

## CHAPTER 4

**DENTAL SERVICE UNIT OPERATIONS****Section I. INTRODUCTION****4-1. General**

Units of the medical battalion (dental service) conduct dental service operations within the TO on an area support basis. Chapters 4 and 5 focus on these operations. Dental service support is an integral part of HSS, which in turn is part of CSS. As with HSS and CSS, dental service operations are conducted IAW the Army's current doctrine for AirLand Battle.

**4-2. AirLand Battle Doctrine**

The Army's AirLand Battle doctrine described in FM 100-5 outlines how Army forces plan and conduct campaigns, major operations, battles, and engagements in conjunction with other services and allied forces. The AMEDD's FM 8-10 is compatible with that doctrine and provides the basis for the dental commander's operational considerations.

*a. Operational Continuum.* The operational continuum encompasses the variety of conditions and range of threat environments in which the US military traditionally operates. This continuum consists of three general states: peacetime competition, conflict, and war. There may be no precise distinction between where one state ends and another begins. Dental involvement can be expected in all three states. Peacetime competition is generally associated with disaster relief, humanitarian assistance, civic action, and other assistance designed to enhance the stability of the HN. Conflict often involves the employment of contingency forces and the use of irregular forces. War, ranging in intensity, involves the sustained use of armed forces and is the primary focus of this manual. Dental operations in low-intensity conflict (LIC) are covered separately in Chapter 7. Refer to FM 8-42 for additional information on LIC.

*b. AirLand Battle Tenets.* The four tenets of AirLand Battle apply equally to dental operations. As an element of CSS, dental operations must complement the maneuver commander's plan at all levels. It is imperative, therefore, that dental commanders understand the overall operational plan

and remain constantly up to date on the tactical situation.

- *Initiative.* The tactical operation must not be affected by a lapse in dental support when required. Dental units must move rapidly to protect and sustain the maneuver force, thus preserving the initiative of the force.

- *Depth.* The dental service plan should provide service as appropriate throughout the depth and width of the battlefield.

- *Agility.* Dental support should be capable of responding to a rapidly changing tactical situation.

- *Synchronization.* Dental support must complement the HSS plan and the overall tactical plan as part of an overall force unity of effort.

**4-3. Medical Threat**

Threat analysis is a basic step in plan formulation and subsequent execution. Of particular importance to the dental commander is analysis of the medical threat which is the composite of all ongoing or potential enemy actions and environmental conditions that reduce the performance effectiveness of the soldier. Enemy combat operations that disrupt or threaten the survival of dental units area direct threat to dental operations; however, this threat is not considered part of the medical threat.

*a. Elements of the Medical Threat.* Specific elements of the medical threat are—

- Naturally occurring infectious diseases.
- Environmental extremes.
- Battle injuries-kinetic energy and fragmentation antipersonnel ordnance/munitions.
- Biological warfare.

- Chemical warfare.
- Directed-energy (DE) devices.
- Blast-effect weapons.
- Combat stress and continuous operations.
- Flame and incendiary weapons.
- Nuclear warfare.

*b. Dental Oral Health Threat.* The oral health threat results from chronic disease that is endemic in American service members. Acute necrotizing ulcerative gingivitis, acute pericoronitis, and periodontal abscesses are known to exacerbate during periods of fatigue, nutritional deficiencies, psychological stress, and poor oral hygiene. Milder gingival and periodontal disease may also increase in incidence and severity. The chronic nature of dental caries predicts that troops who have deployed initially in an orally fit condition will deteriorate if field oral hygiene is not practiced and if sustaining and maintaining dental care is not provided. Oral and maxillofacial injury from both battle and nonbattle increases in operational settings. All oral infections can advance to life-threatening oropharyngeal fascial space infection or cavernous sinus thrombosis if inappropriately managed.

#### 4-4. Operational Tasks

Operational tasks common to all dental units which must be addressed to ultimately accomplish the dental service mission, regardless of the TO and tactical situation, are—

- Dental service planning.
- Unit movement.
- Provision of dental services.
- Sustainment of unit operations.
- Survival in the battlefield environment.

- Reconstitution and redeployment.

These tasks in themselves do not constitute a mission essential task list (METL), but should be considered in METL development. These general tasks are the basis for the subsequent sections in this chapter.

#### 4-5. Standing Operating Procedure

*a. General.* An SOP is a standing order which lists procedures that are unique to the organization. An SOP will vary from unit to unit based on mission, guidance from higher headquarters, and other variables. It facilitates and expedites operations by—

- Reducing the number, length, and frequency of other types of orders.
- Simplifying the preparation and transmission of other orders.
- Simplifying training.
- Promoting teamwork and understanding.
- Providing a reference source for newcomers.
- Reducing confusion and errors.

Field Manual 101-5 provides general guidance on SOPs. There is no specified format for SOP preparation due to the wide range of command guidance and variable factors. In some cases, however, the format for SOPs may be prescribed by higher headquarters.

*b. Dental Unit Standing Operating Procedures.* Dental units should have both a CSOP and a TSOP. Appendix D is a sample format for a CSOP. Appendix E offers a sample TSOP format.

- Clinical standing operating procedure. The need for each DTF within the unit to develop a CSOP is discussed in Chapter 3.

- Tactical standing operating procedure. The TSOP should cover the entire spectrum of collective unit operations with focus on those matters pertaining to unit movement, sustainment, and survival. Technical matters which pertain to a limited number of specialists should not be included. The basic reference for the development of a unit

TSOP should be the TSOP of the higher headquarters. The TSOP of the medical company and medical detachment should reflect the guidance contained in the TSOP of the parent medical battalion. The TSOP of the medical battalion should reflect the guidance contained in the TSOP of the parent medical group or medical brigade.

## Section II. DENTAL SERVICE PLANNING

### 4-6. General

Dental service planning is accomplished at all echelons of HSS and dental command. Dental commanders plan for the execution of guidance provided by higher-level staff dental surgeons in the overall HSS plan. Field Manuals 8-42, 8-55, and 101-5 provide specific guidance on the planning process and must be ready references at all echelons of dental command and staff.

### 4-7. Planning Process

The planning process is dynamic because plans must be constantly revised in response to changing situations. The planning process outlined in FM 8-55 is applicable to dental service planning and subsequent operations.

*a. Essential Elements.* The essential elements of a plan are—a definite course of action and a method for execution. The plan should be based on facts and valid assumptions and should be simple, flexible, and thoroughly coordinated. A good plan must provide for—

- Mission accomplishment.
- Use of existing resources.
- Necessary organization.
- Personnel and materiel.
- Decentralization.
- Coordination between all echelons.
- Control.

*b. Planning Sequence.* The following planning sequence is common to any operation (for additional information on HSS planning, refer to FM 8-55):

- Forecast to determine probable requirements.
- Study probable requirements and establish priority of further preparation.
- Study implications of requirements to formulate an assumed mission.
- Analyze mission to determine.
- Establish guidance.
- Prepare planning studies.
- Select course(s) of action.
- Prepare complete plans.
- Conduct rehearsals.

### 4-8. Types of Plans and Orders

The two types of plans most likely to be prepared by dental units are the operation plan (OPLAN) and the administrative/logistics plan. Plans, when directed to be executed, become orders. There are two general classes of orders: combat and routine.

*a. Combat Orders.* Combat orders deal with the tactical situation, to include CSS. Combat orders most likely to be used by dental units are the OPORD including movement orders, administrative/logistics orders, SOPs, warning orders, and

fragmentary orders (FRAGOs). Directives and letters of instruction (LOI) can also fall into the category of combat orders. Characteristics of a good combat order include—

- Clarity.
- Completeness.
- Brevity.
- Recognition of subordinate commander's prerogative.
- Use of the affirmative form.
- Avoidance of qualified directives.
- Authoritative expression.
- Timeliness.

*b. Routine Orders.* Routine orders cover normal administration such as permanent orders, courts-martial orders, bulletins, circulars, and memorandums. Field Manual 101-5 provides standard formats for all types of orders.

#### 4-9. Staff Dental Surgeon

The roles of the staff dental surgeon and other dental staff officers are covered in Chapter 2. Primary

responsibilities include developing the overall dental service plan for the command, monitoring dental unit readiness and capability within the command, and providing guidance for planning and execution to dental units subordinate to the command. Field Manual 8-55 provides extensive information on the dental surgeon's role in the planning process. The first step in the process is preparation of the dental estimate of the situation as part of the HSS estimate. Working with the command surgeon, the next step is preparation of the dental portion of the HSS plan. Finally, medical brigade dental surgeons work with the brigade Assistant Chief of Staff for Security, Plans, and Operations to develop the brigade OPLAN/OPORD, which in turn provides guidance to subordinate units for preparation of their plans and orders.

#### 4-10. Formats

Formats for most plans and orders generally follow the examples provided in FMs 8-55 and 101-5 unless specific guidance on format is directed by higher headquarters. Whatever the case, formats should be standardized within the unit as a matter of SOP consistent with the above. Time and situation may dictate expediency and the need for an improvised format. In all cases, however, the basic principles for plan/order preparation should be applied.

### Section III. UNIT MOVEMENTS

#### 4-11. General

The tenets of AirLand Battle doctrine place a premium on the ability of a unit to move on the battlefield. Therefore, dental units must be prepared to move via the entire spectrum of tactical mobility. Dental units deploying from outside the TO require proficiency in all means of strategic conveyance. Unit movements and movement by elements within the unit are complex and require detailed planning and coordination as well as effective training. Procedures for unit movements must be detailed in the unit TSOP and unit movement plans. These procedures are supplemented with a formal movement order for each operation. Movements within the TO can be classified as either tactical or administrative. Only tactical movements are discussed in this chapter.

#### 4-12. Strategic Movements

Strategic mobility may involve movement by air, sea, rail, or administratively overland. Each type of movement requires special skills and training. The unit's field executive officer is generally designated as the unit movement officer and must be school trained and certified along with a number of enlisted assistants. Training should be accomplished prior to deployment. Unit movement personnel supervise the loading of the unit's vehicles and equipment as directed by the loadmaster of the particular conveyance. Strategic movements by dental units are usually a part of a larger effort by the parent units and will be primarily directed by those headquarters. Nevertheless, dental units should prepare individual movement plans and orders consistent with the guidance provided by the higher headquarters.

#### 4-13. Movements Within the Theater

AirLand Battle doctrine envisions a dynamic battlefield with rapidly changing situations. Dental units, particularly those in the corps, must be able to move in response to the tactical situation. Tactical road march is the most likely means of movement, but units must be trained in other methods based on the situations they are likely to encounter. With limited organic transportation assets, detailed and prioritized load plans are essential to quickly establish dental services upon arrival at the planned destination. Dental units and their subordinate elements may well be expected to conduct airmobile operations using sling-load techniques which may require special training and certification. An increased use of tactical airlift is envisioned as anticipated depth of the battlefield increases. Increased reliance on innovative methods of movement is also foreseen in the future, placing more emphasis on lightweight equipment, well-trained and conditioned soldiers, and flexibility on the part of the commander. The wise commander will train and certify his unit in preparation for all movement options.

#### 4-14. Convoy Operations

The most likely conveyance for dental units will be by organic vehicles. Tactical road marches are demanding operations and require skilled drivers and well-maintained vehicles. Tactical road marches may be conducted over all types of terrain, to include unimproved roads and cross-country. Environmental conditions and enemy threat, particularly NBC and air, are vital considerations.

*a. Movement Orders.* Movement orders are of two basic types: warning orders and movement directives and orders. The warning order serves to alert the unit and provide initial guidance. The movement order or directive details the movement operation and is often built on guidance provided in the overall OPORD. Movement orders vary in detail based on the complexity of the operation and the thoroughness of the movement section of the unit TSOP. Movement orders should reflect the guidance in both the unit movement plans and the TSOP.

*b. Coordination.* Lines of communication within the TO are carefully controlled and units must

receive clearance for convoy operation from the designated authority. If not specified in an overall higher headquarters movement order, commanders will normally arrange convoy clearance and coordinate additional requirements with the movements officer, normally the supply officer (S4) (logistics) or equivalent, of the higher headquarters.

*c. Execution.* Steps to be taken in the execution of convoy operations are dependent on the tactical situation and the nature of the operation. However, certain steps are common to all convoy operations and should be included in the movements section of the unit TSOP. They are as follows:

- Issue warning order.
- Finalize load plans.
- Coordinate support requirements and convoy clearance.
- Conduct reconnaissance.
- Prepare vehicles and equipment.
- Issue movement order.
- Marshal the convoy.
- Brief key personnel and drivers to include safety briefing and issue of strip maps.
- Dispatch advance/quartering party.
- Cross start point.
- Conduct road march.
- Cross release point.
- Occupy operational area.
- Conduct after-operations maintenance.

Refer to FM 55-30 for more detailed information on convoy operations.

*d. Reaction to Enemy Action.* The most likely threat to dental unit convoy operations will come from enemy air or NBC operations, though enemy ground operations cannot be discounted. Reaction to all these threats must be reflected in the unit TSOP. Special attention must be paid to procedures for convoy crossing of an NBC-contaminated area. Chapter 9 addresses this matter.

#### 4-15. Unit Movement Plans

Unit movement plans contain up-to-date logistical data summarizing transportation requirements, priorities, and limiting factors incident to the unit's movement. The contents of the plan may vary depending on the mission of the unit and guidance from higher headquarters. As a minimum, the unit movement plan should contain the following:

- a.* A detailed listing of personal baggage, organizational equipment, and expendable and non-expendable supplies in shipping configuration.
- b.* The organization for movement; the SOP for the movement staff, advance parties, quartering parties, and rear detachments.
- c.* Procedures to be followed at the beginning of the movement, en route, and at the destination.
- d.* Unit loading plans.

#### 4-16. Procedure for Unit Movement

The unit TSOP should include such unit movement details as the composition of march units; duties of the advance party, rear party, and reconnaissance element; control and communication methods; convoy security; march speed; maintenance, accident, refueling, and field feeding procedures; personnel and equipment load of organic vehicles; conduct of periodic rehearsals; reaction to enemy action; and procedures at the destination. The TSOP must be flexible enough to allow accommodation of the current mission yet thorough enough to allow efficient and predictable action.

#### 4-17. Vehicle Load Plans

Unit loading plans include all individually prepared documents which, taken together, present in detail all instructions for the movement of personnel and the loading of equipment. Load plans are prepared for each of the unit's organic vehicles and should be consistent with the sectional organization of the unit to allow flexibility and maintain sectional integrity. They should also be individually configured to expedite setup of the unit's/section's facilities. Load plans are prepared according to the unit TSOP or the commander's guidance. A separate set of load plans should be maintained for air movements involving hazardous cargo. Load plans are the responsibility of the unit movement officer and should be maintained by the unit, the section, and the individual responsible for each vehicle.

### Section IV. PROVISION OF DENTAL SERVICES

#### 4-18. General

The single most important function of dental service units is, of course, to provide dental services. Dental service units orchestrate the employment of organic DTFs within their area of responsibility in a manner which best accomplishes this overall mission. Field dentistry is covered extensively in Chapter 3. This chapter looks at dentistry and associated dental services at an operational level.

#### 4-19. Patient Population

Army medical and dental care is provided to US Army forces deployed in the TO. This care may also be

provided to other US service members, allied forces, US and allied civilians, indigenous populations, and EPWs. Priority of treatment is based on the patient's medical/dental condition, availability of resources, negotiated agreements, and applicable laws and conventions. Army Regulation 40-3 provides guidance on eligibility for care; however, specific guidance should be provided by the appropriate staff dental surgeon in the HSS plan or medical brigade OPORD.

*a. Geneva Conventions Provision for Prisoners of War.* The Geneva Conventions require provision of health care to friend and foe alike without distinction. Therefore, dental units may be charged with the mission of providing emergency dental

treatment to EPWs. Refer to FM 8-10 for additional information.

*b. Humanitarian Assistance and Civic Action.* Dental civic action operations are generally associated with “nation assistance” and other aspects of LIC which are covered extensively in Chapter 7. However, there will be times in more conventional conflict when dental civic action operations may be called for, particularly as part of overall post-conflict civil affairs (CA) operations. Field Manual 8-42 provides additional information on these subjects.

#### 4-20. Dental Service Related Missions

Though not pure dental service missions, other potential missions of importance have emerged for dental units, all of which are in support of nondental missions.

*a. Alternate Wartime Roles.* The most important of these adjunctive missions are known as

alternate wartime roles, which deal primarily with the augmentation of medical treatment during mass casualty operations. Chapter 8 addresses alternate wartime roles in detail, both individual and unit level.

*b. Casualty Identification.* Identification of casualty remains is part of the overall mortuary affairs operation undertaken by Quartermaster Corps units. Mortuary affairs operations are not a doctrinal AMEDD function; however, dental personnel and units are uniquely qualified to support such operations when needed in the identification process.

*c. Veterinary Support.* Military animals, particularly extremely valuable working dogs, are used extensively in the TO. Working dogs are subject to dental injuries, particularly fractured teeth. Dental officers may be called upon to assist the veterinary staff in the treatment of these injuries and restoration of the involved teeth.

## Section V. SUSTAINMENT OF DENTAL OPERATIONS

#### 4-21. General

Sustainment of dental operations is a critical aspect of mission accomplishment. The tenets of AirLand Battle place a premium on mobility and flexibility, thus requiring careful attention to logistical concerns to ensure they do not encumber the mission. Sustainment issues generally fall into the category of administration and logistics including—

- Personnel management.
- Health service support.
- Morale and welfare activities.
- Chaplain services.
- Postal services.
- Unit administration.
- All classes of supply, I-X.
- Finance services.

- Legal services.
- Maintenance.

Relative to their size and capability, dental operations consume power, fuel, water, and Class VIII supplies and equipment at a high rate. Careful planning for these and other commodities is a must for sustainment. Chapters 10 and 11 discuss administration and logistics in detail; however, some general considerations for planning purposes are addressed here.

#### 4-22. Sustainment Planning

Sustainment planning must be incorporated in the unit’s operations plans and subsequent orders. Sustainment issues are usually included in a service support annex to the basic plan or order, or may be included in paragraph 4, Service Support, of the basic plan. Sustainment issues should also be addressed in the unit’s TSOP, and for those items that pertain to DTF operation, in appropriate CSOPs.

### 4-23. Support Arrangements

Dental units have varying degrees of sustainment self-sufficiency; however, all depend on other units for some of their support.

*a. Types.* Support arrangements are generally directed in the OPLANs and OPORDs of the higher headquarters. They are generally in the form of attachment specified by the parent unit. Other variations include direct support from the headquarters company of the parent command and control organization, collocation with informal support arrangements, and, less frequently, as part of a consolidation into a composite HSS task force. The last two arrangements are more likely to involve detached elements of the medical company (dental service) and medical detachment (dental service). Another possibility is HN support, generally negotiated through the parent headquarters. Whatever the case, the final support agreement must be carefully negotiated, preferably during reconnaissance and prior to occupation of the site. A continued close relationship with the host unit is a must and should include regularly scheduled meetings and updates. In addition to sustainment issues, survival issues such as collective security must be negotiated with the host unit. Survival issues are discussed in Section VI of this chapter.

*b. Types of Supporting Units.* Health service support units providing medical or dental treatment are the most desirable units for attachment of dental units or their subordinate elements.

- *Medical company (dental service).* The HHD of the medical battalion (dental service) doctrinally collocates with one of its companies and is dependent on it for support. The medical company (dental service) is also a logical unit of attachment for the medical team (prosthodontics). Advantages here are offset to some degree by the dependency of the medical company (dental service) on other units for some of its support.

- *Echelon II medical company.* Forward treatment teams of the medical company (dental service) and medical detachment (dental service) provide treatment modules in direct support or reconstitution of the Echelon II medical company dental assets. Class VIII supply and resupply requirements are requested through the Echelon II medical company.

- *Hospital.* With the exception of the MASH, TOE hospitals offer the best supporting unit option, both in terms of available support and operational unity of effort. Hospitals, as stated in Chapter 3, are excellent sites for provision of maintaining care on an area support basis.

- *Other health service support units.* Other HSS units without a specific patient treatment mission (such as command and control units like the medical brigade and medical group) offer advantages primarily in the area of communications.

## Section VI. SURVIVAL IN THE COMBAT ENVIRONMENT

### 4-24. General

The common and collective task which provides the common bond for all units in the TO, regardless of their mission and function, is survival in the combat environment. The threat to survival is broad-based and affects a unit both individually and collectively. Failure to counter the threat will most surely result in failure to accomplish the mission. The threat can be divided into general categories: the environment itself, enemy action, and the concomitant stresses generated. All of these are countered to a large degree by application of common tasks as listed in the soldier's manuals and collective unit tasks appropriate

for dental units as listed in the unit's mission training plan (MTP).

### 4-25. Medical Threat

The medical threat includes those threats which evolve from the immediate environment and climatic conditions. The medical threat includes such things as climate, altitude, type of terrain, native plants and animals, population, and the types and prevalence of endemic diseases. Field sanitation and preventive medicine are key factors in controlling medical threats. Field sanitation is a task common to every soldier and unit in the Army.

*a. Field Sanitation.* The number of soldiers lost to a unit as a result of disease is directly related to the unit's effort and expertise in the area of field sanitation. All field sanitation issues must be addressed, to include: water quality and purification; solid, liquid, and contaminated waste disposal; pest management; preventive medicine measures; and washing facilities. Field sanitation plays an obviously important role in the DTF's infection control program. Field Manuals 21-10 and 21-10-1 provide guidance on field hygiene and sanitation and establishment of field sanitation teams.

*b. Preventive Medicine.* Preventive medicine is an integral part of HSS and is generally provided by a number of units designed specifically to evaluate and counter the medical threat in the area. As health care providers, dental officers have a part in the preventive medicine effort by constantly evaluating the oral health portion of the medical threat and reporting trends and findings through the chain of command. Likewise, the unit's preventive dentistry program is an important part of the overall preventive medicine program.

*c. Stress Control.* Both the environment and enemy actions produce stresses on the individual soldier and the collective unit which, if not managed properly, can significantly degrade performance. A wide range of factors influence the production of stress, ranging from the so-called "shell-shock" of intense enemy action to the tedium of anxious waiting. The responsibility of the unit in this area is prevention and treatment in minor cases. More advanced cases require evacuation through medical channels to supporting stress control units. Elements of stress prevention include adequate rest and food, a viable command climate, and a strong sense of unity within the organization. Field Manual 26-2 provides specifics on stress management.

*d. Heat and Cold.* Temperature extremes and associated factors of humidity and precipitation influence the well-being of the unit and the accomplishment of patient care operations. Management of climatic extremes is both a command and individual responsibility and is directed toward prevention of associated climate-related injuries. Refer to FMs 21-10, 21-10-1, and 21-11 for additional information on the prevention and treatment of heat and cold injuries.

*e. Safety.* Historically, DNBI's far exceed combat casualties in number and impact on readiness. As always, safety is of paramount concern in the prevention of injury-causing accidents. In an austere field environment with its attendant stresses, safety concerns multiply greatly and must be a matter of the highest command interest. Appendix C provides additional information on safety factors.

*f. Personal Conditioning.* The rigors of modern combat and the austere environment in which it is undertaken require soldiers who are well-conditioned physically, mentally, and spiritually. Personal conditioning must be an integral part of the unit's training program. Refer to FM 21-20 for information on physical fitness training.

#### **4-26. Threat from Enemy or Others**

The threat to dental units covers a broad range of capability including—

- Deliberate attack or collateral damage from attacks upon legitimate targets.
- Direct and indirect ground fires.
- Air attack by fixed- and rotary-wing aircraft and guided missiles.
- Special operations.
- Attacks by illegal combatants (bandits and brigands).

Munitions may include conventional ammunition, incendiary munitions, and NBC. Dental units are an unlikely direct target of enemy action; however, they are still at risk based on their location in relation to more lucrative targets. Dental units are perhaps at greatest risk when moving, particularly along main supply routes (MSRs). Dental personnel are armed only with rifles and pistols intended for self-defense and patient protection. They have limited capability for active defense and must rely on passive defense measures and collective security arrangements.

*a. Nuclear, Biological, Chemical Threat.* Dental operations in an NBC threat area pose problems for unit survival and patient care operations.

Chapter 9 deals specifically with dental operations in an NBC environment.

*b. Conventional Threat.* Dental unit reaction to a conventional threat relies primarily on individual and collective passive security measures such as field fortifications and barriers, as well as vigilance and access to intelligence and warning systems.

*c. Tactical Standing Operating Procedure.* Personnel and collective unit response to enemy action should be addressed in the TSOP and drilled as a matter of course during exercises and actual operations. This does not normally include defense against legitimate capture, but does include evacuation to avoid capture and defense against illegal attack.

This paragraph implements STANAG 2931.

#### **4-27. The Effects of the Laws of Land Warfare on Dental Service Support**

The laws of war have many sources. Most noted among these are the Geneva Conventions. Included in these laws are many provisions which pertain to HSS and thus the dental care system. The Geneva Conventions offer protection to units and personnel involved in the provision of dental services, but with certain obligations. Field Manual 27-10 is a good source of information, and FM 8-10 offers a detailed discussion of the effects of the laws of land warfare on HSS. Only the major applications to dental units are discussed in this section.

*a. Protection of Dental Patients.* Dental patients fall into the category of wounded and sick and are protected under the provisions of the Geneva Conventions. This protection applies to friend and foe alike without distinction, as discussed earlier in this chapter.

*b. Protection and Identification of Dental Personnel.* The Geneva Conventions provide special protection for medical/dental personnel exclusively engaged in the provision of HSS. This includes both protection from intentional attack and the requirement for special handling in the form of “retained person status” in the event of capture.

*c. Protection and Identification of Dental Treatment Facilities.* Dental facilities are also protected from intentional attack. Use of the red cross symbol on facilities highlights the status of the facility; however, it is not mandatory. On the other hand, while use of camouflage or other concealment does not in itself result in loss of protected status, it is less likely that the enemy will be aware of the protected status of the unit. The use of camouflage for dental units, therefore, becomes a tactical decision, generally made by the major tactical commander in the area.

#### **4-28. Rear Area Operations**

Dental units depend on some form of collective security for protection and response to both enemy attack and natural disaster. Dental units will most likely be collocated within a base cluster, preferably of medical units, and may be charged with a portion of the base cluster defense perimeter if the entire cluster is made up of medical units. In the event dental units are collocated within a nonmedical base cluster, Army policy is that medical personnel will not man the perimeter so as to avoid any possible conflict with the protected status of medical/dental personnel given by the Geneva Conventions. The dental unit headquarters should be linked with the BCOC and should closely integrate its defense plan with the overall defense plan for the base cluster. Where habitual relationships exist, rear area operations can be integrated with those of the supporting unit or the higher headquarters as a matter of SOP. The first issue for coordination with a supporting unit by detached dental elements should be that element’s role, if any, in the collective security plan. Given their limited firepower, a more efficient use of dental units in rear area operations may be to augment the MTF in the event of an illegal attack.

## Section VII. RECOVERY PHASE OF DENTAL OPERATIONS

### 4-29. General

Upon mission completion, dental units must be able to rapidly recover and redeploy from the TO, or continue support of the overall mission. There are four major areas to be considered in the recovery phase of operations: recovery, reconstitution, redeployment, and documentation. Traditionally, the recovery phase of operations has not received the same degree of emphasis as other operational tasks; however, the need for rapid reaction and flexibility on the modern battlefield demands otherwise. Upon completion of any operation, there is a natural tendency for letdown and corresponding drop in the sense of urgency perceived by the soldiers of the unit. Successful recovery presents the greatest challenge to the commander's ability and is a major test of the unit's level of discipline. Those tasks associated with recovery must be clearly delineated in the TSOP and trained on a regular basis.

### 4-30. After-Action Recovery

Recovery is necessary after each phase of operation, not just at mission completion. The dental officer and his assistant conduct recovery operations at the completion of each patient treatment and also upon conclusion of daily business. They are also appropriate upon completion of convoy operations. Postoperation recovery requires a number of tasks appropriate to the particular mission. The following are some of the major areas of consideration.

*a. Maintenance.* Maintenance must be performed on all items of equipment IAW the appropriate service manuals. Those items which require refueling or replenishment (to include fluid x-ray developers) must be topped off in readiness for the next day's operations or drained in preparation for movement and storage.

*b. Supply.* Consumable supplies must be restocked in individual sets and requisition for replacement stocks placed IAW the TSOP. Unserviceable or destroyed durable items must be reordered.

*c. Personnel.* Personnel needs are often overlooked in recovery operations; however, they are of equal importance to other aspects to ensure that the soldier, too, is ready to continue the mission.

*d. Unit Defenses.* Unit defenses such as barriers and fortifications must be checked, repaired, and upgraded. Defense equipment, such as chemical alarms and detectors and individual masks, must be cleaned, treated, and repaired if necessary. Weapons must be cleaned and serviced.

*e. Calibration.* Equipment requiring calibration should be checked and submitted for calibration as required.

### 4-31. Redeployment

Redeployment applies at the tactical, operational, and strategic levels. Redeployment is fairly self-explanatory and does not need further elaboration. It is important to note; however, that redeployment does not signal termination of the cycle of operational tasks. Rather, it signals the start of a new cycle as the commander initiates planning for the next operation.

### 4-32. Reconstitution

Reconstitution is the basis for the modular concept, which allows manipulation of like modules throughout the battlefield. In the case of dental units, the modules consist of the dentist and dental assistant, along with the lightweight equipment which is found in Echelon II medical units and the forward treatment sections of the medical company (dental service) and medical detachment (dental service). With respect to all dental units, reconstitution will generally consist of cross-leveling or replacing personnel, supplies, and equipment. The medical battalion (dental service) headquarters, when tasked, will usually task one of its subordinates to reconstitute an Echelon II unit with a forward treatment module. There may be occasions for the medical battalion (dental service) to reconstitute one of its subordinate dental units. Of the two basic options for reconstitution—reorganization and regeneration—internal reorganization within the battalion is most likely.

### 4-33. Documentation

Documentation in the form of an after-action report (AA-R) is an important part of recovery operations. The AAR serves not only as a basis for immediate reconstitution, but also acts as a historical reference and a basis for future planning. An AAR should be accomplished after the termination of each mission and again, in greater detail, upon completion of the overall operation. A much greater emphasis is being

placed on the collection of lessons learned; therefore, their documentation in AARs simplifies response to calls from outside agencies. Format for AARs is often specified in the TSOP of higher headquarters, but should be modified to accommodate dental concerns. When no prescribed format is directed by higher headquarters, dental units should develop their own as a matter of SOP. A sample format, patterned after the Joint After-Action Reporting System (JAARS), is provided in Figure 4-1.

## SAMPLE FORMAT

### AFTER-ACTION REPORT

#### PART I. EXECUTIVE SUMMARY (Completed by mission commander.)

- Mission Objectives
- General Description
- Dates, Locations, and Major Participants
- Significant Issues
- Limitations

#### PART II. LESSONS LEARNED (Listed individually.)

- Observation/Issue
- Discussion
- Lessons Learned
- Recommended Action

#### PART III. ATTACHMENTS

- Chronology of Events (Staff Duty Log, DA Form 1594.)
- OPLAN/OPORD
- Supply Expenditures
- Consolidated Patient Treatment Work Load

*Figure 4-1. Sample format for After-Action Report.*