APPENDIX M

SPECIAL OPERATIONS SUPPORT BATTALION MEDICAL PLATOON

M-1. Mission Capability

The ARSOF medical platoon provides Echelon I (BAS) medical care and limited Echelon II (clearing station) medical care. It also provides—

- Emergency resuscitative surgery (forward surgical element) for those surgical patients who cannot be transported over great distances without first having been stabilized.
- Evacuation of the sick and wounded.
- Limited medical intelligence capability.
- Communications capabilities.

M-2. Organization and Functions

The platoon (Figure M-1) is organized into a headquarters and treatment section, ambulance section, surgical section, recovery and holding section, and a MEDLOG section. The medical platoon, organic to the headquarters and main support company, is employed within the operational area of the SOSB (airborne). It establishes the ARSOF clearing station (with an organic surgical capability) and provides DS to ARSOF elements on an area basis. This modularly designed unit has the capability to split into two elements and operate at separate locations for a limited period of time. The main element (first element) is comprised of the headquarters and treatment team A, the first squad of the ambulance section, the surgical and recovery/holding teams A, and the MEDLOG section. The second element is comprised of treatment team B, second squad of the ambulance section, surgery and recovery/holding teams B, and supply personnel as required. The medical platoon operates under the supervision of the medical platoon leader who is also the regional or area (staff) surgeon. The surgical element must be task-organized for specific missions when it is required to deploy independently from the clearing station operation.

a. Headquarters and Treatment Section. The headquarters and treatment section is comprised of two elements as shown in Table M-1. This element primarily provides for the administrative and clinical treatment aspects of the unit, communications between incoming evacuation assets (both air and ground) and the clearing station, and serves as the triage element for the surgical section. This section has the capability to split and operate at two separate locations. This section is 100 percent mobile.

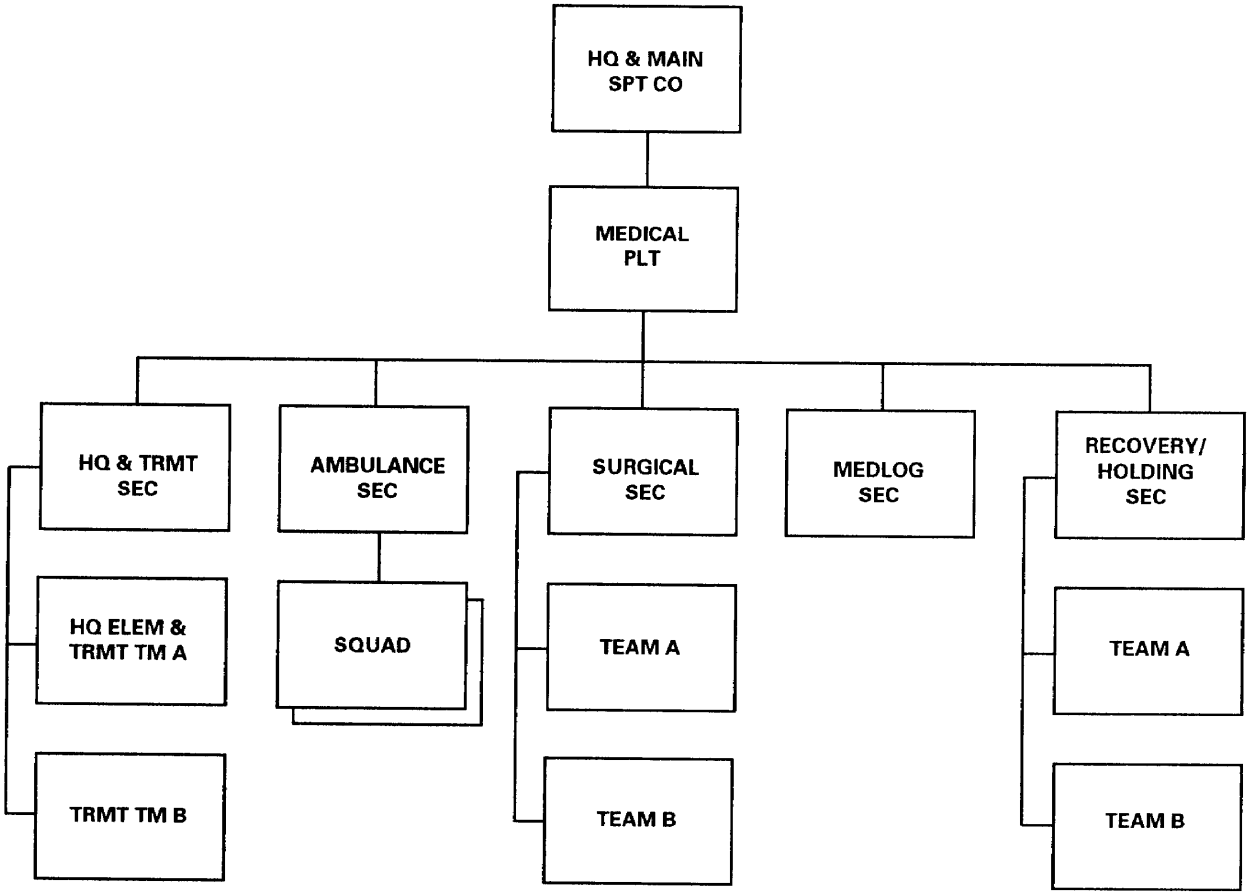

Figure M-1. The special operations support battalion medical platoon.

Table M-1. Typical Organization of the Headquarters and Treatment Section

(Headquarters and Treatment Team A)			
Platoon Leader (Emergency Physician)	MAJ	62A00	MC
Health Services Plans, Operations, Intelligence, and Training Officer/Medical Operations Officer	CPT	67A77	MS
Physician Assistant	CPT	65D00	SP
Special Forces Medical NCO (Platoon Sergeant)	SFC	18D40	NC
Preventive Medicine NCO	SFC	91S4S	NC
Patient Administration Specialist	SPC	71G1P	
(Treatment Team B)			
Field Surgeon (Team Leader)	MAJ	62B00	MC
Physician Assistant	CPT	65D00	SP
Special Forces Medical NCO (EMT)	SSG	18D30	NC
Special Forces Medical NCO (EMT)	SSG	18D30	NC

(1) *Headquarters and treatment team A.* This element along with the first ambulance squad, surgical and recovery/holding teams "A", and the MEDLOG section forms the ARSOF clearing station. Headquarters and treatment team A provides the following:

- Command and control.
- Combat health support operations and planning.
- Triage, ATM, and sick call services.
- Limited emergency dental services.
- Limited Echelon II x-ray and laboratory services.
- Limited PVNTMED services.
- Limited patient accounting, administration, and reporting services.

(2) *Treatment team B.* This second element is part of a total force projection package. Both teams may be deployed into the same theater, then deployed independently or conjointly as the tactical situation dictates. It can also be used to augment ARSOF in a different theater. When deployed separately from team A, it primarily serves as the triage element for surgical team B, This team has the following capabilities:

- Triage, ATM, and sick call services.
- Limited emergency dental services.
- Limited Echelon II x-ray and laboratory services.

b. Ambulance Section. The medical platoon ambulance section (Table M-2) employs two ground ambulance squads (four 2-man ambulance teams). They provide limited ground evacuation to and from the clearing station (with surgical element) and the airhead (or established landing site). These MOS 91B personnel may provide augmentation to the treatment element, if required (such as in a mass casualty situation).

c. Surgical Section. The surgical section is organized as shown in Table M-3. The primary mission of the surgical teams is to provide resuscitative surgery for nontransportable patients to stabilize them for evacuation to an Echelon III facility. The surgical teams receive patients triaged by the treatment teams. This section has the capability to split and operate at two separate locations in tandem with their respective treatment and recovery/holding teams.

Table M-2. Ambulance Squads

(First Squad)			
Aide/Evacuation NCO (Section Chief)	SGT	91B2S	NC
Ambulance Aide/Driver	SPC	91B1S	
Ambulance Aide/Driver	SPC	91B1S	
Ambulance Aide/Driver	PFC	91B1S	
(Second Squad)			
Aide/Evacuation NCO	SGT	91B2S	NC
Ambulance Aide/Driver	SPC	91B1S	
Ambulance Aide/Driver	SPC	91B1S	
Ambulance Aide/Driver	PFC	91B1S	

Table M-3. Surgical Section

(Team A)			
General Surgeon (Section Chief)	MAJ	61J00	MC
General Surgeon	MAJ	61J00	MC
Clinical Nurse Anesthetist	MAJ	66F00	AN
Clinical Nurse Anesthetist	CPT	66F00	AN
Operating Room Nurse	CPT	66E8J	AN
Operating Room Specialist	SGT	91D2P	NC
Operating Room Specialist	SPC	91D1P	
(Team B)			
General Surgeon (Team Leader)	MAJ	61J00	MC
General Surgeon	MAJ	61J00	MC
Clinical Nurse Anesthetist	MAJ	66F00	AN
Clinical Nurse Anesthetist	CPT	66F00	AN
Operating Room Nurse	CPT	66E8J	AN
Operating Room Specialist	SGT	91D2P	NC
Operating Room Specialist	SPC	91D1P	

d. Recovery and Holding Section. The recovery and holding section is organized as shown in Table M-4. The teams provide postoperative ward recovery and holding care for surgical patients. The section deploys 16 recovery beds (8 per team). The recovery/holding teams operate in tandem with their companion surgical teams. The holding capability is evacuation sensitive. Patients may be held as the tactical situation dictates or until such time as they are considered stable enough to tolerate a bed-to-bed transfer. The risk of moving the patient must be weighed against the needs of incoming casualties and the tactical situation. The actual selection of a patient for evacuation is the responsibility of the attending physician.

e. Medical Logistics Section. The MEDLOG section is organized as depicted in Table M-5. This section coordinates for, receives, temporarily stores, and issues Class VIII supplies (to include oxygen, resuscitative fluids, and blood). The section can receive, distribute, and temporarily store up to 2.0 short tons of medical supplies at its base location and up to 0.5 short tons of supplies at another location. It also provides limited medical equipment maintenance support. The MEDLOG section locates and is routinely employed with the headquarters and treatment team A. However, it has the capability to provide two medical logistical personnel to operate a MEDLOG site at a separate location.

Table M-4. Recovery/Holding Section

(Team A)			
Medical-Surgical Nurse (Section Chief)	MAJ	66H8A	AN
Medical-Surgical Nurse	CPT	66H8A	AN
Practical Nurse	SSG	91C3P	NC
Practical Nurse	SSG	91C3P	NC
Practical Nurse	SGT	91C2P	NC
(Team B)			
Medical-Surgical Nurse (Team Leader)	CPT	66H8A	AN
Medical-Surgical Nurse	CPT	66H8A	AN
Practical Nurse	SSG	91C3P	NC
Practical Nurse	SGT	91C2P	NC
Practical Nurse	SGT	91C2P	NC

Table M-5. Medical Logistics Section

Health Service Materiel Officer	CPT	67A78	MS
*Medical Supply Sergeant	SSG	76J3S	NC
Medical Equipment Repair Specialist	SPC	35G1P	
*Medical Supply Specialist	SPC	76J1P	
Medical Supply Specialist	SPC	76J1P	

*May accompany treatment team B, as required.

M-3. Unit Layout and Establishment of Facilities

a. Clearing Station Operations. The SOSB medical platoon can establish the clearing station operation at one location or at two separate locations simultaneously. As with all MTFs, the following should be considered:

- The facility must be laid out in a manner which maximizes patient flow from one element to another within the MTF area. Overlapping internal traffic patterns should be avoided.

- Adequate space must be allocated to accommodate possible augmentation of the treatment or surgical elements.

- Sufficient space must be allocated to allow for ambulance turnaround and easy access to aircraft landing sites.

b. Forward Surgical Element. The forward surgical element (task-organized for a specific mission) can be deployed independently of the clearing station operation for a limited period of time. (The capability of the clearing station operation is effectively reduced while the forward surgical element is independently deployed.) In planning this type of operation, the insertion means is of particular importance. The CHS planner must consider the trade-offs presented either by inserting the element by airborne operations or by airlanding these resources. The greatest mobility and the reduction of damage to sensitive medical equipment is achieved by airlanding the forward surgical element. This is the preferred means of insertion. The weight and cube and the number of airframes required for this method, however, is greater than is necessary for airborne insertion. By airlanding this treatment element, it deploys with its organic vehicles which enable the forward surgical element to displace from the landing zone and establish the MTF where required. The disadvantages of an airborne insertion are the increased damaged to sensitive equipment and the reality that the MTF must be established where it is dropped, as it does not have the organic capability to move its equipment. Therefore, site selection for the drop zone is of particular importance.

M-4. Combat Health Support to Army Special Operations Forces

Combat health support for ARSOF operations is accomplished by unit-level organic CHS assets, the SOSB, and the theater army medical command. A combination of organic, DS, and GS resources are required to effectively accomplish the CHS mission. Further, supported ARSOF elements conduct unconventional warfare (UW), foreign internal defense (FID), counterterrorism, direct action, and special reconnaissance operations across the spectrum of Army Operations. Mission priorities vary from theater to theater. These elements are specifically tailored to organize, equip, train, direct, control, and support indigenous forces. Although each mission is treated separately, they are all interrelated. Some situations will dictate that a committed ARSOF element conduct more than one mission at one time.

a. Special Reconnaissance Missions. These missions are usually conducted deep into hostile territory. Aeromedical evacuation is normally not possible due to the covert nature of the operation and the potential for compromising the mission. The inserted teams must rely on Echelon I care (self-aid / buddy aid, combat lifesaver skills, and the ARSOF medic [MOS 18D]) until the mission is accomplished and the teams are exfiltrated. Prior to the initiation of the mission, the SOSB provides updated medical threat information and appropriate PVNTMED measures and supplies. When teams are exfiltrated, the SOSB medical platoon ensures that the patients are sufficiently stable to be further evacuated to appropriate Echelon III hospitals. Also, the SOSB coordinates for additional conventional CHS resources with the appropriate security clearances, if required.

b. Direct Action Missions. Direct action missions are normally conducted by ARSOF in hostile or denied areas beyond the operational capability of tactical weapons systems and conventional maneuver forces. Direct action operations are usually limited in scope and duration, but may include long-term, stay-behind operations. Conventional CHS for this type of operation focuses

mainly on hospitalization. Organic ARSOF medical resources provide stabilization and evacuation of wounded or injured ARSOF personnel. As these types of operation are conducted in hostile or denied territory, evacuation is accomplished by infiltration/exfiltration platforms. The SOSB may be tasked to provide medical augmentation for infiltration/exfiltration platforms to provide en route medical care to the patients being extracted.

c. Counterterrorism Operations. Combat health support planning for these types of operations includes the tailoring of CHS resources to effectively support the mission. Medical supplies and equipment are kept to an acceptable minimum to support emergencies and routine illnesses. Plans and pre-mission training should focus on EMT and ATM procedures and the treatment of mass casualties. The SOSB provides resupply support to committed ARSOF and ground evacuation support, if feasible.

d. Unconventional Warfare Operations. The objectives of CHS operations in UW are to conserve the guerrilla forces fighting strength and to assist in securing local population support for US and resistance forces operating within the theater. These operations are normally covert or clandestine in nature. Further, often times there are no established MTFs to which the patients can be taken; rather they must be taken with the force, or medical personnel may establish patient-collecting points where the wounded or ill can be left. The UW medical mission is accomplished through training indigenous forces in self-aid/buddy aid and combat lifesaver skills, as well as training resistance medical personnel, providing PVNTMED expertise, providing EMT and ATM to battle casualties, and evacuating patients to friendly areas when possible. Preventive medicine measures must be taught and enforced to reduce the effects of DNBI on resistance forces. The SOSB provides emergency resupply of critical Class VIII supplies; augments committed teams with limited PVNTMED resources; provides a surgical capability for committed teams, when required; and coordinates and/or provides medical evacuation support.

e. Foreign Internal Defense.

(1) Foreign internal defense is not solely an ARSOF mission, rather it is a joint and interagency mission in which ARSOF participates. When US and/or multinational participation is invited by the HN, this mission assists the government which is faced with internal threats to stability and security. The ARSOF role usually includes organizing, training, advising, and assisting HN military and paramilitary forces. Civil-military operations that focus on the relationship between US military forces and the indigenous population are critical for FID operations. Medical services have proven to be one of the most effective ways to gain support for the HN government. Medical assistance programs are requested by the HN government. Programs can include, but not be limited to—

- Providing medical treatment.
- Educating personnel in basic sanitary procedures, hygiene, and other PVNTMED measures.
- Providing sanitary facilities and control of waste disposal.

- Improving the quality of drinking water.
- Conducting immunization programs.

(2) The SOSB medical platoon modular design is ideally suited for providing the required support. Teams can be deployed to target areas to perform training or to provide medical care. The PVNTMED NCO can conduct entomological surveys, develop programs to counter the medical threat, and train indigenous personnel. Additionally, the SOSB can provide limited dental support. The SOSB coordinates for veterinary support, as required.

f. Additional Information. For additional information, refer to FM 8-10-6 and FM 8-42.