

FM 4-02.6 (FM 8-10-1)

THE MEDICAL COMPANY

TACTICS, TECHNIQUES, AND PROCEDURES

AUGUST 2002

HEADQUARTERS, DEPARTMENT OF THE ARMY

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

Change 1

HEADQUARTERS
DEPARTMENT OF THE ARMY
Washington, DC, 9 April 2004

THE MEDICAL COMPANY TACTICS, TECHNIQUES, AND PROCEDURES

1. Change FM 4-02.6, 1 August 2002, as follows:

Remove old pages

iii through viii
A-1 through A-7
F-1 through F-32
Glossary-1 through Glossary-21
References-1 through References-4
Index-1 through Index-8

Insert new pages

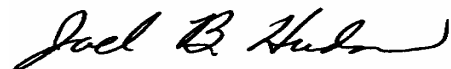
iii through viii
A-1
F-1 through F-26
Glossary-1 through Glossary-21
References-1 through References-4
Index-1 through Index-7

2. New or changed material is indicated by a star (★).
3. File this transmittal sheet in front of the publication.

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

By Order of the Secretary of the Army:

Official:



JOEL B. HUDSON

*Administrative Assistant to the
Secretary of the Army*
0407103

PETER J. SCHOOMAKER
*General, United States Army
Chief of Staff*

DISTRIBUTION:

Active Army, Army National Guard, and US Army Reserve: To be distributed in accordance with the initial distribution 110816, requirements for FM 4-02.6.

THE MEDICAL COMPANY
TACTICS, TECHNIQUES, AND PROCEDURES

TABLE OF CONTENTS

			Page
PREFACE			vii
CHAPTER	1.	COMBAT HEALTH SUPPORT SYSTEM	1-1
Section	I.	Overview of Combat Health Support	1-1
	1-1.	General	1-1
	1-2.	Theater of Operations	1-1
	1-3.	Mission	1-2
	1-4.	Echelons of Medical Care	1-2
	1-5.	The Medical Threat and Medical Intelligence	1-4
	1-6.	Planning for Combat Health Support	1-5
	1-7.	Principles of Combat Health Support	1-7
	1-8.	Modular Medical Support System	1-8
Section	II.	Combat Health Support Functional Areas	1-9
	1-9.	General	1-9
	1-10.	Medical Treatment	1-9
	1-11.	Medical Evacuation and Medical Regulating	1-10
	1-12.	Hospitalization	1-11
	1-13.	Combat Health Logistics	1-12
	1-14.	Dental Services	1-12
	1-15.	Veterinary Services	1-13
	1-16.	Preventive Medicine Services	1-13
	1-17.	Combat Operational Stress Control Services	1-13
	1-18.	Medical Laboratory Services	1-14
CHAPTER	2.	THE MEDICAL COMPANY	2-1
Section	I.	The Medical Company and Division Overview	2-1
	2-1.	General	2-1
	2-2.	Division Overview	2-1
	2-3.	Types of Divisions	2-1
	2-4.	Forward Support Medical Company	2-3
	2-5.	Organizational Structure of Forward Support Medical Companies	2-4

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

*This publication supersedes FM 8-10-1, 29 December 1994.

		Page
	2-6.	Main Support Medical Company/Division Support Medical Company ... 2-9
	2-7.	Organizational Structure of Main Support Medical Company/Division Support Medical Company 2-10
Section	II.	Medical Companies in Separate Brigades, Armored Cavalry Regiments, and Interim Brigade Combat Teams 2-15
	2-8.	Separate Brigade Overview 2-15
	2-9.	Medical Company-Heavy Separate Brigade 2-16
	2-10.	Organizational Structure and Tactical Capabilities of the Medical Company-Heavy Separate Brigade 2-16
	2-11.	Armored Cavalry Regiment Overview 2-17
	2-12.	Medical Troop-Armored Cavalry Regiment 2-18
	2-13.	Organizational Structure and Tactical Capabilities of the Medical Troop-Armored Cavalry Regiment 2-18
	2-14.	Brigade Combat Team Overview 2-19
	2-15.	Brigade Support Medical Company, Support Battalion, Interim Brigade Combat Team 2-19
	2-16.	Area Support Medical Company, Area Support Medical Battalion (Corps and Echelons above Corps) 2-20
CHAPTER	3.	MEDICAL COMPANY OPERATIONS 3-1
Section	I.	Organization and Functions of the Medical Company 3-1
	3-1.	General 3-1
	3-2.	Headquarters Section 3-1
	3-3.	Treatment Platoon 3-3
	3-4.	Ambulance Platoon 3-6
	3-5.	Preventive Medicine Section and Functions 3-7
	3-6.	Mental Health Section Operations and Functions 3-8
	3-7.	Optometry Section Operations and Functions 3-11
Section	II.	Tactical Employment of the Medical Company 3-11
	3-8.	Employment of the Medical Company 3-11
	3-9.	Site Selection 3-12
	3-10.	Establishing the Company Headquarters 3-15
	3-11.	Command Post Operations 3-17
	3-12.	Employment of the Treatment Platoon 3-19
	3-13.	Establishing the Clearing Station/Medical Treatment Facility 3-19
	3-14.	Employment of the Ambulance Platoon 3-22
	3-15.	Divisional and Nondivisional Medical Supply Offices 3-25
	3-16.	Employment of the Preventive Medicine Section 3-25
	3-17.	Employment of the Mental Health Section 3-27
	3-18.	Employment of the Optometry Section 3-27
CHAPTER	4.	COMBAT HEALTH SUPPORT IN SPECIFIC ENVIRONMENTS .. 4-1
	4-1.	Introduction 4-1

		Page
	4-2.	Jungle Environment 4-1
	4-3.	Mountain Environment 4-3
	4-4.	Desert Environment 4-5
	4-5.	Extreme Cold Weather Environment 4-8
	4-6.	Nuclear, Biological, Chemical, and Directed-Energy Environments 4-11
	4-7.	Urban Operations 4-12
	4-8.	Combat Health Support During Night Operations 4-14
	4-9.	Army Special Operations Forces 4-17
★ APPENDIX	A.	LAW OF LAND WARFARE AND GENEVA CONVENTIONS OBLIGATIONS FOR MEDICAL PERSONNEL A-1
APPENDIX Section	B.	COMBAT HEALTH SUPPORT PLANNING B-1
	I.	Combat Health Support Estimate B-1
	B-1.	General B-1
	B-2.	Responsibilities B-1
	B-3.	Format for the Estimate B-2
	B-4.	Sample Format for the Combat Health Support Estimate B-2
Section	II.	Combat Health Support Plan B-9
	B-5.	General B-9
	B-6.	Format for the Combat Health Support Plan B-10
APPENDIX	C.	MASS CASUALTY SITUATIONS C-1
	C-1.	General C-1
	C-2.	Mass Casualty Management C-1
	C-3.	Triage Categories C-3
	C-4.	Control Element C-4
	C-5.	Establishing Triage, Treatment, and Holding Areas C-5
	C-6.	Patient Accountability C-6
	C-7.	Medical Evacuation C-7
	C-8.	Contaminated Patients C-7
	C-9.	Disposition of Remains C-7
APPENDIX	D.	MANAGEMENT OF CLASS VIII ITEMS IN THE FORCE XXI DIVISION D-1
	D-1.	Class VIII Management D-1
	D-2.	Throughput Delivery of Class VIII Items D-2
	D-3.	Additional Combat Health Logistics Support Information D-2
APPENDIX Section	E.	RECORDS AND REPORTS E-1
	I.	Patient Accountability E-1
	E-1.	General E-1
	E-2.	United States Field Medical Card E-1

		Page
	E-3.	Daily Disposition Log E-2
	E-4.	Patient Summary Report E-4
	E-5.	Patient Evacuation and Morality Report E-4
Section	II.	Blood Management Report E-5
	E-6.	General E-5
	E-7.	Blood Management Report E-6
★ APPENDIX	F.	THE BRIGADE SUPPORT MEDICAL COMPANY F-1
Section	I.	Mission and Organization F-1
	F-1.	Organization, Capability, and Functions F-1
	F-2.	Augmentation F-3
Section	II.	Company Headquarters Section Organization and Function F-4
	F-3.	Company Headquarters Section F-4
	F-4.	Command Element F-6
	F-5.	Supply Elements F-6
Section	III.	Employment of the Brigade Support Medical Company F-7
	F-6.	Establishment of the Company Headquarters F-7
	F-7.	Preventive Medicine Section F-8
	F-8.	Mental Health Section F-10
Section	IV.	The Treatment Platoon F-11
	F-9.	General F-11
	F-10.	Treatment Platoon Headquarters F-12
	F-11.	Treatment Squad F-13
	F-12.	Area Treatment Squad F-14
	F-13.	Area Support Squad F-15
	F-14.	Patient-Holding Squad F-16
	F-15.	Employment of the Treatment Platoon F-18
Section	V.	The Evacuation Platoon F-18
	F-16.	General F-18
	F-17.	Evacuation Platoon Headquarters F-19
	F-18.	Evacuation Squads F-20
	F-19.	Employment of the Evacuation Platoon F-23
Section	VI.	Medical Logistics Support for the Stryker Brigade Combat Team F-23
	F-20.	Medical Logistics Support for Early Entry Operations F-23
	F-21.	Functional Medical Logistics Business System F-23
Section	VII.	Medical Logistics Operations F-24
	F-22.	Routine Class VIII Requisitions F-24
	F-23.	Emergency Class VIII Requisitions F-24
	F-24.	Shipment of Class VIII to Stryker Brigade Combat Team Medical Units/Elements F-25
	F-25.	Medical Maintenance F-25
	F-26.	Using Other Systems for Reporting and Requisitioning Class VIII F-25
	F-27.	Blood Management F-26

		Page
	F-28.	Property Exchange..... F-26
APPENDIX	G.	TACTICAL STANDING OPERATING PROCEDURE..... G-1
	G-1.	General G-1
	G-2.	Purpose of the Tactical Standing Operating Procedure G-1
	G-3.	Format for the Tactical Standing Operating Procedure G-1
	G-4.	Sample Tactical Standing Operating Procedure (Sections)..... G-2
	G-5.	Sample Tactical Standing Operating Procedure (Annexes) G-3
APPENDIX	H.	CLINICAL STANDING OPERATING PROCEDURE H-1
	H-1.	General H-1
	H-2.	Purpose of the Clinical Standing Operating Procedure H-1
	H-3.	Sample Clinical Standing Operating Procedure H-1
APPENDIX	I.	COMMUNICATIONS, AUTOMATION, AND POSITION
		NAVIGATION SYSTEMS I-1
Section	I.	Communications and Equipment I-1
	I-1.	General I-1
	I-2.	Frequency-Modulated Radios I-1
	I-3.	Amplitude-Modulated Radios I-2
	I-4.	Ancillary Radio Equipment I-2
	I-5.	Mobile Subscriber Equipment I-4
	I-6.	Position/Navigation Equipment I-4
Section	II.	Combat Net Radios I-5
	I-7.	Combat Net Radio Systems I-5
	I-8.	Radio and Wire Nets I-6
Section	III.	Automation and Digitization I-11
	I-9.	Warfighter Information Network I-11
	I-10.	Tactical High-Speed Data Network I-12
	I-11.	Medical Company Automation/Digitization Enablers I-12
Section	IV.	Medical Communications for Combat Casualty Care System
		Concept I-13
	I-12.	General I-13
	I-13.	Medical Digitization of the Combat Brigades I-14
	I-14.	The Application of Medical Communications for Combat Casualty Care in Combat Health Support Echelons of Care I-15
	I-15.	Medical Command and Control Application I-16
APPENDIX	J.	CLEARING STATION OPERATIONS ON URBANIZED
		TERRAIN J-1
	J-1.	Employment J-1
	J-2.	Site Selection and Unit Layout J-1
	J-3.	Forward Surgical Team J-2

		Page
	J-4.	Mass Casualty Operations J-2
	J-5.	Forward Deployed Medical Treatment, Preventive Medicine, and Medical Evacuation Assets J-2
APPENDIX	K.	MANAGEMENT OF INDIVIDUAL HEALTH RECORDS IN THE FIELD K-1
	K-1.	General K-1
	K-2.	Health Records of Deployed Soldiers K-1
	K-3.	Use of Field Files/DD Form 2766 K-3
	K-4.	Storage of Health Records and Civilian Employee Medical Records K-3
	K-5.	Establishment and Management of the Field File in the Operational Area K-3
	K-6.	Health Assessment after Deployment K-4
	K-7.	Field Record Administration after Hostilities Cease K-5
APPENDIX	L.	CLINICAL GUIDELINES FOR COMBAT CASUALTY CARE L-1
Section	I.	Clinical Guidelines for Physician-Lead, Physician Assistant-Lead, and Nursing-Lead Treatment Modules L-1
	L-1.	General L-1
	L-2.	Field Surgeon (62B00 MC)... L-1
	L-3.	Physician Assistant (65D00 SP) L-1
	L-4.	Medical-Surgical Nurse (66H00 AN) L-1
	L-5.	Forward Surgical Team L-2
Section	II.	Health Care Specialists Treatment and Evacuation Modules L-2
	L-6.	The 91W Health Care Specialist L-2
	L-7.	Core Competencies of the 91W L-2
	L-8.	Medical Training L-4
	L-9.	Semiannual Combat Medic Skills Validation Test L-9
Section	III.	Dental-Lead Treatment and Clinical Diagnostic Support Modules L-10
	L-10.	Comprehensive Dental Officer (63B00 DC) L-10
	L-11.	Dental Specialist (91E) L-10
	L-12.	Core Competencies/Critical Tasks and Training for the 91E L-10
	L-13.	Radiology Specialist (91P) L-12
	L-14.	Radiology Specialist/Sergeant Core Competencies, Critical Tasks and Training L-13
	L-15.	Medical Laboratory Specialist (91K) L-15
	L-16.	Core Competencies of the 91K L-16
	L-17.	Clinical Laboratory Training L-16
Section	IV.	Mental Health Clinical Support Modules L-17
	L-18.	Psychiatrist (60W00 MC) L-17
	L-19.	Social Worker (73A67 MS) L-17
	L-20.	Clinical Psychologist (73B67 MS) L-18
	L-21.	Mental Health Specialist (91X) L-18

		Page
	L-22. Core Competencies of the 91X	L-19
	L-23. Mental Health Specialty Training	L-19
Section	V. Preventive Medicine Support Modules	L-20
	L-24. Preventive Medicine Officer (60C00 MC)	L-20
	L-25. Environmental Science Officer (72D67 MS)	L-20
	L-26. Preventive Medicine Specialist (91S)	L-21
Section	VI. Optometry Clinical Support Modules	L-21
	L-27. Optometry Officer (67F00 MS)	L-21
	L-28. Eye Specialist (91WP3)	L-22
	L-29. Core Competencies of the 91WP3	L-22
	L-30. Training for the 91WP3	L-22
	L-31. Optical Laboratory Specialist (91H10)	L-24
 ★ GLOSSARY		 Glossary-1
 ★ REFERENCES		 References-1
 ★ INDEX		 Index-1

★ PREFACE

This field manual (FM) provides information on the employment, functions, and operations of divisional and nondivisional medical companies of Army of Excellence (AOE) and Army XXI divisions to include separate brigades, the Stryker brigade combat team (SBCT), and the armored cavalry regiment. It is intended to serve as doctrine and a primary reference publication for medical planners and the medical commander and his staff.

There are three terms used in this manual that have changed and/or been replaced with new terms. While Change 1 uses the new terms, the old terms may be seen throughout the manual. Therefore, the following terms are synonymous.

OLD	NEW
interim brigade combat team (IBCT)	Stryker brigade combat team (SBCT)
battle fatigue (BF)	combat operational stress reaction (COSR)
combat stress control (CSC)	combat and operational stress control (COSC)

Users of this publication are encouraged to submit comments and recommendations to improve the publication. Comments should include the page, paragraph, and line(s) of the text where the change is recommended. The proponent for this publication is the United States (US) Army Medical Department

C1, FM 4-02.6

Center and School (AMEDDC&S). Comments and recommendations should be forwarded directly to Commander, AMEDDC&S, ATTN: MCCS-FCD-L, 1400 East Grayson Street, Fort Sam Houston, Texas 78234-5052.

The staffing and organizational structure presented in this publication reflects those established in AOE and Force XXI tables of organization and equipment (TOEs). However, such staffing is subject to change to comply with manpower requirements criteria and can be subsequently changed by your modified table of organization and equipment (MTOE).

As the Army Medical Department (AMEDD) transitions to the 91W military occupational specialty (MOS), positions for 91B and 91C will be replaced by 91W when new unit MTOE take effect.

This publication implements and/or is in consonance with the following North Atlantic Treaty Organization (NATO) Standardization Agreements (STANAGs), American, British, Canadian, and Australian (ABCA) Quadripartite Standardization Agreements (QSTAGs), and Air Standardization Agreements (AIR STDs).

TITLE	STANAG	QSTAG	AIR STD
Medical Employment of Air Transport in the Forward Area	2087	529	
Documentation Relative to Medical Evacuation, Treatment and Cause of Death of Patients	2132	470	
Orders for the Camouflage of the Red Cross and Red Crescent on Land in Tactical Operations	2931		
Aeromedical Evacuation	3204		
Aeromedical Evacuation by Helicopter			44/36A
Selection, Priorities, and Classes of Conditions for Aeromedical Evacuation			61/71

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

Use of trade or brand names in this publication is for illustrative purposes only and does not imply endorsement by the Department of Defense (DOD).

CHAPTER 1

COMBAT HEALTH SUPPORT SYSTEM

Section I. OVERVIEW OF COMBAT HEALTH SUPPORT**1-1. General**

The combat health support (CHS) system is a continuum from the forward edge of the battle area (FEBA) through the continental United States (CONUS) sustainment base. It is a system that provides medical management throughout all echelons of care. The challenge is to simultaneously provide medical support to mobilizing and deploying forces, establish a CHS system within the theater, and continue to provide health care services to the CONUS base. Additionally, there will be a requirement to provide medical support to redeployment and demobilization operations at the conclusion of operations. The basic tenets of CHS for a Force Projection Army involve strict adherence to AMEDD battlefield rules. These battlefield rules provide the basis for the development of medical organizations and force structure. Table 1-1 lists these rules in order of precedence.

Table 1-1. Army Medical Battlefield Rules

BE THERE (MAINTAIN A MEDICAL PRESENCE WITH THE SOLDIER)

MAINTAIN THE HEALTH OF THE COMMAND

SAVE LIVES

CLEAR THE BATTLEFIELD OF CASUALTIES

PROVIDE STATE-OF-THE-ART-MEDICAL CARE

ENSURE EARLY RETURN TO DUTY OF THE SOLDIER

1-2. Theater of Operations

A theater of operations (TO) is that portion of an area of war necessary for military operations and for the administration of such operations. The scenario depicts the size of the TO and the US forces to be deployed. The theater is normally divided into a combat zone (CZ) and a communications zone (COMMZ). The CZ begins at the Army/corps rear boundary and extends forward to the extent of the commander's area of influence. The COMMZ begins at the corps rear boundary and extends rearward to include the areas needed to provide support to the forces in the CZ. In some instances, the COMMZ may be outside the TO.

NOTE

The area encompassed by the COMMZ is often referred to as echelons above corps (EAC), as the COMMZ is no longer routinely established for all operations.

1-3. Mission

The mission of the AMEDD is to conserve the fighting strength. This mission is accomplished by providing a seamless health care delivery system from the initial point of wounding, injury, or illness, through successive echelons of medical care, to a facility that can provide definitive and rehabilitative care for the specific illness/injury. Essential care includes resuscitative care and en route care, as well as care to either return a patient to duty (within the stated theater evacuation policy) or to begin initial treatment required for optimization of outcome and to ensure the patient can tolerate evacuation to the next echelon of care and/or out of the TO.

1-4. Echelons of Medical Care

Combat health support is arranged into five echelons of medical care. Each echelon reflects an increase in medical capabilities while retaining the capabilities found in the preceding echelon. The TO is normally organized into four echelons of support that extend rearward from the FEBA. The fifth echelon is located in CONUS. In the TO, CHS is tailored and phased to enhance patient acquisition, treatment, evacuation, and return to duty (RTD) as far forward as the tactical situation permits.

a. Echelon I. Care is provided by designated individuals or elements organic to combat and combat support (CS) units and elements of the area support medical battalion (ASMB). Major emphasis is placed on those measures necessary to stabilize the patient (maintain airway, stop bleeding, and prevent shock) and allow for evacuation to the next echelon of care.

(1) Echelon I medical care is provided by—

- Medical platoons/sections of combat and CS battalions.
- Divisional and nondivisional medical companies/troops.
- Corps and EAC area support medical companies (ASMCs) and area support medical detachments (ASMDs).

(2) The first medical care a soldier receives is provided at Echelon I. This echelon of care includes the following:

- Immediate lifesaving measures.
- Prevention and treatment of disease and nonbattle injuries (DNBIs).
- Combat operational stress control (COSC) preventive measures.
- Patient collection.
- Medical evacuation from supported units to supporting medical treatment elements.

- Treatment provided by designated trauma specialists or treatment squads (battalion aid stations [BASs]). Major emphasis is placed on those measures necessary for the patient to RTD, or to stabilize him and allow for his evacuation to the next echelon of care. These measures include maintaining the airway, stopping bleeding, preventing shock, protecting wounds, immobilizing fractures, and other emergency measures, as indicated.

(3) The trauma specialist is assisted in his duties by nonmedical personnel performing first-aid procedures. First aid is administered by an individual (self-aid or buddy aid) and by the combat lifesaver.

(a) *Self-aid and buddy aid.* Each individual soldier is trained to be proficient in a variety of specific first-aid procedures. These procedures include aid for nuclear, biological, and chemical (NBC) casualties with particular emphasis on lifesaving tasks. This training enables the soldier or a buddy to apply immediate first aid 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 duty of the combat lifesaver is to provide enhanced first aid for injuries, based on his training before the trauma specialist arrives. The combat lifesaver's training is normally provided by medical personnel assigned, attached, or in direct support (DS) of the unit. The training program is managed by the senior medical person designated by the commander.

(4) Echelon I medical treatment is provided by the trauma specialist or by personnel in the BAS/squadron aid station (SAS).

(a) Emergency medical treatment (EMT) (immediate far-forward care) consists of those lifesaving steps that do not require the knowledge and skill of a physician. The trauma specialist is the first individual in the CHS chain who makes medically substantiated decisions based on medical MOS-specific training.

(b) The physician and the physician assistant (PA) in a treatment squad are trained and equipped to provide advanced trauma management (ATM) to the battlefield casualty. Advanced trauma management is emergency care designed to resuscitate and stabilize the patient for evacuation to the next echelon of care. Each squad can split into two trauma treatment teams. When not engaged in ATM, these elements provide routine sick call services on an area basis. Echelon I care for units not having an organic capability is provided on an area support basis by the supporting medical element/unit in the AO. Like elements provide this echelon of care in divisions, corps, and EAC units.

b. *Echelon II.* Care at this echelon is rendered at the clearing station (division or corps). The clearing station can be augmented with a forward surgical team (FST), as required, for far forward surgical intervention to stabilize a nontransportable patient for further evacuation.

(1) At the clearing station, the patient is examined and his wounds and general status are evaluated to determine his treatment and evacuation precedence, as a single casualty among other casualties.

FM 4-02.6

Those patients who can RTD within 1 to 3 days are held for treatment. Emergency medical treatment (including beginning resuscitation) is continued and, if necessary, additional emergency measures are instituted; but they do not go beyond the measures dictated by the immediate necessities. The division clearing station has blood replacement capability, limited x-ray and laboratory services, patient-holding capability, and operational dental care. The clearing station also provides Echelon I care to those units without organic medical elements within its area of responsibility (AOR).

(2) The FST is a corps augmentation for divisional and nondivisional medical companies without an organic surgical capability (paragraph 1-8). The FST provides emergency/urgent initial surgery and nursing care after surgery for the critically wounded/injured patient until he is sufficiently stable for evacuation to a corps hospital. The FSTs not organic to divisions and regiments will be assigned to a medical brigade and normally attached to a corps hospital when not operationally employed. The FST will be further attached for support to a divisional/nondivisional medical company. For a detailed discussion on the FST, refer to FM 8-10-25.

(3) Echelon II CHS also includes preventive medicine (PVNTMED) activities and COSC. These functions are performed typically by company-sized medical units organic to brigades, divisions, and ASMBs.

c. Echelon III. The first hospital facility, the corps combat support hospital (CSH), is located at this echelon. The CSH is staffed and equipped to provide resuscitation, initial wound surgery, and postoperative treatment. Patients are stabilized for continued evacuation or RTD. Those patients who are expected to RTD within the theater evacuation policy are regulated to an EAC hospital, if present in the TO. For detailed information on theater hospitalization, refer to FM 4-02.10 and FM 8-10-14.

d. Echelon IV. At this echelon, the patient will be treated at the field or general hospital (Medical Force 2000) or the EAC CSH (Medical Reengineering Initiative [MRI]). Those patients not expected to RTD within the theater evacuation policy are stabilized and evacuated out of theater (refer to FM 4-02.10 and FM 8-10-15).

e. Echelon V. This echelon of care is provided in the CONUS. Hospitals in the CONUS sustaining base provide the definitive and rehabilitative treatment capability for patients generated within the theater. Department of Defense hospitals (military hospitals of the triservices) and Department of Veterans Affairs (VA) hospitals are specifically designated to provide the soldier with maximum return of function through a combination of medical, surgical, rehabilitative, and convalescent care. Under the National Disaster Medical System, patients overflowing DOD and VA hospitals are cared for in designated civilian hospitals.

1-5. The Medical Threat and Medical Intelligence

a. The medical threat is a composite of all ongoing or potential enemy actions and environmental conditions that may render a soldier combat ineffective. The soldier's reduced effectiveness results from sustained wounds, injuries, stress, or diseases. The elements of the medical threat include, but are not limited to—

- Diseases endemic to the AO.
- Environmental and occupational health hazards such as toxic industrial material (TIM), heat, and cold.
- Battle injuries from conventional weapons and weapons of mass destruction (WMD) to include NBC warfare agents.
- Physiological and psychological stressors (such as in continuous operations).
- Diseases caused by zoonotic/animal bites.
- Presence of poisonous animals, plants, and insects.
- Level of compliance with the law of war and the Geneva Conventions requirements regarding *respect and protection* of medical personnel, medical facilities, and transportation means (see Appendix A).

b. In order to develop the CHS estimate and plan (see Appendix B of this publication, FM 8-42, and FM 8-55), the CHS planner obtains updated medical intelligence through intelligence and other channels. Medical intelligence is the product resulting from the collection, evaluation, analysis, integration, and interpretation of all available general health and bioscientific information. Medical intelligence is concerned with one or more of the medical aspects of foreign nations or AO. Until medical information is appropriately processed (ordinarily on the national level by the Armed Forces Medical Intelligence Center [AFMIC]), it is not considered to be intelligence.

c. For additional information on the medical threat and medical intelligence, refer to FM 8-10-8, FM 4-02.17, FM 8-42, and FM 8-55.

1-6. Planning for Combat Health Support

a. The extended and nonlinear battlefield stretches CHS capabilities to the maximum. It presents unprecedented challenges to the CHS planner as well as to the tactical commander. While the responsibility for what is or is not done is the tactical commander's alone, he must rely on his staff and his subordinate commanders to execute his decisions. It is imperative that the CHS planner be involved in the initial stages of the planning process. A thorough understanding of the tactical commander's plan is necessary for the CHS commander to support the tactical commander during the absence of orders or communications. Combat health support planning is an intense and demanding process. The CHS planner must know what the organic capabilities of the supported units are and—

- WHAT each supported element will do.
- WHEN it will be done.

FM 4-02.6

- HOW it will be accomplished.
- WHAT threat it faces.

b. The CHS planner must foresee actions beforehand to be able to plan for positive and responsive support to each element supported. He must be prepared to meet the requirements for—

- Medical treatment to include area support (FM 4-02.4 and FM 4-02.24).
- Medical evacuation (to include training of nonmedical personnel to serve as litter bearers) and medical regulating (FM 8-10-6, FM 8-10-26, and FM 8-55).
- Hospitalization (FM 4-02.10, FM 8-10-14, and FM 8-10-15).
- Combat health logistics, to include blood management (FM 4-02.1 and FM 8-10-9).
- Preventive medicine services (FM 4-02.17, FM 21-10, and FM 21-10-1).
- Veterinary services (FM 8-10-18).
- Dental services (FM 4-02.19).
- Combat operational stress control (FM 6-22.5, FM 8-51, and FM 22-51).
- Command, control, communications, computers and intelligence (C4I) (FM 8-10, FM 8-10-8, and FM 8-10-16).
- Medical laboratory services (FM 8-10).

c. To ensure effective support, the CHS planner must stay abreast of the tactical commander's plans and objectives. This ensures that the CHS plan provides the flexibility to meet changes in the CHS requirements. To this end, commanders and their staffs must coordinate horizontally and vertically with both medical and nonmedical staffs. Commanders must be able to reallocate medical resources as the tactical situation changes.

d. On the integrated battlefield, medical units can anticipate situations in which large numbers of patients are produced in a relatively short period of time. These mass casualty (MASCAL) situations may exceed local CHS capabilities. Key factors for effective MASCAL management are on-site triage, EMT, effective communications, and skillful evacuation by ground and air resources (refer to Appendix C).

- The objective of providing the greatest good for the greatest number is achieved by medical units maximizing the use of available resources and prioritizing missions.
- To free medical personnel from nonclinical duties, nonmedical personnel may have to serve as litter bearers, perform rescue operations, or perform other nonmedical tasks, as required.

e. Combat health support planning is an intricate process which enables the CHS commander or command surgeon to develop the most effective and flexible plan for providing CHS to the tactical commander. Appendix B provides a sample of the CHS estimate and the CHS plan. For additional information on the planning for CHS, refer to FM 8-42 and FM 8-55.

1-7. Principles of Combat Health Support

a. Conformity. Conformity with the tactical plan is the most fundamental element for effectively providing CHS. Only by participating in the development of the operation plan (OPLAN) can the CHS planner ensure adequate support at the right time and the right place.

b. Continuity. Combat health support must be continuous since an interruption of treatment may cause an increase in morbidity and mortality. No patient is evacuated any farther to the rear than his physical condition or the military situation requires.

c. Control. Technical control and supervision of medical assets must remain with the appropriate force-level surgeon. Combat health support staff officers must be proactive and keep their commanders apprised of the impact of future operations on CHS resources. The CHS system must be responsive to a rapidly changing battlefield and must support the tactical OPLAN in an effective manner. The medical commander must be able to tailor CHS organizations and direct them to focal points of demand throughout his AO. Treatment performed at each echelon of the CHS system must be commensurate with available CHS resources. Since these resources are limited, it is essential that their control be retained at the highest CHS level consistent with the tactical situation.

d. Proximity. The location of CHS assets in support of combat operations is dictated by the tactical situation (mission, enemy, terrain, troops, time available, and civilian considerations [METT-TC] factors), time and distance factors, and availability of evacuation resources. The speed with which medical treatment is initiated is extremely important in reducing morbidity and mortality. Medical evacuation time must be minimized by the efficient allocation of resources and the judicious location of medical treatment facilities (MTFs). The MTFs cannot be located so far forward that they interfere with the conduct of combat operations or are subjected to enemy interference. Conversely, they must not be located so far to the rear that medical treatment is delayed due to the lengthened evacuation time. Further, the location of the MTFs may be affected by the level of conformance to the Geneva Convention protections by the combatants.

e. Flexibility. Since a change in tactical plans or operations may require redistribution or relocation of medical resources to meet the changing requirements, no more medical resources should be committed nor MTFs established than are required to support expected patient densities. When the patient load exceeds the means available for treatment (MASCAL situation), it may be necessary to give priority to those patients who can be returned to duty the soonest, rather than those who are more seriously injured. This ensures manning of the tactical commander's weapons systems.

f. Mobility. Since contact with supported units must be maintained, CHS elements must have mobility comparable to that of the units they support. Mobility is measured by the extent to which a unit can

move its personnel and equipment with organic transportation. When totally committed to patient care, a CHS unit can regain its mobility only by immediate patient evacuation.

1-8. Modular Medical Support System

a. General. The modular medical support system was designed to standardize all medical sub-elements in Echelons I and II. The divisional medical companies and Echelon II units in the corps and EAC are based on this design. This system enables the medical resources manager to rapidly tailor, augment, reinforce, or regenerate CHS units as needed. This system is designed to acquire, receive, and triage patients and to provide EMT and ATM. Combat health support originates in the forward areas (divisions) with the trauma specialist (Echelon I). From this point, the patient is evacuated to the BAS (Echelon I) and then to the division clearing station (Echelon II). The area support medical company provides Echelons I and II CHS on an area support basis to units without organic medical support operating in the corps and EAC.

b. Modular Medical Support System. The modular medical support system is built around six modules. These modules are oriented to casualty collection, treatment, and RTD or evacuation.

(1) *Trauma specialist.* The trauma specialist (combat medic) module consists of one trauma specialist and his prescribed load of medical supplies and equipment. Trauma specialists are organic to the medical platoons or sections of combat and CS battalions and are attached to the companies of the battalions.

(2) *Ambulance squad.* An ambulance squad is comprised of two ambulance teams and two ambulances. This squad provides patient evacuation and en route medical care throughout the theater (division, corps, and EAC). Ambulance squads are organic to the medical platoons and sections in maneuver battalions, divisional/nondivisional medical companies, and medical detachments. Ambulances of forward supporting medical companies/troops are normally field-sited to BASs/SASs.

(3) *Treatment squad.* This squad consists of a primary care physician, a PA, two health care noncommissioned officers (NCOs), and four health care specialists. The squad is trained and equipped to provide ATM to the battlefield casualty or to treat and return him to duty. To maintain contact with the combat maneuver elements, each squad has two vehicles equipped with four field medical equipment set (MES): two trauma sets and two sick call sets. Each squad can split into two treatment teams (one team is headed by the physician and the other by the PA). These squads are organic to medical platoons or sections in maneuver and designated CS units, as well as being the basic building block of medical companies, medical troops, and medical detachments.

(4) *Area support squad.* This squad is comprised of one dentist trained in ATM, a dental specialist, a radiology specialist, and a medical laboratory specialist. This squad is organic to all divisional and nondivisional medical companies/troops and detachments.

(5) *Patient-holding squad.* This squad consists of one medical-surgical nurse, two health care NCOs, and two health care specialists. It is capable of holding and providing minimal care for up to 40 (20 in the light infantry division) RTD patients. This squad is also organic to all divisional and nondivisional medical companies/troops and detachments.

NOTE

When an area support squad, and a patient-holding squad are collocated, they form the clearing station (Echelon II MTF). This MTF provides CHS on an area basis to all forces within a geographical AOR (clearing station). The area support and patient-holding squads are not capable of independent operations.

(6) *Forward surgical team.* The FST is a corps asset and is an augmentation to Echelon II CHS. It is also organic to the airborne and air assault divisions and the armored cavalry regiment (ACR). The FST provides a rapidly deployable immediate surgery capability. It provides surgical support forward in division, separate brigade, and ACR operational areas. This small lightweight surgical module is designed to complement and augment emergency treatment capabilities for the brigade-sized task forces (TFs). The corps FST is normally attached to the supporting medical company's higher headquarters and collocates with the clearing station. The FST coordinates, through the supported medical company, for general support (GS) such as Class I, II, III, and VIII resupply. The team also coordinates through the medical company for its security and redeployment. For additional information on the operations and functions of the FST, refer to FM 8-10-25.

Section II. COMBAT HEALTH SUPPORT FUNCTIONAL AREAS

1-9. General

The CHS continuum encompasses all of the functional areas within the AMEDD. However, C4I will not be discussed in this chapter; it is included throughout the manual as appropriate. Within the division, the full spectrum of services is provided by a combination of assigned and attached CHS resources.

1-10. Medical Treatment

a. Medical treatment consists of those measures necessary to recover, resuscitate, stabilize, and prepare the patient for evacuation to the next echelon of care. The medical treatment functional area encompasses Echelons I and II medical treatment. These echelons of care are provided on an area support basis from the supporting medical units/elements.

b. Medical treatment is provided through the use of modular medical elements (paragraph 1-8) and units designed to perform specific battlefield medical functions. The composition of each module will be identical regardless of where they are employed. This eases the reconstitution burden on the CHS system. Echelon I CHS elements provide ATM, routine medical sick call, and limited medical ground evacuation. Echelon II medical units duplicate these services in addition to providing limited dental, x-ray, and medical laboratory services, and extensive medical ground evacuation services. Other area medical

support functions include limited optometry, dental support, mental health (MH) and COSC, PVNTMED, and limited patient-holding capabilities.

1-11. Medical Evacuation and Medical Regulating

a. Medical Evacuation. The systematic evacuation of sick, injured, or wounded soldiers within US forces has been an evolutionary process. The current organizational design and doctrine are based on years of experience and the assimilation of lessons learned. Medical evacuation encompasses—

- Collecting the wounded for evacuation.
- Sorting (triage).
- Providing an evacuation mode.
- Providing medical care en route.
- Anticipating complications and being ready and capable to perform emergency medical interventions.

(1) For medical evacuation, the gaining echelon is responsible for arranging for the evacuation of patients from lower echelons of care. For example, Echelon II medical units are responsible for evacuating patients from BASs (Echelon I MTFs). Medical evacuation begins when medical personnel receive the sick, injured, or wounded soldier and continues as far rearward as the patient's medical condition warrants, or the military situation requires.

(2) The theater evacuation policy is established by the Secretary of Defense, with the advice of the Joint Chiefs of Staff, and upon the recommendation of the theater commander. The policy establishes, in days, the maximum period of noneffectiveness (hospitalization and convalescence) that patients may be held within the theater for treatment. This policy does not mean that a patient is held in the TO 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 physician determines that such evacuation will not aggravate the patient's medical condition. For example, a theater evacuation policy of 15 days does not mean that a patient will be held in the TO for 14 days and then evacuated. Rather, it means that a patient is evacuated as soon as it is determined that he cannot be RTD within 15 days following admission.

(3) When the medical evacuation system becomes overwhelmed with patients, as in a MASCAL situation, nonmedical transportation assets may be required to move the wounded. Prior planning to incorporate this requirement into the OPLAN ensures that the use of these assets is integrated with the dedicated medical evacuation platforms. When the use of nonmedical transportation assets is planned, augmentation medical personnel should be requested to provide medical care en route on these vehicles.