unnecessarily burdened, thus decreasing the care and support that could be provided to more properly selected patients.

(4) Evacuation assets, already in short supply, will be used moving patients unnecessarily.

## 4-9. Evacuation Chain

*a. Echelon I Evacuation.*

(1) Wounded or injured casualties on the front lines rely on other unit personnel to perform basic evacuation carries. Carries such as the pistol-belt carry or the fireman's carry are used to evacuate the casualty to a point where a litter is available or where a litter can be improvised. The casualty is subsequently taken to the company aid post or a preplanned casualty collecting point. If possible, this evacuation is supervised by a combat lifesaver (whose primary responsibility is to fight the enemy) or a combat medic. Evacuation duties are performed when the situation permits. Casualty evacuation from the aid post to the BAS is accomplished by ambulances from the medical platoon.

(2) The BAS is not staffed and equipped to provide patient holding. It must be capable of moving on short notice. Only those emergency medical procedures which contribute to initial resuscitation and the preservation of life or limb, and which enable a patient to survive en route to the next MTF, are performed in the BAS.

b. *Echelon II Evacuation.*

(1) The ambulance platoon of the

medical company provides medical evacuation of patients on an area basis from—

- The forward BAS.
- Other BASs and units within the brigade area and division rear area.

(2) Air ambulances from the forward support evacuation teams of the direct support air ambulance company will assist the ambulances of the medical company. These teams are usually collocated with the forward support medical company in the brigade support area. They will normally evacuate patients to the medical company from as far forward as the tactical situation permits.

*c. Echelon III Evacuation.*

(1) The medical brigade or group commander, with the required resources at his disposal, must prevent any undue accumulation of patients in MTFs within the corps by their timely evacuation. Evacuation is accomplished by ground and air and involves patient movement from division and corps medical facilities.

(2) Corps-level medical units are responsible for evacuating patients from division clearing stations, separate clearing stations, nondivisional dispensaries in the corps area, and aid stations to hospitals of the corps. Evacuation is by ground and air ambulance.

(3) The evacuation units usually found in corps are the evacuation battalions; medical ambulance companies; medical companies, air ambulance; and air ambulance detachments. Some of these units are used in the COMMZ as well as in the CZ; however, when they are employed in the COMMZ, they are assigned to the TA MEDCOM rather than the corps medical brigade.

(4) There are several fundamental considerations concerning evacuation of patients in a theater of operations. For each patient that is moved to the rear, there must be a replacement brought forward. Therefore, it is essential that the HSS system avoid evacuating patients that can RTD within the set evacuation policy. However, the need to retain patients in forward areas for rehabilitation and early RTD must be weighed carefully against the risk of immobilizing forward MTFs by accumulating large numbers of patients. The entire scheme of evacuation is based on—

- Providing adequate care en route.
- Providing the most rapid method of transport.
- Causing the least discomfort to the patient.

*d. Echelon IV Evacuation.* Patients are evacuated to locations and facilities where more definitive treatment is provided. The MEDCOM is responsible for coordinating and regulating both surface and air evacuation (Army and USAF) from the CZ to the COMMZ and between medical facilities within the COMMZ.

## 4-10. Medical Ambulance Company, TOE 08-127H41O

This company consists of a company headquarters and 3 ambulance platoons of 12 ambulances each. It provides a single-lift capability for evacuation of 144 litter patients or 288 ambulatory patients from division medical units to supporting medical installations or evacuation points. This company also evacuates patients from area medical units within the CZ. It is assigned to the corps medical brigade on the basis of one per division supported. It is also employed in the COMMZ on the basis of one per two divisions supported. For control purposes, this company is attached to a headquarters and headquarters detachment, medical battalion or headquarters and headquarters detachment, evacuation battalion. The unit is employed to provide a ground evacuation means in areas of expected patient density. This ambulance company maintains liaison not only with the unit from which it evacuates patients, but also with the unit which is to receive the patients. In keeping with the field HSS principle of continuity, the company provides en route medical care for patients being moved. This unit may also be organized with 18 buses (36-45 passenger) in lieu of the 36 ambulances (normally bus units will be in the COMMZ). This gives it a single-lift capability for evacuation of 324 litter patients or 792 ambulatory patients.

## 4-11 Medical Company (Air Ambulance), TOE 08-137H200

*a.* Mission. The mission of this unit is to—

- Provide aeromedical support in the CZ.
- Provide emergency movement of medical personnel and accompanying equipment and supplies to meet a critical requirement.
- Ensure uninterrupted delivery of whole blood, biological, and medical supplies when there is a critical requirement.

*b. Assignment.* This unit is assigned to headquarters and headquarters detachment, medical brigade. It is normally attached to headquarters and headquarters detachment, medical group.

*c. Capabilities.* This unit provides the following:

(1) Aeromedical evacuation of critically wounded or other patients, extrication of personnel from crashed aircraft, and aeromedical evacuation of those patients from the crash site to the appropriate medical facility capable of providing required treatment.

(2) Emergency aid at air crash site, in-flight medical treatment, and/or surveillance for patients en route to MTFs.

(3) Aeromedical evacuation of patients from units in support of combat troops except from an airhead or airborne force objective area that is logistically supported by the USAF.

*d. Basis of Allocation.* This unit is allocated to the corps on the basis of one per four divisions and one per task force not supported by other air evacuation assets.

**NOTE**

Air ambulances evacuate all categories of patients, normally on an *on-call* basis, except battle fatigue unless no other means is available. (Psychiatric cases are not usually evacuated by air; however, mission exigencies may require that a properly sedated, restrained psychiatric casualty be evacuated using AE assets. ) Priority for this evacuation is given to the seriously wounded.

## 4-12. Medical Detachment (Helicopter Ambulance) and Medical Detachment (Ground Ambulance), Medical Evacuation Teams, TOE 08-660H0

*a. Mission.* The mission of the evacuation teams is to evacuate patients to and between MTFs, or to evacuate patients to airfields and airports for further evacuation out of the theater. Evacuation teams consist of Team RA, air ambulance (UH-lV); Team RG, air ambulance (UH-60A): and Team RE, ground ambulance.

*b. Assignment.* Medical evacuation teams are assigned to the MEDCOM or a medical brigade. They may be further attached to other AMEDD command and control units as required by the nature of operations and the forces being supported.

*c. Capabilities.*

(1) *Team RA, air ambulance.* This team—

- Provides immediate AE of all categories of patients except battle fatigue unless no other means is available. Evacuation is provided consistent with evacuation priorities and other operational considerations, from forward areas of the CZ to division clearing stations or further if medically indicated. When employed in the COMMZ, this team provides expeditious movement of patients, consistent with evacuation priorities and other considerations, to and between MTFs, or to airfields or seaports for further evacuation out of the theater.
- Operates 6 air ambulances (each normally configured to carry 3 litter and 4 ambulatory patients) for single-lift evacuation capabilities of 18 litter and 24 ambulatory patients. Depending on rigging, these aircraft can each carry

either 6 or 9 ambulatory patients for single-lift evacuation capabilities ranging between 36 and 54 ambulatory patients.

- Provides air crash rescue support less fire suppression; extricates personnel from crashed aircraft; provides emergency aid at the crash site; and aeromedically evacuates these patients to appropriate MTF's.

- Provides expeditious delivery of whole blood, biological, and medical supplies to meet recurring and critical requirements.

- Provides rapid movement of medical personnel and accompanying equipment and supplies to meet requirements of mass casualty and other emergency situations.

- Has a flight operations section which is staffed for 24-hour operations to receive and coordinate AE missions; other sections are staffed for normal operations.

- Can perform limited AVUM and organizational maintenance on all organic avionics equipment.

- Is dependent upon the supporting AVIM company for supplemental AVUM support and for AVIM.

(2) *Team RG, air ambulance (UH-60A).* This team–

- Provides immediate AE of all categories of patients except battle fatigue unless no other means is available. Evacuation is provided consistent with evacuation priorities and other operational considerations, from forward areas of the CZ to the division clearing stations, or further if medically indicated. When employed in the COMMZ, this team provides for expeditious movement of patients, consistent with evacuation priorities and other operational considerations, to and between MTFs or to airfields or seaports for further evacuation out of the theater.

- Operates 6 air ambulances (each normally configured to carry 4 litter patients and 1 ambulatory patient) for single-lift evacuation capabilities of 24 litter and 6 ambulatory patients. The kit litter may be reconfigured to carry 6 litter or 7 ambulatory patients for single-lift evacuation capabilities ranging between 36 litter, 42 ambulatory, or some combination thereof. If the kit litter is removed, the aircraft can carry 13 ambulatory patients. This team provides in-flight medical care or surveillance for patients during evacuation.

- Provides air crash rescue support. Extricates personnel from crashed aircraft. This team provides emergency aid at the crash site and aeromedically evacuates these patients to appropriate MTFs capable of providing required treatment.

- Provides expeditious delivery of whole blood, biological, and medical supplies to meet recurring and critical requirements.

- Provides rapid movement of medical personnel and accompanying equipment and supplies to meet requirements of mass casualty and other emergency situations.

- Has a flight operations section which is staffed for 24-hour operations to receive and coordinate AE missions; other sections are staffed for normal operations.

- Can perform limited AVUM on organic aircraft and organizational maintenance on all organic avionics equipment.

- Is dependent upon the supporting AIVM company for supplementing AVUM support and for AVIM.

(3) Team RE, ground ambulance. This team—

- Provides ground evacuation of patients to and between MTFs in the COMMZ as well as to airfields or seaports for further evacuation out of the theater. This team may also be used to provide ambulance support on an area basis primarily in high density troop population areas of the COMMZ.

- Operates 6, 1 1/4-ton field ambulances (each with a carrying capacity of 4 litter

or 8 ambulatory patients) for single-lift evacuation capabilities ranging between 24 litters and 48 ambulatory patients. This team provides medical treatment or surveillance of patients during evacuation.

- May be used to provide six 2-man short-haul or three 4-man long-haul litter teams to meet emergency evacuation requirements when ambulance evacuation cannot be accomplished or is otherwise contraindicated. This team provides emergency medical care prior to and during evacuation.

- May be organized with bus ambulances in lieu of truck ambulances to provide bulk ground evacuation of patients. When so organized, operates 3 ambulance buses (each with a carrying capacity of 18 litter or 42 ambulatory patients) for single-lift evacuation capabilities ranging between 54 litter and 126 ambulatory patients depending on the configuration of the ambulance buses.

*d. Basis of Allocation.* The evacuation teams are allocated as follows:

(1) *Team RA, air ambulance (UH-1V).* Two teams are allocated per division supported, one team per separate brigade-size task force not otherwise supported by an AE unit, one team per hospital center, and as required to meet AE needs of the theater when units of less than company size are indicated.

(2) *Team RG, air ambulance (UH-60A).* Two teams are allocated per division supported, one team per separate brigade-size task force not otherwise supported by an AE unit, one team per hospital center, and as required to meet AE needs of the theater when units less than company size are indicated.

(3) *Team RE, ground ambulance.* One team per division or equivalent of approximately 40,000 CZ troops supported from the COMMZ and as required to meet evacuation needs of the theater when units of less than company size are indicated.

### 4-13. Headquarters, Headquarters Detachment, Medical Battalion (Evacuation), TOE 08-446L000

(See paragraph *2-11d,* Chapter 2, for a discussion on this unit.) Medical companies under the H-edition TOE will be converted (or are in the process of conversion) to L-edition TOE discussed in paragraphs 4-14 and 4-15.

### 4-14. Medical Company (Air Ambulance) (UH-lV or UH-60A Aircraft), TOE 08-447L100 and 008-447L200

*a. Mission.* The mission of the medical company (air ambulance) is to provide AE and support within the theater of operations.

*b. Assignment.* The medical company (air ambulance) is assigned to the medical brigade and is normally further attached to the headquarters and headquarters detachment, medical battalion (evacuation).

*c. Capabilities.* This unit provides–

- Fifteen helicopter ambulances to evacuate patients consistent with evacuation priorities and operational considerations, from points as far forward as possible, to division MTFs and corps-level hospitals. Single patient lift capability for the UH-1V units is 90 litter patients or 135 ambulatory patients, or some combination thereof. The UH-60A unit when used with kit AE K40878) installed has the capability to carry 90 litter patients or 105 ambulatory patients, or some combination thereof. When the UH-60A is configured in the troop carrier mode without the kit litter installed, the unit is capable of carrying 195 ambulatory patients.

- Air crash rescue support, less fire suppression.

- Expeditious delivery of whole blood, biologicals, and medical supplies to meet critical requirements.

- Rapid movement of medical personnel and accompanying equipment and supplies to meet the requirements for mass casualty

reinforcement, reconstitution, or emergency situations.

- Movement of patients between hospitals, ASFs, MASFs, seaports, or railheads in both the CZ and COMMZ.

*d. Basis of Allocation.* One in direct support of each division or equivalent force not supported by Teams RA or RG. Additionally, one in general support in the corps per two divisions or fraction thereof not supported by medical air ambulance company.

### 4-15. Medical Company (Ground Ambulance), TOE 08-449L000

*a. Mission.* The mission of the medical company (ground ambulance) is to provide ground evacuation of patients within the theater of operations.

*b. Assignment.* The medical company (ground ambulance) is assigned to the medical brigade and further attached to a headquarters and headquarters detachment, medical battalion (evacuation) for command and control.

*c. Capabilities.* This unit provides–

- Forty truck ambulances with a single-lift capability for evacuation of 160 litter patients or 320 ambulatory patients.

- Evacuation of patients from division medical companies to CZ hospitals.

- Evacuation of patients from area support medical companies to supporting hospitals.

- Reinforcement of division medical company evacuation assets when required.

- Reinforcement for patient evacuation from covering force and deep battle operations.

- Movement of patients between hospitals and ASFs, MASFs, seaports, or railroads in both the CZ and COMMZ.

- Area evacuation support beyond the capability of the area support medical battalion.

- Emergency movement of medical supplies.

*d. Basis of Allocation.* The medical company is allocated to the CZ on the basis of one per division or equivalent-size force supported, to the TA on the basis of one per TA and corps supported, and in the COMMZ as required.

### 4-16. Airspace Coordination

Airspace coordination maximizes joint force effectiveness without hindering the combat power of any of the Services. Friendly aircraft must be able to enter, depart, and move within the area of operations without undue restrictions, while supporting fires and remotely piloted vehicle flights continue uninterrupted. The tempo and complexity of modern combat rule out a system that requires time-consuming coordination. To be simple and flexible, our airspace coordination system operates under a concept of management by exception.

*a.* Each Service may operate its aircraft within the theater airspace. Army aircraft at low altitudes operate under the control of the Army airspace command and control (A2C2 ) system. The USAF aircraft at medium and high altitudes operate under control of the tactical air control system. Navy and Marine Corps aircraft may also provide mission support to the force and will, therefore, operate in theater airspace. The boundary between low- and medium-altitude regimes is flexible and situation-dependent. Coordination between the Services is continuous, but it is especially important when aircraft pass from one regime to another. Generally, Army aircraft operate with fewer restrictions below coordinating altitudes forward of the division rear boundary. Passing information about major movements or high concentrations of fire is necessary to avoid conflicts.

*b.* In practice, USAF support of strategic and operational plans is flown within airspace procedures established by theater or joint force commanders. These procedures may include aircraft of any Service or ally, all using rules and procedures appropriate to operational plans. Aircraft

supporting tactical plans (usually Army aviation) will adhere to theater-wide procedures as augmented by the tactical commander being supported. All airspace management rules and procedures will be standardized to the extent possible, but they will ultimately be applied in a particular theater in accordance with operational direction. The G3 air or S3 air ensures that staff elements in the A2C2 cell conduct the necessary coordination.

*c.* Medical evacuation pilots routinely cross divisional boundaries and may operate in and forward of the brigade support area. They need access to radio frequencies and call signs for all elements within their area of responsibility. To traverse the CZ safely, current situational updates must be available. The evacuation battalion staff has a responsibility to adequately brief their subordinate units on a recurring basis. The briefing of airspace hazards and restrictions must include information on hazards created by corps artillery units. The locations of friendly and enemy antiaircraft units will become important flight planning factors for the safe entry and exit of medical evacuation aircraft to acquire casualties from supported units. Air ambulance companies will obtain A2C2 information from the division A2C2 section and will coordinate with the DMOC in the divisions under the MSB/FSB design or with the medical battalion headquarters for other divisions.

*d.* The lethality and intensity of the modern battlefield will force medical evacuation aviators to invest the planning time required in ensuring avoidance of battlefield hazards. The ability to reach casualties far forward and survive will be improved by the preflight preparations. Although the natural tendency will be to respond immediately, the preflight preparation is necessary to complete the mission.

### 4-17. Enemy Prisoners of War

Sick, injured, or wounded EPW are treated and evacuated through normal medical channels, but remain physically segregated from US and allied patients. Enemy prisoners of war are evacuated from theCZ as soon as possible. Only those sick, injured, or wounded prisoners who would suffer a great health risk by being evacuated immediately may be treated temporarily in the CZ. Accountability and security of EPW and their possessions in MTFs are the responsibilities of the echelon commander. AMEDD resources are not used to guard EPW. (See FM 19-40 for further information concerning E P W evacuation and control.)

# CHAPTER 5

# HOSPITALIZATION

## 5-1. Hospital System

Hospitalization is part of the theater-wide system for managing sick, injured, and wounded patients.

*a.* The hospital system is specifically designed to provide patients with surgical and medical resuscitative, definitive, and specialty treatment. Patients with rare, unusual, or complex conditions are evacuated to hospitals that can provide them with the needed specialized treatment.

*b.* Within the hospital system, the scope of patient care and treatment capabilities can be adjusted. The adjustment may be to—

- Provide maximum effort for individual patients.
- Manage the extreme disparity between available medical resources and the medical work load (mass casualties). (See Chapter 14 for a discussion on mass casualties.)

## 5-2. Selection of Hospital Sites

*a. Coordination.* Selection of hospital sites in the theater of operations requires coordination at the appropriate levels of command. Within the CZ, the major consideration in selecting hospital sites is the tactical commander's plan. Within the base cluster designated by the operations officer of the unit headquarters, specific hospital sites are selected. During the process of selecting these sites, the HSS planner coordinates closely with the logistics staff officer. This officer has staff responsibility for—

- The specific allocation of real estate.
- Planning and coordinating any construction requirements.

*b. Vulnerability to Enemy Actions.* If possible, a hospital should be located away from a potential tactical target such as an airfield, munition and supply dump, railroad, crossroad, or bridge. A hospital could be collocated at or near a site of likely immunity such as a civilian medical, religious, or educational activity. The radius of damage of anticipated enemy weapons (conventional and NBC) should be considered. When a hospital is to be established within an existing or planned defensive perimeter, it should be located where it can be isolated from potential enemy ground or air action.

*c. Accessibility.* Hospital sites must be accessible, under varying weather conditions, to different means of transportation for patients and to supply and service vehicles. Consideration must also be given to locating the hospital within a reasonable distance from an airfield which can accommodate USAF aircraft performing AE missions.

*d. Availability of Utilities* and Com - *munications.* Adequate utilities (water, sewage, wastewater and human and medical waste disposal, electricity, and communications) are required. Where possible, existing utility systems should be used to meet hospital requirements. During the selection process, consultation and coordination are effected with all designated support units—signal, maintenance, and engineers. Engineer site preparation may include construction of semipermanent or field expedient waste disposal systems.

*e. Topography.* A hospital should be located on ground which is relatively high, level but slightly sloped, clear of obstructions, and which requires minimal engineer preparation. The soil should drain rapidly. Coordination is effected with the supporting engineer unit to ensure site clearance and preparation.

*f. Proximity to Other Facilities.* The hospital should be located away from sites likely to cause problems in maintaining good sanitation. The hospital should also be located away from areas subjected to undue noises, smoke, unpleasant odors, and any other distracting or disagreeable nuisances.

*g. Space.* Space should be sufficient to allow for maximum possible expansion of hospital facilities; that is, space is needed for a recreational area and spaces for storage of supplies, equipment, vehicle parking, motor pool, laundry and bath unit, receiving, shipping, waste collection, and waste disposal. Sufficient space in proximity to the hospital receiving or triage area is also needed for a

helicopter landing site. Special consideration should be given to the x-ray exposure area caused by the facility's x-ray equipment.

*h. Special Consideration for Hospitals Within the Communications Zone*. General hospitals must be appropriately located to support patients received from the CZ and patients transferred from other MTFs within the COMMZ. Sites are selected to take advantage of available road, rail, and water routes and to ensure proximity to air and rail terminals used by US Forces. Other COMMZ hospitals should be located to support large troop populations. Station hospitals are located to support permanent troop populations, and field hospitals (FHs) are located to support populations such as temporary troop concentrations, transients, and prisoners of war. (See FM 8-55 for a discussion on base development.)

*i. Existing Buildings*. The advantages of using existing buildings such as schools or other buildings of opportunity are numerous, especially in terms of NBC contamination avoidance.

## 5-3. Passive Defense of Hospitals

The degree to which MTFs should apply passive defense measures concerns both the tactical commander and the medical unit commander. The overriding fact is that the tactical commander is responsible for all decisions incident to the conduct of tactical operations within his area of responsibility. (See Chapter 3 for a discussion on passive defense.)

## 5-4. Relocation of Hospital Units

*a*. Hospitals within the corps area are not always moved to coincide with redeployment of combat units. Consideration is given to–

- Distance.
- Anticipated duration of the tactical operation.
- Requirements for the movement of the physical facilities.
- Requirements for movement and disposition of the patients.

The capability to treat patients is severely degraded during movement of hospital facilities. This must be considered before a decision to move is made. The displacement of hospitals temporarily reduces the number of beds available. This may result in a greater number of patients being evacuated out of the CZ during the period of relocation.

*b*. Relocation of a hospital will require assistance from many sources to include air and ground ambulances, supporting transportation units, and units with rough terrain forklift capability. Nonorganic transportation requirements are coordinated with the medical headquarters to which the hospital is assigned. The type of transportation used depends upon the means of air and ground transportation available, road and weather conditions, and accessible airfields.

*c*. Personnel must be available to–

- Pack, load, and unload medical supplies and equipment.
- Provide patient care simultaneously at both the old and the new hospital sites.

Personnel requirements for relocation can be reduced by the diversion of incoming patients to another hospital in the area at the time relocation is imminent. Another alternative is to have a separate medical company (clearing) temporarily assume responsibility for patients on hand prior to movement of facilities.

*d*. Health service logistics support must remain responsive even though the hospital is relocating. Sufficient medical supplies and equipment must be on hand to sustain patient care at both old and new hospital sites.

*e*. Hospitals and other medical units in the rear area should be incorporated into the base cluster. The rear area operations center must try to provide security for the MTFs whenever possible. These facilities are so numerous that in many cases the ideal type security will not be available. (See Chapter **3** for a discussion on medics in the defense.)

Medical units that are part of base clusters will be provided security as part of the base defense plan.

## 5-5. Corps Hospitalization

Corps hospitalization is provided by hospitals subordinate to the medical brigade/groups. Hospitalization is provided as close as practical to the troops requiring it. The hospital system is comprised of the MASH, CSH, evacuation hospital, and, if required, FHs. The basis of allocation of hospitals in support of a division is one MASH, one CSH, and two evacuation hospitals. The FH (normally a COMMZ hospital) is allocated as required to augment corps hospitalization. The maximum number of personnel are returned to duty within the CZ. All corps-type hospitals are being equipped with Deployable Medical Systems (DEPMEDS). (See Training Circular [TC] 8-13, Deployable Medical Systems–Tactics, Techniques, and Procedures.)

## 5-6. Mobile Army Surgical Hospital, TOE 08-063H000

*a. Mission.* The MASH provides resuscitative surgery and medical treatment necessary to prepare critically injured and wounded patients for further evacuation.

*b. Assignment.* The MASH is assigned to the medical brigade or to a medical group.

*c. Capabilities.* On a 24-hour basis, the MASH provides–

- Resuscitative surgery and medical treatment necessary to prepare critically injured or wounded patients for further evacuation to definitive treatment facilities.
- Preoperative and postoperative intensive care for a maximum of 60 patients.
- Surgical capability based on staffing to operate four operating rooms on the first shift and two operating rooms on the second shift.
- Laboratory, pharmacy, radiology, and blood banking services.

*d. Basis of Allocation.* The MASH is allocated on the basis of one per division. It is allocated on the basis of one per separate brigade when the brigade is not otherwise supported by a CSH.

*e. Concept of Operation and Employment.*

(1) The MASH is employed near the supported division's rear boundary. Under certain conditions, it may be necessary to employ the MASH forward of the division's rear boundary.

(2) The MASH has no formal evacuation policy. The length of stay is dependent upon the patient's stabilization and readiness for further evacuation.

(3) Patients stabilized for evacuation at the MASH will be further evacuated to the evacuation hospital for definitive treatment or evacuation out of the CZ.

(4) The MASH is the only hospital facility that is considered 100-percent mobile.

## 5-7. Combat Support Hospital, TOE 08-123H000

*a. Mission.* The CSH provides hospitalization for general classes of patients in the CZ.

*b. Assignment.* The CSH is assigned to the medical brigade and is normally attached to a medical group.

*c. Capabilities.* On a 24-hour basis, the CSH provides–

- Resuscitative surgery and medical treatment of critically injured, ill, or wounded patients requiring highly specialized care which wiIl prepare them for further evacuation.
- Surgical and medical services for patients held for definitive treatment.
- Intensive, intermediate, and minimal care for up to 200 patients (40 intensive care patients, 80 intermediate care patients, and 80 minimal care patients).
- Consultation services for outpatients referred from other MTFs.

- Oral surgery and emergency dental treatment to inpatients and hospital staff.

- Clinical laboratory, pharmacy, and radiology services for up to 200 inpatients and for outpatients referred to the hospital for consultation.

- Organic laundry for hospital linens, patient hospital clothing, and unit-owned duty personnel work garments.

*d. Basis of Allocation.* The CSH is allocated on the basis of one per division or division equivalent or one per separate brigade.

*e. Concept of Operation and Employment.*

(1) The CSH is routinely employed farther to the rear of the division boundary than the MASH. It retains the capability to receive and treat those critical patients not regulated to the MASH and provides hospitalization support for the critical and noncritical patients from the division and corps units on an area support basis.

(2) The CSH will routinely evacuate stabilized patients directly to the MASF for evacuation out of the CZ.

(3) The CSH will be employed in an area which may require movement. When the tactical situation demands relocating the unit, its patients must be regulated to other MTFs.

(4) The CSH is capable of transporting 250,000 pounds (13,900 cubic feet) of equipment with organic vehicles. The CSH has 392,000 pounds (44,650 cubic feet) of equipment requiring transportation.

### 5-8. Evacuation Hospital, TOE 08-581H400

*a. Mission.* The evacuation hospital provides the most definitive care for all classes of patients within the CZ.

*b. Assignment.* The evacuation hospital is assigned to the medical brigade and normally attached to a medical group.

*c. Capabilities.* On a 24-hour basis, the evacuation hospital provides–

- Resuscitative surgery and medical treatment of critically injured or sick patients requiring highly specialized care which will prepare them for further evacuation.

- Surgical, oral surgical, and medical services for patients held for definitive treatment.

- Intensive, intermediate, and minimal care ward nursing service for 400 patients. Four intensive care wards provide nursing care for up to 40 patients, eight intermediate care wards provide nursing care for up to 160 patients, and ten minimal care wards provide nursing care for up to 200 patients.

- Consultation services for patients referred from other MTFs.

- Primary medical outpatient service for organic personnel only.

- Clinical laboratory, pharmacy, and radiology services for up to 400 patients and for outpatients referred to the hospital for consultation.

- Medical administrative services to support work loads designated above.

- Dental treatment to staff and patients and oral surgery support for military personnel in the immediate area plus patients referred by area support dental detachments.

*d. Concept of Operation and Employment.*

(1) Some patients will be evacuated to the evacuation hospital either for additional treatment or stabilization prior to evacuation to the MASF.

(2) The evacuation hospitals are located in the corps rear and receive patients from throughout the CZ.

(3) The evacuation hospital will normally be employed in an area which does not require frequent relocation.

(4) This unit is capable of transporting 159,000 pounds (7,700 cubic feet) of equipment with organic vehicles. It has 572,600 pounds (65,500 cubic feet) of equipment requiring transportation.

## 5-9. Hospitalization Within the Communications Zone

*a*. Hospitalization in the COMMZ is provided by units subordinate to the MEDCOM. Hospitalization is provided for Army patients originating in the COMMZ and for those received from the CZ. Hospitalization of patients of other Services is provided as directed by higher headquarters. Hospitalization requirements must be forecast so that MTFs can be constructed in advance of the time they are to be occupied. All COMMZ-type hospitals are being equipped with DEPMEDS. These hospitals depend on the availability of technical assistance, labor, and support from engineer units. Two or more GHs and other supporting medical units may be grouped under the command and control of a hospital center headquarters.

*b*. The types of TOE hospitals normally employed in the COMMZ are the 400-bed FH, the 300- or 500-bed station hospital, and the 1,000-bed GH. The number of each type of hospital and the total number of beds may be determined by computing total bed requirements in the COMMZ. (See FM 8-55 for a discussion on estimating bed requirements.)

## 5-10. Field Hospital, TOE 08-510H600

*a*. *Mission.* The FH provides hospitalization for troops in the COMMZ when temporary hospital facilities are required in certain designated areas. It may also be employed within the corps.

*b. Assignment.* The FH is assigned to the TA MEDCOM (the medical brigade in the CZ) and normally is attached to a medical group headquarters.

*c. Capabilities.*

(1) At full strength, it is capable of providing hospitalization and treatment for up to 400 patients when operating at a single location. This unit can also provide oral surgery and emergency dental treatment to inpatients and hospital staffs. It maybe divided into three 100-bed MTFs (called "hospitalization units" [HU]), each of which is capable of operating in a separate location for a limited period of time. Each HU is capable of separate operations and provides nursing care for up to 10 intensive care patients, 60 intermediate care patients, and 30 minimal care patients.

(2) The three HUs also provide additional capabilities in the handling of mass casualties by performing the functions of receiving and sorting patients, providing emergency medical and surgical care, and preparing patients for further evacuation. The hospital receives patients from its area of responsibility and evacuates those patients requiring care beyond its capabilities to the nearest hospital that can provide the required treatment.

*d. Mobility.*

(1) This unit is capable of transporting 78,000 pounds (9,750 cubic feet) of equipment with organic vehicles.

(2) This unit has 211,000 pounds (17,750 cubic feet) of equipment requiring transportation.

*e. Concept of Operations.* The FH and its HUs normally are employed in any area of the COMMZ to provide temporary area HSS. For example, an FH or HU is often located in the marshaling area for a large airborne operation. The marshaling area is the general area in which unit camps and departure airfields are located and from which the air movement is initiated. In amphibious operations, it is the designated area in which as part of the mounting process–

- Units are reorganized for embarkation.
- Vehicles and equipment are prepared to move directly to embarkation areas.
- Housekeeping facilities are provided for troops by other units.

When operating independently from the hospital headquarters element for extended periods, each

HU must be augmented with administrative and logistical personnel. As stated earlier, the FH may also be employed in a corps area to augment CZ hospitals, and it may be assigned a mission of providing care and treatment for an indigenous population, displaced persons, or EPW, and as a holding facility for recovering patients.

### 5-11. Station Hospital, TOE 08-233H700 (300 Beds) and TOE 08-253H700 (500 Beds)

*a. Mission.* The station hospital provides hospitalization to include limited outpatient services to the military population of an installation or specified geographical area.

*b. Assignments.* The station hospital is assigned to the MEDCOM and is normally attached to a medical group. It may be attached to a hospital center.

*c. Capabilities.* Station hospitals provide hospitalization in two configurations: 300- and 500-bed hospitals. Hospitalization for the 300-bed hospital includes up to 30 intensive care patients, 180 intermediate care patients, and 90 minimal care patients. Hospitalization for the 500-bed hospital includes up to 50 intensive care patients, 300 intermediate care patients, and 150 minimal care patients. Station hospitals also provide–

- Area optometry service.
- Dental service to inpatients.
- Limited outpatient services in specialties provided.
- Four operating rooms during the first shift and two operating rooms during the second shift (TOE 08-253H0).

*d. Concept of Operations.* These hospitals operate in semipermanent or permanent facilities and receive all classes of patients in their assigned geographical areas of responsibility. When the situation requires, they may receive patients as overflow from the GHs or directly from CZ hospitals. Patients requiring treatment beyond the capabilities of station hospitals require evacuation to the nearest GH. Those patients who cannot be RTD within the theater evacuation policy and who have been stabilized for evacuation to CONUS are processed through the USAF to ASF for evacuation. Patients who can be returned to duty in-theater but who require the reconditioning available in a convalescent center will be transferred to that facility without first going to a GH.

*e. Mobility.*

(1) Table of organization and equipment 08-233 H700.

*(a)* This unit is capable of transporting 31,500 pounds (2,250 cubic feet) of equipment with organic vehicles.

*(b)* This unit has 52,950 pounds (6,100 cubic feet) of equipment requiring transportation.

(2) Table of organization and equipment 08-253 H700.

*(a)* This unit is capable of transporting 31,500 pounds (2,250 cubic feet) of equipment with organic vehicles.

*(b)* This unit has 261,400 pounds (20,850 cubic feet) of equipment requiring transportation.

### 5-12. General Hospital, TOE 08-303H800

*a. Mission.* The GH provides specialized and definitive hospitalization to the theater army.

*b. Assignment.* The GHs are assigned to the MEDCOM and normally are attached to a hospital center. These hospitals are the primary recipients of patients from all hospitals in the theater. These hospitals will receive patients from direct admissions on an area basis.

*c. Capabilities.* Capabilities of the GH include specialized care and treatment, as well as facilities for studying, observing, and treating serious, complicated, or obscure conditions. The GH operates in relatively permanent facilities and would rarely be moved. Nearly all medical and

surgical specialties are available within the hospital. Patients at the GH may be designated for RTD, moved to a convalescent center, transferred to another GH, or evacuated to CONUS. At full strength the GH provides–

(1) Hospitalization for 1,000 patients (up to 100 intensive care, 600 intermediate care, and 300 minimal care patients).

(2) Area optometry service.

(3) Dental service to inpatients and hospital staff.

(4) Limited area HSS and outpatient services in medical specialties.

(5) Six operating rooms during the first shift and two operating rooms during the second shift.

*d. Mobility.*

(1) This unit is capable of transporting 60,500 pounds (5,100 cubic feet) of equipment with organic vehicles.

(2) This unit has 587,850 pounds (49,850 cubic feet) of equipment requiring transportation.

*e. Concept of Operations.* General hospitals are the major link in the chain of evacuation and treatment for patients who cannot be returned to duty within the CZ. They provide the most definitive and sophisticated hospitalization and treatment in the TA. Patients at the GH may be designated for RTD, moved to a convalescent center, or evacuated out of the theater.

## 5-13. Nonhospitalization Facilities

There are two nonhospitalization facilities that provide inpatient care in the theater: the medical company (clearing) and the convalescent center.

*a.* Although not a hospital by definition and not included in planning for theater bed requirements, the medical company (clearing) is in the hospitalization category. It provides temporary holding capacity and limited inpatient care. Medical companies (clearing) attached to corps or medical battalions establish clearing stations through the corps area to receive patients from nondivisional areas.

*b.* While the convalescent center is not a hospital, it is the facility where the convalescent care phase of HSS is provided. This phase entails guiding the patient from the time he has recovered from his injury or disease to the time when he has sufficient physical strength and stamina to perform his job effectively. A convalescent center may be assigned to the medical brigade to permit rapid restoration of patients to full duty. Patients from corps hospitals requiring only convalescent care and reconditioning are transferred to the convalescent center pending their RTD.

## 5-14. Medical Company (Clearing), TOE 08-128H400

*a. Mission.* The mission of the medical company (clearing) is designed to–

- Receive, sort, and provide emergency or resuscitative treatment for patients until they are evacuated.

- Provide definitive treatment for patients with minor illnesses or injuries.

*b. Assignment.* The medical company (clearing) is assigned to the TA MEDCOM on the basis of one per division supported in the CZ or to corps medical brigade as required. It normally is attached to a medical group or nondivisional medical battalion for command and control.

*c. Capabilities.* At full strength, the medical company (clearing)–

- Operates a single treatment facility with a maximum capacity of 240 patients or up to three clearing facilities, each of which has a maximum capacity of 80 patients.

- May be employed either to expand hospital capacities or to serve as a provisional holding convalescent facility. When augmented with medical professional and ancillary service

teams, this unit can provide increased specialty support.

- May be assigned the responsibility forproviding area or Echelon II HSS.

- Provides a holding capability when augmenting the medical treatment platoon of a division medical company or the medical support company when they are awaiting reconstitution.

- Provides laboratory, pharmacy, and radiology services commensurate with level of treatment provided.

- Provides Echelon I medical supply and resupply support.

- Provides outpatient consultation services for patients referred from Echelon I care.

*d. Mobility.*

(1) This unit is capable of transporting 162,000 pounds (8,100 cubic feet) of equipment with organic vehicles.

(2) This unit has 20,000 pounds (1,350 cubic feet) of equipment requiring transportation.

*e. Concept of Operations.* The medical company (clearing) is attached to a medical battalion or group and used where required. The company, or one or more of its platoons, may operate as a provisional holding unit at such points as airstrips, railheads, ports of debarkation and embarkation, and on feeder roadnets. The company may be used to establish and operate small specialized treatment centers such as psychiatric treatment stations by augmentating it with psychiatric service detachment, Team OM, TOE 620. The clearing company has no significant postoperative capability; therefore, when the company is established as a specialized treatment center involving the care of postsurgical patients, it must be augmented with appropriate nursing service personnel and equipment. The medical company (clearing) is the lowest echelon of care that stores and transfuses blood. All blood will be liquid Group O packed red cells.

**5-15. Convalescent Center, TOE 08-590H500**

*a. Mission.* While the convalescent center is not a hospital, its mission is to provide facilities for recuperating patients who require additional reconditioning before they are returned to duty. The convalescent care phase guides the patient from the time he has recovered from his injury or disease to the time when he has sufficient physical strength and stamina to perform his job effectively.

*b. Assignment.* The convalescent center is assigned to the TA MEDCOM and further attached to a hospital center on the basis of one per 10,000 beds required or a corps medical brigade on an as needed basis.

*c. Capabilities.* The convalescent center consists of a headquarters; an administrative service, a clinical service, and a reconditioning battalion. It is also capable of providing outpatient medical, dental, and optometric care.

(1) The operation of the clinical service is supervised by a senior Medical Corps officer designated by the center commander. The clinical service is comprised of medical, surgical, dental, pharmacy, laboratory, and x-ray sections. The service provides examining, treating and reclassification at periodic intervals so that patient reconditioning may take place in the least amount of time. During the time a patient is at the center, the clinical service is provided with information concerning his exercise tolerance, rate of progress, and reconditioning activities. Whenever practicable, patients originating from the same unit are assigned to the same reconditioning company to maintain morale and esprit de corps.

(2) The reconditioning battalion consists of a headquarters and six reconditioning companies. Each company has a capacity of 200 patients and is designed to provide the type of exercise (light, moderate, or heavy) required by patients. The initial assessment of patients and their rate of progress through the various reconditioning companies are based upon a medical appraisal of their physical status and the evaluation of their exercise tolerance, rate of progress, noncommissioned officer patients are used whenever possible as platoon leaders and instructors in the various phases of the

reconditioning program, including athletic, recreational, and educational activities. Screening for qualifications, special abilities, and combat experience of all patients upon admission affords the opportunity for selecting an individual with the proper background and training for the performance of these duties. When these convalescent patients are physically and mentally fit, they are designated for RTD.

*d. Mobility.*

(1) This unit is capable of transporting 50,000 pounds (3,850 cubic feet) of equipment with organic vehicles.

(2) This unit has 151,300 pounds (10,750 cubic feet) of equipment requiring transportation.

*e. Concept of Operations.* The convalescent center is established in either the CZ or the COMMZ. Its purpose is to prevent unnecessary evacuation of patients who require only convalescent care and physical reconditioning prior to returning to duty. It is not considered a hospital when estimating bed requirements. Its primary function is not that of an MTF.

## 5-16. Army Medical Department Cellular Units

As stated in Chapter 2, AMEDD cellular units may be needed to perform certain medical support functions or to augment capabilities. The following teams provide some of these functions or augment capabilities:

*a. Medical Administrative Teams, TOE 08-610H0.* Medical administrative teams provide facilities or augment existing services of fixed MTFs or provide special type services in the COMMZ as indicated below:

- Team PA, medical illustration.
- Team PB, admission and disposition.
- Team PC, patient records (small).
- Team PD, patient records (medium).
- Team PF, patient records, reports, and statistics.
- Team PG, patient holding.

*b. Area Medical Support Teams, TOE 08-620H0.* Area medical treatment teams provide area HSS for troops not otherwise supported, as follows:

- Team OA, dispensary, provides dispensary service for approximately 1,000 troops.
- Team OB, general dispensary, provides dispensary service for an area with a troop population of 1,000 to 5,000 troops.
- Team OC, general dispensary, provides dispensary service for an area with a troop population of 5,000 to 10,000 Troops.

*c. Medical Professional Teams, TOE 08-630H0.* These teams increase the patient treatment capabilities of fixed strength medical units where less than company size functional augmentations are required. They are allocated on the basis of the troop strength supported and are attached to the hospitals where the particular specialties are most needed.

(1) The following surgical service teams (except for Team KC) are used to augment any medical unit or facility that is organically capable of performing major surgery:

- Team KA, surgical.
- Team KB, orthopedic.
- Team KC, shock intensive care. (Provides special procedures directed toward prevention and treatment of shock. It may be used to augment any MTF which requires additional resources for prevention or treatment of shock or for intensive care.)
- Team KD, maxillofacial.
- Team KE, neurosurgical.
- Team KF, thoracic.
- Team KG, anesthesiology.

- Team KH, ophthalmology.
- Team KI, ears, nose, and throat.

(2) The following medical service teams may augment any MTF providing patient care within their indicated specialities:

- Team LL, dermatology.
- Team LN, renal and electrolyte metabolism, augments a fixed hospital in the COMMZ by providing specialized care for patients with acute renal failure.

(3) The following miscellaneous service and support teams may augment any medical facility which has professionally qualified supervisory personnel and, for Team MP, required cleaning and sterilizing equipment.

- Team MM, laboratory.
- Team MN, radiology.
- Team MO, pharmacy.
- Team MP, central materiel service.

*d. Medical Facility Expansion Teams, TOE 08-640H1*. These teams perform medical professional and ancillary service functions in support and as a part of expanded fixed strength MTFs. They are allocated on the basis of the number of beds by which a hospital's patient capacity is expanded.

(1) The following physical reconditioning teams are normally attached to a convalescent center to expand its capabilities.

- Team LO, reconditioning battalion headquarters, provides command and control for two to six reconditioning companies (Team LP).
- Team LP, reconditioning company, provides reconditioning for up to 200 patients expected to RTD under existing evacuation policies.

(2) Pharmacy, laboratory, and x-ray teams include–

- Team MQ, pharmacy, lab, and x-ray control, provides coordination, professional supervision, and control for Teams MR, MS, and MT.
- Team MR, pharmacy, which is allocated on the basis of 1 per 200 expansion beds required.
- Team MS, clinical laboratory, which is allocated on the basis of 1 per 200 expansion beds required.
- Team MT, x-ray, which is allocated on the basis of 1 per 100 expansion beds required.

(3) Medical and surgical service teams include–

- Team QA, medical service control, provides supervision and control for treatment elements providing services for 100 to 300 medical inpatients.
- Team QB, surgical service control, provides supervision and control for surgical elements providing services for 100 to 300 surgical inpatients.
- Team QC, outpatient service, provides hospital units with an additional outpatient capability to support a population of 3,000 to 5,000 troops.
- Team QD, inpatient medicine, expands the inpatient capability of a MTF by 30 to 50 inpatients.
- Team QE, inpatient surgery, performs surgery, normally as a single operative team.
- Team QF, inpatient convalescent care, provides professional services and control of 75 to 100 convalescent patients and up to 400 patients undergoing reconditioning.
- Team QG, physical therapy (PT), provides PT services for 30 to 50 inpatients per day.

(4) Nursing service teams provide professional nursing services for up to the number of expansion beds as follows:

- Team SA, nursing service control, supervises nursing personnel in support of 100 to 300 inpatients.
- Team SB, nursing ward control, supervises and controls two Teams SF, two to four Teams SG or SH, or one Team SI.
- Team SE, centralized materiel service control, supervises and controls two to six Teams SJ.
- Team SF, intensive care ward nursing, which is allocated on the basis of 1 per 10 intensive care expansion beds required.
- Team SG, intermediate care ward nursing, which is allocated on the basis of 1 per 20 intermediate care expansion beds required.
- Team SH, minimal care ward nursing, which is allocated on the basis of 1 per 20 minimal care expansion beds required.
- Team SI, convalescent care ward nursing, which is allocated on the basis of 1 per 100 convalescent care expansion beds required.
- Team SJ, centralized materiel service, prepares, processes, sterilizes, stores, and issues medical and surgical supplies in support of up to 100 expansion beds.

**5-17. Patient Care at Staging Facilities**

The USAF Military Airlift Command has the responsibility for AE of patients from the CZ to the COMMZ and from the COMMZ to the ZI. This responsibility includes patient care while in flight and at staging facilities. Two types of staging facilities support patient care in the USAF system:

*a. Fixed Aeromedical Staging Facilities.* These facilities, operating transient patient beds, are located on or in the vicinity of an enplaning or deplaning air base or an airstrip. The ASFs vary in capacity from 50 to 250 beds. For patients entering, en route, or leaving the AE system, ASFs provide–

- Reception.
- Limited administrative support.
- Ground transportation.
- Feeding.
- Supportive (rather than definitive) medical care.

b. Mobile Aeromedical Staging Facilities.

(1) The MASF is a mobile, tented, temporary staging facility deployed to provide supportive casualty care and administration. Each MASF is capable of routinely holding and processing 25 patients at any given time. It is not intended to hold casualties overnight or for an extended period of time.

(2) MASFs are located near the runways or taxiways of airfields or forward operating bases that are used by tactical airlift aircraft to resupply combat forces. Each MASF deploys with sufficient medical supplies and equipment to sustain its casualty staging operation for 5 days. If it is to be deployed for a longer period or will receive more casualties than normal capability, it must be resupplied. The MASF is dependent upon the host base to supply food, water, billeting, petroleum, oils, and lubricants (POL), and provide general support.

(3) The MASFs have no organic patient transportation capability. Therefore, the user service is responsible for patient transportation to and from the MASF.

(4) Patients entering the AE system at a MASF should be on a litter with two straps and a blanket; they must be accompanied by required medical supplies and equipment such as respirators and cardiac monitors to allow continuation of required therapy.

(5) The MASFs have no organic patient food service and are dependent on local base food service support, or provision of patient needs by the using Service.

(6) Staffing in a MASF includes flight nurses, AE technicians, and radio operators. Supportive medical care to casualties transiting the MASF is provided by AE technicians under the supervision of a flight nurse. There are no physicians assigned. The radio operators operate the MASF high-frequency radio linking the MASF to the AE communication net.

(7) The MASFs are responsible for–

- Receiving casualties designated for AE from the user service forward MTFs.
- Providing supportive, not definitive, medical care to casualties while awaiting airlift.
- Performing limited administrative support.

### 5-18. Military Police Support of Hospitals and Convalescent Centers

Military police support for medical facilities is provided on an area basis as part of their area security mission. Additional military police support to such facilities should be coordinated through the commander responsible for rear area security.

### 5-19. Communications

*a.* Communications are essential for gathering data, planning hospital operations, performing command and control functions, and supervising performance. Effective management depends greatly upon adequate communications to keep abreast of changing situations. Hospital commanders and their staff must carefully plan for available communications systems, to include host-nation systems.

*b.* Each hospital within the CZ and COMMZ is required to establish and maintain continuous communications with–

- Its higher headquarters.
- Other hospital units, the supporting medical supply, optical, and maintenance (MEDSOM ) unit, and the supporting blood supply unit.
- Other medical headquarters whose units are providing medical evacuation and other specialized medical support.
- Agencies providing them with essential base support.

c. Essential base support includes–

- Staff judge advocate (legal) services.
- Appropriate civil affairs agencies.
- Supporting signal units.
- Supporting personnel units for replacements.
- Supporting maintenance units.

*d.* Hospital units are equipped with organic communications systems which include combat net radios (with FM and improved high-frequency radio [IHFR] capabilities), computers, and mobile subscriber equipment. Other capabilities include telephones with data ports, mobile telephones, facsimile, and teletype. The hospital commander, as well as all medical commanders, must fully understand the total Army communications system, communication systems redundancy, and the area support capabilities provided by the supporting signal element to ensure that their unit's signal requirements can be met. For example, if the area signal system cannot support the automatic transfer of data within the capabilities of the available automated data processing system, then a disk transfer (courier service) may have to be used. In the case of voice telephone incapability during an employment phase, the FM radio or IHFR may become the primary means of communications. (See FM 24-1 and FM 24-35 for a more complete and detailed discussion on Army communications. Also see Chapter 13 for a discussion on the TAMMIS.)

### 5-20. Other Services

Other support services are provided by augmentation or separate units. These include finance, laundry and bath, personnel, and mortuary affairs.

### 5-21. Hospitalization in the Zone of the Interior

Hospitals in the ZI furnish the fifth echelon of HSS. They are fixed hospitals and consists of–

• US Army medical centers (MEDCEN).

• US Army medical department activities (MEDDAC).

• Other federal hospitals (Navy, Air Force, and Veterans Administration).

• Contract civilian facilities.

Figure 5-1 depicts the echelons of HSS.

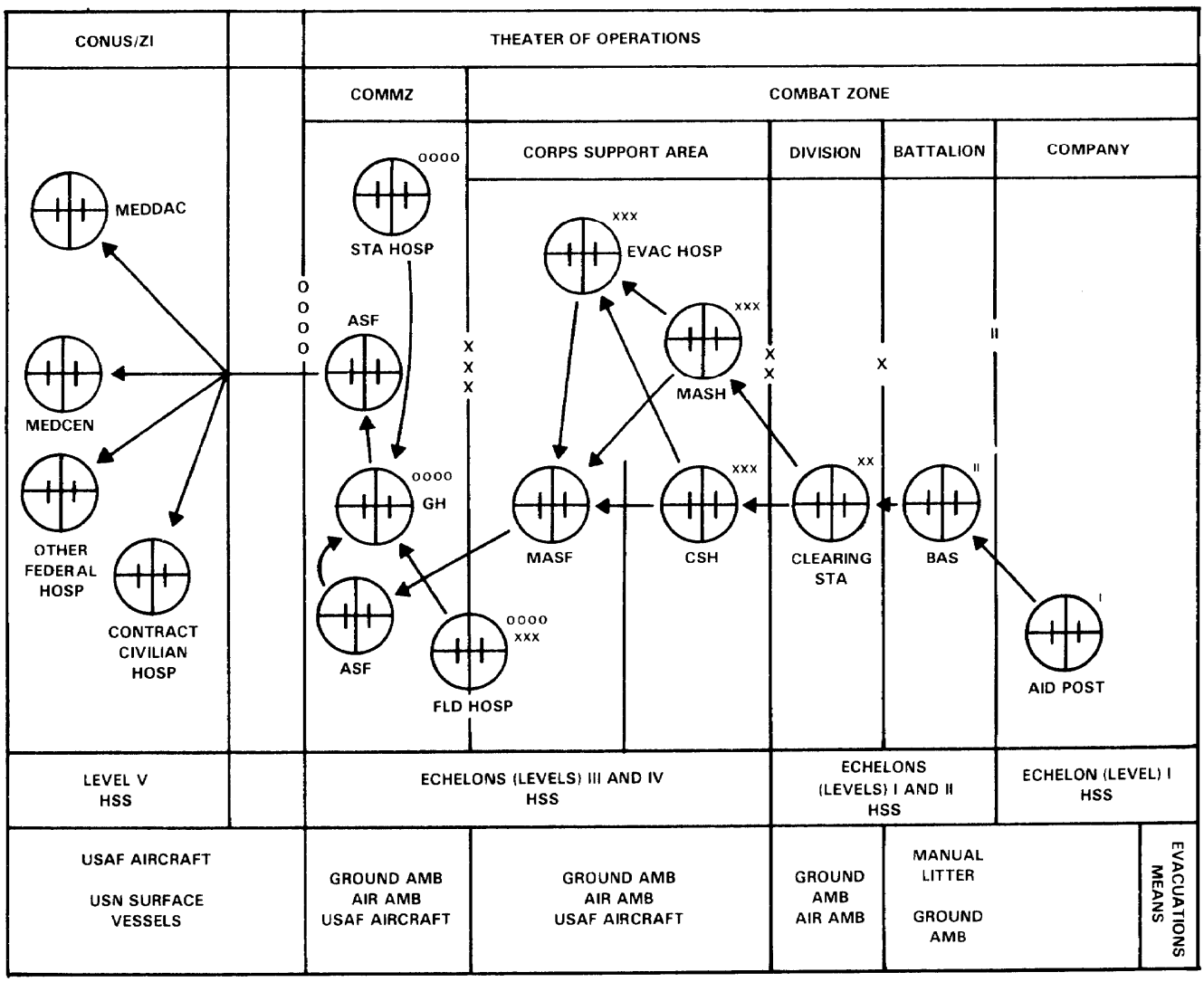



*Figure 5-1. Echelons of HSS (current).*

## 5-22. Medical Force 2000 Hospitalization Units

The TOE H-edition units will be rescinded when the units are converted to the Medical Force 2000 L-edition TOE. The hospital units envisioned under Medical Force 2000 are described in Appendix B.

# CHAPTER 6

# HEALTH SERVICE LOGISTICS

## 6-1. The Health Service Logistics System

Health service logistics support is an integral part of the HSS system. Health service logistics includes medical supplies and equipment, medical equipment maintenance, and optical fabrication. Without the proper mix of supplies and equipment on hand, there is no HSS.

*a.* Medical supplies (Class VIII) consist of medical materiel to include medical-peculiar repair parts used to sustain the HSS system. The Class VIII system is under the direction of The Army Surgeon General. It is a specialized subsystem of the Army's logistics system. The Class VIII system basically follows the requirements of the AR 700 series with exceptions provided in AR 40-61. (See Appendix K for a description of the classes of supply.) Certain *characterstics* set the Class VIII system apart from the other commodities, and they place unique requirements on Army medical materiel managers. These characteristics are—

- The protected status afforded Class VIII supplies under the provisions of the Geneva Conventions. It is therefore necessary to store and distribute medical materiel separately from other classes of supply for it to be considered protected materiel.

- The overriding requirements for a materiel system that is immediately and completely responsive to the health care providers.

- The integral function that health service logistics plays in the patient treatment and evacuation system for which The US Army Surgeon General has sole responsibility.

- The highly technical nature of the commodity and its extensive regulation by the federal government. Medical materiel must be stored under tightly controlled conditions and managed by highly trained professionals who are thoroughly knowledgeable in the specialized requirements of this commodity.

*b.* Medical equipment maintenance ensures that life-sustaining equipment is fully mission capable. This support must be provided as far forward as possible. Maintenance planning must be conducted concurrently with supply planning as the two areas are closely related. A good maintenance program will relieve strain on the supply system by identifying and repairing equipment that would otherwise require replacement. Proper authorized stockage list management improves maintenance turnaround time when repair parts are required beyond prescribed load list stockage capability.

*c.* Optical support includes–

- Fabrication of single-vision and multivision prescription lenses.

- Fabrication of standard spectacles.

- Fabrication of aviation spectacles.

- Fabrication of protective mask inserts.

- Military standard spectacle frame repair.

## 6-2. Development of Health Service Logistics

The TA surgeon advises the TA commander in the development of the health service logistics system. The TA surgeon—

- Provides medical staff advice to the commander on health service logistics.

- Ensures that an adequate health service logistics system exists to meet the needs of the Service.

- Recommends policy and sets priorities.

- Plans and supervises technical inspections of the system.

- Determines TA requirements for medical equipment and supplies.

- Exercises staff supervision over the requisitions, procurement, storage, maintenance,

distribution, and documentation of Class VIII supplies and equipment.

• Provides support to other military Services and to civilian communities, as required. The HSS for military operations is normally provided on an area basis and must be coordinated with the component concerned. Requirements to support civilian communities are developed in coordination with the Deputy Chief of Staff, Host Nation Activities.

### 6-3. Command and Control

*a.* The MEDCOM and medical brigade(s) or group(s) exercise command and control over the MEDSOM units.

*b.* To TA, the basis of allocation for MEDSOM units is as follows:

• In the CZ, one MEDSOM unit per four-division corps.

• In the COMMZ, one MEDSOM unit per corps supported.

*c.* The successful operation of the health service logistics system is directly dependent upon—

• Integration with the complete HSS effort.

• Supervision by appropriate command surgeons.

• Anticipatory and proactive support rather than reactive support.

### 6-4. Communications

The MEDSOM units operating in either the CZ or the COMMZ communicate with supporting and supported units by voice, teletype, and data transmission. Corps MEDSOM units deal with the medical supply activities of divisions and brigades supported. They also serve all corps hospitals that rely on them for medical supplies. In the CZ and the COMMZ, communications are established with the appropriate movement control center for throughput of supplies. Other units with whom communications are established include personnel and administration, supply and services, engineers, and nonmedical maintenance. See Chapter 13 for a discussion on the TAMMIS Medical Supply, Medical Maintenance, and Optical Fabrication (MEDSUP, MEDMNT, and MEDOPT) System.

### 6-5. Health Service Logistics in the Combat Zone

*a. Medical Resupply.*

(1) Although the combat medic carries a basic load that includes the same items that the combat lifesaver carries, it is unlikely that he will have the time or the capability to handle the logistical burden of resupplying the combat lifesaver. Therefore, resupply of the combat lifesaver is accomplished through the normal resupply channels of the maneuver company. The combat lifesaver is resupplied with Class VIII materiel in the same manner as any individual soldier/section/team is resupplied with other classes of supply. However, the exception is that the BAS is the forward supply point for Class VIII materiel. The maneuver unit, therefore, reorders those lines required by the combat lifesaver from the supporting BAS, medical company, or division medical supply office (DMSO). Combat lifesavers in nondivisional units will obtain resupply support from the nearest medical unit capable of supporting them.

(2) Resupply of the combat medic is the responsibility of the BAS. This mission is handled and supervised by medical personnel. The combat medic requests his supplies from the BAS. This action is not a formal request so it can be oral or written. The requests are delivered to the BAS by whatever means available. Usually this will be accomplished by the driver or the medic in the ambulance returning to the BAS with patients. The ambulance will then transport the requester's supplies forward from the BAS to the combat medics. This system is referred to as backhaul. Commonality of supplies between the combat medic and the ambulance equipment set may allow the ambulance crew to fill the combat medic's request from onboard stock. The ambulance crew can then replenish their stocks upon returning to the BAS.

(3) Resupply of forward deployed BASs in a heavy division is the responsibility of the medical company of a FSB. In those divisions not under the MS13/FSB design, resupply of the BAS is the responsibility of the supporting medical company. Medical supply personnel operate a resupply point for the BAS of the maneuver battalions based on supply point distribution. When normal transportation is not available, backhaul transportation of medical supplies using returning ambulances, both air and ground, is an alternative method of moving medical supplies to the maneuver battalions. Coordination for forward movement is the responsibility of the medical platoon leader of the maneuver battalion.

(4) Resupply of the medical companies of the heavy or the light division is by the DMSO. The DMSO has the responsibility to provide medical supply support to all units within the division area. Requests may come by message with returning ambulances (ground or air), by land line, or through existing FM command nets within the division. Requests for medical supplies from BASs and medical companies are filled or forwarded to the supporting CZ ME DSOM. Whenever possible, the DMSO should anticipate demands and push supplies forward based on known operational objectives.

(5) Resupply of the DMSO is provided by the CZ MEDSOM unit. Liquid blood supply of the DMSO is provided by the CZ blood supply unit.

(6) Resupply of the CZ MEDSOM is received through the COMMZ MEDSOM or by direct shipments from CONUS. The CZ MEDSOM unit is normally under the direct command and control of the medical brigade headquarters. It provides medical supply, medical equipment maintenance, and optical fabrication services for units in the CZ area. The CZ MEDSOM establishes the Class VIII supply point in the corps area. Shipment of medical supplies forward is coordinated with the corps movement control center. Emergency resupply will be accomplished by air ambulance.

*b. Medical Maintenance.*

(1) Medical maintenance is the responsibility of the unit commander. The scope of medical maintenance ranges from the maintenance functions for basic mechanical equipment to complicated medical electronic equipment such as x-ray machines. If an item of medical equipment in the BAS requires unit maintenance, it is transported to the medical company for maintenance. Medical maintenance support is provided by the medical equipment repairer (unit) assigned to each medical company. If an item of equipment cannot be repaired at unit level (UL), then the unit must notify the DMSO who will transport the equipment to the corps MEDSOM unit supporting it or request a mobile support team from the MEDSOM unit. The equipment will be serviced if the maintenance service falls within the capability of the MEDSOM unit. Any equipment requiring service beyond the capability of the CZ MEDSOM will be evacuated to the COMMZ MEDSOM unit.

(2) Low-density lifesaving diagnostic and therapeutic equipment will be repaired or replaced immediately. The ME DSOM units will maintain a medical standby equipment program (MEDSTEP) of designated items. Direct exchange of low-density lifesaving equipment through the use of ME DSTEP may be employed if necessary. Reparable exchange (RX) assemblies, modules, and/or printed circuit boards (PCBs) will also be used to maintain high operational availability rates.

## 6-6. The Division Medical Supply Officer

*a*. The DMSO, located in the division's medical battalion (light division) or the MSB (heavy division), is responsible for providing medical supply and medical maintenance support to the medical treatment element within the division. As stated previously, the division surgeon (with the assistance of the DMOC in the heavy division) plans for HSS. The DMSO executes health service logistics plans. He exercises his responsibilities by–

- Procuring, storing, and issuing Class VIII supplies.
- Coordinating with the supported elements to determine requirements for Class VIII materiel and liquid blood.

• Developing and maintaining authorized stockage levels of contingency medical supplies. These levels should be based upon transportation and storage constraints as well as characteristics of the area of operations.

• Managing the division's health service logistics quality control program.

• Supervising the unit-level medical equipment maintenance program.

• Monitoring the division medical assemblage management program.

• Coordinating logistical planning for the assembly, packing, and delivery of standard medical supply sets and locally developed, unit-peculiar resupply bundles.

• Providing guidance to units for calculating unit requirements for preventive medicine.

• Establishing and operating a division Class VIII supply point.

*b.* The reconstitution duties of the DMSO include—

• Reconciling by brigade the shortages in each medical company and treatment platoon as reported by the commander, platoon leader, or the battalion headquarters element.

• Coordinating with the medical battalion commander or the DMOC to determine and acquire the number of medical assemblages required to ensure units maintain medical readiness.

• Coordinating with the CZ MEDSOM to monitor the status of requisitions for medical assemblages due in.

• Coordinating through the medical battalion commander or the DMOC–

• With the DMCC for movement of bulk supplies or assemblages from the DMSO to forward units when backhaul would be inadequate. (The commander or the DMOC directs quick fixes using available assets and controlled exchanges for medical equipment to maximize the capability of returning trained soldiers to duty. )

• With the corps movement control center (MCC) for delivery of supplies from the MEDSOM unit to the DMSO.

• Alerting the appropriate company when modular systems are due to arrive.

• Distributing modular medical assemblages to the units based on guidance from the commander or the DMOC. (The DMSO coordinates with the DMCC, through the DMOC, for transportation assets to deliver modular medical assemblages to the unit being reconstituted.)

• Preparing the critical items listing and consolidating the critical shortages by brigade.

*c.* Division medical maintenance services are provided by organic personnel.

(1) *Operator/user* maintenance. Responsibilities of personnel include—

• Performing operator preventive maintenance checks and services (PMCS).

• Coordinating maintenance services beyond their capability with unit maintenance specialists.

• Maintaining equipment by performing routine services. (Some examples of these services are cleaning, dusting, washing, and checking for frayed cables and loose hardware.)

• Performing equipment operational testing.

• Replacing operator-level spare and repair parts that will not require—

• Extensive disassembly of the end item.

• Critical adjustment after replacement.

• Extensive use of tools.

(2) *Unit-level maintenance.* Responsibilities of divisional medical equipment repairers include—

- Scheduling and performing services. (Services include PMCS functions. electrical safety inspections and tests, and calibration, verification, and certification. )

- Performing unscheduled maintenance functions with emphasis upon the replacement of assemblies, modules, and PCBs.

- Operating a medical equipment repair parts program to include Class VIII as well as other commodity class parts.

- Maintaining a technical library of operator and maintenance technical manuals (TMs) and/or associated manufacturers' manuals.

- Conducting inspections for new or transferred equipment.

- Maintaining documentation of maintenance functions in accordance with the provisions of Technical Bulletin (TB) 38-750-2 or DA standards automated systems.

- Collecting and reporting data for readiness reportable medical equipment.

- Notifying the CZ MEDSOM battalion of requirements for maintenance support services, RX, or MEDSTEP assets.

## 6-7. Health Service Logistics in the COMMZ

*a.* The COMMZ MEDSOM unit provides health service logistics support in the COMMZ. This includes providing backup support to the CZ. The COMMZ MEDSOM unit is organized under the same TOE as the CZ MEDSOM unit. The organization is shown in Figure 6-1. It is assigned to the MEDCOM on the basis of one per corps supported.

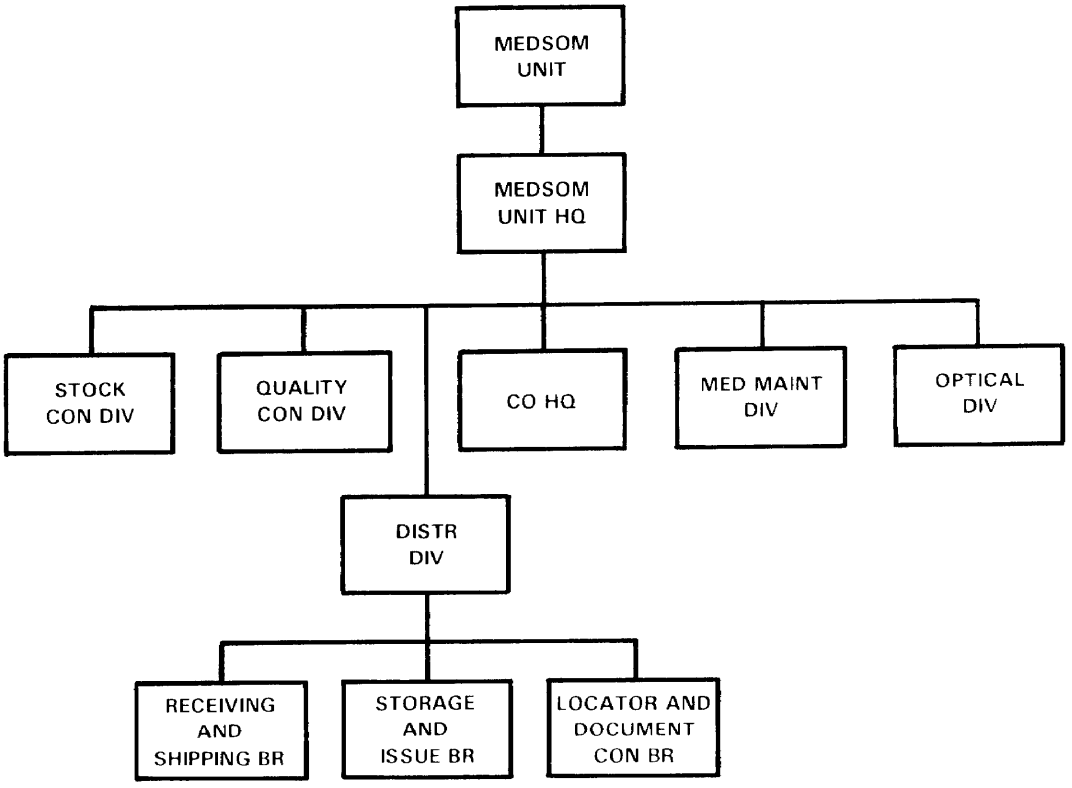



*Figure 6-1. Medical supply, optical and maintenance unit.*

*b*. The MEDCOM may have a COMMZ MEDSOM unit augmented with medical logistics support teams as outlined in paragraph 6-8. This unit will work under the direction and supervision of the MEDCOM assistant chief of staff for supply, maintenance, and services. The COMMZ MEDSOM unit with required augmentation will be responsible for–

- Monitoring the operation of medical logistics units under the jurisdiction of the TA.
- Monitoring the receipt and processing of Class VIII requisitions for medical logistics units.
- Reviewing and analyzing demands and computing theater requirements for critical Class VIII supplies, equipment, optical fabrication, and medical equipment maintenance.
- Monitoring and evaluating the work load, capabilities, and asset position of the supported MEDSOM units, and recommending cross-leveling of work load or resources to achieve maximum efficiency.
- Implementing plans, procedures, and programs for medical materiel management systems.
- Providing medical materiel management data and reports required by the MEDCOM and/or TA surgeon.
- Functioning as the management interface with CONUS-based Class VIII national inventory control points and service item control centers.
- Providing management of critical items and analysis of production capability.

*c*. The CZ and COMMZ hospitals, as well as MEDSOM units, operate as requisition, receipt, storage, and issue sites. Stockage levels will be established by the TA surgeon. Supplies may be requisitioned by and shipped directly to any of these units.

*d*. Supply point distribution is also used in the COMMZ; however, movement elements of the USTRANSCOM may be used for unit distribution. Movement of supplies into the corps is normally accomplished by the USTRANSCOM. In addition, supplies are shipped into the corps directly from CONUS, using throughput procedures.

*e*. The MEDCOM assistant chief of staff for supply, maintenance, and services exercises staff supervision over medical equipment maintenance within the COMMZ. The COMMZ MEDSOM unit provides direct and general support maintenance to medical units located within the COMMZ. The COMMZ MEDSOM units also provide backup general support maintenance to the CZ MEDSOM units. Most items that exceed the capability of COMMZ MEDSOM units may be returned to CONUS.

## 6-8. Augmentation Teams

Corps and COMMZ MEDSOM units may require "tailoring" to individual support requirements by the use of TOE 08-610H0, medical logistical support teams. Capabilities of support teams follow.

*a*. Team BA, medical supply (small), increases the manual stock control capability of a medical supply element by 500 line items stocked in excess of the unit's basic capability.

*b*. Team BB, medical supply (medium), increases the capability of a MEDSOM unit (CZ or COMMZ) to support an additional division force equivalent.

*c*. Team BC, medical supply (large), provides medical supply support to a force of 50,000 troops or major fraction thereof not supported by a MEDSOM unit.

*d*. Team BD, medical inventory control (small) and Team BE, medical inventory control (large), furnish medical inventory control services for medical supply Teams BB and BC and for a CZ or COMMZ, respectively.

*e*. Team BE, medical inventory control (large), provides supply management inventory control service for CZ or COMMZ as required.

*f*. Team EA, medical equipment maintenance (small), Team EB, medical equipment

maintenance (medium), and Team EC, medical equipment maintenance (large), provide direct medical equipment maintenance support for medical facilities. Team EA (small) supports fixed strength medical units. Team EB (medium) augments facilities that support a force of 50,000 and Team EC (large) augments facilities that support a force of 100,000.

*g.* Team GA, spectacle fabrication (small), provides presurfaced single-vision spectacle prescription fabrication and repair services for a force of 50,000.

*h.* Team GB, spectacle fabrication (medium), provides the same services as Team GA plus special type spectacle prescription fabrication for a force of 200,000.

### 6-9. Optical Services in the Theater of Operations

*a.* Optical services include optical repair and fabrication of standard spectacles, aircrew spectacles, and protective mask inserts. Optical services in the theater of operations are important aspects of the total HSS system. Normally, more than one-third of all Army personnel require corrective lenses.

*b.* Spectacle fabrication beyond the capability of the division optometry section is provided by the MEDSOM unit supporting the division. The MEDSOM units in both the CZ and COMMZ provide a full range of optical services. Teams GA and GB, optical fabrication, may be employed to augment a MEDSOM unit, as required.

*c.* Optical support in both the CZ and the COMMZ is provided by Team OH, optometry service. This detachment can provide the full range of optometric service and limited single-vision optical fabrication to include standard spectacles.

*d.* A limited spectacle repair capability is provided in GHs, station hospitals, and convalescent centers. Spectacle fabrication orders and major spectacle repairs are forwarded to the optical fabrication section of the COMMZ MEDSOM unit.

### 6-10. Medical Supplies for Enemy Prisoners of War and Others

*a.* The Army is responsible for providing medical care and treatment for wounded and sick soldiers who fall into our hands. Under certain circumstances, the Army may also be responsible for medical care and treatment of civilians. (See Chapter 3.)

*b.* In computing requirements for supplies and equipment needed to perform this function, available intelligence data should be used.

### 6-11. Captured Medical Supplies and Equipment

Representative samples of all captured medical supplies and equipment items must be preserved and reported according to AR 700-99 and FM 8-10-8. The medical supplies or materiel shall first be used to treat enemy wounded and sick and only after their needs have been fully met may such supplies be used to treat others. If these supplies are unfit for use or not needed, they may be abandoned for enemy use. Under no circumstances will captured medical supplies be destroyed.

### 6-12. Imminent Capture of US Medical Supplies and Equipment

When capture by enemy forces is imminent, medical materiel must not be purposefully destroyed. The Geneva Conventions preclude willful destruction of medical materiel. When a commander, because of military necessity, has decided to abandon patients, he is obligated, as far as military considerations permit, to leave sufficient and adequate medical personnel and materiel for the care of these abandoned patients. Under all other conditions, every attempt must be made to evacuate all medical materiel and equipment. It is a command decision to abandon supplies. The destruction of supplies, other than medical, is also a command decision. Medical units should have an SOP for the evacuation and destruction of their own supplies and equipment (other than medical) based on command priorities.

### 6-13. Flexible Medical Supply Units

Medical supply units must remain flexible to meet changing situations. The threat of nuclear attacks

and the rapidly changing military situation make it necessary that alternative medical supply plans, procedures, and operations be formulated. In certain instances, it may be advisable to establish duplicate records, especially when automated procedures are used, to serve as a backup system. Medical supply levels of units in forward areas should be kept at a minimum to permit relocation of such units whenever necessary.

### 6-14. Storage Facilities

*a*. Class VIII supplies generally require covered storage. Consideration must be given to any special climatic conditions in such areas as deserts, mountains, jungles, or the arctic. Preservation and packing procedures as prescribed in TB MED 1 should be followed. Existing buildings should be considered. They may offer required security, refrigeration, flammable protection, or controlled humidity and temperature storage.

*b*. Overall space requirements are determined from supply control data and from experience factors for handling medical supplies. Detailed space requirements should be based on specific assignments of support missions, supply levels to be carried, area and troops served, and types of supplies. The HSS unit commanders and staff officers should have an appreciation of storage problems to establish appropriate policies concerning storage of medical supplies.

*c*. Efficient use of storage space is basic to economical supply operations. Such factors as accessibility of stored medical supplies and protection from deterioration, fire, weather, theft, rodents, and enemy actions must be considered in ensuring efficient storage procedures.

*d*. Proper medical supply practices require that continuous care be exercised in the surveillance of all medical supplies. Items should be stored and cared for according to the following codes: shelf life months (SLM), storage code (STC), special requirements code (SRC), and additional requirements code. Deteriorating and potency items must receive special consideration in inspections and the rotation of stocks.

### 6-15. Transportation

*a*. Proper methods should be employed to minimize unnecessary shipments, transshipments, and rehandling of medical supplies. Shipments of medical supplies should be accomplished in one move. Movement of supplies through successive supply installations causes delays, risk of damage, misrouting, pilferage, or loss. See paragraph 6-18.

*b*. The availability of transportation assets must be analyzed. Many Class VIII items require special transportation or storage (security and flammable precautions). An efficient and effective transportation system will lessen requirements for strong safety measures and large storage areas. FM 55-1 contains additional transportation planning guidance.

### 6-16. Operations Plans and Administration and Logistics Plans

Health service logistics planners must possess a detailed understanding of all contingency plans their units may be tasked to support. These plans must be reviewed continuously and their portion must be updated as required to ensure adequate support for the mission. The mission must be analyzed both from the tactical and HSS viewpoint.

**This paragraph implements STANAG 2105**

### 6-17. Local Procurement

With certain restrictions, specified items and categories of items of medical supply are authorized for local procurement within the theater. Procurement of certain medical supplies from non-US sources must be authorized by The Army Surgeon General. Consideration in the procurement of medical items from local sources should include manufacturer technical know-how, sterilization techniques, raw material availability, production capabilities, and impact on the economy of the host nation. The high standards established by the US Government make it difficult to consider the use of manufacturers in many areas of the world as possible sources of drug supplies. Drug standards vary in different countries; therefore, drugs from other countries are normally used *only* when US

drugs are not available. (STANAG 2105 provides a cross-index to member nation's combat essential medical materiel.) In practice locally procured materiel is identified and segregated from similar items of US manufacture. Quality control procedures must be followed as prescribed in AR 40-61 and SB 8-75-9. Field Manual 14-7 discusses the guidelines for making local purchases. The following information may only be available from medical intelligence sources:

*a.* Identification of types and sources of indigenous medical materiel available in a given, foreign, geographic area.

*b.* The quality of this type of medical materiel.

*c.* Idiosyncrasies in terms of usage.

*d.* Important technical data such as side effects and contraindications.

### 6-18. Location of Units

*a.* The general locations of medical logistics units are chosen as far forward as possible based on current and projected combat operations. The goal must be to reduce the turnaround time for supplies for using units. When selecting specific locations, however, planners must consider such factors as adequate dispersion because of the nuclear threat, defensibility of installations, local roads, disposition of troops, rail sidings, adequacy of local communication facilities, existing buildings and structures, utilities, and the availability of local labor.

*b.* Within limitations of the tactical situation, medical supply installations must have access to railheads, ports, airfields, and highways to facilitate movement of medical materiel. Medical logistics units have only enough organic transportation assets to relocate supplies and equipment within storage areas. Medical materiel must be delivered to these units by corps and TA transportation assets. To minimize impact on transportation assets, the "throughput" concept is used whenever possible. Throughput allows for the direct delivery of supplies to the using unit whenever possible. This reduces handling and shipping delays and affords the maximum savings to the transportation community, See paragraph 6-15.

### 6-19. Property Exchange

In the process of patient evacuation, litters, blankets, pillows, splints, and like items of supply accompany patients. To ensure items to accompany patients are available, an exchange system must be established. Wherever practicable there is a direct item-for-item exchange. The increased use of AE imposes severe restrictions upon the property exchange system. Ultimately, however, the originating facility is responsible for providing the property necessary for the comfort and safety of the patient. To avoid depletion of property exchange supplies, plans should provide for the stockpiling of such items in areas of probable usage. In addition to normal supplies, items to be authorized for hospitals and other MTFs involved in property exchange will be determined by the medical brigade and MEDCOM commanders. In anticipation of combat operations, stocks of exchange items should be considered in all supply planning.

**NOTE**

Property used during aeromedical evacuation should be accounted for and reported to a central point within the theater of operations. This central point would be tasked to track these items. Aircraft returning from missions should load and return the property to the theater of operations. Within the theater of operations, the equipment could be transported and returned to the owning organization.

### 6-20. Disposal

*a.* Excess, unserviceable, or unidentifiable medical materiel that is not authorized for return to a MEDSOM or a CONUS source, redistribution within the theater, or retention at the MTF will be disposed of in accordance with ARs 40-5, 40-61, 200-1, and the SB 8-75 series. Excess materiel is often generated as a result of inadequate supply

controls and procedures. Measures must be implemented by logistics managers to ensure that medical materiel supply levels are sufficient to meet current needs and to prevent excesses. Excess materiel reduces mobility and increases accounting, storage, surveillance, and security requirements.

*b.* Many pharmaceuticals may pose serious environmental hazards if disposed of improperly. Other medical materiel may pose hazards or may be subject to abuse and may also require controlled disposal methods. Economically recoverable precious metals constitute another category of materiel requiring special disposal techniques.

## 6-21. Conversion of Health Service Logistics Units

Health service logistics units described in this chapter are organized under the H-edition TOE and are in the current structure. However, units will be converted (or are in the process of conversion) to L-edition TOE described in Appendix C.

# CHAPTER 7

# MEDICAL LABORATORY SERVICES

## 7-1. Laboratory Support

Medical laboratory assets function in HSS operations by analyzing body fluids and tissues to determine disease processes or to identify microorganisms. The equipment and personnel available are limiting factors in the scope of laboratory services provided. As in many HSS functions, the sophistication of laboratory services improves at each successive echelon of care.

## 7-2. Echelon I Care

Although laboratory personnel are not assigned to Echelon I units, some laboratory information will be presented to physicians at this echelon. For instance, throat cultures and analysis results will be provided for their routine sick call duties. Since Echelon I units have no holding capability, sophisticated laboratory procedures will not be required.

## 7-3. Echelon II Care

Echelon II is the first point where a laboratory specialist will be located. In addition to the support he provides to medical personnel at Echelon I, he will also provide the same support at Echelon II. There are two laboratory specialists at each treatment station, except in airborne divisions and in nondivisional medical companies (clearing), which only have one. Medical laboratory assets at this echelon are austere to keep pace with a highly mobile organization. Laboratory tests are limited to manual procedures such as hematocrit, white blood cell count, urinalysis, and gram staining.

## 7-4. Echelon III Care

*a.* A laboratory officer is available at this echelon. He is assisted by a laboratory NCO and medical laboratory specialists. They use both manual and semiautomated equipment. These resources are found in corps hospitals. In addition, a pathologist/blood transfusion consultant is available. Augmentation of specific hospital laboratories or augmentation of the laboratory capability of an entire corps is possible with the special teams and detachments discussed in paragraph 7-6.

*b.* Laboratory equipment and the variety of laboratory tests available at each type of hospital in the CZ are similar. However, the laboratory staffs and equipment are tailored to satisfy the unique mission of each hospital type.

## 7-5. Echelon IV Care

*a.* Echelon IV medical laboratory resources consist of pathologists, biochemists, microbiologists, clinical laboratory officers, NCO personnel, medical laboratory specialists, and sophisticated laboratory equipment. These resources are located in COMMZ hospitals.

*b.* The laboratory in the GH is the most sophisticated of all hospital laboratories found in a theater. General hospital laboratory personnel may find demand for their services as medical and paramedical consultants to other hospitals in the COMMZ and CZ. These same consultants may also be asked to provide staff functions to higher headquarters in the theater of operations.

## 7-6. Augmentation of Organic Laboratory Support

*a. Area and Unit Medical Support Teams.* Team OA, dispensary, and Teams OB and OC, general dispensary, have organic laboratory personnel and equipment.

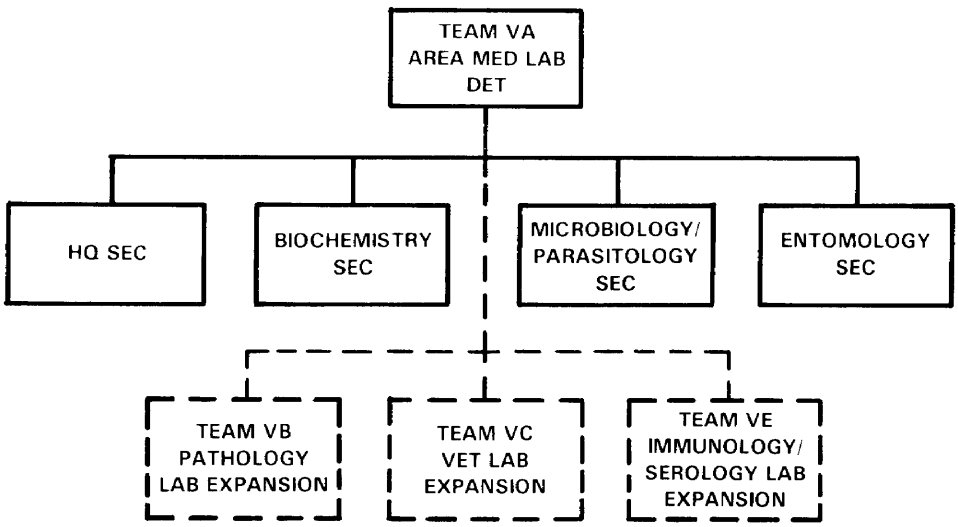
*b. Medical Professional and Ancillary Service Teams.* Team MM, miscellaneous service, can provide a personnel augmentation of three medical laboratory specialists, without equipment or supervision, to MTFs at the rate of one team per 1,600 beds in the CZ and one team per 16,000 beds in the COMMZ. These personnel can be used to accommodate unusually high work loads or aid in the investigation of special problems. An example of a special problem is the outbreak of an infectious disease. Supervision and equipment would be provided by the gaining unit. Supervision can also be augmented, as cited below.

*c. Medical Facility Expansion Teams.*

(1) Team MQ, pharmacy, laboratory, and x-ray control, can provide a total of six personnel, including one clinical laboratory officer and one medical laboratory specialist, for any hospital that undergoes an expansion of 200 to 400 beds. Team MQ would supervise the activities of augmentation Teams MM and MS, as required.

(2) Team MS, clinical laboratory, with nine medical laboratory specialists and equipment can provide clinical laboratory support to any hospital which expands its capability by 200 beds. A 400-bed expansion can be accommodated by collocating and combining the efforts of one each Team MM, MQ, and MS.

*d. Area Medical Laboratory and Expansion Teams, TOE 08-650H0.* There are four area medical laboratory teams that may be employed in the COMMZ and CZ. Team VA, area medical laboratory detachment, is a 35-man stand-alone detachment allocated on the basis of one per corps in the CZ and one per corps supported in the COMMZ. Personnel, supply, and maintenance support is obtained through hospital centers, medical groups, or medical battalions. The Team VA provides effective and efficient reference laboratory services for hospitals in its geographic area of responsibility, with expertise in the clinical laboratory disciplines of biochemistry, microbiology, parasitology, and entomology. This capability is further augmented in the COMMZ by adding five-man teams–Team VB, pathology laboratory expansion; Team VC, veterinary laboratory expansion; and Team VE, immunology and serology laboratory expansion. The addition of Team VB, VC, or VE, alone or in combinations, in the CZ is made only when necessary to meet special requirements in the theater. The employment of one or more of the area laboratory teams anywhere in the theater would depend upon relative military stability and the need for long-term reference laboratory support. The number of teams used would depend upon the size of the theater and the number of hospitals that require support. These teams could also serve as the laboratory base for research and development efforts, as required. Medical and paramedical personnel assigned to these units may be asked to provide staff and consultation services throughout the theater of operations. An area medical laboratory is depicted in Figure 7-1.




NOTES:
1. Number of teams will depend upon the size of the supported forces and the nature of their operations.
2. Teams shown in dotted lines are normally used in the COMMZ only.

*Figure 7-1. Type area medical laboratory.*

## 7-7. Theater Army Medical Laboratory

A high technology independent area medical laboratory is envisioned for the future. (See Appendix D.)

# CHAPTER 8

# BLOOD MANAGEMENT

## 8-1. Blood Bank Services

Blood bank services are provided in a theater of operations to support US military and, as directed, allied military and indigenous civilian medical establishments. The unified commands maintain individual blood programs to meet their own needs. These programs are theaterwide and interface with the CONUS blood bank system. They are a DOD effort. Blood bank services in a theater of operations include–

- Receiving liquid blood and blood components from CONUS.
- Moving, storing, and distributing liquid blood and blood components.
- Storing, processing, and distributing frozen blood products pre-positioned within the theater.
- Collecting and processing liquid blood on an emergency basis.

## 8-2. Providing Blood Products in Unified Commands

Each unified command has a separate, integrated system for providing blood products (Class VIII) to the various component MTFs.

*a.* The joint blood program office (JBPO) serves as the single blood manager in the theater. The single blood manager will interface with the Armed Services Blood Program Office (ASBPO) in CONUS.

*b.* When the capabilities of the blood program of the unified command are exceeded, the JBPO requests assistance from the ASBPO. The ASBPO, in turn, requests support from the Services. The blood collected and processed in CONUS is shipped to blood transshipment centers (BTCs) located throughout each unified command. The BTCs are operated by the USAF. They are centers for receiving and distributing blood. The BTCs are located at major airfields with tactical airlift capability. Once at the BTC, the blood products are under the control of the JBPO.

*c.* Within the unified command, the JBPO will establish area joint blood program offices (AJBPOs). The AJBPO will–

- Implement the blood program policies of the unified command.
- Coordinate the blood activities of the component commands on an assigned geographical area of responsibility (AOR).
- Direct the issue of blood products from BTCs in their AOR to component command blood supply units (BSUs).

*d.* The BSUs function as the retail blood distribution points for their component MTFs. When directed by the AJBPO, BSUs will also provide blood support to other component MTFs.

## 8-3. Army Blood Supply Units

*a.* Army BSUs are task organized from four specialized blood bank units whose individual missions are to–

- Provide command and control.
- Collect, process, and distribute blood products within the theater of operations.

*b.* Team AJ, headquarters, blood bank service, TOE 08-600H0, provides command and control for blood bank service teams. The commander of the Team AJ is the senior blood bank officer. He serves as the blood bank consultant and blood program staff officer to higher headquarters in the theater of operations. One team AJ is allocated per 10 blood bank service teams, or major fraction thereof.

*c.* There are three blood bank service teams, TOE 08-620H0. All three teams are attached to Team AJ.

(1) Team NA, blood processing, is allocated on the basis of one per three Teams NB, blood collecting. Team NA receives, processes, and stores blood collected by up to six NB teams.

(2) Team NB is allocated on the basis of one per 80,000 personnel supported. Team NB collects up to 200 units of blood per day from noncombatants, CS, and CSS personnel.

(3) Team NC, blood distribution, is allocated on the basis of one per 100,000 personnel supported. It provides blood storage and supply point distribution of blood products for MTFs.

## 8-4. Deployment

*a.* The main source of blood for support of wartime casualty care requirements does not come from collecting and processing blood in theater by the blood bank service teams; it comes from the CONUS base. Initial requirements may be met–

- Through a combination of limited in-theater blood collections performed by forward deployed blood bank assets.

- By the use of pre-positioned frozen blood assets.

In addition to meeting the initial theater blood requirements, pre-positioned frozen blood will augment the main liquid blood supply from CONUS. To provide this frozen blood capability, the unified commands are currently establishing component-operated blood product depots (BPD) for the storage of frozen blood products. In a theater of operations, Army BSUs will provide the manpower required to operate these BPDs.

*b.* The task organization of the current blood bank service teams into a BSU requires that these units train in peacetime for their expanded mission to distribute frozen and liquid blood. Blood supply units require food service, administration, communications, and motor maintenance support. They must, therefore, be located near MEDSOM units or MTFs that can provide support. In the future, these specialized teams will be converted into a multipurpose blood bank platoon that will function as a BSU. The blood bank platoon will be part of the medical battalion, (logistics). (See Appendix C.)

**NOTE**

The blood bank mission has changed from collecting blood in theater to a multipurpose BSU concept. This requires careful attention to ensure that a single, specialized blood bank service team is not given a blood support mission that requires a multipurpose BSU.

## 8-5. Echelon II Care

*a.* Blood product support to Army MTFs in the division will be provided by the DMSO. Each clearing station and the DM SO will be equipped with a refrigerator, solid state, biological, portable (National Stock Number [NSN] 4110-01-287-7111). This high-technology refrigerator derives its power from vehicular batteries of transportation assets. (This refrigerator can also provide subsequent storage when connected to a field generator or some other source of electrical power.) The DMSO ships the blood forward to the requesting unit by backhaul on medical vehicles.

*b.* The DMSO obtains Group O liquid red blood cells from a supporting Army BSU located at the corps level.

(1) Shipment of blood forward is either coordinated by the corps BSU with the corps movement control center or accomplished by backhaul on medical vehicles (air or ground).

(2) Emergency resupply can be accomplished by air ambulances in the evacuation battalion.

## 8-6. Echelons III and IV Care

The DEPMEDS improves the blood bank transfusion capability of the Army hospital units. The MASH will have blood storage capability and be provided fresh Group O packed red cells. The other Echelon III and IV hospitals will have blood banks

capable of providing liquid and frozen blood services in a separate 3:1 International Organization for Standardization (IS0) shelter. The blood bank will contain–

• One ultralow temperature freezer that will hold up to 500 units of frozen blood products.

• Four cell washers to deglycerolize the frozen blood products.

• One blood bank refrigerator which can hold up to 500 units of liquid blood products.

• Equipment for compatibility testing for type-specific blood.

• Emergency capability to collect 180 units of blood under emergency conditions.

## 8-7. Communications

*a.* Blood supply units operating in either the CZ or the COMMZ are under the operational control of a medical command and control unit which provides communication support. Blood supply units should communicate with both supporting and supported units by voice, teletype, or data transmission. Direct communication between the BSU and its supported units is an absolute necessity. Due to the critical and urgent nature of many blood requests, the inherent delays caused by communications through command channels should be avoided. Direct communication with theBSU and informational communication with command and control elements is encouraged. Blood supply units should also have access to automatic digital network (AUTODIN) facilities.

*b.* Each activity in the joint blood distribution scheme will communicate blood status information using joint interoperability of tactical command and control system (JINTACCS) approved voice, message, or computer blood report formats. The medical blood management (MEDBLD) subsystem of the TAMMIS has been designed to provide automation to blood program activities in the theater. (See Chapter 13 for a discussion on the TAMMIS MEDBLD subsystem.)

## 8-8. Transportation

Blood products will be transported and delivered by various modes which include ground, air, sea, and parachute. The preferred method is for the BSU to establish a blood supply point from which the MTFs obtain their blood supply. When the tactical situation does not allow for supply point distribution, the procedures for use of AMEDD backhaul, AMEDD-directed assets, or nonmedical transportation assets should be implemented. The BSU must coordinate with the S3 and S4 of the medical command and control unit to which it is attached for the use of AMEDD backhaul or AMEDD-directed assets. The BSU will need to coordinate with the S3 and S4 who will coordinate with the movement control elements of the TRANSCOM to arrange for nonmedical transportation assets.

## 8-9. Blood Support for Enemy Prisoners of War

*a.* The Army is responsible for providing medical care and treatment for EPW. The Army may become responsible for providing medical care or assistance to displaced persons, refugees, civilian internees, and detained personnel. Articles 13 and 130 of the Geneva Convention Relative to the Treatment of Prisoners of War do not prohibit the maintenance of lists of the blood types of prisoners of war who have volunteered to furnish blood. There is nothing improper in accepting donated blood from EPW. To perform this function, available intelligence data should be used in computing requirements for blood support, supplies, and equipment needed. The decision to use donated blood from EPW to treat US casualties, though not a violation of the Geneva Conventions, would also be dependent upon available medical intelligence data concerning the incidence and prevalence of infectious diseases in the EPW population.

*b.* Blood stocks, supplies, and equipment captured from the enemy are considered to be neutral and protected property and are not to be intentionally destroyed. The blood materiel should be turned over to a designated BSU. Since captured medical personnel are familiar with their blood supplies and equipment, the captured items are especially valuable in the treatment of EPW. The BSU will use these blood supplies to support the

MTF assigned responsibility for the care and treatment of EPW. Use of these captured items for EPW and the indigenous population helps to conserve other blood stocks, supplies, and equipment.

**This paragraph implements NATO STANAGs 2939, 2135, and QSTAG 815.**

## 8-10. Allied Support Agreements

The exchange of blood stocks, supplies, and equipment between US forces and those of allied forces is established under bilateral and/or multilateral blood assistance agreements.

*a.* In Europe, NATO STANAG 2939 establishes technical standards for blood, blood donors, and associated equipment. Blood requirements which exceed normal national blood supply capability can be requested from NATO nations using procedures contained in STANAG 2135.

*b.* The aim of QSTAG 815 is to establish a policy for blood supply in the area of operations in which members of two or more participating nations are deployed.

# CHAPTER 9

# VETERINARY SERVICE

## 9-1. Concept of Operations

*a.* Veterinary service is an integral part of HSSwithin a theater of operations. The US Army veterinary service provides support as required for the Army, Navy, Air Force, and Marine Corps.

*b.* Veterinary service in the theater includes–

- Inspection of subsistence.
- Control of foodborne disease.
- Examination of food animals.
- Control of diseases transmitted from animals to humans.
- Treatment and hospitalization for military animals.
- Examination and wholesomeness determination of food and food-producing animals in an NBC environment.
- Other veterinary preventive medicine activities as assigned.

These services are performed by veterinary service detachments and veterinary hospitals under the command and control of Team AF, veterinary service headquarters.

*c.* Veterinary service personnel are assigned to the TA surgeon's staff, the MEDCOM, hospital centers, senior medical headquarters in the corps, headquarters of preventive medicine service teams, military police units, and civil affairs teams.

*d.* Normally, the staff veterinarian advises the commander on matters pertaining to–

- Food wholesomeness, hygiene, safety, and quality assurance to include NBC environment.
- The health of government-owned and indigenous animals of the command.

(See FM 8-55 for a detailed discussion on planning for veterinary services.)

## 9-2. Veterinary Service Structure

*a.* Unit veterinary service in a theater of operations is provided by veterinary personnel organic to nonmedical units such as the military police and military working dog platoon.

*b.* Area veterinary services are provided by veterinary detachments allocated to support geographic areas in both the CZ and the COMMZ. The veterinary detachments are assigned to medical command, medical brigade, or in the absence of a MEDCOM or medical brigade, they are assigned to a medical group. The current veterinary headquarters and service teams are as follows:

(1) Team AF, veterinary service headquarters, provides command and control for four to seven veterinary service, dispensary, or hospital detachments in any combination.

(2) Team JA, veterinary service (small/expansion)–

- Provides food wholesomeness, food hygiene, safety, and related quality assurance inspections in support of a population of up to 20,000 personnel.
- Conducts antemortem and postmortem examinations of food animals.
- Performs procurement and surveillance food inspections.
- Inspects subsistence and food-producing animals exposed to NBC agents.
- Performs veterinary preventive medicine functions to include civic action programs.
- Conducts control programs for those diseases transmitted from animals to humans as food inspection work load permits.

- Provides minimal or emergency care for large animals as food inspection work load permits.

- Performs expedient, limited animal care treatment for approximately 25 military working dogs on an emergency or short-term basis.

- Collocates at one location up to 25 military working dogs for evacuation to Team XA.

(3) Team JB, veterinary service (large), has the same capabilities as Team JA, but it can support a population of up to 100,000 personnel. This capability may be increased to a maximum of 150,000 by augmentation with two Teams JA (one Team JA for each 25,000 personnel in excess of 100,000 to be supported). Team JB consists of four mobile service teams: two with a veterinary service officer, a food inspection NCO, and three food inspection specialists. The other two teams have a veterinary service officer, one food inspection NCO, three food inspection specialists, and one animal care specialist. The Team JB operates in 6 to 12 locations over a 140-kilometer radius. In addition to being augmented by up to two Teams JA, this unit may also be used to command and control up to two other separate veterinary teams (JA, XA, or XB), only one of which may be a Team XA or XB.

(4) Team XA, veterinary combat support hospital, provides–

- Animal medical services which include emergency-resuscitative care for up to 200 military working dogs on an area basis.

- Medical treatment, surgical treatment, and short-term hospitalization for up to 20 military working dogs.

- Consultation services for animal care specialists organic to military dog units and animal health maintenance on an area basis.

- Stabilization of military working dogs requiring long-term treatment for evacuation to Team XB.

- A triage and resuscitation element consisting of one veterinary officer and two animal care specialists for immediate deployment to high or potentially high casualty areas.

- Emergency medical care to large animals in support of civic action programs.

(5) Team XB, veterinary general hospital, performs animal care services in the COMMZ by providing definitive and long-term treatment and hospitalization for up to 50 working dogs which require medical treatment, surgical treatment, or observation. This unit is also capable of providing similar emergency service for large animals on an areas basis in support of civic action programs. It provides emergency-resuscitative care for up to 100 military working dogs on an area basis. Team XB is allocated on the basis of one per 300 to 1,000 military working dogs supported in the theater. (See FM 8-27 for a discussion on veterinary service.)

### 9-3. Areas of Responsibility

*a.* Veterinary personnel are responsible for–

- Food hygiene, safety, and quality assurance inspections.

- Sanitary inspections of food processing facilities.

- Control of zoonotic and foodborne diseases.

- Assistance in the preventive medicine program.

- Health maintenance of military animals.

- Inspecting, monitoring, and testing subsistence for contamination with nuclear, biological, and chemical agents.

- NBC contamination detection for wholesomeness of food and food-producing animals.

*b.* For veterinary services to be effective–

- The services, either routine or emergency, must be available as far forward as

operational requirements and the tactical situation permit.

- The veterinary personnel must concentrate on prevention by reducing the–
  - Deterioration and spoilage of subsistence.
  - Incidence of zoonotic diseases.
  - Incidence of disease and injury in military animals.

## 9-4. Evacuation of Military Working Dogs

The using unit is responsible for the evacuation of sick or wounded military working dogs using any transportation means available. Use of normal evacuation assets (air/ground ambulance) is authorized and encouraged based on mission priority and availability. The veterinary unit must ensure that the location of veterinary support for military working dogs is available to units evacuating sick/wounded military working dogs.

## 9-5. Conversion of Veterinary Service Units

Veterinary units described in this chapter are organized under the H-edition TOE and must be presented as long as they exist in the force structure. However, units will be converted (or are in the process of conversion) to the L-edition TOE described in Appendix E.

# CHAPTER 10

# PREVENTIVE MEDICINE SERVICES

## 10-1. The Medical Threat

*a*. History provides many examples of battles that were lost because troops were immobilized by disease, heat, and cold. The medical threat that accounts for the vast majority of combat noneffectiveness can be reduced to six broad categories. These categories are–

(1) Heat injuries caused by heat stress and insufficient water consumption.

(2) Cold injuries caused by combinations of low temperatures, wind, and wetness.

(3) Diseases caused by arthropod/animal bites, environmental conditions, or biological warfare.

(4) Diarrheal diseases caused by–

- Drinking impure water.
- Eating contaminated foods.
- Not practicing good individual and unit preventive medicine measures.

(5) Diseases, trauma, or injuries caused by physical or mental unfitness.

(6) Environmental or occupational injuries caused by carbon monoxide, noise, blast overpressure, and solvents.

*b*. See FMs 8-50, 8-55, 8-230, 8-250, 21-10, and 21-10-1 for additional discussions on preventive medicine.

## 10-2. Prevention of Disease and Injury

Prevention of disease and injury reduces manpower losses, patient loads, and evacuation requirements. Command interest and commitment to the preventive medicine program are essential. Timely and effective implementation of the appropriate preventative medicine measures to counter the medical threat will serve as a combat multiplier by–

- Enhancing unit effectiveness.
- Reducing individual soldier's exposure to disease and environmental threats.

## 10-3. Scope of Preventive Medicine Services

The scope of preventive medicine services includes–

- Providing assistance in the control of arthropod- and rodentborne diseases, including technical consultation, entomological surveillance, and reinforcement of the tactical unit's organic pest-management capabilities.
- Providing assistance in the control of waterborne diseases by monitoring the water quality.
- Providing assistance in the control of foodborne diseases by monitoring food service operations and providing guidance to commanders.
- Providing policy guidance and monitoring compliance for immunization and drug prophylaxis activities.
- Providing assistance in the control of excessive occupational exposures to such hazards as radiation, toxic gases, noise, and climatic extremes.
- Providing assistance to intelligence analysts in evaluating–
  - Elements of the medical threat.
  - The risk to the force associated with identified elements of medical threat.
  - The integration of intelligence and medical threat into planning and executing HSS operations.
- Educating troops in disease prevention measures including those measures used to reduce risks from BW agents.
- Training unit field sanitation teams.

• Providing technical consultation on selecting and developing bivouac sites, cantonment areas, refugee camps, and EPW compounds.

• Providing professional and technical advice to commanders at all levels on measures to reduce noneffectiveness from disease and nonbattle injury.

• Surveying military environments to detect and identify health hazards and to formulate means for minimizing their effects.

• Investigating disease outbreaks and recommending control measures.

## 10-4. Preventive Medicine Integration

Support for training and combat operations must be an integrated approach. It should begin with the individual soldier, and it should continue through the unit, to the division, the corps, and echelons above corps.

*a.* Individual and Echelon I preventive medicine measures are a command responsibility. Assistance is provided by organic medical personnel and the unit field sanitation team.

*b.* The Echelon II preventive medicine sections of the divisions, separate brigades, and ACRs are responsible for–

• Assessing the medical threat and determining preventive medicine measures.

• Advising commanders and staffs of preventive medicine requirements.

• Training, monitoring, and providing technical assistance to unit field sanitation teams.

• Monitoring the training of all individuals in personal preventive medicine measures.

• Conducting surveys, inspections, and control activities.

## 10-5. Preventive Medicine Technical Support

*a.* Echelon III and IV general support is provided by preventive medicine teams on an area basis. On occasion, these teams can be attached to specific units in a direct support role.

*b.* Preventive medicine teams contribute to the preventive medicine mission of providing services and support within a theater of operations in the areas of epidemiology, entomology, environmental science, and engineering. Teams are assigned on a basis of allocation which may be altered by analyzing the medical threat. These teams require logistical support. The teams are described below.

(1) *Team AM, headquarters, preventive medicine service, TOE 08-600H0.* This team provides command and control for preventive medicine teams and consultation in epidemiology, environmental sanitation, entomology, and preventive medicine aspects of veterinary medicine.

(2) *Preventive medicine teams, TOE 08-*620H0.

*(a)* Team LA, entomology, provides entomology support to include field study, survey, and control of arthropods and rodents. It also provides support in related environmental problem areas. Team LA is capable of dividing into one survey section and three control sections.

*(b)* Team LB, environmental sanitation, provides support and assistance in the evaluation and correction of health hazards associated with food service, water treatment and distribution, troop housing, waste disposal, industrial hygiene, and other environmental areas.

*(c)* Team LC, environmental engineering, provides support and services similar to those of the Team LB. Team LC also provides consultation and services on sanitary engineering aspects of water and waste water treatment and environmental pollution control.

*(d)* Team LD, epidemiology, provides epidemiological evaluation of conditions affecting the health of supported military and civilian populations.

*(e)* Team LE, entomology laboratory, provides laboratory support for one to three LA teams.

*c.* The role of the preventive medicine consultants at the various corps and echelon above corps medical headquarters is discussed in Chapter 2 and Appendix A.

*d.* Additional preventive medicine assets to support the overall theater preventive medicine program are found in civil affairs units. These assets assist in support for the civilian population (displaced persons, refugees, and evacuees) as well as interface with the civilian government on public health issues.

### 10-6. Conversion of Preventive Medicine Units

Preventive medicine units described in this chapter are organized under the H-edition TOE. However, units will be converted (or are in the process of conversion) to the L-edition TOE described in Appendix F.

# CHAPTER 11

# DENTAL SERVICES

## 11-1. Concept of Operations

Dental services are provided to–

- Maintain oral health.
- Enhance combat readiness.

Providing dental services as far forward as possible minimizes the amount of time lost by a soldier to receive treatment.

## 11-2. Dental Surgeon

*a.* A dental officer is assigned to a staff position at the MEDCOM and the medical brigade. The dental surgeon of the TA MEDCOM is normally delegated technical control of subordinate dental units and serves as TA dental surgeon. The dental surgeon advises the commander on matters pertaining to the dental services of the command. He advises the staff surgeon on all matters that impact on the health of the command from a dental perspective. The dental surgeon must be aware of operational and tactical plans to ensure that the dental services plan conforms to them. He cooperates with the surgeon in establishing the HSS plan which may include the dental plan or a portion of it as a special paragraph of the HSS annex.

*b.* The senior dental officer organic to the division is dual-hatted as the assistant division surgeon for dental activities and DISCOM dental surgeon. This is in addition to his duty to provide dental care. As the division dental surgeon/ DISCOM dental surgeon, he provides staff and technical supervision of division dental assets. He provides consultation to the division and DISCOM commanders on the dental health of their commands.

## 11-3. Dental Units

Dental support in a theater of operations is provided by a combination of divisional dental support, hospital dental support, and area dental support.

*a. Echelon II Dental Support.* (See Chapter 3 for a discussion on the echelons of care.) Echelon II dental support is provided by a dental officer and enlisted personnel organic to medical companies of divisions, separate brigades, and Special Forces groups. These services are characterized by emergency dental care. Emergency care includes replacing a troublesome restoration, extracting a tooth, or performing other immediately necessary dental procedures. Patients are returned to duty as quickly as possible or prepared for evacuation to a higher echelon of care.

*b. Echelon III and IV Dental Support.* Hospital and convalescent centers have organic dental services for the treatment of patients admitted to these facilities. Dental personnel provide dental treatment services to staff and patients. Oral surgery services are provided to inpatients and to patients referred from other dental organizations. Area dental support units augment the hospital dental staff for routine dental treatment.

*c. Area Dental Support.* Area dental support is provided in the CZ and COMMZ by dental personnel assigned to a dental headquarters and service team, TOE 08-670H8. Priority of treatment in forward areas is given to combat, CS, and CSS personnel in divisions, separate brigades, and Special Forces groups.

(1) *Mission.* The dental headquarters and service teams provide dental support in a theater of operations.

(2) *Assignment.* Unless specifically limited by capabilities, the elements of this TOE may be assigned to medical command, or medical brigade.

(3) *Capabilities and basis of allocation.* Specific capabilities and basis of allocation of the units organized under this TOE are listed below:

*(a) Team AI, dental service headquarters.* This team commands and controls four to eight dental service detachments (HA) along with

any required dental service augmentation teams (HB, HC, and HD), and a central dental laboratory team (HE). Team AI provides technical expertise, coordination, and support to subordinate units for accomplishing their organizational medical equipment maintenance. It is allocated to TA on the basis of one per four to six dental service detachments (HA).

*(b) Team HA, dental service detachment.* Team HA may be attached to Team AI. Team HA provides command and control for attached dental teams (HB, HC, and HD). It also provides outpatient dental treatment to include routine and emergency care and consultation service on an area basis of 20,000 troops in a theater of operations. This team may be divided into subteams as required to provide dental service for small or forward troop concentrations. The basis of allocation for Team HA is one per 20,000 troops supported.

(c) *Team HB, dental service augrnen tation, general dentistry.* This team is normally attached to Team HA or AI. It augments existing dental facilities to provide outpatient dental service to include routine and emergency care for approximately 5,000 troops. Its basis of allocation is one per 5,000 troops not otherwise supported by dental service detachment, Team HA.

*(d) Team HC, dental service augmentation, removable prosthodontics.* This team is normally attached to Team HA or AI. It augments existing dental treatment facilities to provide increased dental removable prosthodontic services in support of a troop population of 80,000 troops. It is allocated to TA on the basis of one per 80,000 personnel supported.

*(e) Team HD, dental service augmentation, fixed prosthodontics.* This team is normally attached to Team HA or AI. It augments existing dental treatment facilities to provide fixed prosthodontic service in support of a troop population of 80,000. It is allocated to TA on the basis of one per 80,000 personnel supported.

*(f) Team HE, central dental laboratory.* This team is normally attached to Team AI. It provides prosthodontic support, including procedures requiring special fabrication methods, to dental units or facilities that collectively support 200,000 troops. It operates as a fixed facility in the COMMZ. Its basis of allocation is one per 200,000 troops to be supported when dental laboratory support is to be provided in the theater.

## 11-4. Conversion of Dental Units

Dental units described in this chapter are organized under the H-edition TOE. However, units will be converted (or are in the process of conversion) to the L-edition TOE described in Appendix G.

# CHAPTER 12

# COMBAT STRESS CONTROL SERVICES

## 12-1. Prevention and Treatment of Combat Stress Casualties

Combat stress control (CSC) services are a separate AMEDD functional area. The mission of CSC services is to prevent or treat battle fatigue casualties, misconduct combat stress behaviors, and delayed post-traumatic stress problems.

*a.* The following are some examples of causes which make battle fatigue inevitable:

- Sustained operations.
- Weapons of mass destruction.
- Exposure to killed and wounded.
- The potential for forces to become intermingled in high-intensity conflict.
- A 360° battlefield with no defined boundaries.

*b.* In low-intensity conflicts, the guerrilla or terrorist enemy deliberately seeks to provoke misconduct combat stress behaviors. Some examples of misconduct combat stress behaviors are substance abuse, atrocities, and indiscipline. These behaviors impair the Army's will to fight and invalidate its cause.

*c.* After combat, training accidents, or disasters, CSC services provide sound "preventive maintenance" in resolving stress issues. These services decrease later post-traumatic stress problems that would otherwise diminish the Army's fighting strength.

## 12-2. Prevention

Prevention of battle fatigue is primarily a command and leadership responsibility. Medical and mental health personnel at all levels play important supporting roles. Active education and prevention programs–

- Control stressors.
- Promote unit cohesion and realistic training.
- Prepare unit leaders and medics to identify and manage stress and stress behaviors (battle fatigue) in the units.

These programs can reduce the incidence of stress casualties in high-intensity conflict from the common ratio of one per three wounded in action (WIA) to below one battle fatigue casualty per ten WIA. They also reduce the misconduct combat stress behaviors which interfere in completing the mission of a low-intensity conflict. Additionally, medical and mental health personnel must follow the principles of combat stress prevention for self-protection. They must first *protect* themselves from the effects of combat stress. This action will enable them to properly continue their mission to conserve manpower rather than to become casualties themselves.

## 12-3. CSC Functional Area

The AMEDD CSC functional area refers to a coordinated program for–

- The prevention of battle fatigue and other harmful combat stress behaviors.
- The treatment and RTD of those who become casualties.

Combat stress control is implemented by mental health personnel organic to units and by specialized medical CSC units which are corps-level (or echelon above corps) assets. There are six CSC missions: consultation, reconstitution support, combat neuropsychiatric triage, restoration, reconditioning, and stabilization. These missions have differing priorities in different situations, but their usual priorities are in the order described below.

*a.* The consultation mission includes preventive advice, education, and assistance to leaders and staff of supported units. The purpose of the mission is to–

- Control stressors.

- Keep stressed soldiers functioning in their units.

- Reintegrate recovered stress casualties quickly.

*b*. The reconstitution support mission is to deploy CSC teams to assist attrited units when they are withdrawn from action for reconstitution. The mission–

- Facilitates physical and psychological replenishment.

- Reintegrates surviving veterans and new replacements into cohesive teams.

*c*. The combat neuropsychiatric triage mission is to sort fatigue, stress, and neuropsychiatric cases based on where they can be treated to maximize RTD. The following are the neuropsychiatric triage categories–

- "Duty" (keep in original unit).

- "Rest" (rest in nonmedical support unit).

- "Hold" (hold for treatment at this medical unit).

- "Refer" (evacuate, but only to the next medical echelon for reevaluation).

*d*. The restoration mission is to treat with reassurance, rest, food, water, hygiene, and activities to restore confidence within one to three days at forward MTFs.

*e*. The reconditioning mission is to treat with physical training and an intensive program of psychotherapy and military activities for seven or more days. The treatment is provided in a nonhospital setting, usually in the corps. Additional reconditioning may be provided in the COMMZ.

*f*. The stabilization mission is to manage and evaluate severely disturbed battle fatigue and neuropsychiatric patients to–

- Determine RTD potential.

- Prepare for further treatment, administrative disposition, or evacuation to CONUS.

**12-4. Treatment Principles**

*a*. Successful treatment of battle fatigue casualties uses the PIES principle developed during World War I and II.

(1) Proximity. (Treat as close as possible to the soldier's unit and the battle; prevent overevacuation.)

(2) Immediacy. (Treat immediately, without delay.)

(3) Expectancy. (Treat with expressed positive expectation of full and rapid recovery.)

(4) Simplicity. (Treat using simple, brief, nonmysterious methods to restore physical well-being and self-confidence. Use nonmedical terminology and techniques.)

*b*. Treatment consists of–

- Reassurance.

- Rest.

- Physical replenishment (food and fluids).

- Hygiene (shower, shave, and a clean combat uniform).

- Psychotherapeutic activities (a chance to talk about events that occurred and to learn how to manage the stress in the future).

- Occupational activities which restore the soldier's identity and confidence as a soldier.

Treatment must be accomplished in a *nonpatient-care* military environment.

**12-5. Treatment Effectiveness**

With correct treatment, 50 to 85 percent (depending on the intensity of conflict) of soldiers RTD within

one to three days of brief *restoration* treatment. About 50 to 75 percent of the remainder RTD within one to three weeks of intensive reconditioning treatment. However, evacuation too far to the rear or to hospital wards increases morbidity, delays recovery, and often results in chronic disability.

### 12-6. Echelon II Services

Echelon II CSC support is provided by the division mental health section (DMHS) of the medical company, MSB, or the DMHS of the medical battalion. The psychiatrist, the psychologist, and the social work officer, assisted by enlisted behavioral science specialists, provide preventive consultation and education, staff planning, neuropsychiatric triage, and emergency stabilization. A DMHS NCO is routinely allocated to each maneuver brigade as its brigade combat stress control coordinator (BCSCC). The BCSCC coordinates all CSC activities within the brigade for the brigade surgeon. The DMHS NCO–

- Supervises restoration treatment in brigade and division medical companies (clearing) when patient work load permits.

- Coordinates the activities of reinforcing Echelon III CSC teams through the DMOC.

### 12-7. Echelon III Services

*a*. Echelon III CSC support is currently provided by psychiatric service (Team OM), TOE 08-620H00M. This unit has a headquarters section, a 25-cot treatment section, and 3 mobile consultation teams.

(1) The headquarters section consists of a psychiatrist (commander), psychologist, medical operations officer, and 5 enlisted members.

(2) The 25-cot treatment section consists of a psychiatrist, 2 psychology nurses, and 11 enlisted members.

(3) Each mobile consultation section consists of a psychiatrist, two social work officers, and six enlisted members.

*b*. This unit is 100 percent mobile. It collocates with a medical company (clearing) or hospital for administrative and logistical support, but must maintain its separate, *nonpatient-care* identity. It conducts brief restoration or reconditioning programs. Its mobile teams deploy to conduct preventive programs, provide support to units which are undergoing reconstitution, and reinforce Echelon III medical companies (clearing) or DMHSs to provide restoration treatment for large numbers of battle fatigue casualties.

### 12-8. Echelon IV Services

Depending on availability and phase of battle, a Team OM may be allocated to the COMMZ. This team–

- Assists in preventing combat stress casualties.

- Treats local stress casualties.

- Provides additional reconditioning for RTD of cases who must be evacuated from the combat zone.

If no Team OM is available, limited CSC support may be provided by the mental health staff of the general and station hospitals.

### 12-9. Medical Force 2000

Combat stress control units under Medical Force 2000 are discussed in Appendix H.

# CHAPTER 13

# THEATER ARMY MEDICAL MANAGEMENT INFORMATION SYSTEM

## 13-1. Overview

*a.* The Theater Army Medical Management Information System supports the information management requirements of field medical units during contingency operations and in war. This system aids the US Army in effectively transporting, treating, and tracking patients at field (TOE) medical facilities worldwide. Some field medical units were provided the system in fiscal year (FY) 1990. This system will be provided to remaining units during FYs 91 and 92. The system assists the user in the field in carrying out his functional responsibilities. The systemwas designed to–

- Replace a manual system.
- Support what people in the field need to do their jobs.
- Provide the user with a system that is efficient, effective, and user friendly.

*b.* The TAMMIS is the wartime baseline system for the DOD. Adjustments may be made to meet Army, Navy, Marine, and Air Force wartime requirements while ensuring compatibility between Services throughout the theater of operations.

*c.* The TAMMIS assists medical personnel on the battlefield by providing timely, accurate, and relevant information through the following subsystems:

- MEBLD–TAMMIS Medical Blood Products Management.
- MEDPAR–TAMMIS Medical Patient Accounting and Reporting.
- MEDREG–TAMMIS Medical Regulating.
- MEDSUP–TAMMIS Medical Supply.
- MEDMNT–TAMMIS Medical Maintenance.
- MEDOPT–TAMMIS Medical Optical Fabrication Management.

*d.* Each subsystem also has command and control or MEDC2 capabilities which provide the status (summary reports) of medical units, evacuation work load, and critical resources through predetermined reports or from information selected by the user. Table 13-1 displays the medical portion of the US Army CSS automation architecture.

*e.* Controlled accessibility is a TAMMIS feature included both to simplify the system and to increase security. During system setup, the local manager establishes each user's accessibility to each part of the system through system setup files; the user will review only the portion of the system that pertains to his job responsibilities. The local manager can also adjust his unit's system to accommodate local requirements and the operating environment.

*f.* The TAMMIS has flexible communication capabilities and can relay information between units in various ways. The preferred medium, however, involves direct communication between computers through a military communications network. When direct electronic communications links are not available, users may pass information by courier via floppy diskette, tape, or hard copy.

## 13-2. The TAMMIS Blood Products Management System

*a. Purpose.* The MEDBLD system handles information concerning the collection, processing, inventory, transfusion, and distribution of blood products within the theater. The same information is shared with blood managers outside the theater.

*b. Design.* The MEDBLD system is designed to–

- Speed blood shipments by automatically generating blood shipment lists.

*Table 13-1. Medical Portion of the US Army CSS Automation Architecture*

| SYSTEM NAME/USE | SYSTEM FUNCTIONAL AREA | PROPONENT AGENT | USER | MANAGEMENT LEVEL | SYSTEM INTERFACES WITH | SYSTEM OUTPUT | ACTUAL OR TARGETED HARDWARE |
|---|---|---|---|---|---|---|---|
| TAMMIS MEDICAL PATIENT ACCOUNTING AND REPORTING<br><br>(MEDPAR) | PATIENT ACCOUNTING AND REPORTING | DA SURGEON GENERAL | HOSPITALS AT CORPS AND EAC | MEDICAL COMMAND AND CONTROL HQ | MEDREG, SIDPERS-3, CSSCS | ADMISSION AND DISCHARGE OF PATIENTS<br><br>COLLECTION OF STATISTICS<br><br>VSI/SI/SC REPORTING<br><br>PREPARATION OF SPECIAL REPORTS | ATCCS-CHS |
| TAMMIS MEDICAL REGULATING<br><br>(MEDREG) | MEDICAL REGULATING | DA SURGEON GENERAL | MEDICAL COMMAND AND CONTROL HQ AT CORPS AND EAC | MEDICAL GROUPS AND MEDICAL COMMAND AND CONTROL HQ AT CORPS AND EAC | MEDPAR, AECC, TAMCA, JTB, CSSCS, JMRO, DMRIS | MEDICAL FACILITY BED STATUS<br><br>SURGICAL BACKLOG INFORMATION<br><br>LOCATION OF SPECIAL MEDICAL EQUIPMENT | ATCCS-CHS, ACCS |
| TAMMIS MEDICAL SUPPLY, MEDICAL MAINTENANCE, AND OPTICAL FABRICATION MANAGEMENT<br><br>(MEDSUP, MEDMNT, MEDOPT) | MEDICAL LOGISTICS | DA SURGEON GENERAL | DIVISION DMSO, MEDSOM, HOSPITALS AT CORPS AND EAC | DMOC, MED GP/ BDE, MEDCOM | MEDBLD, DAMMS-R, SPBS-R, CSSCS, SARSS, SAMS, STANFINS | PERFORMANCE INDICATORS<br><br>VARIOUS LOGISTICS REPORTS<br><br>GENERAL MANAGEMENT REPORTS<br><br>STATUS OF DUE-IN/-OUT REPORTS<br><br>CRITICAL ITEMS OF SUPPLY LISTINGS<br><br>SUBSTITUTABILITY REPORTS<br><br>QUALITY ASSURANCE REPORTS | ATCCS-CHS/ CTASC-II |

*Table 13-1. Medical Portion of the US Army CSS Automation Architecture (Continued)*

| SYSTEM NAME/USE | SYSTEM FUNCTIONAL AREA | PROPONENT AGENT | USER | MANAGEMENT LEVEL | SYSTEM INTERFACES WITH | SYSTEM OUTPUT | ACTUAL OR TARGETED HARDWARE |
|---|---|---|---|---|---|---|---|
| TAMMIS BLOOD PRODUCTS MANAGEMENT<br><br>MEDBLD | BLOOD PRODUCTS MANAGEMENT | DA SURGEON GENERAL | DIVISION SURGEON, HOSPITALS AT CORPS AND EAC, BLOOD SUPPLY UNIT | MEDSOM | DBMIS, CSSCS, ASWBPL | ACCOUNTING AND CONTROL OF BLOOD PRODUCTS WITHIN THEATER<br><br>MANAGEMENT REPORTS<br><br>CROSS-LEVELING REPORTS<br><br>BLOOD STATUS REPORTS | ATCCS-CHS |

**Legend:**

| | |
|---|---|
| ACCS | Army Command and Control System |
| AECC | Aeromedical Evacuation Control Center |
| ATCCS-CHS | Army Tactical Command and Control--Common Hardware/Software System |
| ASWBPL | Armed Services Whole Blood Processing Laboratory |
| CSSCS | Combat Service Support Control System |
| CTASC II | Corps Theater ADP Service Center II |
| DAMMS-R | Department of the Army Movement Management System-Redesign |
| DBMIS | Defense Blood Management Information System |
| DMRIS | Defense Medical Regulating Information System |
| DMOC | Division Medical Operations Center |
| JMRO | Joint Medical Regulating Office |
| JTB | Joint Transportation Board |
| Med Gp/Bde | Medical Group/Brigade |
| MEDCOM | Medical Command |
| SARSS | Standard Army Retail Supply System |
| SAMS | Standard Army Materiel System |
| SC | special category |
| SI | seriously ill |
| SIDPERS-3 | Standard Installation/Division Personnel System |
| SPBS-R | Standard Property Book System-Revised |
| STANFINS | Standard Financial System |
| TACCS | Tactical Army CSS Computer System |
| TAMCA | Theater Army Movements Control Agency |
| VSI | very seriously ill |

• Track blood inventories by transmitting inventory information on each blood product from one location to another. (Projections of blood usage are provided to blood managers and to command and control locations. This alerts decision makers to potential shortages of blood products within their area of responsibility.)

*c. Automated Capabilities.* The MEDBLD system provides the user with automated capabilities in the following areas:

(1) *Collection and processing.* These functions record blood donor information and results of blood processing tests. The user can print work sheets to perform the testing and to record the components prepared from each unit of blood. The system assists with blood labeling to ensure that correct labels are affixed to each blood unit.

(2) *Inventory functions.*

*(a)* These functions provide the ability to monitor blood product inventories at all levels in the blood distribution system. Managers can determine blood shipment amounts using actual inventory data rather than summary information. Each echelon within the blood distribution chain maintains current inventories for its own location and all locations to whom it supplies blood products. Blood usage information is transmitted up the distribution and management chain so that every echelon is provided information on blood product usage, overages, and shortages. The system allows efficient shipment of bulk amounts of blood products or shipments of specific blood units.

*(b)* These functions allow users to print blood product inventories by total amounts, blood group and type, or by location. Users can also print lists of expired units of blood, blood shipment pull lists, and listings of blood products received. Users can query the system for the status of a specific blood product. They can change the status of any blood product from available in the blood inventory to quarantined, lost, or unusable. They can also print the audit file which contains all shipment, transfusion, and receipts of blood products for that day. They can transmit blood inventory and blood transfusion information from one location to another via floppy diskette or telephone modem.

(3) *Blood shipping and receiving.*

*(a)* These functions allow the efficient shipping of blood products from one location to another. The Distribute Blood Products function is provided to display current inventories at the shipping and receiving locations and to build shipment manifest files. This function also displays the previous shipment amounts and average daily usage of each blood product and computes a recommended shipment amount for the user.

*(b)* These functions are provided to print a pull list for shipping blood products and to print a received list that indicates which products should have been received. If a discrepancy exists in shipment, an exception file is created that can be printed by the receiving location. An audit file that records all shipping, receiving, and transfusion of products is also created and can be printed on demand.

*(c)* These functions are provided to send and receive shipping manifest files (lists of blood products to be shipped with appropriate information) via tape, floppy diskette, or telephone modem. When using the Distribute Blood Products function to ship blood products, the system determines which products are to be shipped; however, other functions are available to allow the user to select a particular unit or box of products to be shipped. A function is also available to record blood products received from sources outside TAMMIS.

*(d)* The division surgeon can order blood products for medical facilities within the division area by forwarding blood orders to a blood manager or blood product depot by modem, tape, or floppy diskette. He can review records of blood shipment orders by printing all orders for subordinate facilities within the past 30 days.

(4) *Transfusion.* These functions provide the ability to record blood products transfused to each patient. Crossmatch and transfusion listings can be printed by patient name.

(5) *Utilities.* These functions provide programs to create and view messages sent from one location to another, to write manifest files to

tape or diskette, to prepare new diskettes for use, and to send manifest files by telephone modem.

(6) *Roll-up reporting.* These functions provide consolidated information to medical command and control personnel.

## 13-3. The TAMMIS Medical Patient Accounting and Reporting System

*a. Purpose.* The TAMMIS MEDPAR system supports facility commanders in the management of patients and resources. The system tracks patients for casualty reporting and personnel strength accounting.

*b. Design.* The TAMMIS MEDPAR system is designed to operate at TOE hospitals within the corps and COMMZ. Individual patient data and medical information are accumulated to determine the availability of medical resources and to support the personnel and casualty reporting systems. The MEDPAR system will operate on the ATCCS-CHS computer.

*c. Automated Capabilities.* The MEDPAR system provides automated capabilities in the following areas:

(1) *Patient admission.* Enables hospital admission and disposition personnel using MEDPAR to quickly collect and maintain demographic information for all patients admitted to a facility. This information is used for patient tracking as well as the management of facility resources. The system prompts the user for information specific to the type of admission being performed. The system will allow patient admission information for patients being transferred from another MTF to be loaded into the data base.

(2) *Patient discharge.* The MEDPAR system quickly collects and maintains discharge data. The system prompts the user for information specific to the type of discharge being performed (RTD, transfer, AWOL, death, discharge from hospital, retired/separated from Service, or discharge to EPW camps). The system will also allow MEDPAR personnel to send transfer data for transfer patients sent to another MTF.

(3) *Patient record management.* Enables the user to produce a hard copy inpatient treatment record, sets of patient labels, and a hard copy of the patient record, including any transactions that have occurred during the patient's stay in the MTF. Personnel using MEDPAR will have the ability to archive and maintain the patient's record after the patient has been discharged from the facility.

(4) *Patient status management.* Allows the user to update information concerning the patient's condition, acuity (sharpness) level, stability, location within the facility, casualty status, and evacuation status. This information will be used to generate patient evacuation requests and patient manifests.

(5) *Patient accounting reports.* Enables the user to produce a Ward Report, Admissions and Dispositions Report, Recapitulation Report, Allied Admissions and Dispositions Report, VSI/SI/SC Roster, Patient Alpha Roster, Patient Roster by Unit, and a Reportable Conditions Roster. The system will allow the user to make Admission and Disposition Corrections to previous Admissions and Dispositions Reports, with the changes reflected on the next Admissions and Dispositions Report produced.

(6) *Facility management reports.* Enables personnel using MEDPAR to produce a Command Interest Roster, Patient Evacuation Roster, Expected Dispositions Report, Bed Status Report, Register Number Listing, Pre-Admission Report, Medical Summary Report Worksheet, and Medical Summary Report. The system also allows the user to print reports received from the MEDREG system and send the Bed Status Report to the MEDREG system via floppy diskette, tape, or modem.

(7) *Command interest roll-up (synopsis) reports.* Allows Recapitulation Reports, Bed Status Reports, Reportable Condition Reports, and Comment Reports to be sent to the next higher headquarters by floppy diskette, tape, or modem.

(8) *MEDPAR system maintenance.* The system enables the MEDPAR system administrator to maintain the MEDPAR system files, the archive log, and the select tables. The

system will allow the MEDPAR system administrator to modify specific report parameters for the Command Interest Report and the environmental information that describes the facility, location of the facility, and the number of operating room suites in the facility. This will give the system administrator the flexibility to meet changing requirements on the battlefield. The system will allow the system administrator to modify a patient register number, ensuring the integrity of the MEDPAR data base. The system will also allow the system administrator to reconcile the bed status of the facility. This useful function should be run when the system fails while a patient activity is being recorded. The system allows the user to make corrections to previous Medical Summary Report Worksheets. These changes are reflected in the monthly Medical Summary Report.

### 13-4. The TAMMIS Medical Regulating System

*a. Purpose.* The MEDREG system assists the medical regulator in managing the evacuation of patients so that patient medical and transportation requirements are most efficiently matched against available resources. The MEDREG provides reliable information on medical capabilities and operational constraints that the MEDCOM can use for medical planning and resource placement.

*b. Design and Automated Capabilities.* The TAMMIS MEDREG system operates at US Army corps levels and at echelons above corps. Medical regulators at medical groups and brigades, hospital centers, MEDCOM, and the JMRO will use MEDREG to designate beds for patients and to coordinate patient movement within the theater. The JMRO (or the senior medical regulating activity in the theater) will also coordinate with the Armed Services Medical Regulating Office (ASMRO) to regulate patients to facilities outside the theater. The MEDREG system provides the user with automated capabilities in the following areas:

(1) *MTF status and information.* The home base regulator uses the MEDREG system to enter, review, update, and print MTF patient evacuation requests from the US Army, other DOD services, allied armed services, and allied civilian MTFs. These processes manage evacuation requests for regulating patients.

(2) *Regulating patients within the command.* The home base regulator uses the MEDREG system to regulate patients within his command. The home base regulator may designate beds, assign transport, deny evacuation, remove bed designations, remove transport assignments, and print reports necessary for regulating patients locally.

(3) *Regulating patients to higher echelon.* The home base regulator uses the MEDREG system to regulate patients to a higher echelon of care. The home base regulator is directed by a regulator at a higher level to coordinate forwarded patient evacuations. These processes allow the home base regulator to enter bed designations, movement instructions and evacuation denials, to remove bed designations and movement instructions, and to print reports for regulating patients to a higher echelon of care.

(4) *Medical regulating reports.* The MEDREG system enables the user to produce and print medical regulating reports. These reports contain consolidated bed status, bed status and information at each MTF, available beds by specialty, airfields supporting each MTF, and evacuation request status. The reports are used to plan patient evacuations, manage medical resources, and optimize transportation.

(5) *Messages, reports, and requests.* The MEDREG system enables the user to produce, send, receive, or process Bed Designation Messages, Movement Instructions, Gaining Facility Messages, Evacuation Denial Messages, MEDPAR Evacuation Requests, Evacuation Delay Messages, MTF Bed Status, Command Summary Reports, and Consolidated Evacuation Requests.

(6) *Automated communications.* The MEDREG system enables the user to produce, send, receive, and process communications using floppy diskettes, tape, or modem. Electronically transmitted communications may be in the form of either electronic mail or transaction processor data. Transaction processor data files are processed automatically to update the receiving system data base. When transmission by electronic means is not possible, the system prints hard copies of the communications.

(7) *Maintaining historical data.* The MEDREG system allows the home base regulator to maintain bed status and evacuation requests for historical purposes. The historical information is produced and put in transaction processor data files which are transferred to floppy diskettes or magnetic tape for future reference.

(8) *Command and control.* The MEDREG system allows the home base regulator to produce and print the Command Summary Report and the Work Load Report by Facility. The reports are logged in an archive so that they may later be sent to the higher medical regulator or the CSSCS. The home base regulator may use these reports to plan evacuations, manage medical resources, and to schedule his work load.

(9) *System maintenance.* The MEDREG system allows the home base regulator to maintain the select table validation code files, clear the multiuser system lock files, and delete obsolete movement instructions. The select tables include patient categories, MOSs, and military grades. The multiuser system lock files enable several users to use MEDREG processes simultaneously. Obsolete movement instructions must be deleted to minimize system response time.

## 13-5. The TAMMIS Medical Supply System

*a. Purpose.* The TAMMIS MEDSUP system automates the comprehensive management and requisitioning of medical materiel (Class VIII supplies) required to support all medical units.

*b. Design.* The TAMMIS MEDSUP system is designed to operate at the DMSO within US Army divisions, at the MEDSOM unit (or medical battalion [logistics]), and TOE hospitals within the corps, and at the MEDSOM unit and TOE hospitals within the COMMZ. At the MEDSOM units, TAMMIS will operate on the CTASC-II which is a mini-mainframe computer. At all other locations (such as DMSO and TOE hospitals), TAMMIS will run on the ATCCS-CHS computer).

*c. Automated Capabilities.* The MEDSUP system provides the user with automated capabilities in the following areas:

(1) *Customer processing.* Enables the user to–

- Enter routine and emergency customer requests for medical materiel.
- Enter, approve, reject, or receive customer turn-ins.
- Maintain a customer request file where requests can be reviewed, modified, or canceled and supply status can be provided to the customer.
- Build and maintain an automated customer reorder list.
- Produce various customer supply and financial reports.
- Prepare files for customers.
- Load and process files from customers.

(2) *Requisitioning, receiving, and due-in items.* Allows the user to–

- Generate, review, and enter replenishment requisitions.
- Review, modify, or cancel due-in records.
- Generate follow-up requests and print due-in items report.
- Enter, process, review, and reverse receipts.
- Prepare files for supplier.
- Load and process files from supplier.

(3) *Maintaining local stocks, quality control, and reporting.*

*(a)* Enables the user to–

- Maintain local stock records and levels by adding or changing stock record files and processing stock number changes.

- Review item request history for stockage of item.
- Recompute requisitioning objective or reorder point (ROP) for stocked items.
- Review contingency versus active stocks.

*(b)* Allows the user to–

- Maintain a stock location file.
- Produce location reports.
- Conduct more efficient physical inventories.
- Perform inventory adjustments.
- Produce inventory reports.

*(c)* Allows the user to perform quality controls and destruction actions by–

- Processing quality control alert messages.
- Scheduling quality control surveillance inspections.
- Entering quality control data for materiel received.
- Entering or updating destruction records.
- Adjusting the stock record file for destruction.
- Printing quality control and destruction reports.

*(d)* Enables the user to–

- Obtain information for current stock status and process catalog changes.
- Perform monthly summary purge and create the STANFINS file.
- Perform periodic and special purpose reporting such as command and control and numerous supply management reports.
- Perform excess stock management and reporting.

(4) *Calling Up by the NSN, due in or due out, or transaction history.* Allows the user to–

- View current stock status, due-in or -out transaction history, and demand history on the screen.
- Modify or cancel customer requests.
- Review, modify, or cancel due-in records.

(5) *Setting up and maintaining system procedures.* Enables the user at initial system setup or during normal system operation to–

- Build or update the supported customer file.
- Build or update the supporting activity file.
- Build or update the environmental data file by entering and updating local destruction date, financial description data requisitioning objective or reorder point calculation data, processing default data, and control data.
- Update month and cutoff dates.
- Update reporting, printing, and display options.
- Perform archive file processing.
- Build an update cost file.
- Update the elements of expense file.

(6) *Reviewing exceptions referred to manager.* Allows the user to review and process exception records from the due-in exception file, customer demand exception file, receipt exception file, and replenishment exception file.

(7) *Ad hoc reports.* Allows the user to create, modify, delete, and print user designed temporary reports.

(8) *Interfaces.* Medical system interfaces with Standard Army Management Information System, specifically DAMMS-R CSSCS, SARSS, and SPBS-R.

### 13-6. The TAMMIS Medical Main

*a. Purpose.* The TAMMIS MEDMNT system supports the scheduled maintenance and repair of medical equipment essential for treating patients.

*b. Design.* The TAMMIS MEDMNT system is designed to operate at the DMSO within the US Army divisions, at the MEDSOM unit and TOE hospitals within the corps, and at the MEDSOM unit and TOE hospitals within the COMMZ. The system is used at each of these locations to manage equipment maintenance and repair for equipment owned by the supporting and supported units. In the MEDSOM units, MEDMNT will operate on the CTASC-II computer. In all other locations (DMSO and hospitals), MEDMNT will operate on ATCCS-CHS.

*c. Automated Capabilities.* The MEDMNT system provides the user with automated capabilities in the following areas:

(1) *Work order processing.* Allows the scheduling, assigning, tracking, and reporting of medical equipment maintenance work orders. It also allows the user to identify and track the status of equipment directly supported by local medical maintenance personnel.

(2) *Supply management.* Allows the unit to maintain information on stockage of items required to support the medical maintenance mission. It also allows the maintenance unit to interface with the supply system through the unit-level logistics system to requisition for nonmedical repair parts.

(3) *Periodic processing and reporting.* Provides a monthly performance report or scheduled and unscheduled maintenance service report to be used by local management or higher commands. It also produces a Materiel Condition Status Report, DA Form 2406, which could be passed to SAMS.

(4) *Command and control.* Provides command interest information concerning scheduled and unscheduled maintenance service performance. It provides the commander with up-to-the-minute status of all readiness significant items of medical equipment. This information may then be sent to the appropriate command level via automatic file transfer.

(5) *Maintenance system setup procedures.* Defines the local environment used to control system processing by identifying supporting activities, supported customers, and processing default data.

### 13-7. The TAMMIS Optical Fabrication Management System

*a. Purpose.* The TAMMIS MEDOPT system automates the management and requisitioning of materiel to support optical fabrication production and laboratory report preparation.

*b. Design.* The TAMMIS MEDOPT system is designed to operate within the corps at the MEDSOM unit, and within the COMMZ at the MEDSOM unit. The system is used at each of these locations to manage materiel required for optical fabrication and to prepare consolidated optical statistical reports.

*c. Automated Capabilities.* The MEDOPT system provides the user with automated information capabilities in the following areas:

(1) Maintaining locally stocked items. Enables the user to identify expendable items required for optical fabrication and to establish and compute the optimal stockage reorder levels and ROPs for each item.

(2) Ordering optical fabrication production materiel.

(3) Entering receipt of materiels.

(4) Updating or displaying status of due-in materiel.

(5) Generating follow-up status request.

(6) Preparing and processing status files.

(7) Preparing/entering Daily Optical Laboratory Report, DA Form 2717. Allows the user to quickly prepare the report daily.

(8) Setting up procedures. Allows the user to define the local unit and build the stock record file.

# CHAPTER 14

# SPECIAL HEALTH SERVICE SUPPORT PROVISIONS

## 14-1 Mass Casualties

Mass casualties may result from any type of warfare. The term *mass casualties* means that a large number of casualties has been produced simultaneously or within a relatively short period of time. It also means that the number of patients requiring medical care exceeds the medical capability to provide treatment in a timely manner. In other words, an absolute disparity exists between the number of patients, the available medical resources (personnel, facilities, equipment, supplies, communications, and evacuation means), and timely treatment.

## 14-2. Mass Casualty Situation

*a.* A mass casualty situation is present when one combat medic is confronted with two critically injured patients at the same time. An inability to provide these patients the required level of emergency medical treatment exists for a period of time. With a large number of casualties, the disparity may be multiplied many times; this greatly disrupts the doctrinal approach to treatment and evacuation. The disruption in adequate treatment distinguishes a mass casualty situation from a peals load of patients. Each patient in a normal peak-load situation can be provided reasonably individualized and timely treatment and evacuation according to normal HSS policy. Whether mass casualties occur during a routine or a peak-load situation, the patients already in (or being received by) the MTF may (could) also be managed according to mass casualty procedures.

*b.* In addition to the treatment and evacuation of a large number of military and civilian casualties, problems may occur from disruptions in the supply, communication, and transportation systems.

## 14-3. Adjustments in Health Service Support During Mass Casualty Situations

When patients are produced in numbers which exceed rated capabilities for conventional warfare, medical units that are within the direct effect within the theater must be prepared to change the standards and scope of medical treatment which they ordinarily provide. These changes in situations of medical disparity must be in compliance with the objectives to *provide the greatest good for the greatest number* and to return soldiers to duty as soon as possible.

## 14-4. Triage of Mass Casualties

Triage (sorting) of mass casualties means evaluating and categorizing casualties for priority of treatment and evacuation. This ensures the medical mass casualty principle: *providing the greatest good for the greatest number*. Triage is accomplished by highly experienced medical personnel who can make sound and quick clinical judgments. Medical personnel identify each patient by a category title which indicates the urgency of his receiving treatment and likelihood of his survival based upon the clinical problems and availability of medical care. Rapid triage assures that the available treatment is directed to the patients who have the best chance to survive. (See FMs 8-9 and 8-10-4 for discussions on triage.)

*a. Treatment Categories of Mass Casualties.* The following are four broad treatment categories of mass casualties:

(1) *Immediate.* This category is for the patient whose condition demands immediate, resuscitative treatment. An example of this treatment is the control of hemorrhage from an extremity. Generally, the procedures used are short in duration and economical in terms of medical resources. (Approximately 20 percent of the casualties are normally in this category.)

(2) *Delayed.* This category is for the patient whose condition is such that, with the application of modest emergency procedures, the possibility of disease or death increases very little by delaying major definitive procedures until they can be performed. An example of this emergency procedure would be an adequately splinted closed

fracture. (Approximately 20 percent of the casualties are normally in this category.)

(3) *Minimal.* This category is for the patient who can be returned to some form of duty by performing procedures requiring minimal resources. Follow-up treatment may be needed after the disparity phase is terminated. (Approximately 40 percent of the casualties are in this category and most are ambulatory.)

(4) *Expectant.* This category is for the patient whose injuries are massive and the probability of his survival is questionable. Examples of patients in this category are those with severe head injuries or massive severe burns. *Providing the greatest good for the greatest number* during the period of medical disparity dictates that a minimal number of medical personnel manage this category of patients. Patients should be managed with alertness (expectancy) to changes in their condition. They should be given symptomatic and supportive care until the available medical resources permit an intensive effort in their behalf. (Approximately 20 percent of the casualties are normally in this category.)

*b. Medical Management.* Although the nature of medical management during a mass casualty situation changes from *most critical come first to the greatest good for the greatest number,* at no time is the abandonment of a single patient contemplated. Therefore, treatment during a mass casualty situation is based on what can be done to save as many lives as possible and to maximize RTD. As each patient is treated, his condition is continually reevaluated to determine if a change in treatment emphasis is warranted. When the disparity between mass casualties and limited medical capabilities has been overcome, conventional principles and practices will prevail.

### 14-5. Command Surgeon Responsibilities in Mass Casualty Operations

*a.* The command surgeon's role in preparing for a mass casualty situation includes the development of a mass casualty plan. In addition to providing support to the normal mission, the command surgeon recommends protective measures against other forms of warfare which could result in the generation of mass casualties. When a mass casualty situation occurs, the surgeon is responsible for management of the casualties.

*b.* The command surgeon must develop a mass casualty plan that is clearly defined and which is sufficiently detailed for understanding at all levels. It must be executable at the appropriate level.

*c.* The command surgeon must address in the plan such items as–

- The medical situation.
- The evacuation policy (including alternate plans) and responsibilities for casualty evacuation and medical regulating.
- Alternate treatment locations and evacuation routes.
- NBC considerations. (For example, should patients with NBC injury or contamination be regulated to certain hospitals; or will all hospitals have to receive NBC contaminated or injured patients? [In World War I, separate hospitals were designated for chemical casualties.])
- Emergency resupply for Class VIII and blood.
- Nonmedical resources (especially personnel and transportation).
- The types of additional nonorganic medical assets needed.
- Priority of support and communications between evacuation assets and treatment assets.
- A clear delineation of medical responsibilities throughout the operational, technical, and administrative chains of command.
- Procedures for keeping necessary records and reports of the flow of casualties.

*d.* Mass casualty operations should be considered as part of an area damage control (ADC) mission, coordinated through and approved by the

tactical commander and his principal staff, and incorporated into the overall tactical plan. The mass casualty plan must–

- Be coordinated with echelons above and below.
- Be adaptable to day and night operations.

*e.* Directives from higher echelons should provide the guidance and support to permit effective execution of the mass casualty plan.

### 14-6. Mass Casualties in a Nuclear, Biological, or Chemical Environment

*a.* Chemical weapons may be encountered anywhere along the operational continuum. The proliferation of chemical and biological warfare capabilities in the armed forces of the Third World raises the specter of use of these agents in future conflicts. Technological advances have increased the vulnerability of established societies by providing more advanced weapons to insurgents and terrorists. The ability to build small nuclear devices and the potential use of chemical or biological weapons by terrorists are growing possibilities across the operational continuum. The threat of NBC use by Third World nations or radical groups vastly increases the perceived potential political leverage exercised by those nations or groups. (See FM 8-42 for a discussion of LIC.) For each of these three types of weapons, the US has separate and distinct national policies. (The policies are discussed in FM 100-1.)

*b.* Enemy employment of a nuclear weapon or of a biological or chemical agent may produce not only an unusually large number of casualties but may also impair the existing provisions for HSS. A nuclear attack reduces the medical capability (facilities and personnel), and contamination from an NBC attack markedly hinders medical operations.

*c.* In an effort to provide adequate HSS in an NBC environment, definitive planning and coordination are mandatory at all command levels. Higher headquarters must distribute timely, well-understood plans and directives to subordinate units. A nuclear medical consultant is assigned to the MEDCOM to assist the surgeon in the development of the HSS plan.

*d.* Although the surgeon is not responsible for making casualty estimates, he makes an appraisal of the number and types of patients so that HSS requirements can be anticipated and the command response on the situation can be managed. However, HSS must not be delayed pending such an appraisal.

*e.* Information on NBC defense is contained in FMs 3-3, 3-4, 3-5, and 3-100. Detailed guidance on the estimation of doses of radiation and the use of unit radiation service categories is contained in FMs 3-3, 8-9, and TM 8-215.

### 14-7. Primary Responsibility of Health Service Support Personnel in an NBC Environment

When NBC warfare is initiated, HSS personnel must protect themselves first from the effects of these agents. This action will enable them to properly continue their mission to conserve manpower rather than to become casualties. This emphasis on HSS personnel protection must be maintained, particularly during the management and treatment of contaminated patients.

### 14-8. Other Responsibilities of Health Service Support Personnel in NBC Environment

Other HSS responsibilities in an NBC environment include the following:

- Protecting patients in MTFs from the effects of agents.
- Identifying illnesses suspected of being caused by biological agents.
- Advising the commander on immunizations and prophylaxis.
- Evaluating field sanitation procedures.
- Ensuring safety of subsistence (food, ice, and water).
- Ensuring therapeutic availability.

- Predicting effects of agents on personnel.
- Avoiding contamination. (See FM 3-3 for guidance.)
- Using individual and collective protection. (See FM 3-4 and TC 8-12 for guidance. )
- Training in NBC decontamination. (See FMs 3-5, 8-10-4, and 8-285 for guidance.)

### 14-9. Commander's Responsibilities in an NBC Environment

*a*. Combat, CS, and CSS commanders at every echelon must ensure that NBC defensive procedures for self-aid, buddy aid, combat lifesaver, individual, and unit are adequately trained. Field Manuals 3-5, 8-10-4, and 8-285 discuss the requirement for supported units to provide manpower for patient decontamination. These field manuals also provide patient decontamination procedures. Nonmedical personnel must be trained to perform search and rescue, immediate first aid, and initial NBC decontamination. Command emphasis is required also to ensure that–

- The soldier's skills to perform self-aid and buddy aid are current.
- The combat lifesaver is also trained and proficient in combat lifesaver skills.

*b.* Extremely limited medical assets require that supported unit commanders establish unit teams to decontaminate contaminated patients at the MTF. These unit teams function under medical supervision while decontaminating patients.

*c.* Based on medical recommendations, commanders establish procedures for the control and administration of nerve agent pretreatment (FM 8-285).

### 14-10. Health Service Support Operations in a Chemical Environment

Enemy forces may employ various kinds of persistent, semipersistent, and nonpersistent agents such as nerve, blood, blister, and choking agents. Contamination may occur in the form of vapor and liquid droplets, aerosol, and thicken agents.

*a*. HSS operations in a chemical environment require the involvement of all unit commanders (combat, CS, and CSS). This allows medical commanders/leaders to make accurate and timely decisions concerning critical medical issues such as–

- Type and amount of pretreatment or antidote to be employed.
- Degree to which collective protection shelters are deployed and employed.
- Management of patient flow.
- Deployment of chemical agent patient decontamination and treatment sets.

*b.* The MTF's must avoid intentionally entering contaminated areas (contamination avoidance). Depending on the topography, the hospital site, its location relative to likely NBC targets, and the climatic conditions, medical units may have to operate from contaminated sites for short periods of time. After determining the type and persistency (longevity) of the contamination hazard, the unit commander will determine if the MTF will continue its mission in place or move to an uncontaminated site. A nonpersistent agent such as a blood agent will dissipate within minutes, whereas a persistent agent such as mustard may not dissipate for days or weeks. The MTFs will relocate from contaminated areas after the appropriate disposition of patients is accomplished and permission is received from higher headquarters.

*c.* Medical equipment will be protected by the use of chemical agent resistant containers, materials, and coatings and will be designed as much as possible to facilitate ease of decontamination.

*d.* Echelon I, II, and III MTFs should employ collective protection shelters when available. These shelters allow treatment personnel to function in contaminated areas. They *eliminate* the need for patients or treatment personnel within these shelters to wear protective clothing and

protective masks. These shelters also allow medical personnel to examine and treat patients unimpeded by the patient's or their own protective gear. They are a total system designed to afford prolonged protection from NBC hazards. (SeeTC 8-12 for discussion.)

### 14-11. Self-aid and Buddy Aid in a Chemical Environment

*a.* Soldiers are equipped and trained to perform basic soldier skill decontamination and first aid to themselves with minimum interruption to their mission.

*b.* Soldiers are equipped and trained to perform basic soldier skill decontamination and first aid to their buddies who are incapacitated or otherwise unable to help themselves. Buddy aid also includes those actions required to prevent further injury to the casualty from the effects of chemical hazards.

*c.* First aid includes the initial and continued administration of antidotes. (See FM 21-11 for discussions on self-aid and buddy aid in a chemical environment.)

### 14-12. Triage in a Chemical Environment

Triage (by separating wounded or chemically injured soldiers according to the type and severity of injury) is used to facilitate the most effective use of limited medical resources and provide the greatest good for the largest number. (See FMs 8-9 and 8-10-4 for discussions.)

### 14-13. Decontamination

*a.* Basic soldier skill decontamination is an individual (self), buddy, and unit responsibility performed with individual decontamination kits. Complete patient decontamination just prior to medical treatment is the responsibility of the patient decontamination team composed of nonmedical personnel from the supported units working under the direct supervision of medical personnel.

*b.* Chemical warfare agent patient treatment sets and patient decontamination sets are provided to MTFs.

*c.* Contaminated patients requiring lifesaving or limb-saving treatment are taken to an area designated for the emergency treatment of contaminated patients. After emergency treatment is performed, they are taken to the decontamination area. Patients are decontaminated, checked for completeness of decontamination, and moved to an uncontaminated treatment environment or into collective protection for further medical treatment. Arriving chemical casualties who have been previously decontaminated are checked for completeness of decontamination during the triage process. If further decontamination is required, and the patients are stable, they are moved to the decontamination area.

### 14-14. Medical Care for Chemical Casualties

*a.* Combat medic (aidman) treatment is normally the first medical care that a chemical casualty receives from medical personnel. In addition to treating for conventional injuries, the aidman rapidly examines the patient for signs of chemical injury and contamination, ascertains the number and type of agent antidote previously administered (if any), and decides if an additional antidote is necessary (see FM 8-285). Antidote(s) administered will be recorded on the patient's field medical card. Field dressings that protect against further contamination will be available.

*b.* When time and severity of injury permit, decontamination is accomplished prior to emergency medical treatment. When chemically contaminated patients are received at the BAS with conventional wounds, life- and limb-saving procedures take precedence over decontamination. As stated in paragraph 14-7, AMEDD personnel must protect themselves. Patients are managed to minimize the danger of the contamination hazard, treated, and then decontaminated without further aggravating their injuries. Medical judgment is rendered to determine which patients receive priority of treatment and evacuation. Priority is given to emergency treatment to preserve life or limb over immediate decontamination. Decontaminated and treated patients are placed in patient protective wraps before evacuation. Complete decontamination of patients at the BAS is limited to those patients requiring medical intervention before evacuation. Patients in mission-oriented protection posture (MOPP) not requiring stabilization care at the BAS will receive spot decontamination of their

protective overgarment. They will then be treated and RTD, or they will be evacuated without having their protective overgarment removed.

*c.* Many patients will have been previously decontaminated and treated at a BAS prior to arriving at the clearing station. Nevertheless, all arriving patients must be checked for contamination and, if necessary, decontaminated by nonmedical personnel from supported units. Patients are then treated and returned to duty; or they will be treated and placed in chemical agent patient protective wraps, and evacuated. Complete decontamination of patients at the clearing station is limited to those patients requiring medical intervention before further evacuation. Patients in MOPP not requiring stabilization care at the clearing station will be evacuated to the next echelon of care without having their protective garment removed.

*d.* Experience from World War I and from civilian toxic chemical, radiation, and infectious disease emergencies show clearly that these invisible, pervasive threats produce many purely psychological casualties, especially in uneducated and inexperienced populations. This is especially true when the agent is persistent, contagious, or produces delayed illness and death. Additionally, casualties who have suffered true, but minor, injury from the agent may have symptoms and disability which are out of proportion, and which continue longer than the actual injury explains. Often, the symptoms of both the pure and the partial psychological casualties may resemble the true injury, at least superficially. Diagnosis may be very difficult when everyone is in individual protection, but must be accomplished as far forward as possible. As with other forms of battle fatigue, evacuation of soldiers to rear areas and hospital environments often result in chronic disability. These casualties must be treated as far forward as possible with strong positive reassurance, rest and nutritional replenishment, and activities which restore confidence so that they may be rapidly returned to duty. Their treatment should be in proximity to their unit with the expectation that they will be returning to duty relatively soon.

*e.* Hospitals are located in uncontaminated areas away from potential tactical targets. Most chemical warfare agent patients arriving at hospitals from forward areas have been decontaminated; however, contaminated patients may come directly (usually from the rear areas) to the hospital. Decontamination of these patients is accomplished by nonmedical personnel from the base cluster or geographic location of the hospital. (See FM 8-285.) Medical personnel will supervise patient decontamination procedures to prevent further injury to the patient. Hospitals provide surgical and medical resuscitative, definitive, and specialty care. Chemical patients are returned to duty when fit, or are evacuated from the theater.

### 14-15. Medical Evacuation

*a.* Following the initial first aid and orderly collection of casualties by nonmedical personnel and the categorical triage and emergency medical treatment by medical personnel (paragraph 14-4), the casualties requiring additional extended treatment must be evacuated to the MTF best able to receive and treat them. Air and ground assets as well as personnel probably will be required from nonmedical units to support the evacuation of patients to the initial MTF. Subject to the provisions of the Geneva Conventions, military police may make EPW who volunteer available to work, and civil affairs units may procure indigenous personnel who may be employed to assist in both military and civilian patient collection and evacuation. Under no circumstances, however, may these EPW or indigenous personnel be exposed to grave danger.

*b.* The characteristics and lethality of an integrated battlefield and their impact on combat operations require the coordination of medical evacuation plans with tactical plans. The method of patient evacuation depends on the tactical situation, degree and type of area contamination, and availability of transportation assets. The evacuation plan supports the tactical commander's plan.

*c.* Caution must be exercised when aeromedical evacuation is employed on the intergrated battlefield. Several problems are associated with usage of aeromedical evacuation in a chemical or nuclear contaminated environment. For example, aircraft are not easily decontaminated, and the rotor or propeller wash may cause contamination to be resuspended and blown into all nearby objects including the aircraft itself. Should it become

necessary to commit air evacuation resources into a contaminated area, then these resources should remain dedicated to operations within contaminated areas.

*d.* The mass casualty potential of NBC warfare establishes the need for backup support for medical evacuation assets. Units will be prepared to use organic vehicles to transport casualties.

# APPENDIX A

# COMMAND AND CONTROL–MEDICAL FORCE 2000

## A-1. Command and Control Units

The major command and control units in the theater of operations are the MEDCOM, the medical brigade, and the medical group. Although the names of the units are the same as current H-edition TOE, the L-edition TOE discussed in this appendix may have significant differences in the areas of mission, assignment, capabilities, and basis of allocation.

## A-2. Headquarters and Headquarters Company, Medical Command, TOE 08-611L000

*a. Mission.* The mission of the headquarters and headquarters company, medical command, is to provide command, control, administrative assistance, technical supervision, and consultation services for assigned and attached units in the theater of operations. A schematic of a MEDCOM is depicted in Figure A-1.

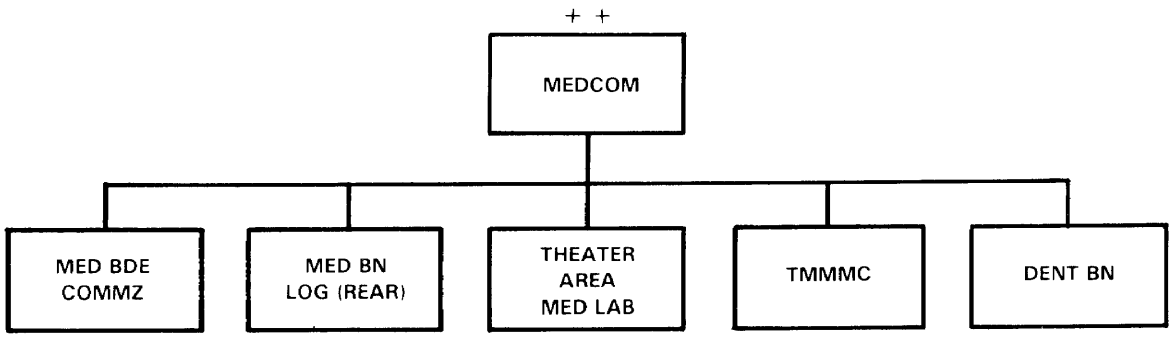



*Figure A-1. Medical command.*

*b. Assignment.* This organization is assigned to the TA.

*c. Capabilities.* This organization provides–

- Command and control units providing HSS in the theater of operations.
- Task organization for all theater of operations medical assets to meet the patient work load. Medical assets are designed by duty functions and are interchangeable throughout the theater of operations to meet work load requirements.
- Advice to senior commanders on the medical aspects of their operations.
- Command, control, staff planning, supervision of operations, and administration of the assigned and attached units. These functions include coordination for employment, patient evacuation, supply and equipment management, administrative services for the headquarters, and coordination between medical units operating in the MEDCOM's area of responsibility.
- Medical regulating and evacuation scheduling for patient movement to and between assigned and attached MTFs. This includes coordination with the Echelon III medical regulating officers and the JMRO in the theater of operations. This office provides technical advice and assistance concerning patient statistics, patient movement, administrative support, and statistical data requirements.
- Consultation services and technical advice in preventive medicine, environmental health, medical entomology, epidemiology, radiological health, sanitary engineering, nursing, dentistry, veterinary services, neuropsychiatry and social work, medicine and internal medicine, surgery, dietetics, optometry, and pharmacy to supported units. Preventive medicine consultative services include assessment of the medical threat,

evaluation of the theater preventive medicine program, technical advise on medical aspects of NBC and directed-energy weapons, and staff coordination of theater preventive medicine services. Neuropsychiatry and social work services include the recommendations for regulating the combat stressed soldier, psychiatric consultation, alcohol and drug prevention/control programs, and providing advice on the coordination of operations of the medical companies, CSC in the MEDCOM's area of responsibility. Dietary services and technical assistance include advice on nutrition in relation to health and fitness and medical food service consultation. Veterinary services and technical advice include status of approved sources of food for local procurement, food in storage, incidence or prevalence of zoonotic diseases, and food NBC contamination determination.

- Advice and assistance in facility site selection and preparation.

- Supervision of Class VIII and general supply usage and resupply movement.

- Unit-level vehicle, communications, weapons, and power generation equipment maintenance advice and management.

- Food service personnel for dining facility support for the headquarters and headquarters company, MEDCOM.

*d. Basis of Allocation.* One MEDCOM is allocated per TA.

### A-3. Headquarters and Headquarters Company, Medical Brigade (Corps, TOE 08422L100, or COMMZ, TOE 08-422L200)

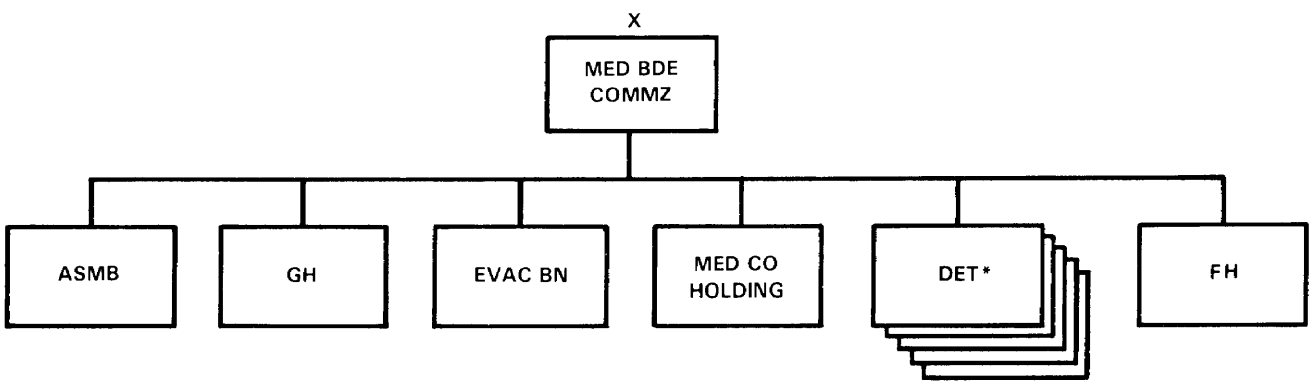
Medical brigade commanders have the ability to task-organize medical assets to meet the patient work load. The medical assets are modularly designed by duty functions and are replicated throughout the theater of operations to meet these requirements. Schematics of the medical brigade (COMMZ and CZ) are at Figures A-2 and A-3.

*a. Mission.* The mission of the unit is to provide command, control, administrative assistance, and technical supervision of assigned and attached medical units.

*b. Assignment.* This company is assigned to—

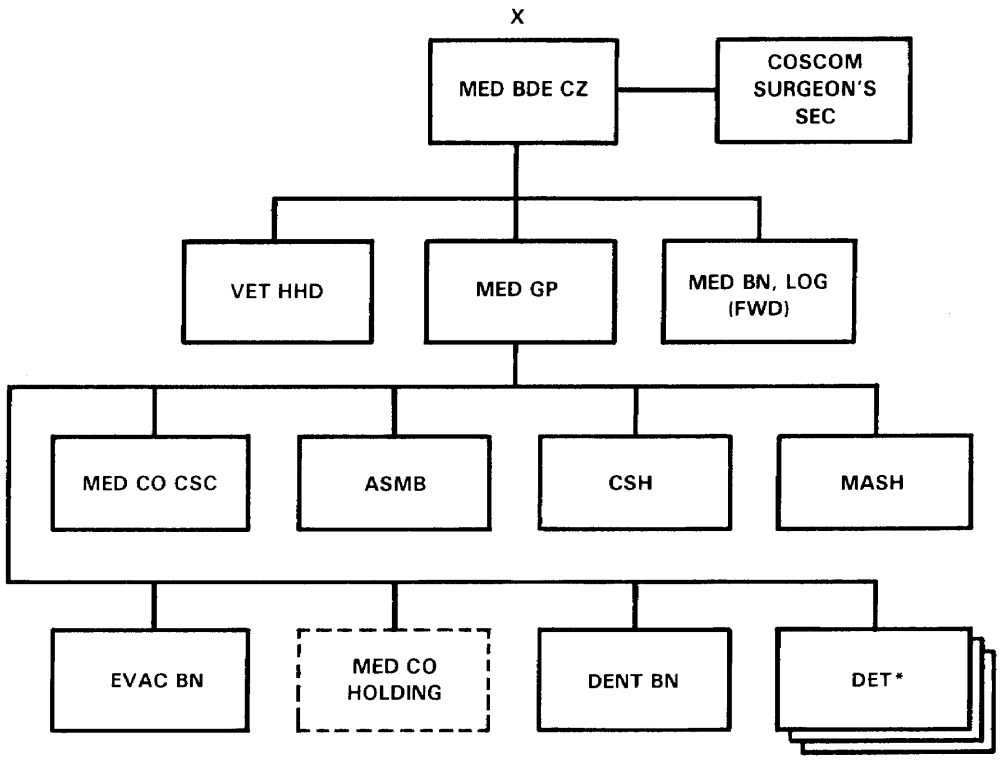
- Corps Support Command, TOE 63-431L000, when organized under TOE 08-422L100.

- MEDCOM, TOE 08-611L000, when organized under TOE 08-422L200.




*May include assigned or attached veterinary, surgical, dental, preventive medicine, and professional services detachments.

*Figure A-2. Medical brigade, COMMZ.*




*May include assigned or attached veterinary, surgical, dental, combat stress control, preventive medicine, and professional services detachments.

*Figure A-3. Medical brigade, CZ.*

*c. Capabilities.* At full strength, this unit provides–

- Command and control of all medical units in its area of operations.
- Task organization of medical assets to meet the patient work load demand. Medical assets are modularly designed by function and replicated throughout the theater of operations.
- Advice to senior commanders on the medical aspects of their operations.
- Medical regulation of patient movements to and between assigned and attached MTFs.
- Coordination with MEDCOM and or JMRO for all medical regulating for evacuation from the medical brigade facilities to supporting MTFs in the COMMZ and CONUS when organized as TOE 08-422L200.
- Consultation services and technical advice in preventive medicine, environmental health, medical entomology, radiological health, sanitary engineering, nursing, dentistry, veterinary services, and neuropsychiatry and social work to supported units.
- Advice and assistance in facility site selection and preparation.
- Control and supervision of Class VIII (medical) supply and resupply movement.

*d. Basis of Allocation. One MEDCOM is* as follows:

- Headquarters and headquarters company medical brigade (corps), TOE 08-422L100–one per corps.
- Headquarters and headquarters company, medical brigade (COMMZ), TOE 08-422L200–

- 0.2 per medical battalion, area support, TOE 08-445LOO0.

- 0.2 per headquarters and headquarters company, evacuation battalion, TOE 08-446L000.

- 0.2 per hospital.

- As a general rule of thumb, there is one medical brigade allocated per three to seven battalion-sized units.

**A-4. Medical Group, TOE 08-432L000**

*a. Mission.* The mission of the medical group is to provide command, control, and administrative supervision of assigned and attached corps medical units.

*b. Assignment and Basis of Allocation.* The medical group is assigned to the medical brigade. As a general rule of thumb, there are three medical groups per corps. As in the medical brigade (paragraph A-3), the commander of the medical group can task-organize his medical assets to meet patient work loads.

*c. Capabilities.* This unit's capabilities include–

- The command, control, staff planning, supervision of operations, and administration of the assigned and attached units which includes ASMBs, hospitals, evacuation battalions, CSCs, dental battalions, and preventive medicine detachments. The command of the assigned medical units includes coordination for employment, patient evacuation, supply and equipment management, and various other headquarters requirements. This command coordination is between its units and other medical elements operating in the medical group's area of responsibility. Units of the medical group may be task-organized to support close, deep, and rear operations.

- Medical regulation for evacuation and the scheduling of medical group facilities in coordination with brigade medical regulating office (MRO) to hospitals assigned to other medical brigades. This includes coordination with the DMOC in those divisions organized under the FSB and MSB concept and the medical battalion headquarters in other divisions to regulate the patient evacuation from the division's area of operation. It also coordinates with medical brigade all medical regulating for further evacuation from the medical group facilities to the supporting MTFs in the COMMZ.

- Consultation services and technical advise in preventive medicine, environmental health, sanitary engineering, nursing, mental health, and facility site selection and preparation to supported units. Preventive medicine consultative services include—

- Assessment of the medical threat.

- Evaluation of theater preventive medicine programs.

- Technical advise on medical aspects of NBC and directed-energy weapons.

- Staff coordination on employment of theater preventive medicine assets.

Mental health consultation includes monitoring the distribution and treatment of neuropsychiatric and battle fatigue casualties, alcohol and drug misuse, the prevention and reconditioning programs, and the supervision of the medical company (CSC) in the medical group's area of operation.

- Supervision of Class VIII and general usage and resupply and movement.

# APPENDIX B

# HOSPITALIZATION–MEDICAL FORCE 2000

## B-1. Hospitalization System

This appendix presents the hospitalization system designed under Medical Force 2000. The current system discussed in Chapter 5 will be replaced by four types of hospitals and a medical company, holding. The four hospitals are the MASH, the CSH, the FH, and the GH. Although the names are the same as current hospitals, they have significant differences in structure and mission. The CSH, FH, and GH are designed using a four-module concept. This concept includes the hospital unit, base (HUB); hospital unit, surgical (HUS); hospital unit, medical (HUM); and hospital unit, holding (HUH). The base can operate independently, is clinically similar, and is located in each hospital as the initial building block. The other three mission-adaptive modules are dependent upon the base. This capability may be further enhanced by *medical detachment augmentation.*

*a. Hospitalization Units at Echelon III.* The MASH, CSH, and the medical company, holding, are at this echelon.

*b. Hospitalization Units at Echelon IV.* The GH and FH are at this echelon. The field hospital may also be employed in the CZ. The MASH, CSH, and medical company, holding, may also be deployed in the COMMZ to support rear operations or contingency operations.

## B-2. Mobile Army Surgical Hospital, TOE 08-765L000

*a. Mission.* The mission of the MASH is to provide hospitalization for patients who require far forward surgery and medical treatment to stabilize them for further evacuation. Although the MASH is an Echelon III unit, it is designated to primarily function within the rear area of the division or the forward edge of the corps.

*b. Assignment.* The MASH is assigned to a medical brigade and may be further attached to a medical group.

*c. Capabilities.* This unit provides–

- Lifesaving initial wound surgery for patients requiring stabilization prior to further evacuation.
- Three wards providing preoperative and postoperative acute nursing care for up to 30 patients.
- Surgical capability based on three operating room tables for general, thoracic, and orthopedic surgical capacity of 60 operating room table hours per day.
- Echelon I HSS, less dental, for organic personnel.
- Pharmacy, clinical laboratory, liquid blood, radiology, and food services.
- Patient administration and logistical services.
- A HUS (forward) that may operate detached for up to 48 hours with the following capabilities:
  - Emergency medical treatment services to receive, triage, and stabilize incoming patients.
  - Surgical capability based on one operating room table for a general surgical capacity of 24 operating room table hours per day.
  - One ward providing preoperative and postoperative acute nursing care for up to 10 patients.
  - Limited central materiel service.

*d. Mobility.* The MASH is 100-percent mobile.

*e. Basis of Allocation.* Two MASHs are allocated per corps.

B-3. Combat Support Hospital, TOE 08-705L000

*a. Mission.* The mission of this 296-bed hospital is to stabilize patients for further evacuation and to RTD those soldiers who fall within the corps evacuation policy. This hospital is capable of handling all types of patients and will normally be employed in the corps area.

*b. Assignment.* The CSH is assigned to a medical brigade and may be further attached to a headquarters and headquarters detachment, medical group.

*c. Capabilities.* At full strength, this unit provides–

- Hospitalization for up to 296 patients consisting of eight wards providing intensive nursing care for up to 96 patients, seven wards providing intermediate nursing care for up to 140 patients, one ward providing neuropsychiatric care for up to 20 patients, and two wards providing minimal nursing care for up to 40 patients.
- Surgical capacity based on eight operating room tables for surgical capacity of 144 operating room table hours per day.
- Consultation services for patients referred from other MTFs.
- Echelon I HSS for organic personnel.
- Pharmacy, clinical laboratory, blood banking, radiology services, and nutrition care services.
- Physical therapy support to patients.
- Medical administrative and logistical services to support work loads.
- Dental treatment to staff and patients and oral surgery support for military personnel in the immediate area plus patients referred by the area HSS units.

*d. Mobility.* The CSH is 35-percent mobile.

*e. Basis of Allocation.* The CSHs are allocated 2.4 per division or 4,223 per 1,000 occupied beds in the CZ.

**B-4. Field Hospital, TOE 08-715L000**

*a. Mission.* This 504-bed facility provides hospitalization for general classes of patients and reconditioning and rehabilitating services for those patients who can RTD within the theater evacuation policy. The majority of patients within this facility will be in the reconditioning and rehabilitating category. The FH will normally be located in the COMMZ; however, circumstances may direct that this hospital be employed in the corps.

*b. Assignment.* The FH is assigned to a MEDCOM. It may be further attached to a medical brigade.

*c. Capabilities.* At full strength, this unit provides–

- Hospitalization for up to 504 patients consisting of two wards providing intensive nursing care for up to 36 patients, seven wards providing intermediate nursing care for up to 140 patients, one ward providing neuropsychiatric care for up to 20 patients, two wards providing minimal nursing care for up to 40 patients, and seven patient support sections providing convalescent care for up to 280 patients.
- Surgical capability based on two operating tables for a surgical capacity of 24 operating room table hours per day.
- Consultation services for patients referred from other MTFs.
- Echelon I HSS for organic personnel.
- Pharmacy, clinical laboratory, blood banking, radiology, and nutrition care services.
- Physical and occupational therapy support.

- Medical administrative and logistical services.

- Dental treatment to staff and patients and oral surgery support for military personnel in the immediate area plus patients referred by area HSS units.

*d. Mobility.* This unit requires organic vehicles to perform housekeeping functions. All movement requirements are the responsibility of theater transportation units.

*e. Basis of Allocation.* Field hospitals are allocated two per division, or 1,462 per 1,000 occupied beds in the COMMZ.

**B-5. General Hospital, TOE 08-725L000**

*a. Mission.* This 476-bed facility provides stabilization and hospitalization for general classes of patients. The GH serves as the primary conduit for patient evacuation to CONUS. The GH will be located in the COMMZ.

*b. Assignment.* The GH is assigned to a MEDCOM and may be further attached to a medical brigade.

*c. Capabilities.* At full strength, this unit provides–

- Hospitalization for up to 476 patients consisting of eight wards providing intensive nursing care for up to 96 patients, sixteen wards providing intermediate nursing care for up to 320 patients, one ward providing neuropsychiatric care for up to 20 patients, and two wards providing minimal nursing care for up to 40 patients.

- Surgical capability based on eight operating room tables for a surgical capacity of 144 operating room table hours per day.

- Consultation services for patients referred from other MTFs.

- Echelon I HSS for organic personnel.

- Pharmacy, clinical laboratory, blood banking, radiology, and nutrition care services.

- Physical and occupational therapy support.

- Medical administrative and logistical services.

- Dental treatment to staff and patients and oral surgery support for military personnel in the immediate area plus patients referred by the area dental companies.

*d. Mobility.* This unit requires organic vehicles to perform housekeeping functions. All movement requirements are the responsibility of theater transportation units.

*e. Basis of Allocation.* The GH is allocated one per division supported or 0.829 per 1,000 occupied beds in the COMMZ.

**B-6. Medical Company, Holding, TOE 08-458L000**

*a. Mission.* The medical company, holding, provides–

- Holding capability within the CZ for up to 1200 minimal care patients.

- Minor medical treatment and rehabilitation for patients being held.

*b. Assignment.* The medical company, holding, is assigned to medical brigade, TOE 08-112H600. If a medical brigade is not yet established, it will be assigned to the senior medical command and control headquarters in the corps.

*c. Capabilities.* This unit–

- Provides five holding platoons, each capable of operating a holding facility with 240 supplemental cots for minimal care type patients. Platoons are organized consisting of six holding squads, each having a capacity of 40 patients, and one treatment squad.

- May be employed by platoon to expand hospital minimal care ward facilities.

• May be employed by platoon in conjunction with CSC squads to hold combat fatigue casualties.

• May be employed to augment USAF MASF.

• May be assigned responsibility for providing limited area HSS.

*d. Mobility.* This unit–

• Is capable of transporting 113,000 pounds (9,978.0 cubic feet) of TOE equipment with organic vehicles.

• Has 40,831 pounds (2,864.3 cubic feet) of TOE equipment requiring transportation.

*e. Basis of Allocation.* This unit is allocated on the basis of .50 per 1000 inpatients in the CZ. The rule of thumb is 4 per a five division corps.

**B-7. Various Hospital Configurations**

As stated earlier, all of the hospitals, except the MASH, are configured using various combinations. The CSH and the GH consist of a base component which is clinically similar in all hospitals and one or more mission-adaptive component (s) to meet work load requirements. The components are as follows:

• Hospital unit, base.

• Hospital unit, surgical.

• Hospital unit, medical.

• Hospital unit, holding.

Figure B-1 depicts the component hospital system.

**NOTE**

This hospital unit is not to be confused with the FH unit discussed in Chapter 5.

**B-8. The Hospital Unit, Base, TOE 08-736L000**

*a. Mission.* The HUB provides hospitalization for patients within the CZ and COMMZ.

*b. Assignment.*

(1) The HUB, TOE 08-736L100, is organic to CSH, TOE 08-705 L000.

(2) The HUB, TOE 08-736 L200, is organic to FH, TOE 08-715 L000.

(3) The HUB, TOE 08-736 L300, is organic to GH, TOE 08-725 L000.

*c. Capabilities.* This unit provides–

• Hospitalization for up to 236 patients consisting of three wards providing intensive nursing care for up to 36 patients, seven wards providing intermediate nursing care for up to 140 patients, one ward providing neuropsychiatric care for up to 20 patients, and two wards providing minimal nursing care for up to 40 patients.

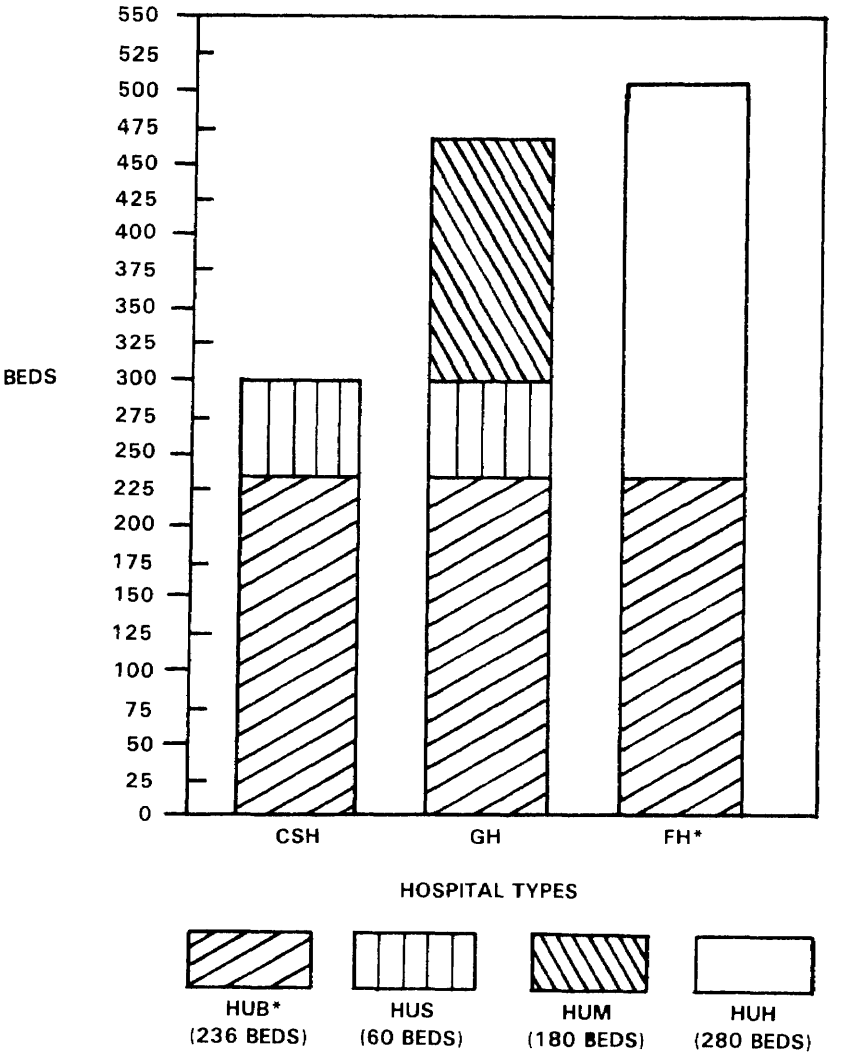
**NOTE**

Although the HUB has 236 beds, when it is used as the base component for the FH, it is only staffed to provide hospitalization for 224 patients. In the FH configuration, the HUB has two intensive care wards that provide care for up to 24 patients. By contrast, in the CSH and GH configuration, the HUB has three intensive care wards that provide care for up to 36 patients. This is therefore the reason for the 12-patient difference in the FH configuration.

• Surgical capability based on four operating room tables for 48 operating room hours per day.

**NOTE**

This capability does not apply to a HUB assigned to a FH.




*NOTE: Although the HUB has 236 beds, when it is used as the base component for the FH, it is only staffed to provide hospitalization for 224 patients. In the FH configuration, the HUB has two intensive care wards that provide care for up to 24 patients. By contrast, in the CSH and GH configuration, the HUB has three intensive care wards that provide care for up to 36 patients. This is therefore the reason for the 12-patient difference in the FH configuration.

*Figure B-1. Component hospital system.*

- Consultation services for outpatients referred from other MTFs.
- Echelon I HSS for organic personnel only.
- Pharmacy, clinical laboratory, blood bank, radiology, and nutrition care services.
- Physical therapy support to patients.
- Medical administrative and logistical services to support work loads.
- Dental treatment to staff and patients and oral surgery support for military personnel in the immediate area plus patients referred by the area HSS units.
- Occupational therapy support.

**B-9. The Hospital Unit, Surgical, TOE 08-737L000**

*a. Mission.* The HUS provides increased surgical capability to a HUB.

*b. Assignment.* A HUS is organic to a CSH, TOE 08-705 L000, and to a GH, TOE 08-725 L000.

*c. Capabilities.* As a component in the CSH or G H, this unit provides–

- Hospitalization for up to 60 patients consisting of five wards providing intensive nursing care.
- Surgical capability based on four operating room tables for a surgical capacity of 96 operating room table hours per day.
- Echelon I HSS, less dental, for organic personnel.
- Radiology augmentation services for up to 60 patients.
- Medical administrative services.

*d. Mobility.* The mobility of the HUS is dependent on corps or theater army transportation support.

*e. Basis of Allocation.* The HUS is assigned (a component) as follows:

- One per CSH, TOE 08-705L000.
- One per GH, TOE 08-725L000.

**B-10. The Hospital Unit Medical, TOE 08-738L000**

*a. Mission.* The mission of the HUM is to provide medical augmentation to a HUB.

*b. Assignment.* A HUM must be assigned to a GH, TOE 08-725L000.

*c. Capabilities.* As a component of the GH, this unit provides–

- Hospitalization for up to 180 patients consisting of nine wards providing intermediate nursing care.
- Consultation services for outpatients referred from other MTFs.
- Pharmacy, clinical laboratory, and radiology augmentation services for up to 180 inpatients.
- Physical and occupational therapy augmentation support.

*d. Mobility.* The mobility of the HUM is dependent on corps or theater Army transportation support.

*e.* Basis of *Allocation.* One HUM is allocated per GH.

**B-11. The Hospital Unit, Holding, TOE 08-739L000**

*a. Mission.* The mission of the HUH is to provide hospitalization for patients returning to duty within the prescribed theater policy.

*b. Assignment.* The HUH must be assigned to the FH, TOE 08-715L000.

*c. Capabilities.* As a component of the FH, this unit provides–

- Hospitalization for up to 280 patients consisting of seven patient support sections providing convalescent care.
- Echelon I HSS, less dental, for organic personnel.
- Physical and occupational therapy support to patients.
- Medical administrative and logistical services.

*d. Mobility.* The mobility of the HUH is dependent on corps or TA transportation support.

*e. Basis Of Allotcation.* One HUH is allocated per FH.

**B-12. Surgical Service Teams**

*a. Mission.* The mission of these teams is to provide surgical augmentation to CZ and COMMZ hospitals.

*b. Assignment.* These teams are assigned to a MEDCOM, medical brigade, or a medical group and may be further attached to subordinate hospitals as required.

*c. Detailed Characteristics of Teams.*

(1) *Medical team, head and neck surgery,* TOE 08-527LA0.

*(a) Capabilities.* This team provides initial and secondary maxillofacial and ear, nose, and throat surgery in support of theater hospitals.

*(b) Basis of allocation.* This team is allocated as follows:

- Combat zone–one per division.
- Communication zone–one per corps supported.

(2) *Medical team, neurosurgery,* TOE 08-527LB00.

*(a) Capabilities.* This team provides initial and secondary neurosurgery in support of theater hospitals.

*(b) Basis of allocation.* This team is allocated as follows:

- Combat zone–one per division.
- Communication zone–one per GH, TOE 08-725L000.

(3) *Medical team, eye surgery,* TOE 08-527LC00.

*(a) Capabilities.* This team provides initial and secondary ophthalmologic surgery in support of theater hospitals and consultative services as required on an area basis.

*(b) Basis of allocation.* This team is allocated as follows:

- Combat zone–one per division.
- Communication zone–one per corps supported.

**B-13. Medical Service Teams**

*a. Mission.* The mission of medical service teams is to provide medical augmentation to CZ and COMMZ hospitals.

*b. Assignment.* These teams are assigned to a MEDCOM, a medical brigade, or a medical group and may be further attached to subordinate hospitals as required.

*c. Detailed Characters tics of Teams.*

(1) Medical team, pathology, TOE 08-537LA00.

*(a) Capabilities.* This team provides investigative pathology support.

*(b) Basis of allocation.* This team is allocated to the COMMZ on the basis of one per corps supported.

(2) *Medical team, renal dialysis,* TOE 08-537LB00.

*(a) Capabilities.* This team provides renal hemodialysis care for patients with acute renal failure and consultative services on an area basis.

*(b) Basis of allocation.* One team is allocated per theater.

(3) *Medical team, infectious disease,* TOE 08-537LC00.

*(a) Capabilities.* This team provides infectious diseases investigative and

consultative services to the hospital to which attached.

*(b) Basis of allocation.* One team is allocated per corps.

# APPENDIX C

# HEALTH SERVICE LOGISTICS UNITS–MEDICAL FORCE 2000

## C-1. Restructuring of Health Service Logistics Units

The current health service logistics system discussed in Chapter 6 lacks early forward support capability, capacity, and flexibility. It hampers early deployment to a contingency theater to support the first increments of deployed forces. The health service logistics organizations discussed in this appendix have been developed to meet the demands of the ALB, Future. Health service logistics units have been restructured into forward and rear medical battalions (logistics) (MEDLOG battalions), the medical detachment (logistics) (support), and a theater medical materiel management center (TMMMC). The MEDLOG battalions will replace the MEDSOM units, medical supply teams, medical equipment maintenance teams, and blood processing, collecting, and distribution teams.

## C-2. The Medical Battalion (Logistics) (Forward), TOE 08-485L00

*a. Mission.* The mission of this organization is to provide Class VIII supplies, optical fabrication, medical equipment maintenance support, and blood storage and distribution to divisional and nondivisional units operating in the supported corps.

*b. Assignment.* This unit is assigned to a medical brigade, TOE 08-442L00.

*c. Capabilities.* At Level 1, this unit–

- Provides command and control, staff planning and supervision of operations, and administration of assigned or attached units engaged in providing Class VIII supplies, optical single lens fabrication, medical equipment maintenance support, and blood storage and distribution.
- Provides Class VIII supply based on 10 days of supply for the supported corps.
- Provides Class VIII supply, optical single lens fabrication, and medical equipment maintenance support to a maximum force of 160,252 troops.
- Receives, classifies, and issues up to 122.4 short tons of Class VIII supplies per day.
- Provides storage of up to 1224.0 short tons of Class VIII supplies.
- Provides unit and intermediate direct support medical equipment maintenance on an area basis.
- Provides for blood processing, storage, and distribution within the corps and division medical units.

*d. Basis of Allocation.* One MEDLOG battalion (forward) is allocated per corps or three division equivalent-sized force.

*e. Major Changes.* In addition to a significant increase in tonnage handling capability, the organizational structure provides greater flexibility to support the corps. The distribution company employs two modular forward support platoons to provide Class VIII support on an area basis for short periods of time. These platoons improve early deployment by supporting the first increments of deployed forces and by allowing the medical brigade commander to tailor forward support capabilities to support the combat commander.

## C-3. The Medical Battalion (Logistics) (Rear), TOE 08-695L00

*a. Mission.* The mission of this unit is to provide Class VIII supplies, optical fabrication, medical equipment maintenance support, and blood storage and distribution to EAC units and corps-level MEDLOG battalions (forward).

*b. Assignment.* This unit is assigned to a MEDCOM, TOE 08-611L00.

*c. Capabilities.* This unit–

- Provides command and control, staff planning and supervision of operations, and administration of assigned or attached units engaged in providing Class VIII supplies, optical multivision lens fabrication, medical equipment maintenance support, and blood storage and distribution.

- Provides Class VIII supply support based on a theater stockage objective of 60 days of which 50 days are found at the MEDLOG battalion (rear).

- Provides Class VIII supply, optical multivision lens fabrication, and medical equipment maintenance support to a maximum force of 653,000 troops.

- Receives, classifies, stores, and issues up to 276.9 short tons of ClassVIII supplies per day.

- Provides storage for up to 16,614 short tons of Class VIII supplies.

- Provides unit maintenance support for medical equipment to supplement additional units not otherwise provided such support.

- Provides for blood processing, storage, and distribution within the EAC and provides backup blood support for the MEDLOG battalion (forward).

- Provides direct support maintenance for medical equipment located in EAC and backup support to corps.

*d. Basis of Allocation.* One MEDLOG battalion (rear) is allocated per three corps supported.

*e. Major Changes.* Under the MEDSOM concept of operations, all MEDSOM units have the same base TOE. Modifications are made by adding teams as outlined in Chapter 6. The recognition of a separate organization which is designed and sized to support EAC represents a major change in doctrine and organization and makes the Class VIII logistics system much more capable to provide support.

**C-4. Theater Medical Materiel Management Center, TOE 08-897L00**

*a. Mission.* The TMMMC provides centralized, theater-level inventory management of Class VIII materiel according to the TA surgeon's policy.

*b. Assignment.* One TMMMC is assigned to MEDCOM, TOE 08-611L00, as an attached unit to MEDLOG battalion (rear).

*c. Capabilities.* The capabilities of this unit are to–

- Monitor the operation of medical logistics units under the jurisdiction of the TA.

- Monitor the receipt and processing of Class VIII requisitions from medical logistics units.

- Review and analyze demands and compute theater requirements for Class VIII supplies, medical equipment, optical fabrication, medical equipment maintenance, and blood processing, storage, and distribution.

- Monitor and evaluate the work load, capabilities, and asset position of the supported MEDLOG battalions (forward and rear) and recommend cross-leveling of work load or resources to achieve compatibility and maximum efficiency.

- Implement plans, procedures, and programs for medical materiel management systems.

- Provide medical materiel management data and reports required by the MEDCOM and TA surgeon.

- Function as the management interface with CONUS-based Class VIII national inventory control points and service item control centers.

- Provide management of critical items and analysis of production capabilities.

*d. Basis of Allocation.* This unit is allocated to MEDCOM, TOE 08-611L000, on the basis of one per MEDCOM.

*e. Major Changes.* The capability provided by this unit has not been available under the MEDSOM concept of operations.

**C-5. The Medical Detachment (Logistics Support), TOE 08-909L00**

*a. Mission.* The mission of this unit is–

- To provide Class VIII supply, optical fabrication, and medical equipment support functions.

- To tailor the capabilities of MEDLOG battalions (forward or rear) where work load or special operations require an increment of less than a battalion-sized unit.

*b. Assignment.* This unit is assigned to MEDLOG battalion (forward), TOE 08-485L00, or MEDLOG battalion (rear), TOE 08-695L00.

*c. Capabilities.* At Level 1, this unit–

- Provides augmentation to the unit of attachment for Class VIII, optical single-vision lens fabrication, and medical equipment maintenance support.

- Receives, classifies, and issues Class VIII supplies.

- Fabricates optical single-vision lens spectacles and mask inserts.

- Provides intermediate direct support maintenance for medical equipment.

*d. Basis of Allocation.* This unit is allocated as required.

*e. Major Changes.* This unit consolidates the functions of a number of separate augmentation detachments into one unit eliminating those units from the force structure.

# APPENDIX D

# MEDICAL LABORATORY SERVICES–MEDICAL FORCE 2000

## D-1. Theater Area Medical Laboratory

Medical Force 2000 assets will include a theater area medical laboratory (TAML), TOE 08-657L000. It will be allocated on the basis of one per theater. It will be under the command and control of the MEDCOM. This independent high-technology laboratory will be established in fixed buildings, with lines of communications and transportation to the MEDLOG battalion (rear).

*a.* The TAML is a 75-person unit which will provide medical laboratory procedures and data for the evaluation of environmental issues, including health of soldiers, within the theater of operations. These services will require skilled personnel and sophisticated high-technology equipment.

*b.* The TAML will have the ability to send specialty teams forward into the corps area to handle unique problems. It will have the capability to analyze–

- Samples to assist in definitive treatment of biological and chemical agent effects.
- Food, water, and other environmental samples and specimens from animals to assist veterinary and preventive medicine personnel in identifying and assessing NBC agents.

*c.* Although staffing for the TAML is austere, it will be adequate to allow for 24-hour operations.

*d.* The TAML will have the following limitations:

- It will be dependent upon appropriate elements of TA for health, finance, religion, mess, legal, personnel, and administrative services and for organizational, communications-electronics, and vehicle maintenance.
- It will have limited mobility. Organic vehicles will be required for day-to-day administration and logistical functions and for task organization of teams.

*e.* The TAML will have the capability to perform–

- Investigative biochemical and toxicological analyses.
- Microbiological identification and characterization.
- Serological testing related to disease diagnoses and prevention.
- Analyses of food items suspected of contamination.
- Detection and diagnoses of zoonotic diseases.
- Entomological analyses and limited pesticide adequacy assessments.
- Epidemiological analyses.
- Evaluation of environmental and clinical samples for NBC contamination.

*f.* The TAML will have the following sections:

- Headquarters section.
- Biochemistry section.
- Anatomical pathology section.
- Microbiology section.
- Veterinary laboratory section.
- Entomology section.
- Epidemiology section.

## D-2. Medical Laboratory Services in Echelons Above Corps

Unlike laboratories organic to hospitals, the TAML will perform functions with a much broader scope

related to the health of the force as a whole. The TAML will perform sample analyses to determine the process of disease or to evaluate contamination from NBC agents. To accomplish these analyses, the laboratory will require high technology identification kits and monitoring devices. Because of dangers inherent in analyzing contaminated samples, strict protection procedures will be implemented by the laboratory. Once the identification is made, samples will be forwarded to CONUS for confirmation. Samples which are beyond the analytical capabilities of the TAML will be forwarded to the appropriate higher level laboratories for more detailed analyses.

# APPENDIX E

# VETERINARY SERVICES–MEDICAL FORCE 2000

## E-1. New Organizations

Highly mobile veterinary service units have been developed that can relocate as rapidly as supported units. The veterinary structure discussed in this appendix replaces the current structure of Teams AF,JA,JB, XA, and XB. The new organizations are the medical detachment, veterinary service (headquarters); medical detachment, veterinary service; medical detachment, veterinary medicine; and medical detachment, veterinary service (small).

## E-2. Medical Detachment, Veterinary Service (Headquarters), TOE 08-409L000

*a. Mission.* The mission of this unit is to provide command and control, administrative assistance, and technical guidance of assigned and attached veterinary units in the theater of operations.

*b. Assignment.* This unit is assigned to a medical brigade (corps), TOE 08-422L100, or medical brigade (COMMZ), TOE 08-422L200. This unit may also be directly assigned to a MEDCOM, TOE 08-611L00.

*c. Capabilities.* This unit–

- Provides command and control of all veterinary functions within the area of operations and implements veterinary policies established by the medical brigade.
- Establishes communications and directs necessary coordination with supported logistical organizations of all uniformed Services and other federal agencies for all veterinary activities within the area of operations. This includes procurement of subsistence for DOD personnel and military working dogs.
- Coordinates veterinary support for military units with government-owned animals.
- Coordinates required veterinary support with host nation public health officials.
- Monitors and evaluates environmental and zoonotic diseases, and food safety data to include those foods exposed to NBC agents. Apprises the medical brigade commander of those factors posing a potential adverse effect on the overall HSS mission.

*d. Basis of Allocation.* One unit is allocated per four to eleven veterinary service and medical detachments.

## E-3. Medical Detachment, Veterinary Service, TOE 08-417L000

*a. Mission.* The mission of this unit is to provide veterinary services for all branches of the uniformed Services throughout the theater of operations. These services include–

- Sanitary inspections of approved food source facilities.
- Procurement and surveillance inspections of foods.
- Environmental and zoonotic disease surveillance.
- Veterinary care for government-owned animals.
- Civic action programs.
- Veterinary preventive medicine.
- Public health functions.
- Wholesomeness determination of food in an NBC environment.

*b. Assignment.* This unit is assigned to a medical brigade (corps), TOE 08-422L100, or medical brigade (COMMZ), TOE 08-422L200. The unit may be placed under the command and control

of the medical detachment, veterinary service (headquarters), TOE 08-409 L00. This unit may also be assigned to a MEDCOM, TOE 08-61lL000.

*c. Capabilities.* This unit–

- Provides command and control of all veterinary functions within the area of operations and implements veterinary policies established by the medical brigade until such time that the theater progresses to a level requiring assignment of the medical detachment, veterinary service (headquarters), TOE 08-409L000.

- Provides a highly flexible organization consisting of six mobile veterinary survey squads which can operate independently and maintains 100-percent visibility within the veterinary survey squad at all times. Squads can be task organized across squad lines or subdivided to meet a variety of functional scenarios within the stated mission. They are equipped to meet the travel requirements dictated by the assigned mission.

- Provides inspection services for commercial food sources in support of procurement organizations, publication and distribution of a directory of approved establishments, and inspection of all government food storage facilities.

- Provides inspections of all food at time of receipt. Performs surveillance inspection of all foods in storage, and at time of issue or resale.

- Monitors and evaluates environmental and zoonotic diseases and food safety data to include data on foods exposed to NBC agents. Apprises the medical brigade commander of those factors posing a potential adverse effect on the overall HSS mission.

- Provides limited veterinary care to DOD units with government-owned animals and veterinary support for civic action programs.

- Establishes communications and directs necessary coordination with supported logistical organizations of all uniformed Services and other federal agencies.

- Coordinates veterinary support for military units with government-owned animals.

- Coordinates required veterinary support with host nation public health officials.

*d. Basis of Avocation.* This unit is allocated as follows:

(1) One per every 70,000 Army personnel in the CZ.

(2) One per every 140,000 Army personnel in the COMMZ.

(3) One per every 140,000 Navy, Marine, and Air Force personnel in the theater.

### E-4. Medical Detachment, Veterinary Medicine, TOE 08-418L000

*a. Mission.* The mission of this unit is to–

- Provide definitive comprehensive veterinary medical care to government-owned animals.

- Provide veterinary support for civic action programs.

- Conduct veterinary preventive medicine to control zoonotic diseases.

- Conduct public health functions in support of the overall HSS system.

*b. Assignment.* The unit is assigned to a medical brigade (COMMZ), TOE 08-422L200. It may be placed under the command and control of the medical detachment, veterinary service (headquarters), TOE 08-409 L000, or a medical detachment, veterinary service, TOE 08-417L000. This unit may also be assigned to a MEDCOM, TOE 08-611L000.

*c. Capabilities.* This unit provides–

- Comprehensive veterinary medical care to government-owned animals. This includes long-term hospitalization for military working dogs.

- Comprehensive veterinary medical care in support of civic action programs.

- A mobile team deployable to high-casualty areas for short durations.

- Procurement of military animals to include military working dogs.

*d. Basis of Allocation.* This unit is allocated as follows:

(1) One per seven military police companies (heavy security) and military patrol dog sections.

(2) One per 200 dogs in support of all branches of the uniformed Services.

## E-5. Medical Detachment, Veterinary Service (Small), TOE 08-419L000

*a. Mission.* The mission of this unit is to provide veterinary services for all branches of the uniformed Services and other federal agencies throughout the theater of operations. These services include–

- Sanitary inspections of approved food source facilities.

- Procurement and surveillance inspections of foods.

- Environmental and zoonotic disease surveillance.

- Wholesomeness determination of food in an NBC environment.

- Limited veterinary care for government-owned animals.

- Civic action programs.

- Veterinary preventive medicine.

- Public health functions.

*b. Assignment.* This unit is assigned to a medical brigade (corps), TOE 08-422 L000, or a medical brigade (COMMZ), TOE 08-422L200. It may be placed under the command and control of the medical detachment, veterinary service, TOE 08-417L000, or medical detachment, veterinary service (headquarters), TOE 08-409L000. This unit may also be assigned to a MEDCOM, TOE 08-611L000.

*c. Capabilities.* The unit–

- Provides inspection services for commercial food sources in support of procurement organizations; publication and distribution of a directory of approved establishments; and inspection of all government food storage facilities.

- Provides inspections of all food at time of receipt.

- Performs surveillance inspection of all foods in storage and at time of issue or resale.

- Monitors and evaluates environmental and zoonotic diseases and food safety data to include data on foods exposed to NBC agents. Apprises the medical brigade commander of those factors posing a potential adverse effect on the overall HSS mission.

- Provides limited veterinary care to government-owned animals in DOD units.

- Provides veterinary support for civic action programs.

- Maintains 100-percent mobility within the unit at all times to meet the travel requirements dictated by the assigned mission to the combat units.

- Establishes communications and directs necessary coordination with supported logistical organizations of all uniformed Services and other federal agencies.

- Coordinates veterinary support for military units with government-owned animals.

- Coordinates required veterinary support with host nation public health officials.

*d. Basis of Allocation.* This unit is allocated as follows:

(1) One per every 10,000 Army personnel in the CZ.

(2) One per every 20,000 Army personnel in the COMMZ.

(3) One per every 20,000 Navy, Marine, and Air Force personnel in the theater.

# APPENDIX F

# PREVENTIVE MEDICINE SERVICES–MEDICAL FORCE 2000

## F-1. New Organizations

The overall concept for theater preventive medicine services does not significantly change under Medical Force 2000. However, the corps and echelons above corps teams have been replaced by smaller, more mobile, more deployable, multifunctional detachments.

## F-2. Preventive Medicine Detachments

There are two types of preventive medicine detachments:

*a. Medical Detachment, Preventive Medicine (Entomology), TOE 08-499L000.* The mission of this unit is to provide preventive medicine support and consultation in the areas of entomology, DNBI prevention, field sanitation, sanitary engineering, and epidemiology to minimize the effects of vectorborne diseases, enteric diseases, environmental injuries, and other health threats on deployed forces in the CZ and COMMZ.

(1) *Assignment.* This unit is assigned to a medical brigade or a medical group, and normally attached to an area support medical battalion.

(2) Capabilities. This unit–

- Provides surveillance and control of disease vectors and reservoirs in assigned areas, to include area and aerial spraying.

- Monitors vector control, field sanitation, water treatment and storage, waste disposal, and DNBI control practices of units in assigned areas. Provides advice and training as necessary.

- Investigates and evaluates vector control, sanitation, water supply, and waste disposal practices; and other environmental health-related problems. Recommends corrective measures as necessary.

- Collects medical data to assist in evaluating conditions affecting the health of the supported military and civilian population.

- Conducts epidemiological investigations.

- Collects environmental samples and specimens and performs selected analyses or evaluations to assist in assessment of the medical threat.

- Coordinates NBC-related biological specimen collection and specimen evaluation with treatment, NBC, laboratory, and intelligence personnel.

- Divides into three teams, as necessary, to perform assigned missions.

- Monitors casualties, hospital admissions, and reports of autopsy for signs and confirmation of chemical or biological warfare agent use.

(3) *Basis of allocations.* One unit is allocated per 66,000 personnel and one per 100,000 EPW.

*b. Medical Detachment, Preventive Medicine (Sanitation),* TOE 08-498L000. The mission of this unit is to provide preventive medicine support and consultation in the areas of DNBI prevention, field sanitation, entomology, sanitary engineering, and epidemiology to minimize the effects of environmental injuries, enteric diseases, vectorborne disease, and other health threats on deployed forces in the theater.

(1) *Assignment.* This unit is assigned to a medical brigade, TOE 08-422L000, or a medical group, TOE 08-433L000. It is normally attached to an ASMB, TOE 08-455L000, or other medical units.

(2) *Capabilities.* This unit–

- Monitors field sanitation, water treatment and storage, vector control, and DNBI control practices of units in assigned areas. Provides advice and training as necessary.

- Investigates and evaluates field sanitation, water supply and waste disposal practices, and other environmental health-related problems.It recommends corrective measures as necessary.

- Provides limited control of disease vectors and reservoirs unassigned areas.

- Collects medical data to assist in evaluating conditions affecting the health of the supported military and civilian population.

- Conducts epidemiological investigations.

- Collects environmental samples and specimens and performs selected analyses or evaluations to assist in assessment of the medical threat.

- Coordinates NBC-related biological specimen collection and specimen evaluation with treatment, NBC, laboratory, and intelligence personnel.

- Monitors casualties, hospital admissions, and reports of autopsy for signs and confirmation of chemical or biological warfare agent use.

(3) *Basis of allocation.* One unit is allocated per 28,000 personnel and one per 50,000 EPW.

### F-3. Preventive Medicine Section, Medical Battalion, Area Support

Preventive medicine support is also provided by the preventive medicine section of the medical battalion, area support. Hereafter this battalion will be referred to as the ASMB. See Appendix I for additional information. Organizationally, the ASMB includes a preventive medicine section identical to that found in the divisional HSS structure. The section is capable of providing preventive medicine support and advice similar to that described above for the preventive medicine detachment (sanitation).

*a.* The staffing of this section permits it to have a more extensive capability than the preventive medicine detachments in epidemiological (infectious disease) investigations and sanitary engineering support. Support provided by this section in these areas is in coordination with preventive medicine detachments and other medical or nonmedical units within the ASMBs.

*b.* As preventive medicine detachments are normally attached to an ASMB, this section assumes technical supervision of the attached detachments to coordinate assignment of specific missions.

*c.* Preventive medicine detachments are attached to, rather than being organic to, the ASMB. The ASMBs are allocated based on medically-related requirements. Preventive medicine support is normally allocated based on the anticipated medical threat.

# APPENDIX G

# DENTAL SERVICES–MEDICAL FORCE 2000

## G-1. Dental Support

Dental support in Medical Force 2000 is arranged into echelons, reflecting an increase in capability at each succeeding echelon. The functions of each lower echelon of dental support are contained within the capabilities of all higher echelons.

*a.* There are three dental care categories in a theater of operations.

(1) *Maintaining care.* Definitive dental treatment to include–

- Most routine dental procedures.
- Removable prosthodontics (dentures).
- Minor oral surgical procedures.
- A preventive dentistry program.

(2) Sustaining care. Routine dental treatment to prevent future dental emergencies using the modular dental equipment available to Echelon II dental support personnel.

(3) *Emergency care.* Expedient dental treatment directed toward the relief of pain and management of infection and oral trauma.

*b.* A fourth category of highly specialized dental support termed comprehensive care is performed only in CONUS.

## G-2. Echelon II Dental Support

Under Medical Force 2000, Echelon II dental support provides emergency and sustaining dental care and is based on the modular concept. The dental module consists of a dental officer and a dental specialist equipped with compact dental equipment which is lightweight and easily transported. A dental module is organic to the medical companies of the divisions, ASMBs, separate brigades, and the Special Forces groups.

## G-3. Area Dental Support

Medical Force 2000 area dental support units are dental companies, dental detachments, and prosthodontic augmentation teams organized under a medical battalion, dental service, assigned to the medical group or medical brigade in the CZ and the MEDCOM in the COMMZ. Area dental support units provide categories of dental support up to and including maintaining care. Area dental support units also provide dental modules for direct support or reconstitution of division, ASMB, and separate brigade dental assets. A description of these organizations follows:

*a. Medical Battalion (Dental Service), TOE 08-475L0.*

(1) *Mission.* The mission of the medical battalion (dental service) is to provide maintaining, sustaining, and emergency dental care on an area basis within a theater of operations.

(2) *Assignment.* This unit is normally assigned to the senior medical headquarters in the TA or corps area (that is, medical command, TOE 08-611L medical brigade, TOE 08-442L, or medical group, TOE 08-432L).

(3) *Capabilities.* This unit provides–

- Maintaining, sustaining, and emergency dental care on an area support basis in the theater of operations.
- Mobile dental treatment teams.
- Field dental clinics.
- Dental treatment modules to reinforce or reconstitute the unit dental modules when necessary.
- Dental treatment modules performing dental services for small or forward troop concentrations.
- Prosthodontic support to troops, dental units, and facilities.

• Emergency medical augmentation to the ATM capabilities of other MTFs during mass casualty situations.

(4) *Allocation.* The basis of allocation of the organizational components of this organization is–

• One headquarters and headquarters detachment (HHD), medical battalion (dental service), TOE 08-476L0, per three to eight subordinate dental service organizations.

• One medical company (dental service), TOE 08-478L0, per 20,000 US Army troops supported.

• One medical detachment (dental service), TOE 08-479L0, per 8,000 US Army troops supported.

• One medical team, prosthodontics, TOE 08-588 LA00, per 40,000 troops supported.

*b. Headquarters and Headquarters Detachment, Medical Battalion (Dental Service), TOE 08-476L0.*

(1) *Mission.*

*(a)* The headquarters provides command and control to assigned and attached dental organizations.

*(b)* The operations and administrative section provides administrative, logistics, and personnel support to the headquarters. It also provides technical guidance on medical equipment maintenance and Class VIII supply.

(2) *Assignment.* This unit is organic to medical battalion (dental service), TOE 08-475L000.

(3) *Capabilities.* This unit–

• Commands and controls three to eight assigned or attached units.

• Furnishes current information concerning the dental aspects of the CSS situation to higher headquarters.

• Plans and allocates dental resources (personnel and equipment) to ensure adequacy of dental treatment to all units within the assigned area of responsibility.

• Provides technical expertise, coordination, and support to subordinate units for accomplishing their medical equipment maintenance and Class VIII supply.

*c. Medical Company (Dental Service), TOE 08-478L0.*

(1) *Mission.* This unit provides maintaining, sustaining, and emergency dental care on an area support basis within a theater of operations.

(2) *Assignment.* This unit is organic to medical battalion (dental service), TOE 08-475L00.

(3) *Capabilities.* This unit provides–

• Maintaining care on an area basis for 20,000 troops.

• Sustaining care on an area basis for 30,000 troops.

• One field dental clinic.

• Dental treatment modules to reinforce or reconstitute the unit dental modules when necessary.

• Unit maintenance for HHD, medical battalion (dental service), TOE 08-476L000.

• Up to six dental treatment modules performing dental services for small or

• Prosthodontic support to troops, dental units, and hospitals.

• Augmentation to the ATM capabilities of other MTFs during mass casualty situations.

*d. Medical Detachment (Dental Service), TOE 08-479L0.*

(1) *Mission.* This unit provides maintaining, sustaining, and emergency dental care on an area support basis within a theater of operations.

(2) *Assignment.* This unit is assigned to medical battalion (dental service), TOE 08-475 L000.

(3) *Capabilities.* This unit provides–

- Maintaining care on an area basis for 8,000 troops.
- Sustaining care on an area basis for 12,000 troops.
- A field dental clinic.
- Dental treatment modules to reinforce or reconstitute the unit dental modules when necessary.
- Up to three dental treatment modules performing dental services for small or forward troop concentrations.
- Augmentation to the ATM capabilities of other MTFs during a mass casualty situation.

*e. Medical Team, Prosthodontics, TOE 08-588LA00.*

(1) *Mission.* Prosthodontic augmentation teams may be attached to dental companies or hospitals to assist in providing maintaining dental care when required by the patient work load. This team can provide fixed and removable prosthodontics support.

(2) *Assignment.* The prosthodontics team is normally assigned to the medical battalion (dental service) with further attachment to the medical company (dental service) or an existing hospital organization.

(3) *Capabilities.* This unit provides additional fixed and removable prosthodontics support for up to 40,000 personnel.

## G-4. Echelons III and IV Dental Support

Hospital dental support (Echelons III and IV) in Medical Force 2000 is provided by the dental service organic to the hospital unit, base (see Appendix B). The dental service consists of an oral surgeon, a comprehensive dental officer, an enlisted preventive dentistry specialist, and an enlisted dental specialist. The dental service provides oral and maxillofacial surgery specialty care and consultation, as well as maintaining dental care for hospital patients and staff.

# APPENDIX H

# COMBAT STRESS CONTROL SERVICES-MEDICAL FORCE 2000

## H-1. Medical Force 2000 Units

Under Medical Force 2000, TOE 08-620H0OM, Team OM, psychiatric service, will be replaced with two new units:

- Medical company, CSC, TOE 08-467L000.
- Medical detachment, CSC, TOE 08-567LA00.

## H-2. Functions of Units

Medical detachment, CSC, will routinely reinforce the organic mental health sections of divisions and separate brigades, Medical company, CSC will–

- Support the corps area.
- Provide staff and special equipment for reconditioning behind each division.
- Exercise command and control of the CSC detachments.
- Reinforce CSC detachments in the divisions when the caseload requires.

## H-3. Organization of Units

A description of the CSC organization follows:

*a. Medical Company, CSC.*

(1) *Mission.* The mission of the medical company, CSC, is to provide combat stress casualty prevention, treatment, and management on an area basis.

(2) *Assignment.* The medical company, CSC, is assigned to a MEDCOM or medical brigade, TOE 08-422L100. It may be further attached to medical group, TOE 08-432L000.

(3) *Capabilities.* This unit provides–

- Planning and staff advice to command and control headquarters regarding the stressors affecting the troops such as combat intensity and sleep deprivation; their mental readiness, morale, cohesion, morals, and spiritual welfare; and the potential for and status of treatment of battle fatigue and other neuropsychiatric and alcohol or drug abuse casualties.
- A preventive section (with psychiatrists, social work officers, and enlisted) that may divide into six 4-person CSC preventive (CSCP) teams, each providing consultation, neuropsychiatric triage, reconstitution support, and medical supervision and return to duty coordination for restoration and reconditioning programs.
- A restoration section (with psychiatric nurses, clinical psychologists, occupational therapy officers, plus enlisted) that may divide into four 1l-person CSC restoration (CSCR) teams, each providing stabilization and restoration or reconditioning for up to 50 battle fatigue casualties, plus consultation, reconstitution support, and neuropsychiatric triage support.

(4) *Employment of teams.* The CSCP and CSCR teams may be employed separately, but more commonly are combined into task-organized sections to staff restoration or reconditioning facilities.

(5) *Mobility.* The CSC teams are 100-percent mobile and can provide austere shelter, heat tray packs, and water for field hygiene for limited numbers of battle fatigue casualties. These teams depend on the units to which they are attached for logistical and communications support. Large restoration or reconditioning centers require augmentation with patient holding assets.

(6) *Basis of allocation.* A company is allocated to the corps on the basis of one medical company, CSC, per two divisions for high-intensity

conflict and one per four or five divisions for mid-intensity conflict. The headquarters section of the medical company, CSC, usually collocates with its higher medical headquarters or with the HSC of an evacuation battalion or ASMB which provides staff coordination, communication, and logistical support. Depending on availability and phase of conflict, a CSC company or elements thereof may also be assigned to the COMMZ.

*b. Medical Detachment, CSC.*

(1) *Mission.* The mission of the medical detachment,CSC, is to provide forward combat stress casualty prevention, treatment, and RTD.

(2) *Assignment.* This unit is assigned to a medical brigade. It may be attached to a medical group or to a medical company, CSC, TOE 08-467 L000. It is routinely attached to the MSB or medical battalion of a division, under operational control of the DMHS.

(3) *Capabilities.* At full strength, this unit provides–

- Planning and staff advice to command and control headquarters regarding the stressors affecting the troops such as combat intensity and sleep deprivation; their mental readiness, morale, cohesion, morals, and spiritual welfare; and the potential for and status of treatment of battle fatigue and other neuropsychiatric casualties including substance abuse casualties.

- A preventive section that divides into three CSCP teams; each provides consultation, combat neuropsychiatric triage, reconstitution support, and medical supervision and RTD coordination for restoration in a BSA.

- One CSCR team that provides stabilization, restoration, and reconditioning for up to 50 battle fatigue casualties, plus consultation, reconstitution support, and combat neuropsychiatric triage support, usually in the DSA.

(4) *Basis of allocation.*

*(a)* One medical detachment, CSC, is allocated per division.

*(b)* One medical detachment, CSC, is allocated per two to three separate brigade-sized forces not otherwise provided CSC support.

## H-4. Mental Health Section in the Area Support Medical Battalion

The ASMB (Appendix I) includes a mental health section which is similar to the division mental health section discussed in paragraph 12-6 except that it does not have a psychologist assigned. It provides area mental health/CSC support in the corps area and the COMMZ.

## H-5. Command and Control

Command and control for Medical Force 2000 CSC/mental health activities will be coordinated by small mental health staff or consultant sections in the MEDCOM, medical brigade (corps and COMMZ), and medical group headquarters.

# APPENDIX I

# AREA MEDICAL SUPPORT–MEDICAL FORCE 2000

## I-1. Medical Battalion, Area Support (Support Command, Corps, or COMMZ), TOE 08-455L0

Area medical support in the CZ and the COMMZ will be provided by the ASMB. This unit replaces many teams in the current structure.

*a. Mission.* The ASMB provides HSS for Echelons I and II and medical staff advice and assistance, as required, for all assigned and attached elements of the corps and COMMZ.

*b. Assignment.* The ASMB is assigned to the medical brigade, TOE 08-422L0, or the medical group, TOE 08-432L0, depending on the density of medical organizations in a theater of operations.

**NOTE**

Do not confuse the medical brigade, TOE 08-422L0, with the medical brigade, TOE 08-112H600,discussed within the main body of this manual.

*c. Capabilities.* This unit provides–

- Medical planning, policies, support operations, and coordination of HSS in an area of operations within the CZ or the COMMZ.
- Advice to commanders and their staffs on the health of their commands and on medical aspects affecting CSS.
- Current information concerning HSS to higher headquarters.
- Echelon II treatment facilities for receiving, sorting, and administering medical and surgical treatment for all classes of patients.
- Reinforcements, reconstitution, or replacement of Echelons I and II HSS.
- Ground evacuation for patients from Echelon II treatment squads to the area support treatment squads and from other units in the CZ or the COMMZ operating in this battalion's area of operations.
- Management of medical supplies and supervision of maintenance on medical equipment.
- Laboratory, pharmacy, and radiological services commensurate with Echelon II medical treatment.
- Emergency dental care to include stabilization of maxillofacial injuries, sustaining dental care designed to prevent or intercept potential dental emergencies, and limited preventive dentistry.
- Mental health services and management of combat stress casualties.
- Eye examinations, treatment of ocular injuries and diseases, spectacle frame assembly using presurfaced single-vision lenses and repair services for CZ or COMMZ units assigned in this battalion's area of operations. For greater optical fabrication and resupply of the optical medical equipment sets, requisitions will be supported by the MEDLOG (Forward).
- Preventive medicine consultation and support to include medical intelligence and technical control of attached preventive medicine detachments.
- Patient holding for up to 160 patients.

*d. Basis of Allocation.* The ASMB is allocated using a basis of .014 per 1,000 troops supported in the corps (rule of thumb is .75 per division) and .018 per 1,000 troops supported in the COMMZ (rule of thumb is three per COMMZ). Figure I-1 depicts the organization of an ASMB.

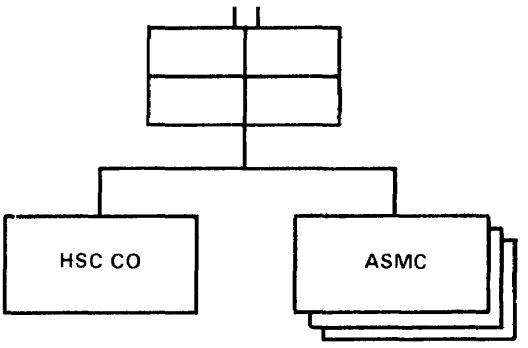



*Figure I-1. Medical Battalion, Area Support.*

**1-2. Headquarters and Support Company, ASMB (Support Command, Corps, or COMMZ), TOE 08-456L0**

*a. Mission.* The mission of the HSC is to provide command and control for the ASMB and to provide Echelons I and II HSS to units assigned in the battalion's area of operations.

*b. Assigment.* The HSC is organic to the ASMB, TOE 08-455L0.

*c. Capabilities.* This unit provides–

- Command and control of organic or attached units to include medical planning, policies, and support operations within the battalion's area of operations.
- Information to commanders and their staffs on the health of their command and on medical aspects affecting CSS.
- Current information concerning medical aspects of the CSS situation to higher headquarters.
- Allocation of medical resources (personnel and equipment) to ensure adequate medical treatment to all assigned or attached units operating in the battalion's area of operations in either the corps or COMMZ.
- Triage and treatment to patients generated in the HSC area of responsibility.
- Evacuation of patients from units within the HSC's area of responsibility to the treatment squads of the HSC.
- Treatment squads which are capable of operating independently of the HSC for limited periods of time to provide trauma and sick call medical support to forces involved in combat or to perform reinforcement, reconstitution, or replacement to forward medical units.
- Medical supply, medical repair parts, and medical maintenance support to units assigned or attached to the battalion's area of responsibility. The medical supply office (MSO) of the HSC will maintain a 3-day stockage level. Resupply of the MSO will be by line item requisition to the supporting MEDLOG battalion (forward).
- Three days of supply level for all sub elements of the HSC upon deployment and during routine operations.
- Laboratory, pharmacy, and radiological services commensurate with Echelon II medical treatment.
- Emergency dental care to include stabilization of maxillofacial injuries, sustaining dental care designed to prevent or intercept potential dental emergencies, and limited preventive dentistry.
- Mental health and CSC services to include preventive consultation, neuropsychiatric triage, stabilization, and restoration of small numbers of battle fatigue casualties. (It also coordinates operations of attached CSC unit teams.)
- Optometry support limited to eye examinations, spectacle frame assembly utilizing presurfaced single-vision lens and repair services for corps or COMMZ units assigned in the battalion's area of operations. For greater optical fabrication and resupply of the optical medical equipment sets, requisitions will be supported by the MEDLOG battalion (forward).
- Preventive medicine consultation and support, to include medical intelligence and coordinating operations of attached preventive medicine detachments operating in the battalion's area of operation.
- Patient holding for up to 40 patients.

- Outpatient consultation services for patients referred from Echelon I HSS facilities.

- Unit-level maintenance for the battalion's wheeled vehicles. The consolidated maintenance section uses contact teams to provide unit maintenance to assigned subunits. Performs unit-level maintenance on organic communication and electronic equipment of the HSC.

- Unit-level administration for elements of the battalion.

- Food service support to staff and patients of the HSC, and to other medical elements dependent upon the HSC for mess support.

*d.* Basis of *Allocation.* One HSC per ASMB.

### I-3. Medical Company, Area Support, ASMB (Support Command, Corps, or COMMZ), TOE 08-457L0

*a. Mission.* The mission of the medical company, area support (ASMC), is to provide Echelons I and II HSS to units assigned to its area of operations.

*b. Assignment.* The ASMC is organic to the ASMB, TOE 08-455L0.

*c. Capabilities.* This unit provides–

- Treatment of patients with diseases and minor injuries, triage of mass casualties, initial resuscitation and stabilization, advanced trauma management, and preparation for further evacuation of ill, injured, and wounded patients who are incapable of RTD within 72 hours.

- Treatment squads which are capable of operating independently of the ASMC for limited periods of time.

- Evacuation of patients from units within the ASMC's area of operations to the treatment squads of the ASMC.

- Emergency medical supply and resupply to units operating within the area of operations of the ASMC.

- A three-day level of supplies for all elements of the ASMC upon deployment and during routine operations.

- Laboratory, pharmacy, and radiological services commensurate with Echelon II HSS treatment.

- Emergency dental care to include stabilization of maxillofacial injuries, sustaining dental care designed to prevent or intercept potential dental emergencies, and limited preventive dentistry.

- Patient holding for up to 40 patients per ASMC.

- Outpatient consultation services for patients referred from Echelon I HSS facilities.

- Food service support to staff and patients of the ASMC and to other medical elements dependent upon the ASMC for mess support.

*d. Basis of Allocation.* Three ASMCs are allocated per ASMB.

# APPENDIX J

# PROPOSED FUNCTIONAL AREA REPLACEMENT T ABLES OF ORGANIZATION AND EQUIPMENT

## HOSPITALS

| CURRENT | | FUTURE/REPLACEMENT | | MEDICAL FORCE 2000 | |
|---|---|---|---|---|---|
| TOE | NOMENCLATURE | TOE | NOMENCLATURE | TOE | NOMENCLATURE |
| 08-063H000 | Mobile Army Surgical Hospital | 08-863L000 | Mobile Army Surgical Hospital | *08-763L000 | Mobile Army Surgical Hospital |
| 08-123H000 | Combat Support Hospital | 08-823L000 | Combat Support Hospital | *08-705L000 | Combat Support Hospital |
| 08-581H000 | Evacuation Hospital | 08-883L000 | Evacuation Hospital | *08-705L000 | Combat Support Hospital |
| 08-233H700 | Station Hospital, 300-Bed | 08-833L000 | Station Hospital, 300-Bed | *08-715L000 | Field Hospital |
| 08-253H700 | Station Hospital, 500-Bed | 08-853L000 | Station Hospital, 500-Bed | *08-715L000 | Field Hospital |
| 08-303H800 | General Hospital | 08-803L000 | General Hospital | 08-725L000 | General Hospital |
| 08-51OH600 | Field Hospital | 08-813L000 | Field Hospital | *08-715L000 | Field Hospital |
| 08-590H500 | Convalescent Center | 08-458L000 | Medical Company Holding | *08-458L000 | Medical Company Holding |

## EVACUATION

| CURRENT | | FUTURE/REPLACEMENT | | MEDICAL FORCE 2000 | |
|---|---|---|---|---|---|
| TOE | NOMENCLATURE | TOE | NOMENCLATURE | TOE | NOMENCLATURE |
| 08-126H300 | Headquarters and Headquarters Detachment, Medical Battalion | 08-446L000 | Headquarters and Headquarters Detachment, Medical Evacuation Battalion | | |
| 08-137H200 | Medical Company, Air Ambulance (UH-I) | 08-447L100 | Medical Company, Air Ambulance (UH-I) | | |
| 08-137H220 | Medical Company, Air Ambulance (UH-60) | | | | |
| 08-660HORA | Medical Detachment, Air Ambulance (UH-I) | | | | |
| 08-660HORG | Medical Detachment, Air Ambulance (UH-60) | | | | |
| 08-127H410 | Medical Ambulance Company | 08-449L000 | Medical Company, Ground Ambulance | | |
| (Obsolete] | Ambulance Train, Rail | *08-439L000 | Medical Detachment, Rail | 08-439L000 | Medical Detachment, Rail |

*NOTE: Indicates units that will be rolled into Medical Force 2000, unless otherwise redeveloped due to changes in doctrine or technology.

## AREA SUPPORT

| CURRENT | | FUTURE/REPLACEMENT | | MEDICAL FORCE 2000 | |
|---|---|---|---|---|---|
| TOE | NOMENCLATURE | TOE | NOMENCLATURE | TOE | NOMENCLATURE |
| 08-129H500 | Medical Collecting Company | Note: Deleted from the force. | | | |
| 08-128H400 | Medical Clearing Company | 08-455L000 | Area Support Medical Battalion | | |
| 08-660HORE | Medical Detachment, Ground Ambulance | 08-449L000 | Medical Company Ground Ambulance | | |
| 08-620HOOA | Medical Advanced Support Team Dispensary | 08-455L000 | Area Support Medical Battalion | | |
| 08-620HOOB | Medical Advanced Support Team General Dispensary | 08-455L000 | Area Support Medical Battalion | | |
| 08-620HOOC | Medical Advanced Support Team General Dispensary | 08-455L000 | Area Support Medical Battalion | | |
| 08-620HOOH | Medical Advanced Support Team Optometry Service | Note: Deleted from the force. | | | |

## DENTAL

| CURRENT | | FUTURE/REPLACEMENT | | MEDICAL FORCE 2000 | |
|---|---|---|---|---|---|
| TOE | NOMENCLATURE | TOE | NOMENCLATURE | TOE | NOMENCLATURE |
| 08-670H8AI | Dental Service Headquarters | 08-476L000 | Headquarters and Headquarters Detachment, Medical Battalion, Dental | | |
| 08-670H8HA | Dental Service Detachment | 08-478L000<br>08-479L000 | Medical Company, Dental Services<br>Medical Detachment, Dental Services | | |
| 08-670H8HB | Dental Service Augmentation, General Dentistry | Note: Deleted from the force. Capabilities assumed by units organic to the Dental Battalion. | | | |
| 08-670H8HC | Dental Service Augmentation, Removable Prosthodontics | 08-588LA00 | Medical Team, Prosthodontics | | |
| 08-670H8HD | Dental Service Augmentation, Fixed Prosthodontics | 08-588LA00 | Medical Team, Prosthodontics | | |
| 08-670H8HE | Central Dental Laboratory | Note: Deleted from the force. Capabilities assumed by other theater dental units and CONUS assets. | | | |

## COMBAT STRESS

| CURRENT | | FUTURE/REPLACEMENT | | MEDICAL FORCE 2000 | |
|---|---|---|---|---|---|
| TOE | NOMENCLATURE | TOE | NOMENCLATURE | TOE | NOMENCLATURE |
| 08-620HOOM | Medical Advanced Support Team, Psychiatry Service | 08-467L000 | Medical Company, Combat Stress Control | *08-467L000 | Medical Company, Combat Stress Control |
| | | 08-567LA00 | Medical Detachment, Combat Stress Control | *08-567LA00 | Medical Detachment, Combat Stress Control |

## PREVENTIVE MEDICINE

| CURRENT | | FUTURE/REPLACEMENT | | MEDICAL FORCE 2000 | |
|---|---|---|---|---|---|
| TOE | NOMENCLATURE | TOE | NOMENCLATURE | TOE | NOMENCLATURE |
| 08-600HOAM | Headquarters, Preventive Medicine | Note: Deleted from the force. | | | |
| 08-620HOLA | Medical Advanced Support Team, Entomology Service | 08-499L000 | Medical Detachment, Preventive Medicine Entomology | | |
| 08-620HOLB | Medical Advanced Support Team, Environmental Sanitation | 08-498L000 | Medical Detachment, Preventive Medicine Sanitation | | |
| 08-620HOLC | Medical Advanced Support Team, Environmental Engineering Service | Note: Deleted from the force. | | | |
| 08-620HOLD | Medical Advanced Support Team, Epidemiology | Note: Deleted from the force. | | | |
| 08-620HOLE | Medical Advanced Support Team, Entomology Laboratory | Note: Deleted from the force. | | | |

## VETERINARY

| CURRENT | | FUTURE/REPLACEMENT | | MEDICAL FORCE 2000 | |
|---|---|---|---|---|---|
| TOE | NOMENCLATURE | TOE | NOMENCLATURE | TOE | NOMENCLATURE |
| 08-680H8AF | Veterinary Service Headquarters, Team AF | 08-409L000 | Medical Detachment, Veterinary Service Headquarters | | |
| 08-680H8JA | Veterinary Service Small/Expansion Team JA | 08-419L000 | Medical Detachment, Veterinary Service (Small) | | |

## VETERINARY (Continued)

| CURRENT | | FUTURE/REPLACEMENT | | MEDICAL FORCE 2000 | |
|---|---|---|---|---|---|
| TOE | NOMENCLATURE | TOE | NOMENCLATURE | TOE | NOMENCLATURE |
| 08-680H8JB | Veterinary Service Large, Team JB | 08-417L000 | Medical Detachment, Veterinary Service | | |
| 08-680H8XA | Veterinary Combat Support Hospital | 08-418L000 | Medical Detachment, Veterinary | | |
| 08-680H8XB | Veterinary General Hospital | 08-418L000 | Medical Detachment, Veterinary | | |

## LABORATORY

| CURRENT | | FUTURE/REPLACEMENT | | MEDICAL FORCE 2000 | |
|---|---|---|---|---|---|
| TOE | NOMENCLATURE | TOE | NOMENCLATURE | TOE | NOMENCLATURE |
| 08-650G800 | Area Laboratory | 08-657L000 | Theater Army Medical Laboratory | | |
| 08-650HOVA | Area Medical Laboratory Detachment | 08-657L000 | Theater Army Medical Laboratory | | |
| 08-650HOVB | Area Medical Laboratory Detachment | 08-657L000 | Theater Army Medical Laboratory | | |
| 08-650HOVC | Area Medical Laboratory Detachment | 08-657L000 | Theater Army Medical Laboratory | | |
| 08-650HOVE | Area Medical Laboratory Detachment | 08-657L000 | Theater Army Medical Laboratory | | |
| 08-630HOMM | Miscellaneous Service Teams | Note: Deleted from the force. | | | |

## LOGISTICS

| CURRENT | | FUTURE/REPLACEMENT | | MEDICAL FORCE 2000 | |
|---|---|---|---|---|---|
| TOE | NOMENCLATURE | TOE | NOMENCLATURE | TOE | NOMENCLATURE |
| 08-287H600 | Medical Unit (Supply, Optical, and Maintenance) | 08-485L000<br>08-695L000 | Medical Battalion, Logistics (Forward)<br>Medical Battalion, Logistics (Rear) | | |
| 08-600HOAJ | Headquarters, Blood Bank | Note: Deleted from the force. | | | |
| 08-620HONA | Blood Processing | Note: Deleted from the force. | | | |
| 08-620HONB | Blood Collection | Note: Deleted from the force. | | | |

## LOGISTICS (Continued)

| CURRENT | | FUTURE/REPLACEMENT | | MEDICAL FORCE 2000 | |
|---|---|---|---|---|---|
| TOE | NOMENCLATURE | TOE | NOMENCLATURE | TOE | NOMENCLATURE |
| 08-620HONC | Blood Distribution | Note: Deleted from the force. | | | |
| 08-610HOBB | Medical Supply Team (Medium) | 08-909L000 | Medical Logistic Support Detachment | | |
| 08-610HOBC | Medical Supply Team (Large) | 08-909L000 | Medical Logistic Support Detachment | | |
| 08-610HOBD | Medical Supply Team (Small) | 08-909L000 | Medical Logistic Support Detachment | | |
| 08-610HOBE | Medical inventory Control Team | 08-909L000 | Medical Logistic Support Detachment | | |
| O8-61OHOEA | Medical Equipment Maintenance Team (Small) | 08-909L00 | Medical Logistic Support Detachment | | |
| 08-610HOEB | Medical Equipment Maintenance Team (Medium) | 08-909L000 | Medical Logistic Support Detachment | | |
| 08-610HOGA | Spectacle Fabrication Team (Small) | Note: Deleted from the force. | | | |

## TEAMS

| CURRENT | | FUTURE/REPLACEMENT | | MEDICAL FORCE 2000 | |
|---|---|---|---|---|---|
| TOE | NOMENCLATURE | TOE | NOMENCLATURE | TOE | NOMENCLATURE |
| 08-630HOKA | Surgical Service Team | 08-407L100 | Medical Detachment (Surgical) | | |
| | | 08-407L200 | Medical Detachment (Surgical) (Airborne) | | |
| 08-630HOKB | Surgical Service Team | 08-527LA00 | Medical Team, Head and Neck Surgery | | |
| 08-630HOKC | Surgical Service Team | 08-527LB00 | Medical Team, Neurosurgery | | |
| 08-630HOKD | Surgical Service Team | 08-527LC00 | Medical Team, Eye Surgery | | |
| 08-630HOKE | Surgical Service Team | 08-537LA00 | Medical Team, Pathology | | |
| 08-630HOKF | Surgical Service Team | 08-537LB00 | Medical Team, Dialysis | | |
| 08-630HOKG | Surgical Service Team | 08-537LC00 | Medical Team, Infectious Diseases | | |
| 08-630HOKH | Surgical Service Team | Note: Deleted from the force. | | | |

## TEAMS (Continued)

| CURRENT | | FUTURE/REPLACEMENT | | MEDICAL FORCE 2000 | |
|---|---|---|---|---|---|
| TOE | NOMENCLATURE | TOE | NOMENCLATURE | TOE | NOMENCLATURE |
| 08-630HOKI | Surgical Service Team | Note: Deleted from the force. | | | |
| 08-630HOLL | Medical Service Team | Note: Deleted from the force. | | | |
| 08-630HOLM | Medical Service Team | Note: Deleted from the force. | | | |
| 08-630HOLN | Medical Service Team | Note: Deleted from the force. | | | |
| 08-630HOMM | Miscellaneous Service and Support Teams | Note: Deleted from the force. | | | |
| 08-630HOMN | Miscellaneous Service and Support Teams | Note: Deleted from the force. | | | |
| 08-630HOMO | Miscellaneous Service and Support Teams | Note: Deleted from the force. | | | |
| 08-630HOMP | Miscellaneous Service and Support Teams | Note: Deleted from the force. | | | |

## COMMAND AND CONTROL

| CURRENT | | FUTURE/REPLACEMENT | | MEDICAL FORCE 2000 | |
|---|---|---|---|---|---|
| TOE | NOMENCLATURE | TOE | NOMENCLATURE | TOE | NOMENCLATURE |
| 08-111200 | Medical Command | 08-611L000 | Medical Command | | |
| 08-112H600 | Medical Brigade | 08-422L100<br>08-422L200 | Medical Brigade (Corps)<br>Medical Brigade (COMMZ) | | |
| 08-122H200 | Medical Group | 08-432L000 | Medical Group | | |
| 08-502H100 | Hospital Center | 08-422L200 | Medical Brigade (COMMZ) | | |
| 08-600HOAC | Company Headquarters | Note: Deleted from the force. | | | |
| 08-600HOAE | Headquarters, Receiving Center | Note: Deleted from the force. | | | |

# APPENDIX K

# CLASSES OF SUPPLY

| Class | Description |
|---|---|
| I | Subsistence, including gratuitous health and welfare items. |
| II | Clothing, individual equipment, tentage, tool sets and tool kits, handtools, administrative and housekeeping supplies and equipment. Includes items of equipment (other than principal items) prescribed in authorization/allowance tables, and items of supply (not including repair parts). |
| III | POL: Petroleum fuels; lubricants, hydraulic and insulating oils, preservatives, liquid and compressed gases, chemical products, coolants, deicing and antifreeze compounds, together with components and additives of such products, and coal. |
| IV | Construction: Construction materials including installed equipment and all fortification/barrier materials. |
| V | Ammunition: Ammunition of all types (including chemical, radiological, and special weapons), bombs, explosives, land mines, fuzes, detonators, pyrotechnics, missiles, rockets, propellants, and other associated items. |
| VI | Personal demand items (nonmilitary sales items). |
| VII | Major end items (tanks, vehicles, or aircraft) which are ready for their intended use. |
| VIII | Medical material including medical-peculiar repair parts and equipment. The following subclasses apply to Class VIII: |
| | 1 — Controlled substances. |
| | 2 — Tax-free alcohol. |
| | 3 — Precious metals. |
| | 4 — Nonexpendable medical items, not restricted. |
| | 5 — Expendable medical items, not restricted. |
| | 6 — All drugs and related items Federal Supply Classification 6505 not otherwise restricted. |
| | 7 through 9 — Commander-designated controlled items. |
| | 0 — US Army Medical Materiel Agency controlled sensitive items. |

| | |
|---|---|
| IX | Repair parts and components including kits, assemblies and subassemblies, and reparable and nonreparable items required for maintenance support of all equipment. |
| X | Materiel to support nonmilitary programs such as agricultural and economic development materials not included in Classes I through IX. |

GLOSSARY

# ABBREVIATIONS, ACRONYMS, AND DEFINITIONS

**A2C2** Army airspace command and control

**ABCA** American, British, Canadian, and Australian

**ABO** agents of biological origin

**ACCS** Army Command and Control System

**ACofS** Assistant Chief of Staff

**ACR** armored cavalry regiment

**ADC** area damage control

**adj** adjutant

**AE** aeromedical evacuation

**AECC** Aeromedical Evacuation Control Center

**AFMIC** Armed Forces Medical Intelligence Center

**AJBPO** Area Joint Blood Program Office

**ALB** AirLand Battle

**AM** amplitude modulated

**amb** ambulance

**AMEDD** Army Medical Department

**AOR** area of responsibility

**AR** Army Regulation

**Armed Services Medical Regulating Office** A jointly staffed organization that coordinates all intertheater patient evacuation. It designates the CONUS hospital that each patient will be evacuated to.

**ASBPO** Armed Services Blood Program Office

**ASF** aeromedical staging facility

**ASG** area support group

**ASMB** medical battalion, area support

**ASMC** medical company, area support

**ASMRO** See *Armed Services Medical Regulating Office*

**ASWBPL** Armed Services Whole Blood Processing Laboratory

**ATCCS-CHS** Army Tactical Command and Control—Common Hardware/Software System

**ATM** advanced trauma management

**AUTODIN** automatic digital network

**AVIM** aviation intermediate maintenance

**AVUM** aviation unit maintenance

**BAS** battalion aid station

**BCSCC** brigade combat stress control coordinator

**bde** brigade

**bn** battalion

**BPD** blood product depot

**br** branch

**BSA** brigade support area

**BSU** blood supply unit

**BTC** blood transshipment center

**BW** biological warfare

**CINC** commander(s) in chief

**cmd** command

**CMO** civil-military operations

**co** company

**CofS** Chief of Staff

**combat service support** The support provided to sustain combat forces, primarily in the fields of administration and logistics. It may include personnel support, religious support, finance support, legal service and support, civil affairs, food service, maintenance, HSS, military police, supply, transportation, and other logistical services. The basic mission of combat service support is to maintain and support our soldiers and their weapon systems in operations on the ALB.

**combat support** Fire support and operational assistance provided to combat elements. May include artillery, helicopter, engineer, military police, signal, and electronic warfare.

**Comdt** Commandant

**command and staff channels** These channels clearly identify the official relationship of commands and staffs and the flow of information as commander to commander, staff to staff, and technical activity to technical activity (see FM 101-5).

- **command channel** This channel is the direct, official link between headquarters and commanders. All others and instructions to subordinate units pass through this channel. Within your authority, you use command channels when acting in the commander's name.

- **staff channel** This channel is the staff-to-staff link between headquarters. It is for coordination and transmission of information.

- **technical channel** Commanders and staffs use this channel to send technical instructions between commands. Technical changes and decisions may affect the mission's accomplishment; therefore, you must inform your commander of any technical change. He can then accurately assess the impact of these changes and take appropriate action.

**command relationships** The US Army routinely confirms the degree of command responsibility and authority through the following command relationships:

- **organic** An organic element or unit is an integral part of a larger organization and is listed in its table of organization and equipment.

- **assigned** An assigned unit is permanently placed within another organization that controls, administers, and provides logistic support for the primary function, or greater portion of the functions, of the unit.

- **attached** An attached unit is temporarily placed within another organization. Sometimes there are limitations to the attachment as outlined in the attachment order. The gaining organization's commander exercises the same degree of command, control, and responsibility for the attached unit as he does over his organic or assigned units. However, the assigned commander retains responsibility for transfers, enforcement of the Uniform Code of Military Justice, and promotion of personnel.

- **operational control** Operational control is the authority commanders use to assign missions or tasks to subordinate commanders. If another unit has operational control over your unit, you may be limited by its function, time available, or location. The gaining commander may deploy, reassign, or retain your unit; or he may assign tactical control of your unit to one of his subordinate units. Operational control does not include administrative and logistic control. Within NATO, operational control does not include the authority to assign separate employment of unit components.

- **operational command** Within the Department of Defense, operational command is the authority commanders of unified and specified commands use over their assigned forces. In this context, it is

synonymous with operational control. Within NATO, operational command is the authority a commander uses to assign missions or tasks to subordinate commanders, to deploy units, to reassign forces, and to retain or delegate operational or tactical control, or both as necessary.

**command, control, and communications** Command and control functions performed through the arrangement of personnel, equipment, communications, facilities, and procedures that provide for direction of combat operations.

**COMMZ** communications zone

**compt** comptroller

**con** control

**CONUS** continental United States

**COSCOM** corps support command

**CS** combat support

**CSA** corps support area

**CSC** combat stress control

**CSCP** combat stress control preventive

**CSCR** combat stress control restoration

**CSH** combat support hospital

**CSS** See *combat service support*

**CSSCS** Combat Service Support Control System

**CTASC II** Corps Theater ADP Service Center II

**CW** chemical warfare

**CZ** combat zone

**DA** Department of the Army

**DAMMS-R** Department of the Army Movement Management System—Redesign

**DBMIS** Defense Blood Management Information System

**DD** Department of Defense

**dent** dental

**DEPMEDS** Deployable Medical Systems

**det** detachment

**direct support** A direct support unit gives priority of support to a specific unit or force. The supporting unit takes support requests directly from the unit or force in need of support. The supporting unit normally establishes liaison and communications; it also provides advice to the supported unit. A unit in direct support has no command relationship with the supported unit or force (see FM 101-5).

**DISCOM** division support command

**distr** distribution

**div** division

**DIVARTY** division artillery

**DMHS** division mental health section

**DMMC** division materiel management center

**DMOC** division medical operations center

**DMRIS** Defense Medical Regulating Information System

**DMSO** division medical supply office

**DNBI** disease and nonbattle injury

**DOD** Department of Defense

**DSA** division support area

**EAC** echelons above corps

**EACIC** echelons above corps intelligence center

**EMT** emergency medical technician

**enteric diseases** Diseases pertaining to the small intestine.

**entomology** That branch of zoology which deals with the study of insects.

- **medical entomology** That concerned with insects that cause disease.

**epidemiology**

- The study of the relationships of the various factors determining the frequency and distribution of disease in a human community.
- The field of medicine concerned with the determination of the specific causes of localized outbreaks of infection such as hepatitis, of toxic disorders such as lead poisoning, or any other disease of recognized etiology.

**EPW** enemy prisoner(s) of war

**etiology** The study or theory of the factors that cause disease and the method of their introduction to the host; the sum of knowledge regarding causes.

**evac** evacuation

**FASCO** forward area support coordinator

**FAST** forward area support team

**FH** field hospital

**fld** field

**FLOT** forward line of own troops

**FM** field manual/frequency modulation

**FSB** forward support battalion

**FSMC** forward support medical company

**fwd** forward

**FY** fiscal year

**G1** Assistant Chief of Staff, G1 (Personnel)

**G2** Assistant Chief of Staff, G2 (Intelligence)

**G4** Assistant Chief of Staff, G4 (Logistics)

**G5** Assistant Chief of Staff, G5 (Civil Affairs)

**GC** Geneva Convention Relative to the Protection of Civilian Persons in Time of War

**general support** A general support unit provides support to the total force—not to any particular subdivision. Therefore, subdivisions may not directly request support from the general support unit. Only the supported force headquarters may determine priorities and assign missions or tasks to the general support unit. A general support unit has no command relationship with the supported unit or force.

**GH** general hospital

**gp** group

**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 Wounded, Sick, and Shipwrecked Members of Armed Forces at Sea

**health service support** This term is used in current doctrine to include all services performed, provided, or arranged by the Army Medical Department to promote, improve, conserve, or restore the mental or physical well-being of personnel in the Army and, as directed, in other Services, agencies, and organizations.

**HHC** headquarters and headquarters company

**HHD** headquarters and headquarters detachment

**hosp** hospital

**host nation** A nation in whose territory US or allied forces are operating or supporting the battle.

**host-nation support** Civil and military assistance rendered in peacetime and in wartime to allied forces and organizations located in the host nation's territory. The bases of such assistance are commitments arising from national agreements concluded among host nation(s), international organizations, and nation(s) having forces operating in the host nation's territory.

**HQ** headquarters

**HSC** headquarters and support company

**HSS** See *health service support*

**HU** hospitalization units

**HUB1** hospital unit, base

**HUH** hospital unit, holding

**HUM** hospital unit, medical

**HUS** hospital unit, surgical

**IG** inspector general

**IHFR** improved high-frequency radio

**info** information

**int** intelligence

**ISO** International Organization for Standardization

**JA** judge advocate

**JBPO** joint blood program office

**JINTACCS** joint interoperability of tactical command and control system

**JMRO** joint medical regulating office

**JTB** Joint Transportation Board

**lab** laboratory

**LIC** low-intensity conflict

**log** logistics

**maint** maintenance

**MASF** mobile aeromedical staging facility

**MASH** mobile army surgical hospital(s)

**MCC** movement control center

**med/MED** medical

**MEDBLD** medical blood products management

**MEDCEN** United States Army Medical Center

**MEDCOM** medical command

**MEDDAC** medical department activity

**medical treatment facility** A facility established for the purpose of providing health services to authorized personnel. It may be, but is not limited to, an aid station, a clinic, a dispensary, or a hospital.

**MEDLOG** medical logistics

**MEDMNT** medical maintenance

**MEDOPT** medical optical fabrication management

**MEDPAR** medical patient accounting and reporting

**MEDREG** medical regulating

**MEDSOM** medical supply, optical, and maintenance

**MEDSTEP** medical standby equipment program

**MEDSUP** medical supply

**METT-T** mission, enemy, terrain (and weather), troops, and time available

**mobility** The percentage of organic equipment and personnel that can be moved in a single lift

using organic vehicles. It does not include patients in MTFs.

**MOPP** mission-oriented protection posture

**MOS** military occupational specialty

**MRO** medical regulating office

**MSB** main support battalion

**MSO** medical supply officer

**MTF** See medical treatment facility

**NATO** North Atlantic Treaty Organization

**NBC** nuclear, biological, and chemical

**NCO** noncommissioned officer

**NCOES** noncommissioned officer education system

**NSN** national stock number

**OCONUS** outside continental United States

**ODA** operational detachment "A"

**op** operations

**operational command** The authority granted to a commander to assign missions or tasks to subordinate commanders, to deploy units, to reassign forces, and to retain or delegate operational or tactical control as may be deemed necessary. It does not, of itself, include administrative command or logistical responsibility.

**operational control** The authority delegated to a commander to direct forces provided him so he can accomplish specific missions or tasks that are usually limited by function, time, or location; to deploy units concerned; and to retain or assign tactical control of those units. It does not include authority to assign separate employment of components of the units concerned, nor does it, of itself, include administrative or logistics control.

**PA** physician assistant

**PCB** printed circuit board

**pers** personnel

**PMCS** preventive maintenance checks and services

**POL** petroleum, oils, and lubricants

**prof** professional

**PT** physical therapy

**QSTAG** Quadripartite Standardization Agreement

**reparable exchange** A supply method of issuing serviceable materiel in exchange for unserviceable materiel on an immediate item-for-item basis. This is accomplished without the normal property accountability documents and with a minimum of paperwork.

**ROP** reorder point

**RTD** return to duty

**RX** See *reparable exchange*

**S1** Adjutant

**S2** Intelligence Officer

**S3** Operations and Training Officer

**S4** Supply Officer

**S&T** supply and transport

**SAMS** Standard Army Materiel System

**SARSS** Standard Army Retail Supply System

**SB** supply bulletin

**SC** special category

**sec** section

**SI** seriously ill

**SIDPERS-3** Standard Installation/Division Personnel System

**SLM** shelf life months

**SOC** special operations command

**SOF** Special Operations Forces

**SOP** standing operating procedures

**SOTI** security, operations, training, and intelligence

**SPBS-R** Standard Property Book System-Revised

**SRC** special requirements code

**sta** station

**STANAG** See *Standardization Agreement*

**Standardization Agreement** The record of an agreement among several nations to adopt like or similar military equipment; ammunition; supplies and stores; and operational, administrative, and logistics procedures.

**STANFINS** Standard Financial System

**STC** storage code

**sup** supply

**supply point distribution** A method of distributing supplies to the receiving unit at a supply point, railhead, or truckhead. The unit then moves the supplies to its own area using its own transportation.

**svc** service

**TA** theater army

**TAACOM** theater army area command

**TACCS** Tactical Army CSS Computer System

**tailgate medical support** An economy of force device employed primarily to retain maximum mobility during movement halts or to avoid the time and effort required to set up a formal, operational treatment facility (for example, during rapid advance and retrograde operations). Tailgate medical support consists of dispensing medications, bandaging and splinting, and performing simple emergency life sustaining procedures. It is literally performed at the "tailgate" of a vehicle or in a structure or other area using an easily reached set of medical supplies and equipment to ensure promptness and efficiency. Mobility of the unit is not affected and only three to five minutes are required to open or close this service.

**TAMCA** Theater Army Movements Control Agency

**TAML** theater army medical laboratory

**TAMMIS** Theater Army Medical Management Information System

**TB** technical bulletin

**TC** training circular

**throughput distribution** Term used to describe shipments that bypass intermediate activities in the supply system, thereby avoiding multiple handling.

**TM** technical manual

**TMMMC** theater medical materiel management center

**TOE** table(s) of organization and equipment

**UL** unit level

**US** United States

**USAF** United States Air Force

**USN** United States Navy

**USTRANSCOM** United States Transportation Command

**vector** A carrier, especially the animal (usually an arthropod) which transfers an effective agent from one host to another.

**vet** veterinary

**VSI** very seriously ill

**WIA** wounded in action

**ZI** zone of interior

# REFERENCES

## SOURCES USED

These are the sources quoted or paraphrased in this publication.

### NATO STANAGs

2027. *Marking of Military Vehicles.* 18 December 1975.
2060. *Identification of Medical Materiel for Field Medical Installations.* 22 October 1984.
2068. *Emergency War Surgery.* 28 October 1986.
2105. *NATO Table of Medical Equivalents–AMedP-1(D).* 26 November 1986.
2135. *Procedures for Emergency Logistic Assistance.* 12 February 1982.
2931. *Camouflage of the Geneva Emblem on Medical Facilities on Land.* 18 October 1984.
2939. *Medical Requirements for Blood, Blood* Donors *and Associated Equipment.* 2 June 1987.

### ABCA QSTAGs

248. *Identification of Medical Materiel to Meet Urgent Needs.* 20 September 1976.
815. *Blood Supply in the Area of Operations.* 19 August 1987.

## DOCUMENTS NEEDED

These documents must be available to the intended users of this publication.

### Army Publications

AR 40-3. *Medical, Dental, and Veterinary Care,* 15 February 1985.
AR 40-5. *Preventive Medicine.* 1 June 1985. (Reprinted w/basic including Cl, September 1986.)
AR 40-61. *Medical Logistics Policies and Procedures.* 30 April 1986. (Reprinted w/basic including Cl, August 1989.)
AR 71-13. *The Department of the Army Equipment Authorization and Usage Program.* 3 June 1988.
AR 190-8. *Enemy Prisoners of War–Administration, Employment and Compensation.* 1 June 1982. (Reprinted w/basic including Cl, December 1985.)
AR 200-1. *Environmental Protection and Enhancement.* 15 June 1982.
*AR 310-25. *Dictionary of United States Army Terms (Short Title: AD).* 15 October 1983. (Reprinted w/basic including Cl, May 1986.)
*AR 310-50. *Authorized Abbreviations and Brevity Codes.* 15 November 1985.
AR 350-41. *Army Forces Training.* 26 September 1986.
AR 640-3. *Identification Cards, Tags, and Badges.* 17 August 1984.
AR 700-99. *Acquisition, Accounting, Control, and Disposal of Captured Enemy Equipment and Foreign Materiel.* 27 April 1976.
AR 750-1. *Army Materiel Maintenance Policy and Retail Maintenance Operations.* 31 October 1989.
DA Pamphlet 25-30. *Consolidated Index of Army Publications and Blank Forms.* 31 December 1989.
*DA Pamphlet 27-1. *Treaties Governing Land Warfare.* 7 December 1956.
*FM 3-4. *NBC Protection.* 21 October 1985.
*FM 3-4-1. *Fixed Site Protection.* 16 August 1989.
*FM 3-5. *NBC Decontamination.* 24 June 1985.
FM 3-100. *NBC Operations.* 17 September 1985.
FM 8-10-4. *Medical Platoon Leaders' Handbook–Tactics, Techniques, and Procedures.* 16 November 1990.
*FM 8-10-8. *Medical Intelligence in a Theater of Operations.* 7 July 1989.
FM 8-15. *Medical Support in Divisions, Separate Brigades, and the Armored Cavalry Regiment.* 21 September 1972.
FM 8-26. *Dental Service.* 9 September 1980.
FM 8-27. *Veterinary Service.* 30 September 1983.
FM 8-35. *Evacuation of the Sick and Wounded.* 22 December 1983.
FM 8-42. *Medical Operations In a Low-Intensity Conflict.* 4 December 1990,
*FM 8-50. *Prevention and Medical Management of Laser Injuries.* 8 August 1990.
*FM 8-55. *Planning for Health Service Support.* 15 February 1985.
*FM 25-100. *Training the Force.* 15 November 1988.

*This source was also used to develop this publication.

FM 26-2. *Management of Stress in Army Operations.* 29 August 1986.
*FM 27-10. *The Law of Land Warfare.* 18 July 1956. (Reprinted w/basic including Cl, July 1976.)
*FM 100-1. *The Army.* 29 August 1986.
*FM 100-5. *Operations.* 5 May 1986.
*FM 100-10. *Combat Service Support.* 18 February 1988.
*FM 100-15. *Corps Operation.* 13 September *1989.*
*FM 101-5. *Staff Organization and Operations.* 25 May 1984.
TC 8-12. *Use of the M51 Shelter System by Division Level Medical Units.* 31 May 1983.
TC 8-13. *Deployable Medical Systems–Tactics, Techniques, and Procedures.* 7 December 1990.
TM 8-215. *Nuclear Handbook for Medical Service Personnel.* 30 April 1969. (Reprinted w/basic including Cl, April 1982.)

**MULTISERVICE PUBLICATIONS**

AR 40-350. *Medical Regulating to and Within the Continental United States.* BUMEDINST 6320.lD; AFR 168-11; BMS Cir 75-15; CGCOMDTINST 6320.8A. 24 April 1975.
AR 40-535. *Worldwide Aeromedical Evacuation.* AFR 164-5; OPNAVINST 4630.9C; MCO P4630.9A. 1 December 1975. (Reprinted w/basic including Cl, May 1979.)
AR 40-538. *Property Management During Patient Evacuation.* BUMEDINST 6700.2B; AFN 167-5. 1 June 1980.
FM 3-3. *NBC Contamination Avoidance. NAVFAC P-462.* 30 September 1986. (Reprinted w/basic including Cl, May 87.)
*FM 8-9. *NATO Handbook on the Medical Aspects of NBC Defensive Operations.* NAVMED P-5059; AFP 161-3. 31 August 1973. (Reprinted w/basic including Cl, May 1983.)
*FM 8-285. *Treatment of Chemical Agent Casualties and Conventional Military Chemical Injuries.* NAVMED P-5041/AFM 160-11. February 1990.
FM 41-5. *Joint Manual for Civic Affairs.* OPNAV 09B291/AFM 110-7; NAVMC 2500. 18 November 1966.
FM 100-20. *Military Operations in Low Intensity Conflict.* AFP 3-20. 5 December 1990.
*This source was also used to develop this publication.

**READINGS RECOMMENDED**

These readings contain relevant supplemental information.

DA Form 2406. *Materiel Condition Status Report (MCSR).* May 1985.
DA Form 2717. *Optics/ Laboratory Report.* June 1968.
FM 1-103. *Airspace Management and Army Air Traffic in a Combat Zone.* 30 December 1981.
FM 8-30. *Veterinary Food Inspection Specialist.* 12 August 1986.
FM 8-230. *Medical Specialist. 24 August 1984.*
FM 8-250. *Preventive Medicine Specialist. 27 January 1986.* (Reprinted w/basic including Cl, September 1986.)
FM 14-7. *Finance Operations.* 9 October 1989.
FM 19-1. *Military Police Support for AirLand Battle.* 23 May 1988.
FM 21-10. *Field Hygiene and Sanitation.* 22 November 1988.
FM 21-11. *First Aid for Soldiers.* 27 October 1988. Cl, August 1989.
FM 25-101. *Battle-Focused Training Management.* 30 September 1990.
FM 41-10. *Civil Affairs Operations. 17 December* 1985.
FM 55-1. *Army Transportation Services in a Theater of Operations.* 30 November 1984.
FM 71-100 (HTF). *Armored and Mechanized Division Operations* (How to Fight). 29 September 1978. (Cl March 1979.)
FM 90-23. *Army-Tactical Air Forces Procedures for Rear Security Operations at EAC.* 14 November 1989.
FM 100-103. *Army Airspace Command and Control in a Combat Zone.* 7 October 1987.
SB 8-75 -S1-S8. *Department of the Army Supply Bulletin, Army Medical Department Supply Information.* (Expires 1 year from date of issue.)
SB 8-75-9. *Army Medical Department Supply Information.* (Expires 1 year from date of issue.)
TB 38-750-2. *Maintenance Management Procedures for Medical Equipment.* 12 April 1987. *(Cl,* November 1987, *C2,* August *1988,* C3, November 1989.)
TB MED 1. *Storage, Preservation, Packaging, Packing, Maintenance, and Surveillance of Material: Medical Activities.* 15 June 1981.

# INDEX

References are to paragraph numbers except where specified otherwise.

By Order of the Secretary of the Army:

CARL E. VUONO
*General, United States Army*
*Chief of Staff*

Official:

PATRICA P. HICKERSON
Colonel, United States Army
The Adjutant General

**DISTRIBUTION:**

***Active Army, USAR, and ARNG:*** **To be distributed in accordance with DA Form 12-11-E, requirements for FM 8-10, Health Service Support in a Theater of Operations (Qty rqr block no. 0810).**

☆ U.S.GOVERNMENT PRINTING OFFICE : 1995 - 387-868 (42236)