

APPENDIX A

MEDICAL CARE IN A THEATER OF OPERATIONS

Section I. THE ECHELONS OF MEDICAL CARE**A-1. Health Service Support**

The doctrinal term health service support includes all services performed, provided, or arranged by the AMEDD to promote, improve, conserve, or restore the mental or physical well-being of personnel in the Army and, as directed, in other Services, agencies, and organizations.

A-2. Theater of Operations

A TO is that portion of an area of conflict including land, sea, and air masses necessary for military operations and the administration incident to such operations. The theater is normally divided into two major zones: the CZ and the COMMZ.

This paragraph implements STANAG 2068 and QSTAG 322

A-3. Organization of the Health Service Support System.

The HSS system extends from the point of wounding, injury, or illness, through the TO to CONUS. Echelon of medical care is a term which can be used interchangeably with the term level of medical care.

a. Each higher echelon of care has the same treatment capabilities as those echelons before it. Each echelon adds a new increment of treatment capability which distinguishes it from the previous echelon. The echelons of care are

referred to as Echelons (or Levels) I through IV, Level V care is provided at CONUS.

b. Health service support includes providing support to organizations that do not possess an organic medical capability. The HSS units required for this support are allocated based on troop strength and anticipated work load. The units are established where and when requirements indicate. Although a COMMZ may not be required in the theater, HSS may include CZ and COMMZ units.

A-4. Echelon I (Level I)

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

- (1) Immediate lifesaving measures.
- (2) Disease and nonbattle injury prevention.
- (3) Combat stress control preventive measures.
- (4) Patient collection.
- (5) Evacuation from supported units to supporting medical treatment.
- (6) Treatment provided by designated individuals or treatment squad (BAS). Major emphasis is placed on those measures necessary to return the patient to duty, or to stabilize him for medical evacuation to the next echelon. These measures include maintaining the airway, stopping bleeding, preventing shock, protecting wounds, immobilizing fractures, and

providing other emergency measures, as indicated.

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

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

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

(a) Self-aid/buddy aid. Each individual soldier is trained to be proficient in a variety of specific first-aid procedures. These procedures include aid for chemical casualties with particular emphasis on lifesaving tasks. This training enables the soldier or a buddy to apply immediate care to alleviate a life-threatening situation.

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

(c) Combat medic (aidman).

This is the first individual in the HSS chain who makes medically-substantiated decisions based on medical MOS-specific training. The combat medic is trained to emergency medical technician (EMT) level. The combat medic is assigned to the medical platoon or section of the HHC, the HSC, or the troop of the appropriate combat or CS battalion. (See paragraph A-11 for an explanation of this phase of care.)

(2) The physician and the physician's assistant in a treatment squad (aid station) are trained and equipped to provide ATM or trauma treatment to the battlefield casualty. This element also conducts routine sick call when the situation permits. Like-elements provide this echelon of care in division, corps, and COMMZ units. (See paragraphs A-12 and A-13 for an explanation of this phase of care.)

NOTE

Patients entering the HSS system will retain their protective mask. Ammunition and individual weapons belonging to patients to be evacuated from the BAS are disposed of as directed by brigade (division artillery, battalion, or squadron) or division policy. Patients evacuated to the rear retain individual equipment as prescribed by division SOP. All excess equipment is collected at the BAS and disposed of by the battalion S4 or as directed by command SOP.

d. Echelon I HSS is provided by the medical platoons/sections of combat and CS battalions, by corps ASMCs, by other corps medical units, and by COMMZ ASMCs.

A-5. Echelon II (Level II)

a. This echelon of care includes the following:

(1) Evacuating patients from Echelon I.

(2) Providing care at the clearing station (division) which is operated by the area support section of the treatment platoon of the medical company. (The area support section consists of a treatment squad, an area support squad, and a patient holding squad. [The ambulance squad operates in conjunction with the treatment squad.] When these squads are collocated, they form a clearing station capable of holding up to 40 patients [20 patients in the light infantry division].) At this echelon of care, the patient is examined; his wounds, illness, and general status are evaluated; and he is treated and returned to duty, or his priority for continued evacuation is determined. The area support section (clearing station) provides HSS on an area basis to all forces within a geographical AOR. The area support section normally operates in the BSA, the DSA, and areas of high concentration of troops in the corps support area (CSA) and COMMZ. The area support and patient holding squads are incapable of independent operations.

b. This echelon of support duplicates Echelon I (see paragraph A-4) and expands services available by adding dental, laboratory, x-ray, and patient holding capabilities. Emergency care, including continuing resuscitation procedures, is provided. (No general anesthesia is available.) (See paragraph A-13 for an explanation of this phase of care.) If necessary, additional emergency measures are instituted; however, they do not go beyond the measures dictated by the immediate need. Those patients who can RTD within 72 hours are held for treatment.

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

- Support battalions of separate maneuver brigades.

- Support squadrons of ACRs.

- Support battalions of DISCOMs.

- Medical battalions (area support) (corps and COMMZ).

A-6. Echelon III (Level III)

a. At this echelon of care, all categories of patients are provided care in MTFs which are staffed and equipped to provide care to them. (See Chapter 5 for a discussion of the care provided at the MASH and the CSH.)

b. This echelon of care expands the support provided at Echelon II. Patients who are unable to tolerate and survive movement over long distances will receive immediate surgical care in a MASH as close to the division rear boundary as the tactical situation will allow. Medical detachment, surgical, and medical detachment, surgical (airborne) provide a rapidly deployable initial surgical service forward in a division's AO as required by the nature of operations of the forces being supported. The medical detachment, surgical provides personnel augmentation to Echelon III hospitals when not task-organized to support Echelon II HSS. (See Chapter 5 for a discussion of these detachments.) Tactical situations or lack of suitable terrain availability may require that Echelon III units locate in offshore support facilities, third country support bases, or in the COMMZ. Those patients whose injuries permit additional transportation without detriment receive surgical care in a hospital farther to the rear. Those patients who are expected to RTD within the corps evacuation policy are regulated to a CSH. (See paragraphs

A-14, A-15, and A-16 for an explanation of this phase of care.)

A-7. Echelon IV (Level IV)

This echelon of care provides treatment to patients in a FH or a GH staffed and equipped for general and specialized medical and surgical care. Paragraphs A-15, A-16, and A-17 discuss the phases of care provided at this echelon.

a. The FH provides hospitalization for general classes of patients and reconditioning and rehabilitative services for those patients who can RTD within the theater evacuation policy. The majority of patients within this facility are in the rehabilitative category.

b. The GH provides hospitalization and stabilization for general classes of patients. It serves as the primary conduit for patient evacuation to CONUS.

A-8. Level V

At Level V, the casualty is treated in CONUS hospitals staffed and equipped for the most

definitive care available within the AMEDD HSS system. Hospitals in the CONUS base represent the final level of HSS.

A-9. Modular Medical System

a. Health service support for Echelons I and II is provided by a modular medical system. The modular design enables the medical resource manager to rapidly tailor, augment, reinforce, or reconstitute modular units that have become ineffective. These modules were designed—

Ž To acquire, receive, and sort casualties.

- To provide EMT and ATM to personnel in divisions and area support to personnel in the corps and COMMZ.

b. The modular system is built around six modules: combat medic, treatment squad, ambulance squad, area support squad, patient holding squad, and surgical squad. The system is oriented to forward casualty assessment, collection, evacuation, treatment, and initial emergency surgery.

Section II. PATIENT CARE AND TREATMENT

A-10. Phases of Patient Care and Treatment

The phases of patient care and treatment include combat medic (aidman) care, EMT, initial resuscitative treatment, resuscitative surgery or care, definitive treatment, convalescent care, and rehabilitative treatment.

A-11. Combat Medic (Aidman) Care

Combat medic care is the first medical treatment that a sick, injured, or wounded soldier receives

from a soldier who holds a medical MOS. If emergency or lifesaving measures are required prior to aidman care, they must be performed by a soldier trained in first aid (self-aid/buddy aid) or by a combat lifesaver. (See NOTE below.) Aidman care entails the skillful application of examining techniques; performance of emergency or lifesaving measures; and continual observation and care to ensure that the airway remains open, that bleeding has ceased, and that shock, infection, and further injury are prevented. It involves the effective use of medical supplies not available to the nonmedical soldier

and arrangement for evacuation by air or ground ambulance, as appropriate.

NOTE

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

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

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

A-12. Emergency Medical Treatment

In the EMT phase, medical skill and judgment of a higher degree are applied. The medical treatment is provided in a relatively safe environment with time to accomplish a more complete examination and start an adequate plan of treatment. Treatment includes the use of intravenous fluids and antibiotics; the preservation of the patient's airway by invasive procedures, if necessary; treatment for shock, and

the application of more secure splints and bandages. These comprehensive elements of medical management make it possible for the patient to be transported to the level of treatment demanded by the nature of his condition. For those patients who cannot be returned to duty, the final step is to arrange for the proper means of evacuation. This phase of treatment is characteristic of an aid station's capabilities and has no holding capacity.

A-13. Initial Resuscitative Treatment

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

A-14. Resuscitative Surgery

a. The resuscitative treatment phase is for patients whose conditions require—

Ž Comprehensive, preoperative diagnostic procedures.

Ž Intensive preparation for surgery.

- Qualified surgical teams.

- The administration of general anesthesia.

Ž Properly equipped operating rooms.

- An adequate postoperative intensive-care environment.

b. The objective of this phase of treatment is to perform those emergency surgical procedures which, in themselves, constitute resuscitation and without which death or loss of limb or body function is inevitable. This phase of treatment is normally provided in a medical company with an attached medical detachment, surgical, or in a hospital.

A-15. Definitive Treatment

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

and equipped and located in an environment with a low level of threat from enemy action.

A-16. Convalescent Care

During this phase in a patient's recovery, medical supervision is still needed, but the patient's condition does not require the frequent or close monitoring characteristic of the acute stage. Convalescent care occurs in several types of settings. This care can be given on an outpatient basis, in a holding unit, or in a hospital. This phase involves clinical judgment to determine when the patient has—

- Recovered from an injury or disease.
- Achieved a state of physical and mental function commensurate with the job to which the soldier will be subsequently assigned.

A-17. Rehabilitative Care

a. Rehabilitation is part of the total medical care provided to patients in the definitive and convalescent phases of care. Preventing or minimizing loss of physical or psychological function for patients capable of being RTD are the primary goals. For patients requiring evacuation, treatment is aimed toward starting basic rehabilitation procedures that can be continued throughout the evacuation process.

b. Physical and occupational therapy are the rehabilitation assets in a TO. Physical therapy staff assets are found at the CSH, FH, GH, and the medical company, holding. Occupational therapy staff assets are found in the FH and GH, the medical company, holding, and as MH officers in CSC units.