CHAPTER 5

COMMAND AND STAFF RESPONSIBILITIES OF THE DIVISION SURGEON

Section I. COMMAND RESPONSIBILITIES

5-1. Assignments

In airborne and air assault divisions, the division surgeon is also the medical battalion commander.

NOTE

In peacetime, the medical battalion commander's position is usually filled by an MS officer, AOC 67 series. When an MS officer commands the battalion, HSS activities involving physician-related areas, such as patient treatment policies and procedures, are referred to a physician.

This section addresses the medical commander's duties and responsibilities, his interactions with the battalion staff and subordinate units, and his interface and coordination with division, DISCOM, and supporting corps medical staff elements.

5-2. Responsibilities

The battalion commander plans, directs, and supervises battalion activities. He is responsible for synchronizing HSS operations for the division. He monitors and directs HSS operations to achieve maximum use of division and corps medical elements in support of the division. He is assisted by the medical battalion headquarters staff. Responsibilities of the battalion commander include–

- Commanding and controlling battalion medical units.
- Planning and providing Echelons (Levels) I and II HSS to include–
  - Identifying HSS requirements.
  - Tailoring and prioritizing medical resources to meet HSS and tactical requirements.
  - Providing medical logistics and medical maintenance support.
  - Coordinating and directing medical evacuation operations.
  - Providing divisionwide support activities pertaining to preventive medicine, mental health, and optometry services.
  - Providing input to the division HSS annex.
  - Ensuring division SOPS, plans, policies, and procedures for HSS are properly executed.
- Developing the medical battalion METL IAW FM 25-100, FM 25-101, and guidance from the division and DISCOM commanders.
- Monitoring unit readiness to ensure the unit maintains the appropriate state of readiness for rapid deployment and wartime contingencies.
- Advising, assisting, and mentoring the medical company commander and battalion-level medical platoon or section leaders.

5-3. Staff Supervision

The battalion commander's principal assistant is the battalion XO. The XO is the key to successful operations at the battalion headquarters level. The battalion commander may delegate staff supervision authority to the XO who will then supervise and coordinate all battalion staff functions.

5-4. Division Support Command Staff Interface

The relationship between the medical battalion commander and the DISCOM staff is like that between any subordinate commander and his higher headquarters staff. The medical battalion commander directs HSS efforts through his battalion staff in coordination with the DISCOM staff

elements. He reacts to tasking and directives from the DISCOM staff elements. The commander and his medical battalion staff proactively provide HSS input to the DISCOM OPLAN and OPORD, and coordinate with the appropriate DISCOM staff element for implementation of HSS operations as required. Successful HSS operations require continuous coordination between the staff elements of the DISCOM headquarters and medical battalion.

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.

5-5. Division Staff Interface

The relationship between the medical battalion commander and the division staff normally occurs through the DISCOM headquarters. Some division operations may require the medical battalion commander, in his role as division surgeon, to interface directly with division staff elements. Casualty estimates, CMO, and host-nation support are some examples where direct interface may be required. (Appendix F provides additional information pertaining to health service estimates.) In most cases, the division surgeon/battalion commander interfaces with division staff elements through the division G1 (Assistant Chief of Staff [Personnel]). See paragraph 5-13 for additional information pertaining to the division surgeon's interactions with division staff elements.

5-6. Corps Medical Staff Interface

Corps interface will again occur through the normal command channel, or in case of specific medical technical areas, directly between the medical battalion and supporting corps medical units. Additional information pertaining to corps medical staff interface is found in FM 8-10-3.

5-7. Training Management

Training is one of the most important responsibilities the medical battalion commander has in peacetime because it prepares his battalion to accomplish its critical wartime mission. A difficult task for the battalion commander is preparing and conducting unit training. Training requirements of particular importance to the commander involve–

- Battle focus. Battle focus was discussed in Chapter 4.

- Mission essential task list development. Development of company METL was also discussed in Chapter 4. The key to the battalion training program is the development of a battalion METL. The battalion METL must support and complement the DISCOM and division METLs. The battalion METL is the base document used in developing the company METL. The same considerations and factors discussed in Chapter 4 pertaining to development of the company METL are used to develop the battalion METL. The battalion commander should involve headquarters staff in developing the battalion METL. Once the DISCOM commander approves the battalion METL, it becomes the source document from which training plans are developed. It should be changed only when the battalion's mission changes.

- Battalion training schedule. The battalion produces long-range (one year), short-range (three months), and near-term (one week) training schedules. The weekly training schedules are normally provided for each company.

5-8. Unit Readiness

Readiness is the ability of a unit to perform as designed. It is a composite of various factors to include equipment, personnel, and training. A unit's ability to perform its mission is directly correlated to these areas. Indicators of the unit's readiness can be found by reviewing equipment maintenance reports, Inspector General reports, ARTEP results, and emergency deployment readiness exercise results. Commanders should familiarize themselves with the above programs. The Army gauges the status of units via the unit status report. This readiness indicator is governed by AR 220-1. The

battalion must submit a DA Form 2715-R on a monthly basis to its higher headquarters. This report is based on personnel, equipment, and training data. Normally, a formal briefing is provided by the battalion commander to the DISCOM commander each month. The DISCOM commander will brief the division commander.

NOTE

Normally, medical equipment and supplies are reported subjectively (for example, in the Commander's Comments). The unit needs to be cognizant of the real medical capabilities.

5-9. Personnel and Administration Functions

Personnel functions for the battalion are provided by the PAC under the supervision of the battalion S1. The battalion commander should be updated weekly on P&A matters to include significant problem areas and possible solutions. The S1 is responsible for supervising all administrative activities for the battalion. These activities include supervision of correspondence, personnel liaison, mail distribution, and dissemination of command information.

5-10. Battalion Maintenance (Medical and Nonmedical)

An effective maintenance program is essential to a unit's ability to perform its mission. The most important element in any unit maintenance program is the equipment operator. He must be familiar with his equipment and be able to maintain it. The medical battalion commander and subordinate medical company commanders must ensure operators are properly trained. Maintenance subject areas and activities include the following:

- Levels of maintenance. Maintenance operations are divided into three levels to efficiently coordinate them with other military operations.

- Unit-level maintenance. Unit-level maintenance is similar to the maintenance applied to privately owned vehicles. It focuses primarily on minor repairs, adjustments, and replacing minor components, such as starters, generators, brakes, and spark plugs. The vehicle operator or crew with the aid of unit mechanics perform unit maintenance. The battalion commander will primarily be involved with this level of maintenance (see FM 43-5).

NOTE

Some light infantry divisions (LIDs) have been reorganized so that only Headquarters and A Company can provide unit-level (organizational) maintenance. The three line forward support medical companies receive unit-level (organizational) maintenance from the forward deployed maintenance battalion elements. Check the local unit's MTOE to see how unit-level (organizational) maintenance is provided.

- Intermediate-level maintenance. The intermediate level of maintenance has two orientations, direct support and general support. The direct support maintenance units perform repair and return-to-the-user functions. They are organic to the division and focus on far forward support. The direct support maintenance units perform repairs beyond the capability of unit maintenance. General support maintenance units perform major repairs and overhaul. Items repaired at the general support level are returned to the supply system. General support maintenance does not perform a repair and return-to-the-user function.

- Depot maintenance. Depot maintenance is performed at fixed facilities in CONUS and major overseas areas. Depot maintenance is characterized by overhaul and rebuild functions.

- Maintenance terms and functions. To understand maintenance, you must first become familiar with terms used to describe various maintenance functions.

- Prescribed load list (PLL). This is the unit's repair parts stockage. It is composed of an authorized stockage list (ASL) which is a list of parts for which sufficient need has been historically established to justify their stockage. Command supported items are parts which the unit commander has directed be stocked.

- Preventive maintenance checks and services. The Army's preventive maintenance systems consist of periodic checks (before, during, and after operations; daily, weekly, monthly) and scheduled services. The operator's technical manual for each vehicle and piece of medical equipment lists the PMCS to be conducted and their frequency. (See TM 8-6500-001-10 for reparable medical equipment.)

- Cannibalization. This is the authized removal of serviceable parts from irreparable equipment by maintenance units.

- Controlled exchange. Controlled exchange is the removal of serviceable parts from unserviceable but reparable equipment to bring a like piece of equipment to operational status. Controlled exchange requires command authorization.

- Technical manuals. Technical manuals provide technical information (operator instructions, repair procedures, and repair parts) about specific pieces of equipment. Technical manuals are referred to as -10s (operator's manuals), -20s (unit and direct support maintenance manuals), -30s (direct support/general support manuals), -40s (general support and depot manuals), and -14s (applies to all levels).

- Maintenance forms and records. Numerous forms and records are used to document maintenance activities (see DA PAM 738-750). These records are maintained for historical purposes, to ensure necessary services are performed, and to establish requirements for repair parts stockage.

- Dispatch. The DD Form 1970 is commonly referred to as a "dispatch." It is issued to the vehicle operator by the unit maintenance clerk before the vehicle is used.

- Inspection and maintenance work sheet. The DA Form 2404 is the "bread and butter" form of unit-level maintenance. The operator uses this form to record faults he cannot correct through PMCS. Unit maintenance personnel refer to the form to identify necessary repairs and annotate the form to indicate that they have corrected the fault. It is used when conducting scheduled service and during any other technical inspection. The DA Form 2404 is quite versatile and is the most frequently used form in the motor pool.

- Maintenance request. The DA Form 2407 is used by unit maintenance as a request to direct support for repair work.

- Lubrication order. The lubrication order (LO) is more like a technical manual than a maintenance form. It details how to lubricate the vehicle, the type of lubricant to use, intervals to be observed, and special precautions. An LO should be kept on each vehicle with the appropriate TM.

- Medical equipment maintenance support. Medical equipment maintenance support was discussed in Chapter 1.

- Battle damage assessment and repair. Battle damage assessment and repair techniques expedite the return of a damaged piece of equipment to the current battle. Battle damage assessment is used to determine the extent of damage to equipment. Equipment is classified according to the type of repair required, and plans are made for repair of each item. Priorities for repair of battle damaged items are usually–

  - Most essential to the immediate mission.
  - Reparable in the least time.
  - Reparable but not in time for immediate mission.

Battle damage repair involves use of emergency repair techniques to return a system to a full or partial mission capability. Battle damage repair is normally used only in combat at the direction of the commander.

NOTE

Battle damage assessment and repair does not include medical equipment.

Section II. DIVISION SURGEON

5-11. Duties

The division surgeon is an MC officer, AOC 60A. He is a special staff officer and is normally under the staff supervision of the G 1 in those divisions under the MSB/FSB design. Generally, the surgeon's duties are administrative; the division commander charges him with the full responsibility for the technical control of all medical activities in the command. The division surgeon coordinates HSS activities through the G 1. In airborne and air assault divisions, the division surgeon is the medical battalion commander. He is assisted by the division surgeon's section of the medical battalion. In those divisions which are under the MSB/FSB design, the division surgeon's staff is assigned to the division surgeon's section of the division HHC. Personnel assigned to this section include a chief medical NCO (MOS 91B50), a clerk typist (MOS 71L1O), and a patient administration specialist (MOS 71G1O). These personnel, along with the DMOC staff, assist the division surgeon in the performance of his duties. The division surgeon advises the division commander on all medical or medical-related issues. These issues include, but are not limited to–

- Health of the command.
- Medical support operations.
- Medical services provided to division personnel.
- Preventive medicine.
- Combat stress control.
- Medical evacuation.
- Dental services.
- Medical training.
- Medical intelligence.
- Civil-military operations.
- Medical logistics.
- Status of wounded.
- Disease and nonbattle injury casualties.

5-12. Responsibilities

The division surgeon is assisted by the medical staff elements identified earlier in this chapter. His responsibilities include–

- Advising on health status of the command and of the occupied or friendly territory within the commander's area of responsibility.
- Reviewing all division OPLANs and contingency plans to identify potential medical hazards associated with geographical locations and climatic conditions.
- Advising on the medical effects of the environment, NBC, and directed-energy devices on personnel, rations, and water.
- Determining requirements for the requisition, procurement, storage, maintenance, distribution management, and documentation of medical, dental, and optical equipment and supplies.
- Identifying medical shortfall items and establishing a supplemental level through an SOP.

NOTE

Common table of allowance 8-100 should be used to further identify items to improve medical readiness. Any supplemental authorization should be routed through the major Army command (MACOM) surgeon for information and documented in an SOP.

- Determining requirements for medical personnel and making recommendations concerning their assignments.

- Coordinating with medical unit commanders (to include leaders of organic medical platoons and sections) for continuous HSS.

- Submitting to higher headquarters those recommendations on professional medical problems which require research and development.

- Recommending use of captured Class VIII supplies in support of EPWs and other recipients.

- Advising on medical intelligence requirements (including the examination and processing of captured medical supplies as directed by the corps surgeon).

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

- Advising commanders about the preventive medicine aspects of reconstitution, and availability y and use of CSC teams.

- Forwarding the Command Health Report IAW Chapter 3, AR 40-5.

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

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

- Planning and coordinating the following HSS operations:

  - The system of treatment and medical evacuation, including aeromedical evacuation by Army air ambulance units.

  - Dental services (in coordination with the division dental surgeon).

  - Veterinary food inspection, animal care, and veterinary preventive medicine activities of the command, as required.

  - Professional support in subordinate units.

  - Preventive medicine services (in coordination with division preventive medicine officer).

  - Medical laboratory and blood banking services.

  - Combat stress control and NP care (in coordination with division psychiatrist).

  - Medical supply, optical, and maintenance support, including technical inspection and status reports.

  - Medical civic actions programs.

  - Health service support within the command.

  - Health service support aspects of rear operations.

  - Assignment of medical personnel.

  - Preparation of reports regarding medical administrative records of injured, sick, and wounded personnel.

  - Collection and analysis of operational data for on-the-spot adjustments in the HSS structure and for use in postwar combat and materiel development studies.

5-13. Interactions with Division Staff

The division surgeon's interactions with the division staff will vary depending on division HSS requirements or HSS initiatives deemed necessary to maintain the health of the command. Civil-military operations, host-nation support, EPW patients, and special operations are only a few of the many other areas which necessitate interactions between the division surgeon and division staff elements. The division surgeon interacts with the appropriate division staff element and, with assistance from his supporting medical staff elements, coordinates and monitors HSS activities throughout the division. He provides technical guidance as necessary to ensure that all HSS activities are accomplished IAW established professional standards, approved doctrine, and division HSS SOPS. The division commander and division staff members are informed and updated as

required on division HSS operations. Examples of subject areas which require interactions between the division surgeon and division staff members or sections are shown in Table 5-1.

Table 5-1. Interactions Between Division Surgeon and Division Staff

	SUBJECT	DIVISION STAFF SECTION
1.	Casualty estimates	G1
2.	Civil affairs/host-nation support	G5
3.	Medical intelligence	G2
4.	Contingency operations	G3
5.	Health service support	G1/G3
6.	Replacement and reconstitution operations	G1/G3/G4
7.	Enemy prisoner of war operations	G1/G3
8.	Army airspace command and control	G3 Air
9.	Food service and preventive medicine matters	G4

5-14. Interactions with the Division Medical Operations Center

The division surgeon and the DMOC must maintain a close working relationship. The DMOC functions under the technical supervision of the division surgeon. The technical supervisory control that the division surgeon exerts over all medical units or elements assigned to the division requires continuous communications and coordination between the division surgeon and the DMOC. The DMOC assists the division surgeon as required with the division surgeon's areas of responsibility. The DMOC assists the division surgeon with the development of the division HSS plan. In coordination with the division surgeon, the DMOC monitors and coordinates division HSS activities. Information and updates are provided to the division surgeon as required on coordination activities of the DMOC and the status of HSS operations. The DMOC and the division surgeon must ensure that HSS activities are sufficient to meet division and tactical requirements. The division surgeon and the DMOC chief must keep the division and DISCOM staff updated on division HSS activities. The division surgeon briefs the division commander and the DMOC chief briefs the DISCOM commander as required on HSS issues. The division surgeon and the DMOC staff communicate and coordinate through technical channels, then use command channels as required to conduct HSS operations or to accomplish HSS requirements. Additional information pertaining to the DMOC is found in FM 8-10-3.

5-15. Interface with Corps Surgeon

The division surgeon interfaces with the corps surgeon while the DMOC or medical battalion staff interfaces with the supporting corps medical units. The division surgeon may focus his attention on critical medical support requirements. The interface between the division surgeon and the corps surgeon is not limited to, but may pertain to, the following:

- Medical evacuation from the division.
- Division HSS requirements.
- Ground and air ambulance support.
- Class VIII resupply and medical maintenance.
- Blood (Group O packed red cells).
- Status of corps medical elements attached to the division.
- Captured medical supplies and equipment.
- Reinforcement and reconstitution of HSS elements.
- Augmentation (for example, surgical squad).
- Civil affairs and host-nation support.

- Communications.
- Locations of medical elements in support of the division.
- Preventive medicine, CSC/mental health, dental, or veterinary consultation or support.
- Dedicated hospital support.
- Personnel replacements (corps supported).

5-16. Division Health Service Support Standing Operating Procedures

The division surgeon is responsible for the development of HSS SOPs for the division. He is assisted with the development of both tactical and garrison SOPs by the DMOC or the division surgeon's section in the medical battalions. The division HSS SOPs serve as the foundation for all subordinate medical units or elements to develop their HSS SOPs. Division HSS SOPs should be clear and concise but provide sufficient details on procedural requirements. HSS SOPs must be maintained and reflect procedural guidance that supports current mission and doctrinal requirements. Division HSS SOPs should be reviewed at least every 6 months. Health service support SOPs are developed or revised as required. Subject areas identified in Table 5-2 should be considered when developing HSS annexes and the division SOPs. Subject areas identified in Table 5-3 should be considered when developing peacetime garrison SOPs.

Table 5-2. Tactical Standing Operating Procedures for HSS Division Operations

1.	Decontamination, treatment, and disposition of nuclear, biological, and chemical casualties.
2.	Medical situation reports.
3.	Medical evacuation.
4.	Class VIII resupply.
5.	Management of captured medical materiels.
6.	Medical threat and intelligence information.
7.	Preventive medicine measures.
8.	Combat stress control preventive measures, triage, and restoration of battle fatigue casualties.
9.	Enemy prisoners of war and detained personnel casualty treatment and disposition procedures.
10.	Division blood management.
11.	Infectious and contaminated waste disposal procedures.
12.	Immunizations.
13.	Medical administrative and reporting requirements.
14.	Safety procedures for patient treatment and care.
15.	Civil affairs and host-nation medical support.
16.	Casualty estimates.
17.	Replacement and reconstitution operations.
18.	Area medical and dental support.
19.	Area ambulance support.
20.	Integration of corps medical elements into division HSS operations.
21.	Ambulance exchange point operations.
22.	Army airspace command and control.
23.	Mass casualty procedures.

5-17. Medical Training

The division surgeon monitors medical training in the division. He observes medical training for medical personnel and self-aid/buddy aid and combat lifesaver refresher training for nonmedical personnel. He monitors training time provided to medical units or elements compared to their medical support role for training. The division surgeon through the division commander and the G3 initiates medical training and first aid and combat lifesaver training programs for the division. These

Table 5-3. Peacetime/Garrison Standing Operating Procedures

1.	Training of medical personnel.
2.	Medical support for division training.
3.	Aid station/troop medical clinic operation procedures in garrison.
4.	Dependent care.
5.	Medical proficiency training.
6.	Professional training.
7.	Credentialing committees.
8.	Granting clinical privileges.
9.	Deployment of division medical elements.
10.	Expert Field Medical Badge training program.
11.	Pregnant soldiers.
12.	Infectious and contaminated waste disposal procedures.
13.	Handling of blood and blood products.
14.	Immunization programs.
15.	Quality assurance.
16.	Medical materiel quality assurance program.
17.	Mobilization.

programs are conducted for the purposes of correcting a known training deficiency or to enhance the proficiency of medical personnel. Medical training deficiencies may be noted as a result of ARTEP test, feedback from brigade, battalion, or company commanders, or from the division surgeon's observations. Some of the medical training programs (first aid and combat lifesaver) may be DA-directed. The division surgeon coordinates with the Director of Health Services (DHS) pertaining to medical proficiency training for division personnel at MTFs. The division surgeon and the DHS develop policies and procedures for training, utilization, and withdrawal of division medical personnel from supporting MTFs. The division surgeon monitors the AMEDD Continuing Health Education (CHE) Program for the division. He monitors CHE points and requirements for AMEDD personnel as required by AR 351-3. He coordinates with the local medical department activity (MEDDAC) commander who is responsible for planning, conducting, and evaluating the local CHE Program. He obtains CHE training schedules from the MEDDAC commander and distributes it to appropriate AMEDD personnel assigned to the division. The division surgeon monitors and provides supervisory approval as required for temporary duty (TDY) for the purpose of obtaining CHE credits. He monitors programs attended by division medical personnel for compliance with AR 351-3. The following is a list of medical training programs and medical training, first aid, and combat lifesaver training which can be initiated by the division surgeon.

- Medical proficiency training program.
- Expert Field Medical Badge.
- Emergency medical technician training program.
- Combat lifesaver.
- Field sanitation team training.
- Nuclear, biological, and chemical patient treatment and decontamination training.
- Mass casualty training.
- Handling of blood and blood products.
- Preventive medicine measures.
- Prevention of sexually transmitted and other communicable diseases.
- Prevention and first aid treatment of cold weather injuries.

- Prevention and first aid treatment of heat injuries.
- Mental health/CSC measures.
- Medical implications of drug and alcohol abuse.
- Suicide prevention.
- Stress management/relaxation training.
- Identifying and treating stress reaction and BF.
- Cardiopulmonary resuscitation certification training.
- Common task training (medical).

5-18. Health Service Support Planning

The division surgeon is assisted with the development of HSS plans for the division by the supporting medical staff elements identified earlier in this chapter. Health service support estimates are provided by the division preventive medicine officer, division psychiatrist, and division dental surgeon (through the DMOC in those division under the MSB/FSB design). These estimates are used by the division surgeon to develop division HSS estimates. All factors must be considered during the initial development stages of the HSS plan. The HSS plan is updated as required to meet tactical or HSS operation requirements. Field Manual 8-55 provides an in-depth discussion of the planning process and considerations for HSS operations. The division surgeon should consider the following factors as he develops, reviews, or provides input to the division HSS plan:

- Mission.
- Threat.
- Division commander's estimates, guidance, and intent.
- Operational conditions.
- Operational constraints.
- Terrain.
- Military population supported.
- Medical personnel status, division medical elements.
- Equipment status of division medical elements.
- Supply status including Class VIII.
- Host-nation support.
- Communications status.
- Training status.
- Current health of the division.
- Casualty estimates.
- Medical evacuation requirements.
- Medical evacuation capabilities.
- Corps medical support.
- Nonmedical support requirements from division (engineers, transportation).
- Division support requirements.
- Special operations requirements.
- Army airspace command and control.
- Records and reports requirements.
- Phases of operations.
- Courses of actions.
- Information requirements (map essential elements of friendly information, updates).
- Policy and procedure updates.
- Humanitarian aid to local nationals.

5-19. Guide for Geneva Conventions Compliance

Medical personnel must advise commanders and leaders when their actions or orders, or the actions of personnel in their command cause the loss of protected status of medical facilities or medical personnel. Examples of outright violations of the Geneva Conventions and possible consequences are provided below.

a. Outright violations of the Geneva Conventions could result when–

- Using medical personnel to man or help man the perimeter of nonmedical facilities such as unit trains, logistics areas, or base clusters.
- Using medical personnel to man any offensive-type weapons or weapons systems.
- Ordering medical personnel to engage enemy forces other than in self-defense or in the defense of patients or MTFs.
- Mounting a crew-served weapon on a medical vehicle.
- Placing mines in and around medical units or facilities regardless of their type of detonation device.
- Placing booby traps in or around medical units or facilities.
- Issuing hand grenades, light antitank weapons, grenade launchers, or any weapons other than rifles and pistols to a medical unit or its personnel.
- Using the site of a medical unit as an observation post, a fuel dump, or to store arms or ammunition for combat.

b. Possible consequences of violations described in *a* above are–

- Loss of protected status for the medical unit and medical personnel.
- Medical facilities attacked and destroyed by the enemy.
- Medical personnel being considered prisoners of war rather than retained personnel when captured.
- HSS capabilities are decremented.
- Fewer medical personnel to provide hands-on care.
- Decreased laboratory and x-ray services.
- Decreased medical evacuation.

c. Other examples of violations of Geneva Conventions include–

- Making medical treatment decisions for the wounded and sick on any basis other than medical priority/urgency/severity of wounds.
- Allowing the interrogation of enemy wounded or sick even though medically contraindicated.
- Allowing anyone to kill, torture, mistreat, or in anyway harm a wounded or sick enemy soldier.
- Marking nonmedical unit facilities or vehicles with the red cross emblem or making any other unlawful use of the red cross emblem.
- Using medical vehicles marked with distinctive Geneva emblem (red cross on a white background) for transporting nonmedical troops and equipment/supplies or using medical vehicles (M577 or Ml13) as a tactical operations center.

d. Possible consequences of violations described in *c* above are–

- Criminal prosecution for war crimes.
- Reprisals taken against our wounded in the hands of the enemy.
- Medical facilities attacked and destroyed by the enemy.

- Medical personnel being considered prisoners of war rather than retained personnel when captured.
- Decreased HSS capabilities.
- Fewer medical personnel to provide hands-on care.
- Decreased laboratory and x-ray services.
- Decreased medical evacuation.

NOTE

The use of smoke and obscurants by medical personnel is not a violation of the Geneva Conventions.

e. Definitive information pertaining to the Geneva Conventions is found in FM 8-10.