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Army Health System Support to Army Special Operations Forces

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Preface

The purpose of ATP 4-02.43 is to provide doctrine in support of Army special operations forces as part of the protection and sustainment warfighting functions in support of multidomain operations. *Army special operations forces* are those Active Component and Reserve Component Army forces designated by the Secretary of Defense that are specifically organized, trained, and equipped to conduct and support special operations (JP 3-05). Army special operations forces consist of special forces, special mission units, Rangers, civil affairs, psychological operations, Army special operations aviation forces, and a sustainment brigade. These forces are assigned to the United States Army Special Operations Command. This publication also discusses joint special operations and provides a limited discussion of other Services capabilities.

The principal audience for this publication includes commanders and their staff at all levels to provide a universal understanding of how the Army Health System must function to support Army special operations forces. Commanders, staffs, and subordinates ensure their decisions and actions comply with the applicable United States, international, and, in some cases, host nation laws and regulations. Commanders at all levels ensure their Soldiers operate in accordance with the law of armed conflict and the rules of engagement. For additional information on the law of armed conflict and the rules of engagement, refer to FM 6-27 and FM 4-02.

Army Techniques Publication 4-02.43 implements agreement between the United States Army, other Services and armies, or other governmental agencies of an ally or potential coalition partner that specifically contributes to compatibility of multinational medical support. This publication implements or is in consonance with the following North Atlantic Treaty Organization (NATO) multinational force compatibility agreements:

Title	NATO STANAGs
Forward Aeromedical Evacuation—AAMedP-1.5	2087
Documentation Relative to Initial Medical Treatment and Evacuation—AMedP-8.1	2132
Allied Joint Doctrine for Medical Support—AJP-4.10	2228
Allied Joint Medical Doctrine for Medical Evacuation—AJMedP-2	2546
Allied Joint Medical Force Health Protection Doctrine—AJMedP-4	2561
Minimum Requirements for Blood, Blood Donors and Associated Equipment—AMedP-1.1	2939
Aeromedical Evacuation—AAMedP-1.1	3204

Army Techniques Publication 4-02.43 uses joint terms where applicable. Selected joint and Army terms and definitions appear in both the glossary and the text. For definitions shown in the text, the term is italicized, and the number of the proponent publication follows the definition. This publication is not the proponent for any Army terms.

This publication applies to the Active Army, Army National Guard/Army National Guard of the United States, and the United States Army Reserve, unless otherwise stated.

The proponent and preparing agency of ATP 4-02.43 is the United States Army Medical Center of Excellence, Directorate of Training and Doctrine, Doctrine Literature Division. Send comments and recommendations on DA Form 2028 *(Recommended Changes to Publications and Blank Forms*) to Commander, United States Army Medical Center of Excellence, ATTN: ATMC-FD (ATP 4-02.43), 2377 Greeley Road, Suite B, JBSA Fort Sam Houston, Texas 78234-7731; by e-mail to usarmy.jbsa.medical-coe.mbxameddc-medical-doctrine@army.mil; or submit an electronic DA Form 2028. All recommended changes should be keyed to a specific page, paragraph, and line number. A rationale for each proposed change is required to aid in the evaluation and adjudication of each comment.

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Introduction

Army Health System support to Army special operations forces is challenging in that Army special operations forces are lightly equipped with limited organic support assets. Therefore, they must be self-sustaining in all areas of medical care across the competition continuum. Since they routinely operate in undeveloped joint operational areas without established support systems, Army special operations forces medical personnel must assume both Army Health System missions of health service support and force health protection responsibilities.

Summary of changes include—

- Aligning this publication with Army doctrine publications FM 3-0, FM 4-0, and the operational medicine keystone publication, FM 4-02.
- Replacing mission command medical function with medical command and control, which is in line with ADP 6-0.
- Replacing "field preventive medicine" with "operational public health" according to AR 40-5.
- Adding global health engagement.

Army Techniques Publication 4-02.43 contains the following six chapters and three appendixes:

Chapter 1 provides an overview of Army Health System support and its mission to provide health care to Soldiers across the competition continuum and operational environment. It identifies and discusses the purpose of the Army Health System and reviews the roles of medical care and the Army Health System principles.

Chapter 2 discusses the missions and activities of Army special operations forces. It also examines Army special operations forces medical capabilities and the range of medical personnel and their responsibilities serving in Army special operations forces.

Chapter 3 lists the medical functions and their relationship to Army special operations forces. In addition, there is a comparison of Army Health System support between conventional forces and Army special operations forces.

Chapter 4 discusses planning for Army Health System support to Army special operations forces. It focuses upon planning requirements for a number of core activities.

Chapter 5 focuses upon Army Health System support to Army special operations forces in joint operations and the various considerations involved in joint task force planning.

Chapter 6 examines medical logistics support to Army special operations forces and its unique requirements.

Appendix A provides an explanation of the law of war, which includes the Geneva Conventions, and the protections afforded to conventional medical personnel, medical aircraft, and medical materiel.

Appendix B discusses medical evacuation planning in the support of Army special operations forces missions and units.

Appendix C discusses the relationship between special operations medical command and control in the joint environment.

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Chapter 1

Overview of Army Health System Support and the Operational Environment

The *Army Health System* (AHS) is a component of the Military Health System that is responsible for operational management of the health service support and force health protection missions for training, predeployment, deployment, and postdeployment operations. The AHS includes all mission support services performed, provided, or arranged by Army Medicine to support health service support and force health protection mission requirements for the Army and as directed for joint, intergovernmental agencies, coalition, and multinational forces (FM 4-02). The AHS is a complex system of systems that is interdependent and interrelated and requires continual planning, coordination, and synchronization to effectively clear the battlefield of casualties and to provide the highest level of care to our wounded or ill Soldiers. The AHS is designed to provide health care to our Soldiers across the competition continuum from austere environments to well-staffed and equipped medical treatment facilities (MTFs). Although many features of Army special operations forces (ARSOF) are common to conventional forces, some unique differences in tactical employment are necessary for ARSOF. The differences arise primarily in how medical assets are employed and the operational, tactical, sociopolitical, and geographical constraints that routinely confront ARSOF medical capabilities. In addition to constraints, ARSOF provide deliberate support to unified action partner forces and local nationals, indeed differing in this way from traditional AHS and joint health service support. Medical planners should review lessons learned from recent operations and from World War II, Korea, and Vietnam era operations to gain a better objective perspective on current and future near-peer and peer (reference to geographical peers and challenges in deployment of United States [U.S.] forces to the operational area) operational environments (OEs). These lessons learned will apply to how near-peer and peer threats will reduce U.S. advantages, leaving the OE more closely resembling earlier wars. Medical planners must utilize lessons learned from both recent and historical conflicts to achieve a balanced perspective of current requirements, when supporting special operations forces (SOF) and unconventional warfare (UW) operations. Study of technological advancement in a multidomain environment is also necessary to capture all potential challenges and the ways and means to overcome those challenges. For a more detailed overview of the AHS, refer to FM 4-02.

PURPOSE

1-1. The purpose of the AHS is to conserve the fighting strength. This includes both the deployed force and the sustaining base. Consistent with operational requirements, the AHS operates in a range across strategic, operational, and tactical levels. In an Army with a joint, expeditionary, and campaign focus, the AHS support must be seamless, deployable, versatile, and sustainable. This will ensure the supported forces are rapidly deployable, lethal, adaptable, and that they possess the capability to sustain operations over prolonged operations. The AHS must be operationally agile and responsive in light of ARSOF extended lines of communication and a broad range of worldwide requirements.

OPERATIONAL ENVIRONMENT

1-2. The Army accomplishes its mission by supporting the joint force in four strategic roles—shape OEs, prevent conflicts, conduct and prevail in large-scale ground combat operations, and consolidate gains. The benchmark for Army readiness is its ability to conduct large-scale combat operations fighting a near-peer to peer threat with potential overmatch across multiple domains (including land, air, maritime, space, cyberspace as well as the electromagnetic spectrum, and the information environment).

1-3. A multidomain approach to operations is not new. Army forces have effectively integrated capabilities and synchronized actions in the air, land, and maritime domains for decades. Rapid and continual advances in technology and the military application of those new technologies to the space domain, the electromagnetic spectrum, and the information environment (particularly cyberspace) require special consideration in planning and converging effects across all domains. Army SOF have a unique role in the strategic and OE in the multidomain threat.

1-4. An OE has a number of threats that consist of enemies, adversaries, neutrals, and hybrid threats (a force that combines traditional, irregular, disruptive, or catastrophic capabilities). The threats are protracted confrontation among individuals, groups of individuals, paramilitary or military forces, state actors, and nonstate actors increasingly willing to use violence to achieve their political and ideological ends. The ARSOF is uniquely suited for the hybrid threat due to its close coordination and synchronization with the conventional force in all domains. There is a probability that, in the future, United States Army forces will conduct operations in an urban environment in and around megacities. Urban areas are becoming safe havens and support bases for terrorists, insurgents, or criminal organizations. For information on the multidomain approach and the OE, refer to FM 3-0.

ROLES OF MEDICAL CARE

1-5. There are four roles of medical care. The AHS is organized to provide Role 1 through Role 3 medical care in an OE. Role 4 medical care is an integral part of the AHS and is provided by the Military Health System in the continental United States or other safe havens. Each role of medical care reflects an increase in medical capabilities while retaining the capabilities found in the lower role of care. Role 1 and limited Role 2 capabilities are found in ARSOF.

1-6. Tactical combat casualty care (TCCC) is administered by nonmedical personnel in the form of self-aid and buddy aid with additional TCCC procedures performed by the combat lifesaver. Such measures assist combat medics in their duties, thereby, reducing morbidity and mortality. In addition, Ranger units have maneuver element TCCC capability (Ranger Regiment). First responder care capability in the operational area is known as TCCC, as noted above, and is the military's counterpart to prehospital trauma life support. All first responders will carry and use DD Form 1380 (*Tactical Combat Casualty Care [TCCC] Card*) to document pre-MTF care at the point of injury. This card is also known as the U.S. Field Medical Card. The Ranger first responder is a nonmedical military occupational specialty (MOS) Ranger within each maneuver unit who is currently registered as an emergency medical technician-basic. This individual serves as a bridge between the administering of self-aid and buddy aid and the Ranger special operations combat medics (SOCMs) in tactical and administrative care.

1-7. The first medical care a Soldier receives is provided at Role 1, and it includes, but is not limited to—

- Immediate lifesaving measures.
- Tactical combat casualty care.
- Disease and nonbattle injury prevention.
- Combat and operational stress control (COSC) preventive measures.
- Patient and casualty collection.
- Medical evacuation (MEDEVAC) from supported units to supporting medical treatment elements, as appropriate.
- Sick call.

1-8. Role 1 medical treatment in conventional forces is provided by the combat medic and the physician assistant (PA) or physician in the battalion aid station Role 1 MTF. In ARSOF, Role 1 medical treatment is

provided by SOCMs (MOS 68WW1); special forces (SF), special forces medical sergeants (SFMSs) (MOS 18D); and physicians or PAs at forward operating bases, special operations civil affairs medical sergeants (SOCAMSs) (MOS 38BW4); SF operations bases or in joint special operations (SO) and task force area of operations (AO).

Note. Special operations forces must often maintain patients for longer periods of time at Role 1 than do conventional forces because evacuation resources may not be available in a hostile or a denied AO. It should be assumed that evacuation is during the next period of darkness at the earliest in these environments. Additionally, ARSOF are often far removed from conventional AHS or joint health services capabilities in austere environments and locations.

1-9. The special operations forces austere medical technician (also known as SOFAMT) was developed to mitigate medical and operational risk for select elements within 1st Special Forces Command Airborne (ABN). These unique entities are composed of MOS nonspecific members, who are operationally deployed in austere environments without organic or adequate medical personnel to provide Role 1 medical capabilities. The special operations forces austere medical technician trains to the level emergency medical technician-basic and remote emergency medical technician with a focus on austere medicine, TCCC, prolonged field care, in-depth telemedicine with an allowed specific medical scope of practice, and the recommended drug list (to include limited narcotics and benzodiazepines). The individual is a bridge between self-aid and higher roles of care.

1-10. The combat lifesaver is a Soldier with a nonmedical MOS selected by the unit commander for training beyond basic TCCC procedures. A minimum of one individual per squad, crew, team, or equivalent-sized unit is trained. The primary duty of this Soldier remains in the Soldier's nonmedical MOS. The additional duty of the combat lifesaver is to provide additional TCCC procedures for injuries based on this training before the combat medic arrives. All members of SFG operational detachments receive enhanced TCCC training above the combat lifesaver level. The standard for all ARSOF first responders is the TCCC committee standards.

1-11. The ARSOF has limited Role 2 medical care. The 528th sustainment brigade (special operations) (airborne) (SB[SO][ABN]) provides limited medical support, medical logistics (MEDLOG), and physical therapy support.

1-12. For more information on Role 3 and Defense Health Agency in the continental United States and outside the continental United States based Role 4 MTF medical care, refer to FM 4-02 and ATP 4-02.10.

PRINCIPLES OF THE ARMY HEALTH SYSTEM

1-13. The medical planner must be mentally agile, forward thinking, and able to work closely with both supported and supporting elements across all the affected Services, different agencies, and other potentially involved organizations, as required. For optimum AHS support, the medical planner must be involved as early as possible in the planning process and in the development of the operation plan. With AHS planning considerations, it is incumbent upon the planner to produce a plan that is straightforward and workable with unnecessary complication. There are six AHS principles: conformity, continuity, control, proximity, flexibility, and mobility. The medical planner uses these principles as a tool to ensure all medical functions are properly analyzed and addressed in the plan.

1-14. Conformity with the operation plan is the most fundamental element for effectively providing AHS support. The medical planner must incorporate ARSOF considerations into the AHS plan to ensure AHS support will be available when and where required. Army Health System planners ensure AHS support operations are in consonance with the combatant commander and meet ARSOF requirements.

1-15. Continuity is vital since an interruption of treatment could cause a deterioration of the patient's condition and result in possible death. No patient is evacuated from the point of injury any farther than the patient's physical condition or the operational situation allows. To ensure continuity of care for ARSOF personnel, the AHS plan must provide for a seamless transition from care provided by ARSOF's limited organic medical assets through acquisition by the conventional AHS support capabilities. This requires direct

coordination with supporting joint medical elements within the evacuation and treatment chain from the point of injury to MTFs in the continental United States. The need for continuity is imperative in all ARSOF operations to include the potential for large-scale combat operations. Prior planning (gaming) and solutions is essential.

1-16. Control is required to ensure scarce AHS resources are efficiently employed and support the operational and strategic plan. It also ensures medical treatment meets professional standards and relevant policies and laws. Technical supervision of AHS assets must remain with the appropriate medical commander or command surgeon due to their professional training, knowledge, and experience. Medical planners must be proactive and keep their commanders and surgeons informed as to the impact of future operations on AHS resources and capabilities.

1-17. Proximity to supported forces and the location of AHS assets in support of operations is dictated by the operational situation (mission, enemy, terrain and weather, troops and support available, time available, civil considerations, and informational considerations [mission variables]). The unique challenges of time and distance of evacuation legs, availability of limited mobility platforms for delivery into the AO, and accessibility of evacuation resources from the operation requires planning and coordination to ensure prompt evacuation. The speed at which medical treatment is initiated is extremely important in reducing morbidity and mortality. As ARSOF operations are often conducted in hostile or denied areas, conventional AHS support must be planned so it does not compromise the security of the operation. However, AHS support must be rapidly and readily accessible once casualties are evacuated from hostile or denied territory.

1-18. Flexibility is the principle that allows AHS resources to be shifted to meet changing requirements. Changes in plans or operations make flexibility in AHS planning and execution essential. When supporting ARSOF, medical planners and commanders must ensure they remain receptive to innovative and nontraditional methods of providing AHS support.

1-19. Mobility is measured by the extent to which a unit can move its personnel and equipment with organic transportation and the ability of its platforms to be sustained and survive in the OE. Since contact with supported units must be maintained, AHS elements must have mobility comparable to the units being supported. The only means available to increase the mobility of AHS units is to evacuate all patients they are holding.

ARMY HEALTH SYSTEM MEDICAL FUNCTIONS

1-20. Army Health System support is provided through ten medical functions by units specifically organized to provide these functions: medical command and control; MEDEVAC (to include medical regulating); medical treatment (organic and area support); hospitalization; MEDLOG; operational public health (provided by preventive medicine [PVNTMED] units, staff officers, and PVNTMED personnel); veterinary services; dental services; COSC; and medical laboratory services. For further information on the AHS medical functions, refer to FM 4-02.

1-21. In SF operations conducted in hostile or denied areas, SF uses the infiltration and exfiltration platforms to perform casualty evacuation (CASEVAC) as conventional forces do not have platforms that can operate in hostile or denied territory. Providing MEDEVAC, CASEVAC, and MEDLOG in support of SO requires detailed planning, flexibility, and practical realistic imaginative execution of missions befitting the supported SO in the OE, along with accurate ground truth.

1-22. Army SOF must employ some unique aspects of AHS medical functions. For example, ARSOF may require specialized MEDEVAC platforms, exceptions to the theater evacuation policy, extended time-distance factors, and extensive use of CASEVAC assets. Operational public health services are extremely important in the AO in that they support ARSOF Soldiers, indigenous personnel, and local populations. The provision of operational public health services prior to, during, and postdeployment is extremely important. The success of the mission and the health of Soldiers are dependent upon good operational public health. When deployed, veterinary services for ARSOF increase in importance in these areas:

- Food procurement, production, and protection.
- Support to multipurpose canines and other government-owned animals.

- Prevention and control of zoonotic diseases.
- Mission effect oriented support to indigenous personnel and local populations.

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Chapter 2
Special Operations Forces Missions and Activities

Special operations missions are inherently joint and may include interagency and multinational efforts. Their operations are conducted across the competition continuum, either independently or integrated with conventional operations. They are targeted on strategic and operational goals. Military information support operations (MISO) and civil affairs (CA) operations are the exceptions; they normally operate at all echelons simultaneously in support of the joint force commander's (JFC's) campaign plan in war or the combatant command plan. They are also able to support each U.S. ambassador's country plan in peacetime, as required. Both political and military considerations frequently shape operations requiring clandestine, covert, or low visibility techniques at the national level. Special operations differ from conventional operations in their methods of employment, operational techniques, independence from friendly support, and dependence on detailed operational intelligence and indigenous assets. The AHS planner and health care provider must apply the fundamentals of providing AHS support across the competition continuum. Given their unique operational requirements, it is imperative to maintain an appropriate role of AHS support for ARSOF. For more information, refer to ADP 3-0, ADP 3-05, ATP 3-05.1, ATP 3-05.40, and FM 3-18.

CORE ACTIVITIES OF ARMY SPECIAL OPERATIONS FORCES

2-1. The ARSOF possess unique capabilities to support United States Army Special Operations Command (USASOC) roles, missions, and functions as directed by Congress in Title 10, United States Code (USC), Chapter 6 (Combatant Commands), Sections 164 and 167, and Title 22 USC Chapter 52 (Foreign Service), Section 3927 (Chief of Mission). Army SOF will often work in chief of mission environments, and the AHS must properly understand the constraints and restraints of that OE.

2-2. During development of joint doctrine for SO, certain legislated SO activities were refined into the SO core activities. Special operations forces may conduct several different core activities simultaneously in a single operation. The goal of the health care provider is to sustain ARSOF activities with seamless high quality medical care within the parameters of the ARSOF mission envelope.

SPECIAL OPERATIONS CORE ACTIVITIES

2-3. Special operations core activities are the military missions for which SOF have unique modes of employment, tactics, techniques, equipment, and training to orchestrate effects, often in concert with conventional forces. These core activities are as follows:

- Unconventional warfare.
- Foreign internal defense (FID).
- Security force assistance.
- Counterinsurgency.
- Direct action.
- Special reconnaissance (also known as SR).
- Counterterrorism (CT).
- Preparation of the environment.

- Military information support operations.
- Civil affairs operations.
- Counterproliferation of weapons of mass destruction. *Counterproliferation* is defined as actions taken to reduce the risks posed by extant weapons of mass destruction to the United States, allies, and partners (JP 3-40).
- Humanitarian assistance and disaster relief.

2-4. These core activities are critical tasks for which SOF of all Services are uniquely suited with appropriate support and coordination with conventional forces of the respective Services. For further information on SO core activities, refer to ADP 3-05 and FM 3-05.

MISSION TASKING AUTHORITY

2-5. Special operations forces support combatant commands, JFC, U.S. ambassadors, and other agencies of the U.S. Government to perform missions for which they are the best suited among available forces and in situations where they are the only appropriate force available. When assigned an operation by its controlling headquarters, that operation becomes the focus of the assigned unit.

2-6. The SOF provides the tasking commander with a candid assessment of their capabilities, limitations, and the risks associated with the operation. In addition, the unique capabilities of SOF enable unique, rapid, tailored response in support of mission requirements regardless of geographic location.

ARMY SPECIAL OPERATIONS FORCE ORGANIZATIONS

2-7. The mission of the 75th Ranger Regiment (Airborne) is to plan and conduct SO and special light infantry operations in any OE across the AO. The primary SO mission of the Ranger Regiment is direct action. Ranger direct action operations may support or be supported by other SOF. They may also be conducted independently or in conjunction with conventional military operations. Rangers can also operate as special light infantry when conventional ABN or light infantry units are unsuited for or unable to perform a specific mission. Ranger units can deploy by land, sea, and air and may operate in a force size ranging from company-level teams to regimental task forces.

2-8. The 160th Special Operations Aviation Regiment (Airborne) (SOAR)(ABN) specialized assets covertly penetrate hostile and denied airspace to conduct and support SO. These assets operate with great precision for extended ranges under adverse weather conditions and during periods of limited visibility. The 160th SOAR(ABN) assets may insert, resupply, and extract U.S. SOF and other designated personnel. They provide forward air control for both U.S. and multinational close air support and indirect fire for SOF. The 160th SOAR(ABN) can provide terminal guidance for precision munitions in support of SOF. The 160th SOAR(ABN) conducts electronic and visual reconnaissance in support of SO. The 160th SOAR(ABN) performs CASEVAC, armed attacks, mine dispersing, and air messenger service in support of SO. The 160th SOAR(ABN) can support and facilitate medical command and control of the SO. The 160th SOAR(ABN) units can provide general aviation support to SOF when the use of other Army aviation assets is unavailable or unfeasible. However, the use of ARSOF aviation assets for these missions detracts from their primary mission of covert penetration into denied areas.

2-9. The special forces group (ABN) (SFG[ABN]) plans, conducts, and supports SO in any OE and across the operational continuum. All SF MOSs are managed as a combat arms career management field. Their primary skills and special expertise are operations and intelligence, light and heavy weapons, engineer, communications, and medical.

2-10. Special forces groups also maintain within their support base specific specialties that enhance their mission capabilities, such as logistics, signal, and limited numbers of AHS professionals. Special operations forces medical personnel include flight surgeons, aviation medicine PAs, dental officers, physical therapists, environmental science and engineer officers (ESEOs) and Medical Corps PVNTMED officers, veterinary officers, and MEDLOG personnel. Special operations forces have the capability to combine, at the lowest operational level, the functions performed by several conventional branches of the Army. Special operations forces commanders integrate and synchronize their organic capabilities with those of other SOF and operational assets.

2-11. Civil affairs personnel and units support both conventional forces and SOF conducting multidomain operations in support of the joint force in all environments across the competition continuum. They may conduct unilateral operations or work with other Army conventional forces, SOF, interagency, or host nation (HN) military and civilian authorities, as well as coordinate efforts with nongovernmental organizations. The medical assets within CA are not assigned clinical duties. They advise, evaluate, and coordinate public health resources and activities for advancing the medical support system available to the general public.

2-12. The Active Army psychological operations (PSYOP) groups conduct regionally focused influence using MISO and other information-related and influence capabilities in support of ARSOF. They provide limited contingency response capabilities supporting conventional forces until Reserve Component PSYOP groups are mobilized. Army SOF PSYOP conduct three primary missions: support to Department of Defense (DOD); interagency and intergovernmental support; and information support activities to civil authorities during domestic disasters. They have limited organic medical staffing and rely on the units they support for all medical requirements. Army SOF PSYOP are trained to provide TCCC, self-aid, buddy aid, and combat lifesaver skills.

2-13. The 528th SB(SO)(ABN) is responsible for providing USASOC medical support at the operational level of sustainment, utilizing a distribution management center, and technically supervising all logistics functions. The 528th SB(SO)(ABN) maintains a medical detachment, which consists of two sections capable of providing patient holding for up to ten patients each. Each patient hold section provides four intensive-critical care (ventilator capable) cots for postsurgical and seriously injured patients. The medical detachment also provides enhanced laboratory services and digital X-ray to each ten-cot section. Neither the 528th SB(SO)(ABN) nor the SFG(ABN) medical sections have any organic surgical capability.

MEDICAL CAPABILITIES OF ARMY SPECIAL OPERATIONS FORCES

2-14. The SFG(ABN) has the most robust AHS support structure of any ARSOF unit. Special forces groups and battalions are usually assigned physicians, PAs, a behavioral science officer, a dentist, an ESEO, a field veterinary service officer, medical noncommissioned officers (NCOs), and two animal care specialists MOS 68T. There are two SFMSs authorized per SFG operational detachment A. However, it is similar to other light units in that it is dependent upon theater AHS assets for timely evacuation and Role 2 support on an area basis.

2-15. The AHS structure in the Ranger Regiment, although not as robust as an SFG(ABN), is comparable to that of an ABN infantry brigade combat team. The primary difference between these two organizations is the lack of a brigade support medical company. In addition, Ranger units have organic SOCMs. The Ranger Regiment and its battalions are dependent upon theater assets for Role 2 and above medical care on an area support basis. The Ranger Regiment requires that every infantry squad maintain an infantryman MOS 11B trained and certified as an emergency medical technician-basic. All Rangers are qualified as Ranger first responders in their selection training or within six months of being assigned to a unit. Ranger first responders must complete yearly recertification.

2-16. Ranger units modify the battalion aid station concept into platoon-, company-, and battalion-level patient (casualty) collection points. Although designated as patient (casualty) collection points, these collection points are locations where emergency medical treatment certified squad personnel, SOCMs, PAs, physical therapists, and physicians render care before patients are evacuated. Ranger Regiment patient (casualty) collection points are often established as joint casualty collection points due to multiple Service elements that are often employed during Ranger operations. The joint casualty collection point manning is mission-dependent and typically requires augmentation. The Ranger Regiment does not have organic MEDEVAC assets and normally uses mission aircraft, such as logistical platforms, to CASEVAC patients to support bases. The Ranger Regiment does not have an organic brigade support battalion and depends heavily on augmentation and area support when placed in a conventional fight. The Ranger Regiment has a field veterinary services officer and two animal care specialists MOS 68T assigned to provide health service support and force health protection for multipurpose canines. The Ranger Regiment has an organic regimental support battalion that offers a support company to each maneuver battalion.

2-17. The 160th SOAR(ABN) is assigned flight surgeons, aviation medicine PAs, a clinical psychologist, and several SOCMs who are qualified as flight medics. However, like other light units, it is dependent upon the theater AHS assets for Role 2 and above support on an area support basis.

2-18. The 528th SB(SO)(ABN) is designed to provide operational, logistical, and signal planning for deployed ARSOF. For ARSOF, the SB has two Active Army and one Reserve Component medical detachments. Each is capable of providing Role 2 medical care when combined with the medical elements in the group support battalion. Role 2 ARSOF medical detachments similarly provide TCCC, including beginning resuscitation, and if necessary, additional emergency measures are instituted. To perform their AHS planning function, the 528th SB(SO)(ABN) has a medical planning cell composed of a command surgeon, two medical operations officers, a MEDLOG officer, a medical operations NCO, a PVNTMED NCO, a medical supply NCO, and a veterinary food inspection specialist. The ARSOF must rely on theater area or joint force support assets for large or sustained operations, and the 528th SB(SO)(ABN) provides the connectivity. The Role 2 MTF has the capability to provide blood products, as well as limited X-ray, medical laboratory, and dental support. Class VIII materiel is managed at the wholesale level in the 528th SB(SO)(ABN) by the medical operations branch. The medical operations branch provides MEDLOG commodity management of Class VIII and the medical maintenance within the 528th SB(SO)(ABN) and ARSOF, as applicable.

2-19. The SO signal battalion possesses limited organic AHS assets. Soldiers are trained as first responders and combat lifesavers during their training cycle. Every small team that deploys has individuals who can provide immediate lifesaving measures. However, the battalion relies upon the supported unit for almost all aspects of AHS support.

2-20. Army CA units have medical personnel assigned with the duties of providing advice, evaluation, and coordination of medical infrastructure, support, and systems issues in foreign countries. Particular emphasis is placed on operational public health services (sanitation and disease prevention), veterinary medicine, and prevention of zoonotic diseases. Therefore, CA units are dependent on the theater assets for most aspects of AHS support. As an exception, assigned SOCMs can provide limited AHS to members of the unit in some mission profiles; however, most AHS support is provided by assigned SOCAMS.

2-21. Army PSYOP units possess no organic AHS assets. They are entirely dependent on the force they are supporting for all operational and tactical AHS support.

MEDICAL PERSONNEL IN ARMY SPECIAL OPERATIONS FORCES

2-22. Army SOF units have medically trained personnel who provide Role 1 medical care to deployed forces. In addition, ARSOF medical personnel provide advice and training to the indigenous personnel and paramilitary organizations they are supporting. The roles and responsibilities of these medical personnel and the organizations to which they are assigned are discussed in the following paragraphs. Special operations forces have reduced organic patient holding capabilities when unit assets are combined with the 528th SB(SO)(ABN). Special operations forces are reliant upon the regional or combatant command theater infrastructure for AHS support above unit organic capabilities on an area support basis for complete Role 2 and above care.

2-23. The ARSOF surgeon, at all levels of command, is responsible for planning, coordinating, and synchronizing AHS functions and missions. This includes the necessary coordination to ensure AHS support is obtained from the theater-wide AHS when requirements exceed the organic capabilities of deployed ARSOF. The ARSOF surgeon duties and responsibilities may include, and are not limited to, determining requirements and providing medical control for the following:

- Requisition, procurement, storage, maintenance, distribution management, and documentation of MEDLOG.
- Assignment of ARSOF medical personnel.
- Financial management of resources allocated and expended for mission accomplishment.
- Planning transportation and MEDEVAC requirements in excess of organic capability.
- Planning with the AHS commanders, task force commanders, or other elements, units, and agencies for continuous AHS support.

- Submission of those recommendations on professional medical problems that require research and development to higher headquarters. (In developing nations, this responsibility takes on added significance as unfamiliar diseases are encountered.)
- Recommendations for the use of captured (or abandoned) Class VIII or locally available medical supplies in support of indigenous forces or other recipients.

2-24. The ARSOF surgeon also advises the combatant command on—

- Health of the command and indigenous forces supported.
- Army Health System resources available within the AO.
- Medical effects of the environment to include chemical, biological, radiological, and nuclear (CBRN) hazards as well as directed-energy weapons systems and devices on personnel and materiel including Class VIII materiel, rations, and water.
- Medical intelligence requirements and considerations.
  - Lethal targeting mitigation strategies to populace health effects.
  - Nonlethal targeting to further strategic and operational influence and to disrupt enemy influence, protect local populace, and contribute to operational preparation of the environment.
  - Contribution to medical and UW operational preparation of the environment.
  - Unified action partners medical common operational picture.
  - Local population assessment.
  - Local populace and HN medical common operational picture.
  - Enemy medical operational picture.
- Planning and coordination (both internally and externally).
  - Medical evacuation by U.S. Air Force or U.S. Navy resources; or resources from the civilian community, HN, and multinational resources.
  - Medical treatment, to include hospitalization in Role 3 MTFs established by other Services, multinational forces, or HN. This also includes MTFs afloat.
  - Dental services.
  - Veterinary food safety and defense inspection, quality assurance inspection, animal care, veterinary public health activities of the command, and global health engagement within the local community.
  - Operational public health services.
  - Medical laboratory services.
  - Foreign humanitarian assistance programs.
  - Behavioral health and COSC programs.
  - Army Health System assessments, estimates, and plans.
- Consideration of and planning for medical operations under CBRN conditions and the mitigation of CBRN effects.
- Medical network development for unified action partners, HN, and UW environments.
- Monitoring the three phases of TCCC.

2-25. The emphasis of the SFMS MOS 18D is UW expertise; they form the backbone of medical care within the SFG operational detachment A. The two SFMSs assigned to each SFG operational detachment A provide emergency and routine medical care for detachment members, associated multinational forces, or indigenous personnel, and local populations. They—

- Provide emergency dental and veterinary care.
- Train, advise, and direct detachment members, multinational forces, or indigenous personnel in routine, emergency, and operational public health, dental, and veterinary care.
- Establish field MTFs to support detachment operations.
- Prepare the medical portion of area studies, operation plans, and operation orders.
- Conduct health threat and counter threat briefings and lessons-learned briefings.

- Train, advise, and lead indigenous operating forces up to company-size.
- Assemble and maintain detachment medical equipment and supplies.
- Supervise routine and emergency medical activities in a field or in a UW environment.

2-26. Special forces medical sergeants certify biennially as emergency medical technician-paramedic through USASOC. The SFMSs receive additional intensive training in anatomy, physiology, laboratory procedures, pharmacology, nursing care, TCCC, combat trauma management (much greater in depth and scope than TCCC) dental care, operational public health, and veterinary medicine. They perform limited surgery, administer anesthetics (local and general), and perform surgical and operating room preparation. The SFMSs have expertise in hazardous material exposure life support procedures. When SFMSs receive sustainment training in an MTF, the scope of practice is delineated in AR 40-68.

2-27. The SOCMs MOS 68WW1 are trained to assess and manage combat trauma at a capability level equivalent to an emergency medical technician-paramedic. The emphasis of the SOCM MOS 68WW1 is trauma and traditional clinical medical expertise. To foster TCCC proficiency, the SOCMs maintain Army emergency medical technician-basic and emergency medical technician-paramedic certifications through biennial attendance at the SOCM Skills Sustainment Program. They concentrate on combat trauma management (much greater scope and breadth than standard TCCC), they ensure medical preparedness, and they assemble and maintain medical equipment sets and supplies. They are assigned to the Ranger Regiment and its battalions, the 528th SB(SO)(ABN), SOAR(ABN), and SOF CA units. The group support battalion at each SFG(ABN) contains three SOCMs by table of organization and equipment.

2-28. The SOCAMS MOS 38BW4 provides public health expertise. The SOCAMS is a SOCM with additional CA specific training. They—

- Provide emergency and routine medical care for team members and associated multinational or indigenous personnel, and provide emergency dental and veterinary care.
- Train, advise, and direct other team members, as well as multinational and indigenous personnel, in routine, emergency, operational public health, dental, and veterinary care.
- Prepare medical portions of area studies, operation plans, and operation orders.
- Conduct health threat, counter threat, and lessons-learned briefs.
- Assemble and maintain team medical equipment sets and supplies.
- Receive additional intensive training in anatomy, physiology, laboratory procedures, pharmacology, nursing care, TCCC, dental care, operational public health, and veterinary medicine.

2-29. The diving medical technicians are SFMSs with additional training to assess and manage diving-related injuries, such as decompression sickness; pulmonary overinflation injuries (including arterial gas embolism barotraumas); effects of breathing gases (such as oxygen toxicity, nitrogen narcosis, hypoxia, hypercarbia, and carbon monoxide poisoning); casualty extraction; transport and management; and AHS requirements for dive operations. In the absence of a diving medical officer, the diving medical technician is authorized to initiate recompression therapy in compliance with AR 611-75.

2-30. The regional support medic is a specifically trained MOS 18Ds, MOS 68WW1s, and MOS 38BW4s from the 1st Special Forces Command ABN enterprise who is capable of providing extended critical care, complex evacuation (physical and sociopolitical), MEDLOG (standard, nonstandard, and improvised), medical mission planning, CBRN, and managing telemedicine consult to deployed small teams. The regional support medic was developed to support unique SOF mission requirements and provide senior enlisted medical leadership.

2-31. The PVNTMED NCO MOS 68S assists the battalion SFMS and SOCAMS assigned to CA units in operations, to include immunization program administration, immunization database entry into the medical protection system, medical record maintenance, and CBRN expertise. The PVNTMED NCO formulates and recommends operational public health programs and courses of action designed to meet the needs identified through surveillance procedures and processes. The PVNTMED NCO assists in the implementation of operational public health programs and evaluation to ensure their effectiveness in maintaining the health of the command, physical fitness, and prevention of disease and nonbattle injury and recommends actions to correct shortfalls to the surgeon. These actions include training; ensuring field sanitation team supplies and

equipment are maintained at each company; collecting information of medical importance; providing operational public health sustainment training to SFMS; and deploying with operational detachments to provide operational public health support, if required. The PVNTMED NCO maintains liaison with medical personnel of other military Services, multinational military forces and civilian public health agencies, and the 528th SB(SO)(ABN). The PVNTMED NCO has the resources and training required to complete occupational and environmental health surveillance assessments and sampling.

2-32. The MOS 68T describes mission and capabilities similar to the description of the MOS 68S as it relates to ARSOF and SO operations. The animal care specialist is primarily responsible for the prevention and control of diseases transmitted from animal to man, as well as the comprehensive care for government-owned animals. They—

- Provide routine daily care for animals in veterinary treatment or research and development facilities.
- Perform physical examinations to detect obvious abnormalities and report findings to the veterinarian.
- Calculate doses and administer oral and topical medications as directed by the veterinarian.

2-33. The MEDLOG NCO MOS 68J performs or supervises the requisition, receipt, inventory management, storage, preservation, issue, salvage, destruction, stock control, quality control, property management, repair parts management, inspection, packing and shipping, care, segregation, and accounting of medical supplies and equipment. The MEDLOG NCO is trained to accomplish all aspects of acquiring, receiving, storing, controlling, issuing, and maintaining medical supplies and equipment. Under most circumstances, a separate logistics NCO would be assigned to accomplish each of the tasks listed above. In smaller conventional units with a medical mission and in all ARSOF units, the MEDLOG NCO will be responsible for performing all duties simultaneously. There are no SOF-unique MEDLOG NCOs trained in the aspects of SO, only conventional force MEDLOG NCOs adapted to support the SOF community. All MEDLOG NCOs must be prepared to assist and collaborate with other staff elements to meet the needs or advise on nonstandard logistics and delivery methods for UW, irregular warfare, and chief of mission requirements.

2-34. Medical Corps officers are advisors to the commander and staff for all matters affecting the behavioral and physical health of the battalion, its attached elements, and its supported indigenous force, and they are trainers for organic medical personnel. They examine, diagnose, and treat or prescribe courses of treatment for disease and nonbattle injury and provide TCCC for wounded Soldiers within the capability of the unit's medical element. They can augment the capabilities of the surgical specialties through triage, stabilization, and surgical assistance. In SOF battalions, the battalion surgeon is the primary medical staff officer and planner as there are no assigned Medical Service Corps officers. In UW operations, Medical Corps officers serve as leaders and advisors of the UW AHS support for indigenous personnel. Physician positions within SFG(ABN) and SOAR(ABN) units are designated as flight surgeons. They provide aviation and diving medicine for Army aviation, diving, and military free-fall personnel.

2-35. Physician assistants are commissioned officers trained and certified to practice primary or specialty medical care with significant autonomy. They focus on the management of illness and injury, disease prevention, and health promotion and may also provide minor surgery and wound care. A full description of their duties, responsibilities, and roles is outlined in AR 40-68. Each SF and Ranger battalion is authorized one PA. Duties include providing primary health care to all assigned personnel. They serve as the primary trainers for SFMS and other assigned medical personnel for sustainment training. They provide guidance on health threats, MEDLOG, and mission planning. They function as special staff officers in the absence of the battalion surgeon. A PA may also be trained as an aviation medicine PA or diving medical officer and may receive advanced training in tropical medicine. In the role of the aviation medicine PA, the PA's duties and responsibilities are similar to the flight surgeon with the exception of reinstating flight status.

2-36. Physical therapists are commissioned officers trained and certified to practice orthopedic and sports physical therapy. Each Ranger battalion and SFG(ABN) is authorized one physical therapist. Duties include primary care diagnosis and treatment of neuromusculoskeletal disorders and conditions to all assigned personnel and dependents. They can earn emergency medical technician-basic or intermediate certification and serve as secondary trainers for SOCM combat trauma management. They assist the surgeon and medical plans and operations officer in the provision of guidance on health threats, MEDLOG, and mission planning, and they function as special staff officers similar to the battalion surgeon and PA. They develop rehabilitation

programs, oversee regimental physical training programs at the battalion level, and provide physical therapy treatment in garrison and on deployment in both developed and austere AO. They also function as advisors for injury prevention, strength, and conditioning programs

2-37. The diving medical officer is a physician or PA who is a qualified military diver and has received advanced training in diving-related injuries and medical care. In addition, they are authorized to use recompression therapy to treat dive-related injuries and illnesses, as needed. Each SFG(ABN) usually has at least two diving medical officers (physicians or PAs). Each forward-deployed SF unit, battalion-size or larger, has one diving medical officer. Other USASOC units with active combat divers normally have at least one diving medical officer assigned.

2-38. The ESEO is a Medical Service Corps officer who is the principal advisor to the group or brigade surgeon and staff on all aspects of policies, programs, practices, and operations directed toward the prevention of disease, illness, and injury. The ESEOs possess the required CBRN expertise for their role as advisor to the organizational surgeon. They assist in executing the operational public health program in the areas of sanitary and public health sciences. The ESEO manages, supervises, advises, and performs professional and scientific work in PVNTMED or occupational and environmental health surveillance activities for the group, brigade, and SFG(ABN). These activities include inspections, investigations, and surveys to determine compliance with existing occupational and sanitation directives, regulations for living quarters, food service facilities, water and wastewater systems, refuse disposal facilities, bivouac areas, and other installations or facilities used by military personnel. They report the results of surveillance to the unit surgeon. The ESEO manages the medical intelligence program and its products, traditional medical intelligence aspects, and lethal targeting mitigation strategies to populace health, and nonlethal targeting to further strategic and operational influence. The ESEO also disrupts enemy influence, protects local population, and contributes to the operational preparation of the environment. The ESEO maintains liaison with representatives of civilian and governmental agencies concerning public health matters.

2-39. The MEDLOG officer is the principal advisor to the group and brigade surgeon and staff on all aspects of MEDLOG and medical equipment maintenance. As with the MEDLOG NCO, the MEDLOG officer must be prepared to assist and collaborate with other staff elements to meet the needs or advise on nonstandard logistics and delivery methods for UW, special reconnaissance, and chief of mission environments. This officer plans, advises, manages, coordinates, and administers the organization's MEDLOG operations.

2-40. The medical plans and operations officer is the principal advisor to SOF, Ranger Regiment, and CA surgeons and staff on all aspects of AHS planning, coordination, and liaison with conventional force medical planners, unified action partners, medical partners, and HN personnel. In addition, they prepare patient estimates, medical materiel consumption rates, medical intelligence, and lethal targeting mitigation strategies to populace health. They also conduct nonlethal targeting to further strategic and operational influence, disrupt enemy influence, protect local populace, and contribute to operational preparation of the environment and threat analysis. The medical plans and operations officer contributes to medical and UW operational preparation of the environment and maintains the medical common operating picture with unified action partners, the local populace, and HN. They seek to understand enemy medical operations.

2-41. The veterinarian is a Veterinary Corps officer and is the principal advisor to the group, brigade, CA brigade and battalions, and the 75th Ranger Regiment surgeon and staff for all matters relating to animal use, veterinary training, zoonotic diseases, foreign animal diseases, food safety and security inspection, and care of multipurpose canines. The veterinary officer is responsible for sustainment training of the SFMS, SOCMs, and SOCAMS in assessing and managing diseases of animals, food inspection, and food hygiene in support of assigned missions. The veterinarian works with indigenous military assets and multinational or foreign government agencies. They assist in planning and executing population and resource control, veterinary global health engagement, and other security development and stability programs. During military and paramilitary operations, the veterinarian assists in planning and executing civic action, foreign humanitarian assistance, and other programs designed to expand the HN government's legitimacy within contested areas. The veterinarian provides estimates and data on the resources essential to build an effective infrastructure for civil health and agricultural administration operations. In CA units, the veterinarian offers technical advice to the commander on issues of agricultural production systems, effects of large-scale cross-border livestock movements, veterinary services, effects from outbreaks of endemic and foreign animal disease control, and cooperation with nongovernmental organizations and international organizations.

2-42. The dental officer, a commissioned Dental Corps officer and trained dentist, is the principal advisor to the group and brigade surgeon and staff for all matters relating to dental health and deployability. The dental officer is responsible for sustainment training of the SFMSs in assessing and managing dental emergencies.

2-43. The ARSOF clinical psychologists apply psychological principles, theories, methods, and techniques in the assessment and selection of personnel for assignment to various positions within SOF. Special operations forces psychologists provide training, teaching, and education for personnel assigned to SOF. They provide consultation with commanders at all levels concerning the effects of COSC on SOF personnel, make recommendations concerning team composition or individual capabilities, and provide feedback concerning unit morale. The SOF psychologists deploy with SOF units to provide support to the operation, and during repatriation support, they can provide a key role in the rehabilitation of U.S. personnel who have been out from under U.S. control. This includes personnel detained by a hostile power, those who have been isolated from U.S. support, and those who have successfully evaded capture. Special operations forces psychologists are trained to provide crisis negotiation support in the form of psychological assistance to a negotiation team and can function in the role of a negotiator. In intelligence consultation or target analysis, the SOF psychologists gather information, use psychological expertise to analyze that information, and then produce behavioral intelligence evaluations. The SOF psychologist can provide support to the interrogation process. Command consultation includes providing recommendations to the chain of command on issues involving the psychological health of the command or any other issues the command deems appropriate. In the area of casualty care, SOF psychologists are trained to provide behavioral health support in crisis situations and under operational conditions. They may also assist medical or surgical teams as requested. Special operations forces psychologists provide limited clinical psychology support to SOF personnel and units while in garrison. Research projects conducted by SOF psychologists are designed to enhance the combat effectiveness of SOF personnel and their units through continuous evaluation of their selection and assessment, professional development, and training programs. Currently, SOF psychologists are assigned throughout the USASOC. The SOF psychology consultant is the Director, Psychological Applications Directorate, USASOC, and functions as a special staff officer to the USASOC commander.

2-44. Operational psychologists provide behavioral science consultation to assist decision makers in understanding, developing, and influencing an individual, group, or organization to accomplish tactical, operational, or strategic objectives. Operational psychologists serve as the command's subject matter expert on human factors and human performance capabilities. Capabilities include—

- Assessment and selection.
- Personnel recovery.
- Partner nation support.
- Operational evaluations.
- Influence and persuasion.
- Performance enhancement.
- Clinical consultation.
- Crisis management.
- Preventive behavioral health.

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Chapter 3

Army Health System Functions in Support of Army Special Operations Forces

Army SOF have limited organic medical resources and are dependent on joint operations area medical units for the majority of their Military Health System and AHS support. To ensure the ARSOF receive comprehensive and timely AHS support, organic and supporting medical planners must determine AHS requirements based on the ten medical functions. Conventional force AHS planners, in coordination with ARSOF planners, determine what support organic assets provide and what support the joint operations area medical assets provide. Early coordination and communication are key to success for AHS support to ARSOF operations.

MEDICAL EVACUATION

3-1. The theater evacuation policy is established by the Secretary of Defense with the input of the Joint Chiefs of Staff and the recommendation of the combatant commander. The joint operations area evacuation policy is driven in large part by the types of forces used in the operation, robustness of AHS assets, and operational considerations of the employment. Though guided by the evacuation policy, the actual selection of a patient for evacuation is based on clinical judgment as to the patient's ability to tolerate and survive the movement to the next role of care. Due to the critical skills, training, and experience ARSOF personnel possess, an exception to the joint operations area evacuation policy may be required to retain ARSOF personnel within the AO for longer periods of time. If the appropriate medical specialties and care are available within the joint operations area and retention will not compromise the Soldier's health, the ARSOF commander may then request an exception to the evacuation policy.

3-2. Medical evacuation consists of the provision of en route care by medical personnel on dedicated, equipped, and properly marked ambulances. Medical evacuation also provides for the emergency movement of medical personnel and resupply of medical supplies. Patients are evacuated from the lower role of care by the higher role of care. Due to the limited assets and AOs (austere, hostile, or denied) in which ARSOF are deployed, the use of dedicated MEDEVAC assets may not be possible. The ARSOF medical planner must integrate the use of nonmedical, nonstandard evacuation assets into the MEDEVAC plan. To accomplish the MEDEVAC mission in hostile or denied areas, operational security dictates that the mission airframes used for the extraction of the force are used to transport patients. The ARSOF medical planner must plan for and designate extraction airframes for evacuation. These airframes are always manned with mission medical personnel. The airframes are sometimes augmented with nonmission medical personnel to manage patients during long evacuation legs or after extended operations where the mission medical personnel will not be physically or mentally ready to manage patients.

3-3. Considerations for MEDEVAC include—

- Organic capability.
- Army SOF and their associated in-theater and area command's ability to meet evacuation needs via all available assets to a higher role of care or a more permissive location.
- All MEDEVAC missions require concise planning and coordination between ARSOF and all associated unified action partner MEDEVAC assets from point to point and at all stops until MEDEVAC mission completion.
- Civilian and operationally developed enablers provide nonstandard means for ARSOF units and commands to develop systems within and beyond the OE.

- Overt-mechanisms used to accomplish evacuation without regard to protecting the mechanism or its affiliation with our forces, such as contracted evacuation, nongovernmental organizations, and partnered forces.
- Clandestine-mechanism used for evacuation in which our forces cannot have the mechanism or affiliation with our forces, such as smugglers or underground resistance forces. Not all potential assets are known prior to or outside of an operation.
- Interagency—utilizing other U.S. Governmental agencies' mechanisms, both overtly and clandestinely, to meet evacuation needs to a higher role of care or a more permissive location.
- Joint theater—traditional joint health service support evacuation mechanisms to higher roles of care.
- Interplay of the above, ARSOF will need to integrate MEDEVAC considerations into a feasible system to meet the operational needs both overtly and clandestinely; this is especially true in denied, near-peer, peer, and low visibility environments.
- A feasible and operationally relevant evacuation mechanism will often incorporate multiple elements. This is considered a passage of lines; some mechanisms will require operational compartmentalization from one another.
- Extensive coordination and planning required of operational forces and various commands to ensure options are available when needed while protecting the security of operational forces and mechanisms used.
- Request for support for and champion mission authorities and capabilities from various sources. The various mechanisms have differing and very specific authorities for crossing legal or sovereign nation boundaries. The ARSOF and AHS must proactively pursue and advise relevant authorities.

3-4. *Casualty evacuation* is the movement of casualties aboard nonmedical vehicles or aircraft without en route medical care (ATP 4-02.13). Special operations forces use modified evacuation equipment or purpose-built specialized equipment to meet their mission profiles. The TCCC CASEVAC set facilitates rescue, recovery, treatment, and evacuation of casualties. More specifically, its Transportation and Sustainment Kits are intended to treat 1-2 patients over prolonged periods in an austere environment and evacuate them through any means of transportation. The target audience and end-users are MOS 18D, MOS 68JWW1, and MOS 68WW4 (all paramedic trained medics). The ability to provide care en route is limited to the equipment carried by the individual providing the care, and when possible, medically trained Soldiers should accompany the casualty. Casualty evacuation for ARSOF may be accomplished using a wide variety of transport options. The nature of the operation and the environment in which it is conducted will influence the evacuation option used. The challenge for the conventional planner and ARSOF medical planners is to ensure a viable CASEVAC plan is embedded during the mission-planning phase and is thoroughly coordinated. On those missions that are covert in nature and require the infiltration and exfiltration of ARSOF, the exfiltration platforms are normally those used to extract patients.

3-5. Medical regulating entails identifying patients awaiting evacuation to the next role of medical care. Medical regulating provides the system for coordinating and controlling the movement of patients through the various roles of medical care and includes the functions of patient reporting and accountability. The formal system of medical regulating does not begin until the patient is admitted to a Role 3 MTF. Operational security for ARSOF units may require separate reporting and accountability methods. Patient tracking of SOF personnel is difficult due to low numbers, wide dispersion, and multiple points of entry into the AHS. One method the USASOC (Assistant Chief of Staff [Personnel]) has favored is keeping positive control on ARSOF patients with liaison NCOs at Role 3 and Role 4 MTFs.

MEDICAL TREATMENT (ORGANIC AND AREA SUPPORT)

3-6. Medical treatment consists of those measures necessary to recover, resuscitate, stabilize, and prepare the casualty for evacuation. It also includes routine sick call and care of minor illness or injury. For those units who do not have organic Role 1 and Role 2 capabilities, medical treatment is provided on an area support basis. An ARSOF entry into immature joint operations areas causes unique challenges for medical coverage. Planning considerations for area medical support of ARSOF must include the unique capabilities

of ARSOF health care providers and their distribution within different ARSOF units. Refer to chapter 2 of this publication for more information.

3-7. Sick call provides the daily care for routine minor illnesses and injuries. Symptomatic care of viral upper respiratory disease, minor trauma from physical training or day-to-day base operations, and administration of routine vaccinations typify this care. The SFMS is trained to provide care independent of immediate technical supervision from a physician or PA. The SFMS abilities to care for routine minor illnesses and injuries provide SF units with sick call capability. The SOCM must be supervised by a physician or PA. In addition, the SOCM may be supervised by a physical therapist for neuromusculoskeletal conditions. Therefore, Ranger and SO aviation units require sick call support from their organic physicians and PAs or from the supporting joint operations area MTF.

3-8. The SFMS provides TCCC combat trauma management and critical care for operational casualties in a deliberately planned prolonged care environment. This includes many Role 2 responsibilities for partnered forces and the HN for operational casualties. This does not include resuscitative surgery. The SFMS is highly trained in the management of combat trauma. The mission profile of SF units places Soldiers at a greater time and distance from resuscitative surgical care capabilities than conventional Soldiers. The TCCC skills of the SFMS enhance the survival of wounded Soldiers in these mission profiles. The SOCMs are used in combat environments where resuscitative surgery is more rapidly accessible than the small unit missions of SF. Physicians and PAs assigned to SOCM units are trained and equipped to provide TCCC. Army Health System support mission planning is vital where the risk of combat penetrating trauma is high and both the time and distance to resuscitative surgery is long. The SOCAMS is placed in smaller elements than SFMS and is frequently the only medical care provider for both the team and partner nation personnel in remote locations, often without direct SF support. The SOCAMS is operating in environments where resuscitative surgery is not readily available. Operations plans and orders must ensure the presence of the medical skills to perform invasive stabilization, regardless of the ARSOF unit involved.

3-9. The forward resuscitative and surgical detachment (FRSD) provides the personnel and equipment needed to perform far forward damage control resuscitative and surgical capability. It does not imply that they possess definitive surgical wound care capability. Forward positioned ARSOF elements do not possess an organic resuscitative surgical capability. This capability must be provided by the joint operations area regional or combatant command for AHS support to any ARSOF unit requiring this type of lifesaving intervention.

3-10. Forward surgical team employments have been used during Operation Enduring Freedom and Operation New Dawn. One may look to both operations for examples of the lessons learned from the employment of these teams in an OE. One of the recurring lessons learned from Operation Enduring Freedom and Operation New Dawn is the need to use unconventional approaches in planning and the use of capabilities to provide Role 2 plus resuscitative care for Soldiers. Lessons learned from World War II, Korea, and Vietnam provide perspective on near-peer and peer OEs to gain insight for surgical operational capability placement on the battlefield. These lessons learned will also apply to how large-scale combat operations will remove U.S. advantages, leaving the OE resembling earlier wars of large-scale combat operations where U.S. forces were in danger of becoming operationally ineffective.

3-11. If the ARSOF surgeon and medical planner recommend options for nonstandard use of the FRSD, they should ensure medical company-like support is present to tie in with the FRSD. This support may be derived from the organic Role 1 abilities of the SOF battalions, SOF groups or regimental support battalions, and 528th SB(SO)(ABN) provided all the critical issues of sustainment, power supply, resupply, and personnel manning are addressed and coordinated. Expeditious evacuation is and will continue to be a joint operations area supported requirement.

HOSPITALIZATION

3-12. Hospitalization is provided by Role 3 MTFs staffed and equipped to provide care for all classes of patients. The ARSOF has no organic Role 3 hospitalization assets. Although the enhanced skills of the SFMS permit patients to be held on a short-term basis, this constitutes a hold capability and not a hospitalization capability. Some of this very limited and austere capability may come from the 528th SB(SO)(ABN).

3-13. For nutrition care support, registered dieticians can provide nutritional advice, perform indigenous population assessments, and coordinate mass treatment and supply plans.

3-14. Role 4 hospitalization provides both medical continuity and the highest level of medical care available. Role 4 hospitalization is located at continental United States-based hospitals and other safe havens (to include robust overseas MTFs). As the Combat Support Agency, the Defense Health Agency manages Role 4 military hospitals in and outside the continental United States.

MEDICAL LOGISTICS

3-15. Class VIII encompasses the management of medical supplies and equipment, medical equipment maintenance and repair support, optical fabrication repair, patient movement items, medical gases, regulated medical waste, health facilities and infrastructure, medical contracting, and blood and blood products. Class VIII support is managed through the MEDLOG system. The ARSOF use the conventional forces MEDLOG system to satisfy its requirements.

3-16. The austerity of SOF MEDLOG is due in part to long supply lines, limited storage, and transportation assets available to SOF. Numerous support requests to locations worldwide create challenges for MEDLOG support to the ARSOF. Support to local nationals and to friendly armed forces is an additional challenge SOF must meet often in austere circumstances. The SFMS is trained in blood typing and crossmatching procedures; however, except in extremely unusual circumstances (such as UW), the use of blood in the management of trauma injuries occurs at Role 2 and above.

VETERINARY SERVICES

3-17. The Army Veterinary Services under the direction of the Secretary of the Army and delegated to the Army Surgeon General is the sole provider for veterinary services.

3-18. According to DODD 6400.04E, the Army Surgeon General has also been delegated to act on behalf of the DOD Executive Agent for the DOD Veterinary Public and Animal Health Services. The Army Veterinary Services mission is to—

- Ensure the food safety, defense, and quality assurance of food sources and storage areas to ensure wholesome food supply for deployed forces.
- Provide Veterinary Role 1 through Role 3 medical and resuscitative surgical care for military or contract working dogs and other government-owned animals, such as equids or U.S. Navy marine mammals.
- Provide Veterinary Role 3 comprehensive canine medical and surgical care for military and DOD contract working dogs and for veterinary public health missions.
- Reduce transmission of zoonotic disease threats to deployed forces through surveillance and investigations of zoonotic disease or food and waterborne illness as well as mitigate the impact of animal diseases of operational importance to working animals or agricultural systems within the continental United States.
- Support to civil-military operations.

DENTAL SERVICES

3-19. Dental support is designed to provide operational care to avoid the loss of trained manpower from dental disease or injury. Army SO dental organizational tables of organization and equipment are by necessity limited in personnel and equipment.

3-20. The ARSOF and conventional applications are similar. For ARSOF, the scope of treatment may also include indigenous personnel.

COMBAT AND OPERATIONAL STRESS CONTROL

3-21. The ARSOF has a limited organic COSC capability. This is based on personnel assets in ARSOF organizations, and the ARSOF relies in great part on area medical support assets.

3-22. Depending upon security requirements, COSC support to traumatic event management is provided on an area support basis by assets within the AO. This support is often limited by geographic and operational requirements. Coordination and assessment are crucial.

MEDICAL LABORATORY SERVICES

3-23. Medical laboratory support consists of limited facilities, equipment, and personnel needed to analyze body tissues and fluids to assist in disease diagnosis and monitoring of therapy. Army SOF laboratory support is based on medical organizational tables of organization and equipment, and the necessity for ARSOF small medical footprint limits robust capabilities.

3-24. The SFMS is highly trained in procedures, such as microscopy and utilizing point-of-care diagnostic analyzers that enhance their ability to assess illness and injury. Army SOF has very limited organic laboratory capability.

MEDICAL COMMAND AND CONTROL

3-25. There are no medical command and control structures within ARSOF. Medical staff provide estimates and recommendations to the commander and staff.

3-26. The command and control of AHS assets within ARSOF remains with the ARSOF commander. All decisions concerning AHS support by ARSOF medical assets concerning deployment are made by the ARSOF commander.

OPERATIONAL PUBLIC HEALTH

3-27. Operational public health encompasses those activities geared toward preventing or reducing the incidence of disease and nonbattle injury. Since ARSOF personnel are deployed into areas where the presence of endemic and epidemic diseases is high, where basic sanitation facilities and practices may not exist, where PVNTMED and veterinary Services personnel may not be readily available, and where environmental conditions may be adverse, these Soldiers are at a higher disease and nonbattle injury risk. Since few PVNTMED and veterinary Service personnel will be available during ARSOF operations, greater emphasis must be placed on the training and equipping of ARSOF personnel in small unit and individual operational public health knowledge, skills, and capabilities. In ARSOF units, operational public health programs are actively pursued, and command emphasis is placed on training in operational public health measures. The application of operational public health measures is the same for ARSOF and conventional forces. The ARSOF operational public health support requirements exceed its organic capability. Operational public health support is provided on an area support basis from joint operations area AHS assets. Significant medical information is collected by operational public health planners in coordination with the intelligence officer or NCO to support the intelligence preparation of the battlefield process. They can be a good source of information regarding the health threat in the AO.

3-28. Operational public health is critical for the success of ARSOF operations. Operational public health promotes the well-being of both ARSOF operators and the indigenous populace. For more information, refer to AR 40-5.

CONVENTIONAL VERSUS SPECIAL OPERATIONS FORCES ARMY HEALTH SYSTEM SUPPORT

3-29. The unique organization of ARSOF units, the diversity of missions (often covert or clandestine in nature), and the limited number of assets (personnel and equipment) dictate the differences between AHS for conventional and ARSOF units. The unique mission profiles of ARSOF require emphasis on operational public health in light of the OE in the ARSOF AO.

3-30. The absence of PVNTMED personnel in ARSOF teams and small units means ARSOF commanders, leaders, and individuals must possess greater operational public health knowledge, skills, and capabilities than their conventional forces counterparts. Therefore, the importance of operational public health activities cannot be overstated. Throughout history, more combat ineffectiveness is caused by disease and nonbattle

injury than from operational injuries. Due to the ARSOFs employment in isolated areas of developing countries, proper hygiene, sanitation (clean water and proper waste disposal), disease and nonbattle injury protection, and personal protective measures are especially critical factors in ARSOF planning considerations. Army SOF Soldiers are frequently exposed to endemic and epidemic diseases, disease vectors, poisonous plants, and wild animals. It is vital that SOF Soldiers are up to date on their immunizations well in advance of any deployment; ARSOF policy may require additional chemoprophylaxis and immunizations.

3-31. Chemical, biological, radiological, and nuclear occupational and environmental hazards also may cause acute or chronic health effects to SOF Soldiers. Required predeployment and postdeployment medical surveillance forms will provide a record of potentially hazardous exposures to the Soldiers and add to the medical information for the AO. However, health impacts may not be attributed to the initial exposure unless a mechanism for tracking, reporting, and utilizing environmental surveillance data is in place. The ARSOF, therefore, require support from public health assets (above their organic capabilities) from the theater.

3-32. To better identify and document occupational and environmental hazards and associated health or operational risks, environmental surveillance samples may be collected and forwarded back to operational public health laboratories, such as the United States Army Public Health Center, for evaluation. The United States Army Public Health Center maintains a classified capability for management of the samples and the resulting data. Data can be analyzed by the United States Army Public Health Center and then channeled back to ARSOF to assist in determining health threats for current and future operations. This post-mission health threat analysis provides an important benefit to current and future missions.

3-33. It is paramount for operational units to be able to provide operational public health for partnered forces and local populations for mission needs, white-space, and security development, to extend operational influence, and to generate good will (operational quid pro quo). It is understood that providing operational public health for partnered forces and local populations has affirmative effects for the health of ARSOFs operating in the area.

Small Units and Austere Army Health System Capability

3-34. Special operations forces are often deployed in small units. Consequently, it is not possible to assign dedicated evacuation and area medical support assets to every ARSOF unit.

3-35. Army SOF possess reduced organic AHS assets capable of providing Role 2 medical care and enhanced medical capabilities or higher. Therefore, ARSOF may require AHS support on an area basis for some Role 1, Role 2, and Role 3 medical care and evacuation to Role 4 MTF in the continental United States or other safe haven based outside the continental United States.

Operations with Partner Nations

3-36. The United States acts unilaterally on its national interests. However, the U.S. military prefers to pursue national security interests through international efforts, such as multinational force operations with partner nations. Multinational operations occur within the structure of an alliance or a coalition. Each partner brings their own medical capabilities and specialties for their own forces when conducting SOF missions. Understanding multinational medical support capabilities and acceptance of these capabilities by mutual agreements will benefit the SOF units operating within the OE. Collaboration with multinational partners will lend to working together as partners and not just alongside partners (FM 3-16).

3-37. Operations in these environments require officers and NCOs to have a thorough knowledge of other Services and multinational forces medical capabilities, limitations, organizations, and procedures. Army SOF missions are primarily conducted with unified action partners. Support is requested by mission authorities with capabilities provided by appropriate sources.

3-38. The various operational mechanisms have differing and very specific authorities, to include crossing legal or sovereign national boundaries. The ARSOF and supporting forces must proactively engage and advise the combatant commander, theater SO command, and chief of mission authorities to enable missions.

REMOTE OPERATING AREAS AND LONG EVACUATION LEG

3-39. Remote operating areas and lengthy evacuation legs provide additional challenges for evacuation. Many small ARSOF units operate at a long distance from airfields suitable for evacuation. The ARSOF units must often operate in areas that impede evacuation by rotary-wing aircraft or where aviation assets are not available from U.S., multinational, or HN assets.

3-40. Remote operating areas and long evacuation legs place a premium on the early application of TCCC skills to stabilize the patient for what may be a prolonged period of evacuation. Remote evacuation cannot rely solely upon air platforms. They must consider integration of multiple modes and sources into a feasible system to meet the operational needs both overtly and clandestinely, while also considering mission needs for partnered forces and key local populace. Planners should consider incorporating allied partners and maritime resources to mitigate long evacuation distances. For continuing evacuation, planners should consider crossing international boundaries versus using a sea platform as a "lily pad."

MEDICAL EVACUATION, MEDICAL REGULATING, AND PATIENT TRACKING

3-41. The function of medical regulating and patient tracking requires an understanding of the nature of potential ARSOF missions and the limited ability of the personnel replacement system to provide replacements. Listing names or units of evacuated Soldiers can compromise classified missions. Sensitive equipment or documents must be accounted for if the Soldier is still in possession of them when evacuated.

3-42. Army SOF Soldiers represent a substantial investment in training time and money. Rapid replacements may not be available. Army SOF Soldiers may require exceptions to joint operations area evacuation policies (length of time for recovery within the AO) if they can recover from their illness or injuries within the capability of the joint operations area medical care assets.

INCREASED THREATS FROM GROUND FIRE, AIR DEFENSE ARTILLERY, AND LACK OF AIR SUPERIORITY

3-43. Army SOF often deploy into tactical situations that are more vulnerable to hostile air defense artillery and enemy aircraft because many ARSOF mission profiles dictate employment far forward before air superiority is established, if it can be established. As a result, evacuation requires airframes of opportunity that can provide movement of patients as well as an armed escort.

3-44. When possible, prior planning should be made to place a medically trained Soldier on the aircraft to provide en route medical care. Furthermore, isolated wounded personnel usually require manual evacuation over extended distances to an area suitable for pickup by air or ground assets. Therefore, it is necessary to plan for delays in ground movement associated with manual evacuation.

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Chapter 4

Planning Army Health System Support to Army Special Operations Forces

The AHS mission is fundamentally the same for either conventional forces or ARSOF. The AHS planning process involving mission requirements, commander's intent, wargaming, development of multiple courses of action, use of the military decision-making process, rehearsal, implementation, and operational tracking is the same for both conventional forces and ARSOF. Since the ARSOF have limited organic medical resources, they will be dependent on the joint operations area medical units for much of their Military Health System and AHS support. Both conventional and ARSOF medical planners must ensure the AHS plan is coordinated and rehearsed to facilitate mission accomplishment. Refer to ADP 5-0 and ADP 6-0 for more information.

HEALTH THREAT

4-1. The health threat is a composite of ongoing and potential enemy actions. These include adverse environmental, occupational, and geographic and meteorological conditions; endemic diseases; and employment of CBRN weapons (to include weapons of mass destruction) that could reduce the effectiveness of friendly forces.

4-2. These actions and conditions also include wounds, injuries, diseases, and psychological stressors. Information to assess the health threat caused by enemy actions should be obtained from intelligence sources. Therefore, the health threat and operational considerations dictate the planning, preparation, and subsequent execution phases of the mission to include appropriate personnel protective measures to counter the health threat.

ARMY SPECIAL OPERATIONS FORCES PLANNING FOR ARMY HEALTH SYSTEM SUPPORT

4-3. The type of mission to be supported often dictates what specific medical functions and services are required. Although the likelihood may exist that some functions will not be required for the primary mission, it is prudent to plan for support in the event it is needed.

4-4. The AHS support planning for SOF assets involves numerous considerations that do not normally apply to conventional forces. Indeed, SOF units and personnel often operate over a wide area and in very isolated and austere locations. Conventional AHS units are normally unable to provide direct support to deployed SOF units. Support to ARSOF is provided on an as-needed basis and must be flexible to provide the required support when and where needed.

4-5. Since ARSOF Soldiers cannot be readily replaced, an exception to the theater evacuation policy may be required to ensure SOF personnel with critical skills remain in the AO. If a SOF patient can recover within the AHS capabilities available in the joint operations area without detriment to the patient's health, an exception may be required to allow for a longer convalescent period within the AO. For example, physical therapists are highly trained in the treatment of neuromusculoskeletal injuries, and this allows SOF personnel to convalesce in the AO for longer periods of time.

4-6. The supporting medical unit's medical command and control headquarters must be able to establish communications links to the theater SO command. The theater SO command has robust communications capabilities ranging from single channel radios to multichannel satellite transmission systems that provide

video teleconferencing; secure voice and data; and more advanced capabilities not listed in this publication. Deployed ARSOF will have multiple communications systems as well. Medical units will establish contact and coordinate AHS support requirements to ensure they can communicate with the units they are required to support. Establishing a primary, alternate, contingency, emergency (also known as PACE) plan is a key requirement for operations in a contested environment. The plan provides prioritized options for redundant means of communication to ensure effective command and control and interoperability:

- Primary—the best, and intended, method of communications.
- Alternate—another common, but perhaps less optimal, method.
- Contingency—method may not be as fast, convenient, or reliable, but it can still accomplish the task.
- Emergency—communications method of last resort. Emergency methods may cause delays or otherwise affect operations. (See FM 6-02 for more information regarding primary, alternate, contingency, emergency plan.)

4-7. The AHS support plan is normally part of Appendix 3 (Health Service Support) of Annex F (Sustainment) and Appendix 9 (Force Health Protection) of Annex E (Protection) to the corps or division operation order or plan. It must be in sufficient detail to designate specific area support responsibilities for all medical support to ARSOF units. This level of detail in the AHS appendix of the operation plan and operation order ensures all medical function capabilities within the supporting medical units are available for support of SOF personnel when required. Regardless of the type of operation to be conducted, the medical planner must consider all medical functions discussed in FM 4-02 when developing the AHS plan.

4-8. Due to the clandestine and covert nature of some ARSOF operations, direct support from conventional medical units within the AO may not be feasible during operations. However, if support is required for SOF units and personnel following the completion of the mission, AO medical units will provide AHS support on an area basis to assigned and attached SOF elements. To ensure this support will be available, the ARSOF medical planner must develop a comprehensive plan and thoroughly coordinate and update the plan with the supporting medical command and control headquarters. In ARSOF operations where medical units are not available in the AO, tasking for specific AHS support requirements and capabilities are critical for adequate AHS support.

Note. Casualty evacuation is not a medical mission. It is the responsibility of the SOF unit commander. When in hostile or denied areas, MEDEVAC assets are not deployed in support of this operation. Once the SOF personnel are extracted from the hostile or denied territory, MEDEVAC assets can be coordinated for support.

DIRECT ACTION

4-9. Direct action missions are short duration strikes that can be executed by both small units and elements in deployments, such as an SFG operational detachment A, or by forces in a company-size or larger contingent. Initial evacuation for SOF casualties may require CASEVAC depending on the threat and the location of the casualties.

4-10. Medical evacuation vehicles are normally used when the ARSOF are no longer in hostile or denied territory. Although these operations are of a short duration, the ARSOF planner must consider all AHS functions to ensure services are available should the operation be prolonged or the forces transition to other missions. Table 4-1, on pages 4-3 and 4-4, depicts organic and joint operations area AHS support requirements for direct action missions. The ARSOF AHS support requirements may include—

- Organic support required includes operational public health, sick call services, and CASEVAC capabilities.
- Joint operations area support required includes MEDEVAC and medical regulating, TCCC resuscitative surgery, hospitalization, and MEDLOG and blood support (human and canine blood).
- Support required after mission completion includes dental, COSC, medical laboratory, and veterinary services.

Table 4-1. Army Health System support requirements for direct action activities

Function	*Mission requirement*	*Justification*	*Provided by*
MEDEVAC and medical regulating			
• CASEVAC	Required (organic).	Extraction of casualties/patients from hostile or denied areas.	ARSOF airframes.
• MEDEVAC	Required (theater).	Continue evacuation within or from the theater.	Theater assets.
• Medical regulating	Required (theater).	Regulate patients within or from theater hospitals.	Theater assets.
Medical treatment			
• Sick call	Required (organic).	Care of minor illness or injury.	SFMS, SOCAMS, SOCMs, physician, PA, or PT.
• TCCC	Required (theater).	Manage combat trauma.	Theater assets.
• Resuscitative surgery	Required (theater).	Emergency surgical stabilization for further evacuation.	FRSD collocated with maneuver BSMC.
Hospitalization	Required (theater).	Provide essential care and services.	Theater assets.
Medical logistics and blood management	Required (theater).	Resupply of medical equipment and Class VIII supplies not anticipated. Trauma injuries dictate additional blood support for SOF medical providers and supporting surgical teams.	Theater, echelon above brigade, and maneuver assets.
Operational public health	Required (organic).	Identify health threats and recommend PPM.	SFMS, SOCAMS physician, or PA.
Veterinary	Minimal (theater).	Class I inspection or animal care-related support.	Theater assets.
Dental	Minimal (theater).	Provide operational dental care (emergency and essential).	SFMS, physician, or PA for emergency care (theater assets for operative dental care and maxillofacial surgery).
Combat and operational stress control	Minimal (theater).	Short duration operation. Support may be required for TEM upon completion of the operation.	Theater assets.

Table 4-1. Army Health System support requirements for direct action activities (continued)

Function	*Mission requirement*	*Justification*	*Provided by*
Medical laboratory services	Minimal (theater).	Used for field or theater confirmatory identification of CB agent samples collected during the mission. This support could be provided by theater assets such as the AML.	Theater assets.

LEGEND:

AML	area medical laboratory	PPM	personnel protective measures
ARSOF	Army special operations forces	PT	physical therapist
BSMC	brigade support medical company	SFMS	special forces medical sergeant
CASEVAC	casualty evacuation	SOCAMS	special operations civil affairs medical sergeant
CB	chemical-biological	SOCM	special operations combat medic
FRSD	forward resuscitative and surgical detachment	SOF	special operations forces
MEDEVAC	medical evacuation	TCCC	tactical combat casualty care
PA	physician assistant	TEM	traumatic event management

SPECIAL RECONNAISSANCE

4-11. Like direct action, special reconnaissance requires availability of AHS support for Soldiers operationally engaged in hostile, denied, or politically sensitive reconnaissance and surveillance actions. Longer mission duration places more emphasis on operational public health. Table 4-2 depicts organic and joint operations area AHS support requirements for special reconnaissance operations. The ARSOF AHS support requirements may include—

- Organic support includes CASEVAC, sick call services, and operational public health.
- Joint operations area support includes MEDEVAC and medical regulating, TCCC, resuscitative surgery, hospitalization, MEDLOG, and blood management.
- Minimal support includes veterinary, dental, COSC, and medical laboratory services.

Table 4-2. Army Health System support requirements for special reconnaissance activities

Function	*Mission requirement*	*Justification*	*Provided by*
MEDEVAC and medical regulating			
• CASEVAC	Required (organic).	Extraction of casualties/patients from the point of injury to casualty collection point, forward operating base, or nearest MTF.	Available platforms.
• MEDEVAC (not in hostile or denied territory)	Required (theater).	MEDEVAC of patient from the point of injury, casualty collection point, or forward operating base to the nearest MTF.	Theater assets.
• Medical regulating	Required (theater).	Regulate patients within or from theater hospitals.	Theater assets.
Medical treatment			
• Sick call	Required (organic).	Care of minor illness or injury.	SFMS, SOCAMS, SOCMs, physician, PA, or PT.

Table 4-2. Army Health System support requirements for special reconnaissance activities (continued)

Function	*Mission requirement*	*Justification*	*Provided by*
• TCCC	Required (theater).	Manage combat trauma.	Theater assets.
• Resuscitative surgery	Required (theater).	Emergency surgical stabilization for further evacuation.	FRSD collocated with maneuver BSMC.
Hospitalization	Required (theater).	Provide essential care and services.	Theater assets.
MEDLOG and blood management	Required (theater).	Resupply of medical equipment and Class VIII supplies not anticipated. Trauma injuries dictate additional blood support for SOF medical providers and supporting surgical teams.	Theater assets (MEDLOG company and blood support detachment).
Operational public health	Required (organic).	Identify health threats and recommend PMM.	SFMS, physician, or PA.
Veterinary	Minimal (theater).	Class I rations inspection or animal care-related support.	Theater assets.
Dental	Minimal (theater).	Provide operational dental care (emergency and essential).	SFMS, physician, or PA for emergency care (theater assets for operative dental care and oral surgical).
Combat and operational stress control	Minimal (theater).	Short to moderate duration operation. Support may be required for TEM upon completion.	Theater assets.
Medical laboratory services	Minimal (theater).	Used for field or theater confirmatory identification of CB agent samples collected during the mission. This support could be provided by theater assets such as the AML.	Theater assets.

LEGEND:

AML	area medical laboratory	PMM	preventive medicine measures
BSMC	brigade support medical company	PT	physical therapist
CASEVAC	casualty evacuation	SFMS	special forces medical sergeant
CB	chemical-biological	SOCAMS	special operations civil affairs medical sergeant
FRSD	forward resuscitative and surgical detachment	SOCM	special operations combat medic
MEDEVAC	medical evacuation	SOF	special operations forces
MEDLOG	medical logistics	TCCC	tactical combat casualty care
MTF	medical treatment facility	TEM	traumatic event management
PA	physician assistant		

FOREIGN INTERNAL DEFENSE

4-12. Army Health System support for FID operations is characterized by a lower likelihood of traumatic injury than direct action or special reconnaissance and an increased risk of disease and nonbattle injury from prolonged contact with the indigenous population and both domestic and wild animals. However, there is a requirement for resuscitative surgery due to the threats in the FID OE. Such threats can be the result of a motor vehicle collision secondary to blackout conditions, a rotary-wing accident secondary to brownout, blunt trauma from falls or all-terrain vehicle accidents, negligent discharges of weapons, and overpressure or penetrating trauma from unexploded ordnance. Although the likelihood for penetrating trauma is less than in direct action, the requirement is mandated by the nature of the environment. This type of mission requires increased emphasis on operational public health. Table 4-3 depicts organic and joint operations area AHS support for FID operations. The support required for ARSOF AHS conducting FID missions may include—

- Organic support required for TCCC.
- Joint operations area in support of MEDEVAC and medical regulating, hospitalization, and MEDLOG.
- Support required from both organic and joint operations area resources incorporates sick call services, operational public health, veterinary, and dental services.
- Minimal support required includes resuscitative surgery consists of COSC and medical laboratory services.

Table 4-3. Army Health System support requirements for foreign internal defense activities

Function	*Mission requirement*	*Justification*	*Provided by*
MEDEVAC and medical regulating			
• CASEVAC	Minimal (organic).	Mission executed in areas accessible by dedicated MEDEVAC assets. Security restrictions do not apply.	Organic.
• MEDEVAC	Required (theater).	May be required for serious illness or injury.	Theater assets.
• Medical regulating	Required (theater).	May be required for serious illness or injury.	Theater assets.
Medical treatment			
• Sick call	Required (organic and theater).	Care of minor illness or injury.	Capability dependent upon type of SOF unit deployed (SFMS, SOCAMS, SOCMs, physician, PA, PT, and theater medical company [area] support).
• TCCC	Required (organic).	Care of traumatic injury.	SFMS, SOCM, or SOCAMS.
• Resuscitative surgery	Required (theater).	Surgical intervention dictated by traumatic injuries.	Theater assets.
Hospitalization	Required (theater).	When recovery requires hospital care and further medical treatment.	Theater assets.

Table 4-3. Army Health System support requirements for foreign internal defense activities (continued)

Function	*Mission requirement*	*Justification*	*Provided by*
Medical logistics and blood management	Required (theater).	Resupply of Class VIII and replacement of medical equipment as required. Blood supply management dictated by mission.	Theater assets.
Operational public health	Required (organic and theater).	Identify health threats and recommend PMM.	SF group SFMS, ESEO, PVNTMED officer, and veterinarian. Theater support for OEH surveillance.
Veterinary	Required (organic and theater).	Class I inspection of rations, care of MWDs, and veterinary PVNTMED. Provides global health engagement.	SF group and civil affairs personnel (SFMS, SOCAMS, and veterinarian).
Dental	Required (organic and theater).	Provide emergency and essential dental care. Manage dental disease in both U.S. and HN personnel.	SF group (SFMS and dental officer). Theater assets for requirements exceeding organic capability.
Combat and operational stress control	Minimal (theater).	Support may be required for TEM and routine BH support.	Theater assets.
Medical laboratory services	Minimal (theater).	Limited diagnostic capability for Role 2 MTFs. Used for field or theater confirmatory identification of CB agent samples collected during the mission. This support could be provided by theater assets such as the AML.	Theater assets.

LEGEND:

AML	area medical laboratory	PMM	preventive medicine measures
BH	behavioral health	PT	physical therapist
CASEVAC	casualty evacuation	PVNTMED	preventive medicine
CB	chemical-biological	SF	special forces
ESEO	environmental science and engineer officer	SFMS	special forces medical sergeant
HN	host nation	SOCAMS	special operations civil affairs medical sergeant
MEDEVAC	medical evacuation	SOCM	special operations combat medic
MTF	medical treatment facility	SOF	special operations forces
MWD	military working dog	TCCC	tactical combat casualty care
OEH	occupational and environmental health	TEM	traumatic event management
PA	physician assistant	U.S.	United States

UNCONVENTIONAL WARFARE

4-13. Forces deployed in UW operations require support to develop a parallel system of AHS support for indigenous guerrilla military operations as opposed to an AHS support system for ARSOF personnel only. The indigenous parallel medical system may take many forms, but its existence is required to both conserve the fighting strength of indigenous forces and to motivate partisan forces. Evacuation of injured indigenous personnel working with ARSOF can impact greatly on a commander's mission in the AO. Selected indigenous personnel may be evacuated on U.S. aircraft depending upon the theater policies and Army regulations. Initially, ARSOF may need additional support from selected joint operations area AHS assets but will generally rely on building organic medical capabilities within the guerrilla paramilitary organization.

4-14. In UW operations, Medical Corps officers serve as leaders and advisors of the UW medical system for indigenous personnel. The expertise required is focused on training indigenous personnel and building a guerrilla medical infrastructure (rather than the actual provision of health care, which must be based upon specific funding authority). The medical planner is required to initially and continuously assess the guerrilla medical capability. The desired end state is to have developed medical infrastructure capable of supporting guerrilla large-scale unit operations. Initially, medical capabilities may be very limited and may be almost completely executed by U.S. forces inserted into the AO. As guerrilla forces mature in their operational capabilities, their medical capabilities must mature in parallel. Thus, the ARSOF medical planner must plan for and coordinate medical support to deployed ARSOF personnel and arrange for any transportation and evacuation as required for routine and emergency medical treatment.

4-15. Due to the expanded role of the SFMS and SOCAMS in UW missions, augmentation of the medical capability may be required. Additional medical equipment sets may be required (dental, laboratory, or veterinary) to enhance mission accomplishment. Deploying with additional medical equipment sets enables the SFMS and SOCAMS to maximize their ability to provide sustainment of guerrilla and ARSOF personnel. Table 4-4 depicts organic and joint operations area AHS support requirements for UW operations. In UW operations, HN support is not available. The following ARSOF AHS support requirements may consist of—

- Organic support required encompasses sick call services, TCCC, operational public health, veterinary, dental, MEDLOG, and medical laboratory services.
- Joint operations area support entails resuscitative surgery, hospitalization, and MEDLOG and blood management.
- Minimal support required entails MEDEVAC (only if authorized by theater policy and regulations, as this requires a dedicated MEDEVAC platform that most likely would not be sustainable by indigenous guerrilla assets and COSC).

Table 4-4. Army Health System support requirements for unconventional warfare activities

Function	*Mission requirement*	*Justification*	*Provided by*
MEDEVAC and medical regulating			
• MEDEVAC	Minimal (organic and foreign nation).	Requires a dedicated medical platform that would not be sustainable by indigenous assets. Theater support is required for ARSOF personnel.	Theater assets.
• Medical regulating	Minimal (theater).	Formal medical regulating is initiated at Role 3 MTFs. Indigenous personnel will not be admitted to U.S. Role 3 MTFs.	U.S. personnel may need to provide training and develop an informal tracking system to support Army Health System being established.

Table 4-4. Army Health System support requirements for unconventional warfare activities (continued)

Functions	*Mission requirements*	*Justification*	*Provided by*
Medical treatment			
• Sick call	Required (organic and foreign nation).	Care of minor illness or injury.	SFMS, SOCAMS, physician, PA, PT, or foreign nation equivalent.
• TCCC	Required (organic and foreign nation).	Management of trauma upon commencement of combat operations.	SFMS, SOCAMS, or foreign nation equivalent.
• Resuscitative surgery	Required (organic and foreign nation).	Management of combat trauma after TCCC.	Theater assets for care of U.S. personnel; foreign nation medial assets for care of foreign nation personnel. Theater assets may be required to augment foreign nation capability.
Hospitalization	Required (theater and foreign nation). Separate systems are required for U.S. personnel and indigenous forces.	Care and recuperation of combat trauma; care of serious illness and injury; and increased risk of disease and environmental injuries may necessitate hospitalization.	Theater assets for U.S. personnel; foreign nation medical assets for their forces, theater assets may be required to augment foreign nation capabilities
MEDLOG and blood management	Required (theater).	Resupply of Class VIII supplies and equipment dependent upon duration of operation. Blood required for SOF medical providers (18D and SOCM) and far forward resuscitative surgery. ARSOF may be the sole source of Class VIII for supported indigenous forces. ARSOF MEDLOG officer may need to secure non-U.S. medical supplies to support clandestine and covert operations. Class VIII resupply system must also be established.	ARSOF and theater assets.
Operational public health	Required (organic and foreign nation).	Identify health threats and recommend PPM	SF group (SFMS, SOCAMS, ESEO, veterinarian, and PVNTMED officer) and foreign nation equivalent.
Veterinary	Required (organic and foreign nation).	Class I rations inspection and animal care-related support.	SFMS, SOCAMS, ARSOF veterinarians, and foreign nation equivalent.
Dental	Required (organic and foreign nation for indigenous forces; theater assets for ARSOF personnel).	Restore dental health of indigenous forces. Provide operational dental support (emergency and essential) for ARSOF personnel.	SFMS, SOCAMS, ARSOF dentists, and foreign nation equivalent. Theater assets.

Table 4-4. Army Health System support requirements for unconventional warfare activities (continued)

Function	*Mission requirement*	*Justification*	*Provided by*
Combat and operational stress control	Minimal (theater).	Theater assets if needed to support PTE and TEM.	Theater assets.
Medical laboratory services	Required (organic and foreign nation).	Establish indigenous capability.	SFMS or foreign nation equivalent.

LEGEND:

ARSOF	Army special operations forces	PVNTMED	preventive medicine
ESEO	environmental science and engineer officer	SF	special forces
MEDEVAC	medical evacuation	SFMS	special forces medical sergeant
MEDLOG	medical logistics	SOCAMS	special operations civil affairs medical sergeant
MTF	medical treatment facility	SOCM	special operations combat medic
PA	physician assistant	SOF	special operations forces
PPM	personnel protective measures	TCCC	tactical combat casualty care
PT	physical therapist	TEM	traumatic event management
PTE	potential traumatizing event	U.S.	United States

COUNTERTERRORISM

4-16. Counterterrorism reflects direct action and special reconnaissance in its AHS support requirements. The accessibility of trauma care is dependent on whether the activity occurs in denied or friendly territory. As the duration of the operation lengthens, AHS requirements will increase. Table 4-5 depicts organic and theater AHS requirements for CT operations. In counterterrorism, the ARSOF AHS support requirements may include—

- Organic support required consists of CASEVAC, sick call services, and TCCC.
- Joint operations area support required encompasses MEDEVAC and medical regulating, resuscitative surgery, hospitalization, MEDLOG and blood management, and medical laboratory services.
- Support required from both organic and theater resources incorporates operational public health, veterinary support, and COSC.
- Minimal support required for dental support.

Table 4-5. Army Health System support requirements for counterterrorism activities

Function	*Mission requirement*	*Justification*	*Provided by*
MEDEVAC and medical regulating			
• MEDEVAC	Required (theater).	Evacuation within or from theater.	Theater assets.
• Medical regulating	Required (theater).	Regulate patients within or from theater hospitals.	Theater and strategic assets.
Medical treatment			
• Sick call	Required (organic).	Care of minor illness or injury.	SFMS, SOCAMS, physician, PA, or PT.
• TCCC	Required (organic).	Manage trauma patients.	SFMS, SOCAMS, physician, or PA.

Table 4-5. Army Health System support requirements for counterterrorism activities (continued)

Function	*Mission requirements*	*Justification*	*Provided by*
• Resuscitative surgery	Required (theater).	Emergency surgical stabilization for further evacuation.	Theater assets. FRSD (collocated with a BSMC).
Hospitalization	Required (theater).	Provide essential care and permit recuperation within theater, if feasible.	Theater assets.
Medical logistics and blood management	Required (theater).	If the duration of the operation is extended, Class VIII resupply may be required. Trauma injuries may dictate additional blood requirements.	Theater assets.
Operational public health	Required (organic and theater).	Identity health threats and recommend PMM.	SFMS and theater support for OEH surveillance.
Veterinary	Required (organic and theater).	Class I rations inspection support. Care of military working dogs used for security and ordnance detection.	SFMS, SOCAMS, ARSOF veterinarians, and theater assets.
COSC	Required (organic and theater).	Support may be required for TEM upon completion of the operation.	SFG(ABN), COSC, and theater assets.
Medical laboratory services	Required (theater).	Required for the identification of suspect CB agent samples collected during the mission. This support may be provided by theater assets such as the AML.	Theater assets.

LEGEND:

AML	area medical laboratory	PA	physician assistant
ARSOF	Army special operations forces	PMM	preventive medicine measures
BSMC	brigade support medical company	PT	physical therapist
CB	chemical-biological	SFG(ABN)	special forces group (airborne)
COSC	combat and operational stress control	SFMS	special forces medical sergeant
FRSD	forward resuscitative and surgical detachment	SOCAMS	special operations civil affairs medical sergeant
MEDEVAC	medical evacuation	TCCC	tactical combat casualty care
OEH	occupational and environmental health	TEM	traumatic event management

COUNTERING WEAPONS OF MASS DESTRUCTION

4-17. The countering weapons of mass destruction mission is similar to CT in its AHS support requirements. The notable exception is the use of special equipment and therapeutic agents against chemical-biological agents. The accessibility of trauma care depends on whether the activity occurs in denied or friendly territory. As the duration of the operation increases, so do the AHS support requirements. Table 4-6, on pages 4-12 and 4-13, depicts organic and theater AHS support requirements for the countering weapons of mass destruction mission. The ARSOF AHS support requirements for countering weapons of mass destruction may include—

- Organic support required includes TCCC.
- Joint operations area support required includes MEDEVAC and medical regulating, resuscitative surgery, hospitalization, MEDLOG and blood management, and medical laboratory services.
- Support required from both organic and theater resources include sick call services, operational public health, and veterinary services.
- Minimal support required includes dental and COSC.

Table 4-6. Army Health System support requirements for countering weapons of mass destruction

Function	*Mission requirement*	*Justification*	*Provided by*
MEDEVAC and medical regulating			
• MEDEVAC	Required (theater).	Evacuate patients from friendly areas.	Theater assets.
• Medical regulating	Required (theater).	Regulate patients within or from theater hospitals.	Theater and strategic assets.
Medical treatment			
• Sick call	Required (organic and theater).	Care of minor illness or injury.	SFMS, physician, or PA, and PT theater asset.
• TCCC	Required (organic).	Manage trauma patient.	SFMS, physician, or PA.
• Resuscitative surgery	Required (theater).	Provide lifesaving surgical intervention for trauma patients.	Theater assets.
Hospitalization	Required (theater).	Provide essential care and permit recuperation in theater, if feasible.	Theater assets.
Medical logistics and blood management	Required (theater).	Resupply of medical equipment, Class VIII as the duration of the mission lengthens. Blood supply and management is required for the care of trauma patients.	Theater assets.
Operational public health	Required (organic and theater).	Identify health threats and recommend PPM.	SFMS and theater support for OEH surveillance.
Medical logistics and blood management	Required (theater).	Resupply of medical equipment, Class VIII as the duration of the mission lengthens. Blood supply and management is required for the care of trauma patients	Theater assets.
Operational public health	Required (organic and theater).	Identify health threats and recommend PPM.	SFMS and theater support for OEH surveillance.
Veterinary	Required (organic and theater).	Care of military working dogs used to detect ordnance. Inspection of Class I ration items.	SFMS, ARSOF, veterinarians, and theater assets.

Table 4-6. Army Health System support requirements for countering weapons of mass destruction (continued)

Function	*Mission requirement*	*Justification*	*Provided by*
Dental	Minimal (theater).	Provide emergency and essential care.	Theater assets.
Combat and operational stress control	Minimal (theater).	Support may be required for TEM upon the completion of the operation.	Theater assets.
Medical laboratory services	Not required unless needed for CB agent identification.	Used for field or theater confirmatory identification of suspect CB agent samples collected during the mission. This support would be provided by theater medical assets such as the AML.	Theater assets.

LEGEND:

AML	area medical laboratory	PPM	personnel protective measures
ARSOF	Army special operations forces	PT	physical therapist
CB	chemical-biological	SFMS	special forces medical sergeant
MEDEVAC	medical evacuation	TCCC	tactical combat casualty care
OEH	occupational and environmental health	TEM	traumatic event management
PA	physician assistant		

CIVIL AFFAIRS OPERATIONS

4-18. The limited medical personnel resources in CA units advise, evaluate, coordinate, and execute AHS activities. Civil affairs engage the civil component of the OE through all phases of operations to enhance military efforts and promote legitimacy of military operations. Their responsibilities include advising the commander on CA operations. They perform medical assessments and health threat analysis and coordinate with HN military and civilian authorities, as well as coordinate efforts with nongovernmental organizations. Table 4-7 depicts organic and theater AHS support requirements for CA operations. Requirements for ARSOF AHS support may include—

- Organic support required includes operational public health and veterinary medicine.
- Joint operations area support required includes MEDEVAC and medical regulating, hospitalization, and dental.
- Support required from both organic and joint operations area resources includes sick call services.
- Minimal support required includes TCCC and resuscitative surgery, MEDLOG and blood management, COSC, and medical laboratory services.

Table 4-7. Army Health System support requirements for civil affairs operations

Function	*Mission requirement*	*Justification*	*Provided by*
MEDEVAC and medical regulating			
• MEDEVAC	Required (theater).	Continue evacuation within or from theater.	Theater and strategic assets.
• Medical regulating	Required (theater).	Regulate patients within or from theater hospitals.	Theater assets.

Table 4-7. Army Health System support requirements for civil affairs operations (continued)

Function	*Mission requirement*	*Justification*	*Provided by*
Medical treatment • Sick call	Required (organic and theater).	Care of minor illness or injury.	Theater assets.
• TCCC	As required.	As required.	Theater assets.
• Resuscitative surgery	As required.	As required.	Theater assets.
Hospitalization	Required (theater).	Provide essential care and permit recuperation within theater, if feasible.	Theater assets.
Medical logistics and blood management	Minimal (theater).	Class VIII resupply may be required for ongoing CA missions. Trauma incidents may increase blood requirements for supporting forward surgical teams.	Theater assets.
Operational public health	Required (organic).	Identify health threats and recommend PPM. Provide operational public health advice to host nation personnel or agencies.	Theater assets.
Veterinary	Required (organic).	Class I inspection or animal medical care-related support.	Theater assets.
Dental	Required (theater).	Provide emergency and essential dental care.	Theater assets.
Combat and operational stress control	Minimal (theater).	May be required for TEM or routine BH support.	Theater assets.
Medical laboratory services	Minimal (theater).	May be required for diagnostic procedures, consultation, and identification of suspect CB agents. This support would be provided by theater assets such as the AML.	Theater assets

LEGEND:

AML	area medical laboratory	MEDEVAC	medical evacuation
BH	behavioral health	PPM	personnel protective measures
CA	civil affairs	TCCC	tactical combat casualty care
CB	chemical-biological	TEM	traumatic event management

MILITARY INFORMATION SUPPORT OPERATIONS

4-19. The AHS support requirements for MISO consist of the conventional AHS support mission to a deployed force. The execution of MISO does not require AHS support, and PSYOP units are dependent upon theater assets to meet their AHS needs (see Table 4-8, on page 4-15). Support is provided on an area basis. The ARSOF AHS support requirements may include—

- Joint operations area support required includes MEDEVAC and medical regulating, sick call services, hospitalization, operational public health, veterinary services, and dental.
- Minimal support required includes TCCC and resuscitative surgery, MEDLOG and blood management, COSC, and medical laboratory services.

Table 4-8. Army Health System support requirements for military information support operations

Function	*Mission requirement*	*Justification*	*Provided by*
MEDEVAC and medical regulating			
• MEDEVAC	Required (theater).	Conventional support to a deployed force.	Theater assets.
• Medical regulating	Required (theater).	Regulate patients within or from theater hospitals.	Theater and strategic assets.
Medical treatment			
• Sick call	Required (theater).	Care for minor illness or injury.	Theater assets.
• TCCC	Minimal (theater).	Manage trauma.	Theater assets.
• Resuscitative surgery	Minimal (theater).	Provide lifesaving surgical intervention for trauma patients.	Theater assets.
Hospitalization	Required.	Provide essential care and permit recuperation within theater, if feasible.	Theater assets.
Medical logistics and blood management	Minimal (theater).	Class VIII resupply not expected.	Theater assets.
Operational public health	Required (theater).	Identify health threats and recommend PPM.	Theater assets.
Veterinary	Required (theater).	Class I inspection or animal care-related support.	Theater assets.
Dental	Required (theater).	Provide emergency and essential dental care.	Theater assets.
Combat and operational stress control	Minimal (theater).	May be required for TEM or routine BH support.	Theater assets.
Medical laboratory services	Minimal (theater).	May be required for diagnostic procedures, consultation, and identification of suspect CB agents. Support would be provided by theater assets such as the AML.	Theater assets.

LEGEND:

AML	area medical laboratory	PPM	personnel protective measures
BH	behavioral health	TCCC	tactical combat casualty care
CB	chemical-biological	TEM	traumatic event management
MEDEVAC	medical evacuation		

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Chapter 5

Army Special Operations Forces in a Joint Operations Area

Joint operations are the military actions or activities of two or more Service forces. They can also be the actions of two or more elements of the same Service, such as Army and Army elements of the USASOC, where only joint support or coordinating authority exists. The AHS mission in joint operations is to minimize the effects of wounds, injuries, and diseases on unit effectiveness, readiness, and morale. This mission is accomplished by a proactive operational public health program and a phased health care system (roles of medical care) that extend from actions taken at the point of wounding, injury, or illness to evacuation from the joint operations area for treatment at an MTF in the support base. The primary objective of AHS support is to conserve the commander's fighting strength of SO land, sea, and air forces. Army Health System support in joint operations requires continuous planning, coordination, and training to ensure prompt, effective, and unified health care delivery.

THE JOINT TASK FORCE

5-1. Generally, joint operations are directed by combatant commands and Service component commands. Combatant commands, however, may conduct operations within their AO by activating joint special operations task forces (JSOTFs). The JSOTFs are established to accomplish specific, limited goals that require the significant and closely integrated efforts of forces from two or more Services (or elements thereof).

5-2. The JSOTF commander is appointed by the combatant commander and exercises operational control over assigned and attached forces. The JSOTF commander may also serve as the commander of a JSOTF Service component.

SPECIAL OPERATIONS FORCES IN JOINT OPERATIONS

5-3. Special operations forces give the joint task force (JTF) commander a valuable asset towards mission accomplishment whether that mission is direct action, foreign humanitarian assistance, or other special operations core activities. The composition of the force is dependent upon the resources available, specific type of operation, and anticipated duration of the operation. How the JTF structures the medical command and control of SOF is also dependent on mission, enemy, terrain and weather, troops and support available, time available, civil considerations and informational considerations (mission variables) factors.

5-4. The JTF commander may establish a JSOTF. If the situation does not warrant a JSOTF, the JTF will have a joint force SO component. The joint force SO component commander makes recommendations to the JTF commander on the proper employment of SOF and the planning and coordination of SO. Typically, the JTF commander will have a surgeon and staff. If a JSOTF is warranted, a JSOTF surgeon is required. It is incumbent upon the JTF surgeon and the planner to coordinate AHS support for the SOF component of the JTF.

ARMY HEALTH SYSTEM CONSIDERATIONS IN JOINT TASK FORCE PLANNING

5-5. The types of operations that may require the activation of a JTF are normally crisis or emergency situations for which there may not be an updated existing operation plan. The combatant command normally identifies and activates the JTF during the course of action development phase. Normally, a JSOTF will have a surgeon and a psychologist to provide operational psychology support. It is equally important that the JSOTF surgeon communicate specific support requirements to the JTF surgeon and staff to coordinate and plan effective AHS support.

5-6. Upon JTF activation, the JTF surgeon begins operational planning. The surgeon must understand that SOF are another Service-like component of the task force that requires detailed planning, coordination, and synchronization for operational success. Specifically, the JTF surgeon should perform the following functions:

- Review standard operating procedures and operations orders.
- Obtain and integrate operational medical information into the AHS planning process.
- Update and standardize AHS support planning factors, as required.
- Determine the extent of and initiate planning to medically support noncombatant evacuation operations. These operations may be conducted in the environments of conflict and war.
- Obtain and review health threat and operational public information pertinent to the operation. Identify any additional medical essential elements of information and request information from the JTF intelligence section.
- Develop JTF AHS policies and procedures.
- Determine deployed SOF AHS support requirements.
- Coordinate with JTF operational planners during concept development and assess health risks associated with alternate course of action.
- Assess multinational and nongovernmental organization medical asset availability.
- Assess HN medical availability.
- Develop and coordinate the JTF AHS concept with component and command surgeons. The JTF surgeon should plan for joint use of assets to ensure minimum essential hospitalization and evacuation support.
- Evaluate projected force deployment flow and ensure timely and responsive medical care, including the intratheater aeromedical evacuation, is available throughout the operation.
- Determine if the combatant commander has designated a single integrated MEDLOG manager and develop the MEDLOG plan as applicable. Consideration should be given to placing an SOF MEDLOG liaison at the supporting MEDLOG unit to coordinate SOF-unique combat configured loads and SOF-unique equipment.
- Activate the theater patient movement requirements center and the Area Joint Blood Program Office and disseminate medical regulating and blood management procedures. Include blood products for military working dogs.

5-7. During the operation, the JTF surgeon may be directed to begin planning follow-on stability operations and CA. As the operation nears completion, the JTF surgeon begins planning AHS support for the redeployment of the JTF and transfer of AHS support responsibilities to a follow-on command. Refer to JP 3-33 for additional information on the JTF headquarters and to JP 4-02 for more information on joint health services.

Chapter 6

Medical Logistics Support to Army Special Operations Forces

Army SOF units, such as the SFG(ABN) and 528th SB(SO)(ABN), possess an organic MEDLOG capability. Army SOF units requisition and receive MEDLOG support that includes medical supplies and equipment, maintenance equipment assistance, optical fabrication, and blood support from the conventional theater MEDLOG supply support activity or MEDLOG company.

ARMY SPECIAL OPERATIONS FORCES MEDICAL LOGISTICS REQUIREMENTS

6-1. The nature of ARSOF missions place some unique requirements on the MEDLOG system. Special concerns of the ARSOF in the MEDLOG arena include—

- Assuring proper and adequate maintenance of medical sets, kits, and outfits and medical equipment items is of paramount importance to ARSOF units due to the possibility and likelihood of short-notice deployments. Unit medical personnel must maintain medical equipment sets through scheduled inventories, quality control and quality assurance inspections, and requisitioning required Class VIII items to maintain basic loads.
- Checking medical equipment for serviceability and electrical safety prior to first use. Medical equipment will be scheduled for periodic maintenance. Refer to AR 40-61 for definitive MEDLOG information. Those ARSOF units assigned a MEDLOG support role must ensure adequate quantities of Class VIII are on hand to support customer organizations until theater Class VIII supply support activity or MEDLOG company becomes operational. The ARSOF MEDLOG officer must inform the supporting conventional medical unit of SOF Class VIII requirements to include SOF-unique items.
- Maintaining an adequate stock level of Class VIII to support deployments into undeveloped theaters. Undeveloped theaters normally will not have a developed MEDLOG system present. Depending upon the type of operation and its anticipated duration, the establishment of a joint operations MEDLOG system may not be planned.
- Coordinating with the ARSOF surgeon and staff to determine the quantity of medical supplies for a specific mission. The established stockage levels are coordinated with the supporting MEDLOG facility. The MEDLOG system must plan for and anticipate supporting SOF Class VIII requirements to include SOF-unique items.
- Minimizing the waste of medical supplies through rotation of about-to-expire stocks back to an MTF where they can be used prior to expiration.
- Ensuring segregation of medical supplies purchased with different fund sites to be used for different missions. For example, medical supplies purchased with operations and maintenance funds may only be used for purposes authorized by operations and maintenance funding. Consult the supporting judge advocate and the resource management office for specific advice about proper funding.

6-2. The ARSOF medical planner must understand how the operation plan is to be executed and anticipate unique challenges in order to provide effective AHS support for ARSOF.

6-3. In direct action operations, combat trauma is anticipated to be the major AHS support concern. The deployed teams must carry sufficient medical supplies to provide TCCC for the anticipated number of casualties. The ARSOF MEDLOG planner should plan for and ensure appropriate coordination is accomplished to have pre-configured loads of Class VIII developed and available in the event the duration of the operation is extended, or casualty rates are higher than anticipated. The ARSOF medical planner should also consider the possibility of distributing blood down to the lowest level (SOCM) under the supervision of a responsible physician.

6-4. Transfusion of blood products is not without risks. The distribution of blood and blood products should be coordinated with the Armed Services Blood Program Division. For more information, refer to DODI 6480.04, for more information on the Armed Services Blood Program. Policies on transfusion protocols should originate from the command surgeon's office and be supervised and cleared with command surgeons and medical laboratory officers. Appropriate and close technical supervision is required for Soldier safety.

6-5. Blood distribution to Role 1 (SOCM) is always administered by exception with the appropriate planning, caution, and supervision balanced against mission requirements. Army SOF currently provide whole blood at the point of need (also known as WBPoN) to support operations. This is done both through agreements with the Armed Services Blood Program and through unit low titer group O whole blood (also known as LTOWB) programs. Although low titer group O whole blood is preferred, other blood products are also available to SOF medical elements via Armed Services Blood Program to include plasma, red blood cells, and cold stored platelets. Each ARSOF medic completes initial and sustainment training at the Joint Special Operations Medical Training Center and unit training events utilizing the *U.S. Special Operations Command's Protocols for Special Operations Advanced Tactical Paramedics.*

6-6. When military working dogs are deployed in support of operations regardless of unit, canine blood products should be included in planning and execution. Resupply is accomplished using ARSOF airframes (infiltration and extraction platforms) or other SO command assets.

6-7. The special reconnaissance teams deployed on these missions normally do not have contact with enemy forces or indigenous civilians. Therefore, the major AHS support requirements are for disease and nonbattle injury rather than combat trauma. Due to the covert nature of these operations and the need of the forces to remain undetected, AHS support is restricted to the organic capabilities of the team and Class VIII materiel deployed with the team. The duration of the operation needs to be accurately forecasted, as resupply is not feasible in clandestine operations.

6-8. A major component of FID operations is foreign humanitarian assistance programs. These programs often include the provision of AHS support to indigenous populations, which require special funding allocated for the execution of these programs under Title 10 USC, Chapter 6 (Combatant Commands), Sections 164 and 167. The MEDLOG planner for these operations must ensure the funds expended to purchase Class VIII materiel are from approved sources. Medical supply requirements may include specific operational public health, veterinary, dental, pediatric, and geriatric supply items. Only in an emergency and with appropriate approval may operations and maintenance funds be used to purchase Class VIII materiel for use with HN military or civilian personnel.

6-9. The duration of UW operations can be lengthy. The Class VIII resources initially deployed with ARSOF will be quickly depleted and will require resupply. The SOF commander must determine if the risks associated with the resupply operations (transporting and air-dropping) outweigh the risks of exposing the location of friendly guerrilla forces. In determining the level of acceptable risk, the ARSOF MEDLOG planner must determine the availability and accessibility of locally produced medical supplies and equipment. Since UW operations initially entail providing AHS to the guerrilla forces (and possibly their families according to specific funding authority) as a guerrilla-based medical infrastructure is built, locally accessible medical supplies and equipment may not be available in sufficient quantities to sustain the guerrilla force.

6-10. The ARSOF MEDLOG planner must develop and have prepared pre-configured push packages to be used to resupply the operation (these may be from U.S. or non-U.S. sources). Further, they must coordinate for their distribution to reduce the risk of exposure during resupply operations. A unique concern of UW operations is the requirement for reuse of disposable medical items due to the mission length and resupply difficulties. In UW operations, operations and maintenance funds may be used to purchase Class VIII materiel to train U.S. medical, dental, and veterinary personnel in the conduct of medical, dental, and

veterinary global health engagement. Such training is referred to as medical, dental, and veterinary readiness and training exercises. The realities of ensuring the execution of these missions to establish and improve a HN MEDLOG system may require proper storage of donated and purchased medical supplies and equipment.

6-11. Presently there are three different types of CA battalions. The Active Army battalion and the Reserve Component SO battalions possess a significant amount of medical equipment. However, the Reserve tactical CA battalions have minimal medical equipment. All efforts should be made by unit medical and logistics personnel to ensure the proper maintenance and serviceability of assigned medical equipment sets. Medical logistics, to include routine and emergency resupply of Class VIII materiel, must be included and emphasized in the overall AHS support plan. Due to the nature of CA, units must rely heavily upon combat lifesaver personnel to provide limited organic capability.

6-12. There should be very limited MEDLOG support necessary for the successful execution of the MISO mission, and PSYOP forces may benefit from guidance. The MEDLOG support to ARSOF provided by ARSOF MEDLOG personnel is to enhance the positive aspects of ongoing MEDLOG activities in support of other ARSOF missions. Due to the organizational structure of PSYOP units, they must rely heavily upon combat lifesaver personnel to provide limited organic capability.

6-13. The CT operations resemble direct action in respect to MEDLOG requirements. However, CT operations may also include the potential exposure to CBRN hazards. Forces deployed in CT operations should have the appropriate medical counter measures to include immunizations, chemoprophylaxis, therapeutic drugs, and barrier creams to protect against the effects of CBRN hazards. In this respect, the MEDLOG requirements for CT operations resemble those operations.

6-14. Countering weapons of mass destruction operations may expose ARSOF personnel to CBRN hazards. When operations may be conducted under CBRN conditions, ARSOF will require additional TCCC supplies due to disposal of supplies that will be deliberately contaminated for initial patient management. Additionally, many ARSOF and joint forces in possible CBRN environments will require 3:1 ratio of medical chemical defense material due to prolonged evacuation (at best, the next period of darkness) and probable recontamination due to austere OEs with minimal equipment carrying capacity. They will also need additional quantities of treatment options due to the same constraints. Therefore, ARSOF personnel must ensure they have the appropriate immunizations, chemoprophylaxis, therapeutic drugs, barrier creams, and other equipment to protect against these CBRN hazards and to counter their effects. Further, the team must deploy with patient decontamination supplies to conduct patient decontamination of their own forces on a limited basis in an austere environment. Due to the short duration of these operations, resupply of Class VIII should not be anticipated.

6-15. Information operations currently have no unique MEDLOG requirements.

DUTIES AND RESPONSIBILITIES FOR THE MANAGEMENT OF MEDICAL LOGISTICS

6-16. Unit surgeons are responsible for the technical supervision of all aspects of MEDLOG to include Class VIII medical materiel, medical equipment maintenance, and blood support within their respective organizations. The unit surgeons have the final approval authority for their respective authorized stockage lists and unit basic loads, as well as the approval authority for any variances.

6-17. Medical logistics officers and NCOs advise the surgeon and detachment commanders on all matters concerning MEDLOG, assist them in developing MEDLOG annexes to operation plans, and enforce applicable policies, regulations, and command guidance on MEDLOG matters. Unit MEDLOG personnel ensure organic medical sets, kits, and outfits and medical equipment items are properly maintained and serviced; Class VIII stock level requirements and usage rates are determined; a medical materiel quality control program is established; Class VIII stocks are rotated to minimize unnecessary losses due to expiration; and proper procedures are followed concerning turn-in, destruction, and proper accountability of Class VIII materiel.

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Appendix A

Army Special Operations Forces and Medical Considerations in the Law of Armed Conflict

Principal sources for the law of armed conflict include treaties like The Hague and Geneva Conventions, cited and discussed in FM 6-27, and customary international law. The 1949 Geneva Conventions treaties that have been signed and ratified by the United States have a force equal to laws enacted by Congress and signed by the President. In addition, customary international law is firmly established by the custom of nations and followed out of a sense of legal obligation. The United States is obligated to adhere to the law of war even when an opponent does not. It is the policy of the DOD and the United States Army to conduct its military operations in a manner consistent with the law of war. In the area of AHS support of ARSOF, the law of war sources are binding on all members of the U.S. Armed Forces. Questions regarding implementation and interpretation of the law of war should be directed to the supporting judge advocate. For further information, refer to FM 1-04 and FM 6-27.

IDENTIFICATION AND PROTECTIONS AFFORDED TO MEDICAL PERSONNEL

A-1. Article 24 of the *Geneva Convention (I) for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field* (GWS), 12 August 1949, 6 UST 3114, T.I.A.S 3362, 75 UNTS 31 (see FM 6-27), provides special protection for "Medical personnel exclusively engaged in the search for, or the collection, transport, or treatment of the wounded or sick, or in the prevention of disease, [and] staff exclusively engaged in administration of medical units and establishments" during international armed conflicts.

A-2. There are two separate forms of protection:

- The first is protection from intentional attack. Medical personnel should wear the armlet with the distinctive emblem to facilitate their identification by the enemy.
- The second protection provided by GWS pertains to medical personnel who fall into the hands of the enemy. Article 28 states that medical personnel are entitled to "retained person" status. Such individuals are not classified as detainees but otherwise benefit from the protections of the *Geneva Convention (III) Relative to the Treatment of Prisoners of War*, dated 12 August 1949, 6 UST 3114, T.I.A.S 3362, 75 UNTS 31 (see FM 6-27). They are authorized to carry out medical duties only and "shall be retained only in so far as the state of health and the number of prisoners of war require."

Note. Army SOF personnel holding MOSs 18D SFMS and 38BW4 are not considered to be exclusively engaged in medical duties and are not considered retained personnel should they be captured. The SFMS and SOCAMS are considered to be combatants and can be targeted. Therefore, they are entitled to the protections afforded to prisoners under the provisions of the *Geneva Convention (III) Relative to the Treatment of Prisoners of War*, dated 12 August 1949, 6 UST 3114, T.I.A.S 3362, 75 UNTS 31 (see FM 6-27). In addition, veterinary service personnel are not considered medical personnel under the Geneva Conventions.

PROTECTION OF MEDICAL AIRCRAFT

A-3. Article 36 of the GWS, 6 UST 3114, T.I.A.S 3362, 75 UNTS 31 (see FM 6-27) pertains to the requirements for and protections afforded medical aircraft during international armed conflicts. The treaty states: "Medical aircraft, that is to say, aircraft exclusively employed for the removal of wounded and sick and for the transport of medical personnel and equipment, shall not be attacked, but shall be respected by belligerents, while flying at heights, times, and on routes specifically agreed upon between the belligerents concerned." They shall bear, clearly marked, the distinctive emblem prescribed in Article 38 of the GWS, 6 UST 3114, T.I.A.S 3362, 75 UNTS 31 (see FM 6-27 and Library of Congress website) together with their national colors, on their lower, upper, and lateral surfaces. Medical aircraft shall also be provided with any other markings or means of identification that may be agreed upon between the belligerents upon the outbreak or during the course of hostilities. Unless agreed otherwise, flights over the enemy or enemy-occupied territory are prohibited. Medical aircraft shall obey every summons to land. In the event of a landing thus imposed, the aircraft and its occupants may continue its flight after examination, if any. In the event of an involuntary landing in enemy or enemy-occupied territory, the wounded and sick, as well as the crew of the aircraft, shall be prisoners of war. The medical personnel shall be treated according to Article 24.

A-4. Medical aircraft may not be armed with crew-served weapons, machine guns, hand grenades, antitank weapons, or other offensive weapon systems. Airframes used by ARSOF for personnel infiltration or exfiltration are not engaged solely in the transport of patients. Consequently, they are not protected under the provisions of GWS or marked with the distinctive emblem.

PROTECTION OF MEDICAL SUPPLIES AND EQUIPMENT

A-5. Medical materiel (supplies and equipment) is protected under the provisions of GWS. Captured medical materiel is to be used first to treat the patients in the captured unit.

A-6. If there are no patients in the captured unit or when all patients have been evacuated, the captured medical materiel is to be used for the treatment of other sick and wounded personnel. The medical materiel of fixed and mobile medical units is not to be intentionally destroyed, even to prevent it from falling into enemy hands.

Appendix B

Planning Medical Evacuation for Army Special Operations Forces

Army SOF routinely operates in austere, denied, hostile, and immature AO. As a result, careful and flexible planning for MEDEVAC must occur. Well-coordinated and executed MEDEVAC will assist in ensuring the continued operational effectiveness of the deployed force.

CONSIDERATIONS FOR PLANNING MEDICAL EVACUATION

B-1. Army SOF does not have an organic MEDEVAC system. The ARSOF is dependent upon the conventional joint operations MEDEVAC system for this support. The ARSOF does have an organic capability to affect CASEVAC using ARSOF airframes (those used for infiltration and extraction of ARSOF personnel). During CASEVAC, the casualty may not receive en route medical care unless specific planning and coordination is accomplished to staff the airframe with medically trained personnel prior to the execution of CASEVAC operations.

B-2. The challenge for the medical planner is to provide patient movement without the benefits of organic dedicated MEDEVAC assets, which are available to the conventional force. Special operations missions are often conducted in sensitive or denied areas beyond the conventional AHS support evacuation umbrella. Medical evacuation of ARSOF casualties is an operational responsibility and must reflect the commander's concept of the operation. A successful MEDEVAC plan must be integrated with the tactical plan and logistics operations. When considering evacuation of SOF military working dogs, the evacuation requires a dog handler all the way to Role 4 veterinary care.

MEDICAL EVACUATION PLANNING FACTORS

B-3. Planning effective MEDEVAC for ARSOF requires an understanding of ARSOF missions and units. Planning for ARSOF MEDEVAC may differ from conventional AHS support planning in the following areas:

- Inability to assign dedicated MEDEVAC platforms to all the teams and small units that are often widely dispersed throughout the AO and are in a hostile or denied territory.
- Lack of U.S. Air Force-approved airfields in many locations in which ARSOF must operate.
- Security requirements of some missions.
- Individually tailored evacuation plans are required to support numerous small teams deployed to separate locations.

B-4. If the ARSOF patient is ambulatory, the patient retains responsibility for any sensitive equipment in the patient's possession. If the patient is unconscious, the equipment is turned over to a team member accompanying the patient. However, if the patient is not accompanied by another team member, the equipment must be secured until it can be transferred back to the patient's parent unit.

B-5. Although the ARSOF have no dedicated MEDEVAC assets, the ARSOF medical planner must be able to plan and coordinate an efficient chain of CASEVAC from isolated locations anywhere in the world. This evacuation chain requires identification of all specific military assets required to complete the mission. Then, the medical planner must ensure the dissemination of point of contact and for every link of the evacuation down to the SOF user level. If required, this should include the point of contact for medical regulating.

B-6. Once the ARSOF Soldier enters the conventional AHS, medical regulating support is provided by medical regulating officers assigned to the theater-level units of medical command (deployment support). The ARSOF medical planner and the ARSOF surgeon must be able to rapidly tailor a CASEVAC plan for ARSOF missions or operations. If ARSOF are assigned to a JSOTF, the ARSOF surgeon (if designated as the JSOTF surgeon) plans for MEDEVAC of the joint SOF. The ARSOF medical planner should plan for MEDEVAC in two distinct phases—intratheater and intertheater.

B-7. Within the joint operations area (intratheater evacuation), ARSOF patients and casualties are often evacuated on the aircraft responsible for extracting the rest of the team. Prolonged exfiltration legs in blackout conditions on board aircraft flying over hostile or denied territory make in-flight patient care delivery difficult. These extraction aircraft must be able to affect rapid communications with the appropriate medical units upon entry into U.S.-multinational controlled airspace. Coordination for dedicated MEDEVAC platforms must be accomplished to meet the incoming aircraft to evacuate the patient to the appropriate role of care. Sensitive equipment and documents in the possession of the patient should be retained by the ARSOF team and not transferred to the evacuation platform. Due to the classified nature of many ARSOF missions, it may be necessary to segregate the ARSOF patient from conventional patients to ensure classified mission parameters are not compromised.

B-8. Once the patient is moved out of the AO and enters the conventional AHS, intertheater evacuation and medical regulating are affected by medical regulating officers at theater levels of command. The ARSOF medical planner must continuously monitor the situation to ensure the plans remain sufficiently flexible to provide the necessary support when it is required. The medical planner must maintain active liaison with the conventional AHS units that will provide support once the ARSOF patient is extracted from the AO. The ARSOF surgeon continues to track ARSOF Soldiers being evacuated out of the AO to keep the ARSOF chain of command apprised and to ensure security concerns are addressed. The ARSOF medical planner should—

- Determine the airfield that ARSOF patients will be evacuated to.
- Determine if any medical equipment and supplies (patient movement items) are required to sustain the ARSOF patient while in flight.
- Coordinate for augmentation of medically trained personnel to be present on board the airframe when the ARSOF patient is picked up. This asset may come from organic ARSOF personnel (SFMS or PA) due to the classified parameters of the mission being supported or because of the use of unique medical items and seriousness of the patient.
- Coordinate for dedicated MEDEVAC support to be present at the destination airfield. Army SOF patients extracted from hostile or denied territory are normally taken to an MTF for evaluation and stabilization prior to further evacuation. They are not normally evacuated directly to an en route patient staging system as these units are neither staffed nor equipped to provide stabilizing medical care.
- Coordinate for a dog handler to accompany a multipurpose canine.

EVACUATION FROM HOSTILE OR DENIED TERRITORY

B-9. The ARSOF planner and the SFG operational detachment A leader must develop a tentative plan for the evacuation of ARSOF patients from hostile or denied territory, when feasible. The planners must consider all options that will not compromise the security of the operation.

B-10. Conventional MEDEVAC platforms normally cannot provide support while the ARSOF team is deployed. The ARSOF planner should consider—

- Classified nature of the mission and the probable outcome if compromised.
- Availability of opportune vehicles and aircraft (such as resupply platforms).
- Infiltration and exfiltration routes.
- Requirements for special medical equipment and supplies.
- Availability of foreign national MTFs, equipment, and supplies to stabilize the patient for an arduous ground evacuation.

- Probable weather in the AO. For example, reduced visibility may enhance the chance of successfully infiltrating the patient, or inclement weather (such as snow or extreme cold) may impose special requirements for sustaining the patient until the patient can be evacuated.
- Landing area requirements and the maximum time the airframe can loiter while awaiting the patient pick up.

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Appendix C

Command and Control Structures and Integrating Elements of Special Operations Forces in the Joint Campaign

Special operations forces are most effective when closely integrated into the support of a JFC, geographic, or country campaign plan. The SOF command and control structures are based upon joint doctrine, which evolved through SOF operational experience across the competition continuum. The key to effective integration is a command and control structure that provides two essential functions, command and control of SOF operating within the theater or JFC AO and staff coordination to ensure SOF is employed effectively in support of a campaign plan. A JFC has wide latitude to create a medical command and control structure based on the mission, enemy, terrain and weather, troops and support available, time available, civil considerations and informational considerations (mission variables).

COMBATANT COMMAND SPECIAL OPERATIONS FORCES

C-1. In peacetime, each combatant commander has a theater special operations command (TSOC) headquarters assigned. This command is a subordinate unified command that serves as the functional SO component. In the joint operations area, SO commands normally exercise operational control of SOF (except for PSYOP and CA units) within their AO. The TSOC commander is the AO joint force SO component commander and reports directly to the geographic combatant command. The joint force SO component commander is the geographical combatant command's principal SO advisor. While the USASOC headquarters provides funding and personnel for the TSOCs commands, they work directly for the combatant commander. It is important to note that TSOCs do not have permanently assigned surgeons or staff medical personnel.

C-2. Unity of effort among SOF and conventional forces is accomplished through a number of various SOF integrating elements. In the following paragraphs are critical integrating components and elements performing critical coordinating tasks. These are the SO medical command and control element, the SO liaison element, and the naval special warfare (NSW) task unit.

C-3. The SO medical command and control element is based on an SFG operational detachment B and is augmented with a special communications package and personnel as required. The SO medical command and control element assists the JSOTF commander in the accomplishment of their supporting commander responsibilities. The SO medical command and control element can exercise medical command control of designated ARSOF (less PSYOP and CA units) when the JSOTF commander determines the need. The SO medical command and control element also provides a monitoring capability for SF units under the control of the Army forces. This is designed to improve the Army forces commander's ability to employ subordinate multinational forces.

C-4. The SO liaison element is composed of SOF air operations planners and liaison officers from other SOF elements. It is the joint SO force component commander's liaison to the joint force air component commander that ensures SOF air and surface operations are integrated with all joint air operations. The SO liaison element accomplishes this through the air tasking order system by reconciling duplicative targeting, resolving airspace conflicts, and preventing fratricide. The SO liaison element reports directly to the joint force SO component commander.

C-5. The NSW task unit is a provisional subordinate unit of an NSW task group. It provides medical command and control, coordinates administrative and logistical support, and integrates SO with maritime operations. Designated NSW forces may be under the operational control of the naval component commander or a joint force SO component commander. Naval special warfare forces often are assigned to conventional naval component commanders, as well as to operational joint force SO component commands. Several NSW task units could be operationally subordinate to an NSW task group, as well as having an NSW task unit under the operational control of a joint force SO component commander.

SPECIAL OPERATIONS FORCES OPERATIONAL COMMAND AND CONTROL

C-6. During operations, three types of SOF JTFs may be formed to support a JFC in the command and control of assigned SOF: the JSOTF; the joint PSYOP task force; and the joint civil-military operations task force (JCMOTF). These JTFs are organized along the lines of a conventional JTF and normally are established to accomplish a specific mission (such as special reconnaissance, MISO, or CA) or to conduct a campaign of limited duration. Special operations forces JTFs are flexible in size and composition, and they can be tailored based on the anticipated duration of the operation.

C-7. A *joint special operations task force* is a joint task force composed of units from more than one Service, formed to carry out a specific special operation or prosecute special operations in support of a combatant command campaign or other operations (JP 3-05). The JSOTF may have conventional units assigned or attached to support specific missions. These missions include the core activities described in chapter 2.

C-8. A joint PSYOP task force is composed of MISO units from more than one Service. The task force is formed to carry out MISO in support of a JFC's campaign or other contingencies. Responsibility for MISO planning and supervision lies with a JFC, assisted by the operations directorate of a joint staff PSYOP officer and forward liaison teams from the Active Army PSYOP group. During peace operations, the JFC may form a joint functional component command to plan, coordinate, and execute all MISO in the theater. The joint PSYOP task force commander is normally tasked to command this operation. The JFC may designate the senior PSYOP unit commander as the joint forces PSYOP component commander. Some PSYOP forces may be assigned or attached to other component commands (for example, JSOTF or Army elements) as the mission dictates. At all times, the joint PSYOP task force commander should retain overall responsibility for the execution of MISO in support of the JFC campaign plan.

C-9. A JCMOTF is composed of civil-military operations units from more than one Service or U.S. Government agency. It is formed to carry out CA in support of a JFC's campaign or other contingencies. Responsibility for CA planning and supervision lies with a JFC, supported by the CA operations officer. Additional planning support may be provided by the CA plans, programs, and policy team, the CA operational planning team, or a liaison team. The JCMOTF may be established by a JFC to assist in carrying out missions of either limited or extended duration involving military forces' coordination with other DOD, U.S. Government agencies, multinational and HN forces, and nongovernmental organizations. The JFC may designate the senior CA unit commander as the JCMOTF commander. Some CA assets may be assigned or attached to other component commands (such as the JSOTF) and should retain all responsibility for the execution of civil-military operations support of the JFC's campaign plan.

OPERATIONAL SPECIAL FORCES INTEGRATING ELEMENTS

C-10. In addition to SO command and control, SO liaison elements, and NSW task units, two additional integration elements may be used for operational command and control of SOF, the civil-military operations center (CMOC) and joint SO air component.

C-11. The JFC may establish a CMOC to integrate and harmonize the various political, humanitarian, and military aspects of a mission. The CMOC is a standing capability formed by all Army CA units from the company to the CA command level. A CMOC is tailored to the specific tasks associated with the mission and normally augmented by available assets (medical, engineer, and transportation) to the supported commander.

C-12. The CMOC serves as the primary coordination interface for U.S. Armed Forces and humanitarian organizations, intergovernmental organizations, nongovernmental organizations, multinational forces, HN governmental agencies, and other civil agencies of the U.S. Government. The CMOC is designed to receive, assign priority to, and validate civilian requests for support and to produce one single coordinated effort in crisis situations. The CMOC is flexible in size and composition, and it provides a venue for necessary communications, coordination, and cooperation between military and civilian authorities. For additional information about the CMOC, refer to FM 3-57.

C-13. The joint SO air component commander is the aviation component commander under a joint force SO component command or joint force command responsible for planning and executing joint SO aviation missions. Ordinarily, all SO aviation is under the operational control of the joint SO air component commander. The joint force SO component command's SO liaison element integrates the joint SO air component commander's missions with the joint force air component commander's operations.

SPECIAL OPERATIONS SUPPORT TO UNITED STATES AMBASSADORS

C-14. An embassy's country team may also initiate requests for SOF support. The specific request will originate with the ambassador, defense attaché, or military assistance group commander. These requests are passed through the appropriate combatant commander to the Joint Chiefs of Staff that ensures proper interagency coordination. If the forces are available in the joint operations area from assigned forces and there are no restrictions on their employment (as there are for counterdrug operations), the request can be approved by the operational SO command. If there are insufficient forces available in the theater, the combatant command will make a request for USASOC forces through the Joint Chiefs of Staff.

C-15. Once a deployment has been approved by all concerned (such as the State Department and DOD), the combatant commander is notified of the SOF, units, or elements to be deployed. With a few exceptions, these forces will be under the operational control of the combatant commander when they enter the AO. The combatant commander will normally exercise operational control through the U.S. military assistance group commander or the chief of the in-country security assistance organization, who, in turn, keeps the ambassador informed of plans and activities during the deployment. Under no circumstances will SOF operate in a combatant commander's AO or in a U.S. ambassador's assigned country without prior notification and approval of the combatant commander and ambassador.

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Glossary

This glossary lists acronyms and terms with Army or joint definitions. Where Army and joint definitions differ, (Army) precedes the definition.

SECTION I – ACRONYMS AND ABBREVIATIONS

AAMedP	allied aeromedical publication
ABN	airborne
ADP	Army doctrine publication
AHS	Army Health System
AJMedP	allied joint medical publication
AJP	allied joint publication
AMedP	allied medical publication
AO	area of operations
AR	Army regulation
ARSOF	Army special operations forces
ATP	Army techniques publication
CA	civil affairs
CASEVAC	casualty evacuation
CBRN	chemical, biological, radiological, and nuclear
CMOC	civil-military operations center
COSC	combat and operational stress control
CT	counterterrorism
DA	Department of Army
DD form	Department of Defense form
DOD	Department of Defense
ESEO	environmental science and engineer officer
FID	foreign internal defense
FM	field manual
FRSD	forward resuscitative and surgical detachment
GWS	*Geneva Convention (I) for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field*
HN	host nation
JCMOTF	joint civil-military operations task force
JFC	joint force commander
JP	joint publication
JSOTF	joint special operations task force
JTF	joint task force
MCTP	Marine Corps tactical publication

MEDEVAC	medical evacuation
MEDLOG	medical logistics
MISO	military information support operations
MOS	military occupational specialty
MTF	medical treatment facility
NATO	North Atlantic Treaty Organization
NCO	noncommissioned officer
NSW	naval special warfare
OE	operational environment
PA	physician assistant
PVNTMED	preventive medicine
PSYOP	psychological operations
SB	sustainment brigade
SB(SO)(ABN)	sustainment brigade (special operations) (airborne)
SF	special forces
SFG	special forces group
SFG(ABN)	special forces group (airborne)
SFMS	special forces medical sergeant
SO	special operations
SOAR(ABN)	special operations aviation regiment (airborne)
SOCM	special operations combat medic
SOCAMS	special operations civil affairs medical sergeant
SOF	special operations forces
STANAG	Standardization Agreements
TCCC	tactical combat casualty care
TSOC	theater special operations command
U.S.	United States
USASOC	United States Army Special Operations Command
USC	United States Code
UW	unconventional warfare

SECTION II – TERMS

Army Health System

A component of the Military Health System that is responsible for operational management of the health service support and force health protection missions for training, predeployment, deployment, and postdeployment operations. The Army Health System includes all mission support services performed, provided, or arranged by Army Medicine to support health service support and force health protection mission requirements for the Army and as directed, for joint, intergovernmental agencies, coalition, and multinational forces. (FM 4-02)

Army special operations forces

Those Active Component and Reserve Component Army forces designated by the Secretary of Defense that are specifically organized, trained, and equipped to conduct and support special operations. (JP 3-05)

casualty collection point

A location that may or may not be staffed, where casualties are assembled for evacuation to a medical treatment facility. (ATP 4-02.2)

casualty evacuation

(Army) The movement of casualties aboard nonmedical vehicles or aircraft without en route medical care. (ATP 4-02.13)

civil affairs

Designated Active Component and Reserve Component forces and units organized, trained, and equipped specifically to conduct civil affairs operations and to support civil-military operations. (JP 3-57)

civil affairs operations

Actions planned, coordinated, executed, and assessed to enhance awareness of, and manage the interaction with, the civil component of the operational environment; identify and mitigate underlying causes of instability within civil society; and/or involve the application of functional specialty skills normally the responsibility of civil government. (JP 3-57)

combat and operational stress control

(Army) A coordinated program of actions taken by military leadership to prevent, identify, and manage reactions to traumatic events that may affect exposed organizations and individuals during unified land operations. (FM 4-02)

combat lifesaver

(Army) A nonmedical Soldier trained to provide enhanced first aid as a secondary mission. (FM 4-02)

counterproliferation

Those actions taken to reduce the risks posed by extant weapons of mass destruction to the United States, allies, and partners. (JP 3-40)

counterterrorism

Activities and operations taken to neutralize terrorists and their organizations and networks to render them incapable of using violence to instill fear and coerce governments or societies to achieve their goals. (JP 3-26)

denied area

(Army) An area that is operationally unsuitable for conventional forces due to political, tactical, environmental, or geographical reasons. It is a primary area for special operations forces. (FM 3-05)

en route care

(Army) The care required to maintain the phased treatment initiated prior to evacuation and the sustainment of the patient's medical condition during evacuation. (ATP 4-02.2)

essential care

(Army) The absolutely necessary initial, en route, resuscitative, and surgical care provided to save, stabilize, and return as many Soldiers to duty as quickly as possible. (FM 4-02)

force health protection

(Army) Force health protection are measures that promote, improve, or conserve the behavioral and physical well-being of Soldiers comprised of preventive and treatment aspects of medical functions that include: combat and operational stress control, dental services, veterinary services, operational public health, and laboratory services. Enabling a healthy and fit force, prevent injury and illness, and protect the force from health hazards. (FM 4-02)

foreign internal defense

Participation by civilian agencies and military forces of a government or international organizations in any of the programs and activities undertaken by a host nation government to free and protect its society from subversion, lawlessness, insurgency, terrorism, and other threats to its security. (JP 3-22)

health service support

(Army) Health service support is support and services performed, provided, and arranged by the Army Medicine to promote, improve, conserve, or restore the behavioral and physical well-being of personnel by providing direct patient care that include medical treatment (organic and area support) and hospitalization, medical evacuation to include medical regulating, and medical logistics to include blood management. (FM 4-02)

irregular warfare

A struggle among state or non-state actors to influence populations and affect legitimacy. (JP 1, Vol 1)

joint special operations task force

A joint task force composed of special operations units from more than one Service, formed to carry out a specific special operation or prosecute special operations in support of a combatant command or other operations. (JP 3-05)

medical evacuation

The timely and effective movement of the wounded, injured, or ill to and between medical treatment facilities on dedicated and properly marked medical platforms with en route care provided by medical personnel. (ATP 4-02.2)

medical regulating

The actions and coordination necessary to arrange for the movement of patients through the roles of care and to match patients with a medical treatment facility that has the necessary health service support capabilities and available bed space. (JP 4-02)

medical treatment facility

(Army) Medical treatment facility refers to any facility established for the purpose of providing medical treatment. This includes battalion aid stations, Role 2 facilities, dispensaries, clinics, and hospitals. (FM 4-02)

military information support operations

Planned operations to convey selected information and indicators to foreign audiences to influence their emotions, motives, objective reasoning, and ultimately the behavior of foreign governments, organizations, groups, and individuals in a manner favorable to the originator's objectives. (JP 3-13.2)

operational public health

The application of public health practices and conduct of public health-related activities within a geographic area where military operations are conducted by TOE units. Examples of military operations include training and exercises conducted in field environments or locations outside of a permanent U.S. military installation, humanitarian support, contingency operations, and combat or stability operations. (AR 40-5)

patient

A sick, injured or wounded individual who receives medical care or treatment from medically trained personnel. (FM 4-02)

patient movement

(Army) The act of moving a sick, injured, wounded, or other person to obtain medical and/or dental treatment. (ATP 4-02.2)

public health

The science and practice of promoting, protecting, improving, and, when necessary, restoring the health of individuals, specified groups, or the entire population (adapted from A Dictionary of Public Health). Public health encompasses a wide range of capabilities, organizations, and professional disciplines operating in a systematic manner to effectively execute the 10 Essential Public Health Services. (AR 40-5)

Rangers

Rapidly deployable airborne light infantry organized and trained to conduct highly complex joint direct action operations in coordination with or in support of other special operations units of all Services. (JP 3-05)

special forces

United States Army forces organized, trained, and equipped to conduct special operations with an emphasis on unconventional warfare capabilities. (JP 3-05)

special operations

Activities or actions requiring unique modes of employment, tactical techniques, equipment, and training often conducted in hostile, denied, or politically sensitive environments. (JP 3-05)

special operations task force

A scalable unit, normally of battalion size, in charge of the special operations element, organized around the nucleus of special operations forces and support elements. (JP 3-05)

special reconnaissance

Reconnaissance and surveillance actions conducted as a special operation in hostile, denied, or diplomatically and/or politically sensitive environments to collect or verify information of strategic or operational significance, employing military capabilities not normally found in conventional forces. (JP 3-05)

theater evacuation policy

A command decision indicating the length in days of the maximum period of noneffectiveness that patients may be held within the command for treatment, and the medical determination of patients that cannot return to duty status within the period prescribed requiring evacuation by the first available means, provided the travel involved will not aggravate their disabilities or medical condition. (ATP 4-02.2)

unconventional warfare

Activities conducted to enable a resistance movement or insurgency to coerce, disrupt, or overthrow a government or occupying power by operating through or with an underground, auxiliary, and guerrilla force in a denied area. (JP 3-05)

weapons of mass destruction

Chemical, biological, radiological, or nuclear weapons capable of a high order of destruction or causing mass casualties, excluding the means of transporting or propelling the weapon where such means is a separable and divisible part from the weapon. (JP 3-40)

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14 August 2023

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