

FM 8-10-6

**MEDICAL EVACUATION
IN A THEATER OF
OPERATIONS**

TACTICS, TECHNIQUES, AND PROCEDURES

HEADQUARTERS, DEPARTMENT OF THE ARMY

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PREFACE

This field manual (FM) provides the philosophy of and doctrine for medical evacuation in a theater of operations (TO). Tactics, techniques, and procedures for accomplishing the medical evacuation of sick, injured, or wounded soldiers are included. Medical evacuation, with the provision of en route medical care, is a vital link in the continuum of care from the point of injury through the combat health support (CHS) system to medical treatment facilities (MTFs) with the required definitive or restorative medical treatment capabilities. This publication is intended for use by medical and nonmedical unit commanders and their staffs. This publication also discusses the following:

- Coordination requirements for and use of nonmedical transportation assets to accomplish the medical evacuation mission. These nonmedical assets may be used in a mass casualty situation or other circumstances when the available medical evacuation assets are overwhelmed.
- Definitive guidance for the performance of hoist rescue missions.
- Techniques for evacuating casualties from minefields.

The information in this publication on manual and litter carries may be used to instruct personnel in the proper methods of handling and moving casualties.

The use of the term *continental United States (CONUS)* includes the continental United States (US), Hawaii, Alaska, and its territories and possessions.

The proponent of this publication is the US Army Medical Department Center and School (AMEDDC&S). Send comments and recommendations on Department of the Army (DA) Form 2028 directly to the **Commander, AMEDDC&S, ATTN: MCCS-FCD-L, 1400 East Grayson Street, Fort Sam Houston, Texas 78234-6175.**

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) which were current at the time of publication of this manual. However, such staffing is subject to change to comply with manpower requirements criteria outlined in Army Regulation (AR) 71-32 and can be subsequently changed by your modified table of organization and equipment (MTOE).

This publications implements 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
Marking of Military Vehicles		512	

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Title	STANAG	QSTAG	AIR STD
Stretchers, Bearing Brackets, and Attachment Supports	2040		
Stretchers		519	
Medical Employment of Air Transport in the Forward Area	2087	529	
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CHAPTER 1

**INTRODUCTION TO THE COMBAT HEALTH SUPPORT
SYSTEM AND MEDICAL EVACUATION****1-1. General**

a. The purpose of the CHS system is to conserve the fighting strength. This includes both the deployed force and the sustaining base. Consistent with military and logistical operations, CHS operates in a continuum across strategic, operational, and tactical levels. In a force projection army, the CHS system supports a force which is rapidly deployable, lethal, versatile, and expandable. The Force XXI battle space will be characterized by dispersion, lightning-quick military operations, increased mobility requirements, rapid task organization, and lengthening lines of communication (LOC). The CHS system must be strategically, operationally, and tactically agile in order to be responsible to the broad range of worldwide requirements.

b. Medical commanders must effectively use their resources to treat, evacuate, and, when possible, return to duty (RTD) sick, injured, and wounded soldiers.

1-2. Threat

a. The post-Cold War international environment presents the US with security challenges that are unprecedented in ambiguity, diversity, risk, and opportunity. For many decades, nearly all US intelligence analysis was directed toward one country. The Soviet strategic doctrine and tactics for conducting offensive and defensive operations were well understood and confident estimates of Soviet weapons capabilities existed. Further, during the Cold War, the US National Security Strategy carefully rationed the use of military force to only those conflicts which promoted democracy over communism. The world was a dangerous place, but the superpowers were held in check by the knowledge that each had the capability to destroy the planet.

b. The end of the Cold War signaled the emergence of a "New World Order." Unfortunately, reality has proven that this new order is neither new nor orderly. The old forces of adventurism, nationalism, and separatism have reappeared, often with violent and unpredictable consequences. Coupled with this is a new National Security Strategy, still in its infancy, which allows for US military involvement in complicated scenarios such as peacemaking operations, nation assistance, and humanitarian assistance.

c. With the diminished threat of a large-scale military confrontation, military force size and capabilities are being affected in countries throughout the world. Many of the major military powers are moving toward smaller, better-equipped, and better-trained forces. Developed nations have also improved military capabilities through greater access to military system technologies and the increased availability of a wide range of advanced military equipment on the international market. How well these nations are able to integrate advanced weapons systems for a high technology status may increase their leverage over another regional power. While high technology weapons will be available, either through direct purchase or through third party countries, many hostile forces, especially paramilitary or insurgent forces, will maintain a low technology inventory. This low technology weapons environment does not translate into a low threat environment for US forces. Small hostile forces often demonstrate a creativity and flexibility for

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use of low technology weapons that is unexpected, thereby compounding the problems associated with assessing their capabilities. The implication for the US Army is clear. United States forces must be continually prepared to face a variety of threat forces, many with credible military capabilities.

d. The Army Medical Department (AMEDD) views threat from two perspectives. Both viewpoints are rooted in a potential adversary's capability to conduct combat operations. The first of these viewpoints is similar to the way threat is viewed in the Army. This is a potential adversary's capability to disrupt CHS operations on the battlefield. The second is the AMEDD's responsibility to anticipate and prevent the degradation of soldiers' performance by diseases, environmental hazards, and military capabilities. This second perspective is called the *medical threat*. Soldiers are the targets of these threats. Weapons or environmental conditions that will generate casualties beyond the capability of the CHS system are considered to be significant medical threats. (The medical threat is further discussed in paragraph 1-3.)

e. For a discussion of CHS operations in stability operations and support operations, refer to FM 8-42.

1-3. 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—

- Diseases endemic to the area of operations (AO).
- Environmental factors (heat, cold, humidity, and high altitude).
- Battle injuries.
- Biological warfare (BW) agents.
- Chemical warfare (CW) agents.
- Directed-energy (DE) sources.
- Blast effect munitions.
- Flame and incendiary weapons.
- Nuclear weapons.
- Toxic industrial materiel/chemicals (to include radioactive material).
- Combat stress and continuous operations.

1-2

- Level of compliance with the Law of Land Warfare and the Geneva Conventions (Appendix A) requirements regarding *respect and protection* of medical personnel and their patients, MTFs, and medical vehicles and aircraft.

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, and analysis, integration, and interpretation of all available general health and bioscientific information. Medical intelligence is concerned with one or more aspects of foreign nations or the AO. Until medical information is processed (ordinarily at the national level by the Armed Forces Medical Intelligence Center [AFMIC]), it is not considered to be intelligence.

c. For additional information on medical intelligence, refer to FM 8-10-8.

1-4. Medical Evacuation Versus Casualty Evacuation

a. Medical evacuation is the timely, efficient movement and en route care by medical personnel of the wounded, injured, or ill persons from the battlefield and/or other locations to MTFs. The provision of en route care on medically equipped vehicles or aircraft enhances the patient's potential for recovery and may reduce long-term disability by maintaining the patient's medical condition in a more stable manner.

(1) The gaining MTF is responsible for arranging for the evacuation of patients from the lower echelon of care. For example, Echelon II medical units are responsible for evacuating patients from Echelon I MTFs.

(2) Medical evacuation begins when medical personnel receive the wounded, injured, or ill soldier and continues as far rearward as the patient's medical condition warrants or the military situation requires.

b. Casualty evacuation (CASEVAC) is a term used by nonmedical units to refer to the movement of casualties aboard nonmedical vehicles or aircraft.

CAUTION

Casualties transported in this manner do not receive en route medical care; if the casualty's medical condition deteriorates during transport, an adverse impact on his prognosis and long-term disability may result.

(1) If dedicated medical vehicles or aircraft are available, casualties should be evacuated on these conveyances to ensure they receive en route medical care.

(2) If available medical evacuation resources are overwhelmed (such as in a mass casualty situation), some casualties (usually with minimal or nonlife-threatening injuries) may be required to be transported on nonmedical vehicles. Medical personnel on-site will determine the priority for evacuation by available medical vehicles and aircraft.

NOTE

When possible, nonmedical vehicles/aircraft transporting casualties should be augmented with a combat medic or combat lifesaver. (On nonmedical aircraft, sufficient space may not be available to permit a caregiver to accompany the casualties.) The type of en route surveillance and medical care/first aid provided is limited by the following factors:

- Skill level of the individual providing care.

(The combat medic is military occupational specialty [MOS]-qualified to provide emergency medical treatment [EMT]; the combat lifesaver is trained to provide enhanced first aid.) The combat medic can provide emergency medical intervention, whereas the combat lifesaver can only monitor the casualty and ensure that the basic lifesaving first-aid tasks are accomplished.

- Equipment available.
- Number of casualties being transported.
- Accessibility of the casualties. (If the nonmedical ground vehicle is loaded with the maximum number of casualties, the combat medic/combat lifesaver will not be able to attend to the casualties while the vehicle is moving. At best, if the condition of a casualty deteriorates and emergency measures are required, the vehicle will have to be stopped to permit care to be given.)

1-5. Theater Evacuation Policy

a. 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 number of days, the maximum period of noneffectiveness (hospitalization and convalescence) that patients may be held within the theater for treatment. This policy does not mean that a patient is held in the 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 the CONUS or other safe haven. This is done providing that the treating physician determines that such evacuation will not aggravate the patient's

disabilities or medical condition. For example, a theater evacuation policy of 15 days does not mean that a patient is held in the theater for 14 days and then evacuated. Instead, it means that a patient is evacuated as soon as possible after the determination is made that he cannot be returned to duty within 15 days following admission to an Echelon III or above hospital.

b. To the degree that unplanned for increases in patients occur (due perhaps to an epidemic or heavy combat casualties), a temporary reduction in the policy may be necessary. This reduction is used to adjust the volume of patients being held in the TO hospital system. A reduction in the evacuation policy increases the number of patients requiring evacuation out-of-theater and increases the requirement for evacuation assets. This action is necessary to relieve the congestion caused by the patient increases. A decrease in the theater evacuation policy increases the evacuation asset requirements.

c. The time period established by the theater evacuation policy starts on the date the patient is admitted to the first hospital (combat zone [CZ] or echelons above corps [EAC]). 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. Though guided by the evacuation policy, the actual selection of a patient for evacuation is based on clinical judgment as to the patient's ability to tolerate and survive the movement to the next echelon of hospitalization. An exception to the theater evacuation policy may be required with respect to special operations forces (SOF) personnel. This exception may be required to retain low density MOS skills within the theater. Retaining these personnel within the theater for an extended period of time is possible if the medical resources are available within the theater to treat their injuries and provide for convalescence and rehabilitation. If retention within the theater would result in a deterioration of their medical condition or would adversely impact on their prognosis for full recovery, they are evacuated from the theater for definitive care.

d. The evacuation policy has different meanings for different personnel. For example, to the—

(1) Physicians and dentists engaged in direct patient treatment and decisions relating to patient disposition, it means that there is a maximum period within which clinical staffs may complete the necessary treatment needed to return the patient to full duty within the theater. If the theater policy is 15 days and full RTD can be predicted within that time, the patient is retained in the theater hospital system. If the patient cannot be returned to full duty within 15 days, the patient is evacuated out-of-theater as early as clinically prudent.

(2) Combat health support planner, it means that he can compute the beds required in theater, if given the theater evacuation policy and other factors. This can be translated into the type, mix, number, and distribution of hospital beds required in the theater.

(3) Nonmedical logistician, it means, in part, that he can estimate his total obligation to support this system.

(4) United States Air Force (USAF) planner, it means that he can accurately plan the USAF aeromedical evacuation (AE) requirements for both intra- and intertheater patient movements.

(5) Combat health support operator, it means that he has a management tool which, when properly adjusted and used, provides the balance between patient care and tactical support requirements. The CHS operator is able to tailor a CHS package specifically designed to handle the patient workloads, with maximum benefit to the patients and with maximum economy of available resources.

1-6. Factors Determining the Evacuation Policy

To fully understand how the theater evacuation policy affects CHS operations, the CHS operator should be aware of the factors that influence the establishment of this policy. The following factors are used in determining the evacuation policy:

a. Nature of Tactical Operations. A major factor is the nature of the combat operations. Will they be operations of short duration and with a low potential for violence? Will they be operations of long duration with significant combat operations? Will weapons of mass destruction (WMD) (to include nuclear, biological, and chemical [NBC] or DE weapons) be employed? Will only conventional weapons be used? Is a static combat situation expected? Is there a significant threat of terrorist activities? Are the majority of patients anticipated to be disease and nonbattle injury (DNBI) patients or those with combat-related trauma?

b. Number/Type of Patients. Another factor is the number and types of patients anticipated and the rate of patient RTD. Admission rates vary widely in different geographical areas of the world and in different types of military operations.

c. Evacuation Means. The means (quantity and type of transportation) available for evacuation of patients from the TO to CONUS is an essential factor impacting on the evacuation policy.

d. Availability of Replacements. The capability of CONUS to furnish replacements to the theater is another consideration. For each patient who is evacuated from the theater to CONUS, a fully trained and equipped replacement must be provided. During a small-scale conflict overseas, the CONUS replacement capability is much greater than when compared to a large-scale conflict such as World War II.

e. Availability of In-Theater Resources. Limitations of all CHS resources (such as insufficient number and types of CHS units in EAC to support the CZ and an insufficient amount of combat health logistics [CHL] and nonmedical logistics) will have an impact on the theater evacuation policy. The availability, type, and timing of engineering support is also a consideration. The more limitations (or shortages), the shorter the theater evacuation policy.

1-7. Impact of Evacuation Policy on Combat Health Support Requirements

a. A short theater evacuation policy—

- Results in fewer hospital beds required in the theater and a greater number of beds required elsewhere.

- Creates a greater demand for intertheater USAF evacuation resources. (A shortened intratheater evacuation policy would likewise increase the number of airframes required in the theater.)
 - Increases the requirements for replacements to meet the rapid personnel turnover which could be expected, especially in combat units. (The impact this would have on both intra- and intertheater transportation and other requirements must also be considered.)
- b.* A longer theater evacuation policy—
- Results in a greater accumulation of patients and a demand for a larger CHS infrastructure in the theater. It decreases bed requirements elsewhere.
 - Increases the requirements for CHL (medical supplies and equipment and medical maintenance) and nonmedical logistics support.
 - Increases the requirements for hospitals, engineer support, and all aspects of base development for CHS. (It demands the establishment of a larger number of hospitals in EAC.)
 - Provides for a greater proportion of patients to RTD within the theater, and thus reduces the loss of experienced manpower.
- c.* The evacuation policy has no impact on the patient stabilization period for movement. This period is known as the *evacuation delay*. It is the period of time planned for between the time of patient reporting and the time of AE of the patient to the next echelon of care. Evacuation delays normally range from 24 to 72 hours and are designated by the theater surgeon.

1-8. Adjustments to the Evacuation Policy

When patients are received at a rather constant rate, the evacuation policy at a specific echelon may be adjusted to retain or RTD those patients who do not require specialized treatment in EAC hospitals. However, when increased patient loads are anticipated, the intratheater evacuation policy must be adjusted to make additional beds available for current and anticipated needs. As a result, a larger proportion of patients admitted in the CZ are evacuated to EAC facilities much earlier than under normal conditions. The displacement of hospitals temporarily reduces the number of beds available and may result in a greater number of patients being evacuated out of the CZ during the period of relocation.

1-9. Planning for Combat Health Support

a. 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 CHS commanders to maintain CHS to sustain the tactical commander during the absence of orders and communications. Combat health support planning is an intense and demanding process. The planner must know—