CHAPTER 3

THE HEALTH SERVICE SUPPORT CONTINUUM OF CARE

Section I. DEVELOPING THE CONTINUUM

3-1. Single Integrated System

The HSS system is a single integrated system. It begins at the forward line of own troops (FLOT) and ends in the CONUS. This system entails the effective medical regulation of sick, injured, and wounded patients in the shortest possible time to the MTFs that can provide the required treatment. All sick, injured, and wounded patients are regulated and evacuated without regard to lateral or rear boundaries. Health service support involves delineation of support responsibility by geographical area. The effectiveness of the system is measured by its abilit y to return soldiers to duty.

3-2. Medical Assistance to Nonmilitary Personnel

As specified in Army Regulation (AR) 40-3, nonmilitary personnel who accompany combat forces or who function within a theater of operations are authorized both treatment in military MTFs and evacuation. Medical assistance to other civilians is provided within the limits of available health service resources. The civil affairs organizations are responsible for working with and through civilian health agencies. The civil-military operations (CMO) officer, associated civil-military units, and the appropriate command surgeon coordinate required support.

3-3. Transportation for Return-to-Duty Personnel

Under provisions of Geneva Conventions, medical units are prohibited from transporting soldiers discharged from MTFs to their units. The prompt and timely performance of this function by nonmedical units prevents possible adverse impact on the operational effectiveness of MTFs. (See paragraph 3-19a(1)(b).)

3-4. Considerations in Developing Health Service Support

a. A number of considerations affect the organization and operation of HSS in a theater of operations. The organization of the system is prescribed to a great extent by the–

- Tactical and strategic mission.
- Requirements of troop commanders.
- Medical threat.

b. Commanders and HSS planners must know the medical threat. Obtaining the required medical intelligence to know the medical threat assists commanders in developing HSS which is responsive to the unique aspects of a theater of operations. (See FM 8-10-8.)

c. Medical intelligence is that product resulting from the collection, evaluation, analysis, and interpretation of *foreign* medical, bio-technological, and environmental information. It includes intelligence on–

- Endemic and epidemic diseases, public health standards and capabilities, and the quality and availability of health services.
- Medical supplies, medical services, health service facilities, and the number of trained HSS personnel.
- Environmental conditions.
- Foreign animal and plant diseases, especially those diseases transmissible to humans.
- Health problems relating to the use of local food supplies.
- Medical effects of and prophylaxis for chemical and biological agents and radiation.
- The impact of newly developed *foreign* weapons systems as they relate to casualty production.

d. In the normal course of duty, medical personnel at all echelons gain information of medical intelligence value. Such information should be

reported on a timely basis to the supporting intelligence elements according to FM 8-10-8.

e. Requests for medical intelligence and requirements for military intelligence of medical interest should be accomplished through the command's supporting intelligence staff element, or the military intelligence analytical elements. (Some of these elements are the echelons above corps intelligence center (EACIC) and the tactical operations center support element.)

f. There is no medical intelligence or health service intelligence analytical and production capability within the theater. Possible exceptions to this are–

- The NBC and medical intelligence platoon of the military intelligence company (technical intelligence).

- The analyst company, technical intelligence battalion, military intelligence brigade (echelons above corps [EAC]).

However, the primary focus of the above organizations is the exploitation of weapons, equipment, and other materiel found, captured, or acquired within the theater. The focus is not on analyzing combat information and raw intelligence reports to support tactical- and operational-level intelligence preparation of the battlefield and HSS operations planning and execution. Medical intelligence officers and NCOs at medical command, medical brigade, and medical group level will be required to fill this void in the absence of additional health service intelligence analytical resources. A special health service intelligence analytical cell may be established within the theater at MEDCOM, medical brigade, and/or EACIC.

g. Military intelligence staff elements (G2, J2 [Intelligence]) and units maintain current intelligence reference materials which can include medical intelligence data, if requested.

This paragraph implements NATO STANAG 2068

3-5. Organization of Health Service Support System

The Army's HSS system in a theater of operations is organized into unit, division, corps, and EAC levels of care which extend throughout the theater. *Echelon of care* is a term used in NATO STANAG 2068 which can be used interchangeably with the term *level of care.*

a. Each higher echelon of care possesses the same treatment capabilities as those echelons forward of it. Each echelon adds a new increment of treatment capability which distinguishes it from the lower echelons of care. The echelons of care are referred to as Echelons (or Levels) I through IV. Zone of interior (ZI) is Level V.

b. The organization for all aspects of HSS is designed to be flexible. It is influenced principally by–

- The mission.
- The enemy.
- The terrain (and weather).
- The troops.
- The time available.
- Such constraints as the availability of specific types of HSS units, depending on different tactical situations and operational environments.

Although a COMMZ may not be required in the theater, HSS may include CZ and COMMZ units.

c. 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.

Section II. THE ECHELONS OF MEDICAL CARE

3-6. Echelon I (Level I)

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

(1) Immediate lifesaving measures.

(2) Disease and nonbattle injury prevention.

(3) Combat stress control preventive measures.

(4) Casualty 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 stabilize and allow for the evacuation of the patient to the next echelon of care. These measures include: maintain the airway, stop bleeding, prevent shock, protect wounds, immobilize fractures, and other emergency measures, as indicated.

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

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

(1) Immediate far forward 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 assists the combat medic by providing immediate care for injuries. The 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 military occupational specialty (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 headquarters and headquarters company, the headquarters and support company, or the troop of the appropriate combat or CS battalion. (See paragraph 3-12 *a* for an explanation of this phase of care.)

(2) The physician and the PA 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 paragraph 3-12 *b* for an explanation of this phase of care.)

d. Ammunition and individual weapons belonging to patients to be evacuated from the BAS are disposed of as directed by brigade (DIVARTY, 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.

NOTE

Patients entering the HSS system will retain their protective mask.

e. Echelon I HSS is provided by the medical platoons/sections of combat and CS battalions, by divisional medical companies, by corps area support medical companies, and by other corps medical units.

3-7. 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. When these squads are collocated, they form a clearing station capable of holding up to 40 patients.) At this echelon of care, the casualty is examined; his wounds 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 area of responsibility. The area support section normally operates in the brigade support area (BSA), the division support area (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 3-6) and expands services available by adding dental, laboratory, x-ray, and patient holding capabilities. Emergency care, including beginning resuscitation procedures, is continued. (No general anesthesia is available.) 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 24 to 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 (heavy division).
- Medical battalions of DISCOMs (airborne and air assault divisions).
- Nondivisional medical battalions (corps and COMMZ).

3-8. Echelon III (Level III)

a. This echelon of care includes the following:

(1) Evacuating patients from supported units.

(2) Providing care for all categories of casualties in an MTF with the proper staff and equipment.

(3) Providing support on an area basis to units without organic medical units.

b. This echelon of care expands the support provided at Echelon II (division level). Casualties who are unable to tolerate and survive movement over long distances will receive surgical care in a hospital as close to the division rear boundary as the tactical situation will allow. Echelon III characterizes the care that is provided by units such as mobile army surgical hospitals (MASH), combat support hospitals (CSH), and evacuation hospitals. Tactical situations or lack of suitable terrain availability may require that these Echelon III units locate in offshore support facilities, third country support bases, or in the COMMZ. Those whose injuries permit additional transportation without detriment receive surgical care in a hospital farther to the rear. Those patients who are expected to RTD are regulated to an RTD-type facility. (See paragraph 3-12 *d*, *e*, and *f* for an explanation of this phase of care. Also see Chapter 5 for a discussion on hospital units.)

3-9. Echelon IV (Level IV)

This echelon of care includes the following:

a. Treating the casualty in a general hospital (GH) and other COMMZ-level facilities staffed and equipped for general and specialized medical and surgical care. This echelon of care provides further treatment to stabilize those patients requiring evacuation to CONUS. See paragraph 3-12e for an explanation of this phase of care.

b. Providing area HSS to soldiers within the COMMZ.

3-10. Zone of Interior (Level V)

In ZI HSS, the casualty is treated in ZI 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.

3-11. Tailoring Health Service Support to the Battlefield Situation

Health service support is tailored to the constantly changing battlefield situation. In this adjustment process, the methods of employment of medical TOE units must not be confused with their basis of allocation. The staff planners of HSS develop the medical troop list for a theater, using primarily the basis of allocation for the various medical units selected; whereas HSS operators in the various medical command and control headquarters deploy these units on the basis of need which results from shifting patient densities and/or the METT-T. For example, evacuation hospitals are normally allocated to the TA on the basis of two per division. However, the two evacuation hospitals will not always be found in tandem with each division, and the same two evacuation hospitals will not remain associated exclusively with the same division throughout a campaign. An erroneous belief that the basis of allocation controls the methods of employment for a unit could cause misunderstandings between medical unit commanders and supported commanders and could result in noneffective use of a valuable battlefield health care delivery tool. (See FM 8-55 for a discussion on medical force planning.)

Section III. PATIENT CARE, TREATMENT, AND REPORTING

3-12. Phases of Patient Care and Treatment in Health Service Support

a. Combat Medic (Aidman) Care. Combat medic care is the first medical care 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 utilization 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 casualty 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 casualt y'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.)

b. Emergency Medical Treatment. In the emergency medical treatment 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 surgical procedures, if necessary; 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.

c. Initial Resuscitative Treatment. The initial resuscitative treatment phase is distinguished by the application of clinical judgment and skill of a team of physicians and a dentist. This team is supported by a staff, basic laboratory capability, a 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 clearing station's capabilities.

d. Resuscitative Surgery or Care. The resuscitative treatment phase is for patients whose conditions require comprehensive, preoperative diagnostic procedures, intensive preparation for surgery, the presence of qualified surgical teams, the capability to administer general anesthesia, provision for properly equipped operating rooms, and an adequate postoperative intensive-care environment. 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. Performance of such procedures requires no less than the clinical capability described in *c* above; therefore, this phase of treatment is normally provided only in a hospital.

e. 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. 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.

f. Convalescent Care. The convalescent-care phase of HSS entails guiding the patient from the time when it can be said that he has recovered from his injury or disease to the time when it can be determined that he has achieved a state of physical strength and stamina commensurate with the job to which he will be subsequently assigned. This phase involves clinical judgment as to the proper time for the patient to move to successively more intense reconditioning so that he is not challenged beyond the capabilities of his strength.

g. Restorative and Rehabilitative Treatment.

(1) The phases of patient care and treatment have been addressed (*a* through *f,* above) in relation to combat wounds and injuries. The philosophy expressed also applies to patients who suffer illness or nonbattle injuries; however, the manner of providing treatment for disease-related conditions is somewhat different. For relatively minor conditions, virtually all of the phases can be accomplished at the lower operational levels. Deviations in the patient care and treatment phases may take place due to conditions beyond the control of the theater HSS system.

(2) Restorative treatment and rehabilitative treatment are available in the theater of

operations at the station, field, and general hospitals. Further convalescence is available beyond the theater of operations as required. In the Medical Force 2000 structure, the majority of physical therapy staff assets to provide these phases of care will be found in the field hospital and the medical company (holding). Minimal physical therapy staff assets to provide this care will also be found in the CSH and the GH.

3-13. Reporting Aspect of Health Service Support

Individuals entering the HSS system must be accounted for at all times. Prompt reporting of patients and their health status to the next higher headquarters is necessary to track patients for casualty reporting and personnel strength accounting. Correct and timely reports and reporting procedures are also necessary to determine the availability of HSS. However, the reports required must be limited to those absolutely necessary for ensuring HSS provisions in a theater of operations. This minimizes the administrative burden on health service units and the theater communications system. The AR 40 series, FM 8 series, and local command SOPs govern various HSS reports, including command health, patient admissions and disposition, medical summaries, and dental service. The Theater Army Medical Management Information System (TAMMIS) assists in this aspect through the medical patient accounting and reporting (MEDPAR) subsystem. (See Chapter 13 for a discussion on this subsystem.)

Section IV. THE EFFECTS OF THE LAWS OF LAND WARFARE ON HEALTH SERVICE SUPPORT

3-14. The Law of War

a. The conduct of armed hostilities on land is regulated by the law of land warfare. (See DA Pam 27-1 and FM 27-10.) This body of law is inspired by the desire to diminish the evils of war by–

- Protecting both combatants and noncombatants from unnecessary suffering.
- Safeguarding certain fundamental human rights of persons who fall into the hands of the enemy, particularly prisoners of war, the wounded and sick, and civilians.
- Facilitating the restoration of peace.

b. The law of war places limits on the exercise of a belligerent's power in the interest of furthering that desire (diminishing the evils of war), and it requires that belligerents–

- Refrain from employing any kind or degree of violence which is not actually necessary for military purposes.
- Conduct hostilities with regard for the principles of humanity and chivalry.

3-15. Sources of the Law of War

a. The law of war is derived from two principal sources.

(1) Treaties (or conventions) such as the Hague and Geneva Conventions.

(2) Custom–practices which by common consent and long-established uniform adherence have taken on the force of law.

b. Under the Constitution of the United States, treaties constitute part of the "Supreme Law of the Land," and thus must be observed by both military and civilian personnel. The unwritten or customary law of war is also part of the law of the United States. It is binding upon the United States, citizens of the United States, and other persons serving this country.

3-16. The Geneva Conventions

The United States is a Party to numerous conventions and treaties pertinent to warfare on land. Collectively, these treaties are often referred to as the Hague and Geneva Conventions. Whereas the Hague Conventions concern the methods and means

of warfare, the Geneva Conventions concern the victims of war or armed conflict. The Geneva Conventions are four separate international treaties, signed in 1949, and are respectively entitled:

a. "Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field" (GWS).

b. "Geneva Convention for the Amelioration of the Condition of Wounded, Sick, and Shipwrecked Members of Armed Forces at Sea" (GWS Sea).

c. "Geneva Convention Relative to the Treatment of Prisoners of War" (GPW).

d. "*Geneva* Convention Relative to the Protection of Civilian Persons in Time of War" (GC).

The Conventions are very detailed and contain many provisions which are tied directly to the HSS mission.

3-17. Protection of the Sick and Wounded

The essential and dominant idea of the GWS is that the soldier who has been wounded or who is sick, and for that reason is out of the combat in a disabled condition, is from that moment protected. Friend or foe must be tended with the same care. From this principle numerous obligations are imposed upon Parties to a conflict.

a. Protection and Care. Article 12 of the GWS imposes several specific obligations regarding the protection and care of the wounded and sick.

(1) The first paragraph of Article 12, GWS, states: "Members of the armed forces and other persons mentioned in the following Article, who are wounded or sick, shall be respected and protected in all circumstances."

(a) The word "respect" means "to spare, not to attack," and "protect" means "to come to someone's defense, to lend help and support." These words make it unlawful to attack, kill, ill-treat, or in any way harm a fallen and unarmed enemy soldier. At the same time, these words impose an obligation to come to his aid and give him such care as his condition requires.

(b) This obligation is applicable "in all circumstances." The wounded and sick are to be respected just as much when they are with their own army or in no-man's-land as when they have fallen into the hands of the enemy.

(c) Combatants as well as noncombatants are required to respect the wounded. The obligation also applies to civilians, in regard to whom Article 18 specifically states: "The civilian population shall respect these wounded and sick, and in particular abstain from offering them violence."

(d) The GWS does not define what is meant by "wounded or sick," nor has there ever been any definition of the degree of severity of a wound or a sickness entitling the wounded or sick combatant to respect. Any definition would necessarily be restrictive in character and would thereby open the door to misinterpretation and abuse. The meaning of the words "wounded and sick" is thus a matter of common sense and good faith. It is the act of falling or laying down of arms because of a wound or sickness which constitutes the claim to protection. Only the soldier who is himself seeking to kill may be killed.

(e) The benefits afforded the wounded and sick extend not only to members of the armed forces, but to other categories of persons as well, classes of whom are specified in Article 13, GWS. Even though a wounded person is not in one of the categories enumerated in the Article, we still must respect and protect that person. There is a universal principle which says that any wounded or sick person is entitled to respect and humane treatment and the care which his condition requires. Wounded and sick civilians have the benefit of the safeguards of the GC.

(2) The second paragraph of Article 12, GWS, provides that the wounded and sick ". . .shall be treated humanely and cared for by the Party to the conflict in whose power they may be, without any adverse distinction found on sex, race, nationality, religion, political opinions, or other similar criteria. . . ."

(a) All adverse distinctions are prohibited. Nothing can justify a belligerent in making any adverse distinction between wounded or sick who require his attention, whether they be friend or foe. Both are on equal footing in the matter of their claims to protection, respect, and care. The foregoing is not intended to prohibit concessions, particularly with respect to food, clothing, and shelter, which take into account the different national habits and backgrounds of the wounded and sick.

(b) The wounded and sick shall not be made the subjects of biological, scientific, or medical experiments of any kind which are not justified on medical grounds and dictated by a desire to improve their condition.

(c) The wounded and sick shall not willfully be left without medical assistance, nor shall conditions exposing them to contagion or infection be created.

(3) The only reasons which can justify priority in the order of treatment are reasons of medical urgency. This is the only justified exception to the principle of equality of treatment of the wounded.

(4) Paragraph 5 of Article 12, GWS, provides that if we must abandon wounded or sick, we have a *moral* obligation to, "as far as military considerations permit," leave medical supplies and personnel to assist in their care. This provision is in no way bound up with the absolute obligation imposed by paragraph 2 to care for the wounded. A belligerent can never refuse to care for enemy wounded on the pretext that his adversary has abandoned them without medical personnel and equipment.

b. Enemy Wounded and Sick. The protections accorded the wounded and sick apply to friend and foe alike without distinction. Certain provisions of the GWS, however, specifically concern enemy wounded and sick. There are also provisions in the GPW which, because they apply to prisoners of war generally, also apply to enemy wounded or sick.

(1) Article 14 of the G WS states that persons who are wounded and then captured have the status of prisoners of war. However, that wounded soldier is also a person who needs treatment. Therefore, a wounded soldier who falls into the hands of an enemy who is a Party to the GWS and the GPW, such as the United States, will enjoy protection under both Conventions until his recovery. The GWS will take precedence over the GPW where the two overlap.

(2) Article 16 of the GWS requires the recording and forwarding of information regarding enemy wounded, sick, or dead. (See AR 190-8 for disposition of an EPW after hospital care.)

(3) When intelligence indicates that large numbers of EPWs may result from an operation, medical units may require reinforcement to support the anticipated additional EPW patient work load. Procedures for estimating the medical work load involved in the treatment and care of EPW patients are described in FM 8-55.

c. Search for and Collection of Casualties. Article 15 of the GWS imposes a duty on combatants to search for and collect the dead and wounded and sick as soon as circumstances permit. It is left to the tactical commander to judge what is possible, and to decide to commit his medical personnel to this effort. If circumstances permit, an armistice or suspension of fire should be arranged to permit this effort.

d. Assistance of the Civilian Population. Article 18, GWS addresses the civilian population. It allows a belligerent to ask the civilians to collect and care for wounded or sick of whatever nationality. This provision does not relieve the military authorities of their responsibility to give both physical and moral care to the wounded and sick. The GWS also reminds the civilian population that they must respect the wounded and sick, and in particular must not injure them.

e. Enemy Civilian Wounded and Sick. Certain provisions of the GC are relevant to the HSS mission.

(1) Article 16 of the GC provides that enemy civilians who are "wounded and sick, as well as the infirm, and expectant mothers, shall be the object of particular protection and respect." The Article also requires that, "as far as military

considerations allow, each Party to the conflict shall *facilitate* the steps taken to search for the killed and wounded [civilians], to assist. . .other persons exposed to grave danger, and to protect them against pillage and ill-treatment [emphasis added]."

(a) The "protection and respect" to which wounded and sick enemy civilians are entitled is the same as that accorded to wounded and sick enemy military personnel.

(b) While Article 15 of the GWS requires Parties to a conflict to search for and collect the dead and wounded and sick members of the armed forces, Article 16 of the GC states that the Parties must "facilitate the steps taken" in regard to civilians. This recognizes the fact that saving civilians is the responsibility of the civilian authorities rather than of the military. The military is not required to provide injured civilians with medical care in a CZ. However, if we start providing treatment we are bound by the provisions of the GWS. Provisions for treating civilians (enemy or friendly) will be addressed in COMMZ regulations.

(2) In occupied territories, the Occupying Power must accord the inhabitants numerous protections as required by the GC. The provisions relevant to medical care include–

- The requirement to bring in medical supplies for the population if the resources of the occupied territory are inadequate.

- A prohibition on requisitioning medical supplies unless the requirements of the civilian population have been taken into account.

- The responsibility of ensuring and maintaining, with the cooperation of national and local authorities, the medical and hospital establishments and services, public health, and hygiene in the occupied territory.

- The requirement that medical personnel of all categories be allowed to carry out their duties.

- A prohibition on requisitioning civilian hospitals on other than a temporary basis and then only in cases of urgent necessity for the care of military wounded and sick and after suitable arrangements have been made for the civilian patients.

- The requirement to provide adequate medical treatment to detained persons.

- The requirement to provide adequate medical care in internment camps.

3-18. Protection and Identification of Medical Personnel

Article 24 of the GWS provides special protection for "Medical personnel *exclusively engaged* in the search for, or the collection, transport, or treatment of the wounded or sick, or in the prevention of disease, [and] staff *exclusively engaged* in the administration of medical units and establishments. . . [emphasis added]." Article 25 provides limited protection for "Members of the armed forces specially trained for employment, should the need arise, as hospital orderlies, nurses, or auxiliary stretcher-bearers, in the search for or the collection, transport, or treatment of the wounded and sick. . . *if they are carrying out those duties at the time when they come into contact with the enemy or fall into his hands* [emphasis added]."

a. Protection. There are two separate and distinct forms of protection.

(1) The first is protection from intentional attack if medical personnel are identifiable as such by an enemy in a combat environment. Normally this is facilitated by medical personnel wearing an arm band bearing the Distinctive Emblem (a red cross or red crescent on a white background), or by their employment in a medical unit, establishment, or vehicle (including medical aircraft and hospital ships) that displays the Distinctive Emblem. Persons protected by Article 25 may wear an arm band bearing a miniature Distinctive Emblem only while executing medical duties.

(2) The second protection provided by the GWS pertains to medical personnel who fall into the hands of the enemy. Article 24 personnel are entitled to "retained person" status. They are not deemed to be prisoners of war, but otherwise benefit from the protections of the GPW. They are

authorized to carry out medical duties only, and "shall be retained only in so far as the state of health . . . and the number of prisoners of war require." Article 25 personnel are prisoners of war, but shall be employed on their medical duties in so far as the need arises. They may be required to perform other duties or labor, and they may be held until a general repatriation of prisoners of war is accomplished upon the cessation of hostilities.

b. Specific Cases. The AMEDD personnel and non-AMEDD personnel assigned to medical units fall into the category identified in Article 24 provided they meet the *exclusively engaged* criteria of that article. The US Army does not have any personnel who officially fall into the category identified in Article 25. While it is not a violation of the GWS for Article 24 personnel to perform nonmedical duties, it should be understood, however, that Article 24 personnel lose their protected status under that article if they perform duties or tasks inconsistent with their noncombatant role. Should those personnel later take up their medical duties again, a reasonable argument might be made that they cannot regain Article 24 status since they have not been exclusively engaged in medical duties and that such switching of roles might at best cause such personnel to fall under the category identified in Article 25.

(1) While only Article 25 refers to nurses, nurses are Article 24 personnel if they meet the *exclusively engaged* criteria of that article.

(2) The AMEDD officers and NCOs assigned to nonmedical positions in an FSB, MSB, or DISCOM are neither Article 24 nor Article 25 personnel. Such assignments place them in the role of a combatant. Examples of such personnel are–

(a) The AMEDD officers serving as commanders of FSBs or MSBs with responsibility for base or base cluster defense as well as command and control of medical and nonmedical units.

(b) The AMEDD officers and NCOs assigned to nonmedical staff positions with an FSB or MSB with responsibility for planning and supervising the logistics support for a combat maneuver brigade or other combat unit.

(3) Article 24 personnel who might become Article 25 personnel by virtue of their switching roles could include the following:

(a) A medical company commander, a physician, or the executive officer, an MSC officer, detailed as convoy march unit commander with responsibility for medical and nonmedical unit routes of march, convoy control, defense, and repulsing attacks.

(b) Helicopter pilots who are permanently assigned to a dedicated medical aviation unit to fly medical evacuation helicopters, but fly helicopters not bearing the red cross emblems on standard combat missions during other times.

(4) The GWS does not itself prohibit the use of Article 24 personnel in perimeter defense of Nonmedical units such as unit trains logistics areas or base clusters under overall security defense plans, but the policy of the US Army is that Article 24 personnel will not be used for this purpose. Adherence to this policy should avoid any issues regarding their status under the GWS due to a temporary change in their role from noncombatant to combatant. Medical personnel may guard their own unit without any concurrent loss of their protected status.

c. Identification Cards and Arm Bands. Medical personnel who meet the *exclusively engaged* criteria of Article 24, GWS, are entitled to wear an arm band bearing the Distinctive Emblem of the red cross and carry the medical personnel identification card authorized in Article 40, GWS (in the US armed services, Department of Defense (DD) Form 1934), Article 25 personnel and medical personnel serving in positions that do *not* meet the *exclusively engaged* criteria of Article 24 are *not* entitled to carry a standard military identification card or wear the Distinctive Emblem arm band. Such personnel carry a standard military identification card (DD Form 2A) and, under Article 25, may wear an arm band bearing a miniature Distinctive Emblem when executing medical duties. (For a discussion of ID cards, see AR 640-3.)

This paragraph implements STANAGs 2931, 2027, 2060, and QSTAG 248.

3-19. Protection and Identification of Medical Units and Establishments, Buildings and Materiel, and Medical Transports

a. Protection. There are two separate and distinct forms of protection.

(1) The first is protection from intentional attack if medical units, establishments, or transports are identifiable as such by an enemy in a combat environment. Normally, this is facilitated by medical units or establishments flying a white flag with a red cross and by marking buildings and transport vehicles with the red cross emblem.

(a) It follows that if we cannot attack recognizable medical units, establishments, or transports, we should allow them to continue to give treatment to the wounded in their care as long as this is necessary.

(b) All vehicles employed exclusively on medical transport duty are protected on the field of battle. Medical vehicles being used for both military and medical purposes such as moving wounded personnel during an evacuation and carrying retreating belligerents as well are not entitled to protection.

(c) Medical aircraft, like medical transports, are protected from intentional attack, but with a major difference: they are protected only "while flying at heights, times, and on routes specifically agreed upon between the belligerents concerned," Article 36, GWS. Such agreements may be made for each specific case or may be of a general nature, concluded for the duration of hostilities. If there is no agreement, belligerents use medical aircraft at their own risk and peril.

(d) The second paragraph of Article 19 imposes an obligation upon belligerents to "ensure that the said medical establishments and units are, as far as possible, situated in such a manner that attacks against military objectives cannot imperil their safety." Hospitals *should* be sited alone, as far as possible from military objectives. The unintentional bombardment of a medical establishment or unit due to its presence among or in proximity to valid military objectives is not a violation of the GWS. Legal protection is certainly valuable, but it is more valuable still when accompanied by practical safeguards.

(2) The second protection provided by the GWS pertains to medical units, establishments, materiel, and transports which fall into the hands of the enemy.

(a) Captured mobile medical unit materiel is to be used first to treat the patients in the captured unit. If there are no patients in the captured unit, or when those who were there have been moved, the materiel is to be used for the treatment of other wounded and sick persons. (See Chapter 6 for additional information on captured enemy equipment.)

(b) Generally, the buildings, materiel, and stores of fixed medical establishments will continue to be used to treat wounded and sick. However, after provision is made to care for remaining patients, tactical commanders may make other use of them. All distinctive markings must be removed if the buildings are to be used for other than medical purposes.

(c) The materiel and stores of fixed establishments and mobile medical units are not to be intentionally destroyed, even to prevent them from falling into enemy hands. The actual buildings may in certain extreme cases have to be destroyed for tactical reasons.

(d) Medical transports which fall into enemy hands may be used for any purpose once arrangements have been made for the medical care of the wounded and sick they contain. The distinctive markings must be removed if they are to be used for nonmedical purposes.

(e) A medical aircraft is supposed to obey a summons to land for inspection. If it is performing its medical mission, it is supposed to be released to continue its flight. If examination reveals that an act "harmful to the enemy" (that is if the aircraft is carrying munitions, for example) has been committed, it loses the protections of the Convention and may be seized. If a medical aircraft

makes an involuntary landing, all aboard, except the medical personnel, will be prisoners of war. A medical aircraft refusing a summons to land is a fair target.

b. Identification. The GWS contains several provisions regarding the use of the red cross emblem on medical units, establishments, and transports (the identification of medical personnel has been previously discussed).

(1) Article 39 of the GWS reads as follows: "Under the direction of the competent military authority, the emblem shall be displayed on the flags, armlets, and on all equipment employed in the Medical Service."

(a) There is no obligation on a belligerent to mark his units with the emblem. Sometimes a commander (generally no lower than a brigade commander for US forces) may order the camouflage of his medical units in order to conceal the presence or real strength of his forces. The enemy must respect a medical unit if he knows of its presence, even one which is camouflaged or not marked. The absence of a visible red cross emblem, however, coupled with a lack of knowledge on the part of the enemy as to the unit's protected status, may render that unit's protection valueless.

(b) The distinctive emblem is not a red cross alone; it is a red cross on a white background. Should there be some good reason, however, why an object protected by the Convention can only be marked with a red cross without a white background, belligerents may not make the fact that it is so marked a pretext for refusing to respect it.

(c) Some countries use the red crescent on a white background in place of the red cross. This emblem is recognized as an authorized exception under Article 38, GWS. Although not specifically authorized as a symbol in lieu of the red cross, enemies of Israel in past wars have recognized the red Star of David and have afforded it the same respect as the red cross. This showed compliance with the general rule that the wounded and sick must be respected and protected when they are recognized as such, even when not properly marked.

(d) The initial phrase of Article 39 shows that it is the military commander who controls the emblem and can give or withhold permission to use it. He is at all times responsible for the use made of the emblem and must see that it is not improperly used by the troops or by individuals.

(2) Article 42 of the GWS specifically addresses the marking of medical units and establishments.

(a) "The distinctive flag of the Convention shall be hoisted only over such medical units and establishments as are entitled to be respected under the Convention, and only with the consent of the military authorities," paragraph 1, Article 42, GWS. Although the Convention does not define "the distinctive flag of the Convention," what is meant is a white flag with a red cross in its center. Also, the word "flag" must be taken in its broadest sense. Hospitals are often marked by one or several red cross emblems painted on the roof. Finally, the military authority must consent to the use of the flag (see the above comments on Article 39) and must ensure that the flag is used only on buildings entitled to protection.

(b) "In mobile units, as in fixed establishments, [the distinctive flag] may be accompanied by the national flag of the Party to the conflict to which the unit or establishment belongs," paragraph 2, Article 42, GWS. This provision makes it optional to fly the national flag with the red cross flag. It should be noted that on a battlefield, the national flag is a symbol of belligerency and is therefore likely to provoke attack.

(3) In a NATO conflict, NATO STANAG 2931 provides for camouflage of the Geneva emblem on medical facilities where the lack of camouflage might compromise tactical operations. Medical facilities on land, supporting forces of other nations, will display or camouflage the Geneva emblem in accordance with national regulations and procedures. When failure to camouflage would endanger or compromise tactical operations, the camouflage of medical facilities may be ordered by a NATO commander of at least brigade level or equivalent. Such an order is to be temporary and local in nature and countermanded as soon as the circumstances permit. It is not envisaged that fixed, large, medical facilities would be camouflaged. The Standardization Agreement

defines "medical facilities" as "medical units, medical vehicles, and medical aircraft on the ground." (For information on camouflage painting, see AR 750-1.)

NOTE

There is no such thing as a "camouflaged" red cross. When camouflaging a medical unit, either cover up the red cross or take it down. A black cross on an olive drab background is not a symbol recognized under the Geneva Conventions.

(4) Medical evacuation vehicles and medical materiel containers will, unless ordered otherwise, be marked with the Distinctive Emblem (red cross on a white background) and other distinguishing insignia and color markings when required by international STANAGs. (See STANAGs 2027 and 2060 and QSTAG 248.)

3-20. Loss of Protection of Medical Establishments and Units

Medical assets lose their protected status by committing acts "harmful to the enemy," Article 21, GWS. A warning must be given to the offending unit and a reasonable amount of time allowed to cease such activity.

a. Acts Harmful to the Enemy. The phrase "acts harmful to the enemy" is not defined in the Convention, but should be considered to include acts the purpose or effect of which is to harm the enemy by facilitating or impeding military operations. Such harmful acts would include, for example, the use of a hospital as a shelter for able-bodied combatants, as an arms or ammunition dump, or as a military observation post. Another instance would be the deliberate siting of a medical unit in a position where it would impede an enemy attack.

b. Warning and Time Limit. The enemy has to warn the unit to put an end to the harmful acts and must fix a time limit on the conclusion of which he may open fire or attack if the warning has not been complied with. The phrase "in all appropriate cases" recognizes that there might obviously be cases where no time limit could be allowed. A body of troops approaching a hospital and met by heavy fire from every window would return fire without delay.

c. Use of Smoke and Obscurants. The use of smoke and obscurants during medical evacuation operations does not differ from the use of camouflage and does not constitute an act harmful to the enemy.

3-21. Conditions Not Depriving Medical Units and Establishments of Protection

a. Article 22 of the GWS reads as follows: "The following conditions shall not be considered as depriving a medical unit or establishment of the protection guaranteed by Article 19:

"(1) That the personnel of the unit or establishment are armed, and that they use the arms in their own defense, or in that of the wounded and sick in their charge.

"(2) That in the absence of armed orderlies, the unit or establishment is protected by a picket or by sentries or by an escort.

"(3) That small arms and ammunition taken from the wounded and sick and not yet handed to the proper service, are found in the unit or establishment.

"(4) That personnel and materiel of the veterinary service are found in the unit or establishment, without forming an integral part thereof.

"(5) That the humanitarian activities of medical units and establishments or of their personnel extend to the care of civilian wounded or sick."

b. These five conditions are not to be regarded as acts harmful to the enemy. These are particular cases where a medical unit retains its character as such, and its right to immunity, in spite of certain appearances which might have led to the contrary conclusion or, at least, created some doubt.

(1) Defense of medical units and self-defense by medical personnel. A medical unit is granted a privileged status under the laws of war. This status is based on the view that medical personnel are not combatants and that their role in the combat area is exclusively a humanitarian one. In recognition of the necessity of self-defense, however, medical personnel may be armed for their own defense or for the protection of the wounded and sick under their charge. To retain this privileged status, they must refrain from all aggressive action, and may only employ their weapons if attacked in violation of the Convention. They may not employ arms against enemy forces acting in conformity with the law of war and may not use force to prevent the capture of their unit by the enemy (it is, on the other hand, perfectly legitimate for a medical unit to withdraw in the face of the enemy). Medical personnel who use their arms in circumstances not justified by the law of war expose themselves to penalties for violation of the law of war and, provided they have been given due warning to cease such acts, may also forfeit the protection of the medical unit or establishment which they are protecting.

(a) Medical personnel may carry only small arms, such as rifles or pistols or authorized substitutes. Army Regulation 71-13 provides the policy that governs the small arms medical personnel are authorized to carry. Army Regulation 350-41 also supports this policy. It states "AMEDD personnel and non-AMEDD personnel in medical units will not be required to train or qualify with weapons other than individual or small arms weapons. However, AMEDD personnel attending training at NCOES [noncommissioned officer education system] courses will receive weapons instruction that is part of the curriculum. This will ensure that successful completion of the course is not jeopardized by failure to attend the weapons training portion of the curriculum."

(b) The presence of machine guns, grenade launchers, booby traps, hand grenades, light antitank weapons, or mines (regardless of the method by which they are detonated) in or around a medical unit or establishment would seriously jeopardize its entitlement to privileged status under the GWS. The deliberate arming of a medical unit with such items could constitute an act harmful to the enemy and cause the medical unit to lose its protection, regardless of the location of the medical unit. See the previous discussion of loss of protection of medical units and establishments.

(2) *Guarding of medical units.* As a rule, a medical unit is to be guarded by its own personnel. However, it will not lose its protected status if the guard is performed by a number of armed soldiers. The military guard attached to a medical unit may use its weapons, just as armed medical personnel may, to ensure the protection of the unit. But, as in the case of medical personnel, the soldiers may only act in a purely defensive manner, and may not oppose the occupation or control of the unit by an enemy who is respecting the unit's privileged status. The status of such soldiers is that of ordinary members of the armed forces. The mere fact of their presence with a medical unit will shelter them from attack. In case of capture, they will be prisoners of war.

(3) *Arms and ammunition taken from the wounded.* Wounded arriving in a medical unit may still be in possession of small arms and ammunition, which will be taken from them and handed to authorities outside the medical unit. (See paragraph *3-6d.)* Should a unit be captured by the enemy before it is able to get rid of these arms, their presence is not of itself cause for denying the protection to be accorded the medical unit under the GWS.

(4) *Personnel and materiel of the veterinary corps.* The presence of personnel and materiel of the veterinary corps with a medical unit is authorized, even where they do not form an integral part of such unit.

(5) Care of civilian wounded or sick. A medical unit or establishment protected by the GWS may take in civilians as well as military wounded and sick without jeopardizing its privileged status. This clause merely sanctions what is actually done in practice.

3-22. 1977 Protocols to the Geneva Conventions

Amendments to the Geneva Conventions have been ratified by some of our allies and potential

adversaries. The United States representative to the diplomatic conference signed these amendments, but they have not been officially ratified by our government.

Section V. RECONSTITUTION OF UNITS AND PERSONNEL

3-23. Reconstitution

a. Reconstitution is focused action to restore ineffective units to the level of effectiveness required by the mission. Reconstitution may include—

- Reestablishing or reinforcing command and control.
- Cross-leveling or replacing personnel, supplies, and equipment.
- Conducting mission-essential training.
- Reestablishing unit cohesion.

b. Reconstitution—

- May be required for combat, CS, or CSS units and may be required at any level of command.
- Uses organic systems and resources.
- Must be an integral part of the estimate process.

(See FMs 100-5 and 100-10 for discussion on reconstitution in the ALB.)

3-24. Reconstitution Options

Commanders have two options available for reconstituting units: reorganization and regeneration.

a. Reorganization consists of measures such as internal redistribution of equipment and personnel and the formation of composite units. The AMEDD commanders use reorganization to shift resources within an attrited unit to improve its ability to provide HSS.

b. Regeneration consists of incremental or whole-unit generation. Both involve the rebuilding of a unit.

c. Regeneration of entire medical units accomplishes the goal of reconstitution more rapidly. Whole-unit regeneration is the keystone of the modular medical system. The advantage of whole-unit regeneration is that the replacement unit will be able to immediately perform the HSS mission. A possible disadvantage of whole-unit regeneration is that some otherwise usable assets will be evacuated along with the noneffective portions of the replaced unit.

d. Reorganization and regeneration can be used separately or in combination. Their application depends upon current and anticipated situations, as well as resources and time available.

e. 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 to acquire, receive, and sort casualties and to provide emergency medical treatment to personnel in divisions. 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.

f. As stated earlier, Appendixes A through J describe HSS units designed to provide medical care on the battlefield of the future. The modular concept is used in many of these units.

3-25. Health Service Support in Personnel Reconstitution

a. Personnel for reconstitution of units operating forward are partially obtained by maximizing the RTD rate of combat soldiers. Maximizing the RTD of combat soldiers provides a pool of personnel for reconstituting units operating forward.

b. Injuries categorized as minimal during the triage process (see Chapter 14) are treated as soon after injury as possible to rapidly return the soldier to duty. However, under some circumstances there may be a period of time that ambulatory patients will be expected to participate in reorganization activities after receiving first aid and will continue to fight prior to more definitive treatment.

c. Soldiers incapacitated by combat stress will receive immediate treatment as close to their units as possible in a nonhospital military setting. This treatment practice is designed to quickly return the soldiers to duty with their unit and allow medical units to concentrate on patients with life-threatening injuries. To assist in this effort, combat stress control teams are echeloned far forward, perform assessments, and advise commanders on matters relating to combat stress, reaction capabilities, and the "will to fight." These teams deploy to units which are withdrawn from action for reconstitution along with other CSS teams as part of the reconstitution support package. There they assist command in assuring sleep, nutrition, and hygiene. They then foster the reintegration of surviving veteran and new replacements into cohesive units. They treat battle fatigued soldiers in the unit without labeling them as casualties. (See Chapter 12 for a discussion on combat stress control units.)

d. The reassignment of RTD personnel is the responsibility of personnel organizations. Patient treatment and disposition information is provided to lateral personnel organizations to assist in accurate personnel casualty reporting and replacement operations. The replacement companies maintain liaison with medical facilities to arrange for transportation from the MTF to the unit of assignment, to the weapons system replacement operation for crew training on a weapons system, or to a unit being reorganized.

3-26. Commander's Decision

a. Sustained combat, heavy casualties, and massive destruction of equipment will require commanders to *reorganize* (rebuild) or *regenerate* units during operations. When the commander determines that a unit is not sufficiently effective to meet operational requirements, reorganization or regeneration of that unit should begin.

b. The commander's decision to reorganize or regenerate a unit is normally based on the—

- Unit's personnel losses, including MOS shortages or shortages in leadership structure.
- Unit's equipment status including shortages of mission-essential items, low operational ready rates of major items, or lack of maintenance and repair parts.
- Unit's psychological condition including its internal cohesion and the physical and mental condition of its members.
- Impact of reIeasing the unit on the operations of the supported and supporting forces, including the time and resources available to reconstitute it.

c. Based on an analysis of these considerations and any others which may be relevant, the staff determines a unit's level of effectiveness and recommends to the commander measures to correct problems. No single report will provide the commander and staff with the necessary level of detail to determine relative effectiveness. Commanders must determine their unit's capabilities, taking into consideration both objective and subjective effectiveness indicators. Objective indicators include a comparison of personnel and equipment authorizations with on-hand strengths. Subjective indicators include evaluations of the levels of leadership, cohesion, training, and morale.

3-27. Responsibilities in Reconstitution

a. Responsibilities of commanders at all levels include–

- Conducting assessments before, during, and after battle, and conducting necessary planning.
- Establishing reconstitution priorities that are aligned with operational or tactical objectives.

- Determining reconstitution method, location, and unit combat effectiveness goals.

- Developing and executing training programs for units undergoing reconstitution.

b. Responsibilities of surgeons' include–

- Providing recommendations on allocation and redistribution of AMEDD personnel, health service logistics, and HSS units during the reconstitution process.

- Advising commanders about preventive medicine aspects of reconstitution and availability and use of combat stress control teams.

- Advising commanders on the effects of accumulated radiation exposure and possible delayed effects from exposure to chemical or biological agents.

- Advising commanders on disposition of personnel exposed to lethal but not immediately life-threatening doses of radiation or chemical and biological agents.

c. Responsibilities of MTF and medical supply units include–

- Returning a maximum number of personnel to duty.

- Coordinating requirements (on-site support) for health service logistics.

- Assisting the unit being reconstituted in acquiring the necessary medical equipment.

d. Responsibilities of MEDCOM and medical brigades are to ensure appropriate HSS is provided to units being reconstituted in corps and division areas.

Section VI. TRAINING

3-28. Commanders' Responsibilities

a. Training is a key element of success. It is a full-time duty for commanders in peacetime, and it continues in wartime as well. Personnel and units will perform as well or as poorly as they were trained prior to the day of the battle. Forward deployed medical units may have to react on a few hours notice. Other components of the AMEDD may have only days or weeks to make final preparations for supporting combat operations. Commanders must have exceptionally effective plans in concept and execution for those important days or weeks. (See FM 8-55.) They must train their units for the specific missions they anticipate. They must ensure that each person in their unit is prepared and equipped to perform his job in completing the overall HSS mission. Field Manual 25-100 provides the necessary guidelines on how to plan, execute, and assess training at all levels.)

b. Health service support leaders at all echelons of care are responsible for training of subordinates. The requirement to train HSS personnel is discussed in Chapter 2. Chapter 14 also discusses the role HSS personnel play in mass casualty situations and the importance of regularly exercising mass casualty plans.

3-29. Unit Training

Personnel receive important training in their units under conditions that approximate HSS to combat units in a theater of operations. There they can-

- Familiarize themselves with their units.
- Train as individuals.
- Train as members of teams.
- Use actual field medical equipment.