

Joint Publication 4-02



Doctrine for Health Service Support in Joint Operations



30 July 2001



PREFACE

1. Scope

This publication delineates requirements and considerations for the health service support (HSS) system as well as the HSS aspects of joint planning, special operations, and military operations other than war. It also addresses force health protection, the health threat, and the requirement for medical intelligence.

2. Purpose


This publication has been prepared under the direction of the Chairman of the Joint Chiefs of Staff. It sets forth doctrine to govern the joint activities and performance of the Armed Forces of the United States in joint operations and provides the doctrinal basis for US military involvement in multinational and interagency operations. It provides military guidance for the exercise of authority by combatant commanders and other joint force commanders (JFCs) and prescribes doctrine for joint operations and training. It provides military guidance for use by the Armed Forces in preparing their appropriate plans. It is not the intent of this publication to restrict the authority of the JFC from organizing the force and executing the mission in a manner the JFC deems most appropriate to ensure unity of effort in the accomplishment of the overall mission.

3. Application

a. Doctrine and guidance established in this publication apply to the commanders of combatant commands, subunified commands, joint task forces, and subordinate components of these commands. These principles and guidance also may apply when significant forces of one Service are attached to forces of another Service or when significant forces of one Service support forces of another Service.

b. The guidance in this publication is authoritative; as such, this doctrine will be followed except when, in the judgment of the commander, exceptional circumstances dictate otherwise. If conflicts arise between the contents of this publication and the contents of Service publications, this publication will take precedence for the activities of joint forces unless the Chairman of the Joint Chiefs of Staff, normally in coordination with the other members of the Joint Chiefs of Staff, has provided more current and specific guidance. Commanders of forces operating as part of a multinational (alliance or coalition) military command should follow multinational doctrine and procedures ratified by the United States. For doctrine and procedures not ratified by the United States, commanders should evaluate and follow the multinational command's doctrine and procedures, where applicable and consistent with US law, regulations, and doctrine.

For the Chairman of the Joint Chiefs of Staff:


S. A. FRY
Vice Admiral, U.S. Navy
Director, Joint Staff

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EXECUTIVE SUMMARY

COMMANDER'S OVERVIEW

- **Discusses the Force Health Protection Mission and Objectives**
 - **Provides the Principles of Health Service Support (HSS)**
 - **Discusses HSS Planning and Coordination**
 - **Discusses Requirements for HSS in Special Operations**
 - **Discusses HSS in US Coast Guard Operations**
 - **Discusses HSS Command, Control, Communications, Computers, and Intelligence Systems**
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Force Health Protection Mission and Objectives

The primary objectives of force health protection are to protect the health of and provide health service support to US forces.

The three pillars of force health protection (FHP) are a healthy and fit force, casualty prevention, and casualty care management. These pillars correlate to the National Military Strategy pillars of “Shape”, “Prepare”, and “Respond”. The FHP mission in joint operations is to minimize the effects of wounds, injuries, disease, environment, occupational hazards, and psychological stressors on unit effectiveness, readiness, and morale. The combatant commander is responsible for the execution of the FHP mission within his or her area of responsibility. The success of casualty care management with limited medical forces in theater is directly dependent upon the combatant commander’s aggressive enforcement of the first two pillars. A proactive preventive medicine program and a phased health care delivery system accomplish the mission that extends from actions taken prior to and at the point of injury or illness through the completion of definitive treatment. FHP in joint operations requires continuous intelligence gathering and analysis, planning, coordination, and training to ensure a prompt, effective, and unified health care effort.

Health Service Support Principles

There are six principles of health service support (HSS).

The principles of health service support (HSS) include the following.

- **Conformity.** Integrate and comply with the commander's plan.
- **Responsiveness.** Provide timely access to HSS through proximity or evacuation.
- **Flexibility.** Shift HSS resources to meet changing requirements.
- **Mobility.** Anticipate the need for rapid movement of HSS resources to support combat forces during operations.
- **Continuity.** Provide optimum, uninterrupted care and treatment.
- **Coordination.** Ensure that HSS resources are efficiently employed and used effectively to support the planned operation.

Health Service Support Planning and Coordination

Timely, effective planning and coordination are essential to ensure adequate and sustainable HSS in a theater.

Proper planning permits a systematic examination of all factors in a projected operation and ensures interoperability with the campaign or operation plan. **Organization of the HSS** system is determined largely by the joint force's mission, the medical threat, medical intelligence, and the theater evacuation policy.

Each commander of a combatant command, subunified command, and joint task force should appoint a joint force surgeon (JFS). Combatant command JFSs are responsible for coordinating and integrating HSS within their theaters. They need to assess component commands' HSS requirements and capabilities, both quantitatively and qualitatively, and provide guidance to enhance the effectiveness of HSS through shared use of assets. Distribution of the respective component's HSS capabilities (as directed by the geographic combatant commander) will aid in ensuring efficient use of limited HSS resources.

Timely patient movement plays an important role in HSS.

Patient movement functions include medical regulating, patient evacuation, and en route medical care (i.e., medical staffing and patient movement items). Patient movement can be by surface (land or water) or by air (rotary-wing or fixed-wing aircraft); however, **air is preferred**. Initial transport of patients to the first and second levels of medical care is normally a Service component responsibility. Army aeromedical ambulance assets provide dedicated patient movement to and from Navy hospital ships. Intratheater patient movement is coordinated by a Theater Patient Movement Requirements Center (TPMRC). Intratheater forward aeromedical evacuation may be coordinated by an aeromedical evacuation liaison team. Patient movement from the theater is a collaborative effort between TPMRC, the Global Patient Movement Requirements Center, and the component lift control agency.

The medical estimate includes an **analysis of information pertaining to enemy intentions, allied or coalition partners' capabilities, limitations, courses of action, environmental factors, occupational hazards, and potential FHP consequences associated with a contemplated operation.**

The medical estimate includes all FHP facts, assumptions, and deductions that can affect the operation. Based upon the medical estimate of the situation, the JFS, in coordination with the component command surgeons, must plan HSS for the joint force and develop policies and procedures that can best support the joint operation.

Health Service Support in Special Operations

Because of the nature of their missions, special operations units have a very limited HSS structure and a limited number of medical personnel.

The nature of special operations requires small, highly skilled, self-contained teams that can be easily inserted and extracted by air, sea, and land delivery methods. However, these same mission requirements mandate that special operations forces' (SOF) medical personnel possess a variety of enhanced medical skills that enable them to operate under a multiplicity of circumstances with limited equipment. To compensate for deficiencies inherent in SOF HSS capabilities, special operations **HSS planning must integrate conventional support into the concept of the special operations mission** without compromising the security and objectives. The planning must also articulate the unique aspects of the operation that will complicate the delivery of HSS by conventional units.

Health Service Support in US Coast Guard Operations

Department of Defense HSS units may be required to support US Coast Guard units.

United States Coast Guard (USCG) participation in Department of Defense (DOD) operations may require some HSS from nearby DOD units, since organic USCG HSS is limited. USCG helicopters may be utilized in medical evacuations as a lift of convenience, but they are not normally outfitted with medical equipment or personnel.

Command, Control, Communications, Computers, and Intelligence Systems

HSS requires adequate command, control, communications, computers, and intelligence systems support.

Effective command, control, communications, computers, and intelligence (C4I) systems are vital to successful HSS. Early identification of a theater's C4I system requirements for HSS connectivity is essential. HSS management information systems support the information management requirements of HSS units across the range of military operations. Records, reports, and integrated systems are required to pass information and assist in the evaluation of policies and procedures.

CONCLUSION

HSS provides prompt, effective, and unified health services to enhance the combat fighting ability of joint forces. HSS in operations requires continuous planning, coordinating, synchronizing, and training. HSS is based upon a phased health services system with varying capabilities of care and situationally tailored to each operation.

CHAPTER I

FORCE HEALTH PROTECTION

“Better use medicines at the outset than at the last moment.”

Darius Publius, 42 BC

1. Overview

a. Force health protection (FHP) includes all measures taken by the chain of command and the military health system to promote, improve, conserve, or restore the mental or physical well-being of personnel across the range of military operations. The three pillars of FHP are a healthy and fit force, casualty prevention, and casualty care management. Figure I-1 shows the relationship between the pillars of the National Military Strategy (“Shape”, “Prepare”, and “Respond”) and the corresponding pillars of FHP.

b. The geographic combatant commander is responsible for the implementation of FHP within his or her

area of responsibility (AOR). The joint force surgeon (JFS), appointed by the geographic combatant commander, is responsible for the coordination and integration of the health service support (HSS) mission among the participating Service components. This ensures that maximum use and efficiency are attained from the deployed HSS resources. The success of casualty care management with limited medical forces is directly dependent upon the combatant commander’s aggressive enforcement of the first two pillars.

c. FHP is accomplished through the promotion of wellness, physical and mental conditioning, medical surveillance, preventive medicine, and the establishment of a phased health care delivery system.

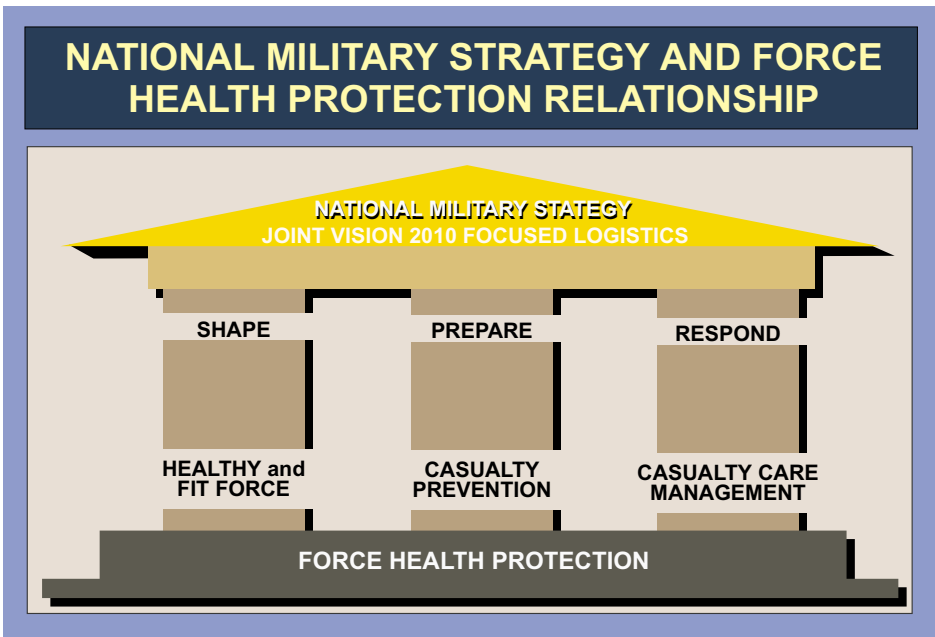


Figure I-1. National Military Strategy and Force Health Protection Relationship

HSS includes, but is not limited to, the following areas: medical treatment (to include area support), patient movement, hospitalization, to include forward resuscitative surgery, dental services, preventive medicine, veterinary services, combat stress control and mental health care services, health service logistic support, medical laboratory services, blood collection and distribution, and command, control, communications, computers, and intelligence (C4I).

d. FHP employs the right mix of HSS capabilities, at the right time and at the right place, to provide effective and efficient care for US forces. The past HSS concept of providing definitive care in theater to maximize returned to duty (RTD) status has evolved to a concept that provides essential care in theater to either RTD within the theater patient movement policy or stabilize for patient movement to the next level of care, with enhanced en route medical care and definitive care. Although this reduces the medical footprint in theater, it is dependent on uninterrupted airlift and will place increased demands on the personnel replacement system. Increased reliance on replacements rather than RTD may also affect unit cohesion.

2. Force Health Protection Pillars

a. **The first pillar of FHP promotes a healthy and fit force and provides the commander with an optimally fit Service member capable of withstanding the physical and mental rigors associated with combat and other military operations. Effective and enhanced quality of life guards the force against disease and nonbattle injury (DNBI), combat and operational stress reactions (COSR), and other health threats.** Wellness requires continuous attention before, during, and after deployment to sustain maximum readiness and operational capability.

- **Wellness programs in joint operations include physical and mental fitness, health promotion, and environmental and occupational health.** Physical fitness improves performance through programs that build and maintain endurance, strength, flexibility, and good emotional health. Health promotion encourages healthy life-styles through good nutrition, preventive dentistry, stress management, avoidance of substance abuse, and the promotion of health education and healthy family relationships.

- Physical and emotional fitness, health promotion, and environmental and occupational health keep US forces healthy on and off duty. Aggressive wellness programs promote quality of life. **Fit military members are less likely to be injured accidentally, can more readily withstand exposure to diseases and excessive stress, and more promptly heal from wounds or injuries.**

b. **The second FHP pillar is casualty prevention. Casualty prevention focuses on threats posed by enemy forces and occupational and environmental health threats.** Failure to counter these threats jeopardizes mission accomplishment.

- **Enemy Threat.** The enemy threat depends on the enemy's willingness and ability to use force (conventional and nonconventional weapon systems, munitions, and nuclear, biological, and chemical (NBC) agents) to produce casualties. **Aggressive HSS enhances the force's ability to minimize combat injuries resulting from continuous operations, combat stress, and/or exposure to NBC agents.**

- **Health Threat.** The health threat depends on a complex set of



Immunizations are a vital part of casualty prevention.

environmental and occupational factors that combine to produce DNIBs and COSRs and are a serious threat to US forces. There must be a comprehensive medical data collection system with continuous surveillance and preventive medicine measures (such as immunization, pretreatment, and chemoprophylaxis programs and policies) to continuously counter the health threat. To manage or reduce COSR, stress control measures should be implemented. These measures include surveying the unit to identify stressors and excess stress and advising the commander on interventions. This early intervention will reduce COSR-identified personnel requiring additional help, and lessen the chances of long-term disability such as posttraumatic stress disorder. These interventions occur before, during, and after deployment of forces (see Appendix A, “Health Threat”).

- A robust health surveillance system is a critical component of FHP. Deployment health surveillance includes identifying the population at risk (through, but not limited to, pre- and post-deployment health assessments), recognizing and

assessing hazardous exposures (medical, environmental, psychological, and occupational), employing specific countermeasures, and monitoring health outcomes.

c. The third FHP pillar, casualty care management, includes patient care and movement. It encompasses care provided from the point of injury through successive phases of medical care, including definitive and rehabilitative management in hospitals in the continental United States (CONUS) and outside the continental United States (OCONUS).

3. Five Phases of Casualty Care Management

The phases of casualty care management are first responder, forward resuscitative surgery, theater hospitalization, en route care, and care outside the theater (see Figure I-2). These phases ensure that patients receive the essential care in theater and movement to definitive care outside the theater as soon as practical.

a. **Phase I — First Responder.** The first response may include self-aid and buddy aid,



Figure I-2. Phases of Casualty Care Management

combat lifesavers, combat medics, hospital corpsmen, physician assistants (PAs), physicians, or other medical personnel. The first medical responder should have a working knowledge of the next level of care available and the patient movement system. Within this phase, the focus of all health care providers is to save life and limb and stabilize the patient sufficiently to evacuate to the next level of care. A stabilized patient is one whose airway is secured, hemorrhage is controlled, shock is treated, and fractures are immobilized. Threat to life or limb still exists but has been decreased with medical intervention. Stabilization is a necessary precondition for further patient movement. In combat settings, advance trauma management may differ significantly in priorities and procedures from that practiced in peacetime.

- **First Aid.** Basic first aid is provided by the individual (self-aid) or a buddy (buddy aid). Advanced first aid requires additional training and includes the initiation of vascular volume replacement through the use of intravenous (IV) fluids. Advanced first aid is provided by the combat lifesaver. First aid is the emergency or lifesaving

care given to a sick, injured, or wounded person when a medically trained individual is not immediately available. Every Service member is expected to know and apply basic lifesaving measures. Lifesaving measures are applied to restore breathing and circulation, to stop bleeding, to help prevent shock and infection, and to splint or immobilize fractures.

- **Combat Medic and/or Corpsman Care.** Combat medic and/or corpsman care is the first medical care that a sick, injured, or wounded individual receives from a medically trained individual. Combat medic and/or corpsman care entails the skillful application of physical examination techniques; performance of emergency or lifesaving measures; and continual observation and care to ensure that the airway remains open, that bleeding has ceased, and that shock, infection, and further injury are prevented. It involves the effective use of medical supplies not available to the first aid provider and arrangement for patient movement, as appropriate.
- **Advanced Trauma Management.** This phase of treatment includes care provided by personnel (physicians, dentists, PAs, and nurse practitioners) specifically trained and equipped for trauma management. Procedures can include invasive measures (such as venous cut downs or chest tubes) required to stabilize the patient prior to further movement.

- b. **Phase II — Forward Resuscitative Surgery.** The forward resuscitative surgery phase is the urgent initial surgery required to render a patient stabilized enough to withstand further movement to the next level of care. Forward resuscitative surgery is typically performed on patients with signs and symptoms of initial airway compromise, difficult breathing, and circulatory shock and



A corpsman provides medical care.

who do not respond to initial advanced trauma management procedures. This resuscitation and stabilization is dependent upon far forward lightweight and mobile surgical units. The capabilities, locations, and relationships of far forward surgical units to first responders and to more definitive levels of care must be clearly delineated and communicated throughout the joint force.

c. **Phase III — Theater Hospitalization.** Theater hospitals will provide essential care to patients and prepare those who require higher care for evacuation out of theater.

d. **Phase IV — En Route Care.** En route care involves the medical treatment of

patients during movement. This provides uninterrupted care from the point of injury or initial illness until the patient arrives at the next level of care.

e. **Phase V — Care Outside the Theater.** Care that is provided outside the theater may include convalescent, restorative, and rehabilitative services and normally is provided by military, Department of Veteran Affairs, CONUS civilian hospitals, and commander in chief (CINC)-approved safe havens. It may include a period of minimal care and increased physical activity necessary to restore patients to functional health.

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CHAPTER II

HEALTH SERVICE SUPPORT OPERATIONS

"The preservation of the soldier's health should be [the commander's] first and greatest care."

George Washington

1. Mission

The HSS mission in joint operations is to minimize the effects of wounds, injuries, diseases, environmental and occupational hazards, and psychological stressors on unit effectiveness, readiness, and morale. This mission is accomplished by a comprehensive HSS plan and phased medical care that extends from actions taken at the point of injury or illness, to movement from a theater for treatment. The effectiveness of HSS is measured by its ability to save life and limb; to reduce the DNBI and COSR rates; to return patients to duty as quickly and as far forward in the theater as possible; and to evacuate patients with minimum delay to theater hospitals or out of the theater, as appropriate.

2. Objective

The primary objective of HSS is to conserve the fighting strength of the forces. This objective is most effectively achieved through optimum use and integration of available HSS assets. HSS in joint operations requires continuous planning, coordinating, synchronizing, and training to ensure a prompt, effective, and unified health care effort.

3. Principles

Each Service component has an HSS system that encompasses six health care principles. Figure II-1 depicts these principles.

a. **Conformity.** Conformity with the combatant commander's operation plan



Figure II-1. Health Service Support Principles

(OPLAN) is the most fundamental element for effectively providing HSS. Only by participating in the development of this plan can the HSS planner ensure adequate support at the right time and the right place.

b. **Responsiveness.** The speed with which medical treatment is initiated is extremely important in reducing morbidity and mortality. The efficient allocation of resources and the judicious location of medical treatment facilities (MTFs) must optimize access to care.

c. **Flexibility.** Since a change in tactical plans or operations may require redistribution or relocation of HSS resources to meet the changing requirements, no more medical resources should be committed nor MTFs established than are required to support expected patient densities.

d. **Mobility.** Since contact with supported units must be maintained, HSS elements must



Helicopters provide mobility for health care providers.

have mobility comparable to that of the units they support. Mobility is measured by the extent to which a unit can move its personnel and equipment with organic transportation.

e. **Continuity.** HSS must be continuous since an interruption of treatment may cause an increase in morbidity and mortality.

f. **Coordination.** The objective of this principle is to ensure that HSS resources in short supply are efficiently employed and used effectively to support the planned operation. Continuous coordination ensures that medical facilities are not placed in areas that interfere with combat operations. Additionally, continuous coordination ensures that the scope and quality of medical treatment and care meet professional standards and policies.

4. Organization

HSS is organized into five levels of care (see Figure II-2).

a. **Level I.** Level I care consists of care rendered at the unit level. It includes self-aid, buddy aid, and combat lifesaver skills, examination, and emergency lifesaving measures such as the maintenance of the airway, control of bleeding, prevention and control of shock, splinting or immobilizing fractures, and the prevention of further injury. Treatment may include restoration of the airway by invasive procedures; use of IV fluids and antibiotics; and the application of splints and bandages. These elements of medical management prepare patients for RTD or for transportation to a higher level of care. Supporting medical units are responsible for coordinating the movement of patients from supported medical facilities.

b. **Level II.** At a minimum, Level II care includes physician-directed resuscitation and stabilization and may include advanced trauma management, emergency medical procedures, and forward resuscitative surgery. Supporting capabilities include basic laboratory, limited x-ray, pharmacy, and temporary holding facilities. Patients are treated and RTD, or are stabilized for movement to a MTF capable of providing a higher level of care. Surface or air movement is coordinated for transfer to a facility possessing the required treatment capabilities. Level II is the first level where Group O liquid packed red blood cells will be available for transfusion.

c. **Level III.** Care is administered that requires clinical capabilities normally found in a facility that is typically located in a reduced-level enemy threat environment. The facility is staffed and equipped to provide

LEVELS OF HEALTH SERVICE SUPPORT

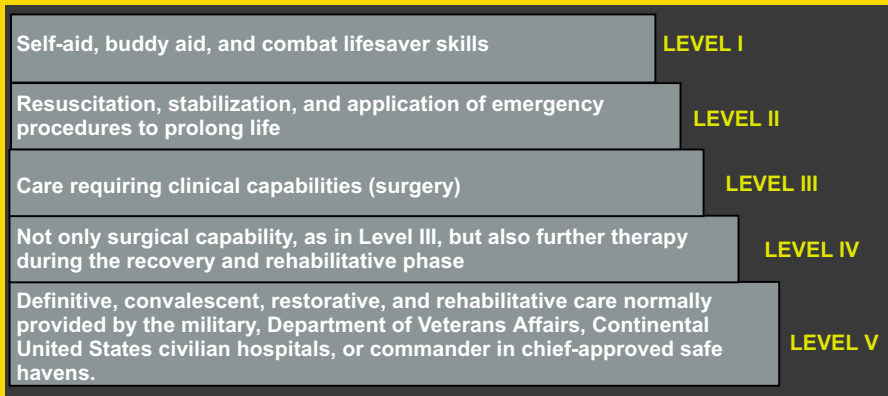


Figure II-2. Levels of Health Service Support

resuscitation, initial wound surgery, and postoperative treatment. This level of care may be the first step toward restoration of functional health, as compared to procedures that stabilize a condition to prolong life. Blood products available may include fresh frozen plasma, Groups A, B, and O liquid cells and may include frozen Group O red cells and platelets.

d. **Level IV.** In addition to providing surgical capabilities found at Level III, this level also provides rehabilitative and recovery therapy for those who can RTD within the theater patient movement policy. This level of care may only be available in mature theaters.

e. **Level V.** Level V definitive care includes the full range of acute convalescent, restorative, and rehabilitative care and is normally provided in CONUS by military and Department of Veterans Affairs hospitals, or civilian hospitals that have committed beds for casualty treatment as part of the National Defense Medical System. On occasion, OCONUS military or allied and/or host nation hospitals in CINC-approved safe

havens may also be used. This level may include a period of minimal care and increasing physical activity necessary to restore patients to functional health and allow them to RTD or to a useful and productive life.

5. Relationships and Responsibilities

a. Geographic combatant commanders are ultimately accountable for HSS and for coordinating and integrating HSS within their theaters. In joint operations, joint use of available medical assets will be accomplished to support the warfighting strategy and concept of operations.

b. A JFS should be appointed for each combatant command, subunified command, and joint task force (JTF). As a specialty advisor, the JFS may report directly to the joint force commander (JFC). The JFS coordinates FHP matters for the JFC. The JFS section should be jointly staffed and should be of sufficient size to effectively facilitate the following.



Theater hospitals provide a full range of capabilities.

- Joint coordination of HSS initiatives.
 - Performance of health threat assessment.
 - Health service logistic support and blood requirements.
 - Standardization and interoperability.
 - Development of the HSS plan and course of action (COA) analysis.
 - Review of subordinate plans and operations.
 - Joint coordination of intratheater patient movement.
 - Theater health surveillance.
- c. The **combatant command JFS assesses component command HSS requirements and capabilities**, both quantitatively and qualitatively, and **provides guidance to enhance the effectiveness of HSS**. The **combatant command JFS has the responsibility to perform the following**.
- Advise the combatant commander on all HSS operations.
 - Recommend and monitor preventive medicine and care provided to the civilian population and other beneficiaries.
 - Assist the combatant commander in formulating a recommended theater patient movement policy within the geographic area.
 - Assist the component commands in identifying HSS requirements and coordinating cross-Service support, where practical.
 - Advise the combatant commander concerning the following.
 - The health of the command and other medical factors that could affect operations.
 - HSS aspects of combat operations.
 - Intratheater rest, rotation, and reconstitution policies and procedures.
 - Preventive medicine procedures.
 - Occupational and environmental health.

- Joint reception, staging, onward movement, and integration (JRSOI).
- Monitor and inform the combatant commander on the **status of HSS resources**.
- Inform the combatant commander concerning the status of and assistance required by and provided to the civilian populace, Department of Defense (DOD) civilian employees, DOD contract personnel, enemy prisoners of war (EPWs), nongovernmental organizations (NGOs), and international organizations (IOs). Advise supporting civil affairs forces on humanitarian and civic assistance (HCA) activities within the theater.
- Coordinate HSS provided to or received from, allies, coalition partners, host nation (HN) military, or other friendly nations.
- Coordinate medical intelligence (Appendix B, “Medical Intelligence”) support for HSS organizations.
- Supervise the activities of the Theater Patient Movement Requirements Center (TPMRC) and the Joint Blood Program Office (JBPO).
- Coordinate support from the Global Patient Movement Requirements Center (GPMRC). (The GPMRC is a United States Transportation Command asset.)

This center is discussed in detail in Joint Publication (JP) 4-02.2, Joint Tactics, Techniques, and Procedures for Patient Movement in Joint Operations.

- Coordinate support from the Armed Services Blood Program Office (ASBPO). **The ASBPO is responsible for the coordination of the blood**

programs of the military Services and the combatant commands. The ASBPO provides an **orderly system for collection, storage, and distribution of blood products** across the range of military operations. The primary responsibility of the ASBPO is to ensure that blood products, in the required types and amounts, reach the theater in a ready-to-use condition.

For a detailed discussion of blood management, refer to JP 4-02.1, Joint Tactics, Techniques, and Procedures for Health Service Logistics in Joint Operations.

- Prepare the **HSS Annex Q** to the OPLAN.
- Prepare **patient movement (lift-bed) requirements** based on the casualty estimates provided by the appropriate staff.
- Obtain Service specific casualty rate information to model HSS force structure and casualty flow for the joint operation. When the size of the joint operation warrants, use the most current Chairman of the Joint Chiefs of Staff (CJCS)-approved automated medical planning tools to generate patient requirements and identify shortfalls in medical force structure, equipment, and supplies.
- Identify possible requirements for fixed-wing patient airlift based on casualty estimates.

d. The subordinate joint force JFS assesses component command HSS requirements and capabilities (both quantitatively and qualitatively) and provides guidance to enhance the effectiveness of HSS. The subordinate joint force JFS has the responsibility for the following.

- Assist the component commands in identifying HSS requirements and coordinating cross-Service support, where practical.
- Advise the subordinate JFC concerning:
 - HSS aspects of combat operations;
 - Preventive medicine;
 - Health of command and other medical factors that could affect operations;
 - Occupational and environmental health; and
 - JRSOI.
- Monitor and inform the subordinate JFC on the status of HSS resources.
- Inform the subordinate JFC concerning the status of and assistance required by and provided to the civilian populace, DOD civilian employees, DOD contract personnel, EPWs, NGOs, and IOs. Advise supporting civil affairs (CA) forces on HCA activities within the joint force operational area.
- Coordinate HSS provided to or received from allies, coalition partners, HN military, or other friendly nations.
- Coordinate medical intelligence (Appendix B, “Medical Intelligence”) support for HSS organizations.
- Prepare the FHP HSS Annex Q to the joint force OPLAN (See Appendix C, “Format for Annex Q to an Operation Plan”).
- Prepare patient movement (lift-bed) requirements based on the casualty estimates and rates provided by the appropriate staff.
- Advise the subordinate JFC on all HSS operations.
- Define and monitor preventive medicine and care provided to civilian population and other beneficiaries.
- Assist HSS personnel and facilities to comply with the 1949 Geneva Conventions.
 - e. The combatant commander has directive authority for logistics within the AOR, to include the execution of the health service logistic support mission. One way the combatant commander may exercise this authority is by designating one of the Services within the AOR (normally the predominant user) as the single integrated medical logistics manager (SIMLM). The SIMLM’s mission, roles, and responsibilities for supporting joint forces must be clearly identified in concept and operation plans.

Further information on the SIMLM is in JP 4-02.1, Joint Tactics, Techniques, and Procedures for Health Service Logistics in Joint Operations.
 - f. The US Army is the DOD Executive Agent for veterinary services for all Services and the advisor to the JFS on all veterinary affairs. This mission includes the control of zoonotic diseases, veterinary care of DOD-owned animals, veterinary laboratory support, inspection and examination of subsistence items for quality and, when authorized, veterinary care for animals belonging to local indigenous personnel in conjunction with nation assistance or other operations. Army Veterinary Corps, Navy Preventive Medicine, and Air Force Public Health provide food safety services, assuring food quality.

6. Patient Movement

Timely patient movement plays an important role in FHP and the design of

HSS. Patient movement functions include medical regulating, patient movement, patient in-transit visibility, and providing en route care (e.g., medical staffing and patient movement items (PMIs), etc.). Patient movement can be by surface (land or water), or by air (rotary-wing or fixed-wing aircraft); however, **air is preferred.**

a. Initial movement of patients to a theater hospital has historically been a Service component responsibility, but patient movement can be coordinated within an AOR, as required, by a Joint Patient Movement Requirements Center. Intratheater forward aeromedical evacuation (AE) may be coordinated by an AE liaison team. Army aeromedical ambulance assets may provide dedicated patient movement to and from Navy hospital ships. Intratheater patient movement is coordinated by a TPMRC. Patient movement from the theater is a

collaborative effort between the TPMRC, GPMRC, and the component lift control agency.

Patient movement procedures in joint operations are described in JP 4-02.2, Joint Tactics, Techniques, and Procedures for Patient Movement in Joint Operations.

b. PMI refers to specific medical equipment and durable supplies that must be available to support patient movement. The mission of the PMI system is to support in-transit medical capability by minimizing the removal of equipment from patients; exchange PMIs without degrading medical capabilities; and provide prompt recycling of PMIs.

The PMI system is outlined in JP 4-02.1, Joint Tactics, Techniques, and Procedures for Health Service Logistics Support in Joint Operations.

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CHAPTER III

HEALTH SERVICE SUPPORT PLANNING

“A corps of medical officers was not established solely for the purpose of attending the wounded and sick . . . the labors of medical officers cover a more extended field. The leading idea, which should be constantly kept in view, is to strengthen the hands of the Commanding General by keeping his army in the most vigorous health, thus rendering it, in the highest degree, efficient for enduring fatigue and privation, and for fighting. In this view, the duties of such a corps are of vital importance to the success of an army, and commanders seldom appreciate the full effect of their proper fulfillment.”

Major Jonathan Letterman
Medical Director of the Civil
War Army of the Potomac

1. The Joint Operation Planning Process

The Joint Operation Planning and Execution System is the policy, procedures, and automated data processing system used for developing, coordinating, reviewing, approving, and disseminating joint OPLANs. Operational planners must take many factors into account to select the best or most appropriate means of performing a joint force mission. The amount of time available for planning influences the entire process. Joint operation planning is comprised of deliberate and crisis action planning. The Global Command and Control System (GCCS) provides the means by which planners develop and execute OPLANs and operation orders (OPORDs). The GCCS furnishes warfighters at all levels with the needed connectivity, rapid access, flexibility, and simplicity in operations for a comprehensive, interoperable, global command and control (C2) capability.

2. Health Service Support Planning Considerations

Timely, effective planning and coordination are essential to ensure adequate and sustainable HSS in a theater. Proper planning

permits a systematic examination of all factors in a projected operation and ensures interoperability with the campaign plan or OPLAN (see Appendix C, “Format for Annex Q to an Operation Plan”). Organization of the HSS system is determined by the joint force’s mission, the health threat, medical intelligence, anticipated number of patients, duration of the operation, the theater patient movement policy, available lift, and hospitalization and movement requirements (see Figure III-1).

a. **Threat.** The threat is a composite of ongoing or potential enemy actions; occupational, environmental, geographical, and meteorological conditions; endemic diseases that can reduce the effectiveness of the joint force through wounds, injuries, illness, and psychological stressors; and the employment of weapons of mass destruction (WMD). See Appendix A, “Health Threat.”

b. **Medical Intelligence.** Medical intelligence is produced from the collection, evaluation, and analysis of information concerning the health threats and medical capabilities of foreign countries that have immediate or potential impact on policies, plans, or operations. See Appendix B, “Medical Intelligence.”

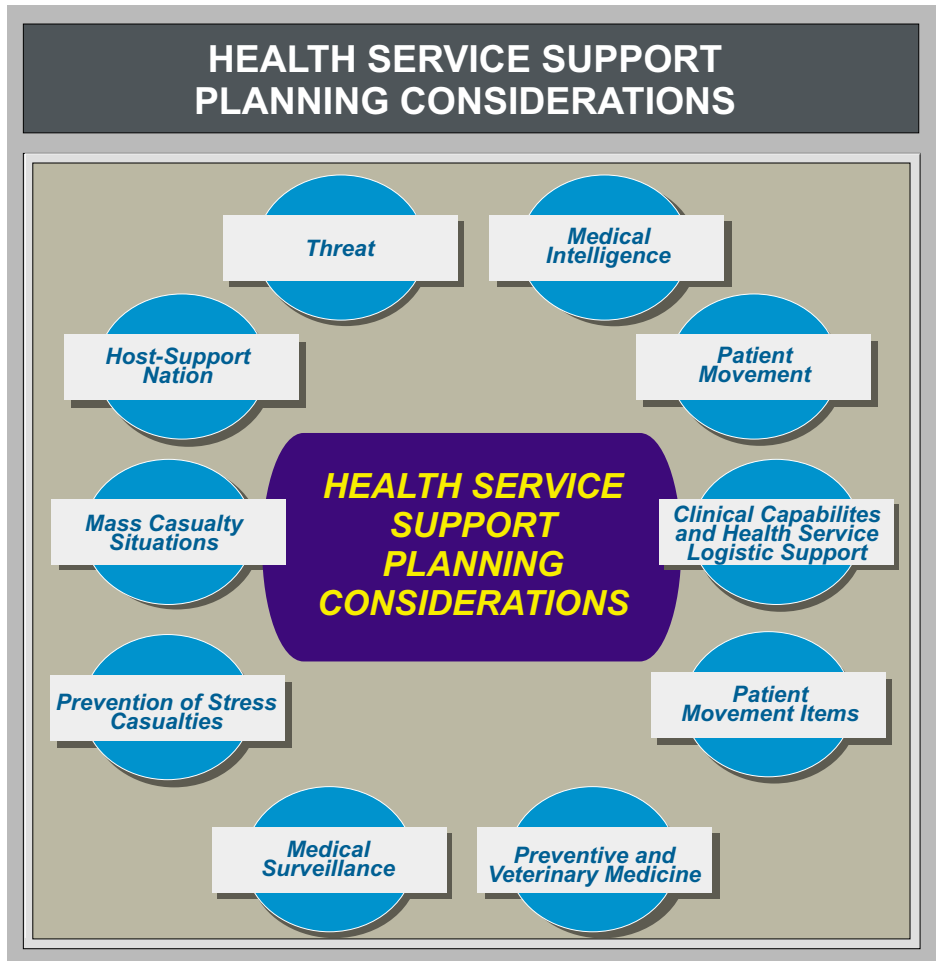


Figure III-1. Health Service Support Planning Considerations

c. Patient Movement. Timely patient movement plays an important role in the design of HSS. Patient movement is the end result of the collaborative lift-bed planning, and involves selection of patients for movement based on consideration of medical condition, locating available beds, route planning, and the selection of movement platforms and movement control. The HSS planner should consider using all means of patient movement.

For further guidance, refer to JP 4-02.2, Joint Tactics, Techniques and Procedures for Patient Movement in Joint Operations.

d. Clinical Capabilities and Health Service Logistic Support. Specific clinical capabilities, location, health service logistic supportability, and bed requirements must be considered when planning HSS and must be detailed in the respective OPLAN. HSS planners must consider the following.

- Sufficient personnel with the clinical capabilities necessary to provide care for the expected number and types of patients in the theater.
- Specific clinical capability, relative mobility, logistic supportability, and the



Planners must account for the medical situation in the operational area.

necessity to ensure a logical expansion of capabilities in theater.

- Critical time and distance factors that impact on morbidity and mortality rates.
- Health service logistic issues, including:
 - Standardization;
 - Use of a SIMLM system;
 - Items requiring special handling;
 - Transportation;
 - Type and quantity of medical supplies needed;
 - Supply procedures and sustainment requirements; and
 - Medical equipment maintenance and support requirements.
- Blood supply and distribution.

e. **Patient Movement Items.** PMIs are specific medical equipment and durable supplies that must be available to support the

patient. Examples of PMIs include ventilators, litters, patient monitors, and pulse oximeters. The mission of the PMI system is to support patients in-transit, to exchange in-kind PMIs without degrading medical capabilities, and to provide prompt recycling of PMIs. It is the originating MTF's responsibility to provide the PMIs required to support the patient during movement. PMIs accompany a patient throughout the chain of movement, from the originating MTF to the destination MTF, whether it is an intratheater or intertheater transfer. Planners must ensure that PMIs are available at the correct location and ready for use and PMI centers are established (establishment of theater PMI centers and cells is the responsibility of the US Air Force). PMI centers are established to support worldwide theater requirements. PMI centers will be located at airports of embarkation and/or debarkation within CONUS and OCONUS to match AE support plans. PMI centers and cells will receive, refurbish (i.e., technical inspection, calibration, repair, and replenishment of expendable supplies to maintain a 3-day level of supplies), redistribute, and return PMIs collected from MTFs. PMI centers can be augmented with personnel and equipment from the other Services; liaison personnel

may also be assigned. At the time an MTF initiates a patient movement request requiring PMIs, the PMI center and/or cell will initiate action for the exchange of in-kind PMIs.

For further guidance on PMIs, refer to JP 4-02.2, Joint Tactics, Techniques and Procedures for Patient Movement in Joint Operations.

f. Preventive Medicine and Medical Surveillance. Risk assessment and analysis as well as preventive medicine measures must be included early in HSS planning.

The theater medical surveillance program is initiated and the means to counter the health threats in the operational area are identified before the forces arrive. Specific preventive medicine procedures are generally the responsibility of the component commands. However, the geographic combatant commander, with advice from the JFS, may exercise directive authority and change component responsibilities based on operational or geographic considerations.

- **Preventive medicine is the anticipation, communication, prediction, identification, prevention, education, risk assessment, and control of communicable diseases, illnesses and exposure to endemic, occupational, and environmental threats.** These threats include nonbattle injuries, combat stress responses, WMD, and other threats to the health and readiness of military personnel. Communicable diseases include anthropod-, vector-, food-, waste-, and waterborne diseases. Preventative medicine measures include field sanitation, medical surveillance, pest and vector control, disease risk assessment, environmental and occupational health surveillance, waste (human, hazardous, and medical)

disposal, food safety inspection, and potable water surveillance.

- **Medical surveillance is defined as the ongoing, systematic collection of health data essential to the evaluation, planning, and implementation of public health practice, closely integrated with timely dissemination of data as required by higher authority.** Theater medical surveillance is essential for early identification of health threats within the operational area in order to prevent, neutralize, minimize, or eliminate them. The medical surveillance program must cover all periods from predeployment, deployment, redeployment and post deployment. This information must be included in the Health Services Support Annex (Annex Q) to the joint OPLAN and/or OPORD supporting the operation. A comprehensive medical surveillance program includes preventive and epidemiological activities to ensure that commanders are kept informed on the health of the force, health threats, occupational and environmental threats, stressors, risks, and available preventive medicine and stress control measures before, during, and after deployment.

For further information refer to JP 3-35, Joint Deployment and Redeployment Operations, DOD Directive 6490.2, Joint Medical Surveillance, and DOD Instruction 6490.3, Implementation and Application of Joint Medical Surveillance for Deployments.

- Protocols are required for vaccines, chemoprophylaxes, barrier creams, and pretreatments which are recommended for deployed forces and which are not approved for general use or are not approved for the purpose for which they are being administered

under the Food and Drug Administration's guidelines. If the vaccine or medication is to be administered without a member's prior consent, the Secretary of Defense must generally obtain a waiver of informed consent requirements in accordance with title 10, US Code (USC), section 1107(f).

- Establishment of a central repository for all specimens and samples, to include suspected biological warfare and chemical warfare agents and data, must be coordinated with the Assistant Secretary of Defense (Health Affairs).

g. Prevention of Stress Casualties.

Prevention of stress casualties and control of combat and operational stress is a command and leader responsibility. HSS and other personnel at all levels play important supporting roles. A coordinated program must be planned for the prevention, treatment, and RTD of combat stress reaction casualties. Active education, training, and prevention programs assist with controlling stress and preparing unit leaders and HSS personnel to identify and manage stress reactions in units.

h. Mass Casualty (MASCAL) Situations. Procedures for handling MASCALs must be established to include casualty management resulting from WMD, combat, or other military operations. Particular emphasis is placed on the flexibility of HSS units to respond to sudden changes in the casualty situation. Successful management of a MASCAL situation is a complex task where success relies as much on well-practiced logistics and communications as it does on skilled medical treatment. The JFS must ensure that the communications, transportation, triage and emergency management, patient movement, and health service logistic support management aspects of the MASCAL plan are thoroughly rehearsed.

i. Host-Nation Support (HNS). HNS can be a significant force multiplier. HNS should be equivalent to US standards or acceptable to the geographic combatant commander. The JFS must assess HN medical capabilities and make recommendations to the JFC on their use for deployed US forces. In many operations, HN blood supplies do not meet US standards of care. The JFS should make arrangements to store and use blood products from US-approved sources even if HN MTFs are planned to support the



Mass casualties can also result from natural disasters.

deployed force. HNS may reduce the lift requirements necessary to deploy HSS to the joint operations area (JOA).

For further information, refer to JP 5-00.2, Joint Task Force Planning Guidance and Procedures.

j. Additional HSS Planning Considerations. Additional HSS planning considerations that the JFS must take into account to support joint operations are as follows.

- **Ensure that an adequate joint medical communications** architecture is established to provide compatible and responsive communications for the military HSS system.
- **Ensure that adequate standardization and interoperability policies** are in place to ensure that all deployable medical systems supporting joint operations are interoperable between Service components.
- **Review entitlements, applicable laws, and regulations** for the provision of US military HSS to nonmilitary beneficiaries (civilian employees, DOD contractors, or other nonmilitary participants) and military and nonmilitary personnel of another nation. Ensure that policies are published, disseminated and understood by all HSS personnel.
- **Coordinate HSS requirement in support of natural disasters.**
- **Coordinate support with outside relief agencies** (Red Cross, NGOs, and IOs) in theater to ensure complete visibility for overall medical situation and requirements, including integrated transfer of responsibilities for policies and procedures.

- **Amphibious Task Force.** Amphibious task force HSS planning responsibilities are closely related to those of the landing force. Detailed, coordinated, and parallel planning is required between the commander of the amphibious task force and the commander of the landing force. Each surgeon of these commands has specific HSS planning responsibilities that are detailed in JP 3-02, *Joint Doctrine for Amphibious Operations*.

- **Airborne Operations.** Airborne operations establish a lodgment in an isolated uncertain or hostile environment. Detailed, coordinated, and joint planning is required between the commander of the airborne task force and the JFC. Each surgeon of these commands has specific HSS planning responsibilities that are detailed in JP 3-17, *Joint Doctrine and Tactics, Techniques, and Procedures for Air Mobility Operations*, and JP 3-18, *Joint Doctrine for Forcible Entry Operations*.

Additional considerations and a detailed HSS planning checklist can be found in JP 5-00.2, Joint Task Force Planning Guidance and Procedures.

k. HSS for Returned US Prisoners of War (POWs) and Detained Personnel. The geographic combatant commander establishes a theater plan on the proper handling and provision of HSS for returned US POWs and detained personnel.

1. **HSS for EPW.** In consonance with provisions outlined in the Geneva Conventions, EPWs held by US forces are afforded the same level of HSS as US forces. Seriously wounded, injured, or sick EPWs will be segregated from US, allied, and coalition patients and will be evacuated from the combat zone through HSS channels as soon as possible. The JTF commander must

ensure that appropriate security is provided to guard the EPWs. Medical personnel will not be used as guards. As much as possible, medical care of EPWs will be provided by qualified retained or detained medical personnel from that same nation.

m. **Dental Service**

- **Joint operations planning must include the consideration of two categories of dental services.** One category of dental care is provided within the operational area and an additional category in the support base (see Figure III-2).
- The planning process includes an evaluation of the size and anticipated duration of the operation, along with categories of dental care required to support the operation.
 - **Category I — Operational Care.** Care given for the relief of oral pain, elimination of acute infection, control of life-threatening oral conditions (hemorrhage, cellulitis, or respiratory difficulties), and treatment of trauma to teeth, jaws, and associated facial structures is considered **emergency care**. It is the most austere type of care and is available to Service members

engaged in tactical operations. Common examples of emergency treatments are simple extractions, antibiotics, pain medication, and temporary fillings. **Essential non-emergency care** includes dental treatment necessary to intercept potential emergencies. This type of operational care is necessary for prevention of lost duty time and preservation of fighting strength. Personnel in Dental Class 3 (potential dental emergencies) should be provided this level of care as the tactical situation permits. Common examples of **essential non-emergency care** are basic restorations, extractions, interim pulpal therapy (pulpectomy), treatment of periodontal conditions, and simple prosthetic repairs. Essential non-emergency care is consistent with Level II HSS. **Essential non-emergency care** is also intended to maintain the overall oral fitness of personnel at a level consistent with combat readiness. Most dental disease is chronic and recurring. Oral health status will deteriorate from the day of deployment if essential care is not provided by deployed dental support. Those in Dental Class 2 (untreated oral disease) should be provided essential care as the tactical situation and availability of dental resources permit. This level of care is the highest category

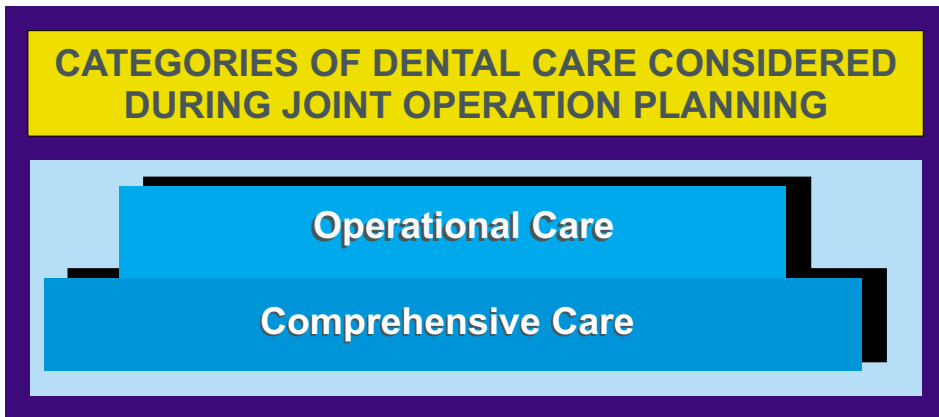


Figure III-2. Categories of Dental Care Considered During Joint Operation Planning

of operational care available in the operational area and is provided by area support dental units.

•• **Category II — Comprehensive Care.** Treatment to restore an individual to optimal oral health, function, and esthetics. Comprehensive dental care may be achieved incidental to providing operational care in individuals whose oral condition is healthy enough to be addressed by the category of care provided. This category of care is usually reserved for HSS plans that anticipate an extended period of reception and training in theater. The scope of facilities needed to provide this level of dental support could equal that of Level III medical facilities.

- **Planning for dental services must include the potential for augmenting the medical effort during MASCAL situations.** Joint operations of limited size or duration may limit dental services to predeployment screening, which eliminates planning for deployment of dental personnel and equipment.

n. **Veterinary Service**

- The US Army is the DOD Executive Agent for veterinary support for the Services. In some instances, support is also provided to allies and/or coalition partners, HN agencies, and other federal agencies. The appropriate mix of veterinary units provides support. These units are tasked-organized to support food safety and quality assurance, and the health care mission for government-owned animals. Services include sanitary surveillance for food source and storage facilities, and procurement, surveillance, and examination of foodstuffs for food safety. The veterinary unit through the geographic combatant commander is responsible for publication of a directory

of approved food sources for the operational area.

- When deployed in military operations, veterinary support and preventive medicine capabilities reduce the vulnerability of multinational and US forces to DNBI. The CONUS-based force projection forces require an early veterinary and preventive medicine presence in the operational area wherever subsistence, bottled water, and/or ice are procured, shipped, stored, or issued. Procurement of fresh foods and beverages is supported by veterinary personnel through sanitary inspection of local food establishments in the operational area. Food inspection is necessary to ensure food safety, quality assurance, and adequate food hygiene. The potential of food-borne disease, the threat of NBC contamination of subsistence, the need to assess the zoonotic endemic disease threats, and the need to provide health care to military working dogs all require an early veterinary presence throughout the entire operational area. To ensure protection of the force against the threats identified above, veterinary services must be active participants in all joint and multinational operations.
- Comprehensive veterinary medical and surgical programs are required to maintain the health of government-owned animals. Veterinary animal health care provides an effective combat multiplier by providing complete medical care to all military working dogs supported in the operational area and by monitoring endemic animal disease threats of military significance. Veterinary personnel work closely with Army, Air Force, and Navy preventive medicine units to provide coordinated FHP support.

For additional information on veterinary services, see field manual (FM) 8-10-18, Veterinary Services.

3. Health Service Support Command, Control, Communications, Computers, and Intelligence Systems

Effective C4I systems are vital to successful HSS in joint operations. HSS functions depend upon responsive C4I systems to tie all aspects of support together and allow JTF commanders to direct, monitor, and be proactive in decisionmaking as situations develop (see Figure III-3).

a. **C2 of HSS organizations normally rests with the component commands.** The JFS will recommend C2 relationships based on mission, enemy, terrain and weather, troops and support available, and time available.

b. **Early identification of a theater's C4I system requirements for HSS connectivity is essential.** At a minimum, HSS communications must support reliable, constant communications within a theater, from the theater to CONUS, and link the most forward HSS elements in the theater through each level in the phased HSS system, through the Service component command's headquarters or JTF headquarters to the final

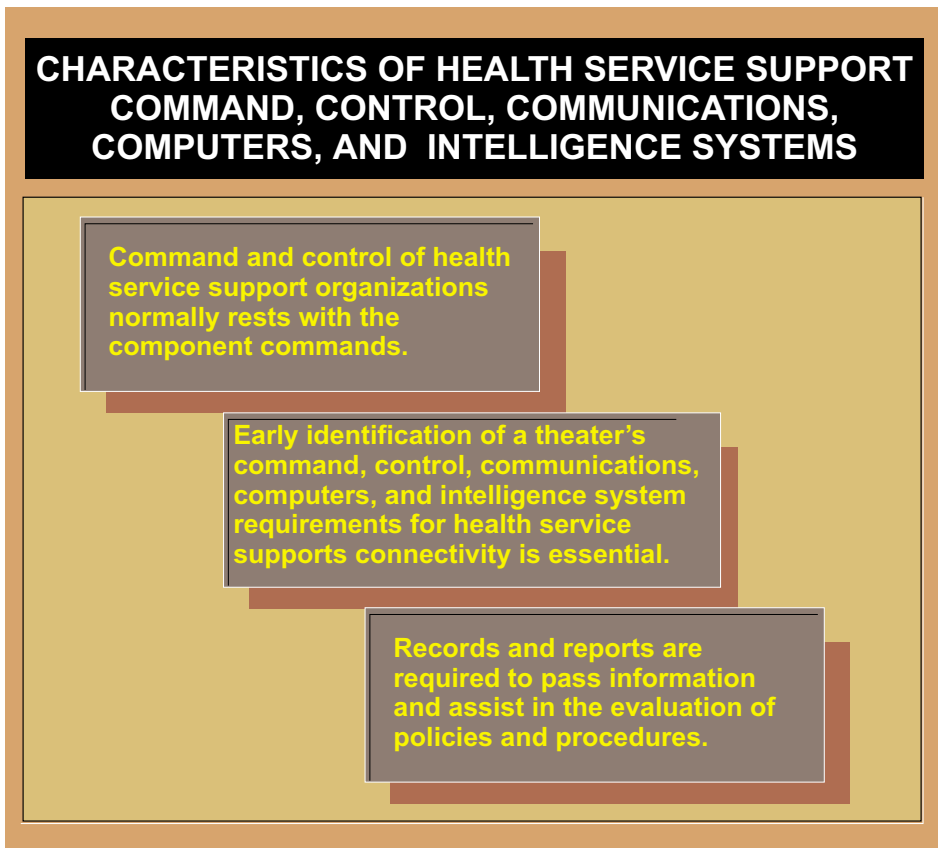


Figure III-3. Characteristics of Health Service Support Command, Control, Communications, Computers, and Intelligence Systems

destination MTF. The success of HSS operations depends upon reliable communications over dedicated and parallel systems. HSS communications planners, working with the joint force command, control, communications, and computer systems directorate (J-6), must identify frequencies and encryption sets and/or codes that are common between Service component support forces assigned to HSS missions. If no commonality exists, then planners should consider assigning a component to develop a theater communications plan that ensures adequate communications support to all components. A theater communications plan should be formulated during deliberate planning. This is done through complete and detailed descriptions of systems and systems' requirements (frequency, classification, etc.) in all Service documents and consolidated in a joint OPLAN or operation plan in concept format.

- Patient movement vehicles and aircraft must be equipped with the proper communications equipment to facilitate in-theater communications in support of HSS operations. The component command HSS units must plan to provide the necessary communications equipment.
- Long-haul telecommunications services will be provided through the Defense Information Services Network and its component systems, the Defense Switched Network, Defense Data Network, Automated Digital Network (and its follow-on replacement, the Defense Message System), Secure Internet Protocol Router Network, Nonsecure Internet Protocol Router Network, and the Defense Satellite Communications System.
- All **frequency requirements** for organic equipment must be coordinated with the JFC's J-6 staff. **All HSS should be**

developed and certified to operate on the Global Combat Support System.

- Theater medical information programs must be **timely, accurate, and relevant**. They must cover the following:
 - Theater medical information;
 - Blood management;
 - Patient tracking and movement;
 - Health service logistic support; and
 - Medical surveillance.

c. Records and reports are required to pass information and assist in the evaluation of policies and procedures.

The combatant command surgeon (a JFS) will determine the amount and nature of HSS information essential to the geographic combatant commander and forward appropriate reporting guidelines to any subordinate JFSs or component command surgeons. These subordinate surgeons will consolidate their command or component reports and forward them to the unified command surgeon.

Medical information in itself is not classified. **However, medical information can become an operations security (OPSEC) indicator in the context of a particular military operation.** OPSEC measures to reduce or eliminate these indicators may entail **restrictions on medical information dissemination** and are detailed in OPLANs or OPORDs. OPSEC measures may require encryption of medical information for transmission. However, hospital ships may not possess or use a classified code for their radios or other means of communications without risking loss of their Geneva Conventions protections. Patient information is sensitive and prudent measures must always be taken to protect

patient confidentiality pursuant to the Privacy Act of 1974 and consistent with international law. This is one area in which the JFS and his or her staff should seek legal advice to ensure that a hospital ship or other medical unit retains its protected status under the Geneva Conventions while still complying with US law.

4. Health Service Support in Special Operations

a. **General. Special operations forces (SOF) are specially organized, trained, and equipped forces of the Army, Navy, and Air Force that conduct unconventional warfare, direct action, special reconnaissance, foreign internal defense, combatting terrorism, psychological operations, CA, counterproliferation of WMD, and information operations.** SOF missions are often highly classified and conducted in remote and/or denied settings. The nature of SOF missions requires small, highly skilled, self-contained teams that can be easily inserted and extracted by air, sea, and land. **HSS of special operations units is characterized by an austere structure and a limited number of medical personnel with enhanced medical skills, to include emergency treatment, advanced trauma management (ATM), preventive medicine and limited veterinary and dental care.** The primary focus of SOF HSS is to provide Level I and II essential care and sustain casualties until force extraction from the operational area. Consequently, joint medical planners must develop a flexible medical structure linking the required conventional health care pillars as far forward as the joint special operations task force, forward operations bases, and intermediate staging bases. Critical support requirements include forward surgical support, blood and blood products, and linkage to strategic air movement.

b. Organic HSS Capability

- **Medical planning.** The United States Commander in Chief, Special Operations Command, provides SOF to the supported commanders. To provide the necessary unity of command, each geographic combatant commander has established a subordinate unified command to serve as the functional special operations command (SOC). The SOC component commander coordinates conventional HSS packages to augment SOF organic medical capability.
- **SOF HSS.** SOF enlisted medical personnel receive enhanced medical training that allows independent duty capabilities which exceed those of their conventional counterparts.
- **Operational detachments**
 - Army special operations forces (ARSOF) HSS assets assigned to special forces teams and Ranger companies are capable of providing Level I care. ARSOF support units have surgeons, flight surgeons, PAs, emergency medical technicians (EMTs), and medics to provide Level I capabilities. CA units have no organic HSS. CA battalions have medical personnel assigned, but are organized to provide advice and expertise to the supported missions and not HSS to the force. Medically trained personnel of CA battalions provide assistance in identifying and assessing foreign public and private health systems, to include health and sanitation systems, agencies, personnel, and facilities. CA specialists work with nongovernmental and international health organizations to rehabilitate or develop functional health and sanitation systems within the AOR. The other organic HSS capabilities of

preventive medicine, laboratory, veterinary, and dental support are located in the special forces groups (SFGs). A health service logistic capability exists in SFGs, Ranger battalions, and SOF support units. Because ARSOF possess no organic medical movement capability, SOF units often depend on casualty evacuation (CASEVAC). CASEVAC is the transport of casualties by nonmedical units, utilizing nonmedical assets without en route medical care. Utilization of vehicles of opportunity for transport of casualties may be necessary.

- Naval special operations forces' (NAVSOFs') organic capabilities include Level I HSS for the unit. Health care and medical movement beyond Level I are supported by various Navy conventional units, such as the floating platform from which the team is staged, or Army and Air Force conventional units providing medical support on an area basis. Additionally, conventional Navy and Marine Corps units with organic Level II capability can provide HSS to the NAVSOF units. AE is not available and must be provided by supporting units. NAVSOF units have no preventive medicine, laboratory, veterinary, or dental support. NAVSOF units deploy with basic loads of medical supplies and can be resupplied.

- Air Force special operations forces (AFSOF) HSS capabilities are aligned with AFSOF operational units and consist of SOF medical elements (flight surgeons, PAs, and independent duty trained EMTs-paramedics) trained to perform CASEVAC, to include medical stabilization and emergency intervention in-flight utilizing aircraft of opportunity. In addition, AFSOF forces include pararescue specialists. Although they

may be EMTs, paramedics are trained for pre-hospital trauma life support (and in some cases, advanced trauma life support), pararescue specialists on special tactics teams are not medical assets under Geneva Conventions and are not counted against medical billets. AFSOF have Level I and limited Level II capability, to include emergency medicine, ATM, CASEVAC for SOF units, preventive medicine, medical intelligence, field laboratory, limited biological warfare and chemical warfare agent treatment, and short-term patient holding and staging capabilities. Mission requirements may dictate deploying a stand-alone personnel package and/or utilizing medical rapid response deployment kits or in conjunction with a SOF air transportable treatment unit.

c. SOF Health Service Support Planning

- The goal of special operations HSS planning is twofold: first, provide integrated, augmented conventional support into the concept of the special operations mission without compromising the objectives; second, articulate the unique challenges of the operation that will complicate the delivery of HSS by conventional units. The SOF HSS must ensure that the conventional HSS planner understands these aspects. The conventional HSS planner must translate SOF-unique requirements into the conventional HSS infrastructure best suited to support the mission.
- Unique challenges of HSS to SOF must be incorporated into HSS planning at the theater JFS staff level, with full knowledge and concurrence of SOC planning staff. (SOC components are authorized HSS planners and command surgeons during full mobilization.) HSS

must be planned and coordinated with subordinate joint force elements by the theater JFS staff.

- The JFS and theater SOC and/or SOF component HSS planners develop comprehensive operational area-specific plans to support the special operations mission planning and execution cycle. Essential aspects of these plans link SOF with conventional HSS. Additionally, strategic and operational circumstances may require arrangement for HN hospital support for special operations missions terminating in friendly territories within a theater.
- Typically, casualties will be evacuated by pre-planned team extraction on SOF platforms.
- Consider a modified movement (extended) policy for SOF to allow longer recovery periods and to permit efficient RTDs.
- Segregate SOF casualties from the conventional patient population to facilitate debriefing.
- SOF entry to the conventional HSS system normally will occur at the first MTF of admission.

Refer to JP 3-05.1, Joint Tactics, Techniques, and Procedures for Joint Special Operations Task Forces Operations, for detailed SOF-unique HSS planning considerations.

5. Health Service Support in US Coast Guard Operations

a. **General.** The US Coast Guard (USCG) frequently supports DOD operations, both in CONUS and OCONUS. USCG support may consist of cutters with helicopters, land-based

port security units, and coastal patrols with small boats. These individual units may be assigned to different Service components or commands, and often they must rely on resources, including HSS from other units. The resources should be provided by the nearest Service component.

b. USCG HSS Capability

- USCG HSS is limited to partial Level I capability. Small boats on coastal patrols will have an EMT only. Each cutter will have one independent duty corpsman, and each port security unit will have a PA.
- Helicopters deployed aboard cutters are designed as surveillance platforms and lack medical equipment of any kind. They may be used in CASEVAC situations.

6. Health Service Support Planning Factors for Joint Operations

In addition to **coordinating joint force HSS requirements**, HSS planning for joint operations involves other major considerations, including coordinating HSS requirements with other combatant commands, allied, and other friendly forces. **The tool approved for calculating medical requirements is the medical analysis tool (MAT).** MAT is an automated application program that takes Service-specific casualty rates, admission rates, and population at risk (PAR) from time-phased force and deployment data (TPFDD), deliberate planning, theater patient movement policy, and merges those figures to generate joint medical requirements. The planners then perform a risk assessment and COA analysis to assess the most effective use of medical forces. **MAT produces credible medical requirements for beds, patients to be**

evacuated, Class VIII (both medical resupply and blood), losses to be replaced, and numbers of hospital admissions. In addition, it provides medical requirements for PAR reports, planning factors used, and bed capabilities (as compared to bed requirements) report. The MAT can input a PAR report from the TPFDD, and merge Service scenarios to create a joint scenario. Services are responsible for generating and maintaining casualty rates for contingency operations. JFSs should obtain Service-specific casualty rates through the combatant command.

a. Theater Patient Movement Policy

- The theater patient movement policy is set by the Secretary of Defense (SecDef) in coordination with the geographic combatant commander prior to OPLAN execution. Upon execution, the geographic combatant commander adjusts the theater patient movement policy as needed.
- The theater patient movement policy is executed by the CINC. The theater patient movement policy delineates the maximum number of days that patients may be held within the command for treatment prior to further movement or RTD. Patients who cannot be RTD within the specified number of days are evacuated to the next higher level of care for further treatment. Shorter movement policies within the theater reduce theater bed requirements and increase the number of beds required elsewhere. Shorter movement policies also increase movement requirements. The theater patient movement policy is flexible and can change as the tactical situation dictates.
- In accordance with SecDef policy and CJCS guidance, the patient movement

policy is normally 7 days for the combat zone and a combined total of 15 days for the combat zone and communications zone. This does not imply that a patient must be held in theater for the entire period. Patients not expected to RTD within the number of days expressed in the theater patient movement policy will normally be evacuated:

- As soon as their medical condition permits or when local stabilization capabilities have been reached; or
- When medical authorities have determined that travel will not aggravate their medical condition (at a minimum, patients will have their airway secured, bleeding stopped, shock treated, and fractures stabilized); and
- When suitable receiving MTFs and transportation have been arranged.

b. Estimate for Theater HSS Requirements. The estimate for theater HSS requirements is based on empirical data accumulated for each Service for the major categories of patients wounded-in-action and DNBI. Planning factors, such as the theater patient movement policy, bed availability, casualty rates, admission rates, and the patient movement delay policy are analyzed to calculate HSS theater requirements. Empirical data includes:

- PAR;
- Patient movement delay;
- Average length of stay;
- Percent evacuated; and
- Dispersion factors. Dispersion factors are contained in the Joint Strategic

Capabilities Plan, Health Service Planning Guidelines. These guidelines should be used as defaults for all CJCS-directed planning factors.

c. **Planning Factor for Class VIII(b) Blood Products.** The planning factor for blood products in a theater is 4.0 units of liquid red blood cells per initial admission. This factor accounts for all blood use through all levels of care. An appropriate breakout is 1.0 unit per wounded in action and/or nonbattle injury at Level I, 2.0 units at Level II and 1.0 unit at Levels III and IV. **The receipt, storage, and distribution of blood products require special consideration and**

procedures to ensure a coordinated effort and maximum use of communications, storage facilities, and transportation. **The Air Force component will staff and operate blood transshipment centers (BTCs).** The centers are located at major airfields, and blood products are managed by the JBPO or area JBPO. One or more BTCs are located in each joint force AOR and/or JOA.

See JP 4-02.1, Joint Tactics, Techniques, and Procedures for Health Service Logistics Support in Joint Operations, for detailed information on Class VIII supplies and blood support operations.

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APPENDIX A

HEALTH THREAT

1. General

A health threat is the composite of all ongoing or potential enemy actions and environmental conditions that could reduce the effectiveness of friendly forces. These actions and conditions include wounds, injuries, or diseases. Information to assess the medical threat caused by enemy actions should be obtained from the Intelligence Directorate (J-2) and Operations Directorate communities.

2. Elements of the Health Threat

a. Infectious diseases which occur naturally are also referred to as endemic diseases. Historically, **infectious diseases have been responsible for four times more casualties than battle injuries.** Many naturally occurring infectious diseases have **short incubation periods.** They may cause significant numbers of casualties within the first 48 hours of a deployment or contact. Other infectious diseases with **longer incubation periods** may not create casualties for several weeks. Some examples of militarily significant, naturally occurring infectious disease threats are as follows.

- Acute upper respiratory diseases
- Acute diarrheal diseases
- Viral hepatitis
- Japanese encephalitis
- Scrub typhus
- Malaria
- Sexually transmitted diseases

- Leishmaniasis
- Leptospirosis
- Arbovirus infections (dengue, sandfly fever)
- Hemorrhagic fever with renal syndrome
- Schistosomiasis

b. **Extreme environmental conditions** in the form of heat, cold, high humidity, and high altitude **can pose significant health hazards** to an unacclimated, unprepared, and poorly conditioned military force. Employment of US forces in areas where these conditions exist without adequate opportunity for acclimatization may significantly decrease combat performance.

c. **Conventional warfare munitions** include small arms, high velocity weapons, rockets, bombs, artillery, bayonets, and other wounding devices, either individual or crew-served. **This threat may be encountered in all geographic areas and can be employed by adversaries across the range of military operations.** Research and development in smart munitions and extended range artillery, coupled with more powerful high explosives, will increase the threat from these types of weapons. Area denial munitions are likely to be present and pose a major psychological and physical threat. Wounds from booby traps, mines, and nontraditional weapons can also be encountered.

d. **Biological warfare is the employment of biological agents to produce casualties in humans or animals or cause damage to plants or materiel.** The intentional use of these disease-causing organisms (pathogens), toxins, or other agents of biological origin is

designed to weaken resistance to attack and reduce the will and/or the ability to wage war.

- Historically, **biological warfare** has primarily involved the use of pathogens to sabotage food and water supplies and spread disease among populations. These pathogens may fall into one of the following categories:

- Naturally occurring, unmodified infectious agents;
- Toxins, venoms, and their biologically active fractions;
- Modified infectious agents; and
- Bioregulators and physiologically active compounds.

- **Biotechnology is a tool for the production of biological warfare agents.** Naturally occurring infectious organisms can be made more virulent and drug resistant and could possibly be manipulated to render protective vaccines ineffective. Such developments could greatly complicate the ability to detect and identify biological warfare agents and the ability to operate in areas contaminated by these agents or while under biological attack. The causative agents for anthrax, tularemia, plague, and cholera, as well as botulinum toxin, staphylococcus, enterotoxin, and mycotoxin, are believed to have been adopted as biological warfare agents by potential US adversaries. The reports of the use by the former Soviet Union of toxins in Southeast Asia have heightened the concerns of possible future use of biological agents.

e. **Chemical warfare is the employment of chemical agents to produce casualties in humans or animals, or to secure terrain.** As a result of confirmed chemical warfare

agent use by Iraq against Iranian forces and probable use by the former Soviet Union in Afghanistan, there is continuing heightened interest in the use of **chemical munitions and delivery methods**. Nerve and blister agents appear to be the agents most available in developing countries. Agents which could be employed by numerous conventional weapons systems include:

- Nerve agents — O-Ethyl S-Diisopropylaminoethyl Methylphosphonothiolate (VX), thickened VX, sarin, and thickened soman;
- Vesicants (thickened lewisite and a mustard and lewisite mixture);
- Choking agents (phosgene); and
- Cyanogens— (hydrogen cyanide and cyanogen chloride).

Toxic industrial chemical and material contamination poses a significant environmental threat to joint and multinational forces, not because of the weaponization of chemical munitions but as a result of the collateral effects accompanying conventional destruction. This is particularly true in densely populated, built-up industrialized regions.

f. **Directed-energy weapons focus radiation on a target to induce electronic, thermal, or structural and human (particularly eye) damage and can cause mission failure.** The radiation is composed of three types: **radio frequency, laser, and charged particle beam**. There have been numerous reports of personnel sustaining eye damage while using optic devices and being exposed to a bright flashing light emanating from warships or other sources. These reports suggest an increasing threat from lasers to both air and ground forces.

g. **Blast effect weapons**, such as fuel air explosives, **represent an emerging medical**

threat. Gas-filled body organs, such as ears, lungs, and digestive tract, are the most susceptible to primary blast injury. This emerging threat may result in lower lethality but a greater number of wounded and a significantly increased medical workload.

h. **Strategic deployability of US forces** is a major element of US political and military strategy. **Forces may be required to operate without rest for extended periods of time** during mobilization, staging, airborne transportation, and combat insertion into hostile areas. **Modern combat**, with its increased lethality, rapid maneuvers, technological skill requirements, exposure to NBC weapons, and day or night all-weather operations, **will stress personnel to their endurance limits.** Under these conditions, the significance of **stress as a major contributor of casualties** cannot be overstated.

i. **Flame and incendiary systems** include napalm and white phosphorus for aerial delivered bombs. Possible uses of flame and incendiary weapons include the clearing of difficult defensive positions such as caves, bunkers, buildings, and soft shelter or vehicular targets. Flame has also been used quite effectively in previous conflicts in an antitank role.

j. **The primary nuclear warfare threat** was the Soviet Union. However, open-source information suggests that other countries have developed a nuclear weapons capability. Planners expect a minimum of 10 to 20 percent casualties within a division-size force that has experienced a nuclear strike. This percentage may be a low estimate, **since proximity to ground zero is the critical factor in determining weapon effects on the force.** In addition to casualties, a nuclear weapon detonation can generate an electromagnetic pulse that will result in catastrophic failure of some electronic

equipment components (including patient support equipment).

k. Enemy uses of **radioactive material or radiological dispersal devices (RDDs)** in operational areas pose a new threat to deployed US forces. These devices or radioactive material can create areas of radioactivity without causing the blast or thermal effects of nuclear weapons. US forces can be exposed to potentially hazardous levels of radiation in an otherwise conventional operational environment. Terrorists, assassins, individuals sympathetic to a specific country's views, or opposing forces can disperse radioactive material or employ RDDs. Planners must consider the possibility of radioactive material and/or RDDs being used against US forces in future operations. The casualty load generated by this potential hazard can overwhelm an MTF, especially in immature theaters and military operations other than war (MOOTW) environments.

l. **Disease Surveillance and Reporting.** Joint Staff directives require all deployed military organizations to have a medical unit to conduct disease and nonbattle injury surveillance; track incidence and trends of diseases, injury, and health conditions of military operational significance; and provide real-time risk reduction recommendations to commanders.

3. The Threat to HSS Personnel and Operations

a. **Commanders can anticipate increased casualty densities among HSS personnel** over those experienced in most previous conflicts. **Health threat elements** with the greatest potential for force degradation during combat operations are as follows.

- **Battle injuries** because of artillery, small arms, and fragmentation weapons.

- Casualties caused by **combat stress**.
 - The **collective effects** of NBC, RDDs, and conventional weapons.
 - **Premeditated attack** upon HSS units, personnel, or Class VIII supplies.
 - The continually increasing range of **indirect fire weapons**.
 - The **enhanced wounding capability and destructiveness** of munitions and weapon systems.
 - Significant increases in casualty densities that cause local or general **overloads of the HSS system, resulting in physical and psychological stress**.
 - Infectious diseases, temperature extremes, and toxic industrial chemicals and/or materials.
- b. **Enemy combat operations** in friendly rear areas **may interdict lines of communications and disrupt necessary health service logistic activities**. This disruption will produce a **serious negative effect on the ability of personnel to retrieve and evacuate wounded, injured, and sick personnel and deliver health care**. Although enemy combat operations may threaten the HSS combat mission by disrupting HSS operations or threatening the survival of HSS personnel, they are not considered for the purposes of this publication to be medical threats.

c. Prolonged periods of intense, continuous operations will tax HSS personnel to the limit of their psychological and emotional endurance. **This stress and fatigue will cause both quantitative and qualitative degradation in the ability of the HSS system to deliver health care at a sustained level. The proper training of dental personnel in procedures such as taking vital signs and performing minor surgery may allow for augmentation of the medical staff, and provide some temporary relief.**

d. HSS units are not expected to be the primary target for NBC attacks; however, **logistic base complexes may be prime candidates for such enemy operations**. As elements of logistic complexes, **HSS organizations must anticipate collateral contamination from attacks on adjacent facilities**. Forward HSS assets have an even higher probability of being required to operate in or near areas contaminated by NBC weapons. Decontamination of casualties is normally the responsibility of the Service unit by nonmedical personnel; however, medical personnel should be prepared to conduct decontamination operations for those early casualties arriving at the MTF who have not been previously decontaminated. This ensures that medical units can provide treatment of casualties. Patient decontamination sites may be located in the general proximity of MTFs to ensure that medical supervision of patient decontamination is available.

APPENDIX B

MEDICAL INTELLIGENCE

1. General

a. **The Defense Intelligence Agency (DIA) develops and disseminates medical intelligence.** The two major intelligence categories of primary use to the HSS planner are **general medical intelligence** (DOD Directive 6420.1R, *Armed Forces Medical Intelligence Center*) and **medical intelligence**. Armed Forces Medical Intelligence Center (AFMIC), Fort Detrick, Maryland, is the sole producer of medical intelligence for DIA. AFMIC currently produces and disseminates finished intelligence products via studies, message traffic, compact disk-read only memory (CD-ROM), and on-line electronic systems.

b. DOD military medical personnel frequently use the term medical intelligence incorrectly to mean any medical information of military importance; however, **the term “medical intelligence” officially refers to intelligence on medical and related matters.** By this definition, medical intelligence includes only finished intelligence products produced by an authorized intelligence agency such as AFMIC through the intelligence cycle. **Medical intelligence is intended to provide HSS operations and planning staffs with basic guidance** for understanding, acquiring, using, and applying intelligence and intelligence systems in the conduct of HSS operations, medical threat analysis and management, threat-based concept development, medical research, and doctrine development. **Other sources of medical information may be used in assessing potential threats** (e.g., US Army and Air Force preventive medicine units and Naval environmental and preventive medicine units, Defense Pest Management Information Analysis Center, and the World Health Organization).

2. Medical Estimate of the Situation

a. The medical estimate’s purpose is to provide an analysis of HSS information pertaining to enemy intentions, allied or coalition partner’s capabilities, limitations, COAs, and potential HSS consequences associated with a contemplated operation. The HSS estimate may be written or oral.

b. **The HSS estimate will include all HSS facts, assumptions, and deductions that can affect the operation.** The JFS must be familiar with the concept of operations and obtain medical intelligence concerning the theater from indigenous sources, the supporting intelligence activity, AFMIC, and national intelligence agencies. The JFS must conduct a **thorough evaluation of the enemy situation, the friendly situation, and the theater** from the standpoint of effects on the health of the joint force and HSS operations.

c. Prior to deployment, the JFC should ensure that a predeployment vulnerability assessment has been conducted. These assessments will normally include a medical member qualified to evaluate the safety and vulnerability of local food and water sources, perform an epidemiological risk assessment, evaluate local medical capabilities, perform a vector-pest risk assessment, determine the adequacy of hygiene in local billeting and public facilities, industrial contaminants (past and present), and perform an environmental risk assessment coordinated with the engineer baseline environmental survey.

d. **The medical estimate is an analysis of the health threat and HSS capabilities** to determine vulnerabilities and estimated requirements of the joint force.

- **Patient estimates are calculated** to determine requirement, distribution of medical assets, PAR, possible MASCALS, and patient movement. The JFS consults Service wartime planning references to assist in determining requirements for the operation. Hospital estimates and other support requirements are derived from these data.
- Having determined the HSS requirements, **the JFS considers the resources that are readily available** to meet the requirements. Maximum use of available personnel, supplies and equipment, and joint use of facilities promote effectiveness of the command's HSS. **Considering support requirements and resources available, the JFS determines the proposed COA that can be supported.**
- The JFS identifies shortfalls that may impact on the JTF COA development and selection.

e. Based upon the medical estimate of the situation, **the JFS**, in coordination with the joint force component command surgeons, **must plan for HSS policies and procedures that can be best adapted to the joint operation.** In many instances, existing standing operating procedures can be used with little or no modification. In other instances, entirely new procedures may have to be developed and implemented. Standards must be established to deal with the type and timing of physical, dental, and mental examinations and inspections necessary to ensure that personnel in the theater or those arriving are fit for duty. Physical standards are normally Service-specified; however, the geographic combatant commander may direct additional or special requirements based on operational, geographic, or climatic conditions.

3. Significance of Medical Intelligence

a. **Accurate and timely intelligence is a critical combat support tool** for planning, executing, and sustaining military operations. **It is equally important in achieving optimum planning, execution, and sustainment of HSS operations**, the medical readiness of the command, and the overall combat readiness of the unit.

b. At the **strategic level**, the objective is to contribute to the formulation of national and military strategies. At the **operational level**, intelligence focuses on the joint campaign and operations. At the **tactical level**, intelligence is oriented toward the specific operational area and a given operation in greater detail. **Intelligence**, properly used and applied, **can become a powerful force multiplier** by providing the critical essential elements of information required to assist HSS staffs.

4. Sources of Medical Intelligence

AFMIC Products. Most **AFMIC products** commonly used by HSS planners fall into the category of **recurring, finished intelligence**. These products include (but are not limited to) the following.

a. **Infectious disease risk assessments (IDRAs)**, which assess the risk from infectious diseases of operational military significance on a country-by-country basis worldwide. IDRAs are available on INTELINK and INTELINK S. **(For access to INTELINK and INTELINK S programs, contact your intelligence officer.)**

b. **Environmental health risk assessments (EHRAs)**, which assess environmental health risks of military

significance on a country-by-country basis worldwide. EHRAs are available on INTELINK.

c. **Medical, environmental, disease intelligence, and countermeasures CD-ROMs** provide worldwide infectious disease and environmental health risks hyperlinked to the joint Service-approved countermeasure recommendations, military and civilian health care delivery capabilities, operational information, disease vector ecology information, and reference data.

d. **Health service assessments** are designed to provide consumers the bottom-line assessment of the health service capabilities of a country, with limited descriptive data and examples relating only to critical elements of the civilian and military health care systems. The studies are produced on countries with a validated production requirement by an intelligence consumer, or with a high potential for US force deployment.

e. The **AFMIC's quick reaction support** responds to **time-sensitive, quick reaction intelligence production and support requests** for operational contingencies. Quick reaction tasking is normally accepted by AFMIC if the requirements of the task can be completed in a maximum of 40 personnel hours of analytical work. Requests are accepted telephonically (open and secure communications) and by direct correspondence or message format.

Whenever possible, formal methods of communications are encouraged. The JFS should request medical intelligence via their J-2.

f. **AFMIC Wire**, which is a current intelligence document, presenting analysis of newly reported information of potential interest to consumers. In addition to the scheduled wire, special wires are produced periodically, generally on topics of immediate interest to deployed or deploying forces.

g. **Disease Occurrence World Wide**, which provides time-sensitive updates to the IDRAS. It is published weekly as an unclassified message, with a classified supplement, if necessary.

h. **Communications with AFMIC.** The request for information is a way of asking AFMIC for answers to questions that are not found in published studies. Generally, a request for information is a project requiring 40 or fewer hours for AFMIC to complete. Request for information should be directed through command J-2 to AFMIC.

- Mailing address:
Director, Armed Forces Medical Intelligence Center (Operations)
1607 Porter St
Fort Detrick, MD 21702-5004
- Message: DIRAFMIC FT DETRICK MD//OPS//

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APPENDIX C

FORMAT FOR ANNEX Q TO AN OPERATION PLAN

(Classification)

Headquarters
Location
Date, time, and zone

ANNEX Q TO _____ OPLAN _____ ()
HEALTH SERVICE SUPPORT()

() **REFERENCES:**

- a. Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field, 12 August 1949.
- b. Geneva Convention for the Amelioration of the Condition of the Wounded, Sick, and Shipwrecked Members of Armed Forces at Sea, 12 August 1949.
- c. Geneva Convention Relative to the Treatment of Prisoners of War, 12 August 1949.
- d. Geneva Convention Relative to the Protection of Civilian Persons in Time of War, 12 August 1949.
- e. JP 3-11, *Joint Doctrine for Operations in Nuclear, Biological, and Chemical (NBC) Environments*.
- f. JP 4-01, *Joint Doctrine for the Defense Transportation System*.
- g. JP 4-02, *Doctrine for Health Service Support in Joint Operations*.
- h. JP 4-02.1, *Joint Tactics, Techniques, and Procedures for Health Service Logistics Support in Joint Operations*.
- i. JP 4-02.2, *Joint Tactics, Techniques, and Procedures for Patient Movement in Joint Operations*.
- j. JP 4-04, *Joint Doctrine for Civil Engineering Support*.
- k. JP 4-05, *Joint Doctrine for Mobilization Planning*.
- l. Center of Military History Publication 83-3, *Emergency War Surgery: 2d US Revision of the Emergency War Surgery North Atlantic Treaty Organization (NATO) Handbook*, 1988.

1. () Situation

- a. () General.
 - () Purpose. To provide a concept of operations, assign tasks, and provide guidance to ensure an effective HSS system to support the operations envisaged in the OPLAN.
 - () Applicability. Refer to TASK ORGANIZATION, OPLAN. List other commands to which this appendix applies.
- b. () Enemy Forces. Annex B (Intelligence).
- c. () Friendly Forces. Summarize capabilities (including weapon systems that may influence the HSS system mission).
- d. () Assumptions. List key assumptions affecting HSS planning.
- e. () Limitations. List key limiting factors affecting HSS capability.

2. () Mission. State a clear, concise statement of the overall mission of the HSS system

3. () Execution

- a. () Concept of Operations. Describe the overall concept of HSS to meet mission requirements.
 - () Transition. State the concept of transition from peacetime HSS posture to wartime.
 - () Responsibility and command relationships. State component command's responsibility. Indicate responsibility and scope of HSS of US forces under operational control of other than US commanders and allied forces to provide HSS for each other's combatants.
 - () Hospitalization. Describe the concept of operations for hospitalization. Include a brief assessment of initial in-theater HSS treatment capabilities.
 - () Patient movement (to include validating, regulating, and movement). Describe the overall concept of patient movement (land, sea, and air).
 - () Host-nation support. Address HN HSS-availability and assess the status of these activities.
 - () Adjunct HSS. If applicable, address the following: EPWs, civilian internees, detainees, formerly captured US military personnel, evasion and recovery operations, noncombatant evacuation operations, and civil affairs. Outline the concept to provide HSS and treatment as well as personnel and material support.

- () Joint blood program. Outline the concept for blood components support and resupply.
 - () Preventive medicine, medical surveillance, and combat stress control. Describe the concept for support.
 - () Theater patient movement policy. State the objective theater patient movement policy (to establish requirements) and the supportable policy.
 - () Medical regulating. Outline the concept for medical regulating to, within, and from the theater.
 - () Dental services. Include the scope and responsibility for dental services in each operational area.
 - () Veterinary services. As dictated by the mission.
 - () Other areas. As dictated by the mission.
- b. () Tasks. Identify joint responsibilities of subunified, joint task force, and component commanders for HSS.
- c. () Coordinating Instructions. Outline the required key intracommand coordination (for example, personnel, Joint Transportation Board, and engineering support).

4. () Administration and Logistics

- a. () HSS Materiel. Describe the general concept for supply and resupply support, including single manager (if applicable), regionalization, and procedures for cross-leveling and redistributing HSS materiel and policies for local acquisition.
- b. () Reports. State what and how to format all HSS reports.

5. () Command and Control

- a. () Command. Ensure HSS C2 is fully consistent with the overall command structure.
- b. () HSS Communications. Briefly describe how to transmit HSS information within and from the theater. Identify any dedicated secure or unsecure communication requirements and capability.

t/
General
Commander in Chief

Appendices:

- 1 — Patient Movement Requirement System
- 2 — Joint Blood Program
- 3 — Hospitalization
- 4 — Return to Duty
- 5 — Health Service Logistics (Class VIII A) System
- 6 — Preventive Medicine
- 7 — HSS Command, Control, Communications, and Computers
- 8 — Host-Nation Support
- 9 — HSS Sustainability Assessment
- 10 — HSS Intelligence Support to Military Operations
- 11 — Veterinary Service
- 12 — HSS Planning Responsibilities and Task Identification
- 13 — Medical Laboratory Services
(Classification)

Headquarters

Location

Date, time, and zone

APPENDIX D

MULTINATIONAL OPERATIONS

1. Health Service Support in Multinational Operations

General. General logistic support doctrine applies equally to HSS. Multinational support operations are complicated by a number of characteristics that impact fundamentally upon the provision of HSS.

a. Unique nature of every individual operation.

b. Geographic, topographic, and climatic variations of the operational area.

c. Numbers of individual nations involved in each operation.

d. Variations in national standards of HSS and equipment.

e. Language and communications differences.

f. Political complexity and dynamic nature of each operational scenario.

g. Mission of medical support forces.

h. Differences in individual national objectives and/or restrictions for participation in operations and integration of overall mission goals.

i. Medical staffs face unique problems affecting the health of multinational personnel deployed on operations. Therefore, operational HSS requires clearly defined and distinctive guidance. JFCs and staff should determine which guidance and/or standards to follow in multinational operations.

j. HSS plans must be tailored to each operation and meet the demands of geography, individual national needs, language, and communication difficulties. Plans must be capable of rapid implementation, but at the same time be flexible enough to manage rapidly changing operational demands.

k. Every deployed multinational force must have a surgeon and/or chief medical officer (CMO) who has direct access to the multinational force commander (MNFC).

l. Each deployed national contingent that has HSS personnel must have a single designated individual who has the clinical responsibility for all national HSS matters. Under North Atlantic Treaty Organization terminology, this person is known as the national Senior Medical Officer.

2. Multinational Operations Principles

Contributing nations retain ultimate accountability for the health of their forces, but, the MNFC will normally share the responsibility for or have an interest in the health of assigned forces. To meet this requirement, the MNFC needs appropriate HSS staff available at the early stages of planning HSS for an operation.

a. **International Conventions for the Treatment of the Sick and Wounded.** HSS for operations will comply with provisions of the Geneva Conventions. Persons entitled under the terms of the Conventions shall, without discrimination, receive medical treatment on the basis of their clinical needs and the availability of HSS resources.

b. **Standards of HSS.** Operational HSS to multinational forces must meet standards that are acceptable to all participating nations. Care provided to US forces participating in a multinational operation must meet US standards.

c. **Estimation of Medical Risk.** Estimation of medical risk and the associated casualty rates is the responsibility of the individual nation with HSS advice of the multinational operational staffs.

d. **Multinational Levels of HSS.** In multinational operations, there are four levels of HSS that should be available to all multinational forces. They are organized on a progressive basis. Levels of HSS will be provided appropriately to a particular operation. Policy for national contributions will generally be as follows.

- Level I — National responsibility.
- Level II — National and/or Lead Nation. For the United States, Level II is a national responsibility.
- Level III — National and/or Lead Nation. For the United States, Level III is a national responsibility.
- Level IV — National and/or Force Provided (Contracted). For the United States, Level IV is a national responsibility.

3. Health and Fitness Entry Standards

To qualify to participate in the multinational force (and for subsequent multinational resourced medical treatment, patient movement, and personal disability compensation), national contingents and individuals allocated or contracted to multinational operations must meet the basic

standards of individual health and physical fitness laid down by the CMO staff.

4. Statement of Requirement

HSS requirements are to be determined by the appropriate MNFC in consultation with contributing nations and the HSS planning staff. HSS resources will be specified as those necessary to prevent and control DNBI and to collect, evacuate, and treat casualties.

5. National Structure

National HSS systems should be retained as an organic force structure to the contributing nation's forces as much as possible. However, HSS planners must seek to take advantage of economies of scale which may be achieved from multinational concepts such as lead nation responsibilities, role specialization, and mutual assistance.

6. Provision of Resources

Contributing nations bear ultimate responsibility for ensuring the provision of HSS to their forces allocated to multinational operations. This may be discharged in a number of ways, including agreements with other nations or the appropriate multinational planning staffs and MNFCs.

7. Treatment of Entitled Personnel

From the outset of an operation, policy must be established regarding the entitlement of non-US military and/or nonmilitary staffs and other authorized personnel in-theater and for all medical treatment other than emergency measures.

8. HSS Liaison

HSS planning staffs are to ensure that methods are established to provide regular and

efficient liaison between national contingents and theater HSS resources, particularly monitoring inpatients at Levels III and IV, and for all intratheater and intertheater patient movement.

9. HNS Capability

The HNS resources available in the operational area are the key to determining the size and capability of the HSS organization that the multinational force must establish. The more HNS available for use, the less that has to be found from contributing nations. Overall, a mixture of medical intelligence analysis and on-the-ground reconnaissance assesses HNS capabilities. A key issue will be the standards of HSS available, compared to the multinational force and national contingent criteria.

10. Considerations

a. **Maximum effort** must be made to tailor HSS mission requirements. HSS planners must find a balance of capabilities. An example may be to organize a single nation to provide a particular function, such as AE, for all contingents.

b. **Establishing the patient movement policy** is a command decision of each nation. HSS and logistic staffs will advise. The force theater surgeon (sometimes known as the multinational CMO) will promulgate recommendations and will monitor the established patient movement policy.

c. **C4I.** Comprehensive and effective C4I is fundamental to the HSS plan. It begins prior to deployment, with the establishment of a competent HSS planning team at the multinational force headquarters. It is also crucially dependent upon the following.

- Clearly established lines of accountability and control agreed to by all participating contingents.

- Liaison at every level including HNS and any NGOs and IOs in theater.

d. **Preventive Medicine Capability.** The expertise to manage preventive medicine responsibilities must be made available at all levels. The requirement will be for preventive medicine units as well as individual experts. The provision of this capability lends itself well to a lead nation approach. The shape and size of in-theater preventive medicine capability will be dictated primarily by the following.

- The size of the multinational force to be supported, its dispersal, and the theater topography.
- The capability of national contingents to implement preventive measures independently.
- The responsibility to ensure that personnel are prepared and appropriately trained in field preventive medicine measures prior to deployment to an operation. This must include the necessary pretreatments, chemoprophylaxes, barrier creams, and immunizations.
 - Recommendations for pretreatment, immunization, and chemoprophylaxis for the multinational force will be made by the CMO during the initial planning stage, but it remains the responsibility of each nation ultimately to ensure that its personnel are adequately protected.
 - A multinational force policy must be issued as early as possible regarding the prophylaxis measures that must be taken by all individuals deploying into the operational area. Instructions must cover measures to be taken prior to deployment, while in-theater, and during post-deployment.

- It is a national responsibility to maintain high standards with regard to the provision of food and water, as well as field sanitation standards.

- JFS and/or CMO will inspect and audit national measures to ensure that acceptable standards are maintained in these areas.

- Minimum standards acceptable to all participating nations must be maintained if the MTFs are to be used to support personnel outside the respective national force.

e. The CMO's force hygiene officer is responsible for coordinating preventive medicine services such as regional spraying or vector control and advising on placing local population centers and/or facilities off limits.

f. Education on prevention of diseases is a national responsibility.

11. Patient Movement in Multinational Operations

The theater patient movement policy, known in some nations as a holding policy, is the key to balancing the treatment capability available at each level of care against the required medical patient movement assets. The provision of resources will be coordinated by the multinational force HSS planning staff, but will comprise assets from a number of sources, including HNS. Theater medical patient movement requires careful planning and an acquisition cross-Service agreement.

a. Patient movement from point of injury to Level I — National responsibility.

b. Patient movement from Level I to Level II/III — National, Force, and Lead Nation.

c. Patient movement to Level IV — Force, National, and Lead Nation.

12. Personnel in Multinational Operations

a. National contingents will be expeditiously notified through designated national liaison points of contact of individuals that become critically injured and/or ill or die.

b. Medical obligations under international law will be particularly crucial to the management of non-force personnel such as EPWs, civilian refugees, detainees, and non-force combatants. HSS plans must detail the degree of care to be offered to these groups and how continuity of care is to be provided, when needed.

c. Only urgent medical treatment, within the capability of the deployed multinational medical force and not otherwise available, will be offered to civilian refugees.

- Detainees and non-force combatants may receive urgent medical treatment in force MTFs, but are unlikely to remain in Level III or be evacuated to force-provided Level IV MTFs for continuing treatment. An alternative source of definitive treatment must be organized as part of the overall HSS plan.

- National law will concern a range of issues, particularly regarding the provision of medical evidence for inquiries into deaths and severe injury.

13. Health Service Logistics in Multinational Operations

The holding, issuing, and accounting for all medical, dental, and veterinary supplies (equipment, pharmaceutical, and consumables) to a multinational force is a major undertaking. It is a joint responsibility of the CMO and the chief health service logistics officer, whose offices must cooperate to create a system with the necessary reliability, flexibility, and speed. The supply

of blood and blood products to multinational operations is a complex and sensitive issue, stemming from the wide disparity of standards between nations and the legal constraints incumbent upon some of them. Consequently it is considered as a separate function within health service logistics. The availability of blood and blood products is essential for management of the seriously injured and sick. For the majority of multinational operations, this will require its provision at Level III and at Level II if providing resuscitative surgical care.

a. For multinational operations, the general principle is that national contingents should be responsible for the supply of blood to their own injured and sick. In reality, this is not always a practical proposition. The requirement must, therefore, be that all blood and blood products used in-theater comply with internationally agreed upon standards. Where a particular nation cannot accept this as policy, they must organize their own system of supply at national expense.

b. The most cost-effective and rational approach is for the force HSS planning staffs to coordinate supplies through the lead nation, using supplies from a nation whose blood and

blood products are acceptable to all contingents.

Refer to JP 4-02.1, Joint Tactics, Techniques, and Procedures for Health Service Logistics Support in Joint Operations.

14. Legal Issues in Multinational Operations

a. Both international and national law, particularly concerning the medical management of refugees, detainees, and non-entitled civilians, must be considered in multinational operations. JFSs should be particularly sensitized to the limits imposed by title 10, USC, which outlines under what conditions non-DOD beneficiaries can receive medical treatment from US medical forces.

b. Any pathological materials and/or tissues taken in the course of conducting an autopsy or preparing a death certificate must be turned over to the decedent's national representative. Human remains are returned through designated mortuary affairs personnel. In addition to the legal issues, there are many cultural differences with regard to the disposition of deceased personnel.

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APPENDIX E

MILITARY OPERATIONS OTHER THAN WAR

1. HSS in Military Operations Other Than War

a. The health threat is traditionally evaluated for its impact on US forces alone. When preparing for and conducting operations during MOOTW, elements of the health threat to the indigenous population, allied and coalition forces, US Government employees, DOD contractors and, as appropriate, IOs and NGOs must also be assessed. **The impact of the health threat as a contributing factor to social, political, and economic stability in both peace and other operational environments must be considered.** The general environment in which these types of operations are conducted ranges from peaceful, developing countries with no apparent internal or external instabilities to countries with limited resources and a poorly led population assailed by active insurgent movements, diseases, and dependency on foreign humanitarian assistance (FHA).

b. **Within MOOTW, US efforts may focus on foreign internal defense operations such as security assistance, FHA, or HN logistic support.** These operations are often conducted in areas where social services have been disrupted, resulting in poor sanitation, inadequate food and water distribution, civil disturbances, and general civil unrest. Significant health threats are likely to be naturally occurring endemic and epidemic diseases, uncontrolled distribution of hazardous wastes and hazardous materials, and environmental extremes.

c. **In general,** areas where assistance teams and units may be employed will likely have a very low standard of living and high incidence of endemic and epidemic diseases. US forces serving in these areas will enter with very little,

if any, natural immunity to endemic diseases. The degree of cultural and social interaction required to support the mission, as well as the sharing of food, quarters, and recreational facilities with local nationals, will increase exposure of US personnel to diseases endemic to the host country. For the most part, assistance operations will last a relatively extended period of time (past 30 days) and will increase the risk of contracting the endemic disease.

d. **In MOOTW environments, insurgent or terrorist forces may not recognize protection afforded to MTF and HSS personnel by the Geneva Conventions.** HSS activities may be perceived as prime targets by these groups, especially if these facilities are perceived as making a major contribution to the HN government. MTFs will also be vulnerable to theft and raids on Class VIII supplies by insurgents or terrorists for their own support or to support black market activities.

e. **In some situations, the in-country components of the US logistic system in support of US assistance forces will be austere.** Often the HSS structure will require reliance on contracting from local sources for food, water, sanitation, public health, and health industry resources if in compliance with regulatory and policy guidance. Procurement of fresh foods and beverages and contracting of food storage facilities are supported by veterinary personnel through sanitary inspection of local food establishments in the operational area. Coordination with Commander in Chief, US Transportation Command for intertheater patient movement can be greater in MOOTW scenarios than in war. US Navy and US Marine Corps transportation assets may be used to support all aspects of HSS in MOOTW, based on the

availability and proximity to coastal waters. When tarmacs are available, coordination with US Air Force transportation should be considered when time is a factor. These circumstances will demand comprehensive HSS planning. HSS planning must be based on current, accurate medical intelligence and include the total involvement of the Country Team prior to the execution of operations.

For additional information on MOOTW, refer to JP 3-07, Joint Doctrine for Military Operations Other Than War.

f. Legal issues during MOOTW may concern both international and national law.

- Medical obligations under international law will be particularly crucial to the management of non-force personnel such as EPWs, civilian refugees, detainees, and non-force combatants. HSS plans must detail the degree of care offered to these groups and how continuity of care is to be provided, when needed.
- Urgent medical treatment, not otherwise available, will be offered to civilian refugees and is dependent upon the operational situation.

- Detainees and non-force combatants may receive urgent medical treatment in force MTFs, but are unlikely to remain in Level III or be evacuated to force Level IV MTFs for definitive treatment. An alternative source of definitive treatment must be organized as part of the overall HSS plan.

- National law will concern a range of issues, particularly regarding the provision of medical evidence for inquires into deaths and severe injury.

g. Financial issues for consideration during MOOTW include:

- The size and shape of HSS resources available to support the HSS concept of operations;
- Maintenance costs, particularly the provision of medical materiel, resupply, and patient movement; and
- Donated medical supplies, eligibility determination, credentialing, malpractice suits, and reimbursement procedures for HSS and supplies.

APPENDIX F

REFERENCES

The development of JP 4-02 is based upon the following primary references.

1. Multinational Documents

- a. NATO STANAG 2068, *Emergency War Surgery (Edition 4) (Amendment 3)*, 17 October 1991.
- b. Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field, 12 August 1949.
- c. Geneva Convention for the Amelioration of the Condition of the Wounded, Sick, and Shipwrecked Members of Armed Forces at Sea, 12 August 1949.
- d. Geneva Convention Relative to the Treatment of Prisoners of War, 12 August 1949.
- e. Geneva Convention Relative to the Protection of Civilian Persons in Time of War, 12 August 1949.

2. DOD Publications

- a. DOD Directive 6420.1R, *Armed Forces Medical Intelligence Center (AFMIC)*, 30 September 1996.
- b. DOD Directive 6490.2, *Joint Medical Surveillance*, 30 August 1997.
- c. DOD Instruction 6480.4, *Armed Services Blood Program (ASBP) Operational Procedures*.
- d. DOD Instruction 6490.3, *Implementation and Application of Joint Medical Surveillance for Deployments*, 7 August 1997.
- e. DOD Publication 5200.2-R, *Personnel Security Program*, January 1987.
- f. DOD Regulation 515.21-M1,

3. Joint Publications

- a. JP 0-2, *Unified Action Armed Forces (UNAAF)*.
- b. JP 1-0, *Doctrine for Personnel Support to Joint Operations*.
- c. JP 1-02, *Department of Defense Dictionary of Military and Associated Terms*.
- d. JP 3-02, *Joint Doctrine for Amphibious Operations*.

- e. JP 3-05.3, *Joint Special Operations Operational Procedures*.
- f. JP 3-07, *Joint Doctrine for Military Operations Other Than War*.
- g. JP 3-17, *Joint Tactics, Techniques, and Procedures for Air Mobility Operations*.
- h. JP 3-33, *Joint Force Capabilities*.
- i. JP 3-35, *Joint Deployment and Redeployment Operations*.
- j. JP 3-50.2, *Doctrine for Joint Combat Search and Rescue (CSAR)*.
- k. JP 3-50.21, *Joint Tactics, Techniques, and Procedures for Combat Search and Rescue*.
- l. JP 3-57, *Joint Doctrine for Civil-Military Operations*.
- m. JP 3-57.1, *Joint Doctrine for Civil Affairs*, (under development).
- n. JP 4-01, *Joint Doctrine for the Defense Transportation System*.
- o. JP 4-02.1, *Joint Tactics, Techniques, and Procedures for Health Service Logistics Support in Joint Operations*.
- p. JP 4-02.2, *Joint Tactics, Techniques, and Procedures for Patient Movement in Joint Operations*.
- q. JP 4-04, *Civil Engineering Support*.
- r. JP 4-05, *Joint Doctrine for Mobilization Planning*.
- s. JP 5-00.2, *Joint Task Force Planning Guidance and Procedures*.
- t. CJCSI 3110.03, *Logistics Supplement to Joint Strategic Capabilities Plan*, 1 March 1999.

4. Army Publications

- a. FM 8-10-18, *Veterinary Services*.
- b. FM 8-55, *Planning for Health Service Support*, 9 September 1994.

5. Navy and Marine Corps Publications

NAVMAT P-4000-2 Series.

6. Air Force Publications

- a. AFI 41-106, *Medical Readiness Planning and Training*, 1 March 1999.
- b. *USAF War and Mobility Plan (WMP 1)*, Volume 1, Medical Service Annex F, Sept. 97.

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APPENDIX G

ADMINISTRATIVE INSTRUCTIONS

1. User Comments

Users in the field are highly encouraged to submit comments on this publication to: Commander, United States Joint Forces Command, Joint Warfighting Center Code JW100, 116 Lake View Parkway, Suffolk, VA 23435-2697. These comments should address content (accuracy, usefulness, consistency, and organization), writing, and appearance.

2. Authorship

The lead agent for this publication is the US Army. The Joint Staff doctrine sponsor for this publication is the Director for Logistics (J-4).

3. Supersession

This publication supersedes JP 4-02, 26 April 1995, *Doctrine for Health Service Support in Joint Operations*.

4. Change Recommendations

a. Recommendations for urgent changes to this publication should be submitted:

TO: HQDA WASHINGTON DC//DASG-HCD-D//
INFO: JOINT STAFF WASHINGTON DC//J7-JDETD//

Routine changes should be submitted to the Director for Operational Plans and Joint Force Development (J-7), JDETD, 7000 Joint Staff Pentagon, Washington, DC 20318-7000, with info copies to the USJFCOM JWFC.

b. When a Joint Staff directorate submits a proposal to the Chairman of the Joint Chiefs of Staff that would change source document information reflected in this publication, that directorate will include a proposed change to this publication as an enclosure to its proposal. The Military Services and other organizations are requested to notify the Director, J-7, Joint Staff, when changes to source documents reflected in this publication are initiated.

c. Record of Changes:

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5. Distribution

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- b. Only approved joint publications and joint test publications are releasable outside the combatant commands, Services, and Joint Staff. Release of any classified joint publication to foreign governments or foreign nationals must be requested through the local embassy (Defense Attaché Office) to DIA Foreign Liaison Office, PSS, PO-FL, Room 1A674, Pentagon, Washington, DC 20301-7400.
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GLOSSARY

PART I — ABBREVIATIONS AND ACRONYMS

AE	aeromedical evacuation
AFMIC	Armed Forces Medical Intelligence Center
AFSOF	Air Force special operations forces
AOR	area of responsibility
ARSOF	Army special operations forces
ASBPO	Armed Services Blood Program Office
ATM	advanced trauma management
BTC	blood transshipment center
C2	command and control
C4I	command, control, communications, computers, and intelligence
CA	civil affairs
CASEVAC	casualty evacuation
CD-ROM	compact disk read-only memory
CINC	commander in chief
CJCS	Chairman of the Joint Chiefs of Staff
CMO	chief medical officer
COA	course of action
CONUS	continental United States
COSR	combat and operational stress reactions
DIA	Defense Intelligence Agency
DNBI	disease and nonbattle injury
DOD	Department of Defense
EHRA	environmental health risk assessment
EMT	emergency medical technician
EPW	enemy prisoner of war
FHA	foreign humanitarian assistance
FHP	force health protection
FM	field manual
GCCS	Global Command and Control System
GPMRC	Global Patient Movement Requirements Center
HCA	humanitarian and civic assistance
HN	host nation
HNS	host-nation support
HSS	health service support

Glossary

IDRA	infectious disease risk assessment
IO	international organization
IV	intravenous
J-2	intelligence directorate of a joint staff
J-6	command, control, communications, and computer systems directorate of a joint staff
JBPO	Joint Blood Program Office
JFC	joint force commander
JFS	joint force surgeon
JOA	joint operations area
JP	joint publication
JRSOI	joint reception, staging, onward movement, and integration
JTF	joint task force
MASCAL	mass casualty
MAT	medical analysis tool
MNFC	multinational force commander
MOOTW	military operations other than war
MTF	medical treatment facility
NAVSOF	Naval special operations forces
NBC	nuclear, biological, and chemical
NGO	nongovernmental organization
OCONUS	outside continental United States
OPLAN	operation plan
OPORD	operation order
OPSEC	operations security
PA	physician assistant
PAR	population at risk
PMI	patient movement item
POW	prisoner of war
RDD	radiological dispersal device
RTD	returned to duty
SecDef	Secretary of Defense
SFG	special forces group
SIMLM	single integrated medical logistics manager
SOC	special operations command
SOF	special operations forces
TPFDD	time-phased force and deployment data
TPMRC	Theater Patient Movement Requirements Center

USC	United States Code
USCG	United States Coast Guard
VX	nerve agent (O-Ethyl S-Diisopropylaminomethyl Methylphosphonothiolate)
WMD	weapons of mass destruction

PART II — TERMS AND DEFINITIONS

aeromedical evacuation. The movement of patients under medical supervision to and between medical treatment facilities by air transportation. (JP 1-02)

aeromedical evacuation liaison team. An Air Force medical team that provides enhanced liaison support between the forward user and the aeromedical evacuation system. The aeromedical evacuation liaison team provides operational, clinical, and communications links necessary to prepare patients for flight, and initiates fixed wing evacuation of casualties. Also called AELT. (This term and its definition are applicable only in the context of this publication and cannot be referenced outside this publication.)

casualty. Any person who is lost to the organization by having been declared dead, duty status—whereabouts unknown, missing, ill, or injured. (JP 1-02)

casualty category. A term used to specifically classify a casualty for reporting purposes based upon the casualty type and the casualty status. Casualty categories include killed in action, died of wounds received in action, and wounded in action. (JP 1-02)

casualty evacuation. The movement of casualties. It includes movement both to and between medical treatment facilities. Any vehicle may be used to evacuate casualties. Also called CASEVAC. (This term and its definition are approved for inclusion in the next edition of JP 1-02.)

casualty status. A term used to classify a casualty for reporting purposes. There are seven casualty statuses: (1) deceased, (2) duty status—whereabouts unknown, (3) missing, (4) very seriously ill or injured,

(5) seriously ill or injured, (6) incapacitating illness or injury, and (7) not seriously injured. (JP 1-02)

casualty type. A term used to identify a casualty for reporting purposes as either a hostile casualty or a nonhostile casualty. (JP 1-02)

combat and operational stress. The expected and predictable emotional, intellectual, physical, and/or behavioral reactions of Service members who have been exposed to stressful events in war or military operations other than war. Combat stress reactions vary in quality and severity as a function of operational conditions, such as intensity, duration, rules of engagement, leadership, effective communication, unit morale, unit cohesion, and perceived importance of the mission. (This term and its definition are approved for inclusion in the next edition of JP 1-02.)

combatant command. A unified or specified command with a broad continuing mission under a single commander established and so designated by the President, through the Secretary of Defense and with the advice and assistance of the Chairman of the Joint Chiefs of Staff. Combatant commands typically have geographic or functional responsibilities. (JP 1-02)

combat service support. The essential capabilities, functions, activities, and tasks necessary to sustain all elements of operating forces in theater at all levels of war. Within the national and theater logistic systems, it includes but is not limited to the support rendered by Service forces in ensuring the aspects of supply, maintenance, transportation, health services, and other services required by aviation and ground combat troops to

permit those units to accomplish their missions in combat. Combat service support encompasses those activities at all levels of war that produce sustainment to all operating forces on the battlefield. Also called CSS. (JP 1-02)

combat zone. 1. That area required by combat forces for the conduct of operations. (JP 1-02)

command and control. The exercise of authority and direction by a properly designated commander over assigned and attached forces in the accomplishment of the mission. Command and control functions are performed through an arrangement of personnel, equipment, communications, facilities, and procedures employed by a commander in planning, directing, coordinating, and controlling forces and operations in the accomplishment of the mission. Also called C2. (JP 1-02)

communications zone. Rear part of theater of war or theater of operations (behind but contiguous to the combat zone) which contains the lines of communications, establishments for supply and evacuation, and other agencies required for the immediate support and maintenance of the field forces. Also called COMMZ. (JP 1-02)

directed energy. An umbrella term covering technologies that relate to the production of a beam of concentrated electromagnetic energy or atomic or subatomic particles. (JP 1-02)

disease and nonbattle injury casualty. A person who is not a battle casualty but who is lost to the organization by reason of disease or injury, including persons dying of disease or injury, by reason of being missing where the absence does not appear

to be voluntary, or due to enemy action or to being interned. (JP 1-02)

en route care. The care required to maintain the phase treatment initiated prior to evacuation and the sustainment of the patient's medical condition during evacuation. (This term and its definition are approved for inclusion in the next edition of JP 1-02.)

essential care. That care received within a theater that is dependent upon the mission, enemy, terrain, troops, time available, and other civilian considerations. It includes first responder care, forward resuscitative surgery, and en route care as well as treatment and hospitalization to return the patient to duty or to stabilize for movement to a higher level of care. (This term and its definition are approved for inclusion in the next edition of JP 1-02.)

evacuation. 1. The process of moving any person who is wounded, injured, or ill to and/or between medical treatment facilities. (JP 1-02)

evacuation policy. 1. Command decision establishing the maximum number of days that patients may be held within the command for treatment. Patients who, in the opinion of responsible medical officers, cannot be returned to a duty status within the period prescribed are evacuated by the first available means, provided the travel involved will not aggravate their disabilities. (This term and its definition modify the existing term and its definition and are approved for inclusion in the next edition of JP 1-02)

first responder phase. A phase of medical care in which health care providers' focus is to save life and limb and stabilize the patient sufficiently to withstand evacuation to the next level of care. This first response

may include first aid (self-aid and buddy aid, combat lifesavers) or medical assistance by combat medics, hospital corpsmen, physician assistants, or physicians. (This term and its definition are approved for inclusion in the next edition of JP 1-02.)

force health protection. All services performed, provided, or arranged by the Services to promote, improve, conserve, or restore the mental or physical well being of personnel. These services include, but are not limited to, the management of health services resources, such as manpower, monies, and facilities; preventive and curative health measures; evacuation of the wounded, injured, or sick; selection of the medically fit and disposition of the medically unfit; blood management; medical supply, equipment, and maintenance thereof; combat stress control; and medical, dental, veterinary, laboratory, optometry, medical food, and medical intelligence services. (This term and its definition are approved for inclusion in the next edition of JP 1-02.)

foreign internal defense. Participation by civilian and military agencies of a government in any of the action programs taken by another government to free and protect its society from subversion, lawlessness, and insurgency. (JP 1-02)

forward aeromedical evacuation. That phase of evacuation that provides airlift for patients between points within the battlefield, from the battlefield to the initial point of treatment, and to subsequent points of treatment within the combat zone. (JP 1-02)

forward resuscitative surgery. The urgent initial surgery required to render patients transportable for further evacuation to medical treatment facilities staffed and equipped to provide for their care. Forward

resuscitative surgery is performed on patients with signs and symptoms of initial airway compromise, difficult breathing, and circulatory shock and who do not respond to initial emergency medical treatment and advanced trauma management procedures. (This term and its definition are approved for inclusion in the next edition of JP 1-02.)

Global Patient Movement Requirements

Center. A joint activity reporting directly to the Commander in Chief, US Transportation Command, the Department of Defense single manager for the regulation of movement of uniformed services patients. The Global Patient Movement Requirements Center authorizes transfers to medical treatment facilities of the Military Departments or the Department of Veterans Affairs and coordinates intertheater and inside continental United States patient movement requirements with the appropriate transportation component commands of US Transportation Command. (JP 1-02)

health service logistic support. A functional area of logistic support that supports the joint force surgeon's health service support mission. It includes supplying Class VIII medical supplies (medical material to include medical peculiar repair parts used to sustain the health service support system), optical fabrication, medical equipment maintenance, blood storage and distribution, and medical gases. See also health service support; joint force surgeon. (JP 1-02)

health service support. All services performed, provided, or arranged by the Services to promote, improve, conserve, or restore the mental or physical well being of personnel. These services include but are not limited to the management of health services resources, such as manpower, monies, and facilities; preventive and

curative health measures; evacuation of the wounded, sick, or injured; selection of the medically fit and disposition of the medically unfit; blood management; medical supply, equipment, and maintenance thereof; combat stress control; and medical, dental, veterinary, laboratory, optometric, medical food, and medical intelligence services. Also called HSS. (JP 1-02)

health threat. A composite of ongoing or potential enemy actions; environmental, occupational, and geographic and meteorological conditions; endemic diseases; and employment of nuclear, biological, and chemical weapons (to include weapons of mass destruction) that can reduce the effectiveness of joint forces through wounds, injuries, illness, and psychological stressors. (This term and its definition modify the term “medical threat” and its definition and are approved for inclusion in the next edition of JP 1-02.)

hospital. A medical treatment facility capable of providing inpatient care. It is appropriately staffed and equipped to provide diagnostic and therapeutic services, as well as the necessary supporting services required to perform its assigned mission and functions. A hospital may, in addition, discharge the functions of a clinic. (JP 1-02)

hostile casualty. A person who is the victim of a terrorist activity or who becomes a casualty “in action.” “In action” characterizes the casualty as having been the direct result of hostile action, sustained in combat or relating thereto, or sustained going to or returning from a combat mission provided that the occurrence was directly related to hostile action. Included are persons killed or wounded mistakenly or accidentally by friendly fire directed at a hostile force or what is thought to be a hostile force. However, not to be considered as sustained in action and not

to be interpreted as hostile casualties are injuries or death due to the elements, self-inflicted wounds, combat fatigue, and except in unusual cases, wounds or death inflicted by a friendly force while the individual is in an absent-without-leave, deserter, or dropped-from-rolls status, or is voluntarily absent from a place of duty. (JP 1-02)

host-nation support. Civil and/or military assistance rendered by a nation to foreign forces within its territory during peacetime, crisis or emergencies, or war based upon agreements mutually concluded between nations. Also called HNS. (JP 1-02)

INTELINK and INTELINK-S. Secure, classified intelligence networks that can provide medical intelligence products. (This term and its definition are applicable only in the context of this publication and cannot be referenced outside this publication.)

intertheater evacuation. Evacuation of stabilized patients between the originating theater and points outside the theater, to include the continental United States and other theaters. En route care is provided by medical attendants qualified for the specific mode of transportation. (This term and its definition modify the existing term and its definition and are approved for inclusion in the next edition of JP 1-02.)

in-transit visibility. The ability to track the identity, status, and location of Department of Defense units, and non-unit cargo (excluding bulk petroleum, oils, and lubricants) and passengers; medical patients; and personal property from origin to consignee or destination across the range of military operations. Also called ITV. (JP 1-02)

intratheater evacuation. Evacuation of stabilized patients between points within the

theater. En route care is provided by medical attendants qualified for the specific mode of transportation. (This term and its definition modify the existing term and its definition and are approved for inclusion in the next edition of JP 1-02.)

joint force. A general term applied to a force composed of significant elements, assigned or attached, of two or more Military Departments, operating under a single joint force commander. (JP 1-02)

joint force commander. A general term applied to a combatant commander, subunified commander, or joint task force commander authorized to exercise combatant command (command authority) or operational control over a joint force. (JP 1-02)

joint force surgeon. A general term applied to a medical officer appointed by the joint force commander to serve as the joint force special staff officer responsible for establishing, monitoring, or evaluating joint force health service support. (This term and its definition modify the existing term and its definition and are approved for inclusion in the next edition of JP 1-02.)

killed in action. A casualty category applicable to a hostile casualty, other than the victim of a terrorist activity, who is killed outright or who dies as a result of wounds or other injuries before reaching a medical treatment facility. See also casualty category. (JP 1-02)

mass casualty. Any large number of casualties produced in a relatively short period of time, usually as the result of a single incident such as a military aircraft accident, hurricane, flood, earthquake, or armed attack, that exceeds local logistical support capabilities. See also casualty. (JP 1-02)

medical evacuees. Personnel who are wounded, injured, or ill and must be moved to or between medical facilities. (JP 1-02)

medical intelligence. That category of intelligence resulting from collection, evaluation, analysis, and interpretation of foreign medical, bioscientific, and environmental information which is of interest to strategic planning and to military medical planning and operations for the conservation of the fighting strength of friendly forces and the formation of assessments of foreign medical capabilities in both military and civilian sectors. (JP 1-02)

medical regulating. The actions and coordination necessary to arrange for the movement of patients through the levels of care. This process matches patients with a medical treatment facility that has the necessary health service support capabilities and available bed space. (This term and its definition modify the existing term and its definition and are approved for inclusion in the next edition of JP 1-02.)

medical surveillance. The ongoing, systematic collection of health data essential to the evaluation, planning, and implementation, of public health practice, closely integrated with timely dissemination of data as required by higher authority. (This term and its definition are approved for inclusion in the next edition of JP 1-02.)

medical treatment facility. A facility established for the purpose of furnishing medical and/or dental care to eligible individuals. (JP 1-02)

National Command Authorities. The President and the Secretary of Defense or their duly deputized alternates or successors. (JP 1-02)

nonhostile casualty. A person who becomes a casualty due to circumstances not directly attributable to hostile action or terrorist activity. Casualties due to the elements, self-inflicted wounds, and combat fatigue are nonhostile casualties. (JP 1-02)

not seriously injured. The casualty status of a person whose injury may or may not require hospitalization; medical authority does not classify as very seriously injured, seriously injured, or incapacitating illness or injury; and the person can communicate with the next of kin. See also casualty status. (JP 1-02)

occupational and environmental health threats. Threats to the health of military personnel and to military readiness created by exposure to hazardous agents, environmental contamination, or toxic industrial materials. (This term and its definition are approved for inclusion in the next edition of JP 1-02.)

originating medical facility. A medical facility that initially transfers a patient to another medical facility. (JP 1-02)

patient. A sick, injured, wounded, or other person requiring medical/dental care or treatment. (JP 1-02)

patient movement. The act or process of moving a sick, injured, wounded, or other person to obtain medical and/or dental care or treatment. Functions include medical regulating, patient evacuation, and en route medical care. (This term and its definition are approved for inclusion in the next edition of JP 1-02.)

patient movement requirements center. A joint activity that coordinates patient movement. It is the functional merging of joint medical regulating processes, Services' medical regulating processes, and

coordination with movement components for patient evacuation. This may be joint, reporting to the joint task force surgeon; theater, reporting to the theater surgeon; or global, reporting to the United States Transportation Command surgeon. (This term and its definition are approved for inclusion in the next edition of JP 1-02.)

preventive medicine. The anticipation, communication, prediction, identification, prevention, education, risk assessment, and control of communicable diseases, illnesses and exposure to endemic, occupational, and environmental threats. These threats include nonbattle injuries, combat stress responses, WMD, and other threats to the health and readiness of military personnel. Communicable diseases include anthropod-, vector-, food-, waste-, and waterborne diseases. Preventative medicine measures include field sanitation, medical surveillance, pest and vector control, disease risk assessment, environmental and occupational health surveillance, waste (human, hazardous, and medical) disposal, food safety inspection, and potable water surveillance. (This term and its definition are approved for inclusion in the next edition of JP 1-02.)

prisoner of war. A detained person as defined in Articles 4 and 5 of the Geneva Convention Relative to the Treatment of Prisoners of War of August 12, 1949. In particular, one who, while engaged in combat under orders of his or her government, is captured by the armed forces of the enemy. As such, he or she is entitled to the combatant's privilege of immunity from the municipal law of the capturing state for warlike acts which do not amount to breaches of the law of armed conflict. For example, a prisoner of war may be, but is not limited to, any person belonging to one of the following categories who has fallen into the power of the enemy: a

member of the armed forces, organized militia or volunteer corps; a person who accompanies the armed forces without actually being a member thereof; a member of a merchant marine or civilian aircraft crew not qualifying for more favorable treatment; or individuals who, on the approach of the enemy, spontaneously take up arms to resist the invading forces. (JP 1-02)

restorative and rehabilitative care. A period of minimal care and increasing physical activity necessary to restore patients to functional health and allow their return to duty or useful and productive life. Restorative and rehabilitative treatment may be available in theater on a limited basis due to the theater evacuation policy. This treatment is normally provided in the continental United States. (This term and its definition are approved for inclusion in the next edition of JP 1-02.)

resuscitative care. The aggressive management of life- and limb-threatening injuries. Interventions include emergency medical treatment, advanced trauma management, and lifesaving surgery to enable the patient to tolerate evacuation to the next level of care. (This term and its definition are approved for inclusion in the next edition of JP 1-02.)

safe haven. 1. Designated area(s) to which noncombatants of the United States Government's responsibility and commercial vehicles and materiel may be evacuated during a domestic or other valid emergency. (JP 1-02)

seriously ill or injured. The casualty status of a person whose illness or injury is classified by medical authority to be of such severity that there is cause for immediate concern, but there is not imminent danger to life. See also casualty status. (JP 1-02)

seriously wounded. A casualty whose injuries or illness are of such severity that the patient is rendered unable to walk or sit, thereby requiring a litter for movement and evacuation. (This term and its definition modify the existing term and its definition and are approved for inclusion in the next edition of JP 1-02.)

slightly wounded. A casualty whose injuries or illness are relatively minor, permitting the patient to walk and/or sit. (This term and its definition modify the existing term and its definition and are approved for inclusion in the next edition of JP 1-02.)

unaccounted for. An inclusive term (not a casualty status) applicable to personnel whose person or remains are not recovered or otherwise accounted for following hostile action. Commonly used when referring to personnel who are killed in action and whose bodies are not recovered. See also casualty; casualty category; casualty status; casualty type. (JP 1-02)

very seriously ill or injured. The casualty status of a person whose illness or injury is classified by medical authority to be of such severity that life is imminently endangered. See also casualty status. (JP 1-02)

walking patient. A patient whose injuries and/or illness are relatively minor, permitting the patient to walk and not require a litter. (This term and its definition modify the existing term and its definition and are approved for inclusion in the next edition of JP 1-02.)

wellness. Force health protection program that consolidates and incorporates physical and mental fitness, health promotion, and environmental and occupational health. (This term and its definition are approved for inclusion in the next edition of JP 1-02.)

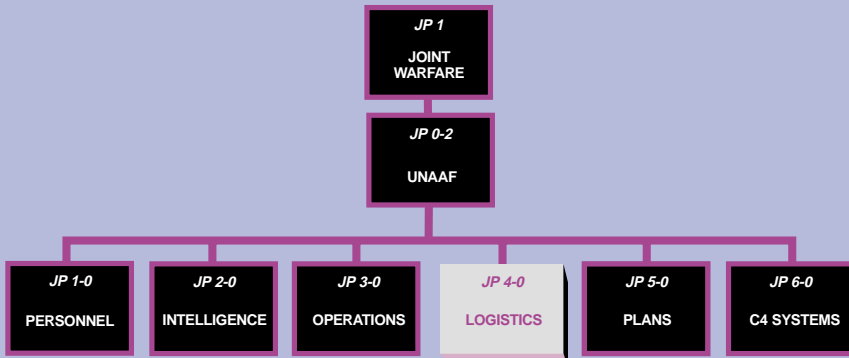
wounded. See seriously wounded; slightly wounded. (JP 1-02)

wounded in action. A casualty category applicable to a hostile casualty, other than the victim of a terrorist activity, who has incurred an injury due to an external agent or cause. The term encompasses all kinds of wounds and other injuries incurred in action, whether there is a piercing of the body, as in a penetration or perforated

wound, or none, as in the contused wound. These include fractures, burns, blast concussions, all effects of biological and chemical warfare agents, and the effects of an exposure to ionizing radiation or any other destructive weapon or agent. The hostile casualty's status may be very seriously ill or injured, seriously ill or injured, incapacitating illness or injury, or not seriously injured. See also casualty category. (JP 1-02)

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JOINT DOCTRINE PUBLICATIONS HIERARCHY



All joint doctrine and tactics, techniques, and procedures are organized into a comprehensive hierarchy as shown in the chart above. **Joint Publication (JP) 4-02** is in the **Logistics** series of joint doctrine publications. The diagram below illustrates an overview of the development process:

