

Joint Pub 4-02



Doctrine for Health Services Support in Joint Operations



26 April 1995

PREFACE

1. Scope

This publication delineates requirements and considerations for the health service support (HSS) system as well as HSS aspects of joint planning, special operations, and military operations other than war. It also addresses the medical threat and the need for medical intelligence.

2. Purpose

This publication has been prepared under the direction of the Chairman of the Joint Chiefs of Staff. It sets forth doctrine to govern the joint activities and performance of the Armed Forces of the United States in joint operations as well as the doctrinal basis for US military involvement in multinational and interagency operations. It provides military guidance for the exercise of authority by combatant commanders and other joint force commanders and prescribes doctrine for joint operations and training. It provides military guidance for use by the Armed Forces in preparing their appropriate plans. It is not the intent of this publication to restrict the authority of the joint force commander (JFC) from organizing the force and executing the mission in a manner the JFC deems most appropriate to ensure unity of effort in the accomplishment of the overall mission.

3. Application

a. Doctrine and guidance established in this publication apply to the commanders of combatant commands, subunified commands, joint task forces, and subordinate components of these commands. These principles and guidance also may apply when significant forces of one Service are attached to forces of another Service or when significant forces of one Service support forces of another Service.

b. The guidance in this publication is authoritative; as such, this doctrine will be followed except when, in the judgment of the commander, exceptional circumstances dictate otherwise. If conflicts arise between the contents of this publication and the contents of Service publications, this publication will take precedence for the activities of joint forces unless the Chairman of the Joint Chiefs of Staff, normally in coordination with other members of the Joint Chiefs of Staff, has provided more current and specific guidance. Commanders of forces operating as part of a multinational (alliance or coalition) military command should follow multinational doctrine and guidance ratified by the United States. For doctrine and procedures not ratified by the United States, commanders should evaluate and follow the multinational command's doctrine and procedures, where applicable.

For the Chairman of the Joint Chiefs of Staff:



T.R. PATRICK
Colonel, USA
Secretary, Joint Staff

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EXECUTIVE SUMMARY

COMMANDER'S OVERVIEW

- **Discusses the Health Service Support (HSS) Mission and Objectives in Joint Operations**
 - **Covers Planning and Coordination for HSS Services**
 - **Provides Special Planning Considerations for Unique Operations**
 - **Discusses Requirements for HSS in Special Operations**
 - **Covers HSS in Military Operations Other Than War**
-

Health Service Support Mission and Objectives

Effective health service support (HSS) enhances the combat strength of the joint force.

The health service support (HSS) mission in joint operations is to minimize the effects of wounds, injuries, and disease on unit effectiveness, readiness, and morale. This mission is accomplished by a proactive preventive medicine program and a phased health care system (echelons of care) that extends from actions taken at the point of wounding, injury, or illness to evacuation from a theater for treatment at a hospital in the continental United States (CONUS). **The primary objective of HSS is to conserve the commander's fighting strength of land, sea, air, and special operations forces.** HSS in joint operations requires continuous planning, coordination, and training to ensure a prompt, effective, and unified health care effort.

Echelons of Health Care

Five echelons of care make up the HSS system.

Echelon I. Care is rendered at the unit level and includes self aid and buddy aid, examination, and emergency lifesaving measures.

Echelon II. Care is administered at an HSS organization by a team of physicians or physician assistants, supported by appropriate medical technical or nursing staff.

Echelon III. Care administered requires clinical capabilities normally found in a medical treatment facility (MTF).

Echelon IV. Care provided is not only a surgical capability as provided in Echelon III, but also further definitive therapy for patients in the recovery phase.

Echelon V. Care is convalescent, restorative, and rehabilitative and is normally provided by military, Department of Veterans Affairs, or civilian hospitals in CONUS.

Health Care Principles

Each Service component has an HSS system that encompasses six health care principles.

Conformity. Integration and compliance with the commander's plan.

Proximity. Provide HSS as close to combat operations as the tactical situation permits.

Flexibility. Shift HSS resources to meet changing requirements.

Mobility. Anticipate requirements for rapid movement of HSS units to support combat forces during operations.

Continuity. Provide optimum, uninterrupted care and treatment to the wounded, injured, and sick.

Coordination. Ensure that HSS resources in short supply are efficiently employed and used to effectively support the planned operation.

Operational Planning and Coordination

Operational planners must select the best or most appropriate means of performing a joint force mission.

Timely, effective planning and coordination are essential to ensure adequate and sustainable HSS in a theater. Proper planning permits a systematic examination of all factors in a projected operation and ensures interoperability with the campaign or operation plan. **Organization of the HSS** system is determined largely by the joint force's mission, the medical threat, medical intelligence, the theater evacuation policy, and hospitalization and evacuation requirements.

The geographic combatant commander has overall responsibility for health care within the theater.

Geographic combatant commanders are responsible for coordinating and integrating HSS within their theaters. A joint force surgeon (JFS) should be appointed for each combatant command, subunified command, and joint task force. JFSs need to assess component command HSS requirements and capabilities, both quantitatively and qualitatively, and provide guidance to enhance the effectiveness of HSS through shared use of assets. The movement of casualties to or between MTFs within the combat zone or forward of corps level is a Service component responsibility. Distribution of respective component HSS capabilities, as directed by the geographic combatant commander, will aid in ensuring efficient use of limited HSS resources, particularly assets and beds.

Patient evacuation requires detailed planning for successful execution.

Timely patient evacuation plays an important role in the design of the treatment sequence from front to rear. When the echelons of HSS become more sophisticated, the means of patient evacuation also become more sophisticated. **Patient evacuation** involves route planning, movement control, and the locating of evacuation facilities. A major factor in the evacuation of patients through the five echelons of medical care is that specific medical equipment and durable supplies designated as **patient movement items must be available** to support the patient during the evacuation.

The HSS estimate's purpose is to provide an analysis of HSS information.

The HSS estimate provides an **analysis of HSS information pertaining to enemy intentions, allied or coalition partner's capabilities, limitations, courses of action, and potential HSS consequences associated with a contemplated operation.** The HSS estimate will include all HSS facts, assumptions, and deductions that can affect the operation. Based upon the HSS estimate of the situation, the JFS, in coordination with the component command surgeons, must plan for medical policies and procedures that can be best adapted to the joint operation.

Special Health Service Support Planning Considerations

Special HSS planning considerations are necessary for unique operations and situations.

Amphibious Task Force. Amphibious task force medical planning responsibilities are closely related to those of the landing force; their facilities are mutually supporting. Detailed, coordinated, and parallel planning is required between the commanders, amphibious task force, and landing force.

Combat Search and Rescue (CSAR). The HSS capabilities of CSAR units vary from component to component, but are generally limited. Certain component CSAR units are dedicated to CSAR operations while others perform CSAR as a secondary mission. Although CSAR units require HSS similar to other units, supported geographic combatant commanders must establish a flexible HSS system to meet the demands of CSAR operations.

The Return of US Prisoners of War (POWs). The geographic combatant commander establishes a theater protocol on the proper handling and provision of HSS for return of US POWs. HSS will be administered within a reasonably short period upon return to friendly forces, treatment assessments will be established, and operational specialty medical support will be provided immediately.

Enemy Prisoners of War (EPWs). In consonance with provisions outlined in the Geneva Conventions, patients who are EPWs are afforded the same level of HSS and medical care as patients of the detaining power. Seriously wounded, injured, or sick EPWs will be evacuated through medical channels, but will be segregated from US and allied patients. The joint force commander must ensure appropriate security is provided to guard the EPWs.

Command, Control, Communications, and Computer Systems

HSS functions depend upon responsive command, control, communications, and computer systems.

Effective command, control, communications, and computer (C4) systems are vital to successful HSS in joint operations. Early identification of a theater's C4 system requirements for HSS connectivity is essential. HSS system management information systems support the information management requirements of HSS units across the range of military operations. Records and reports are required to pass information and assist in the evaluation of policies and procedures.

Dental Services

The HSS dental service is a major contributor to maintaining unit fighting strength.

Joint operation planning must include consideration of the **various roles of dental services.** The planning process includes an evaluation of the size and anticipated duration of the operation, along with the levels of dental care required throughout the operation. **The four levels of dental care are: Emergency Dental Care, Sustaining Dental Care, Maintaining Dental Care, and Comprehensive Care.**

Special Operations

Special operations forces have unique requirements for medical support.

The nature of special operations requires that units be small, highly skilled, self-contained teams that can be easily inserted and extracted by air, sea, and land delivery methods. **Medical support of special operations units is characterized by an austere structure and a limited number of medical personnel.** The nature of special operations forces (SOF) missions requires that SOF medical personnel possess a variety of enhanced medical skills that enable them to operate under a multiplicity of circumstances. Special operations medical support **planning must provide integrated, augmented conventional support into the concept of the special operating mission** without compromising the objectives. The planning must also articulate the unique aspects of the operation that will complicate the delivery of HSS services support by conventional units.

Military Operations Other Than War

Military operations other than war encompass a wide range of activities.

Military operations other than war are usually joint operations, often performed in concert with other government agencies, nongovernmental organizations, and private volunteer organizations. **HSS policies during military operations for operations other than war may be substantially different from the policies associated with a general war.** HSS operations conducted to enhance the stability of a host-nation government must be well-coordinated with all concerned agencies and integrated into the respective US Embassy plan. Independent, unplanned medical civic action programs should not be undertaken.

Humanitarian and civic assistance activities are designed to provide assistance to the host-nation populace.

Humanitarian and civic assistance (HCA) programs **operate in conjunction with US military operations or exercises.** HCAs serve the local populace by furnishing assistance that the local government is not capable of providing. HSS is often provided within a larger military involvement. A significant number of humanitarian assistance programs involve disaster relief operations. The military can provide assistance to help ease the effects of natural disasters and manmade events.

CONCLUSION

HSS attempts to provide prompt, effective, and unified health care services to enhance the combat fighting ability of joint forces. HSS in joint operations requires continuous planning, coordination, and training. HSS is a phased health care system that is based on five echelons of care.

CHAPTER I

THE HEALTH SERVICE SUPPORT SYSTEM

“The soldier’s health must come before economy or any other consideration.”

Napoleon I

1. Mission

The Health Service Support (HSS) mission in joint operations is to minimize the effects of wounds, injuries, and disease on unit effectiveness, readiness, and morale. This mission is accomplished by a **proactive preventive medicine (PVNTMED) program** and a **phased health care system (echelons of care)** that extends from actions taken at the point of wounding, injury, or illness to evacuation from a theater for treatment at a hospital in the continental United States (CONUS). **One measure** of this system’s effectiveness is its ability to save life and limb, to reduce the disease and nonbattle injury rate, and to return patients to duty quickly and as far forward in the theater as possible. **Another measure** is the system’s ability to evacuate patients to the Communications Zone or out of the theater as appropriate, within the operational evacuation policy, with a minimum delay.

2. Conserving the Fighting Strength

a. **The primary objective of HSS is to conserve the commander’s fighting strength** of land, sea, air, and special operations forces. In joint operations, this objective is most effectively achieved through **optimum use** and **integration** of available component command HSS assets.

b. **Effective HSS enhances the combat strength of the joint force** by maintaining physically and emotionally fit personnel and by treating the wounded, injured, or sick to promote their survival, recovery, and

rapid return to duty (RTD). By applying the HSS principles and using the echelons of care discussed in this chapter, **commanders can retain acclimated and experienced personnel**, thus minimizing the requirements for replacements, patient evacuation, and additional logistic support.

c. At their inception, the principles of HSS and echelons of care did not specifically address joint or multinational operations; however, **their implementation is common among Service components** and applies to HSS planning and execution by joint force commanders (JFCs). HSS in joint operations requires continuous **planning, coordination, and training** to ensure a **prompt, effective, and unified health care effort.**

3. Echelons of Care

Five echelons of care make up the HSS system, extending from the point of wounding, injury, or illness (Figure I-1). Each succeeding echelon possesses the **same treatment capabilities** as those echelons forward and **adds a new treatment capability.**

a. **Echelon I.** Care is rendered at the **unit level** and includes **self aid** and **buddy aid, examination, and emergency lifesaving measures** such as maintenance of airway, control of bleeding, prevention and control of shock, and prevention of further injury by trained personnel. **This echelon may include an aid station that has physicians or physician assistants.** Treatment at the aid station includes restoration of the airway by surgical procedure; use of intravenous

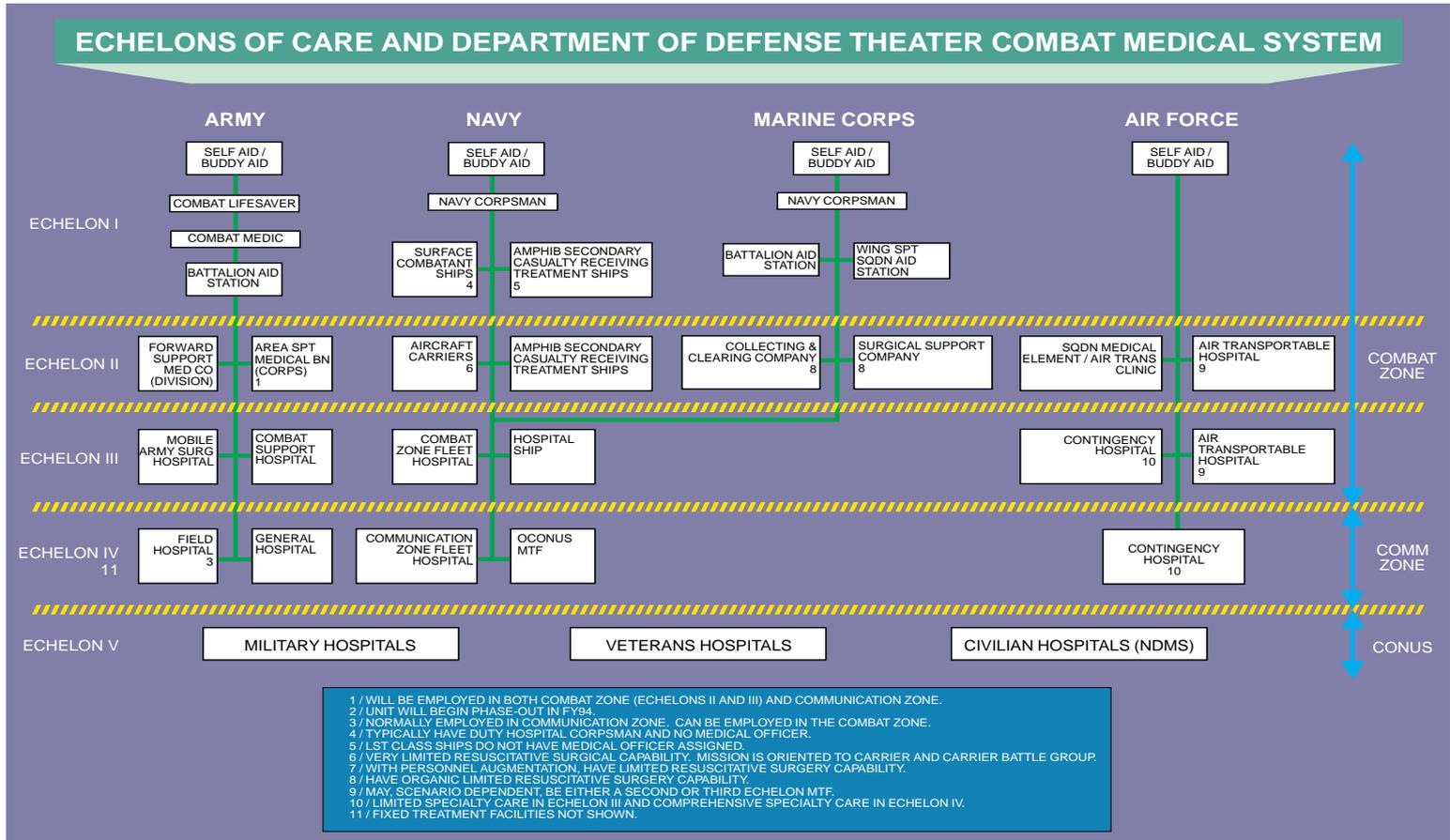


Figure I-1. Echelons of Care and DOD Theater Combat Medical System

fluids, including Ringer's Lactate and Human Albumin; antibiotics; and application of splints and bandages. These elements of medical management prepare patients for RTD or for transportation to a higher echelon of care. **Supporting medical units are responsible for evacuation of patients** from medical treatment facilities (MTFs) forward of the supporting medical unit's position.

b. **Echelon II.** Care is administered at an HSS organization by **a team of physicians or physician assistants, supported by appropriate medical, technical, or nursing staff.** As a minimum, this echelon of care includes basic resuscitation and stabilization and may include surgical capability, basic laboratory, limited x-ray, pharmacy, and

surface or air evacuation is available to a facility possessing the required treatment capability. This is the first echelon at which Group O liquid packed red blood cells will be available for transfusion.

c. **Echelon III.** Care administered requires **clinical capabilities normally found in a MTF** that is typically located in a lower-level enemy threat environment. The MTF is staffed and equipped to provide resuscitation, initial wound surgery, and post operative treatment. This echelon's care may be the first step toward **restoration of functional health**, as compared to procedures that stabilize a condition or prolong life. It does not have the crises aspects of initial resuscitative care and can proceed with **greater preparation and deliberation.** Blood products available



Hospital Ships, a mobile element of the Theater Combat Medical System, provide Echelon III medical care, a capability designed to restore functional health and return the wounded, injured, or ill to their units as soon as possible.

temporary holding ward facilities. **At this echelon, examinations and observations are accomplished more deliberately than at Echelon I.** This phase of treatment applies emergency procedures, such as resuscitation, to prevent death, loss of limb, or body functions. For those patients who require more comprehensive treatment,

include fresh frozen plasma, platelets, frozen Group O red cells, and Groups A, B, and O liquid cells.

d. **Echelon IV.** This echelon of care will provide not only a **surgical capability** as provided in Echelon III, but also further **definitive therapy for patients in the**

recovery phase who can return to duty within the theater evacuation policy. Definitive care is normally provided by a communications zone Fleet Hospital, General Hospital, or overseas MTF. If rehabilitation cannot be accomplished within a predetermined holding period, the casualties/patients are evacuated to the zone of Interior, Echelon V.

e. **Echelon V.** Care is **convalescent, restorative, and rehabilitative** and is normally provided by military, Department of Veterans Affairs, or civilian hospitals in CONUS. This phase may include a period of **minimal care and increasing physical activity** necessary to restore patients to functional health and allow their RTD or useful life.

4. Patient Evacuation

Patient evacuation in the combat zone or from Echelon I to Echelon II, from Echelon II to Echelon III, and within Echelon III is normally the responsibility

of the component commands and is coordinated by a Theater Patient Movements Requirements Center (TPMRC). These movements can be by surface (land or water), rotary-wing aircraft, or tactical aeromedical aircraft. Dedicated patient evacuation for Navy hospital ships is provided by Army air ambulance assets. **Tactical aeromedical evacuation from the combat zone (Echelon III) to the communications zone (Echelon IV) is normally a responsibility of the supporting Air Force component. Patient evacuation from the theater is the responsibility of US Commander in Chief, Transportation Command (USCINCTRANS),** who is responsible for establishing, operating, training, and maintaining the common-user aeromedical evacuation system worldwide. This mission is executed by the Air Mobility Command. Patient evacuation procedures in joint operations are described in Joint Publication 4-02.2, "Joint Tactics, Techniques, and Procedures for Patient Evacuation in Joint Operations."

VIETNAM: FROM THE FIELD TO THE HOSPITAL

Field evacuation and hospitalization of wounded in Vietnam was different from any previously carried out in any war. In addition it varied both in time and place within Vietnam. It was characterized by the absence of front lines and the traditional chain of evacuation. In general, the wounded Soldier was apt to receive his wounds while with a small group or unit isolated deep in roadless jungle, and the wounds were more apt to be multiple over all parts of the body than in any previous war. First aid and emergency medical treatment given on the site by company aid men, however, differed little from previous times. Resuscitative equipment and procedures included pressure dressings, tourniquets, and airways. Morphine was available but seldom used, as pain was not usually a problem at this point and aid men were aware of the depressant effects of morphine. In all likelihood, the patient would be evacuated within a relatively few minutes by helicopter, either a medical ambulance craft or a tactical one. The facilities available for resuscitation aboard the helicopter varied depending on whether it was a medical ("dust-off") helicopter or a combat helicopter. IV fluid, usually Ringer's Lactate solution, was often available, and trained medical technicians and emergency equipment were also present on dust-off helicopters.

The destinations of the helicopters varied. In some areas patients were taken to aid stations or medical companies. More often the helicopter flew the patients directly to a surgical hospital where they could receive definitive care. Blood and electrolyte solutions were often available at aid stations and medical and clearing companies, as was some surgical capability. Complete surgical facilities, including anesthetists, were available at clearing companies, but definitive surgery was usually not done here. At times battalion surgeons flew forward to a site of combat, bringing blood and other supplies which were given on the spot.

Hospitals fulfilled much the same function for combat wounded, whether they were surgical hospitals, field hospitals, or evacuation hospitals. By and large they were all “semipermanent,” usually buildings set on a concrete floor, air-conditioned and with all utilities and other equipment of a first-rate hospital in the continental United States.

Resuscitation of a Vietnam war casualty was an extremely rapid and sophisticated procedure. The patient would often be brought to the hospital directly from the battlefield by medical evacuation helicopter, frequently in less than an hour. Usually he received emergency treatment on the battlefield, to include control of hemorrhage, wound dressing, respiratory control, and often the starting of intravenous fluid. At the hospital, he was immediately taken to the resuscitation area where he was surrounded by a large team of highly trained physicians, nurses, and technicians.

The results of this prompt and efficient treatment may perhaps be best illustrated by comparing them with similar statistics from previous wars. In Vietnam, 46,000 of 346,000, or 13 percent, of all wounded American Soldiers died. If 22 percent had died, as was true in Korea, there would have been 77,840 deaths, 31,840 more than actually occurred. In World War II, 28 percent of all wounded American Soldiers died. If the medical treatment of Vietnam had been available during World War II, 117,748 Soldiers would have been saved.

SOURCE: Hardaway, Robert M., M.D., *Care of the Wounded in Vietnam*, Sunflower University Press, 1988.

5. HSS Principles

As shown in Figure I-2, each Service component has an HSS system that encompasses six health care principles:

a. **Conformity. Integration and compliance with the commander’s plan** are the basic elements of effective HSS. HSS planners can help ensure conformity by taking part in development of the commander’s operation plan.

b. **Proximity.** The objective of proximity is **to provide HSS to the wounded, injured, or sick as close to combat operations as the tactical situation permits.** In many cases, time may be as important a factor as distance. Patients are evacuated to an MTF, or the MTF is moved to the area where the patient population is the greatest.

c. **Flexibility.** Changes in tactical plans or operations make this HSS principle essential. **Units must be prepared to shift**



Figure I-2. Health Service Support Principles

HSS resources to meet changing requirements. All HSS units are used within the theater with none held in reserve, so plans for redistribution of HSS resources are required.

d. **Mobility.** Using both organic and nonorganic transportation resources, **commanders should anticipate requirements for rapid movement of HSS units to support combat forces during operations.** This HSS principle is closely aligned to that of proximity.

e. **Continuity.** The objective is **to provide optimum, uninterrupted care and treatment to the wounded, injured, and sick.** Continuity in care and treatment is achieved by moving the patient through a progressive, phased HSS system, which extends from the forward area of the combat zone to an area as far rearward as the patient's condition requires, possibly to CONUS. Continuity is also achieved by providing continued care during movement.

f. **Coordination.** The objective of this principle is **to ensure that HSS resources in short supply are efficiently employed**

and used to effectively support the planned operation. Continuous coordination ensures that MTFs are not placed in areas that interfere with combat operations. Additionally, continuous coordination ensures that the scope and quality of medical treatment and care meet professional standards and policies.

6. Relationships and Responsibilities for Joint HSS

See Figure I-3.

a. **Geographic combatant commanders are responsible for coordinating and integrating HSS within their theaters.** Where practical, **joint use of available medical assets** will be accomplished to support warfighting strategy and concept of operations.

b. **A joint force surgeon (JFS) should be appointed for each combatant command, subunified command, and joint task force.** As a specialty advisor, the **JFS reports directly to the JFC.** The JFS will **coordinate HSS matters** for the JFC. The JFS section should be **jointly staffed** and should be of **sufficient size** to effectively facilitate:

- Joint coordination of HSS initiatives.
- Regionalization.
- Standardization and interoperability.
- Development of the HSS plan.
- Review of subordinate plans and operations.

c. **JFSs need to assess component command HSS requirements and capabilities,** both quantitatively and qualitatively, **and provide guidance to**

RESPONSIBILITIES FOR JOINT HEALTH

COMBATANT COMMANDERS

Combatant commanders are responsible for coordinating and integrating HSS within their theaters.

JOINT FORCE SURGEON (JFS)

The JFS coordinates matters for the JFC.

Facilitates:

- Joint coordination of HSS initiatives.
- Regionalization.
- Standardization and interoperability.
- Development of HSS plan.
- Review of subordinate plans and operations.

Assesses component command HSS requirements and capabilities.

Provides guidance to enhance effectiveness of HSS.

Monitors the status of:

- Patient beds.
- Blood products.
- Health service logistics.
- HSS staffing.

Advises the JFC and informs on status of HSS units.

Coordinates medical intelligence and support for HSS organizations (including assistance from allies).

Supervises the activities of the Theater Patient Movement Requirements Center (TPMRC) and the Joint Blood Program Center (JBPO).

Prepares the HSS annex to joint force plans.

Prepares bed requirement estimates.

Liaison must be established between the JFS and each component surgeon.

Figure I-3. Responsibilities for Joint HSS

enhance the effectiveness of HSS through shared use of assets. **JFSs should have the responsibility to:**

- Assist the combatant commander in formulating a **recommended patient evacuation policy** within the geographic area.
- Assist the component commands in **identifying HSS requirements** of each component and **assigning cross-Service support** where practical.
- **Advise the JFC concerning:**
 - HSS aspects of combat operations.
 - Intratheater rest, rotation, and reconstitution policies.
 - Preventive medicine.
 - Other medical factors that could affect operations.
- Inform the JFC on the **status of HSS units**, highlighting problems and other areas of interest or concern.
- **Monitor the status of:**
 - Patient beds.
 - Blood products.
 - Health service logistics.
 - HSS staffing.
 - Other issues affecting medical readiness.
- Inform the JFC concerning the **status of HSS and any assistance required** by and provided to the civilian populace, US nationals, and enemy prisoners of war (EPW). Advise
 - supporting civil affairs forces on humanitarian and civic assistance (HCA) activities within the joint force operations area.
 - Coordinate HSS provided to or received from **allies** or **other friendly nations**.
 - Coordinate **medical intelligence support** for HSS organizations.
 - **Supervise the activities of the TPMRC and the Joint Blood Program Office (JBPO)**.
 - Prepare the **HSS annex** to joint force plans.
 - Prepare **bed requirement estimates** based on the casualty estimates provided by the appropriate staff (J1, DP, N1, and G1) and extracted from the Joint Operation Planning and Execution System (JOPES) medical planning module (MPM).
 - In conjunction with the joint force's legal office, advise the JFC on **HSS aspects of the Geneva Conventions**.
 - d. **Liaison must be established between the JFS and each component surgeon.** This liaison ensures that mutual understanding of technical medical and dental procedures, unity of purpose and action, and joint HSS are maintained.
 - e. **Medical regulating of patients** will occur by the same process across the range of military operations. **The movement of casualties to or between MTFs within the combat zone or forward of corps level is a Service component responsibility.** If, in the opinion of the attending physician, a casualty cannot be returned to duty within the theater evacuation policy, the originating MTF will request that the

patient be regulated to another MTF for more definitive care. **Patients may be regulated to destinations within the theater, to another theater, or to CONUS.** Patient regulating includes accounting for bed availability, medical airlift capability, and patient in-transit visibility (the ability to track an individual patient's status and location). This will be accomplished through a command and control system known as **TRANSCOM's Regulating and Command and Control Evacuation System (TRAC2ES)**. TRAC2ES is a multi-nodal system composed of three basic collaborative parts:

- The first of these is the **Global Patient Movements Requirements Center (GPMRC)** located at Scott AFB, IL. **The GPMRC coordinates aeromedical evacuation worldwide** and encompasses those duties formerly associated with the Armed Services Medical Regulating Office and the Aeromedical Evacuation Coordination Center (AECC). In practice, the GPMRC will coordinate and allocate assets to the TPMRCs. It will also collaborate and integrate TPMRC schedules and plans, and communicate lift/bed requirements.
 - **The second integral part of patient regulating is the TPMRC. TPMRCs assume responsibilities formerly performed by the Joint Medical Regulating Office and theater AECCs.** Active TPMRCs are located in US European Command and US Pacific Command. Other TPMRCs would be established in US Atlantic Command (USACOM), US Central Command, US Southern Command, and CONUS as the need arose. The primary role of TPMRCs is to **generate theater plans and schedules, and then modify (as needed) and execute GPMRC-delivered schedules,**
- ultimately delivering the patient to the MTF (which includes both fixed and deployable, Veterans Administration, DOD, and National Disaster Medical System hospitals).
- The last part of the patient regulating process is the respective **MTF** that receives/sends patients.
- f. The **Single Integrated Medical Logistics Management (SIMLM)** mission specifies that Class VIIIA and Class VIIIB (blood) sustainment be provided and managed by a single organization or Service component operating in a theater. **The Army component has the responsibility of providing, when tasked by a JFC, effective, responsive theater SIMLM.** The Army component carries out this mission through its Medical Logistics Battalions and theater medical materiel management centers. **The SIMLM mission, roles, and responsibilities for supporting joint forces must be clearly identified in concept and operation plans.** Further information on SIMLM is in Joint Pub 4-02.1, "Joint Tactics, Techniques, and Procedures for Health Service Support Logistics in Joint Operations."
- g. **The Armed Services Blood Program Office (ASBPO)**, established by the Assistant Secretary of Defense for Health Affairs, **is responsible for the coordination of the blood programs** of the Military Services and the combatant commands. The Armed Services Blood Program provides an **orderly system for collection, storage, and distribution of blood products** across the range of military operations (Figure I-4). The primary responsibility of the ASBPO is to ensure blood products, in the required types and amounts, reach the theater in a ready-to-use condition.

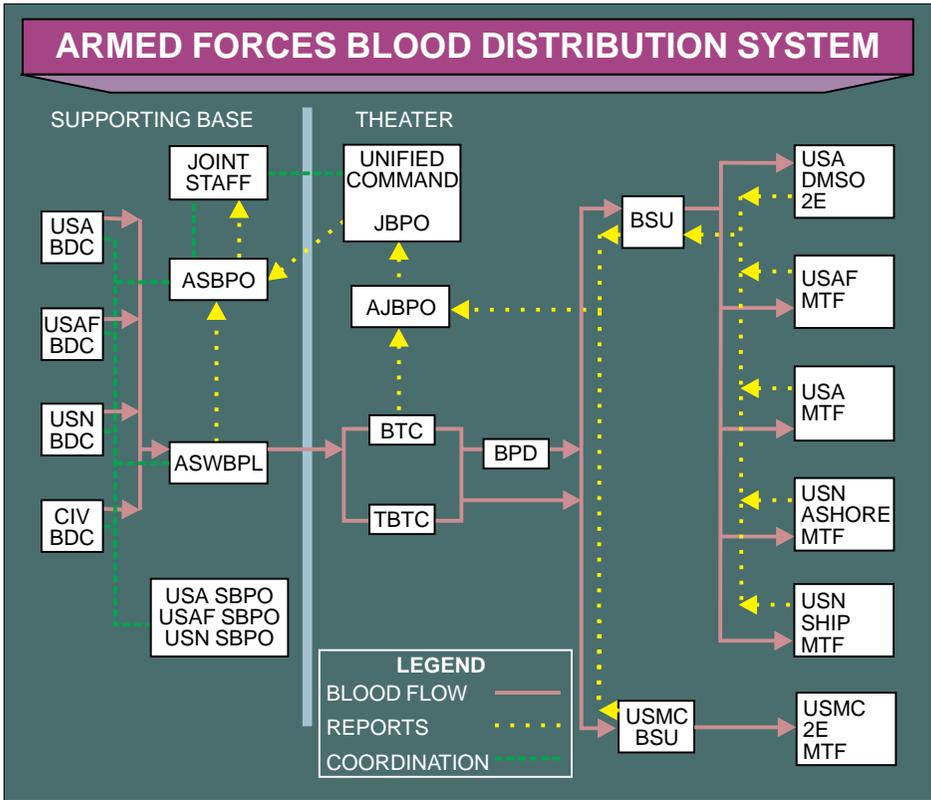


Figure I-4. Armed Forces Blood Distribution System

- Each theater has a **standard jointly operated blood distribution system**. A JBPO is established within the joint force surgeon’s office and functions as part of the staff. The **JBPO** is the **single manager for blood products** in the combatant command and is responsible for **management and coordination of the total joint blood products requirements and capabilities** in the theater. Each theater is subdivided and coordinated by an **Area Joint Blood Program Office (AJBPO)**. Responsibilities of the JBPO and AJBPOs include:
 - Monitoring compliance with DOD blood program policies.
 - Coordinating component blood programs.
 - Planning and executing blood program exercises.
 - Managing the wartime theater blood distribution system (JBPO only).
- **Blood transshipment centers (BTCs)**, operated by the Air Force, are established in each theater and are located at major airheads. The BTCs serve as the central receiving point of blood products from CONUS for distribution within the theater. Each BTC has the capacity to re-ice and store 7,200 units of liquid blood. Blood is provided to each Service component blood supply unit (BSU) and, in turn, distributed to each MTF.
- Each MTF is responsible for locating and notifying its respective AJBPO for

coordination of blood requirements and submission of blood reports (BLDREPs) and requests. MTFs will be notified by the AJBPO which BSU is their supplier of blood and blood products. During operations, MTFs will submit daily BLDREPs to the BSU with an information copy to the AJBPO. Each AJBPO will submit daily BLDREPs to the JBPO. The JBPO, in turn, will submit daily BLDREPs for the theater to the ASBPO. Every blood shipment will require preparation and transmission of the blood shipment report.

h. While it is important that each component command properly plan to operate its portion of the overall hospitalization and evacuation systems and determine its own requirements, **it is imperative that prior joint planning occur.** Distribution of respective component HSS capabilities, as directed by the geographic combatant commander, will aid in ensuring efficient use of limited HSS resources, particularly assets and beds.

- Each component should provide sufficient **MTFs** for its own requirements and provide all **treatment** and **evacuation support** in an area occupied or used extensively by that component.
- Within each component command, the **command surgeon** should exercise technical supervision of all HSS functions.
- Each MTF will prepare and submit, within 24 hours of entering the theater,

a **readiness report** to the JFS. This report briefly discusses resource capability and level of HSS that can be readily provided to the geographic combatant commander.

i. The Army veterinary service provides support to all component commands, including:

- **Control of zoonotic diseases.**
- **Veterinary care of DOD-owned animals.**
- When authorized, **veterinary care for animals of local indigenous personnel** in conjunction with medical civic action and civil affairs programs conducted by the Service components.
- **Veterinary laboratory support.**
- **Inspection and laboratory examination** of subsistence items for wholesomeness and quality.

j. The Army veterinary service provides the food safety service listed below to the Army, Navy, and Marine Corps components. The **Air Force** provides the same support to its forces when on Air Force installations:

- **Inspection of all subsistence items** that are received, stored, and issued in the theater following nuclear, biological, and chemical (NBC) exposure.
- **Inspection of facilities** supplying, storing, and issuing subsistence items.

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CHAPTER II

JOINT HEALTH SERVICE SUPPORT PLANNING

“A corps of Medical officers was not established solely for the purpose of attending the wounded and sick...the labors of Medical officers cover a more extended field. The leading idea, which should be constantly kept in view, is to strengthen the hands of the Commanding General by keeping his army in the most vigorous health, thus rendering it, in the highest degree, efficient for enduring fatigue and privation, and for fighting. In this view, the duties of such a corps are of vital importance to the success of an army, and commanders seldom appreciate the full effect of their proper fulfillment.”

Major Jonathan Letterman
Medical Director of the Civil War Army of the Potomac

1. The Joint Operation Planning Process

Operational planners must take many factors into account to select the best or most appropriate means of performing a joint force mission. Because the planning process is complex, it must be orderly and thorough. The amount of time available for planning influences the entire process. **The JOPES, established by the Chairman of the Joint Chiefs of Staff, is the policy, procedures, and automated data processing system used by the joint planning and execution community for developing, coordinating, reviewing, approving, and disseminating joint operation plans.** Joint operation planning comprises the following two time-dependent planning methods:

a. **Deliberate planning is the JOPES process involving the development of operation plans (OPLANS) for contingencies identified in joint strategic planning documents.** Conducted principally in peacetime, deliberate planning procedures are accomplished in prescribed cycles that complement other DOD planning cycles and in accordance with the formally established Joint Strategic Planning System. Development, coordination, reviews, and approval of these

plans can take up to 18 months. Deliberate planning procedures are described in Joint Pubs 5-03.1, 5-03.2, and 5-03.3 (“Joint Operation Planning and Execution System Volumes I, II, and III”).

b. **Crisis action planning is the JOPES process involving the time-sensitive development of operation orders (OPORDs) and campaign plans in response to an imminent crisis.** Crisis action planning follows prescribed crisis action planning procedures to formulate and implement an effective response within the time frame permitted by the crisis. Crisis action planning procedures are found in Joint Pub 5-03.1, “Joint Operation Planning and Execution System Volume I.”

2. Health Service Support Planning Considerations

Timely, effective planning and coordination are essential to ensure adequate and sustainable HSS in a theater. Joint HSS planning demands the JFS remain sensitive to HSS requirements generated from the operation. **Proper planning permits a systematic examination of all factors in a projected operation and ensures interoperability with the campaign or operation plan.** Organization of the HSS system is

determined largely by the joint force's mission, the medical threat, medical intelligence, the theater evacuation policy, and hospitalization and evacuation requirements. **Plans for health care in the theater should ensure proper interface with the evacuation health care plan**

c. **Timely patient evacuation plays an important role in the design of the treatment sequence from front to rear.** When the echelons of HSS become more sophisticated, the means of patient evacuation also become more sophisticated. **Patient evacuation involves route**



Health service plans must consider the evacuation of patients/casualties who cannot be returned to duty in the combat zone (Echelons I-III) to more capable hospitals in the communication zone or CONUS.

detailed in USACOM's Integrated CONUS Medical Operations Plan.

a. The **medical threat** is a composite of ongoing or potential enemy actions and environmental conditions that might act to reduce the effectiveness of the joint force through wounds, injuries, diseases, or psychological stressors. Appendix A, "Medical Threat," discusses the medical threat.

b. **Medical intelligence** is intelligence produced from the collection, evaluation, and analysis of information concerning the medical aspects of foreign areas that have immediate or potential impact on policies, plans, or operations. A more detailed discussion of medical intelligence can be found in Appendix B, "Medical Intelligence."

planning, movement control, and the locating of evacuation facilities. The evacuation of patients in a theater will primarily be by aircraft when air transportation is available, feasible, and the patient's condition permits. **The JFS must plan the means for treatment, logistics support, and movement of joint force patients** that exceed the capability of individual MTF's, just as the **individual MTFs and medical units must have established internal operating procedures** for these unforeseen surges in patient flow. The JFS must develop and exercise these plans for **interorganizational support** within the joint force, as well as **those medical resources** that will come from higher echelons or adjacent forces.

d. **The geographic combatant commander may issue specific guidance**

for the medical evacuation of former detained US forces, civilians accompanying US forces, EPW, and civilian internees.

e. **Specific clinical capabilities, as well as MTF location, logistics supportability, and number of beds, must be considered.** MTFs must have the clinical capabilities necessary to provide care for the **expected number** and **types of patients** in the theater. The **location of an MTF** should be determined by its specific clinical capability, relative mobility, logistical supportability, and the necessity to ensure a logical progression of MTF capabilities from the forward areas of the combat zone to the rear of the joint force. The location of MTFs is affected further by critical time and distance factors that impact on mortality and morbidity rates.

f. **Recommendations must be prepared by the JFS to the geographic combatant commander concerning supply issues.** Specifically, the following should be considered:

- Use of a SIMLM system.
- Types of medical supplies needed.
- Supply procedures.
- Stock levels.
- Size and location of medical supply installations.
- Medical equipment maintenance support.

g. **A major factor in the evacuation of patients** through the five echelons of medical care **is that specific medical equipment and durable supplies designated as patient movement items (PMI) must be available to support the patient during the evacuation.** Examples

of PMI include ventilators, litters, patient monitors, and pulse oximeters.

- **Theater-owned medical equipment and supplies often depart the originating MTF as patients are evacuated.** In general, the PMI accompanies a patient throughout the chain of evacuation from the originating theater MTF to the destination MTF, whether it is an intratheater or intertheater transfer. **The JFC will ensure procedures are established for units to have their PMIs replaced** prior to their losses becoming a detriment to the air evacuation and patient care mission.
- **An established concept which can be implemented by the JFC to prevent theater and unit shortfalls of the critical PMI**—which are either air certified, non-expendable, or essential to the air evacuation mission—**is illustrated in Figure II-1.** A PMI pool(s) of these items can be established and operated by any designated Service, but is normally operated by the Army as a single integrated medical logistics management manager. When the theater PMI pool is notified that a PMI is to leave the originating MTF for an intertheater transfer, a like PMI will be provided to the losing organization from the PMI pool. To the maximum extent possible, this exchange should take place as the patient moves through the evacuation process. The PMI which accompanies the patient will be cleaned and returned to the theater's equipment pool through CONUS collection points located at a Defense Logistics Agency depot. The PMI will be inspected, repaired, refurbished, and resupplied prior to return to the theater pool(s). Joint Pub 4-02.1, "Joint Tactics, Techniques, and Procedures

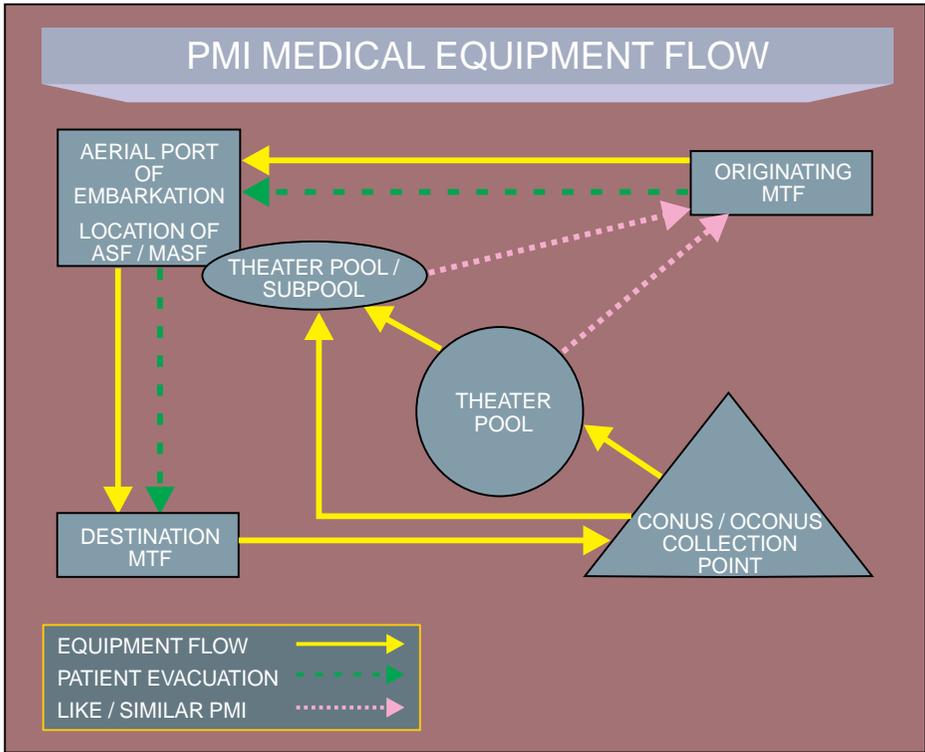


Figure II-1. PMI Medical Equipment Flow

for Health Service Support Logistics in Joint Operations,” and Joint Pub 4-02.2, "Joint Tactics, Techniques, and Procedures for Patient Evacuation in Joint Operations," detail this PMI support system.

generally the responsibility of the component commands. However, the geographic combatant commander may exercise directive authority and change component responsibilities based on operational or geographic considerations.

h. Veterinarians and food inspectors must be included early in joint HSS planning. They advise the JFS and the JFC on the health of government-owned and indigenous animals; the proposed use and locations of military and indigenous animals; and food wholesomeness, hygiene, safety, and quality assurance, including NBC contaminated items.

j. Prevention of combat stress reaction is primarily a command and leadership responsibility. **HSS and other personnel at all levels play important supporting roles.** A coordinated program must be planned for the prevention, treatment, and RTD of combat stress reaction casualties. **Active education and prevention programs** control stress and prepare unit leaders and HSS personnel to identify and manage stress reactions in units.

i. Preventive medicine personnel must be included early in joint HSS planning. They conduct preliminary investigations for endemic diseases, arthropod and rodent infestations, and water quality. Specific preventive medicine procedures are

k. Mass casualties (MASCAL) may result from combat operations, and procedures for handling the casualties are required. Particular emphasis is placed

on the flexibility of HSS units to respond to sudden changes in the casualty situation. Successful management of MASCALs is a complex task where **success relies as much on well-practiced logistics and communications as it does on skilled medical treatment.** While many medical personnel receive basic exposure to the principles of battlefield triage and emergency management, there is much less familiarity with communications, transportation, evacuation, and supply management in a simulated MASCAL or combat setting. **JFSs must ensure that the MASCAL plan is rehearsed** with all components represented. Particular emphasis must be placed on the flexibility of HSS units to respond to changes in the casualty situation.

- Enemy employment of **NBC weapons produces an unusually large number of casualties** and may impair existing provisions for HSS. An NBC weapons attack significantly hinders all operations, including HSS operations.
- 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.

3. HSS Estimate of the Situation

a. **The HSS estimate's purpose is to provide an analysis of HSS information** pertaining to enemy intentions, allied or coalition partner's capabilities, limitations, courses of action, **and potential HSS consequences** associated with a

contemplated operation. The HSS estimate may be written or oral.

b. **The HSS estimate will include all HSS facts, assumptions, and deductions that can affect the operation.** The JFS must be familiar with the concept of operations and obtain medical intelligence concerning the theater from indigenous sources, the supporting intelligence activity, the Armed Forces Medical Intelligence Center, and national intelligence agencies. The JFS must conduct a **thorough evaluation of the enemy situation, friendly situation, and the theater** from the standpoint of effects on the health of the joint force and HSS operations.

c. **The HSS estimate is an analysis of the medical threat and HSS capabilities** to determine vulnerabilities and estimated requirements of the joint force.

- **Patient estimates are calculated** for numbers, distribution, areas of density, possible MASCALs, and evacuation. The JFS consults component experience tables to assist in determining requirements for the operation. Hospital estimates and other support requirements are derived from these data.
- Having determined the HSS requirements, **the JFS considers the resources that are readily available** to meet the requirements. Maximum use of available personnel, supplies and equipment, and joint use of facilities promotes effectiveness of the command's HSS. **Considering support requirements and resources available, the JFS determines the proposed course of action that can be supported.**

4. HSS Planning Factors

In addition to coordinating joint force HSS requirements, HSS planning for joint operations involves other major considerations, including **coordinating HSS requirements** with other combatant commands and coordinating with allied and other friendly forces. **The HSS planning tool approved for medical planning is the JOPEs MPM.** The module is an automated application program that takes Service-specific casualty figures using a deliberate planning theater evacuation policy, merges them to provide joint requirements, and projects the impact of an operation on the HSS system. **MPM provides an estimate of requirements** for such things as the medical evacuation, requirements, and number of hospital beds at Echelons III, IV, and V. A more complete discussion on the use and application of the MPM can be found in Joint Pub 5-03.2, “Joint Operation Planning and Execution System Volume II (Planning and Execution Formats and Guidance)” and the MPM Users Manual, DSSO UM 534-92.

a. **The theater evacuation policy is established by the Secretary of Defense** upon the advice of the Chairman of the Joint Chiefs of Staff and recommendation of the geographic combatant commander. (The policy states, in number of days, the maximum period of noneffectiveness [hospitalization or convalescence] that casualties may be held within the theater for treatment.) The policy does not imply that a casualty must be held in the theater for the entire period for treatment. **Casualties who are not expected to RTD within the number of days expressed in the theater evacuation policy are evacuated as soon as their medical condition permits.**

- **Shorter evacuation policies** within the theater reduce theater bed requirements and increase the number of beds required elsewhere. Shorter policies also increase evacuation requirements.

- The time period stated in the theater evacuation policy starts when a patient is admitted to the first hospital (Echelon III). **The total time a patient spends in all MTFs in the theater** for a single episode of wounding, injury, or illness **should not exceed the number of allowable days of noneffectiveness stated in the theater evacuation policy.** This policy is flexible and changes as the tactical situation shifts. This ensures that nonfixed MTFs retain mobility and the capability to accommodate anticipated surges of patients.

b. **The estimate for theater HSS requirements is based on empirical data** accumulated for each Service for the major categories of patients—wounded-in-action and disease and nonbattle injury. As shown in Figure II-2, planning factors such as the theater evacuation policy, bed availability, combat intensity rates, and admission rates are analyzed to calculate HSS theater requirements.

- **Population at risk.**

- **Accumulation factors.**

- Number of patients not evacuated at the end of a specified time period (theater evacuation policy).

- Proportion of patients admitted on any one day that will remain at the end of each specified period (length of stay/evacuation delay).

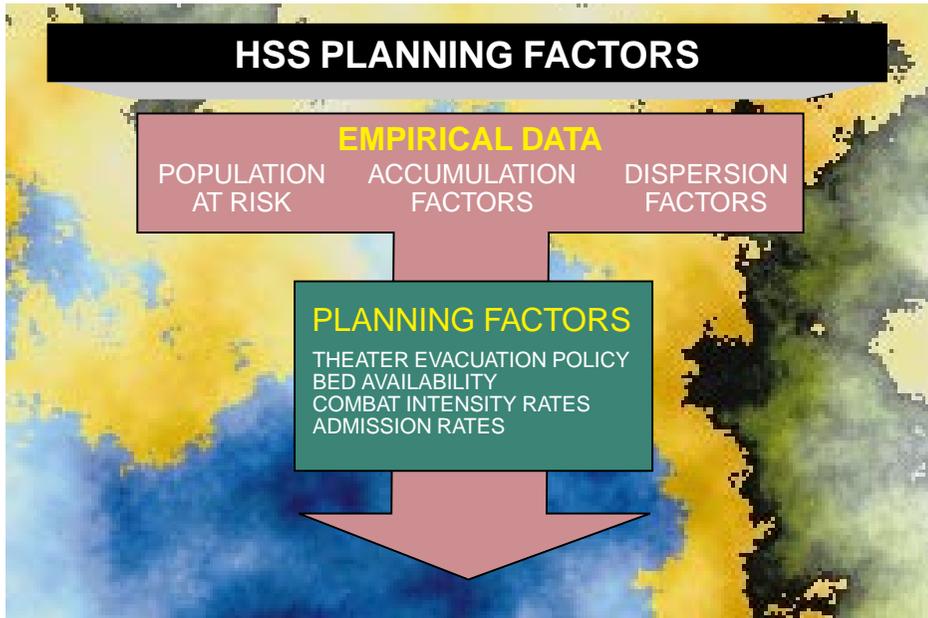


Figure II-2. HSS Planning Factors

- **Dispersion factor.** (Factors, allowances, and other computation details are presented in FM 8-55, FM 101-10-1, AFR 168-4, and NAVMAT P-4000-2 series.)

c. The planning factor for blood products in a theater is 4.0 units of liquid red cells per initial admission. **The receipt, storage, and distribution of blood products require special consideration and procedures** to ensure a coordinated effort and maximum use of communications, storage facilities, and transportation. **The Air Force component will staff and operate BTCs.** The centers are located at major airfields, and blood products are managed by the JBPO or AJBPO. One or more BTCs are located in each joint force area. The BTCs:

- **Receive blood products** shipped to the theater from other blood program agencies such as the Armed Services Whole Blood Processing Laboratory or BTCs.

- **Receive and store** up to 7,200 units of **blood products** for future distribution to theater MTFs when directed by the AJBPO or the JBPO.
- **Perform quality control checks on blood shipments**, ensuring that appropriate temperatures have been maintained during shipment and there is no gross evidence of contamination or cellular destruction.
- **Provide resupply of blood products** to other BSUs or other BTCs.

5. HSS Policies and Procedures

Based upon the HSS estimate of the situation, **the JFS**, in coordination with the component command surgeons, **must plan for medical policies and procedures that can be best adapted to the joint operation.** In many instances, existing standing operating procedures can be used with little or no modification. In other instances, entirely new procedures may

have to be developed and implemented. Standards must be established to deal with the type and timing of physical, dental, and mental examinations and inspections necessary to ensure that personnel in the theater or those arriving are fit for duty. Physical standards are normally Service-specified; however, the geographic combatant commander may direct additional or special requirements based on operational, geographic, or climatic conditions.

6. Special HSS Planning Considerations

a. Amphibious task force medical planning responsibilities are closely related to those of the landing force; their facilities are mutually supporting. **Detailed, coordinated, and parallel planning is required between the commanders, amphibious task force, and landing force.** Each surgeon of these commands has specific medical planning responsibilities that are detailed in Joint Pub 3-02, "Joint Doctrine for Amphibious Operations."

b. **Combat search and rescue (CSAR) operations are specific tasks performed by rescue forces to recover distressed personnel during wartime or contingency operations.** Each component command performs CSAR in support of its own operations. JFCs have the primary authority and responsibility for CSAR in support of US forces within their area of responsibility/joint operations area and also must ensure creation of a joint rescue capability. The HSS capabilities of CSAR units vary from component to component, but are generally limited. Certain component CSAR units are dedicated to CSAR operations while others perform CSAR as a secondary mission. Marine Corps aviation units currently do not conduct CSAR, they do, however, possess the capability to conduct tactical

recovery of aircraft and personnel, which may involve ground units as well. This mission has a different emphasis and application than the traditional CSAR mission. Additional information on CSAR can be found in the Joint Pub 3-50 series.

- **Joint force CSAR HSS capabilities** are limited to recovering or evacuating the sick or injured from low- to medium-threat environments. They provide medically supervised evacuation of the sick and injured from both peacetime and wartime situations. HSS personnel on rescue aircraft are capable of providing emergency medical treatment (EMT) for traumatic injuries as well as continuing treatment of life-threatening injuries or diseases during transportation.
- Although CSAR units require HSS similar to other units, **supported geographic combatant commanders must establish a flexible HSS system to meet the demands of CSAR operations.** A majority of CSAR HSS requirements can be met by the component surgeon; however, several key issues must be emphasized in any joint CSAR HSS plan:
 - **Adequate intelligence** for the theater is critical to the success of CSAR operations.
 - **Support requirements** for CSAR operations are shown in Figure II-3.
 - Some CSAR units do not deploy with organic **flight surgeon support.** Other units require flight surgeon support for technical assistance in the areas of EMT and administration of medication, continuing medical care and education, and CSAR mission support requirements.

SUPPORT REQUIREMENTS FOR COMBAT SEARCH AND RESCUE (CSAR) OPERATIONS

- Replenishment of used or outdated medical supplies (medication and material).
- Oxygen supplies.
- Medical equipment maintenance.
- Narcotic storage and control.
- Storage of temperature-sensitive medical material.
- Optical fabrication.
- Blood supply, storage, and distribution.

Figure II-3. Support Requirements for Combat Search and Rescue Operations

7. HSS for the Return of US Prisoners of War

The geographic combatant commander establishes a theater protocol on the proper handling and provision of HSS for return of US prisoners of war (POWs). Detailed study of this subject area is currently under way; however, the following basic assumptions must be included in the return of POW planning process:

a. **In-theater HSS will be administered** within a reasonably short period upon return to friendly forces.

b. **Treatment assessments will be established**, since short- and long-term therapy may be required.

c. **Group cohesiveness will be maintained.**

d. **Operational specialty medical support**, such as flight surgeon support to aviators, **will be provided immediately.**

e. **Multi-Service HSS units will be established** to coordinate and assist in possible contingencies.

8. HSS for EPWs

In consonance with provisions outlined in the Geneva Conventions, **patients who are EPWs are afforded the same level of HSS and medical care as patients of the detaining power.** Seriously wounded, injured, or sick EPWs will be evacuated through medical channels, but will be segregated from US and allied patients. EPWs will be evacuated from the combat zone as soon as possible. The JFC must ensure appropriate security is provided to guard the EPWs while a patient is in the MTF and throughout evacuations.

Nonmedical personnel should not be used as guards if it can be avoided. Qualified medical retained personnel (RP) will be used as much as possible in medical and hygiene work needed for the well-being of EPWs; however, medical RP will belong to the same armed forces as the EPW.

9. Command, Control, Communications, and Computer Systems

Effective command, control, communications, and computer (C4) systems are vital to successful HSS in joint operations. HSS functions depend upon responsive C4 systems to tie together all aspects of support and to allow JFCs to direct, monitor, question, and react as situations develop.

a. **Command and control (C2) of HSS organizations normally rests with the component commands.** The geographic combatant commander may provide detailed theater communication plans or assign theater communication management responsibilities to a single Service component for specific functions during joint operations.

b. **Early identification of a theater's C4 system requirements for HSS connectivity is essential.** At a minimum, **HSS communications must support reliable, constant communications within a theater**, from the theater to CONUS, and link the most forward HSS elements in the theater through each echelon in the phased HSS system to the final destination MTF. **The success of HSS operations depends upon reliable communications over dedicated and parallel systems.** HSS communications planners working with the joint force communications section must identify frequencies that are common between Service component support forces

assigned to HSS missions. If no commonality exists, then planners should consider assigning a component to develop a theater plan that ensures adequate communications support to all components.

- **Short-range radio communications** should be provided between MTFs and evacuation vehicles or aircraft. These radios should be provided by component command HSS units.
- Depending on the theater infrastructure and deploying Service component capabilities, **long-range communications will be provided by high-frequency radios**, Defense Switched Network, Defense Data Network, and Automatic Digital Network communications systems.
- **Satellite communications** offering access to commercial phone systems or point-to-point systems may be available when ground-sourced facilities are unavailable.
- **Secure communications** are provided through the use of speech and data security communications equipment.
- All **frequency requirements** for organic equipment must be coordinated with the joint force commander's J-6 staff.
- c. **HSS system management information systems support the information management requirements of HSS units** across the range of military operations. The systems also assist the user in carrying out functional responsibilities.
- HSS management information systems must be **interoperable** with DOD medical management information systems.

- HSS management information systems should provide **timely, accurate, and relevant information** through the following subsystems:
 - Blood management.
 - Patient tracking and movement.
 - Medical logistics.
- Each subsystem will have C2 capabilities that provide the **status** (summary reports) **of HSS units, evacuation work load, and critical resources** through predetermined reports or from information selected by the user.

d. **Records and reports are required to pass information and assist in the evaluation of policies and procedures.** The JFS must determine the amount of HSS information essential to the geographic combatant commander and make provisions to obtain this information through a minimum number of medical records and reports. In making this determination, the JFS must be familiar with the records and reports required by the component commands involved in the operation. JFS should recognize that these records and reports can serve information requirements without modification or supplementation.

e. Medical information in itself is not classified. However, **medical information can become an operations security (OPSEC) indicator** in the context of a particular military operation. OPSEC measures to reduce or eliminate these indicators may entail **restrictions on medical information dissemination** and are detailed in OPLANs or OPORDs. OPSEC measures may require encryption for transmission only of medical information.

10. Dental Services Support

a. The HSS dental service is a major contributor to maintaining unit fighting strength. **Joint operation planning must include consideration of the various roles of dental services.** Historical review indicates that dental problems cause as much as 8 percent of a unit's noncombat casualty losses.

b. The planning process includes an **evaluation of the size and anticipated duration of the operation**, along with the **levels of dental care as shown in Figure II-4 required** throughout the operation.



Figure II-4. Levels of Dental Care

- **Level I--Emergency Dental Care.** Austere treatment of dental emergencies that immediately return troops to duty. This minimal level of care does not require dental facilities.
- **Level II--Sustaining Dental Care.** Expedient dental treatment that intercepts potential emergencies to

minimize troop loss to units in combat operations. This level of care is essential to the preservation of fighting strength early in the conflict, which is usually provided in combat service support areas adjacent to Echelon II medical support. Planners can include dental personnel to augment medical units during periods of MASCALs reception.

- **Level III--Maintaining Dental Care.**

Definitive treatment to prevent and treat dental and oral conditions early enough to preserve satisfactory oral health. This level of care is necessary when planning HSS for lengthy military operations.

- **Level IV--Comprehensive Care.**

Treatment to restore an individual to optimal oral health, functions, and esthetics. Comprehensive dental care may be achieved incidental to

maintaining, sustaining, and providing emergency care in individuals whose oral condition is healthy enough to be addressed by the levels of care provided. This level of care is usually reserved for HSS plans that anticipate an extensive period of reception and training in theater. The scope of facilities needed to provide this level of detail support can equal that of Echelon III medical facilities.

- c. **Deliberate planning for dental services must include the potential for augmenting the medical effort during MASCALs.** Joint planning requires a statement **specifically excluding dental services**, if deemed appropriate. Joint operations of limited size or duration may **limit dental services** to predeployment screening, which eliminates planning for deployment of dental personnel and equipment.

CHAPTER III

HEALTH SERVICE SUPPORT IN SPECIAL OPERATIONS

"...for bad indeed is the condition of a General when he has a sickness among his men and an enemy to contend with at the same time."

Niccolo Machiavelli
The Art of War

1. General

Special operations forces (SOF) are specially organized, trained, and equipped forces of the Army, Navy, and Air Force that conduct the following operations: unconventional warfare, strategic reconnaissance, direct action, foreign internal defense, counterterrorism, civil affairs, and psychological operations. The nature of special operations requires that units be small, highly skilled, self-contained teams that can be easily inserted and extracted by air, sea, and land delivery methods. **Medical support of special operations units is characterized by an austere structure and a limited number of medical personnel with enhanced medical skills.** The special operations medical personnel provide emergency treatment and a basic level of medical care at the team level. To meet the operational requirements of SOF infiltration and exfiltration, characteristics of larger medical elements of Echelons II, III, and IV cannot be applied or incorporated. **Medical support provided to the teams in the area of operations is planned and conducted by SOF surgeons and medical personnel.** Provision of medical support beyond this area of influence or capability depends on the thoroughness of advanced planning so that the conventional medical support structure umbrella is extended to cover lack of capability or meet requirements for additional medical assets (i.e., medical evacuation). Medical capability that is not part of a Service conventional medical system will be based on a complete mission analysis and a

coordinated support plan developed by the medical planner. SOF should be provided all functions of health service support at the point their personnel enter the conventional force medical structure.

2. Organic HSS Capability

a. **Commander in Chief, US Special Operations Command**, as a supporting commander, **normally provides SOF to the commanders of other combatant commands** for operational employment. SOF based in-theater are under the combatant command (command authority) of the geographic combatant commander. To provide the necessary unity of command, **each geographic combatant commander has established a subordinate unified command** to serve as the functional special operations component. The Army component consists of Special Forces units that are regionally oriented on specific areas of the world. Rangers can also be included along with Army Special Operations Aviation. The Navy component consists of regionally oriented sea-air-land (SEAL) teams, as well as special boat units, and SEAL delivery vehicle teams. The Air Force component consists of regionally oriented squadrons forward-deployed with a mix of aircraft specially suited to support special operations missions. **The special operations command (SOC) is the level at which medical planning is coordinated in sufficient detail to support special operations with conventional medical packages to augment the lack of SOF organic medical capability.**

b. **Organic SOF HSS assets** of the Army, Navy, and Air Force **are extremely austere**. The nature of SOF missions requires **that SOF medical personnel possess a variety of enhanced medical skills** that enable them to operate under a multiplicity of circumstances. **SOF**

to provide advice and expertise to the supported missions and not medical support to the force. Echelon II treatment capability is not organic to all ARSOF. Army Special Forces and Ranger battalions have limited Echelon II capabilities. Casualty



Special Operations Forces deploy with medical support capable of providing emergency treatment and a basic level of medical care (Echelon I).

enlisted personnel receive enhanced medical training that exceeds the level and scope of that training afforded their conventional medical counterparts.

- **Army SOF (ARSOF) HSS assets are organic to Special Forces and Ranger units and Army Special Operations Aviation units.** Special Forces teams and Ranger companies are capable of providing Echelon I care. Army Special Operations Aviation units have flight surgeons but do not provide Echelon I capability. Civil affairs and psychological operations battalions have no organic medical assets for medical care to their unit and are dependent on area medical support from conventional forces. Civil affairs and psychological operations battalions have medical personnel assigned but are organized

evacuation by dedicated aeromedical aircraft is the preferred method of evacuation. ARSOF do not possess this capability. The other organic medical capabilities of preventive medicine, lab, veterinary, and dental support are located in the Special Forces groups. A medical supply capability exists in Special Forces groups and Ranger battalions.

- **Navy SOF HSS assets are organic to the SEAL teams and provide Echelon I care.** Health care and medical evacuation beyond Echelon I are supported by various Navy conventional units, such as the floating platform from which the team is staged, or Army and Air Force conventional units providing medical support on an area basis. This can include Army Special Forces forward operating

bases. Additionally, conventional Navy and Marine units with organic Echelon II capability can provide medical support to the SEAL teams. Aeromedical evacuation is not available and must be provided by supporting units. Navy SEAL teams have no preventive medicine, lab, veterinary, and dental support. SEAL teams deploy with basic loads of medical supplies and can be resupplied.

- **Air Force Special Operations Forces (AFSOF) HSS capabilities are aligned with AFSOF operational units and consist of SOF medical elements (SOFME) (flight surgeons and aeromedical technicians) and pararescue specialists assigned to special tactics teams.** AFSOF have Echelon I and limited Echelon II capability. Echelons III and IV capability must be provided to the force. SOFME provide Echelons I and II care for AFSOF and other SOF and provide flight medicine, limited military public health and bioenvironmental engineering, medical intelligence, field laboratory, patient decontamination, and short-term patient holding and staging capabilities. Mission requirements will dictate deploying a stand-alone personnel package utilizing medical rapid response deployment kits or in conjunction with a SOF air transportable treatment unit.
 - **Special tactics pararescue specialists perform advanced battlefield trauma care and emergency medical treatment (Echelon I and limited Echelon II) care.** They function as the primary responders in support of personnel recovery operations, conduct casualty collection in direct action missions, and provide medical survival and

recovery assistance in sensitive, hostile, or denied areas.

- Although AFSOF have no organic conventional tactical or strategic aeromedical evacuation (AE) capability, **both SOFME and special tactics teams have the capability to provide medical treatment during casualty evacuation onboard SOF aircraft.** AE for SOF is difficult because SOF frequently operate at distant locations without any other assets in theater. Remote locations in immature theaters not served by the strategic evacuation system requires close coordination between the supporting Air Force component command and joint medical planners to identify the details and procedures for AE.

3. SOF Medical Support Planning

a. **The goal of special operations medical support planning is twofold: first,** provide integrated, augmented conventional support into the concept of the special operating mission without compromising the objectives; **second,** articulate the unique aspects of the operation that will complicate the delivery of medical care, evacuation, PM support, dental, combat stress, or veterinary support by conventional units. The SOF medical planner must ensure that the conventional medical planner understands these aspects. The conventional medical planner must translate SOF-unique requirements into the conventional medical framework best suited to support the mission.

b. **These issues are complicated by the nature of SOF operations** and the ability of SOF units that routinely work together mixing Army, Navy, and Air Force assets. SEAL teams could, for example, be

evacuated by Army aircraft to an Army Echelon III facility. The issues that warrant attention are matters pertaining to the different methods used by the Services for executing medical care and evacuation that will disrupt continuity or jeopardize medical care for the casualty.

c. Unique aspects of medical support, as shown in Figure III-1, to SOF must be incorporated into medical planning at the theater JFS staff level, with full knowledge and concurrence of SOC planning staff. (SOC components are authorized medical planners and command surgeons during full mobilization.) **Medical support must be planned and coordinated** with subordinate joint force elements by the theater JFS staff. The integration of medical support from the conventional side extended to the full range of missions conducted by SOF must be synchronized with the tactical plan prior to execution.

- **Extended distances and isolated locations create problems for conventional units** if they have to support SOF. Extending the health service support functions to SOF is
- **Conventional medical units often are tasked beyond their organic capabilities to support**, and often their support missions are prioritized accordingly at the unified level. This

beyond the normal mission responsibility of the conventional medical units. The level of detail in planning and coordination is much greater, and the difficulty of support to SOF increases. An extended evacuation mission with aeromedical aircraft, such as an extended range UH-60 helicopter, requires detailed advance planning. There are a limited number of these aircraft available to support medical missions. Allocating these aircraft for SOF missions also impacts on the conventional force's mission. This allocation can be a problem when there are competing missions and the aircraft must be tasked to support a SOF mission that is external to the command and not the primary mission of the medical evacuation unit. The theater JFS must prioritize the mission and plan accordingly.

CHALLENGES OF SPECIAL OPERATIONS FORCES (SOF) MEDICAL SUPPORT

- Extended distances and isolated locations.
- Limited organic capabilities to support.
- Limited equipment capabilities.
- Underdeveloped theaters with minimal health care support.
- Operational security requires restricted access.
- Politically sensitive missions.
- Retaining injured personnel in-theater as critical assets.

Figure III-1. Challenges of SOF Medical Support

- problem of **multiple taskings and limited resources** makes the integration of support to SOF another focus of the exchange between SOC nonmedical planners and theater JFS planners.
- **Evacuation of casualties within the joint special operations area** can be done by SOF aircraft, but these aircraft are not medically equipped or staffed to be used in a backhaul capacity. The conventional planner must understand this limitation when determining how to best support SOF-generated evacuation requirements.
 - **SOF will often operate in theaters that are underdeveloped** with little or no health care support structure. Point-to-point movement or medical regulating and strategic AE might be required.
 - Some programs or missions are compartmented, and **the need for operational security requires restricted access for planning purposes**. The medical planner must establish an exchange of only sufficient information to provide medical support for the plan.
 - **SOF medical support beyond inherent unit capabilities** is totally reliant on the theater JFS for all other medical support. The theater JFS has coordinating responsibility for all medical forces assigned to or operating in the geographic area.
 - There is often **a requirement to safeguard the patient's identity**, which might compromise the unit's presence or jeopardize the mission. SOF missions are often politically sensitive.
 - **A modified evacuation policy for SOF personnel** must be published so they can be retained in-theater as a critical asset. Transportation out of theater should be precluded whenever possible, dependent on the condition of the casualty.
 - **The entry points into the conventional system** might include nonmedical aircraft that could transport SOF casualties from point of injury directly to an Army, Navy, or Air Force Echelon III MTF. The conventional medical planner must ensure that the MTF in that area is knowledgeable of this unique method and be prepared to respond. The MTF might be a hospital ship, casualty receiving and treatment ship, or an Air Force air transportable hospital.
 - **Communications and control of medical assets** may be problematic. Conventional Army, Navy, or Air Force medical elements have incompatible hardware and software telecommunications equipment that differs from SOF telecommunications equipment. Connectivity plans and the procedures for communicating must be developed in order to pass real-time information across signal waves so that casualties can be moved with success.
- d. The following list is provided as a guide for **developing a joint HSS plan that meets the unique SOF operational requirements** by focusing on the health service functions not organic to SOF that the conventional system would provide:
- A statement of **the medical situation**.
 - A statement of the **medical evacuation policy**.

- **Clear delineation** of the medical responsibilities, organizations, and employment of available medical support system elements, with particular emphasis on shifts in responsibility during the several phases of the operation and on the measures necessary to ensure coordinated medical action by all elements of the task force.
- Projection of the **requirements for medical support** and **the existing capabilities available** to provide that support at the projected location.
- Provisions for medical services in connection with **the evacuation of casualties** from the objective area (en route medical care).
- **Medical supply**, including replenishment of supplies and exchange of medical equipment.
- Procedures and responsibilities for keeping **necessary records and reports** on the flow of casualties and individual patient status information.
- Provisions **for medical service to patients** (dental, laboratory, X ray, combat stress).
- Provisions for **obtaining medical intelligence**.
- Measures for **preventive medicine; nuclear, biological, chemical warfare medicine; and hygiene and sanitation procedures**.
- Procedures for **distribution of blood and blood products**.
- Procedures for medical surveillance, collection, and reporting.

CHAPTER IV

HEALTH SERVICE SUPPORT IN MILITARY OPERATIONS OTHER THAN WAR

“Pay every attention to the sick and wounded. Sacrifice your baggage, everything for them. Let the wagons be devoted to their use, and if necessary your own saddles...”

Napoleon I

1. General

Military operations other than war (MOOTW) encompass a wide range of activities where the military instrument of

they are an important element of the US National Military Strategy. They are basic building blocks for two of the foundations of that strategy: forward presence and crisis response. **The provision of HSS becomes**



Joint Task Force medical personnel provide assistance and process a Haitian refugee who was rescued during Operation SEA SIGNAL.

national power is used for purposes other than the large-scale combat operations usually associated with war. They can involve operations in support of foreign governments or US civil authorities. **They are usually joint operations, often performed in concert with other government agencies, nongovernmental organizations, and private volunteer organizations.** Some military operations, such as disaster relief and combatting terrorism, may be conducted on US soil. Regardless of where these operations occur,

a primary means of assistance in these operations.

a. **HSS operations** conducted to enhance the stability of a host-nation (HN) government **must be well-coordinated with all concerned agencies** and integrated into the respective US Embassy plan. Independent, unplanned medical civic action programs should not be undertaken. Coordination by the geographic combatant commander should be accomplished with:

- Assistant Secretary of Defense (Operations and Low Intensity Conflict)/Humanitarian and Refugee Affairs.
 - HN government and health service officials.
 - The Ambassador and the Country Team.
 - The United States Agency for International Development.
 - Security assistance forces.
 - US military on-scene commander, including military civil affairs elements.
 - Nongovernment organizations, private volunteer organizations, and religious groups.
- b. **The Security Assistance Organization monitors psychological operations** and alerts HN counterparts to the psychological impact of all military actions, operations, and acts of the HN's armed forces. Medical assistance in operations other than war include **provision of HSS for HCA programs**. HSS personnel in this type of environment must be prepared to protect themselves from and initiate appropriate responses to terrorist activity.

OPERATION IDA

On 1 September 1962, a series of earthquakes struck northwestern Iran, and on the 3rd the Joint Chiefs of Staff directed United States Army, Europe (USAREUR), to send aid to the victims. Early the next morning, the airlift of the 8th Evacuation Hospital with a professional staff drawn from several hospitals in Europe began at Ramstein Air Force Base. With the 8th Evacuation Hospital went helicopter elements of the 421st Medical Company (Air Ambulance), a field maintenance detachment from the 29th Transportation Company, a preventive medicine detachment from the 485th Laboratory (Preventive Medicine), and a water purification unit from the 299th Engineer Battalion. Lt. Col. Alexander M. Boysen, 8th Evacuation Hospital commander, assumed command of the entire relief force.

When the Americans arrived in Tehran, Iranian officials instructed them to locate their hospital on the plain of Kazvin, a site near the worst area of destruction but adjacent to a rail line and a hard surface road. Iranian drivers transported the unit, and the Americans worked through the night to become operational at 0900 hours on 6 September. The next day the Americans established a base camp near Buin, further into the disaster area, to serve both as a first aid station and as a helicopter base. From it, crews flew medical teams into the distressed area and evacuated seriously injured victims to the hospital. On the flight back into the area to pick up the teams, the helicopters brought in food, tents, and other essentials. In all, the choppers flew 404 sorties, delivered 45,000 pounds of supplies, and evacuated 66 patients.

Operations at the 8th Evacuation Hospital where the helicopters brought the casualties did not proceed without difficulties. High winds wreaked havoc on the unit's tents because pegs did not hold in the sandy soil. After two days' service, the laundry exploded, badly burning three enlisted men. Supply shortages developed, particularly of items not ordinarily required by a fighting

unit—catheters for small children, for example. The professional staff drawn from various facilities in Europe had never trained with the hospital, and the resulting confusion hindered operations.

Another difficulty, the suspicion and hostility of the local population was only overcome through Iranian cooperation and American flexibility. Local government officials, and the shah himself during a visit, urged the people to cooperate. Even with a royal endorsement, however, the 8th Evacuation Hospital's staff had to make minor adjustments to local customs—such as constructing latrines that pointed south. Its commander reported: “Many decisions that...were strange to Americans were made because they were not strange to Iranians...When one helps a foreign nation you accept their strange philosophy in many things, if by doing this it means you eventually gain your objective.”

As it solved its organizational problems and slowly secured the cooperation of the Iranians, the 8th Evacuation Hospital became an efficient emergency hospital. It admitted 182 victims, provided a total of 794 patient-days of care, and reported five deaths. Its surgeons performed seventy-five surgical procedures, most involving multiple fractures or internal injuries. Many victims suffered cuts and bruises; other patients had been badly burned, and one of the burn cases had a baby during her stay in the hospital. Fortunately, a doctor assigned for general medical work had an obstetrical specialty, and he delivered a healthy baby, promptly named Ida after the code name of the American relief operation (Iranian Disaster Assistance). Hospital staff members cut fingers from rubber gloves to make bottles, the kitchen crews and pharmacists improvised a formula, and a sergeant constructed a crib for Ida from packing crates.

In addition to nursery service, hospitalization, and helicopter support, the American relief force furnished preventive medicine assistance within the disaster area. Working out of the base at Buin, Army specialists visited some 150 villages where they supervised delousing and immunization teams and instructed the local populace in personal hygiene and public health. The Americans also tried to ensure a clean, pure water supply for each of the villages. The Erdlator, a water purification machine the engineers had brought with them, proved useless since the ambling, truck-mounted monster could not traverse the rugged terrain. The Americans relied on the simpler Water Purification Set No. 3 or chlorinated water from deep wells distributed in tank trucks.

By September the medical and sanitary situation in the area had stabilized, and the United States ambassador approved the withdrawal of the 8th Evacuation Hospital. Because of difficulties in air transportation, all were not able to leave until the middle of October; when they finally did depart, the Americans left the equipped hospital for the Iranians.

SOURCE: Foster, Gaines M., *The Demands of Humanity: Army Medical Disaster Relief*, US Army Center of Military History, 1983.

2. Humanitarian and Civic Assistance, Humanitarian Assistance, and Domestic Support Programs

a. As shown in Figure IV-1, **HCA activities are designed to provide assistance to HN populace in conjunction with US military operations or exercises.** Humanitarian assistance (HA) operations are conducted to relieve or reduce the results of natural or manmade disasters or other endemic conditions such as human pain, disease, hunger, or privation that might present a serious threat to life or that can result in great damage to, or loss of property until the appropriate civilian agencies can accept this responsibility. **HSS has been involved in domestic support operations within the United States.** Both programs

focus on **assisting the local populace by furnishing assistance that the local government is not capable of providing.** These programs offer much-needed services to the populace, allowing time for the local medical infrastructure to develop or regenerate. **HSS is often provided within a larger military involvement.** It may be conducted in any terrain or geographic area. Prior to undertaking such action, **the geographic combatant commander should ensure that the mission statement of the HSS organization clearly supports the HA operation.** Coordination with the JFS or component command surgeon is essential to ensure that the HSS organization is capable of and legally allowed to fulfill the requirements of the mission statement. Organizations described in subparagraphs 1a and 5d must make

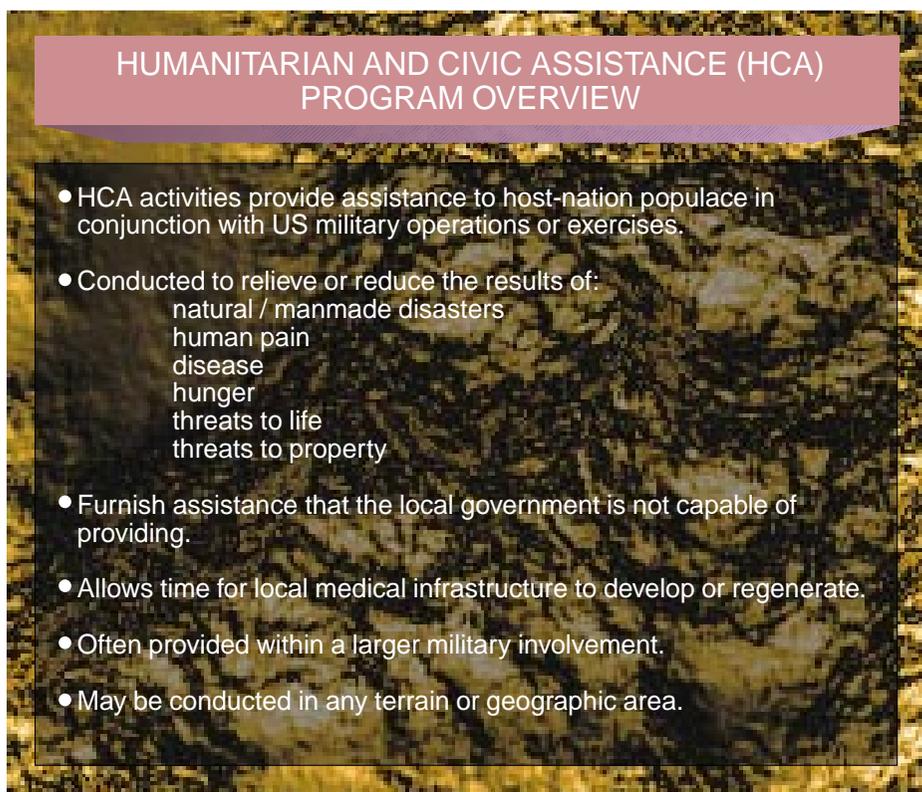


Figure IV-1. Humanitarian and Civic Assistance (HCA) Program Overview

every effort to analyze and consider all political and cultural factors prior to commencing operations. In the case of domestic support operations and military support to civil authorities within CONUS, the military HSS organizations must consider the various civilian agencies such as the Federal Emergency Management Agency (FEMA) and the Department of Health and Human Service's Public Health

Service, that play a significant role in civilian-managed relief operations. Consequently, the level of autonomous decisionmaking ability characteristic of military operations is often restricted.

b. **The parameters required to assess the HN needs vary with each situation or country.** Assessment factors are shown in Figure IV-2.

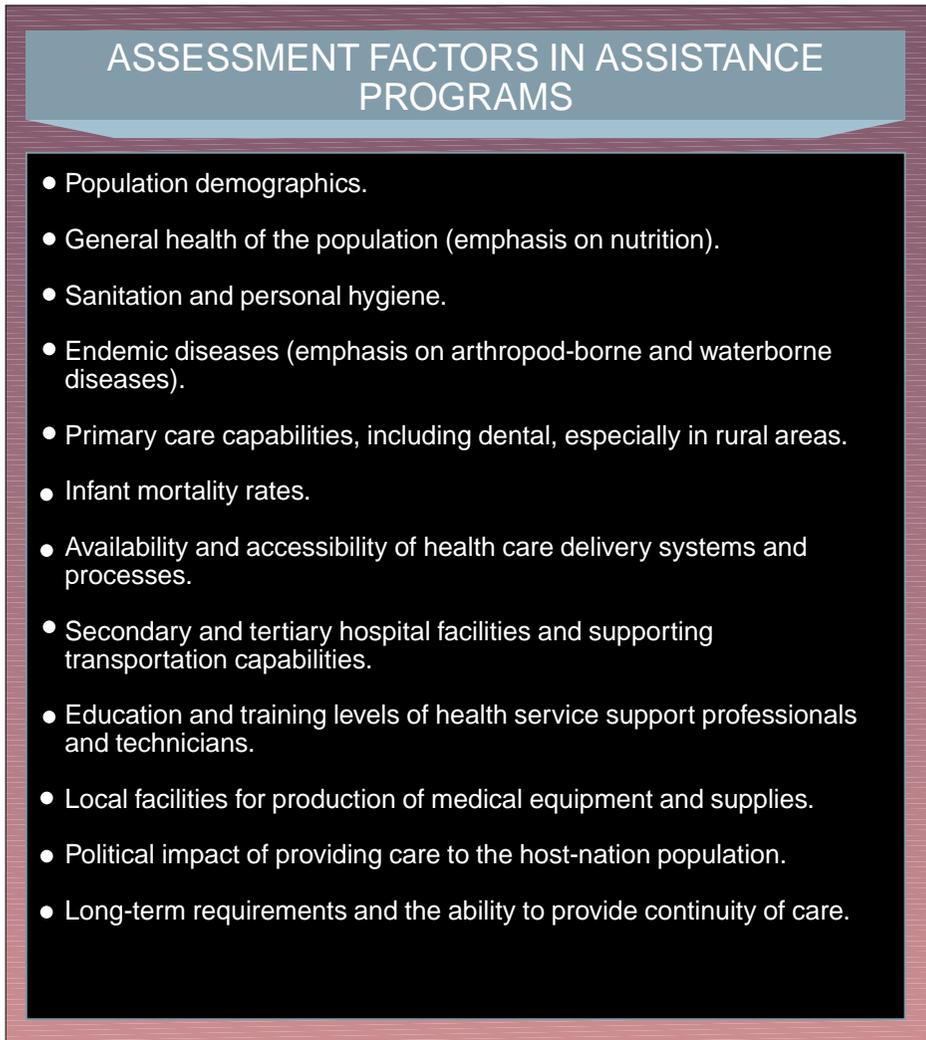


Figure IV-2. Assessment Factors in Assistance Programs

3. Other HA

HSS planning factors include careful consideration of a wide variety of patients. There may be indigenous allies, friendly and unfriendly civilians or paramilitary organizations, representatives of various civilian and military agencies, and civilian contractor personnel employed by the United States. Any individual may be treated on a humanitarian basis if space and staff are available.

4. HSS Aspects of Combatting Terrorism

All HSS units must have the capability to react quickly and decisively once a terrorist incident has occurred. Additionally, they must be prepared to defend themselves and their patients.

a. Because terrorist acts can occur any time and any place, **it is imperative that all MTFs have well-conceived and updated disaster casualty control plans and contingency support plans.** The plans must include a strategy for conducting patient evacuation operations under hazardous conditions.

b. **Contingency plans must be established that consider the location and capability of sources for HSS.** At a minimum, these plans must consider terrain, population densities, major access roads, and possible landing zones.

c. **The JFS or component command surgeon may designate rapid response medical teams at specific MTFs.** These teams must be able to rapidly deploy to the site of an incident, assess the HSS requirements, and obtain the needed assistance to effectively manage the situation.

d. **HSS staffs must be trained in the debriefing process** to assist victims of terrorist-related activities in working

through the emotions and feelings associated with their experiences.

5. Disaster Relief Assistance

A significant number of HA programs involve disaster relief operations. The military can provide assistance to help ease the effects of natural disasters and manmade events. Characteristics of Disaster Relief Assistance are shown in Figure IV-3 and are discussed below.

a. **HSS assistance requires rapid assessment of the damage** caused by the disaster **and a rapid tailoring of an HSS element** to meet the needs of the affected populace. The HSS element should have a **wide range of specialties available** to conduct an accurate assessment.

b. **PVNTMED plays a key role in the relief effort** since natural disasters can disrupt the ecological balance, causing **potential disease outbreaks.** Measures to ensure sanitation and disease vector control must be planned for and implemented as soon as possible.

c. **The treatment rendered may be austere** and possibly provided in rudimentary facilities.

d. **The HSS response must be able to reach the disaster site rapidly, with the right mix of specialties, and be coordinated with concerned agencies.** In addition to applicable entities identified in subparagraph 1a, coordination should be established, as appropriate, with:

- Director of Military Support.
- FEMA.
- State and local office of emergency services.

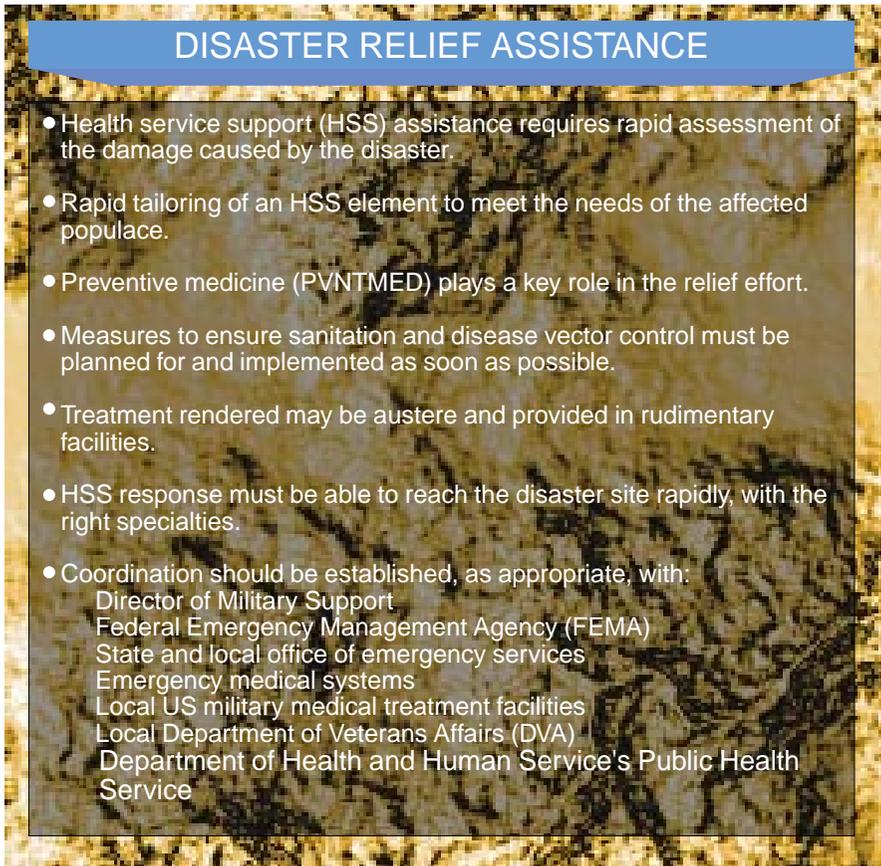


Figure IV-3. Disaster Relief Assistance

- Emergency medical systems
 - Local US military medical treatment facilities and Department of Veterans Affairs medical treatment facilities (including their role as coordinators of national disaster medical systems).
 - Department of Health and Human Service's Public Health Service.
- operational area, the theater evacuation policy may call for AE within a few hours of a casualty being wounded. In the case of contingency or humanitarian operations, **casualties may be moved as soon as they are medically stabilized for airlift.** The regulating process may rapidly develop into one that is fixed for the duration, with evacuation limited to one destination. **An operation could normally employ the same AE elements that are found in the wartime scenario,** with the type, number of elements employed, and location(s) tailored to fit the contingency situation. Most limited AE operations are expected to rapidly develop into a repeatable pattern of origin locations, destination locations, and a fixed frequency of operational missions.

6. The AE Role

The **casualty evacuation policy** during military operations for operations other than war **may be substantially different from the policy associated with a general war.** Because of limited MTFs within the

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APPENDIX A

MEDICAL THREAT

1. General

The medical threat is the composite of all ongoing or potential enemy actions and environmental conditions that could reduce the effectiveness of friendly forces. These actions and conditions include wounds, injuries, or diseases. Information to assess the medical threat caused by enemy actions should be obtained from the J2 and J3 community.

2. Elements of the Medical Threat

a. Infectious diseases which occur naturally are also referred to as endemic disease. Historically, **infectious diseases have been responsible for more casualties than battle injuries.** Many naturally occurring infectious diseases have **short incubation periods.** They may cause significant numbers of casualties within the first 48 hours of a deployment or contact. Others with **longer incubation periods** may not create casualties for several weeks. Some examples of militarily significant naturally occurring infectious disease threats are:

- Acute diarrheal diseases.
- Viral hepatitis.
- Japanese encephalitis.
- Scrub typhus.
- Malaria.
- Sexually transmitted diseases.
- Leishmaniasis.

- Leptospirosis.
- Arbovirus infections.
- Hemorrhagic fever with renal syndrome.
- Schistosomiasis.

b. **Extreme environmental conditions** in the form of heat, cold, high humidity, and high altitude **can pose significant health hazards** to an unacclimated, unprepared, and poorly conditioned military force. Employment of US forces into areas where these conditions exist without adequate opportunity for acclimatization may significantly decrease combat performance. Appendix C, "References," contains references concerning HSS in different geographic areas and climates, such as desert, tropics, arctic, and mountains.

c. **Conventional warfare munitions** include small arms, high velocity weapons, rockets, bombs, artillery, bayonets, and other wounding devices, either individual or crew-served. **This threat may be encountered in all geographic areas and can be employed by adversaries across the range of military operations.** Research and development in smart munitions and extended range artillery, coupled with more powerful high explosives, will **increase the threat from these types of weapons.** Area denial munitions are likely to be present and pose a major psychological and physical threat. Wounds from booby traps, mines, and nontraditional weapons can also be encountered.

d. Biological warfare is the employment of biological agents to produce casualties in humans or animals or cause damage to plants or materiel.

The intentional use of these disease-causing organisms (pathogens), toxins, or other agents of biological origin is designed to weaken resistance to attack and reduce the will to wage war.

- Historically, **biological warfare has primarily involved the use of pathogens to sabotage food and water supplies and spread contagious disease among populations.** These pathogens have generally fallen into one of the following categories:

- Naturally occurring, unmodified infectious agents.

- Toxins, venoms, and their biologically active fractions.

- Modified infectious agents.

- Bioregulators and physiologically active compounds.

- **Biotechnology is a tool for the production of biological warfare agents.** Naturally occurring infectious organisms can be made more virulent, drug resistant, and can be manipulated to render protective vaccines ineffective. Such developments could greatly complicate the ability to detect and identify biological warfare agents and the ability to operate in areas contaminated by these agents. The causative agents for anthrax, tularemia, plague, and cholera, as well as botulinum toxin, staphylococcus, enterotoxin, and mycotoxin, are believed to have been developed as biological warfare agents by potential US adversaries.

e. As a result of **confirmed chemical warfare agent** use by Iraq against Iranian forces, probable use by the former Soviet Union in Afghanistan, and reported use of chemical agents and toxins in Southeast Asia, there is continuing heightened interest in the use of **chemical munitions and delivery methods.** Nerve and blister agents appear to be the agents most available in developing countries. Agents which could be employed by numerous conventional weapons system include:

- Nerve agents—VX, thickened VX, GB (sarin), thickened GD (soman).

- Vesicants (thickened lewisite and a mustard and lewisite mixture).

- Choking agents (phosgene).

- Cyanogens—AC (hydrogen cyanide) and CK (cyanogen chloride).

- Riot control agents.

f. Directed-energy weapons focus radiation on a target to induce electronic, thermal, or structural and human (particularly eye) damage and can cause mission failure.

The radiation is composed of three types: **radio frequency, laser, and charged particle beam.** There have been numerous reports of personnel sustaining eye damage while using optic devices and being exposed to a bright flashing light emanating from warships or other sources. These reports suggest an increasing threat from lasers to both air and a ground forces.

g. **Blast effect weapons** such as fuel and air explosives **represent an emerging medical threat.** Gas-filled body organs such as ears, lungs, and digestive tract are the most susceptible to primary blast injury. This emerging threat may result in lower lethality but a greater number of wounded and a significantly increased workload.

h. Strategic mobility of US 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**, with its increased lethality, rapid maneuvers, technological skill requirements, exposure to NBC weapons, and day or night all-weather operations, **will stress personnel to their endurance limits**. Under these conditions, the significance of **stress as a major contributor of casualties** cannot be overstated.

i. **Flame and incendiary systems** include napalm and white phosphorus for aerial delivered bombs. Possible uses of flame and incendiary weapons include the clearing of difficult defensive positions such as caves, bunkers, buildings, and soft shelter or vehicular targets. Flame has also been used quite effectively in previous conflicts in an antitank role.

j. Until recently, the **primary nuclear warfare threat** has been from the Soviet Union. However, open-source information suggests that other countries may develop nuclear weapons capability within the next decade. Planners expect a minimum of 10 to 20 percent casualties within a division-size force that has experienced a nuclear strike. This percentage may be a low estimate, since **proximity to ground zero is the critical factor in determining weapon effects on the force**. In addition to casualties, a nuclear weapon detonation can generate an electromagnetic pulse that will result in catastrophic failure of some electronic equipment components.

3. The Threat to HSS Personnel and Operations

a. **Commanders can anticipate increased casualty densities among HSS personnel** over those experienced in most previous conflicts. **Medical threat elements** with the greatest potential for force degradation during combat operations are:

- **Battle injuries** because of artillery, small arms, and fragmentation weapons.
- Casualties caused by **combat stress**.
- **NBC** and combined casualties.
- **Premeditated attack** upon medical organizations, personnel, or Class VIII supplies.
- The continually increasing range of **indirect fire weapons**.
- The **enhanced wounding capability and destructiveness** of munitions and weapon systems.
- The **collective effects** of conventional, chemical, biological, or nuclear weapons.
- Significant increases in casualty densities that cause local or general **overloads of the HSS system, resulting in physical and psychological stress**.
- **Infectious diseases** and **environmental extremes**.

b. **Enemy combat operations** in friendly rear areas **will interdict lines of communications and disrupt necessary logistic activity.** This disruption will produce a **serious negative effect on the ability of personnel to retrieve and evacuate wounded, injured, and sick personnel and deliver health care.** Although enemy combat operations may threaten the HSS combat mission by disrupting HSS operations or threaten the survival of HSS, they are not considered to be medical threats for the purposes of this publication.

c. Prolonged periods of intense, continuous operations will tax HSS personnel to the limit of their psychological and emotional endurance. **This stress and fatigue will cause both quantitative and qualitative degradation in the ability of the HSS system to deliver health care at a sustained level.** Proper training, such as taking vital signs, or minor surgical procedures of dental personnel to augment medical staff, may provide some temporary relief.

d. HSS organizations are not expected to be the primary target for biological or chemical attacks; however, **logistic base complexes may be prime candidates for such enemy operations.** As elements of logistic complexes, **medical organizations must anticipate collateral contamination from attacks on adjacent facilities.** Forward HSS assets have an even higher probability of being required to operate in or in proximity to areas contaminated by biological and chemical weapons.

4. The Medical Threat in Military Operations Other Than War

a. The medical threat is traditionally evaluated for its impact on US forces alone. **When preparing for and**

conducting operations during MOOTW, elements of the medical threat to the indigenous population must also be assessed. The impact of the medical threat as a contributing factor to social, political, and economic stability in both peace and other operational environments must be considered. The general environment in which these types of operations are conducted ranges from peaceful, developing countries with no apparent internal or external instabilities to countries with limited resources and a poorly led population assailed by active insurgent movements, diseases, and dependent on HA.

b. Within the military operations, **US efforts may focus on foreign internal defense operations** such as security assistance, HA, or HN logistic support. **These operations are often conducted in areas where social services have been disrupted,** resulting in poor sanitation, inadequate food distribution, possible lawlessness, and general civil unrest. **Significant medical threats** are likely to be naturally occurring infectious diseases and environmental extremes.

c. There are **varied scenarios** under which US forces could be employed in nation assistance, disaster relief, and HA missions involving Third World countries. In general, **areas where assistance teams and units may be employed will likely have a very low standard of living and high levels of endemic infectious diseases.** Many of these diseases could be considered exotic to most US HSS personnel. **US forces serving in these areas will enter with very little, if any, natural immunity to many endemic diseases.** The degree of cultural and social interaction required to support the mission, as well as the sharing of food, quarters, and recreational facilities with local nationals, will increase exposure of US personnel to diseases endemic to the

host country. For the most part, assistance operations will last a relatively extended period of time (past 30 days) and will increase the exposure to and raise the risk from endemic disease.

d. In these environments, **protection afforded to MTF and HSS personnel by the Geneva Conventions may not be recognized by insurgent or terrorist forces.** HSS activities may be perceived as **prime targets** by these groups, especially if these facilities are seen as making a major contribution to the HN 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.

e. In some situations, **the in-country components of the US logistic system in**

support of US assistance forces will be austere. Often the HSS structure will require **significant reliance on contracting** for local food, water, sanitation, public health, localized medical treatment, and health industry resources. There will be **increased reliance on tactical medical support and evacuation.** Coordination with USCINCTRANS for intertheater patient evacuation can be greater in these operations than in other war scenarios. US Navy and US Marine Corps transportation assets should be used to support all aspects of HSS in military operations other than war scenarios, based on the availability and location in coastal waters. **These circumstances will demand solid HSS planning.** This planning must be based on current, accurate medical intelligence and include the total involvement of the Country Team prior to the execution of operations.

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APPENDIX B

MEDICAL INTELLIGENCE

1. General

a. **The Defense Intelligence Agency (DIA) develops and disseminates medical intelligence.** The two major intelligence categories of primary use to the HSS planner are **general medical intelligence** (DOD 6420.1R) and **medical intelligence** (Joint Pub 1-02). For DIA, medical intelligence is produced by the Armed Forces Medical Intelligence Center (AFMIC), Ft. Detrick, Maryland. AFMIC currently produces and disseminates finished intelligence products via studies, message traffic, and online electronic systems.

b. DOD military medical personnel frequently use the term “medical intelligence” incorrectly to mean any medical information of military importance; however, **the term “medical intelligence” officially refers to finished intelligence on medical and related matters.** By this definition, medical intelligence includes only finished intelligence products produced by an authorized intelligence agency such as AFMIC through the intelligence cycle. **Medical intelligence is intended to provide HSS operations and planning staffs with basic guidance** for understanding, acquiring, using, and applying intelligence and intelligence systems in the conduct of HSS operations, medical threat analysis and management, threat-based concept development, medical research, and doctrine development. **Other sources of medical information may be used in assessing potential threats** (e.g., Naval Environmental and PVNTMED units, Defense Pest Management Information Analysis Center, and the World Health Organization).

2. Significance of Medical Intelligence

a. **Accurate and timely intelligence is a critical combat support tool** for planning, executing, and sustaining military operations. **It is equally important in achieving optimum planning, execution, and sustainment of HSS operations,** the medical readiness of the command, and the overall combat readiness of the unit.

b. At the **operational level,** intelligence focuses on the joint campaign and operations. At the **strategic level,** the objective is to contribute to the formulation of national and senior military policy. At the **tactical level,** intelligence is oriented toward the specific area of operations and a given operation in greater detail. **Intelligence, properly used and applied, can become a powerful force multiplier** by providing the critical essential elements of information required to assist HSS staffs.

3. Sources of Medical Intelligence

Most AFMIC products commonly used by HSS planners fall into the category of **Recurring Finished Intelligence.** These products include (but are not limited to) the following:

a. **Medical Capabilities. Finished intelligence studies prepared on foreign countries** that include, but are not restricted to, environmental health factors, diseases, civilian health services, and military health services. (Medical capabilities are different from the Medical Civilian Action Program.)

b. **Disease Occurrence Worldwide.** A **monthly intelligence summary** in electronic message format, provided as an unclassified message, supplemented by a separate classified message. The primary focus of the product is on militarily or strategically significant disease occurrences and events.

c. **Scientific and Technical Intelligence Studies.** **Finished intelligence studies** prepared by AFMIC on **militarily significant life science issues** and published and disseminated through DIA. Examples of generic topics covered include biological warfare and biotechnology.

d. **AFMIC Wire.** A **summary of current medical intelligence** prepared and transmitted in electronic message format on a biweekly basis to authorized consumers. AFMIC's wires are classified through the level of SECRET collateral material.

e. **AFMIC Quick Reaction Support.** AFMIC can respond to **time-sensitive quick reaction intelligence production and support requests** for operational contingencies. Quick reaction tasking is normally accepted by AFMIC if the requirements of the task can be completed in a maximum of 40 personnel hours of analytical work. Requests are accepted telephonically (open and secure communications) and by direct correspondence or message format. Whenever possible, formal methods of communications are encouraged.

f. **Communications with AFMIC**

- Mailing address:

Director, Armed Forces Medical Intelligence Center (Operations)
Building 1607, Fort Detrick,
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MD//OPS//

APPENDIX C

REFERENCES

1. Multinational Documents

- a. NATO STANAG 2068, 17 October 1991, “Emergency War Surgery Handbook (Second United States Revision).”
- b. NATO STANAG 2874, 27 November 1981, “Planning Guide for the Estimation of Battle Casualties (Nuclear) (A Med P-8).”
- c. “Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field,” 1949.
- d. “Geneva Convention for the Amelioration of the Condition of Wounded, Sick, and Shipwrecked Members of Armed Forces at Sea,” 1949.
- e. “Geneva Convention Relative to the Treatment of Prisoners of War,” 1949.
- f. “Geneva Conventions for the Protection of War Victims,” 12 August 1949.

2. DOD Directives

- a. DODD 6480.5, 16 June 1972, “Military Blood Program.”
- b. DODD 6015.5-M, March 1989, “Glossary of Healthcare Terminology.”

3. Joint Publications

- a. Joint Pub 0-2, 24 February 1995, “Unified Action Armed Forces (UNAAF).”
- b. Joint Pub 1-01, Change 1, 14 September 1993, “Joint Publication System, Joint Doctrine and Joint Tactics, Techniques, and Procedures Development Program.”
- c. Joint Pub 1-02, 23 March 1994, “Department of Defense Dictionary of Military and Associated Terms.”
- d. Joint Pub 3-0, 1 February 1995, “Doctrine for Joint Operations.”
- e. Joint Pub 3-02, 8 October 1992, “Joint Doctrine for Amphibious Operations.”
- f. Joint Pub 3-05, 28 October 1992, “Doctrine for Joint Special Operations.”
- g. Joint Pub 3-05.3, 25 August 1993, “Joint Special Operations Operational Procedures.”

- h. Joint Pub 3-50.2, 12 July 1994, “Doctrine for Joint Combat Search and Rescue (CSAR).”
- i. Joint Pub 3-57, (In Development), “Doctrine for Joint Civil Affairs.”
- j. Joint Pub 4-0, 22 January 1995, “Doctrine for Logistic Support of Joint Operations.”
- k. Joint Pub 4-01.1, In Development, “JTTP to Airlift Support to Joint Operations.”
- l. Joint Pub 4-01.3, 26 January 1994, “JTTP for Joint Movement Control.”
- m. Joint Pub 4-02.1, In Development, “JTTP for Health Service Support Logistics in Joint Operations.”
- n. Joint Publication 4-02.2, In Development, “JTTP for Patient Evacuation in Joint Operations.”
- o. Joint Pub 5-03.1, 4 August 1993, “Joint Operation Planning and Execution System (JOPES), Volume I (Planning Policies and Procedures).”
- p. Joint Pub 5-03.2, 10 March 1992, “Joint Operation Planning and Execution System (JOPES), Volume II, (Planning and Execution Formats and Guidance).”
- q. Joint Pub 5-03.3 (In Development), “Joint Operation Planning and Execution (JOPES), Volume III, (ADP Support).”
- r. CM-1502-92, 23 November 1992, “A Doctrinal Statement of Selected Joint Operational Concepts.”
- s. USACOM CONPLAN 2730-YR, “Integrated CONUS Medical Operations Plan.”

4. Multi-Service Publications

- a. AFR 1687-11/AR40-350/BUMEDINST 6320.1E/(PHS) CCPM 60/COMDTINST M6320.8B/NOAAR 56.52C, 30 March 1990, “Patient Regulating To and Within the Continental United States.”
- b. AR 10-64/OPNAVINST 6700.2/AFR 16020/MCO 5420.18A, 16 August 1988, “Organizations and Functions—Joint Field Operating Functions of the Office of The Surgeon General of the Army.”
- c. FM 8-285/Navy NAVMED P5041/Air Force AFM 160-11, 28 February 1990, “Treatment of Chemical Agent Casualties and Conventional Military Chemical Injuries.”
- d. TB MED 81/NAVMED P-5052-29/AFP 161-11, 30 September 1976, “Cold Injury.”

5. Army Publications

- a. FM 8-10, 1 March 1991, “Health Service Support in a Theater of Operations.”
- b. FM 8-55, 15 February 1985, “Planning for Health Service Support.”
- c. FM 21-10, 22 November 1988, “Field Hygiene and Sanitation.”
- d. FM 101-10-1/1, 7 October 1987, “Staff Officers Field Manual—Organizational, Technical, and Logistical Data (Volume I).”
- e. FM 101-10-1/2, 7 October 1987, “Staff Officers Field Manual—Organizational, Technical, and Logistical Data, Planning Factors (Volume II).”

6. Navy and Marine Corps Publications

- a. Naval Warfare Publication (NWP) 6 (REV C), March 1989, “Operational Medical and Dental Support.”
- b. BUMED 6440.5A, 19 April 1994, “Medical Augmentation Program.”
- c. FMFM 4-50, 19 September 1990, “Health Service Support.”
- d. OPNAVINST S3060.1 (RESTRICTED), “Navy Capabilities and Mobilization Plan.”

7. Air Force Publications

- a. AFR 8-5, September 1983, “United States Air Force Foreign Clearance Guide.”
- b. AFR 28-3, June 1986, “USAF Operations Planning Process.”
- c. AFR 28-40, November 1991, “Mobility for Tactical Air and Strategic Aerospace Defense Forces.”
- d. AFR 28-42, June 1986, “Mobility for Military Airlift Command Forces.”
- e. AFR 160-15, August 1991, “Medical Support at Remote Sites.”
- f. AFR 164-5, December 1975, “Worldwide Aeromedical Evacuation.”
- g. AFR 168-4, April 1990, “Administration of Medical Activities.”
- h. AFP 160-98, February 1991, “Air Force Medical Service Guidance for Wartime and Peacetime Contingency Operations.”
- i. USAF War and Mobilization Plan (WMP-1), Volume I, “Medical Service,” Annex F, May 1988.

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APPENDIX D

ADMINISTRATIVE INSTRUCTIONS

1. User Comments

Users in the field are highly encouraged to submit comments on this publication to the Joint Warfighting Center, Attn: Doctrine Division, Fenwick Road, Bldg 96, Fort Monroe, VA 23651-5000. These comments should address content (accuracy, usefulness, consistency, and organization), writing, and appearance.

2. Authorship

The lead agent for this publication is the US Army. The Joint Staff doctrine sponsor for this publication is the Director for Logistics (J-4).

3. Change Recommendations

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GLOSSARY

PART I—ABBREVIATIONS AND ACRONYMS

AE	aeromedical evacuation
AECC	aeromedical evacuation coordination center
AFMIC	Armed Forces Medical Intelligence Center
AFSOF	Air Force special operations forces
AJBPO	area joint blood program office
ARSOF	Army special operations forces
ASBPO	Armed Services Blood Program Office
ASWBPL	Armed Services Whole Blood Products Laboratory
BDC	Blood Distribution Center
BLDREP	blood report
BPD	Blood Product Depot
BSU	blood supply unit
BTC	blood transshipment center
C2	command and control
C4	command, control, communications, and computer systems
CINC	Commander in Chief
CONUS	continental United States
CSAR	combat search and rescue
DIA	Defense Intelligence Agency
EMT	emergency medical treatment
EPW	enemy prisoner of war
FEMA	Federal Emergency Management Agency
GPMRC	Global Patient Movement Requirements Center
HA	humanitarian assistance
HCA	humanitarian and civic assistance
HN	host nation
HSS	health service support
JBPO	joint blood program office
JFC	joint force commander
JFS	joint force surgeon
JOPES	Joint Operation Planning and Execution System
MASCAL	mass casualty
MOOTW	military operations other than war
MPM	Medical Planning Module
MTF	medical treatment facility

Glossary

NBC	nuclear, biological, and chemical
OPLAN	operation plan
OPORD	operation order
OPSEC	operations security
PMI	patient movement item
POW	prisoner of war
PVNTMED	preventive medicine
RP	retained personnel
RTD	return to duty
SBPO	Service Blood Program Office
SEAL	sea-air-land (US Navy)
SIMLM	single integrated medical logistics management
SOC	special operations command
SOF	special operations forces
SOFME	special operations forces medical elements
TBTC	Transportable Blood Transshipment Center
TPMRC	Theater Patient Movement Requirements Center
TRAC2ES	TRANSCOMs' Regulating and Command and Control Evacuation System
USACOM	United States Atlantic Command
USCINCTRANS	Commander in Chief, US Transportation Command

PART II—TERMS AND DEFINITIONS

aeromedical evacuation. The movement of patients under medical supervision to and between medical treatment facilities by air transportation. (Joint Pub 1-02)

casualty. Any person who is lost to the organization by having been declared dead, duty status-whereabouts unknown, missing, ill, or injured. (Joint Pub 1-02)

casualty category. A term used to specifically classify a casualty for reporting purposes based upon the casualty type and the casualty status. Casualty categories include killed in action, died of wounds received in action, and wounded in action. (Joint Pub 1-02)

casualty status. A term used to classify a casualty for reporting purposes. There are seven casualty statuses: (1) deceased, (2) duty status—whereabouts unknown, (3) missing, (4) very seriously ill or injured, (5) seriously ill or injured, (6) incapacitating illness or injury, and (7) not seriously injured. (Joint Pub 1-02)

casualty type. A term used to identify a casualty for reporting purposes as either a hostile casualty or a nonhostile casualty. (Joint Pub 1-02)

combatant command. A unified or specified command with a broad continuing mission under a single commander established and so designated by the President, through the Secretary of Defense and with the advice and assistance of the Chairman of the Joint Chiefs of Staff. Combatant commands typically have geographic or functional responsibilities. (Joint Pub 1-02)

combat service support. The essential capabilities, functions, activities, and

tasks necessary to sustain all elements of operating forces in theater at all levels of war. Within the national and theater logistic systems, it includes but is not limited to the support rendered by service forces in ensuring the aspects of supply, maintenance, transportation, health services, and other services required by aviation and ground combat troops to permit those units to accomplish their missions in combat. Combat service support encompasses those activities at all levels of war that produce sustainment to all operating forces on the battlefield. (Joint Pub 1-02)

combat zone. 1. That area required by combat forces for the conduct of operations. (Joint Pub 1-02)

command and control. The exercise of authority and direction by a properly designated commander over assigned and attached forces in the accomplishment of the mission. Command and control functions are performed through an arrangement of personnel, equipment, communications, facilities, and procedures employed by a commander in planning, directing, coordinating, and controlling forces and operations in the accomplishment of the mission. (Joint Pub 1-02)

communications zone. Rear part of theater of operations (behind but contiguous to the combat zone) which contains the lines of communications, establishments for supply and evacuation, and other agencies required for immediate support and maintenance of the field forces. (Joint Pub 1-02)

directed energy. An umbrella term covering technologies that relate to the

production of a beam of concentrated electromagnetic energy or atomic or subatomic particles. Also called DE. (Joint Pub 1-02)

disease and nonbattle injury casualty. A person who is not a battle casualty but who is lost to the organization by reason of disease or injury, including persons dying of disease or injury, by reason of being missing where the absence does not appear to be voluntary, or due to enemy action or to being interned. (Approved for inclusion in the next edition of Joint Pub 1-02)

evacuation. 1. The process of moving any person who is wounded, injured, or ill to and/or between medical treatment facilities. (Joint Pub 1-02)

evacuation policy. 1. Command decision, indicating the length in days of the maximum period of noneffectiveness that patients may be held within the command for treatment. Patients who, in the opinion of responsible medical officers, cannot be returned to duty status within the period prescribed are evacuated by the first available means, provided the travel involved will not aggravate their disabilities. (Joint Pub 1-02)

foreign internal defense. Participation by civilian and military agencies of a government in any of the action programs taken by another government to free and protect its society from subversion, lawlessness, and insurgency. Also called FID. (Joint Pub 1-02)

Global Patient Movement Requirements Center. A joint activity reporting directly to the Commander in Chief, US Transportation Command, the DOD single manager for the regulation of movement of uniformed services patients. The GPMRC authorizes

transfers to medical treatment facilities of the Military Departments or the Department of Veterans Affairs and coordinates intertheater and inside CONUS patient movement requirements with the appropriate transportation component commands of US Transportation Command. (Approved for inclusion in the next edition of Joint Pub 1-02)

health service support. All services performed, provided, or arranged by the Services to promote, improve, conserve, or restore the mental or physical well-being of personnel. These services include, but are not limited to, the management of health services resources, such as manpower, monies, and facilities; preventive and curative health measures; evacuation of the wounded, injured, or sick; selection of the medically fit and disposition of the medically unfit; blood management; medical supply, equipment, and maintenance thereof; combat stress control; and medical, dental, veterinary, laboratory, optometric, medical food, and medical intelligence services. (Approved for inclusion in the next edition of Joint Pub 1-02)

hostile casualty. A person who is the victim of a terrorist activity or who becomes a casualty “in action.” “In action” characterizes the casualty as having been the direct result of hostile action, sustained in combat or relating thereto, or sustained going to or returning from a combat mission provided that the occurrence was directly related to hostile action. Included are persons killed or wounded mistakenly or accidentally by friendly fire directed at a hostile force or what is thought to be a hostile force. However, not to be considered as sustained in action and not to be interpreted as hostile casualties are injuries or death due to the elements, self-

inflicted wounds, combat fatigue, and except in unusual cases, wounds or death inflicted by a friendly force while the individual is in an absent-without-leave, deserter, or dropped-from-rolls status or is voluntarily absent from a place of duty. (Joint Pub 1-02)

host-nation support. Civil and/or military assistance rendered by a nation to foreign forces within its territory during peacetime, crisis or emergencies, or war based upon agreements mutually concluded between nations. (Joint Pub 1-02)

intertheater evacuation. Evacuation of patients between the originating theater and points outside the theater, to include the continental United States and other theaters. En route care is provided by trained medical personnel. (Approved for inclusion in the next edition of Joint Pub 1-02)

intratheater evacuation. Evacuation of patients between points within the theater. En route care is provided by trained medical personnel. (Approved for inclusion in the next edition of Joint Pub 1-02)

joint force. A general term applied to a force composed of significant elements, assigned or attached, of two or more Military Departments, operating under a single commander authorized to exercise operational control. (Joint Pub 1-02)

joint force commander. A general term applied to a combatant commander, subunified commander, or joint task force commander authorized to exercise combatant command (command authority) or operational control over a joint force. Also called JFC. (Joint Pub 1-02)

joint force surgeon. A general term applied to an individual appointed by the joint force commander to serve as the theater or joint task force special staff officer responsible for establishing, monitoring, or evaluating joint force health service support. (Approved for inclusion in the next edition of Joint Pub 1-02)

medical intelligence. That category of intelligence resulting from collection, evaluation, analysis, and interpretation of foreign medical, bio-scientific, and environmental information which is of interest to strategic planning and to military medical planning and operations for the conservation of the fighting strength of friendly forces and the formation of assessments of foreign medical capabilities in both military and civilian sectors. (Joint Pub 1-02)

medical regulating. The actions and coordination necessary to arrange for the movement of patients through the echelons of care. This process matches patients with a medical treatment facility that has the necessary health service support capabilities, and it also ensures that bed space is available. (Approved for inclusion in the next edition of Joint Pub 1-02)

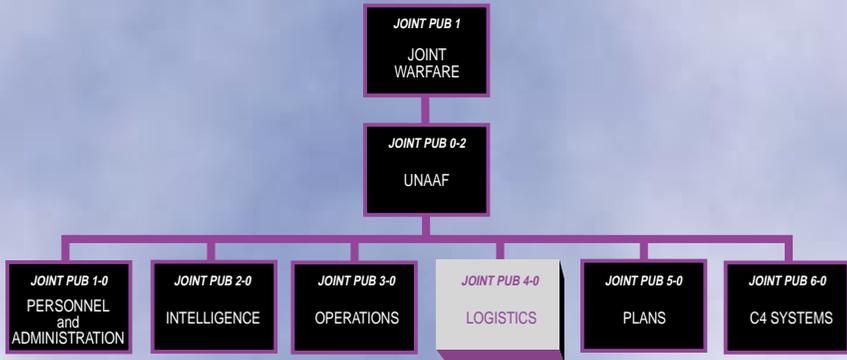
medical threat. A collective term used to designate all potential or continuing enemy actions and environmental situations that could possibly adversely affect the combat effectiveness of friendly forces, to include wounding, injuries, or sickness incurred while engaged in a joint operation. (Approved for inclusion in the next edition of Joint Pub 1-02)

medical treatment facility. A facility established for the purpose of furnishing medical and/or dental care to eligible individuals. (Joint Pub 1-02)

National Command Authorities. The President and the Secretary of Defense or their duly deputized alternates or successors. Also called NCA. (Joint Pub 1-02)

nonhostile casualty. A person who becomes a casualty due to circumstances not directly attributable to hostile action or terrorist activity. Casualties due to the elements, self-inflicted wounds, and combat fatigue are nonhostile casualties. (Joint Pub 1-02)

JOINT DOCTRINE PUBLICATIONS HIERARCHY



All joint doctrine and tactics, techniques, and procedures are organized into a comprehensive hierarchy as shown in the chart above. **Joint Pub 4-02** is in the **Logistics** series of joint doctrine publications. The diagram below illustrates an overview of the development process:

