

THE MEDICAL COMPANY TACTICS, TECHNIQUES, AND PROCEDURES

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P R E F A C E

This field manual (FM) provides the doctrine and the tactics, techniques, and procedures required for the operation of the medical company. It is intended for use by the medical commander and his staff.

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

The staffing and organizational structure presented in this publication reflects those established in living tables of organization and equipment (LTOEs). However, such staffing is subject to change to comply with manpower requirements criteria outlined in Army Regulation (AR) 570-2 and can be subsequently changed by your modified table of organization and equipment (MTOE).

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

Title	STANAG	QSTAG	Air STDs
Marking of Military Vehicles	2027	512	
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	
Military Routes and Route/Road Networks	2174		
orders for Camouflage of the Red Cross and Red Crescent on Land in Tactical Operations	2931		
Aeromedical Evacuation	3204		
Aeromedical Evacuation by Helicopters			44/36A
Selection, Priorities, and Classes of Conditions for Aeromedical Evacuation			61/71

When amendment, revision, or cancellation of this publication is proposed which will affect or violate the international agreements concerned, the preparing agency will take appropriate reconciliatory action through international standardization channels.

CHAPTER 1

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

This chapter provides an overview of the combat health support (CHS) system designed to provide health care to our soldiers on the battlefield. The system was designed to provide a continuum of care, from the point of injury and/or forward line of own troops (FLOT) through successive echelons of care, to definitive and rehabilitative hospitals in the continental United States (CONUS) sustaining base.

1-2. Echelons of Medical Care

Combat health support is arranged in echelons of care (Figure 1-1). Each echelon reflects an increase in medical capabilities while retaining the capabilities found in the preceding echelon.

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

- Immediate lifesaving measures.
- Disease and nonbattle injury (DNBI) prevention.
- Combat stress control (CSC) preventive measures.
- Patient collection.
- Medical evacuation from supported units to supporting medical treatment elements.

● Treatment provided by designated combat medics or treatment squads (battalion aid stations [BASS]). Major emphasis is placed on those measures necessary for the patient to return to duty (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.

(1) The combat medic 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 chemical 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 combat medic 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.

(2) Echelon I medical treatment is provided by the combat medic or by personnel in the BAS.

(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 combat medic is the first individual in the CHS chain who makes medically-substantiated decisions based on medical military occupational specialty (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. This element also conducts routine sick call when the situation permits. Like elements provide this echelon of care in divisions, corps, and communications zone (COMMZ) units.

(c) Echelon I medical care is provided by-

- Medical platoons/sections [Figure 1-2] of combat and combat support (CS) battalions.
- Divisional medical companies.
- Corps and COMMZ area support medical companies (ASMCs).

b. Echelon II care is provided at the clearing station which is operated by the treatment platoon of the medical company. Here the patient is evaluated to determine his priority for continued evacuation to the rear, or is treated and returned to duty. Emergency care, including beginning resuscitation, is continued and, if necessary, further emergency measures are instituted; however, these measures do not go beyond the measures dictated by the tactical situation. Those patients who can RTD within 72 hours are held for treatment. Units providing Echelon II care are located in the combat zone (CZ) (brigade support area [BSAJ, division support area [DSA], corps support area [CSA], and the COMMZ.

c. Echelon III care is provided in medical treatment facilities (MTFs) staffed and equipped to provide care for all categories of patients (combat support hospital [CSH]) and for patients whose wounds make them nontransportable and require surgical care by a surgical squad/detachment or a mobile army surgical hospital [MASH] prior to further evacuation. The MASH is normally deployed in the division rear area and is located close to the division clearing station.

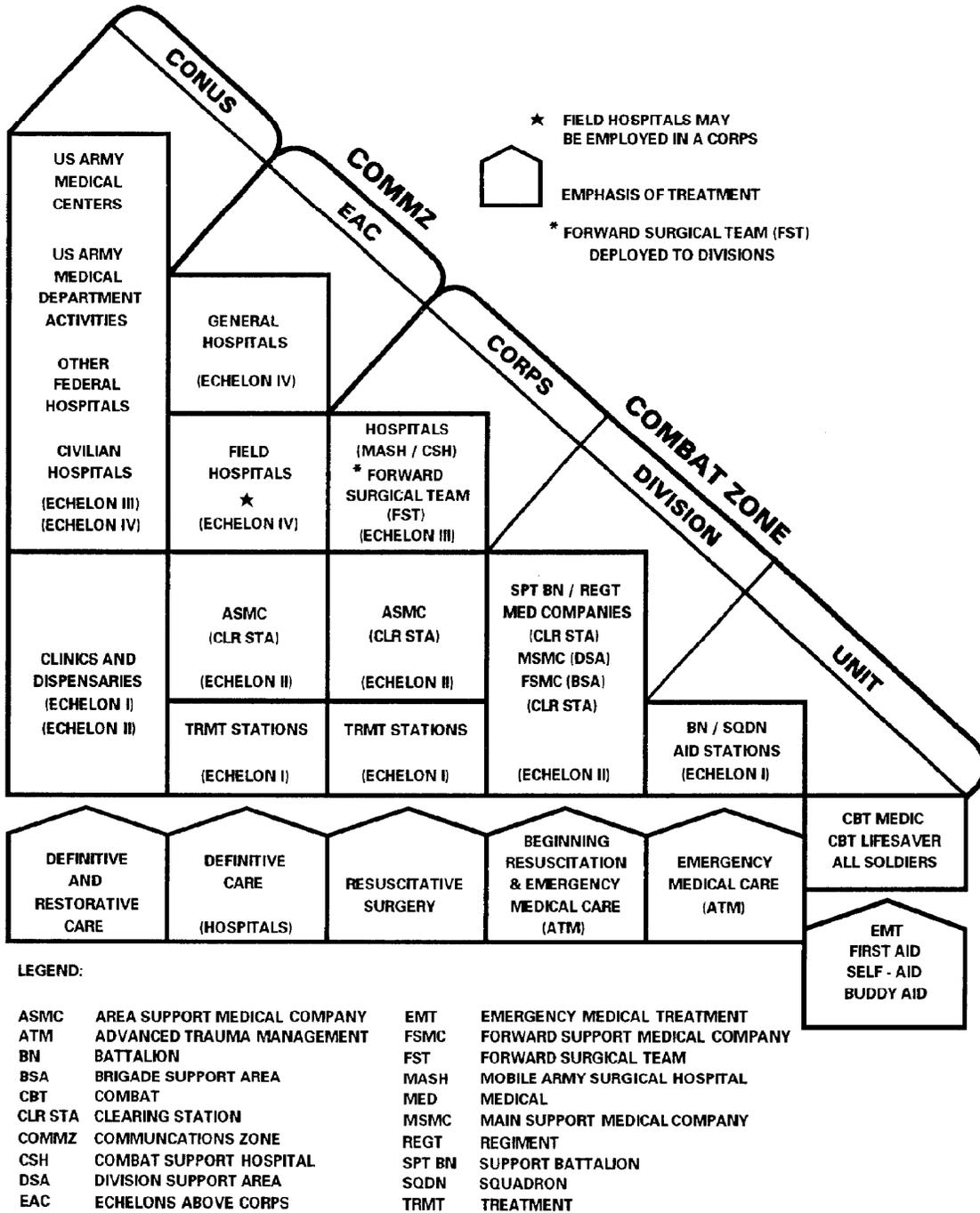
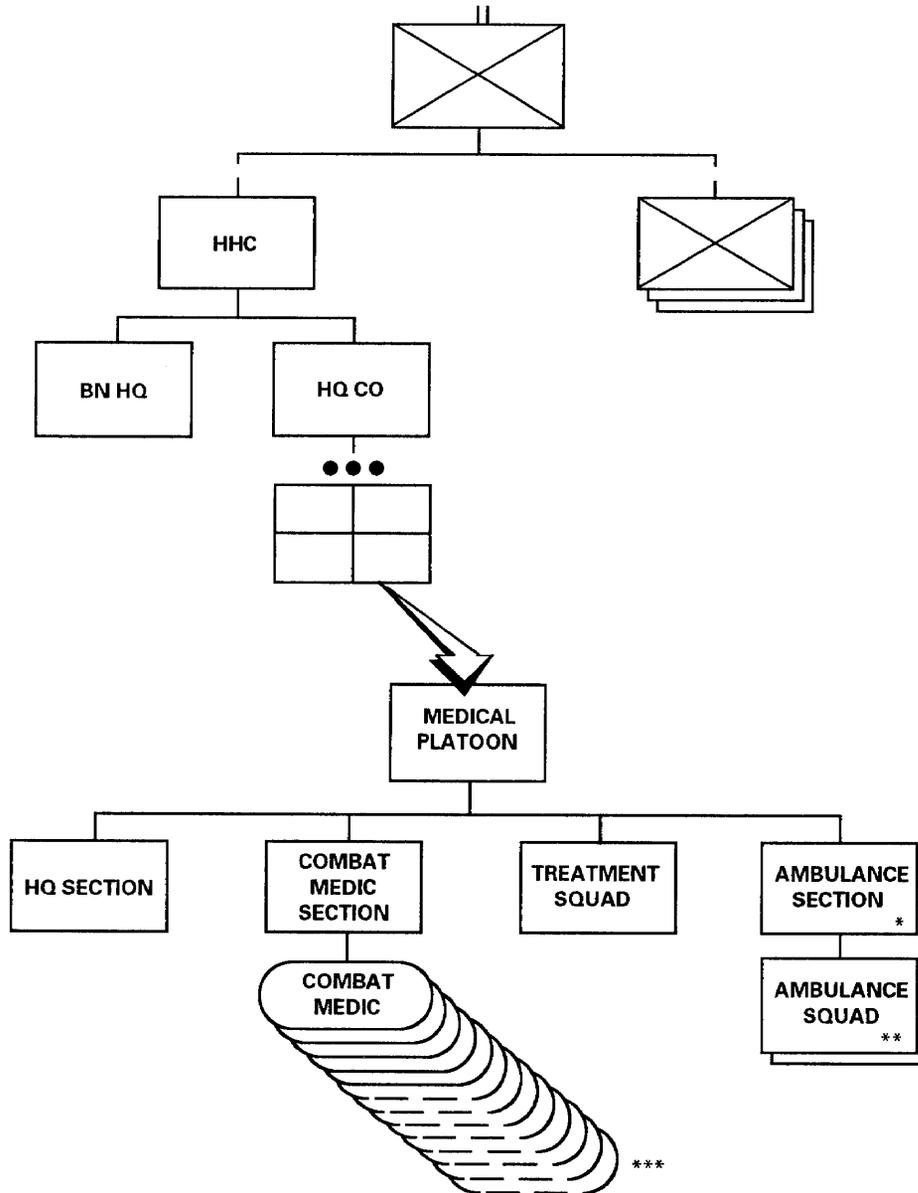


Figure 1-1. Echelons of care.



NOTE:

* MECHANIZED INFANTRY AND ARMOR UNITS HAVE 4 AMBULANCE SQUADS.

** TWO AMBULANCE TEAMS.

*** AIRBORNE AND AIR ASSAULT UNITS HAVE 12, LIGHT INFANTRY UNITS HAVE 9, ARMOR UNITS HAVE 5, AND MECHANIZED INFANTRY UNITS HAVE 13.

Figure 1-2. Medical platoon.

d. Echelon IV medical care enables the patient to be treated in a general hospital (GH) staffed and equipped for general and specialized medical and surgical care, or a field hospital (FH) which provides rehabilitative and convalescent care for those patients who are expected to RTD within the theater evacuation policy. These units are normally located in the COMMZ.

1-3. 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-induced performance deterioration, or diseases. The elements of the medical threat include, but are not limited to—

- Diseases endemic to the area of operations (AO).
- Environmental factors (heat, cold, humidity, and significant elevations above sea level).
- Battle injuries from conventional and nuclear, biological, and chemical (NBC) and directed-energy (DE) weapons/devices.
- The level of compliance with the law of war and the Geneva Conventions (Appendix A) requirements regarding “respect and protection” of medical personnel, medical facilities, and transportation means.
- Physiologic and psychological stressors.

b. In order to develop the CHS estimate and plan (Appendix B), 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 [AFMICI]), it is not considered to be intelligence.

For additional information on the medical threat and medical intelligence, refer to paragraph 1-13 and to FM 8-10, FM 8-10-8, FM 8-42, and FM 8-55.

1-4. 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

FM 8-10-1

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 sustain 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.
- HOW it will be accomplished.

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—

● Patient evacuation (to include training of nonmedical personnel to serve as litter bearers) and medical regulating.

- Hospitalization.
- Health service logistics, to include blood management.
- Preventive medicine (PVNTMED) services.
- Veterinary services.
- Dental services.
- Combat stress control.
- Command, control, communications, computers, and intelligence (C⁴I).
- Medical laboratory services.
- Area medical support.

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 situations

may exceed local CHS capabilities (Appendix C). Key factors for effective mass casualty management are on-site triage, EMT, effective communications, and skillful evacuation by ground and air resources.

- 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 nontreatment 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 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 8-10, FM 8-42, FM 8-55, FM 101-10-1/1, and FM 101-10-1/2.

1-5. 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, and time available [METT-T] 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 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 Conventions 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 (mass casualty 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.

1-6. Capabilities of the Combat Health Support System

a. The CHS capabilities of each echelon are designed to meet the characteristics of the operational environment. They play a specific part in the phased treatment, hospitalization, and evacuation of sick, injured, or wounded soldiers. Each successive echelon of CHS has the capabilities to perform functions of the lower echelon and has additional capabilities that cannot be located farther forward. This allows higher CHS echelons to regenerate lower echelons and to provide CHS on an area basis.

b. Prevention begins with the individual soldier's awareness of the means to protect himself against DNBIs through health and personal hygiene education, stress management, proper nutrition, physical fitness, safety procedures and training, and other similar measures. This awareness is further enhanced through—

- Expanded self-aid, buddy aid, and combat lifesaver training programs.
- Continuous interface with Echelons I and II treatment personnel.
- Preventive medicine programs.
- Combat stress control training.
- Leadership emphasis at all levels of command.

NOTE

Prevention is the most effective, least expensive method of providing the tactical commander with sustained combat power. The key to prevention begins with soldiers maintaining a high level of personal hygiene.

c. Medical elements within the division require flexibility and responsiveness if they are to provide effective and timely CHS. Effective CHS enables rapid treatment and RTD for those casualties who are either sick or suffering from minor wounds or injuries. More seriously wounded patients are provided prompt stabilizing treatment and evacuated to an MTF equipped to provide for their medical conditions.

1-7. Army Medical Department Battlefield Rules

The Army Medical Department (AMEDD) has developed medical battlefield rules to aid in establishing priorities and resolving conflicts for competing priorities within CHS activities.

- a. These battlefield rules are (in order of their priority) to-
 - Maintain medical presence with the soldier.
 - Maintain the health of the command.
 - Save lives.
 - Clear the battlefield.
 - Provide state-of-the-art care.
 - Return soldiers to duty as early as possible.
- b. For additional information, refer to FM 8-55.

1-8. Modular Medical Support System

a. *General.* The modular medical support system was designed to standardize all medical subelements in Echelons I and H. The divisional medical units and Echelon II units in the corps and COMMZ 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 combat medic (Echelon I). From this point, the patient is evacuated to the BAS (Echelon I) and then to the division clearing station (Echelon II). The ASMC provides Echelons I and II CHS on an area basis to units operating in the corps and COMMZ.

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) *Combat medic.* The combat medic module consists of one combat medical specialist and his prescribed load of medical supplies and equipment.. Combat medics 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 four medical specialists and two ambulances. This squad provides patient evacuation throughout the division (and/or corps and COMMZ) and medical care en route. Ambulance squads are organic to the medical platoons or sections in the maneuver battalions and division/nondivisional medical companies and the ASMCs. In the division medical company, ambulance squads may be collocated with the BAS or forward sited with the companies of the maneuver brigades.

(3) *Treatment squad.* This squad consists of a primary care physician, a PA, and six medical specialists. The squad is trained and equipped to provide ATM to the battlefield casualty or to treat and return him to duty. Advanced trauma management is physician- or PA-directed emergency medical care designed to resuscitate and stabilize the patient for evacuation to the next echelon of medical care. To maintain contact with the combat maneuver elements, each squad has two vehicles equipped with trauma treatment medical equipment sets (MESS). 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 the medical company.

(4) *Area support squad.* This squad is comprised of one dentist trained in ATM, a dental specialist, an x-ray specialist, and a medical laboratory specialist. The squad is organic to the medical companies within the BSA, DSA, CSA, or COMMZ.

(5) *Patient-holding squad.* This squad consists of two practical nurses and two medical specialists. It is capable of holding and providing minimal care for up to 40 (20 in the light infantry division [LID]) RTD patients. This squad is also organic to the medical companies within the BSA, DSA, CSA, or COMMZ.

NOTE

When a treatment squad, an area support squad, and a patient-holding squad are collocated, they form an area support section. This section provides CHS on an area basis to all forces within a geographical area of responsibility (clearing station). The area support section normally operates in the BSA, DSA, CSA, or COMMZ. The area support and patient-holding squads are incapable of independent operations.

(6) *Medical detachment (surgical,) and surgical squad.* The medical detachment (surgical) is a corps asset and is an augmentation to Echelon II CHS. It deploys as far forward as necessary to support division/task-force operations. This detachment must collocate with a patient-holding squad for support. Each airborne and air assault division has two surgical squads which are organic to the main support medical company (MSMC). Both the corps medical detachment (surgical) and the airborne and air assault division organic surgical squads have the same basic design. They are organized to provide early resuscitative surgery for seriously wounded or injured casualties, to

save lives, and to preserve function. Early surgery is performed whenever a likely delay in the evacuation of a patient threatens life or is anticipated to significantly affect the quality of recovery. The task-force medical detachment (surgical) and organic surgical squads will normally be employed in the DSA, but may be employed in the BSA during task-force operations. (Normally, the medical detachment (surgical) is attached to a treatment platoon and collocated with the division clearing station or possibly an ASMC). Postsurgical patients, awaiting evacuation, are held by the patient-holding squad with nursing care provided by the nurses of the surgical module.

Section II. COMBAT HEALTH SUPPORT FUNCTIONAL AREAS

1-9. General

The CHS continuum encompasses all of the functional areas within the AMEDD, to include C⁴1. However, C⁴1 will not be discussed in this chapter; it is included throughout the manual as appropriate. Within the division, the full spectrum of services are provided by a combination of organic, assigned, attached, in DS, and in general support (GS) CHS resources.

1-10. Patient Evacuation and Medical Regulating

a Patient 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 intervention.

(1) *Responsibilities.* 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 Echelon I medical units. Medical evacuation