

CHAPTER 4

COMMAND AND STAFF RESPONSIBILITIES OF THE BRIGADE SURGEON

Section I. FORWARD SUPPORT MEDICAL COMPANY COMMANDER'S RESPONSIBILITIES AND DUTIES

4-1. Commander's Responsibilities

The FSMC commander plans, directs, and supervises the operations and employment of the company. He is responsible for the training, discipline, billeting, and security of the company. The FSMC commander also serves as the surgeon to the supported ground maneuver brigade.

NOTE

In peacetime, the FSMC is usually commanded by an MS Officer, AOC 67B, Field Medical Assistant. When an MS officer commands the unit, HSS activities involving physician-related areas, such as patient treatment policies/procedures, are referred to a physician.

This section focuses on the major areas pertaining to the duties and responsibilities of the FSMC commander which require his attention and involvement. The commander must have a thorough knowledge of the FSMC organizational structure, capabilities, and mission. He needs to be familiar with each enlisted military occupational speciality code (MOSC) assigned to his unit. Additional information pertaining to the organizational structure, mission, and capabilities of the FSMC is found in the unit's TOE, FM 8-10, and FM 63-20. Additional information pertaining to AOC codes and MOSCs is found in Army Regulation (AR) 611-101 for officers and AR 611-201 for enlisted personnel.

4-2. Unit Readiness

Unit readiness must be a high priority for the FSMC commanders. The FSMC must maintain a high state of readiness at all times and be prepared for deployment on short notice. Elements of the company

must be prepared for rapid, forward deployment to meet HSS requirements of the brigade. The readiness of the FSMC is monitored by higher headquarters through the unit status reporting system and the Command Health Report (see AR 40-5). The battalion headquarters must submit DA Form 2715-R on a monthly basis to its higher headquarters. Medical company commanders are usually not required to complete an official status report. However, many battalion commanders have their subordinate companies prepare this report in order to give the commander an appreciation for the system. The company commander will provide feeder reports for the unit status report to the battalion headquarters in accordance with command SOP. This report is completed IAW AR 220-1. The unit status rating is based on the following data:

- Personnel.
- Equipment on hand.
- Equipment capability/readiness.
- Training.

Training data provided in this report shows the current ability of the unit to perform its wartime mission. The standards against which the unit's training status is to be measured is its mission essential task list (METL). The commander determines the training level based on his knowledge of the proficiency of the unit in accomplishing METL tasks. The unit status report has an overall security classification of *confidential*. No information classified higher than confidential will be entered into this report.

4-3. Training

Training and training management are of major concern to the US Army in its efforts to maintain a highly trained, combat-effective force. Training consumes valuable time and major expenditures of

dollars. Because of time and money issues, it is evident that highly efficient training management is needed to achieve unit training readiness requirements.

a. Battle Focus. The unit's wartime missions are the source from which all training activities are derived. This is referred to as the battle focus. The objective of battle focus is a successful training program achievable by continually narrowing the focus to a reduced number of vital tasks essential to mission accomplishment. This is accomplished through the development of the METL.

b. Mission Essential Task List Development. The commander of each unit in the Army, from corps to company level, must develop a METL for his unit. Prior to developing the company's METL, the company commander obtains a copy of the battalion METL. He should review, then discuss, the battalion METL with the battalion commander or the battalion S3. The company commander then implements the METL development process for his unit. It is important that he involve all of his subordinate leaders in this process. Most importantly, the METL is driven by how the commander envisions battlefield requirements. The commander and unit leaders must actively anticipate worse-case scenarios and think through ideas when developing the company METL. The commander will develop his METL based on—

- Higher command guidance.
- Battle plans.
- The Army Training and Evaluation Program (ARTEP).
- Feedback from subordinates.
- Other sources of information.
 - Mission training plans (MTPs).
 - Capstone mission guidance.
 - Mobilization and deployment plans.
 - Division HSS plan.

The battalion commander is the approving authority for the company METL. After he approves the company METL, it becomes the source document for development of company training plans. The METL should only be changed when the company's mission changes. The company commander should also develop a condition statement and standards list for each METL. Definitive information pertaining to the development of the unit's METL is found in FMs 25-100 and 25-101.

c. The Army Training Management System. The Army Training Management System (ATMS) is a systematic approach used by all Army organizations to schedule, fund, and conduct military training. It is based on fundamental management techniques requiring input from every level of the organization. As with all things in the military, the commander is responsible for the conduct of all training within the command. The battalion commander is responsible for all the training in the battalion and the company commander is responsible for the training conducted in the company. The commander should be familiar with FM 25-4, FM 25-5, FM 25-100, FM 25-101, AR 350-1, and AR 350-41 prior to investing much time in providing training input. The ATMS is structured as a training management process and contains four basic management techniques.

(1) *Plan.* This area includes a review and update of the unit mission, review of the current training program, and determination of training requirements. The trainer must be able to access the training environment, set priorities, and schedule and prepare the training program.

(2) *Resource.* The training manager must be the resource for the training. He must allocate time, funds, supplies, facilities, and equipment. Without resourcing, the probability of success is very low.

(3) *Conduct.* The trainer must conduct the training as planned. Training must inform, challenge, and have value. It must be conducted using the task, condition, and standards specified; it must result in qualitative performance.

(4) *Feedback.* This is the key to a good training program. An evaluation of what is good or bad and what improvements might be required

must be accomplished. Knowing and understanding the evaluation process is extremely important to anyone responsible for training.

d. Types of Training. Military training tends to be a building block program with very few independent factors. Training is broken down into the following types:

(1) *Individual.* Those tasks and skills that require the individual soldier to function as a member of a team. These include weapons training, NBC training, common task training (CTT), and the skill qualification test (SQT). These are generally basic skills or military occupational specialty (MOS) skills which are specific in nature. The medical proficiency training (MPT) program was created to provide hospital-based clinical skills training and development to medical personnel assigned to TOE units. The individual training (MPT) should also support the unit METL. This individual training program allows an established number of medical personnel to rotate through the supporting hospital at set intervals for a period of 90 to 180 days. Officer professional development programs are conducted to promote tactical and technical proficiency for accomplishment of battlefield requirements.

(2) *Team.* These are team or squad tasks that are specifically directed toward mission accomplishment.

(3) *Leader.* These are skills required by leaders to accomplish assigned missions or designated missions.

(4) *Collective/unit.* This area brings together all of the above; it involves the training of mission essential tasks required to accomplish the overall unit mission. These tasks are found in the unit's METL and the standards are found in the ARTEP MTPs.

(5) *Multiechelon training.* This involves the simultaneous training of individuals, leaders, and units at each echelon in the organization during training events. Multiechelon is the most efficient and effective way of training and sustaining a diverse number of mission essential tasks within limited periods of training time.

e. Training Exercises. Training exercises are used to train and practice the performance of

mission essential and collective tasks. Training exercises may include—

(1) *Situational training exercise.* The situational training exercise (STX) is a short, scenario-driven mission-oriented tactical exercise that provides a vehicle to train a group of closely related collective tasks.

(2) *Field training exercise.* The field training exercise (FTX) is a high-cost, high-overhead exercise conducted under simulated combat conditions in the field. It exercises command and control of all echelons in battle functions against actual or simulated opposing forces. The FTX provides a logical sequence for the performance of tasks which were previously trained during STXs. The METL and overall wartime mission provides the FTX orientation for the FSMC's training.

(3) *Tactical exercise without troops.* The tactical exercise without troops (TEWT) is a low-cost, low-overhead exercise conducted in the field on actual terrain suitable for training units for specific missions. It is used to train subordinate leaders and battle staff on terrain analysis, unit and weapon emplacement, and to plan the execution of the unit mission,

(4) *Command post exercise.* The command post exercise (CPX) is a medium-cost, medium-overhead exercise in which the forces are simulated and may be conducted from garrison locations or in between participating headquarters.

(5) *Deployment exercise.* The deployment exercise (DEPEX) is an exercise which provides training for individual soldiers, units, and support agencies in the tasks and procedures for deploying from home stations or installations to potential areas of hostilities.

(6) *Map exercise.* The map exercise (MAPEX) is a low-cost, low-overhead training exercise that portrays military situations on maps and overlays that may be supplemented with terrain model and sand tables. It enables commanders to train their staffs in performing essential integrating and control functions under simulated wartime conditions.

f. Training Plans and Schedule. Training plans involve long-range, short-range, and near-term

training plans. The Command Training Guidance (CTG) is published at division and brigade (or equivalent) levels to document the organization's long-range training plans. The FSMC commander will provide input to the battalion and the brigade on medical training requirements. He is responsible for developing the FSMC training schedule. The FSMC training schedule must support the battalion training schedule and meet the training objectives of the battalion commander. The FSMC commander provides input to the FSB S3 or the brigade S3 on any training events he wants on the training calendar. Training events are planned and scheduled to meet annual training requirements, to correct a known training deficiency, and to conduct new equipment training. Training events may be command-directed or be required sustainment and proficiency training to maintain unit readiness. *Remember, if it is not on the training calendar, you are going to have a problem making it happen.* Additional information pertaining to planning and the unit training schedule is found in FM 25-100 and FM 25-101. Some of the training events to consider are—

- Skill qualification test.
- Common task training for self-aid and buddy aid.
- Expert Field Medical Badge (EFMB) training and testing.
- Medical proficiency training.
- Emergency medical technician training.
- Cardiopulmonary resuscitation (CPR) training.
- Army Training and Evaluation Program.
- Operational readiness training (ORT).
- Command inspection (medical).
- Patient play activities.
- Division/brigade FTXs.

- Installation support cycles.

4-4. Maintenance

Maintenance requirements in the FSMC involve vehicle and equipment maintenance and medical maintenance. The commander has the responsibility for directing all unit-level maintenance operations IAW DA Pam 738-750.

a. Vehicle and Equipment Maintenance.

Vehicle and equipment maintenance is supervised by the commander and leaders within the FSMC and consists mainly of operator maintenance and PMCS (see FM 43-5). Organizational and direct support maintenance of FSMCs in the airborne and air assault divisions are provided by the battalion headquarters and/or the supporting maintenance battalion. In those divisions under the MSB/FSB design, the organizational maintenance is organic to the FSMC, and direct support maintenance is provided by the maintenance company which is organic to the FSB. The commander's maintenance activities will involve—

- Supervising implementation of PMCS for compliance with SOP and battalion commander's guidance.
- Identifying company operational levels by reviewing vehicle and equipment status reports.
- Identifying current or anticipated maintenance problems.
- Coordinating resolution of maintenance problems with the supporting maintenance element.
- Approving battle damage assessment and repair (BDAR) procedures (see Chapter 5, paragraph 5-10).
- Preparing materiel condition status report.
- Inspecting vehicles, weapons, and equipment to ensure proper operator maintenance IAW SOP, TMs, or FSB commander's guidance.
- Requesting on-site repairs.

- Checking vehicle and generator log books for appropriate entries.
- Developing and updating the maintenance SOP which delineates the maintenance responsibilities and requirements for FSMC.

b. Medical Maintenance. The medical company is responsible for operator maintenance and PMCS. Unit-level medical maintenance support is provided by the DMSO. Definitive information pertaining to medical maintenance was provided in Chapter 1.

4-5. Unit Supply Operations

Unit supply operations involve both general and medical supply activities within the FSMC. The FSMC commander has the overall responsibility for supervising both. The supply elements of the company provide general supply and armorer support for the FSMC. They provide routine and emergency medical resupply for the FSMC and all supported medical elements within the brigade AO. This element is typically staffed with a unit supply sergeant, a medical supply specialist, and an armorer. Major activities in conducting unit supply operations involve property accountability, security, stock levels, quality control, and resupply.

a. Property Accountability. Department of the Army policy requires the commander of a unit to be responsible for all property assigned to that unit. At unit level, property accountability is called hand-receipt accountability. This requires accurate record keeping of all unit property authorized by modification table of organization and equipment (MTOE), common table of allowances (CTA), and/or their guidance. Hand receipts and property are managed by a property book officer (PBO) appointed at the division/brigade level. The FSMC commander could also be the PBO for the unit but is usually a hand-receipt holder. Regardless of whether he is the PBO or not, the commander has the command responsibility for all unit property, whether he has signed a hand receipt for it or not. The commander subhand receipts organization and installation equipment and property to identify section and individual responsibility. Additional information pertaining to property accountability is found in AR 710-2, AR 40-61, DA Pam 710-2-1, FM 10-14, and FM 10-14-1.

b. Security. Security procedures for safeguarding government property are established IAW AR 190-51. The commander must personally supervise the physical security of unit property. In the field where facilities are not adequate, the commander may be required to use his own initiatives. Some of the following methods may be employed by the commander to maintain security of unit property, supplies, and equipment:

- Control access to storage areas.
- Maintain key control.
- Establish procedures in the SOP for controlling expendable supplies.
- Establish procedures in the SOP for controlling, safeguarding, and accounting for controlled medical items such as some pharmaceuticals, needles, syringes, and high-dollar-value items.
- Mark unit supplies and equipment.
- Include measures in the unit SOP for control of property issued to unit personnel.
- Ensure that all property accountability records are kept up to date.
- Establish procedures in the SOP which provide for security of the unit supply area.

c. Stock Levels. Stock levels for organizational and medical supplies are maintained to meet basic load and unit readiness requirements. Required inventories are conducted at various times and intervals throughout the year to determine stock levels and the serviceability of the stock on hand. Additional information pertaining to inventory requirements for supplies and equipment is found in DA Pam 710-2-1. Medical supply stock levels consist of those consumable medical materials that are components of medical sets, kits, and outfits (SKO) and as authorized by CTA 8-100 and division commander's guidance. These SKO are authorized by the MTOE for medical companies and sections within the division. The SKO are authorized in sufficient quantities to support combat operations for 3 to 5 days.

d. Quality Control. Quality control measures are necessary to prevent costly disposal and replenishment actions. Approximately 36 percent of the medical materiel found in the treatment platoon are potency dated. Each unit having SKO must maintain a potency-date file using a DA Form 4998-R for each shelf-life item of materiel IAW AR 40-61. Items with sensitive or restricted codes and those requiring special storage are included. Early awareness and actions to rotate stock to active patient care areas (MTFs) can save considerable dollars and ensure continued readiness of the set. When the FSMC is performing its wartime mission, potency dates are checked and stock is rotated to facilitate the use of potency-dated items prior to their expiration dates. Quality control procedures must also ensure that all items are stored IAW appropriate TM, manufacturers' instructions, and unit SOP. Medical materiel must be stored properly if they are to maintain their effectiveness and shelf life. Additional information pertaining to quality control procedures is provided in AR 40-61.

e. Resupply. Resupply of nonmedical supply items is requested from the FSB Supply Officer (S4). In those units which are not under an FSB/MSB design, the FSMC requests resupply from the medical battalion S4, or when deployed forward in a tactical environment, the FSMC requests resupply through the FASCO from the supporting element of the supply and transportation battalion. Resupply of medical items is requested from the DMSO. The FSMC is responsible, as previously stated, for providing emergency resupply to all medical elements operating in the supported brigade AO. In combat, supply point distribution is used to move medical supplies to the FSMC in the BSA. From this point, medical supplies are carried forward using ground or air ambulance or any vehicles that are going forward. Resupply of controlled substances is accomplished IAW the DMSO and unit SOP.

4-6. Personnel and Administration Functions

The personnel and administration (P&A) functions for the battalion are centralized at the Personnel Administration Center (PAC). The Adjutant (S1) has overall responsibility for P&A functions. The PAC operates the personnel management program, takes or secures actions on personnel matters, and furnishes personnel information and guidance to

designated commanders and staff. The PAC also reports to higher headquarters and provides information required on such matters as personnel losses and replacement requirements. The PAC accomplishes as many personnel actions as possible to reduce personnel administration at unit level. The PAC exists to increase the efficiency of the battalion and to relieve unit commanders of their administrative burden. However, it is neither intended nor designed to interfere in any way with unit commanders' authority and prerogatives.

a. Forward Support Medical Company Commanders' Personnel and Administration Responsibilities. The company commander is the primary P&A manager for the unit, assisted by the medical operations officer (executive officer [XO]) and the first sergeant. Specifically, the commander is responsible for—

- Using assigned personnel properly according to MOS, training, experience, and the desire and needs of the organization.
- Reporting all status changes to the PAC promptly.
- Requesting reclassification of soldiers who are physically unable to perform in their primary MOS, better qualified in another MOS, or inefficient.
- Authenticating administrative documents and actions on personnel actions and forwarding them IAW prescribed procedures.
- Enforcing discipline within their units (see Appendix B).

b. Company First Sergeant. The company first sergeant is normally responsible for the following P&A functions:

- Overseeing company-level administration.
- Advising the company commander of troop assignments, reassignments, promotions, and other personnel actions.
- Supervising replacement activities to include the indoctrination of newly assigned personnel.

- Verifying and monitoring strength and personnel accounting reports to include battle roster change reports, casualty feeder reports, and personnel daily summary.

c. Additional Information. Additional information pertaining to P&A operations is found in FM 12-6, FM 101-5, and DA Pamphlets 600-8 and 600-8-1.

4-7. Graves Registration Responsibilities

All commanders are responsible for unit graves registration (GRREG) and proper disposition of remains. Selected unit personnel should be trained on unit-level GRREG tasks to ensure proper handling of remains and the deceased's personal effects. The FSB has one GRREG-trained soldier assigned to the headquarters of the FSB supply company. He is available to train all FSB personnel on GRREG procedures. Additionally, the medical company, by the very nature of its HSS mission, will necessitate continuous interface with GRREG personnel. The headquarters section, medical company, is responsible for coordinating disposition of remains (either medical company personnel or patients) and personal effects to the GRREG collection point. A temporary morgue area may be required at the medical company to hold remains (patients and unit personnel only) while waiting for transportation to the GRREG collection point. If established, this temporary morgue area must be placed away from and out of sight of patient treatment and holding areas. Remains of deceased unit personnel or patients that are placed in the temporary morgue area must have a completed (reviewed and signed by an MC officer) Field Medical Card (FMC) attached. An exception to this procedure may be made during a mass casualty situation. The remains may be tagged IAW unit SOP and the FMC completed when time permits. Coordination for transporting remains to the GRREG collection point should be accomplished

without delay. When GRREG collection point personnel are operating in the BSA, they must see that all remains received have a completed FMC. When remains arrive at the GRREG collection point without an FMC or the card is not signed by a Medical Corps officer, they will coordinate with the medical company as discussed in FM 10-63. Graves registration personnel will transport the remains to a medical officer for completion of the FMC or have the medical officer come to the GRREG collection point. The FMC should be protected from the weather and body fluids whenever possible. See FMs 10-63, 10-63-1, and 63-20 for definitive information.

NOTE

Governing Principles for Medical Disposition of Deceased Personnel

1. Deceased personnel are segregated from other casualties.
2. The dead, as determined by the senior medical authority, are not evacuated with other casualties. ADD Form 1380 should be initiated and attached to the remains, if possible.
3. Casualties requiring treatment are not placed in the same vehicle with deceased personnel.
4. Medical evacuation resources should not be used to transport deceased personnel.
5. All deceased personnel should have an FMC, signed by a medical officer, before being transported from the GRREG collection point operating in forward areas (BSA).

Section II. BRIGADE SURGEON'S RESPONSIBILITIES, STAFF ACTIVITIES, AND RELATIONSHIPS

4-8. Brigade Surgeon's Responsibilities

The aviation brigade is the only brigade that has a brigade surgeon assigned to its headquarters. (See

Appendix C for information pertaining to aviation medicine.) In those divisions under the MSB/FSB design and those divisions with a medical battalion, the maneuver brigade surgeon's responsibilities are

performed by the FSMC commander. In the armored cavalry regiment, the brigade surgeon is called the regimental surgeon. In the remainder of this text, the term *brigade surgeon* is used, but information provided also applies to the regimental surgeon. The brigade surgeon is normally a Major with AOC 62B (Field Surgeon). This officer is tasked with both command and staff responsibilities. He is a commander, a physician, and a special staff officer at both battalion and brigade levels as a medical technical advisor. His consolidated duties and responsibilities are focused toward ensuring that HSS is available and adequate to support the mission of the brigade. His knowledge of the functions and responsibilities of each staff element in the brigade and supporting CSS unit or elements is essential for proper staff interaction and coordination. Additional information pertaining to command and staff functions and estimates is provided in Appendix D.

4-9. Maneuver Brigade Staff and Brigade Surgeon

The maneuver brigade headquarters was previously discussed in Chapter 1. The brigade staff includes the brigade XO, brigade S1, brigade S2 (Intelligence Officer), brigade S3, brigade S4, and the brigade S5 (Civil Affairs Officer) when authorized. The brigade surgeon is a special staff officer. This paragraph provides general information pertaining to the responsibilities of the brigade staff and the brigade surgeon. Additional information pertaining to the staff is found in FM 101-5.

a. Brigade Commander and Staff

(1) *Brigade commander.* The brigade commander plans, directs, and supervises the brigade's activities, and prescribes policy, procedures, missions, and standards.

(2) *Brigade executive officer.* The XO is the principal assistant to the brigade commander. He is instructed by the commander to supervise and coordinate the functions of the brigade staff.

(3) *Brigade S1.* The S1 functions as the commander's principal assistant on matters concerning human resources and personnel matters. He exercises general staff responsibilities for monitoring, assessing, and ensuring personnel

service facilities, policies, and procedures that support soldier readiness. He exercises command policy and plans based on input from the coordinating and special staff. He is concerned with health services such as field medical support, treatment and prevention of disease, mental health, dental, and other essential services. He projects casualty estimates and coordinates with the brigade surgeon on tactical medical intelligence matters and replacement requirements. The S1 is concerned with the consequences of HSS on the soldier. He is responsible for operational and technical control of the administrative support function. He provides information to the surgeon for formulation of the HSS plan. Additional information pertaining to the functions of the S1 may be found in Training Circular (TC) 12-17 and FM 12-6.

(4) *Brigade S2.* The S2 advises the commander on all intelligence matters. He prepares and disseminates intelligence estimates. He develops the initial intelligence preparation of battlefield (IPB). The IPB provides detailed information on the enemy, weather, and terrain. He disseminates IPB products such as an analysis of AO. He recommends priority intelligence requirements to the commander based on information and recommendations of other staff officers. He plans and supervises the use of civilian labor. He develops, plans, and coordinates all reconnaissance assets with the S3 to include ground-based signal intelligence assets. He prepares counterintelligence estimates. He plans and supervises the implementation of counterintelligence measures to support all operations.

(5) *Brigade S3.* The brigade S3 advises the commander on combat and CS matters and on organization and training. Based on the commander's guidance, and input from other staff officers, he prepares operation estimates and develops operation plans (OPLANs). He plans and supervises tactical troop movement. He establishes priorities for communications to support the tactical operations. He prepares and supervises the execution of the training programs. The S3 is concerned with the operational conduct of training and integration of HSS in operation plans and orders.

(6) *Brigade S4.* The brigade S4 maintains the status of and advises the commander

on CSS units and systems. He supervises transportation resources and controls nontactical movement. He determines requirements for supply, rations transportation, maintenance, and field services. Based on the commander's guidance and information from other staff officers, he prepares logistics estimates. He provides overall supervision for supply, transportation, and maintenance activities within the brigade. The S4 is concerned with planning, coordinating, and integrating HSS functions with other CSS. He may, as directed by the brigade commander, provide C2 for the BSA.

(7) *Brigade S5.* The brigade S5, when authorized, advises and makes recommendation to the brigade commander pertaining to civil-military operations (CMO). He coordinates host-nation support. He provides liaison for procurement of civilian medical facilities. He provides the S1 with information pertaining to requirements for evacuation or hospitalization of civilians. He provides information to all staff elements pertaining to the civilian population. He coordinates the use of captured enemy supplies and materiel. He advises the commander on the impact of military operations on the civilian population.

b. Surgeons Interaction with the Brigade Staff. The brigade surgeon coordinates his brigade staff initiatives with the FSB commander and staff or with the FASCO depending on his organizational assignment. He is responsible for reviewing all brigade OPLANs and contingency plans to identify potential medical hazards associated with geographical locations and climatic conditions. He keeps the brigade commander informed on the medical aspects of the brigade operations. This is accomplished through the FASCO or through the FSB commander, or the surgeon may provide periodic update/briefings (see Appendix E) to the brigade commander. Some issues may require coordination with the brigade staff members. The surgeon should have an understanding of how the brigade staff actions are accomplished. Listed below are points of contact that will assist the surgeon in influencing HSS action.

(1) *The S1.* The surgeon normally coordinates all staff action through the S1. The S1 provides the best link to the command group. The S1 ensures that the command group stays informed on the surgeon's issues and coordinates face-to-face meetings when required.

(2) *The S2.* Early contact must be made with the S2 to verify the surgeon's clearance and access to meetings and information. The S2 can provide the surgeon with current threat intelligence, area studies, and a myriad of other information. Examples of other information may include medical intelligence such as—

- Disease resulting from endemic or epidemic pathogens.
- Suspected enemy biological agent employment.

If the surgeon is assigned to an FSB, the FSB S2/S3 can provide this information. Additional information pertaining to medical intelligence is found in FM 8-10-8.

(3) *The S3.* The S3 can provide the surgeon with access to information on current and future operations. The surgeon, through the S3, can influence required medical training programs and medical support operations.

(4) *Operations NCO.* The operations NCO is normally a staff sergeant major or master sergeant with whom the surgeon can communicate when the S3 is not available. This NCO is very capable and should be able to answer most of the surgeon's questions.

(5) *The S4.* The S4 maintains the administrative/logistical overlay for all operations. He ensures that all medical activity locations are plotted on this overlay. He manages traffic entering or leaving main supply routes.

(6) *The S5.* In combat operations, the S5, when authorized, can provide assistance to the surgeon. He can coordinate host-nation support activities and keep the surgeon aware of refugee and straggler concentrations. He may also request and coordinate medical support required to enhance operations with the local populace.

(7) *Communications-Electronics officer (if assigned).* The Communications-Electronics (CE) officer controls all communications assets of the brigade. He can provide assistance on coordination of communication with supporting units and other units participating in an operation.

c. Synchronization of Health Service Support. The brigade surgeon is responsible for synchronizing HSS for the brigade. Specific responsibilities include—

- Ensuring implementation of the health service section of the division SOP.
- Determining the allocation of HSS resources within the brigade.
- Supervising the technical training of medical personnel and the combat lifesaver program in the brigade area.
- Developing and monitoring the evacuation plan (ground and air) which supports the brigade's maneuver plan. This includes recommending ambulance exchange point (AXP) locations.
- Writing the HSS portion of the brigade SOP, OPLANs, and operation orders (OPORDs).
- Monitoring requests for aeromedical evacuation from supported units.
- Monitoring the health of the command and advising the commander on measures to counter the medical threat.
- Monitoring and assisting units with their mild/moderate BF cases and determining capability to restore battle fatigue casualties (BFCs) within the brigade's AO.
- Informing the division surgeon, DMOC, of the brigade's HSS situation.
- Supervising corps medical units within the brigade's AO when directed.
- Exercising technical supervision of subordinate battalion surgeons.
- Assuming technical supervision of PAs organic to subordinate units in the absence of their assigned physician.
- Advising PAs assigned to artillery and engineer battalions, as required.

NOTE

The HSS commander and staff must be proactive; they must anticipate future tactical operations and formulate sound HSS plans to support those operations in advance. The commander and staff have failed if they react to tactical operations as opposed to anticipating such operations.

4-10. Brigade Surgeon's (Forward Support Medical Company Commander) Interaction with Medical Battalion Headquarters Staff

Key members of the medical battalion headquarters staff are members of the command section. The battalion command section consists of the battalion commander and his immediate staff. These personnel supervise functions of the organizational elements of the battalion headquarters. Additional information pertaining to the overall responsibilities of each of the headquarters elements is found in FM 8-10.

a. Medical Battalion Commander and Staff.

(1) *Battalion commander (division surgeon).* The battalion commander plans, directs, and supervises battalion activities, and prescribes policy, procedures, missions, and standards. The duties and responsibilities of the division surgeon are discussed in Chapter 5.

(2) *Battalion executive officer.* The XO is the principal assistant to the battalion commander. He supervises and coordinates the functions of the battalion staff. He develops the battalion base defense plan and coordinates with the base cluster commander.

(3) *Battalion S1.* The S1 advises the commander on administrative and personnel matters. He develops and issues instructions for submission of records and reports. The S1 also authenticates and supervises the preparation and distribution of orders and instructions, and participates in the development of OPORDs.

(4) *Battalion S2/S3.* The S2/S3 is the operations, intelligence, and training officer. This

officer advises and assists the battalion commander in planning and coordinating battalion operations. He supervises planning, operations, security, NBC intelligence, communications, and training activities of the battalion. He also authenticates and supervises the preparation and distribution of OPORDs.

(5) *Battalion S4*. The S4 directs the logistical activities of the battalion and advises and assists the battalion commander in all matters pertaining to logistics. He also coordinates with the S3 in planning and implementing damage control measures. The duties and functions of the S4 are discussed in detail in FM 10-14-2.

(6) *Command sergeant major*. The command sergeant major (CSM) is the battalion commander's principal enlisted assistant. He maintains liaison between the commander and first sergeants of subordinate units. The CSM is the battalion commander's chief advisor on battalion individual training matters. The CSM advises and assists NCOs in accomplishing their assigned missions. He also assists the commander in the inspection of subordinate units.

b. Brigade Surgeon's (Forward Support Medical Company Commander) Interaction with the Forward Area Support Coordinator. In those divisions with a medical battalion, the brigade surgeon (FSMC commander) commands a company that is organic to the medical battalion. When the FSMC is deployed forward in support of a maneuver brigade, the brigade surgeon/FSMC commander continuously interacts with the FASCO on HSS requirements in the BSA. The FASCO directs all CSS operations, but coordination for both technical and administrative matters continues between the FSMC and the medical battalion headquarters. This medical channel is designed to enhance reaction time of both the battalion headquarters and the FSMC. The FASCO coordinates all formal requests for assistance or medical resupply. The medical battalion headquarters coordinates HSS requirements through the FASCO with the medical company. Interface between the brigade surgeon and the medical battalion and the FASCO may include—

- Health service support operations—S2/S3.

- Ambulance exchange points—S2/S3.
- Corps-level medical elements in direct support—S2/S3.
- Emergency Class VIII resupply/medical equipment replacement—S4/DMSO.
- Tactical situation/threat update—S2/S3.
- Communications—S2/S3.
- Status report on HSS elements—S1, S2/S3, S4, DMSO.
- Reinforcement/reconstitution of medical elements—S1, S2/S3.
- Preventive medicine—S2/S3, preventive medicine section.
- Combat stress control operations—S2/S3, mental health section.
- Nuclear, biological, and chemical operations—S2/S3, S4.
- Brigade Army airspace command and control (A2C2) (when appropriate)—S2/S3.

4-11. Forward Area Support Coordination Officer

The FASCO is assigned to the security, plans, and operations office of the DISCOM HHC in the airborne and air assault divisions. There are three FASCOs, one for each of the maneuver brigades. The FASCO coordinates the efforts of the FAST. The FAST is task-organized to meet the needs of the brigade. The composition of the FAST changes by augmentation of other DISCOM or corps support command (COSCOM) elements to meet varying needs of the brigade and other supported units. The FAST normally consists of an FASCO, a forward supply company of the supply and transport battalion, a forward maintenance company of the maintenance battalion, and an FSMC of the medical battalion. The FASCO is assisted by the commander and leaders of the FAST units. The FASCO coordinates logistic support missions between the

brigade XO, or the S4, and DISCOM elements operating in the BSA. Additional information pertaining to the FASCO is found in FM 63-2.

4-12. Forward Support Battalion Staff

The FSB headquarters has five sections: command, PAC/S1, S2/S3, support operations, and S4. The command section is the command element and is made up of those staff officers that supervise the functions of the major organizational elements. Additional information pertaining to the FSB headquarters and headquarters detachment (HHD) is found in FM 63-20.

a. Forward Support Battalion Commander and Staff.

(1) *Forward support battalion commander.* The FSB commander may be either a quartermaster, transportation, ordnance, or MS officer. Working through the command section, he plans, directs, and supervises battalion activities and prescribes policies, procedures, missions, and standards.

(2) *Battalion executive officer.* The XO is the principal assistant to the battalion commander. He supervises and coordinates the functions of the battalion staff as directed by the commander.

(3) *Battalion S1.* The battalion S1 is the primary staff officer for the commander on all matters concerning human resources. He advises the commander on administrative personnel matters. The S1 is assisted by and directs the activities of the PAC section.

(4) *Battalion S2/S3.* The battalion S2/S3 is the plans, operations, intelligence, security, and training officer. He is responsible for internal FSB operations. The S2/S3 advises and assists the FSB commander in planning, coordinating, and supervising the communications, operations, training, security, and intelligence functions of the battalion. The S2/S3 is assisted by the S2/S3 section which has two branches—plans and operations branch and communications branch.

(5) *Support operations officer.* The support operations officer coordinates and provides

technical supervision for the FSB CSS mission. This mission includes direct support supply, field service, intermediate direct support maintenance (IDSM) HSS, and limited transportation functions. In this capacity, the support operations officer advises the commander on requirements versus available assets. The support operations officer must ensure that CSS to supported units remains at a level consistent with the type of tactical operations being conducted. The support operations officer is assisted by the support operations section whose activities he directs. For HSS, the support operations section is assisted by the brigade surgeon (medical company commander) who provides input to the service support annex on HSS.

(6) *Battalion S4.* The battalion S4 officer provides technical supervision and assistance for unit-level support within the battalion. He is responsible for preparing the logistics estimates and making recommendations to the commander on internal logistics activities. He also plans the service support annex to the battalion OPORD/OPLAN. The S4 is assisted by the S4 section.

b. The Brigade Surgeon's (Forward Support Medical Company Commander) Interaction with the Forward Support Battalion Staff. The brigade surgeon continuously interacts with the FSB staff on HSS requirements in the BSA and taskings from the DMOC. The brigade surgeon (FSMC commander) maintains technical channels of communication with the division surgeon and DMOC for coordinating HSS activities. The DMOC will utilize command channels through the FSB headquarters when tasking the FSMC or elements of the FSMC. The brigade surgeon interacts with the FSB staff on the following:

- Health service support operations—S2/S3, support operations section.
- Ambulance exchange points—support operations section.
- Corps level medical support in direct support—S1, support operations section.
- Emergency Class VIII resupply/medical equipment replacement—support operations section.

- Tactical situation/threat update—S2/S3 (S2 operations cell).
- Communications—S2/S3 (communications branch).
- Status reports on HSS elements—support operations section.
- Reinforcement and reconstitution of medical elements—support operations section, S1, S4.
- Preventive medicine—support operations section.
- Combat stress control operations—support operations section, S4, S1.
- Nuclear, biological, chemical, and directed-energy operations—support operations section.
- Brigade A2C2—support operations section.
- Tactical SOPs—S1.
- Logistics requirements (non-medical)—S4.
- Operation order/OPLAN—support operations section.
- Personnel estimates for casualties and replacement requirements—S1.

4-13. Separate Brigade and Regimental Surgeons

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

- Ensures the implementation of the health service section of the division or corps SOP.

- Recommends the allocation of medical resources within the brigade or ACR.
- Exercises direct supervision over the technical training of medical personnel assigned to brigade or ACR units and manages the combat life-saver program.
- Determines procedures, techniques, and limitations in the conduct of routine medical care, EMT, and ATM procedures.
- Monitors the health of the command and advises the commander on measures to counter the medical threat.
- Monitors requests for aeromedical evacuation originating in units subordinate to the brigade.
- Ensures, through coordination with appropriate headquarters, that the brigade and its subordinate units receive adequate HSS for their assigned missions.
- Provides the COSCOM surgeon, in the case of a separate brigade or ACR, with information concerning the brigade's or ACR'S plans and operations for HSS of attached units.
- Assumes OPCON (when directed) of augmentation medical units.
- Supervises activities of subordinate battalion or squadron surgeons.
- Assumes technical supervision of PAs organic to subordinate units in the absence of their assigned physicians.
- Advises and/or supervises all division CS and CSS medical elements operating within the brigade's AO as required.
- Advises regarding and oversees the plans of the battalions or squadrons for preventing and managing stress and BFCs.
- Coordinates technical supervision of enlisted mental health personnel in the medical company by mental health officers of other commands.

4-14. Division Medical Operations Center

The DMOC's medical operations branch coordinates with the FSB medical company through medical channels pertaining to HSS operations. The DMOC will task elements of the FSB medical company through command channels. Additional information pertaining to the DMOC is found in FM 8-10-3. The FSB medical company will interface with the DMOC on—

- Health service support operations.
- Ambulance exchange points.
- Corps-level medical elements supporting the FSMC.
- Emergency Class VIII resupply and medical equipment replacement.
- Tactical situation and threat medical intelligence information update.
- Communications.
- Status reports on HSS elements.
- Reinforcement/reconstitution of medical elements.
- Preventive medicine.
- Combat stress control operations.
- Nuclear, biological, chemical, and directed-energy operations directed against supported division forces.
- Brigade A2C2 (when appropriate).