CHAPTER 2

ORGANIZATIONAL RELATIONSHIPS

2-1. Theater of Operations

A theater of operations is that area of land, sea, and air required to support and perform military operations against the enemy. United States forces deployed to the theater may range from a relatively small task force, to a full array of large land, sea, and air forces. The theater is organized into a CZ and a communications zone (COMMZ). (See Figure 2-l.)

a. The CZ is the territory forward of the corps rear boundary. It is that area required by tactical forces for the conduct of operations. The depth of the CZ depends onthe–

- Forces involved.
- Nature of planned operations.
- Lines of communications.
- Terrain and enemy capabilities.

Normally, the CZ is divided into corps areas and division areas.

b. The COMMZ is the rear part of a theater of operations (behind but not necessarily contiguous to the CZ). It contains the–

- Lines of communications.
- Establishments for supply and evacuation.
- Other agencies required for the immediate support and maintenance of the field forces.

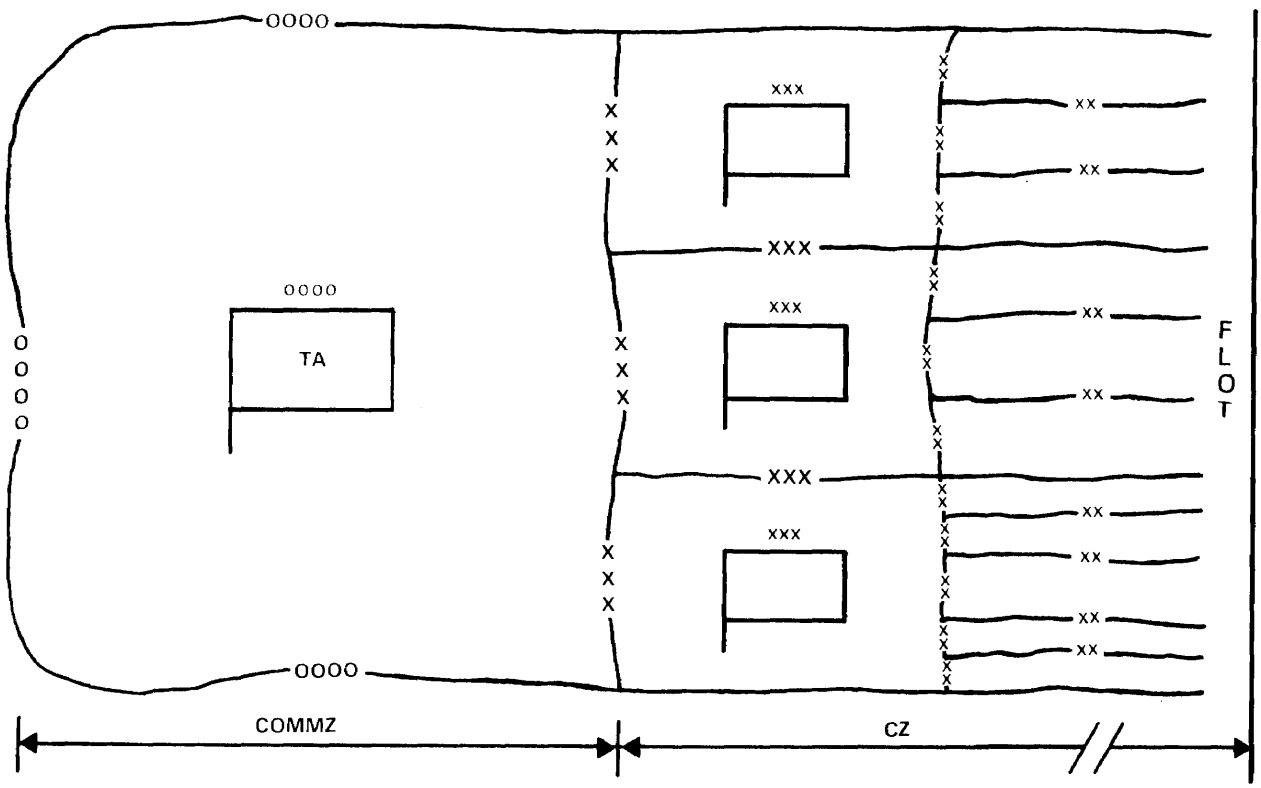


Figure 2-1. Theater zones.

2-2. Theater Army

a. Army Service Component. The theater army (TA is normally the Army service component command in a unified command. Third US Army, Seventh US Army, and Eighth US Army are examples of theater armies. The TA as the service component has both operational and support responsibilities. Its exact tasks are assigned by the theater CINC. These tasks may be exclusively operational missions, solely logistics tasks, or a combination of both types of responsibility.

b. Assigned Forces. The TA commander is responsible to the unified commander for recommending how assigned US Army forces should be allocated and employed. The TA commander's support responsibilities include the requirements to organize, equip, train, and maintain Army forces in the theater.

c. Organization. The organization of a TA is not standard. It varies between theaters according to the size of the US Army component in a force. It also varies with the factors of mission, enemy, terrain, troops, and time available (METT-T). Other levels of command can also perform TA functions. For example, a corps staff could perform the TA function if only a single corps were committed to a contingency area. On the other hand, a larger separate staff may be necessary to handle the administrative, legal, logistics, personnel, intelligence, operations, and communications tasks of a large force deployed overseas. Liaison between a TA and another headquarters employing its forces must be performed whenever theater armies release operational control of their units.

2-3. Theater Army Commander

a. The TA commander has two types of support organizations with which to accomplish the mission. They are–

- Area-oriented organizations with geographic responsibilities (theater army area commands [TAACOMs] and area support groups [ASGs]).
- Mission-oriented organizations with functional responsibilities (such as a personnel command, an engineer command, and a medical command [MEDCOM]).

b. Responsibility for the COMMZ is assigned to the TA commander whose primary responsibility in time of war is CSS of assigned forces.

2-4. Health Service Support for the Army Component

Health service support for the Army component in a theater of operations is the responsibility of the TA commander. On the commander's special staff is a TA surgeon.

2-5. Theater Army Surgeon

Normally, the MEDCOM commander or the senior medical commander in the COMMZ functions as the TA surgeon. As TA surgeon, he provides information, recommendations, and professional medical advice to the TA commander and to the general and special staffs. He also maintains current data regarding the status, capabilities, and requirements for the HSS of the TA. As the medical staff adviser, he is responsible to the TA commander for staff planning, coordinating, and developing policies for the HSS of TA forces. The TA surgeon–

- Determines the medical threat.
- Provides advice concerning the health services of the command and the occupied or friendly territory within the TA commander's area of responsibility.
- Provides advice concerning the medical effects of the environment and of NBC weapons on personnel, military working dogs, rations, and water.
- Recommends changes to the theater evacuation policy.
- Provides advice concerning the combat stress threat and its interaction with–
  - The medical and environmental threats.

- Other stress factors in the theater and home front.

- Determines requirements for the requisition, procurement, storage, maintenance, distribution, management, and documentation of Class VIII materiel and special hospital-peculiar items of subsistence.

- Develops and supervises a mass casualty plan. (See Chapter 14 for a discussion on the mass casualty plan.)

- Recommends priority of fills for all AMEDD officer and warrant officer vacancies and makes recommendations concerning the assignment of enlisted personnel with AMEDD specialties within the TA.

- Plans and coordinates medical training in the command.

- Coordinates with medical brigade commander(s) and corps surgeon(s) for continuous HSS.

- Monitors continuously the following HSS areas of interest:

  - The system of treatment and patient evacuation, including aeromedical evacuation (AE) by Army air ambulance units, air movement of patients by Air Force evacuation units, and evacuation by Navy ships.

  - Dental service.

  - Veterinary food inspection, animal care, and veterinary preventive medicine activities. (See FMs 8-27 and 8~30.)

  - Medical food service.

  - Professional medical support in subordinate units.

  - Preventive medicine and, as required, preventive medicine in public health activities in coordination with the assistant chief of staff (civil affairs) (G5).

  - Medical laboratory service.

  - Blood services.

  - Optical service.

  - Medical supply, optical, maintenance, and repair facilities, including technical inspection and reporting of status.

  - Medical intelligence, including the examination of captured medical supplies and equipment.

  - Technical inspection of medical materiel.

  - The equipment status reporting system within his area of responsibility.

  - Medical civic action programs coordination with the G5.

  - Health service support aspects rear operations.

NOTE

As a result of ALB doctrine, the term rear operations supersedes the terms rear area protection and rear area combat operations. (See FMs 71-100, 90-23, and 100-15 for doctrine pertaining to rear operations.)

  - Consolidation of medical reports and other hospital administrative records of injured, sick, and wounded personnel.

  - Mental health/combat stress control services. These services include prevention and treatment programs for battle fatigue, misconduct combat stress reactions, and substance abuse.

  - Required automatic data processing support for appropriate medical agencies within the command.

  - Collection and analysis of operational data for the purpose of on-the-spot adjustments in the theater medical support structure and for use in combat materiel development studies.

• Reconstitution to include reorganization and regeneration. (See Section V, Chapter 3.)

2-6. Theater Army Surgeon's Section

The size and composition of the TA surgeon's section, which is a part of the MEDCOM headquarters, will vary in accordance with the strength of the Army forces in the theater, the nature of the military operations to be conducted, and the specific responsibilities assigned. The section may perform administrative, intelligence, operational, training, and logistical functions.

2-7. Consultants to Theater Army Surgeon

Professional consultants in various services and specialties assist the TA surgeon. These services and specialties may include entomology, environmental engineering, medicine, nuclear medicine, neuropsychiatry and social work (combat stress control), nursing, preventive medicine, surgery, dietary, optometry, pharmacy, dentistry, veterinary, and medical intelligence. The Armed Forces Medical Intelligence Center (AFMIC) should be considered as a source for consultation for medical intelligence. When time and manpower permit, intelligence exchanges should take place between this strategic asset and senior tactical medical authorities; however, this is done only with the advice and consent of organic intelligence sources. Consultants to the TA surgeon–

• Make recommendations which aid in establishing patient management policies for the command.

• Assist in personnel management decisions governing clinical specialists.

• Monitor quality of clinical performance and adherence to established policy through staff visits and reviews of records and reports.

• Recommend clinical investigations to solve critical patient-care problems. (When required, and depending upon the particular table(s) of organization and equipment (TOE), individuals in medical specialties at various subordinate or lower echelon medical headquarters and units also act as consultants.)

• Provide professional and technical consultation in functional areas.

2-8. Theater Army Area Command

The TAACOM accomplishes its support mission of supply, maintenance, and personnel services through subordinate units known as ASGs. The number of ASGs depends upon the size of the COMMZ and the number of troops supported. The senior medical unit commander located within the geographical boundaries of an ASG will normally provide medical staff advice for the ASG commander. Standing operating procedures (SOP) will normally be developed by the MEDCOM and the ASG to govern the relationship between each ASG commander and the senior medical unit commander in his area. Health service support is provided to the ASG on an area basis. Medical units are not subordinate to the ASG but do provide HSS on an area basis.

2-9. Theater Army Medical Command, TOE 08-111H200

a. The mission of the MEDCOM is to provide command and control and supervision of assigned and attached units in the TA COMMZ.

b. The MEDCOM is assigned on the basis of one per TA.

c. The capabilities of the MEDCOM are–

• Command and control, staff planning, supervision of operations, training, and administration of hospital centers and medical groups engaged in providing COMMZ health services.

• Medical services to include–

• Keeping the TA commander and his staff informed on the health of the command and on medical aspects of matters affecting CSS.

• Providing current information concerning the medical aspects of the CSS situation to the surgeons of higher headquarters.

- Coordinating HSS operations of the COMMZ.

- Providing advice to the commanders of personnel command, transportation command, and civil affairs units on medical matters.

- Centralized control and coordination of all medical regulating functions for evacuation of patients from the CZ to and within the COMMZ as well as centralized coordination of all medical regulating functions for further evacuation out of the theater.

- Professional specialty consultation service.

- Policy and guidance for management of medical materiel and medical equipment maintenance.

- Coordination and direction of medical scientific and technical intelligence and medical technical intelligence activities within the COMMZ.

d. The number and type of HSS units assigned to the MEDCOM depend on various factors. Some examples are—

- Size, composition, and location of forces to be supported.

- Type of operations conducted.

- Anticipated work load.

- Theater evacuation policy. (See Chapter 4 for a discussion on evacuation policy.)

e. A signal operating company is attached, less operational control, to the MEDCOM to provide internal headquarters communications. This signal unit interrelates with the MEDCOM headquarters company in supporting internal operations of the MEDCOM.

f. The MEDCOM will be tailored to adjust to theTA mission and retain flexibility. This will permit the MEDCOM to respond rapidly to changing HSS requirements. The organization of a MEDCOM headquarters and an example of overall task organization of MEDCOM (current structure) are illustrated on the following pages. (See Figures 2-2 and 2-3.)

g. Since all HSS units in the COMMZ are assigned to the ME DCOM, units of other major commands such as the TAACOM, personnel command, or transportation command must receive HSS from MEDCOM units. This support is most efficiently and economically provided on an area basis. Area HSS, to include outpatient care, is provided by area dispensaries operated by separate medical companies (clearing) and dispensary detachments of various sizes. Patient evacuation, hospitalization, preventive medicine services, optometry services, dental services, and health service logistics are also provided on an area basis. The various HSS units required for this support are allocated on the basis of troop strength supported and are established where troop concentrations dictate.

2-10. Command and Staff Relationships

a. Command. The M EDCOM commander reports directly to the TA commander. The coordination of MEDCOM staff matters with the TA staff is normally conducted through command channels. However, health service professional matters are coordinated through technical channels directly with the TA headquarters surgeon's section. The TA headquarters provides policy, direction, and broad guidance on HSS planning. The MEDCOM coordinates with other TA commands on mutual support requirements. To ensure that adequate HSS is provided throughout the COMMZ, close coordination between the MEDCOM and the major commands in the COMMZ is necessary. The MEDCOM commander must know the extent and location of troop concentrations to be supported. Supported unit commanders must know where their supporting MTFs are located and what type of support is available.

b. Staff. Staff elements of theMEDCOM headquarters conduct normal staff relationships (both command and technical) with the staffs of assigned subordinate medical headquarters. In the absence of command and control teams, the dental surgeon, preventive medicine staff officer, and veterinary staff officer may be delegated operational control, in their respective areas, of subordinate units.

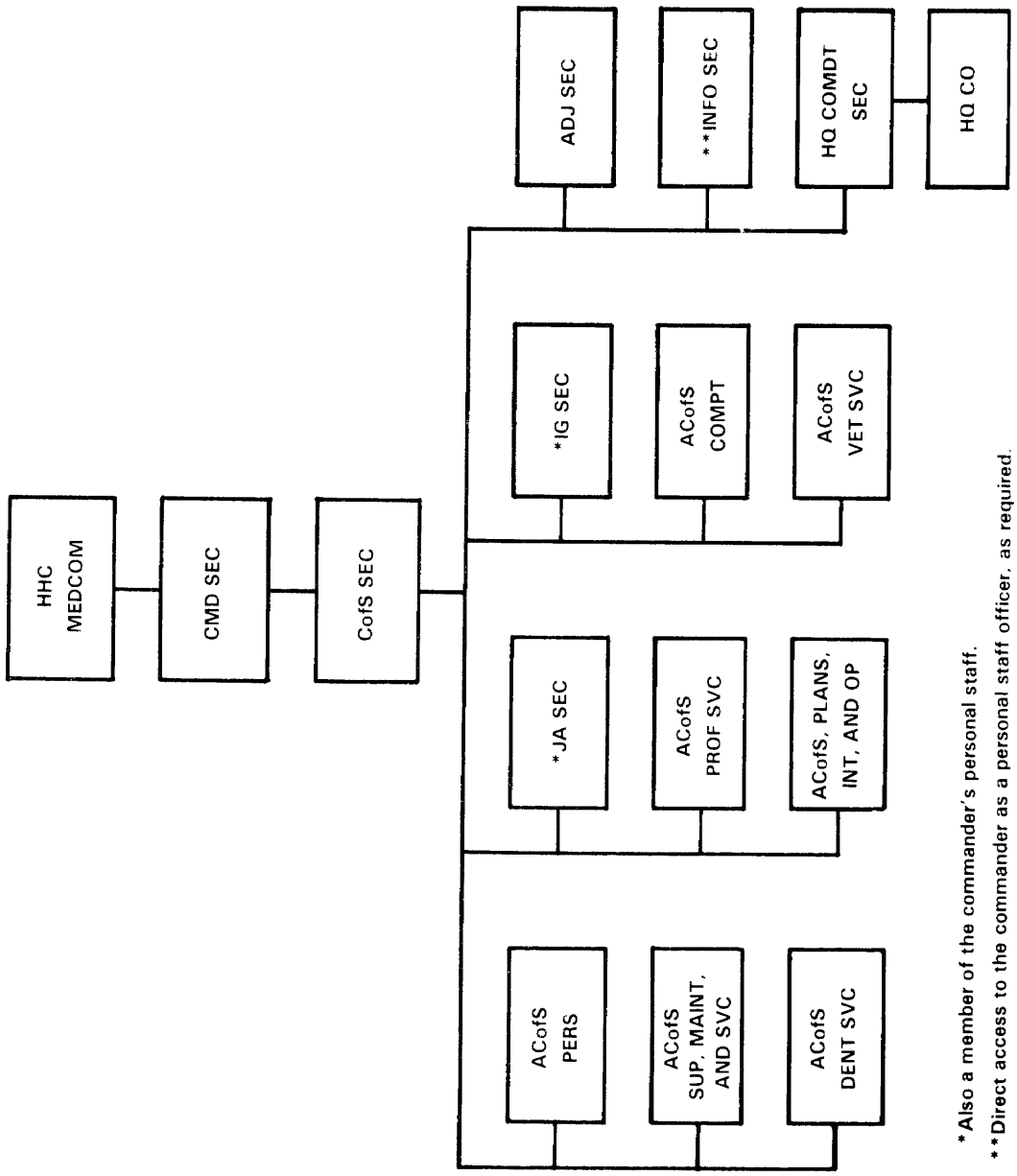
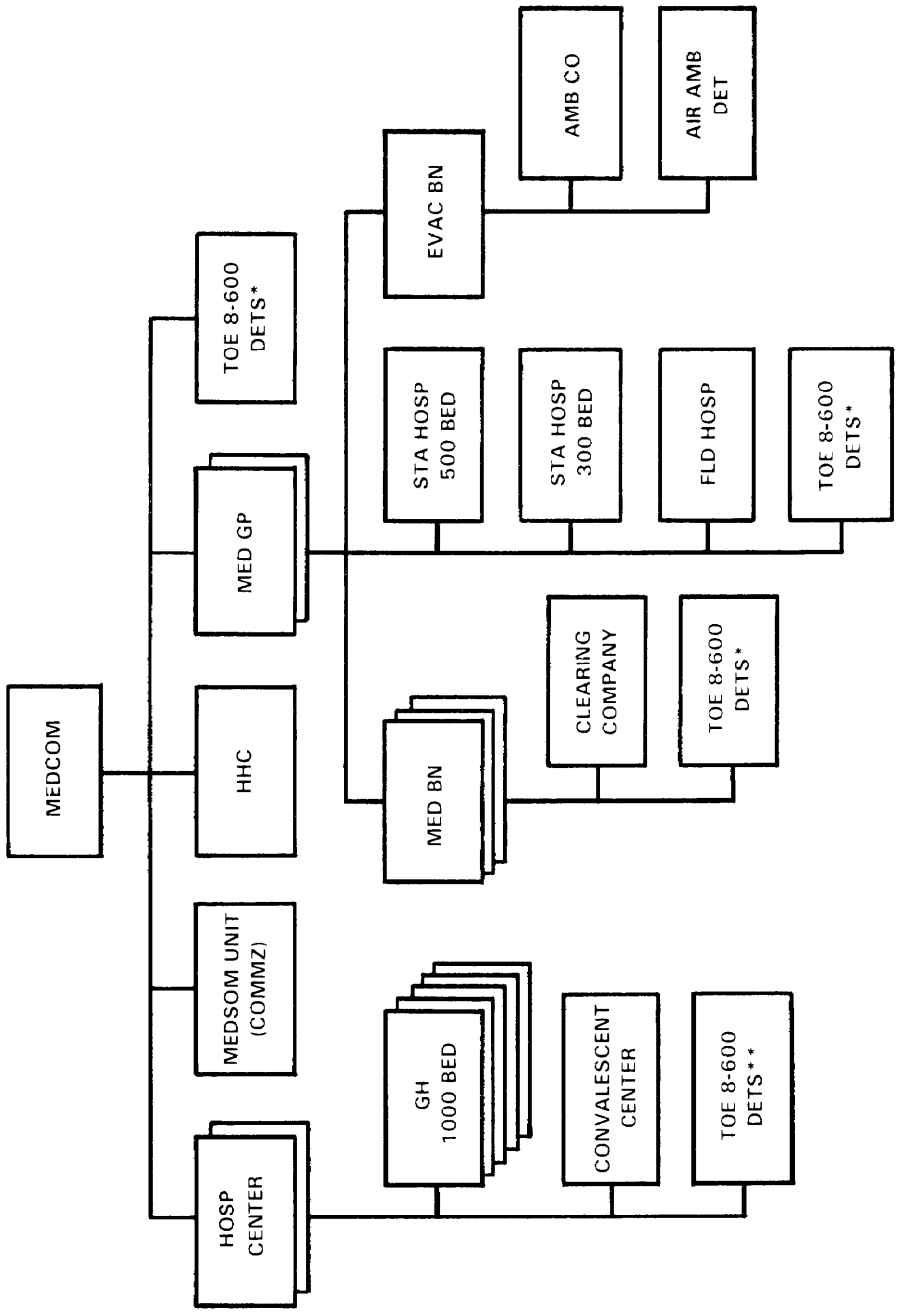


Figure 2-2. Headquarters, medical command.



*Includes preventive medicine, dental, psychiatry (combat stress control), veterinary, dispensary, laboratory, and professional specialty teams.

**Includes air and ground evacuation, preventive medicine, dental, psychiatry (combat stress control), veterinary, dispensary, laboratory, and professional specialty teams.

NOTE: This figure illustrates a *type* MEDCOM. The number and type units assigned in any given theater will depend on the mission and the composition of the supported force.

Figure 2-3. Example of task organization of MEDCOM (current structure).

c. Liaison with CZ. Liaison with the major medical headquarters within the corps is maintained for evacuation of patients from the CZ and for required reinforcement to the corps. Direct coordination concerning technical matters is also authorized between the MEDCOM and the major medical headquarters in each corps area (medical brigade or group). This coordination ensures that the respective corps surgeon is kept advised.

2-11. Command and Control

The MEDCOM headquarters commands and controls all assigned and attached units. Its major subordinate command and control units are hospital center headquarters, medical group headquarters, nondivisional medical battalion headquarters, and evacuation medical battalion headquarters.

a. Headquarters and Headquarters Detachment, Hospital Center, TOE 08-5O2H1OO.

(1) Mission. The mission of this unit is to command and control general hospitals and other health service units.

(2) Assignment and basis of allocation. This unit is assigned to the MEDCOM on the basis of one per two to eight general hospitals or their equivalent in a combination of general hospitals and other health service units (maximum of 8,000 fixed beds).

(3) Capabilities. In addition to providing command and control for attached general hospitals, the hospital center provides medical regulating and professional specialty consultation service.

(4) Concept of operations.

(a) Location. Hospital centers are located only in the COMMZ. Since a hospital center headquarters, including its assigned hospitals, requires not only extensive ground areas but certain adjuncts (water, power, and sewage disposal facilities) for its operations, ideal sites are seldom encountered. However, so far as possible, the center's location should conform to established principles regarding the location of medicaI installations. These basic principles include the adaptability of existing physical plant structures to the center's requirements.

(b) Centralized functions. The hospital center commander and staff, using their centralized facilities, correlate and coordinate the overhead activities of assigned hospitals. They assist the attached hospital's staffs by coordinating and consolidating a major portion of the administrative details associated with such services as supply and maintenance, transportation, utilities, and similar essential services. These actions result in the economical use of personnel and equipment. The hospital center commander exercises control over the movement of patients to and from attached hospitals. Certain hospitals operating under the command and control of the hospital center may be staffed and equipped to provide specialized treatment. Thus, the hospital center affords the opportunity for increased specialization in certain fields of medicine. Such a procedure ensures the additional advantage of fully utilizing the skills possessed by highly qualified professional personnel.

b. Headquarters and Headquarters Detachment, Medical Group, TOE 08-122H200.

(1) Mission and assignment. This unit provides command and control and administrative supervision of assigned or attached medical units. It is assigned to the TA MEDCOM in the COMMZ based on the general support requirements of the corps forces supported.

(2) Concept of operations. Medical units are assigned or attached to the group headquarters by the TA MEDCOM. The nature of the COMMZ requires that medical groups be employed to perform mission responsibilities consisting of HSS to forces in the COMMZ. Medical groups located in the COMMZ provide support on an area basis. This support consists of units furnishing station-type hospitalization, short-haul patient evacuation, patient holding, and other support. Assets from COMMZ medical groups may be used to replace ineffective units in the CZ. Medical groups may contain such medical attachments as dispensary, preventive medicine, dental, and veterinary units. Units are readily reallocated between groups by action of the MEDCOM to accomplish shifts in work loads.

c. Headquarters and Headquarters Detachment, Medical Battalion, TOE 08-126H300.

(1) Mission and assignment. This unit provides command and control and planning for a medical battalion (nondivisional) to include supply and organizational maintenance support. It is assigned to the TA MEDCOM, TOE 08-11lH200, or medical brigade, TOE 08-112H600, on the basis of one per three to seven nondivisional medical companies or equivalent-size units. The unit may operate directly under the MEDCOM, but it is often attached to a medical group, TOE 08-122H200. The number and types of companies or detachments attached to the medical battalion will depend upon the mission.

(2) *Employment.* The medical companies of the nondivisional medical battalion have essentially the same roles in the COMMZ as they do in the corps support area.

d. Headquarters and Headquarters Detachment, Medical Battalion (Evacuation), TOE 08-446LOOO.

(1) *Mission.* This unit provides command and control and planning of air and ground medical evacuation units within the theater of operations.

(2) *Assignment.* The medical battalion (evacuation) is assigned to the MEDCOM, TOE 08-111H200, in the COMMZ, or the medical brigade, TOE 08-112H600, in the corps.

(3) *Capabilities.* This unit provides–

- Command and control, supervision of operations, training, and administration of a combination of three to seven assigned or attached medical companies (air ambulances), TOE 08-447L100, and medical companies (ground ambulances), TOE 08-449 L000, medical detachments, TOE 08-660H0, and medical air ambulance company, TOE 08-137H200.
- Staff and technical supervision of aviation operations, safety, and aviation maintenance (AVUM) within attached ambulance companies.
- Coordination of medical evacuation operations and communications functions on a 24-hour, two-shift basis.
- Medical supply support to attached units.
- Echelon I HSS.

(4) *Basis of allocation.* One per combination of the following units:

- Three to four medical companies, air ambulance.
- Three to four medical companies, ground ambulance.

2-12. The Corps

a. The Largest Tactical Unit. Corps are the largest tactical units in the US Army, the instruments by which higher echelons of command conduct maneuvers at the operational level. Corps are tailored for the theater and the mission for which they are deployed. Once tailored, however, they contain all the combat, combat support (CS), and CSS capabilities required to sustain operations for a considerable period.

b. Flexible Organization. Corps may be assigned divisions of any type required by the theater and the mission. They possess support commands and are assigned combat and CS organizations based on their needs for a specific operation. Armored cavalry regiments, corps artillery brigades, engineer brigades, air defense artillery brigades, and aviation brigades are the nondivisional units commonly available to the corps to weight its main effort and to perform special combat functions. Separate infantry or armored brigades may also be assigned to corps. Signal, military intelligence, military police, and chemical brigades are the usual CS organizations present in a corps. Civil affairs and psychological operations units are often used to augment the CS role; however, they are not normally present within the corps. Other special operations forces may support corps combat operations as required, particularly when the corps is conducting an independent operation. The CSS organization of the corps is the

corps support command (COSCOM). The COSCOM provides supply, field services, transportation, maintenance, and HSS to the divisions and nondivisional units of the corps. Within the corps, corps support groups provide supply (less Class V and VIII), maintenance, and field service to division and nondivisional units. Transportation, ammunition supply, and medical support are provided by functional commands.

c. Headquarters. The corps headquarters is a tactical headquarters with responsibility for providing administrative and logistical support for its subordinate units. (See FM 100-15 for further discussion on corps operations.)

2-13. Health Service Support in the Corps

Generally, the mission of Echelon III (Level III) HSS is to provide the divisions and troops in the corps area with hospitalization and other HSS for continued care and treatment of their sick, injured, and wounded. Functions included in the mission are described in subsequent chapters.

2-14. The Corps Surgeon

a. Special Staff Officer. The corps surgeon is a special staff officer in the corps headquarters. This officer has a small staff section to assist in completing the mission. The corps surgeon has direct access to the corps commander on HSS matters. He keeps the commander and his staff informed concerning the health of the command and the health service aspects of combat operations and effectiveness. As the principal medical staff officer, he advises the corps commander and staff on all HSS matters related to personnel, intelligence, operations, logistics, and civil-military operations. He does not command medical troops unless assigned the responsibility by the corps commander. The corps surgeon exercises staff supervision over HSS in the COSCOM, divisions, and other subordinate corps units. The surgeon normally functions under the coordinating staff supervision of the assistant chief of staff (personnel) (G1) or directly under the corps chief of staff depending on the desires of the corps commander. Coordination with surgeons and medical commanders of higher, subordinate, and adjacent headquarters is through command channels, except for technical matters which may be coordinated through technical channels.

b. Duties. The corps surgeon and his staff perform the following duties:

- Develop and coordinate the HSS portion of corps plans to support the commander's decisions according to information provided by the senior medical headquarters of the corps (medical brigade or group).
- Provide current information on the corps health service situation to surgeons of the next higher, adjacent, and subordinate headquarters.
- Recommend policies concerning support of civil affairs and civic actions.
- Monitor the availability of and recommend the assignment, reassignment, and utilization of AMEDD personnel within the corps (to include critical occupational specialty personnel).
- Coordinate health consultation services within the corps.
- Evaluate and interpret health service statistical data.
- Recommend policies and determine requirements and priorities for medical supply, blood products, and medical equipment maintenance services according to information provided by the senior medical headquarters of the corps.
- Recommend and coordinate corps patient evacuation policies.
- Determine corps health service training policies and programs as required.
- Develop policies pertaining to the treatment of the sick, injured, and wounded personnel in coordination with the senior medical headquarters of the corps and the TA surgeon.
- Ensure compliance with the TA blood bank service program.

- Initiate preventive medicine programs and procedures within the corps.

- Recommend combat stress control, mental health, and substance abuse control programs and procedures within the corps.

- Coordinate access to intelligence of medical interest with the assistant chief of staff, (intelligence) (G2); ensure that medical threat, medical intelligence, and intelligence of medical interest are integrated into HSS plans and orders.

2-15. Corps Surgeon's Staff Relationships

The surgeon and his staff section interrelate with other members of the corps general and special staffs, as well as with surgeons of other commands. The corps surgeon exercises medical technical control over the HSS system of the entire corps.

a. Assistant Chief of Staff for Personnel (G1) Staff Supervision. The G1 exercises general staff supervision over the surgeon. The surgeon is responsible for the management of health services and must be professionally and technically qualified to assume this responsibility. On medical and technical matters affecting the health of the command and HSS of combat operations, the surgeon has direct access to the corps commander.

b. Relationship with The Assistant Chief of Staff for Intelligence (G2). The G2 has medical intelligence responsibilities in support of health services. He and the surgeons coordinate medical intelligence requirements. When appropriate, the staff surgeon may also assist the G2 with the integration of significant elements of medical threat, medical intelligence, and intelligence of medical interest into the intelligence preparation of the battlefield process.

c. Relationship with the Assistant Chief of Staff for Logistics (G4). The G4 has logistics responsibilities in support of health services. He reviews the surgeon's medical plans to determine logistics support requirements. In addition, he provides staff guidance and coordinates with the surgeon and the G1 concerning possible adjustments due to logistics considerations. He reviews the locations of medical units and installations to preclude any conflict with locations of logistical units. He advises and makes recommendations concerning logistics aspects of the command medical evacuation plan.

d. Relationship with COSCOM Surgeon/ Senior Medical Headquarters Commander. The corps surgeon coordinates with the COSCOM surgeon/senior medical headquarters commander and develops the health service portions of corps plans to support the commander's decisions.

e. Relationship with Division Surgeon. The relationship of the corps surgeon to the surgeons of lower commands depends in part on the policies of the corps commander. The corps surgeon, however, exercises staff supervision of all HSS for which his commander is responsible and is normally delegated full authority over the technical aspects of health services. The corps surgeon's relationship to the division surgeons is primarily technical. He exercises no command or operational control or authority over the divisional HSS system. The corps surgeon influences HSS in the division through the policies and directives of the corps commander. The division surgeons keep the corps surgeon apprised of the health service situation within the division.

f. Relationship with the TA Surgeon. The relationship between the corps surgeon and the TA surgeon is similar to that existing between the division surgeon and the corps surgeon. Except for direct coordination of technical matters, coordination with the TA surgeon is through command channels.

2-16. The Corps Support Command

The COSCOM is the principal logistics organization in the corps. It provides supply, field services, transportation (mode operations and movement control), maintenance, and HSS to the divisions and nondivisional units of the corps. Within the COSCOM, corps support groups provide supply (less Class V and VIII), maintenance, and field service to divisions and nondivisional units. Transportation, ammunition supply, and HSS are provided by functional commands. Depending upon the size of the corps, the senior medical organization may be a medical brigade or a medical group.

2-17. The Corps Support Command Surgeon

The COSCOM does not have an organic surgeon or surgeon's section. While the COSCOM surgeon's section is organic to the headquarters and headquarters company (HHC) medical brigade (TOE 08-112 H600), it may be collocated with the COSCOM headquarters upon deployment. The medical brigade commander within the COSCOM also serves as the COSCOM surgeon (or director of health services when the COSCOM is configured for a contingency-oriented corps). (This staff role is subordinate to the command role.) If the medical group headquarters is the highest medical headquarters, the senior medical corps officer assigned serves as the COSCOM surgeon. The COSCOM surgeon is a special staff officer of the COSCOM commander. He keeps the commander and his staff informed of the health of the command and of the medical aspects of CSS to the corps. He functions under the general staff supervision of the COSCOM G1 only in his role as COSCOM surgeon. He coordinates medical matters with other members of the staff. He provides advice to the commander and staff and assistance to supported and subordinate unit commanders on HSS matters. The surgeon is authorized direct access to the COSCOM commander and staff on the health of the command or the medical aspects of CSS operations. In conjunction with the corps surgeon, the COSCOM Assistant Chief of Staff (ACofS), Security, Operations, Training, and Intelligence (SOTI), and the COSCOM surgeon develop policies, plans, and programs for HSS of the corps. The COSCOM surgeon also assists the ACofS, SOTI, in HSS planning for rear operations. The surgeon's functions include–

- Developing, preparing, and coordinating the HSS policies of the command and the HSS portion of COSCOM plans.
- Providing current information on the HSS aspects of the CSS situation to the surgeons of higher and lower headquarters.
- Coordinating HSS operations of the corps.
- Providing the planning and coordinating aspects of medical supply arid medical maintenance.
- Maintaining liaison with the G5 on HSS.

2-18. Tailoring of Health Service Support in the Corps

a. The Mission, Composition of Forces, and Geographic Area. Health service support is tailored to the mission, composition of the force, and geographical area of operations. All nondivisional medical units located in the corps area are assigned to the major medical headquarters within the corps.

b. Medical Brigade.

(1) A medical brigade consists of a HHC and those subordinate medical units necessary for providing Echelon III HSS. It is assigned to a corps and is normally attached to the COSCOM. Like the corps itself, the medical brigade is a flexible organization, having no fixed composition. Its mission is to provide Echelon III HSS within a corps area.

(2) The number and types of units assigned and attached to the brigade will depend upon the mission, strength, and tactical disposition of the corps. The brigade is responsible for—

- Planning for HSS of the corps. The corps surgeon makes long-range plans (96 hours and beyond) for HSS. The commander of the medical brigade or group converts these plans into day-to-day operations for the fulfillment of the health service mission.
- Direction of subordinate medical unit operations.
- Implementation of hospitalization and evacuation policies, which includes medical regulating activities. (See Chapter 4 for a discussion on patient regulating.)
- Preparation of medical records and reports.
- Adjusting the priorities of Echelon III HSS as required.
- Modifying plans for future action.

c. Health Service Support by Function. Health service support is provided in functional areas by units specifically organized to provide the following functions:

- Evacuation.
- Treatment and hospitalization.
- Health service logistics.
- Medical laboratory services.
- Blood management.
- Veterinary services.
- Preventive medicine.
- Dental services.
- Combat stress control.
- Command and control.

Included in these functions are reconstitution of forward elements and HSS of enemy prisoners of war (EPW) and indigenous civilians.

d. Centralized Control of Decentralized Operations. The HSS mission is accomplished through centralized control of decentralized operations. Policies are provided for the effective integration of health service activities in the corps and are coordinated with supported units. The major subordinate command and control elements of the medical brigade in a corps are the headquarters of the medical groups and/or separate medical battalions. The major subordinate command and control elements of the medical group in a corps are normally the headquarters of separate medical battalions.

2-19. Medical Brigade or Group Commander

The commander of the major medical subordinate command (medical brigade or group) of the COSCOM is directly responsible to the COSCOM commander for the accomplishment of the HSS mission. He does not serve as the corps surgeon. He is both the director and the operator of the corps HSS system. As stated previously, the medical brigade commander is also the COSCOM surgeon. In addition to his other duties, he coordinates health service command and staff matters with the corps commander, corps surgeon, and other members of the corps staff. However, health service technical matters are coordinated with the corps surgeon. The corps medical brigade or group commander, in conjunction with the corps surgeon, coordinates directly with the TA MEDCOM for required reinforcements to the corps and for professional health service matters. His command and staff duties include the following:

a. Command and Control. He commands and controls all medical units assigned and attached to the corps.

b. Plans. He develops, refines, adjusts, coordinates, and implements HSS plans in consonance with the assigned mission.

c. Policy. He develops HSS policy in consonance with policies of higher headquarters and implements procedures to assure adherence to established policy in his jurisdiction.

d. Area HSS. He controls and directs the area HSS operations.

e. Reporting on Health of the Command. He furnishes current information to the COSCOM commander and staff concerning the health of the command and the command aspects of medical matters affecting combat effectiveness, combat operations, and CSS operations.

f. Liaison and Coordination. He maintains medical liaison and coordinates technical matters with the surgeons of higher, lateral, and subordinate headquarters.

2-20. Command and Staff Relationships

a. Relationship to Higher Commands. The medical brigade commander reports directly to the COSCOM commander. The coordination of staff matters with the corps commander and staff is normally through command channels, except that technical matters are coordinated with the corps surgeon.

b. Relationship to Lower Commands. The staff elements of the medical brigade headquarters have normal staff relationships with respect to subordinate elements. The dental and veterinary staff officers of the brigade headquarters may be delegated operational control of subordinate dental and veterinary units.

c. Relationship to Division. Coordination with division headquarters is through normal command channels, except that technical matters may be coordinated directly with the division surgeons.

d. Relationship to the MEDCOM. Direct coordination between the medical brigade and the TA MEDCOM is desirable concerning health service technical matters.

2-21. Other Corps Units

Separate brigades may be assigned to the corps. Brigades may be used as a force, as part of the TA reserve, or to augment the combat power of a corps. The brigade, with its attached battalions, may be assigned to a rear area or flank security mission, be employed as a corps reserve, or be assigned or attached to a division. Maneuver battalions may be attached or detached for specific missions as required.

2-22. Separate Brigade and Regimental Surgeons

The separate brigade or regimental surgeon's primary responsibility is to ensure that HSS is available and adequate to support the mission of the brigade or armored cavalry regiment (ACR). The separate brigade/regimental surgeon is the commander of the medical company/ troop assigned to provide HSS. The surgeon provides the commander with information regarding the medical aspects of combat effectiveness within the brigade or ACR and performs staff functions similar to those of the division surgeon. In addition, this surgeon–

- Ensures the implementation of the health service section of the division or corps SOP.
- Recommends the allocation of medical resources within the brigade or ACR.
- Exercises direct supervision over the technical training of medical personnel assigned to brigade or ACR units and manages the combat lifesaver program.
- Determines procedures, techniques, and limitations in the conduct of routine medical care, emergency medical treatment, and advanced trauma management (ATM) procedures.
- Monitors the health of the command and advises the commander on measures to counter the medical threat.
- Monitors requests for AE originating in units subordinate to the brigade.
- Ensures, through coordination with appropriate headquarters, that the brigade and its subordinate units receive adequate HSS for their assigned missions.
- Provides the COSCOM surgeon, in the case of a separate brigade or ACR, with information concerning the separate brigade's or ACR'S plans and operations for HSS of attached units.
- Assumes operational control (when directed) of augmentation medical units.
- Supervises activities of subordinate battalion or squadron surgeons.
- Assumes technical supervision of physician assistants (PAs) organic to subordinate units in the absence of their assigned physician.
- Advises PAs of artillery and engineer battalions as required.
- Advises on and oversees the plans of the battalions or squadrons for preventing and managing stress and battle fatigue casualties. Coordinates technical supervision of enlisted mental health personnel in the medical company by mental health officers of other commands.

2-23. The Division

a. The division is the basic unit of maneuver at the tactical level and performs major tactical operations for the corps. The division is a fixed,

combined arms organization capable of performing a tactical mission and is largely self-sustaining. The division can conduct large-scale ground combat operations because it contains combat, CS, and CSS units capable of sustaining it.

b. The mission of the division is twofold:

- To destroy enemy military forces.
- To control land areas including populations and resources. Each type of division has its own unique capabilities and limitations.

2-24. Types of Divisions

Army divisions are classified as either heavy or light. Division subcategories are heavy (armored and mechanized infantry) and light (airborne, infantry, light infantry, and air assault). (See FM 71-100 for further discussion on these divisions.)

2-25. Major Commands in the Division

The division has six major subordinate commands: three combat brigades, an aviation brigade, a division artillery, and a division support command (DISCOM).

2-26. The Division Base

The US Army division has a fixed nucleus called the division base. It consists of the command and control, combat, CS, and CSS units necessary to support the maneuver elements of the division. Various combinations of maneuver (combat) battalions are attached to the division base.

2-27. The Combat Support Elements of a Division

The CS elements of a division are the division artillery, an air defense artillery battalion, an engineer battalion, a signal battalion, an aviation brigade, a military intelligence battalion, a military police company, an NBC defense company, and a division band.

2-28. Combat Element of the Division Base

The combat element of the division base consists of a cavalry squadron and an attack helicopter battalion in heavy divisions and a reconnaissance squadron in the light divisions.

2-29. Division Surgeon

The division surgeon is a special staff officer of the division commander. He normally functions under the general staff supervision of the division's G1. (In the light division, the commander of the medical battalion also functions as the division surgeon and is the medical staff officer of the D ISCOM.) His duties as division surgeon generally are administrative. The division commander normally charges him with responsibility for staff supervision to include technical supervision of all HSS activities in the command. He has direct access to the division commander and staff on HSS matters. As a special staff officer, he advises the division commander on all medical matters. In conjunction with the division medical operations center (DMOC) in the heavy division or the medical battalion intelligence officer (S2)/operations and training officer (S3) in the light division, the surgeon also–

- Prepares the HSS annex to the division SOP and the division HSS plan.
- Provides plans and current information pertaining to the medical situation and combat operations to the Echelon III medical units operating within the division area.
- Informs the G2 of medical information or intelligence requirements. Also assists in the examination and processing of captured medical supplies. (See FM 8-10-8 for a complete discussion on medical intelligence.)
- Plans and coordinates the following HSS operations:
  - Treatment and patient evacuation.
  - Dental services.
  - Preventive medicine services.
  - Combat stress control and mental health services, assisted by the division mental health section.
  - Medical laboratory services.

- Blood services.
- Optical support.
- Medical supply and medical maintenance support.
- Medical personnel assignments.
- Medical reporting.
- Collection and analysis of operational data.
- Submits to higher headquarters those recommendations on technical problems which require research and development.
- Plans for and requests Echelon III HSS assets and support of division operations.

2-30. Division Support Command of the Heavy or the Light Division

To achieve and maintain readiness, division commanders need the right supplies, equipment, and personnel at the right place, at the right time, and in the right quantity. The DISCOM is responsible for monitoring this readiness and ensuring that the force is manned, armed, fueled, fixed, and transported. The DISCOM is organized to provide logistics, Echelons I and II HSS, maintenance, and administrative services to all organic and attached elements in the division area.

a. The DISCOM of the heavy division includes the HHC and the division materiel management center (DMMC), an aviation intermediate maintenance (AVIM) company, three forward support battalions (FSBs), and a main support battalion (MSB).

b. The DISCOM of the light division includes an HHC, a maintenance battalion, a supply and transport (S&T) battalion, a medical battalion, and an AVIM company (battalion for the air assault division).

c. The organization of the DISCOM headquarters is structurally the same for all divisions. Each DISCOM uses a functional-type staff including an executive officer; a chief, division medical operations officer (heavy division); a personnel staff officer; a security, plans, and operations officer; and a command logistics officer. The DISCOM commander is also assisted by a chemical staff officer, a communications-electronics officer, an automatic data processing officer, an ammunition officer, a chaplain, a movement control officer, and three forward area support coordinators FASCOs) in the light division. The medical battalion commander, as the division surgeon in the light division, is a staff officer of the DISCOM.

2-31. The Division Medical Operations Center (Heavy Division)

The DMOC staff is responsible to the DISCOM commander for staff supervision of HSS within the DISCOM. The division surgeon exercises technical control of all medical activities within the division. The DMOC coordinates HSS according to technical parameters established by the division surgeon. All HSS issues and requirements are coordinated with the DISCOM units, division staff, and division surgeon prior to committing any HSS resources. The DMOC staff assists the division surgeon in planning and accomplishing division HSS operations. The DMOC consists of a medical operations branch, medical materiel management branch, a patient disposition and reports branch, and a medical communication branch. (See FM 8-10-3.) The DMOC staff–

- Plans and ensures that Echelons I and II HSS for the division is provided.
- Plans and monitors HSS operations of DISCOM organic medical assets and attached corps assets to include reinforcement and reconstitution.
- Monitors medical training and provides information to division surgeon.
- Monitors health service logistics and logistical aspects of blood management for the division.
- Monitors and recommends medical personnel assignments and replacements in coordination with the division surgeon and the DISCOM S1.

- Plans, coordinates, and directs patient evacuation from Echelon I MTFs to Echelon III MTFs through the medical brigade or group medical regulating office.

- Plans, monitors, and allocates preventive medicine resources and programs in coordination with the division surgeon.

- Plans, monitors, and coordinates the division mental health/combat stress resources and programs in coordination with the division surgeon and the division psychiatrist/mental health section.

- Monitors medical equipment maintenance programs for the division.

- Monitors medical threat, coordinates health service intelligence requirements, and facilitates functional integration between health service support and military intelligence staff elements within the division in support of intelligence preparation of the battlefield. (See FM 8-10-8 for a complete discussion on this subject.)

- Coordinates HSS planning in rear operations.

- Monitors reporting aspects of HSS.

- Ensures that division SOPs, plans, policies, and procedures for HSS are prepared and executed.

- Coordinates for guards in the movement of EPW casualties.

- Coordinates the identification, exploitation, and disposition of captured medical material with appropriate staff elements. (See FM 8-10-8, FM 34-54, and 101-5 for discussions on this subject.)

- In coordination with the DISCOM S3, prioritizes the reallocation of organic and corps medical augmentation assets to the division as required by the tactical situation.

- Monitors blood product management.

- Integrates intelligence into Echelon II HSS operations planning and execution.

2-32. The Division Support Command Surgeon

The DISCOM surgeon assigned to the DMOC provides medical staff advice to the DISCOM commander, the DISCOM adjutant (S1), and the chief, DMOC. This individual provides technical medical advice to the Echelon II medical assets within the DISCOM and maintains and manages priorities throughout the DISCOM.

2-33. Communications in the Division Medical Operations Center

To facilitate prompt patient management and evacuation, all divisional medical elements are in contact by radio. This radio net includes the medical operations center, the DI SCOM S3, the respective medical companies, the division surgeon, and the corps senior medical headquarters. Patients requiring evacuation out of the division are reported to the corps medical group or brigade through the DMOC. The DMOC–

- Continuously monitors evacuation requests from medical companies and other elements throughout the division.

- Determines resource allocations.

- Provides coordination when necessary or requested.

2-34. Command and Control of the Medical Company (Heavy Division)

A medical company is assigned to each FSB and the MSB of the heavy division. These companies are under the command and control of the respective battalion commander.

2-35. The Forward Area Support Coordinators (Light Division)

a. Each of the three FASCOs in the light infantry division is assigned to coordinate support to an infantry brigade. The FASCOs operate in the brigade support area, and they report to the DISCOM commander. Their primary responsibility is to ensure that forward area support team (FAST) elements provide the required support to the

infantry brigade. The FASCOs coordinate support missions between the brigades and other units operating in the brigade support area and the supporting DISCOM elements. A FAST usually includes the forward area support coordination office, a forward supply company of the S&T battalion, a forward maintenance company of the maintenance battalion, a forward support medical company (FSMC) of the medical battalion, and a unit maintenance team from the headquarters and light maintenance company. It may also include support elements from corps.

b. As he does with other FAST elements, the FASCO coordinates with the brigade S3/supply officer (S4) to ensure geographical space for elements of the FSMC and oversees the movement and security of the company. In addition, the FASCO keeps the medical company commander informed of the tactical plans of the brigade to enable the commander to plan for support on the basis of projected requirements.

2-36. Medical Battalion (Light Division)

a. The medical battalion is under the overall command and control of the DISCOM commander. The medical battalion commander also functions as the division surgeon and is also the primary medical staff officer for the DISCOM. The battalion S2/S3 section assumes the planning and operations functions that have traditionally been associated with the division surgeon's section. The medical battalion commander, his staff, and subordinate medical commanders employ direct channels of communications on technical matters.

b. The medical battalion is organized to provide Echelon II HSS for the entire division. The battalion also provides Echelon I HSS on an area basis for assigned and attached units operating within the division's area of operations. The medical battalion is modular in design and consists of a headquarters and support company (HSC) and three forward medical companies.

NOTE

The HSC has the same capabilities as the medical company, MSB, and the forward medical company has the same capabilities as the medical company, FSB, in the heavy division.

c. The support company, medical battalion, DISCOM, airborne division, contains two surgical squads which are not found in other light forces.

d. The medical battalion, air assault division, also provides the following capabilities:

- Air crash rescue.
- Patient evacuation by organic AE helicopters.
- Supplemental patient evacuation by ground transportation. These capabilities are required because of the air assault division's–
  - Use of organic rotary-wing aircraft.
  - Requirement for the medical support element to be capable of flexible employment and quick response to unpredictable situations.

2-37. Command and Control of the Medical Company (Light Division)

The medical companies are assigned to the medical battalion. They are under the command and control of the battalion commander.

2-38. Communications in the Light Division

The commander, medical battalion, has the capability to communicate by amplitude modulated (AM)/frequency modulated (FM) voice and data link communications, together with automatic data processing, to the maximum extent available. All of these systems assist in the effective control of medical units, patient evacuation, and medical regulating. He communicates with the DISCOM S3, the respective medical companies, and the corps senior medical headquarters. Patients being evacuated out of the division are reported to the medical group or brigade through the commander, medical battalion. He is continually advised as to the corps hospital of choice by the medical group or the medical brigade medical regulating officer. The commander, medical

battalion, then relays information to the medical companies. Medical platoons of the maneuver elements coordinate evacuation directly with the FSMCs. The division surgeon monitors evacuation requests, establishes priorities, determines resource allocations, and provides coordination when necessary or required.

2-39. Division Artillery Surgeon

The medical officer in the division artillery (D IVARTY) headquarters is the surgeon for his unit. His duties are similar to those described for the brigade surgeon. The DIVARTY surgeon operates the battalion aid station (BAS) within HHC, DIVARTY.

2-40. Staff Flight Surgeon

The medical officer in the combat aviation brigade is the flight surgeon for his unit. His duties are similar to those of the brigade surgeon. In addition, the aviation brigade medical officer is trained in aviation medicine. The flight surgeon of the combat aviation brigade serves as special staff officer to the division surgeon for aviation medicine planning and programs.

2-41. Brigade Surgeon

Each brigade has a medical officer who is dual-hatted as the brigade surgeon and commander of the FSMC, FSB (heavy division), or commander of a forward medical company of the medical battalion (light division). The staff role is subordinate to the command role. The brigade surgeon exercises staff supervision and technical control over the medical elements of the command. He serves under the general staff supervision of the brigade executive officer. The brigade surgeon's primary responsibility is to ensure that adequate HSS is available to the brigade. He provides the brigade commander with information regarding the HSS aspects of combat effectiveness within the brigade and performs staff functions similar to those of the division surgeon. He is responsible for supervising the professional activities of the battalion surgeons who function in the medical platoons of the combat battalions attached to his brigade. The brigade surgeon–

- Ensures the implementation of the division HSS SOP.
- Recommends the allocation of HSS resources within the brigade.
- Supervises technical training of medical personnel and the combat lifesaver programs in the brigade area.
- Determines procedures, techniques, and limitations in the conduct of routine patient care, emergency medical treatment, and ATM.
- Monitors requests for AE from supported units.
- Ensures implementation of automated medical systems.
- Informs the division surgeon and chief, DMOC, on the brigade's HSS situation.
- Monitors the health of the command and advises the commander on measures to counter the medical threat.
- Assumes operational control of augmentation medical units when directed.
- Exercises technical supervision of subordinate battalion surgeons.
- Advises PAs of artillery and engineer battalions as required.
- Assumes technical supervision of PAs organic to subordinate units in the absence of their assigned physician.

2-42. Battalion and Squadron Surgeons

The duties of the battalion and squadron surgeons are similar to those of the brigade and regimental surgeons. The medical officer is also the battalion/squadron medical platoon leader. (The staff role is subordinate to the command role.)

2-43. Medical Platoon Leader

The platoon leader of the medical platoon in the combat battalions and certain CS battalions serves in the dual capacity of medical platoon leader and medical adviser to the battalion commander. (See FM 8-10-4 for a complete discussion.) In the absence of a Medical Corps officer, a Medical Service Corps lieutenant serves as the medical platoon leader. The responsibilities and functions of the battalion medical platoon leader include–

- Providing input to operations orders, administrative/logistics orders, overlays, and SOPs.
- Assisting the S3 in planning and supervising individual and unit training of the battalion medical platoon or section.
- Providing the battalion commander and staff with current data on the health of the command.
- Supervising the administration, maintenance, discipline, organization, training, and employment of the platoon or section.
- Regulating patient evacuation from combat/CS companies/batteries/troops to the aid station.
- Providing technical guidance for medical training of the nonmedical personnel within the battalion.

2-44. Physician Assistant

The PA is a highly skilled individual who is not a physician, but who by experience and formal training has become well qualified to perform certain patient treatment procedures formerly undertaken only by a physician. He is either assigned to the medical platoon of a combat battalion or squadron, where he functions as the treatment team leader under the command and administrative supervision of the medical platoon leader, or he is assigned to the medical section of a CS battalion as section leader. In either case, his technical treatment duties are supervised by the first Medical Corps officer in his chain of command. Under the direction of the medical platoon leader and the technical supervision of the brigade surgeon, the PA is responsible for–

- Conducting and supervising training of battalion nonmedical personnel in first aid, field sanitation, personal hygiene, patient evacuation procedures, and medical aspects of injury (accident) prevention.
- Arranging for the conduct of the battalion preventive psychiatry (combat stress control) program, with technical assistance from the division psychiatrist, to include training of battalion troop leaders in methods of preventing battle fatigue, substance abuse, and psychiatric disorders, especially combat exhaustion.
- Establishing and operating an aid station/treatment squad.
- Treating, within his medical capabilities and limitations, those patients reporting on sick call. Patients who require additional treatment beyond the capability of the PAs are referred to the medical company (division treatment station). He will advise the platoon leader as to whether a patient should be treated and returned to duty or stabilized and evacuated.
- Providing emergency medical treatment to wounded and injured personnel, to include–
  - Establishing and maintaining an airway.
  - Controlling bleeding.
  - Preventing and treating shock.
  - Protecting wounds.
  - Immobilizing fractures.
  - Other emergency measures, as indicated.

2-45. Cellular Teams, TOE 08-600 Edition

a. The mission of AMEDD cellular units or teams is to–

- Perform HSS functions where units of less than company size are required.

- Increase the capabilities of fixed-strength units where increments of less than company size are needed.

b. Cellular units or teams may be attached or assigned, as required, to fixed-strength units or may be organized into HSS composite units to perform HSS functions under varying conditions.

c. The capabilities of units organized under the TOE 08-600 edition vary with the size and grouping of the teams used. Teams are organized to provide command and control; medical supply; ambulance support; preventive medicine; veterinary service; and medical, surgical, dental, and blood services. Unless specifically provided for in the basic organization, these teams must be furnished food service, administration, and motor maintenance support.

d. A brief description of some of the cellular teams in the TOE 08-600 edition are discussed in subsequent paragraphs and in specific functional area chapters throughout this manual.

2-46. Medical Command, Control, and Staff Section Teams, TOE 08-600H0

a. Team AC, company headquarters, commands and controls two or more medical detachments or equivalent not to exceed 150 individuals. This unit is more often allocated to a corps medical brigade/group or task force than to a TA MEDCOM. Basis of allocation is one per two or more medical detachments not otherwise provided command and control.

b. Team AE, headquarters, receiving center, provides administrative support and control of nondivisional medical units withdrawn for reorganization or those arriving from the zone of interior and awaiting assignment to sites where the mission of the unit will be performed. This unit normally requires the attachment of postal, finance, adjutant general, engineer, military police, supply, and maintenance elements for performance of those functions.

c. Team AJ, headquarters, blood bank service, provides command and control for blood bank service teams. It is allocated to TA MEDCOM on the basis of one per 10 blood bank service teams.

d. Team AM, headquarters, preventive medicine service, provides command and control for two or more preventive medicine detachments, TOE 08-620. It also provides consultants in epidemiology, preventive medicine, entomology, and preventive medicine aspects of veterinary medicine.

2-47. Special Operations

a. Special operations are military operations conducted by forces of the Department of Defense (DOD) in pursuit of US national objectives. These forces are specially trained, equipped, and organized to accomplish strategic, operational, and tactical missions.

b. Special operations may be conducted during periods of peace or hostility. They may support conventional operations, or they may be prosecuted independently when the use of conventional forces is either infeasible or inappropriate.

2-48. Special Operations Forces Within the Department of the Army

The following are the five component elements of Special Operations Forces within the Department of the Army :

- Special Forces.
- Rangers.
- Psychological operations.
- Civil affairs.
- Special operations aviation.

2-49. Command and Control of Special Operations Forces

a. Special Operations Forces (SOF) are theater-level assets. Operational- and tactical-level commanders request SOF through the unified commander. An SOF command and control element is established at any headquarters, combined or US, employing SOF. This ensures that unique mission requirements and employment procedures are met.

b. The CINC directs theater special operations and the employment of SOF through his subordinate special operations command (SOC). The theater SOC is a joint command that controls Army, Navy, and Air Force SOF. As strategic assets, SOF elements are deployed to the theater of operations and placed under SOC operational control.

c. Special Operations Forces units do not have an organic combined arms capability and are not designed for sustained combat operations. These units require the support or attachment of other combat, CS, and CSS assets. The SOF units are entirely dependent upon the resources of the TA to support and sustain their operations.

2-50. Health Service Support Capability of Special Operations Forces Units

The organic HSS capability of SOF units is extremely austere. Consequently, SOF are dependent upon the conventional HSS structure for HSS in theater. Special Operations Forces missions require organic assets to perform Echelon I (Level I) and Echelon II (Level II) medical care. Echelon III (Level III) and Echelon IV (Level IV) medical care must be provided to the force.

a. Special Forces.

(1) The Special Forces group is a unique combat arms organization capable of planning, conducting, and supporting special operations activities in all operational environments and across the strategic continuum. Special Forces units are characterized by the quality, motivation, training, and individual skill of their members.

(a) The Special Forces group consists of a group HHC, a group support company, and three Special Forces battalions. The group can operate as a single unit, but normally the battalions plan and conduct operations from widely separated locations.

(b) The Special Forces company consists of a company headquarters ("B" detachment) and six operational detachments ("A" detachments or ODAs). The "A" detachment (twelve-man team) is the basic Special Forces unit and is specifically designed to conduct special operations activities in remote areas and intolerable environments. This unit can operate for extended periods with a minimum of external direction and support. The high-grade structure and experience level of the "A" detachment is required to permit it to develop, organize, equip, train, and advise or direct indigenous military and paramilitary organizations of up to battalion size. For other special operations activities that do not require its full capabilities, the "A" detachment serves as a manpower pool from which Special Forces commanders organize tailored Special Forces teams to execute specific missions.

(2) The Special Forces group has the ability to perform Echelon I and limited Echelon II medical care. Individual care consists of self-aid and buddy aid, combat lifesaver, and aidman (Special Forces medic) care. There are two Special Forces medics assigned each ODA. The Special Forces medic is often the sole source of medical care for his ODA and the indigenous personnel (and their families) with whom his ODA interfaces. Medical assets with the Special Forces group can provide limited support in the following areas:

- Preventive medicine.
- Medical information.
- Veterinary and dental medicine.
- Laboratory support for clinical diagnosis.
- Minor surgery.
- Short-term trauma management.
- Medical resupply.

(3) A flight surgeon and PA are assigned to each Special Forces battalion. At the battalion forward operating base, the flight surgeon and PA can perform ATM procedures and provide limited resuscitative care. However, medical evacuation to the forward operating base is unlikely due to the considerable distances that may separate the ODAs from the forward operating base.

Additionally, the battalion's forward operating base has a preventive medicine noncommissioned officer (NCO) capable of providing medical threat evaluation and limited direct preventive medicine support.

(4) The Special Forces operating base, normally established in the COMMZ, has a flight surgeon, dental officer, veterinary officer, medical operations officer, medical logistics officer, and an environmental science officer assigned. At this level, the medical officers perform primarily as staff advisers to the group commander and provide medical staff assistance to the deployed Special Forces battalions/forward operating bases.

b. Rangers.

(1) The Ranger regiment is a unique light infantry unit capable of planning, conducting, and supporting special operations activities. The Ranger regiment provides the National Command Authority with the capability to deploy a credible military force quickly to any region of the world. The primary Ranger mission in special operations is to conduct direct action operations best accomplished by conventional light infantry forces using special techniques. Ranger direct action operations may support or may be supported by other special operations activities, or they may be conducted independently or in conjunction with conventional military operations.

(2) The Ranger regiment has the capability to perform Echelon I and limited Echelon II care. Echelon III care must be provided to the force. Rangers have organic HSS similar to conventional light infantry battalions; however, they do not have an aid station/treatment squad capability. A general medical officer and PA are assigned to each Ranger battalion. The Ranger companies are assigned Career Management Fields 91A and 91B medics.

c. Psychological Operations.

(1) Psychological operations are planned operations to convey selected information and indicators to foreign audiences to influence their emotions, motives, and objective reasoning. These operations ultimately influence the behavior of foreign governments, organizations, groups, and individuals. Army psychological operations units may be employed by the National Command Authority in pursuit of national security objectives. These psychological operations may be designed to–

- Maintain the support of groups and nations friendly to the United States.
- Gain support and cooperation of neutral countries.
- Strengthen or alter alliances.
- Deter a nation from aggression.
- Induce the surrender of hostile forces.

(2) Psychological operations units have no organic HSS. They are dependent on area HSS from the theater medical command. These units also require timely and accurate information on all public health and host-nation support initiatives to accomplish their mission.

d. Civil Affairs.

(1) The civil affairs foreign internal defense and unconventional warfare battalion is a specialized unit that plans and conducts civil-military operations in support of SOF. This battalion employs specialized, regionally oriented, and language-qualified teams. The teams train, advise, and/or assist US and indigenous forces in the conduct of civil-military operations that support both foreign internal defense and unconventional warfare missions.

(2) Civil affairs units have no organic HSS. They are dependent on area HSS from the theater MEDCOM.

e. Special Operations Aviation.

(1) The special operations aviation regiment is a unique Army aviation unit that provides dedicated combat aviation support to Army and other SOF. This support is provided in all operational environments and across the strategic continuum. Because of current force structure and

contingency requirements, the regiment does not operate as a single unit. Instead, it tailors special operations aviation battalion or company task forces to perform specific missions. The primary mission of special operations aviation assets is to clandestinely penetrate hostile and sensitive airspace to conduct and support special operations activities.

(2) The special operations aviation has a flight surgeon and a psychiatrist assigned at group level. This unit is dependent on area HSS from units it is supporting (typically the Special Forces operating base). It does not have specifically designated medical aircraft with a primary mission of medical evacuation.