

Chapter 10
Medical Company

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ORGANIZATION AND MISSION

The support battalion medical company provides brigade (division) level HSS for units operating in the brigade area. This HSS includes medical staff advice and assistance as required on an area basis to all units in the brigade area. The company also provides unit-level HSS to units without organic medical support. Figures 10-1, 10-2, 10-3, and 10-4 show the organizational structures of the HSB, SIB/TDB, and ACR medical companies. Each company consists of a company headquarters, brigade/regimental medical supply section, treatment platoon, and ambulance platoon. The HSB and SIB/TDB also have a preventive medicine section, mental health team, and optometry team. The medical company of the support squadron depends upon elements of corps for mental health, optometry, and supplemental preventive medicine services. The HSB and SIB medical companies also have a surgical squad.

The companies perform the following services and functions:

- Provision of HSS advice to the brigade commander.
- Treatment of patients with minor diseases and illnesses, triage of mass casualties, initial resuscitation and stabilization, and emergency medical treatment. They also provide patients with advanced trauma management, initial surgery, and preparation for further evacuation of patients incapable of returning to duty.
- Ground evacuation for patients from battalion aid

- stations and designated patient-collecting points.
- Emergency dental care.
- Medical supply, medical equipment, medical unique (Class VIII) repair parts, and medical maintenance support to units in the brigade area.
- Medical laboratory and radiology services commensurate with division-level treatment.
- Outpatient consultation services for patients referred from unit-level MTFs.
- Patient holding for up to 40 patients able to return to duty within 72 hours.
- Level II surgical support service. (HSB and SIB only)
- Optometry support limited to eye examinations single vision, spectacle frame assembly, and repair services.
- Preventive medicine and consultation service for brigade units.
- Forward treatment support to forces involved in combat operations.
- Coordination with the UMT for required religious support.
- Reinforcement of unit-level medical elements. They also provide medical supervision for PAs in unit-level medical elements without an assigned physician.

MODULAR MEDICAL SUPPORT SYSTEM

The modular medical support system standardizes all medical treatment subunits within the brigade. The medical system duplicates modules at different levels of health care. Duplications allow the medical managers to

rapidly tailor, augment, or reinforce medical units where the need is most critical. This support system acquires, receives, triages, and provides EMT and advanced trauma management for patients within the brigade area.

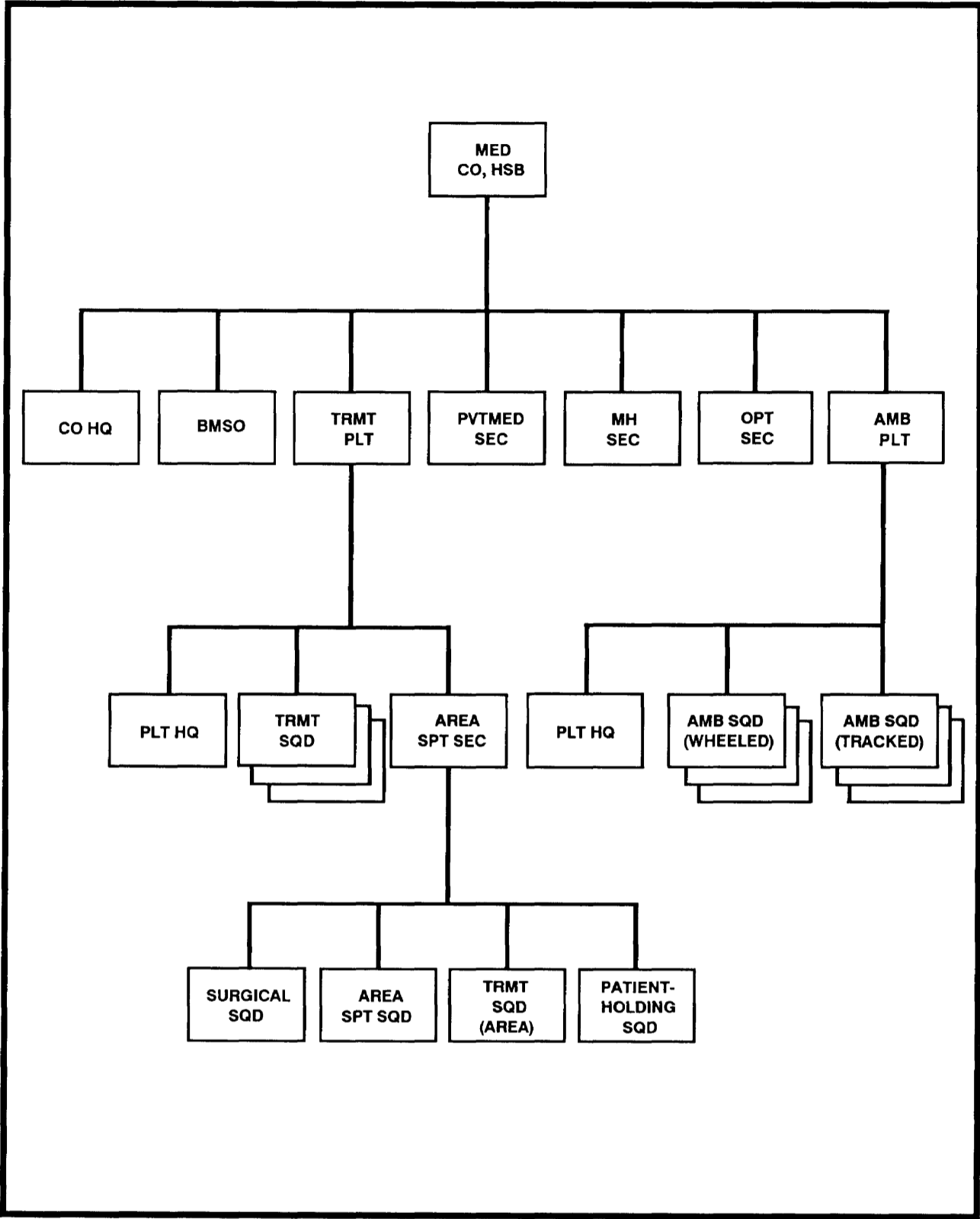


Figure 10-1. Medical company, heavy separate brigade.

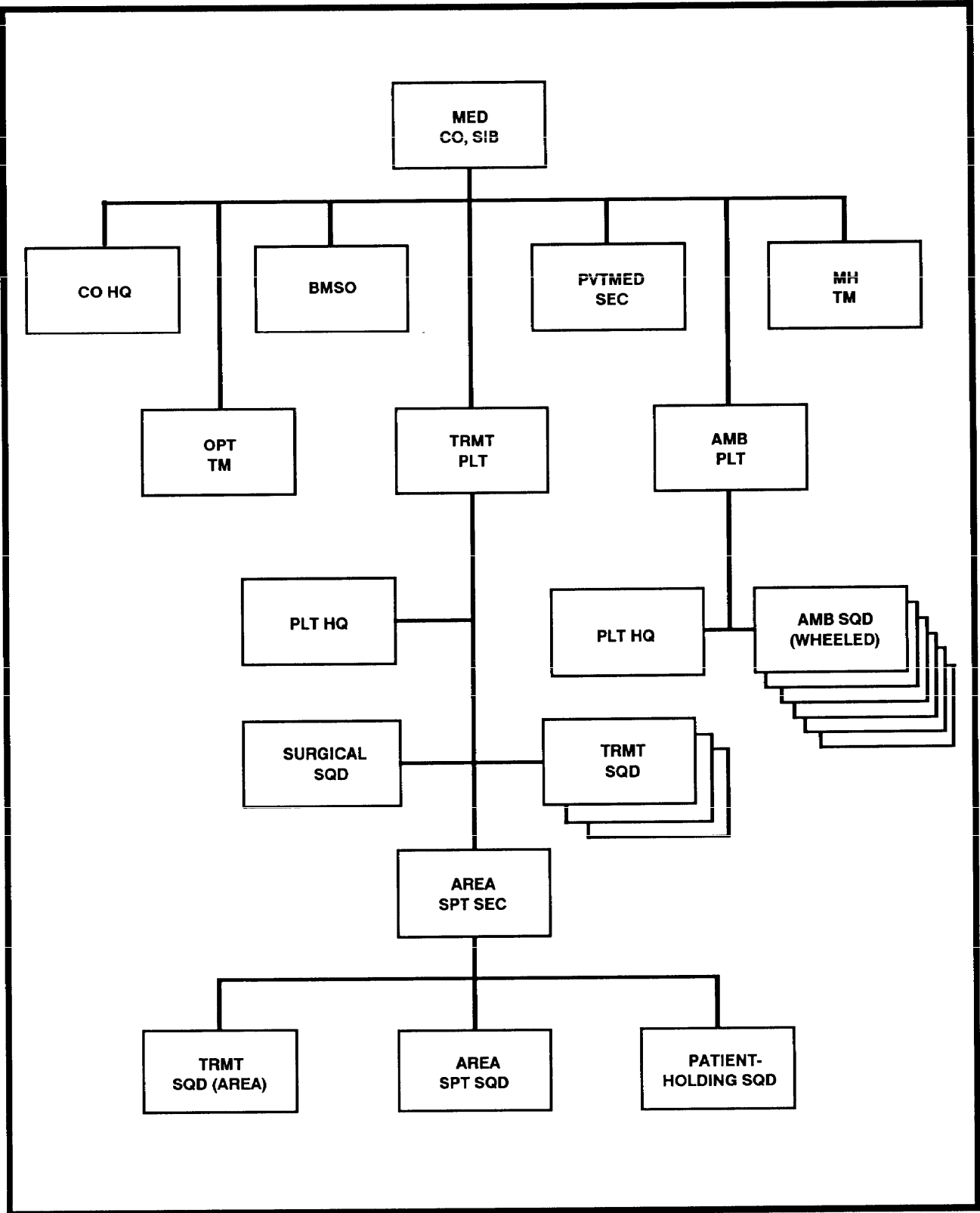


Figure 10-2. Medical company, separate infantry brigade.

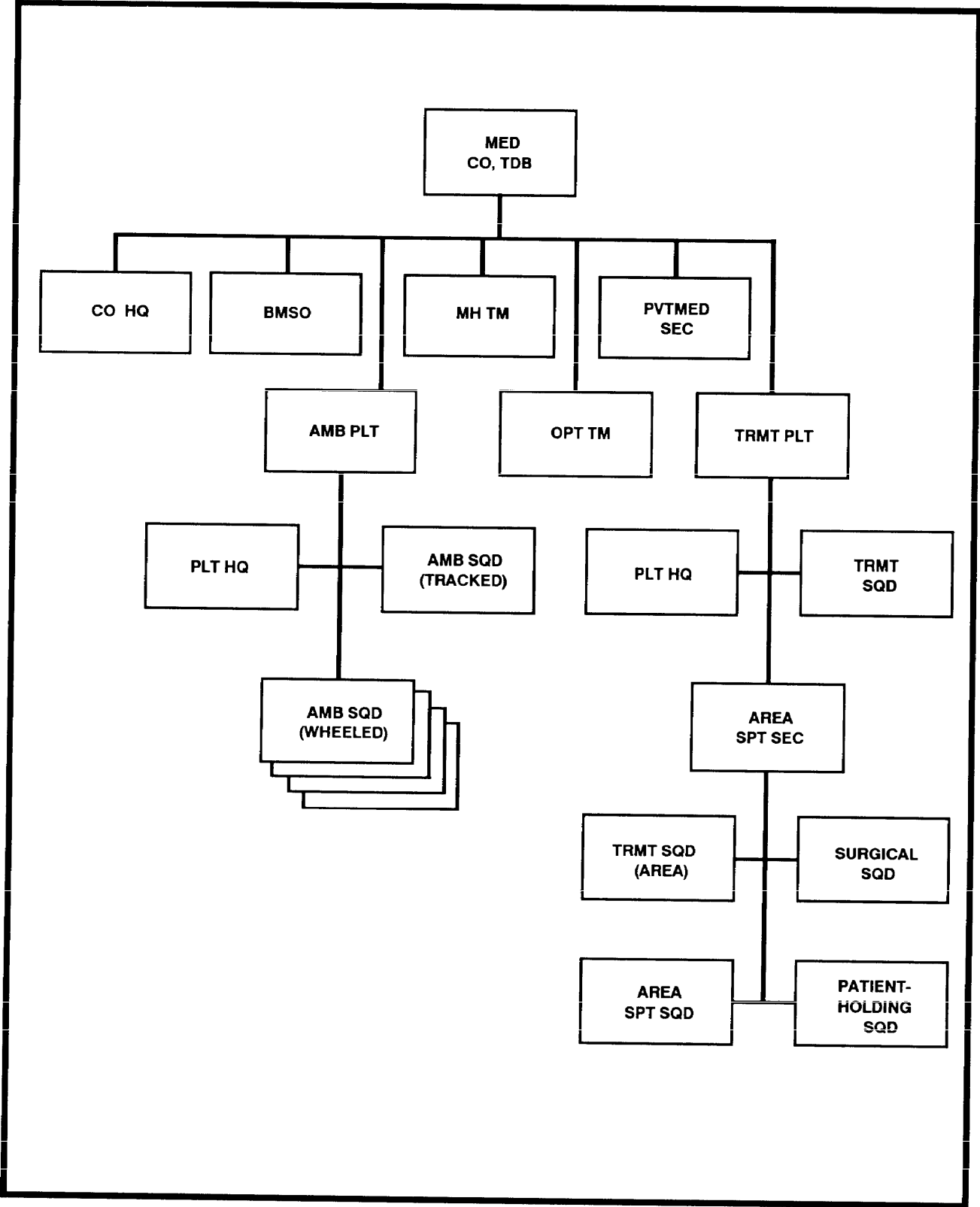


Figure 10-3. Medical company, theater defense brigade.

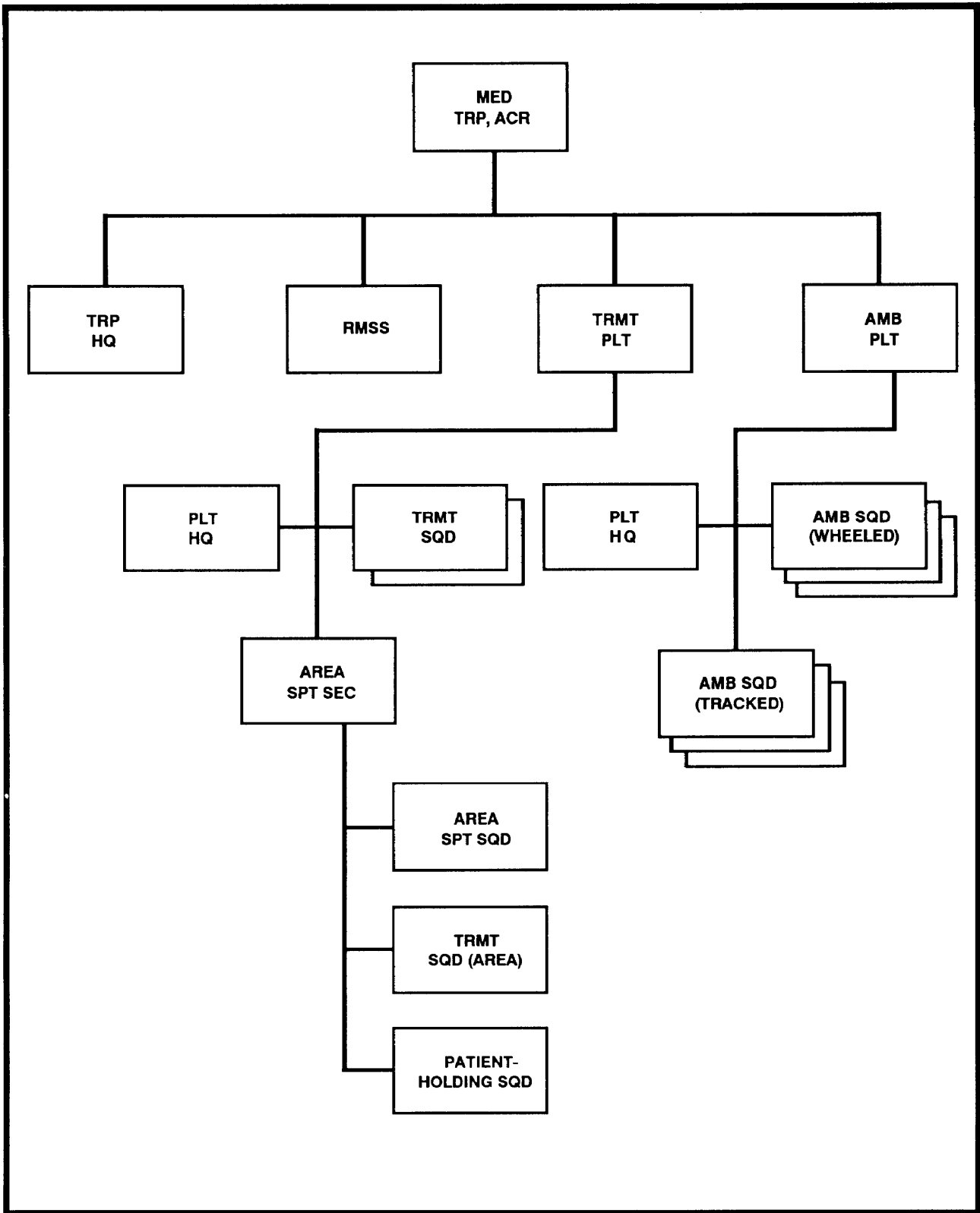


Figure 10-4. Medical troop, armored cavalry regiment.

Medical support originates in the forward area with a combat medic supporting each combat platoon. From this point HSS personnel evacuate a patient through the medical platoon BAS of a maneuver battalion to the support battalion medical company, if required. The support battalion medical company functions as the brigade clearing station. Five modules of the modular support system are —

- **Combat medic.** The combat medic is the first person in the HSS chain who makes medically substantiated decisions based on formal training. The combat medic is organic to medical platoons and sections of combat and combat support battalions. Medics provide support to the platoons and companies of the battalions.
- **Ambulance squad.** This squad, which can split into two teams, evacuates patients and provides care en route.
- **Treatment squad.** This squad provides advanced trauma management to battlefield casualties. ATM is emergency care that resuscitates and stabilizes patients for evacuation. Squads are organic to medical platoons of maneuver battalions and to support battalion medical companies. When not engaged in ATM, these squads provide routine sick call on an area basis. The treatment squad also treats and RTD those soldiers with minor illnesses or injuries.
- **Area support squad.** The area support squad provides emergency dental care and basic medical laboratory and X-ray diagnostic support. The squad collocates with a treatment squad and patient-holding squad. The three form an area support section. This section provides HSS on an area basis.
- **Patient-holding squad.** This squad holds and provides minimal care for up to 40 patients who return to duty within 72 hours. This squad is organic to the support battalion medical company.

ECHELONS OF CARE

The objective of HSS is to conserve trained manpower. The tailored and phased HSS system ensures the greatest number of RTD personnel as far forward as possible. Echelons of care provide medical treatment. Each echelon of care contains capabilities represented by each lower echelon of care or treatment (Figure 10-5).

Echelon I (Unit Level)

Designated individuals or elements organic to combat, CS, and medical units provide this medical support and

treatment. Unit-level HSS places major emphasis on those measures (maintain the airway, stop bleeding prevent shock) necessary to stabilize. Unit-level HSS allows for the evacuation of the patient to the next level of care.

Individual. This immediate far forward care consists of those life-saving steps that do not require the knowledge and skill of a physician. Two different skill levels provide the care required in the forward area and form a major source of RTD personnel.

- **Self-aid/buddy-aid.** Each soldier is proficient in a variety of specific first aid procedures. These procedures include aid for chemical casualties, with particular emphasis on lifesaving tasks. This training enables the soldier or buddy to apply immediate care to alleviate a life-threatening situation. FM 21-11 discusses lifesaving measures.
- **Combat lifesaver.** The unit commander selects non-medical unit members to receive additional training to increase medical skills beyond basic first aid procedures. After training these soldiers are called combat lifesavers. The unit commander selects one soldier per squad, crew, team, or equivalent-sized unit. The soldier performs the additional duty of combat lifesaver when the tactical situation permits.

Combat Medic. This is the first individual in the HSS chain who makes medically substantiated decisions based on medical MOS-specific training.

Treatment Squad (Battalion Aid Station). This element has personnel trained and equipped to provide physician-directed ATM. They provide ATM to battlefield casualties and, when not engaged in combat, routine sick call. Like elements provide this level of care in division, brigade, corps, and COMMZ units.

Echelon II (Division Level)

This echelon is also known as division level. HSS personnel provide care at the clearing station which is operated by the treatment platoon of a medical company. Additional capabilities include enhanced diagnostic aids, emergency dental care, radiological and laboratory services, and limited holding capacity. Here, HSS personnel evaluate the patient to determine his priority for continued evacuation to the rear or they treat and RTD him.

Echelon III (Corps)

Echelon III is the lowest echelon with hospital facilities. Within the COMMZ, the mobile army surgical hospital and the combat support hospital provide

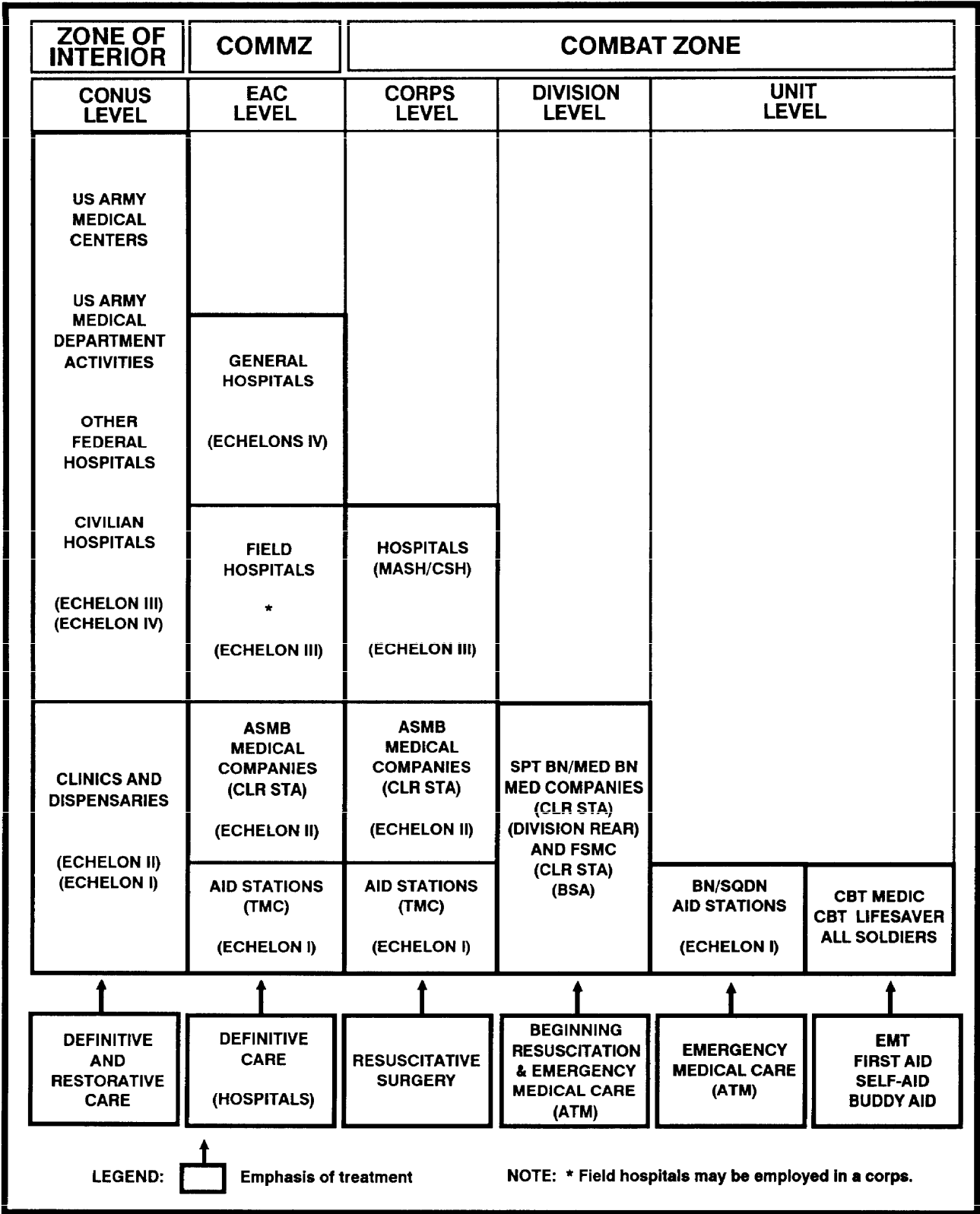


Figure 10-5. Levels and echelons of health service support.

the capability for initial surgery/medical intervention. HSS personnel stabilize patients for continued evacuation or RTD. In the COMMZ, the field hospital provides Echelon III area support and RTD care. Although the field hospital is located in the COMMZ, it is an Echelon III facility.

Echelon IV

At this echelon, HSS personnel may treat the patient at the general hospital. The COMMZ facilities are more sophisticated and specialized. Emphasis is directed to definitive care. HSS personnel may stabilize the patient for further evacuation to CONUS or for reconditioning rehabilitation for RTD.

Echelon V

Medical support provides this echelon of care in CONUS. HSS personnel evacuate to CONUS those patients not expected to RTD within the theater evacuation policy. Military facilities and Bureau of Veteran Affairs hospitals provide hospitalization, possibly overflowing into civilian hospitals.

MASS CASUALTY MANAGEMENT

Early medical intervention and sorting and continuing evaluation of patients are necessary to minimize mortality and morbidity. Forward medical support is critical to meet this need. Medical planners and leaders anticipate and manage mass casualty situations. These situations severely tax brigade and corps medical systems. When possible, the brigade shifts its resources to meet these needs. The corps medical brigade/group has to provide additional resources.

The keys to managing these situations are the use of on-site triage and EMT teams, effective communications, and skillful use of air and ground ambulances. Rapid buildup of evacuation assets at the mass casualty location eases the situation. Also, planning for prompt movement of patients to all available treatment facilities helps. This move dissipates the medical work load by distributing casualties on the basis the patient's condition and the treatment facility capabilities.

Medical planners establish and thoroughly coordinate medical contingency plans for the handling of

mass casualty work loads. They synchronize other battlefield operating systems to alleviate the situation. Planning includes –

- Deploying (immediately) available treatment and evacuation elements in direct support of the affected force for triage and evacuation.
- Coordinating for on-call available corps medical assets to support the forward medical company so it can continue to support forces not affected.
- Maintaining brigade SOPs for the use of nonmedical vehicles and aircraft to alleviate Level II medical evacuation backlog.
- Identifying nonmedical vehicles to help in evacuation.
- Providing en route medical care on nonmedical vehicles.
- Identifying required communications nets and procedures.
- Identifying procedures for medical equipment exchanges.
- Identifying the sites of medical facilities.

In mass casualty situations, the principle behind medical management changes from treating the worst cases first to providing the greatest good to the greatest number. At no time is the abandonment of a single patient contemplated. Medical managers base the categorization and scope of treatment on clinically sound criteria. They place emphasis on what can be done to save the lives of as many casualties as possible. As each patient moves from one treatment station to another (BAS to brigade clearing station), his condition is continually evaluated. Once medical assets are no longer overwhelmed by the number of casualties, treating the worst first again becomes the overriding principle.

CENTRALIZED CONTROL

The medical company commander retains control of the medical company assets. Medical resources are limited. The medical company commander employs medic-id elements to respond to the brigade commander's plans in a timely manner.

SECTION FUNCTIONS

COMPANY HEADQUARTERS

The company headquarters provides command and control of the company and other medical units that are

attached. It provides unit-level administration, general supply, and NBC operations and communications support. FM 10-14 discusses unit supply operations, FM 43-5

discusses unit maintenance, and FM 10-63-1 discusses unit mortuary affairs functions.

The medical company commander also serves as the brigade surgeon. As such, he keeps the brigade commander informed on the medical aspects of brigade operations and the health of the command. He regularly attends brigade staff meetings to provide this input and to obtain information to facilitate medical planning. Specific duties in this area include –

- Assures implementation of the health service support section of the brigade SOP.
- Recommends the allocation of medical resources within the brigade.
- Supervises technical training of medical personnel and the combat lifesaver program in the brigade or ACR.
- Determines procedures, techniques, and limitations in the conduct of routine medical care, EMT, and ATM.
- Monitors and coordinates requests for aeromedical evacuation from supported units.
- Ensures implementation of automated medical systems.
- Informs the COSCOM surgeon (and DISCOM surgeon if operating as part of a division) on the brigade's medical support situation.
- Monitors the health of the command and advises the commander on measures to counter disease and nonbattle injury.
- Assumes operational control of augmentation medical units when directed.
- Exercises technical supervision of subordinate battalion or squadron surgeons.
- Assumes technical supervision of the physician assistants organic to subordinate units in the absence of their assigned physicians.
- Provides the medical estimate (FM 8-55) and medical threat input for inclusion in the commander's estimate.

BRIGADE MEDICAL SUPPLY SECTION

The BMSS plans, supervises, and controls medical supply and medical equipment support for the brigade. The BMSS provides Class VIII resupply, medical equipment repair parts, and medical equipment maintenance support to brigade and attached units on an area basis. The BMSS develops and maintains prescribed loads of

contingency medical supplies. It manages the medical quality control program and supervises unit biomedical equipment maintenance support. The section monitors the brigade medical assemblage management program. It also coordinates the development of preconfigured Class VIII packages.

PREVENTIVE MEDICINE SECTION

The PVTMED section supervises the command preventive medicine program and ensures preventive medicine measures that protect brigade personnel against the following

- Food-borne diseases.
- Water-borne diseases.
- Arthropod-borne diseases.
- Environmental injuries (heat and cold injuries).

This section provides advice and consultation in the areas of environmental sanitation and epidemiology. It provides the same for entomology, limited sanitary engineering, and pest-management. This section also trains unit field sanitation teams.

The specific functions of this section include but are not limited to the following:

- Assists the brigade surgeon in staff estimate preparation.
- Assists the battalion S2/S3 in determining requirements for medical intelligence collection, particularly with respect to disease prevalence. See FM 8-10-8 for more information on medical intelligence collection.
- Deploys PVTMED teams in support of specific units and operations.
- Monitors water supplies.

MENTAL HEALTH SECTION

The HSB mental health section (for the SIB/TDB – mental health team) provides staff supervision for the command preventive psychiatry/combat stress control program in accordance with AR 40-216. The section collocates with the brigade clearing station in the BSA. Acting for the brigade surgeon, this section establishes policy and guidance for the prevention, diagnosis, management, and RTD of battle fatigue casualties. It has technical responsibility for the diagnosis, treatment, and disposition of neuropsychiatric disorders and disease cases. It also has responsibility for the psychological aspect of nuclear surety programs.

During tactical operations, mental health personnel ensure a 24-hour NP diagnostic and evaluation capability at the clearing station. The brigade psychiatrist or his authorized representative evaluates the BF and NP patients before they are evacuated out of the brigade. If patients will RTD within 72 hours, mental health personnel hold them for treatment at the BSA patient-holding facility. In cases where patients require longer than the holding policy at brigade level allows, HSS personnel transfer them to the corps-level CFRP facility.

For all BF and NP patients being RTD, the mental health personnel work actively through the personnel system. They also work through contact with each soldier's unit to ensure successful reintegration into his original unit or into a new unit.

OPTOMETRY SECTION

The optometry section provides treatment within the capabilities of its equipment. It focuses on prevention of eye problems and support of the treatment squads. The optometry section also provides:

- Routine eye examinations and refraction.
- Spectacle frame assembly using presurfaced single-vision lens.
- Optical repair services.

TREATMENT PLATOON

The treatment platoon operates the brigade clearing station in the BSA. It also provides assets to reinforce supported unit medical elements. Platoon elements receive, triage, treat, and determine disposition of patients. The treatment platoon in each medical company has a headquarters, treatment squads, and an area support section.

The platoon headquarters is the command and control element of the platoon. It determines and directs the disposition of patients and coordinates their further evacuation.

The area support section operates the brigade clearing station. The area support section consists of several squads that operate as a single medical unit and are not normally used to reinforce other units. The area treatment squad is the base treatment element of the clearing station. The squad consists of two teams which provide troop clinic service, trauma treatment, and tail-gate medical support. When the clearing station moves, one of the treatment squads along with elements of the holding squad serves as a jump element. They set

up the new clearing station while remaining elements close out operations at the old site. The area support squad consists of the dental and diagnostic support elements of the clearing station. The patient-holding squad operates a 40-bed facility for patients awaiting evacuation and patients expected to be RTD within 72 hours.

The surgical squad in the HSB and SIB/TDB provides lifesaving or initial surgical service to brigade units. It performs early surgery whenever a likely delay in the evacuation of a patient threatens life or the quality of recovery. The squad performs initial surgery for up to 40 wounded/injured patients with its organic medical equipment set. The squad collocates with the patient-holding squad to provide pre/postoperative care.

Each of the medical companies has four treatment squads in the treatment platoon. (In the separate brigade, one of the squads is included in the area support section. In the ACR, two are.) Each squad employs treatment vehicles with medical equipment sets — two trauma sets and two general sick call sets. These squads provide troop clinic services and trauma treatment. The treatment platoon reinforces supported units medical elements and alleviates mass casualty situations. Each treatment squad may be split into two treatment teams. The treatment squads are not track mounted. They carry the equipment and supplies necessary to treat chemical agent casualties, to include the M51 shelter system.

AMBULANCE PLATOON

The ambulance platoon performs ground evacuation from units in the brigade area requiring brigade-level medical treatment. It provides ambulance reinforcement to the battalion aid stations. It also provides ambulance support from designated collection points to the clearing station. The platoon has a headquarters and ambulance squads. Refer to Figures 10-1, 10-2, 10-3, and 10-4 for the number and type of ambulance squads for each separate brigade. The headquarters provides command and control and plans for the employment of the platoon. It coordinates support with the medical platoons of the supported maneuver battalions. It also plans ambulance routes and establishes AXPs for ground and air ambulances as required. Each squad splits into two ambulance teams and provides evacuation from forward areas.

OPERATIONS

The company commander/brigade surgeon has direct access to the brigade commander. He advises the brigade commander on medical aspects of brigade operations and on the health of brigade personnel. The company XO (the field medical assistant) is the principal assistant to the company commander on the tactical employment of the company assets. Figure 10-6 shows a sample medical company layout. The basic considerations which influence the employment of medical assets within the brigade are —

- The brigade commander’s plan.

- The anticipated patient load.
- Expected areas of casualty density.
- Medical treatment and evacuation resources available.

Within their limits, HSS personnel may have to defend themselves against a Level I threat. Planners include HSS in rear operations and area damage control planning.

Having a single manager of HSS in an area of operations enables shifting scarce medical resources. The

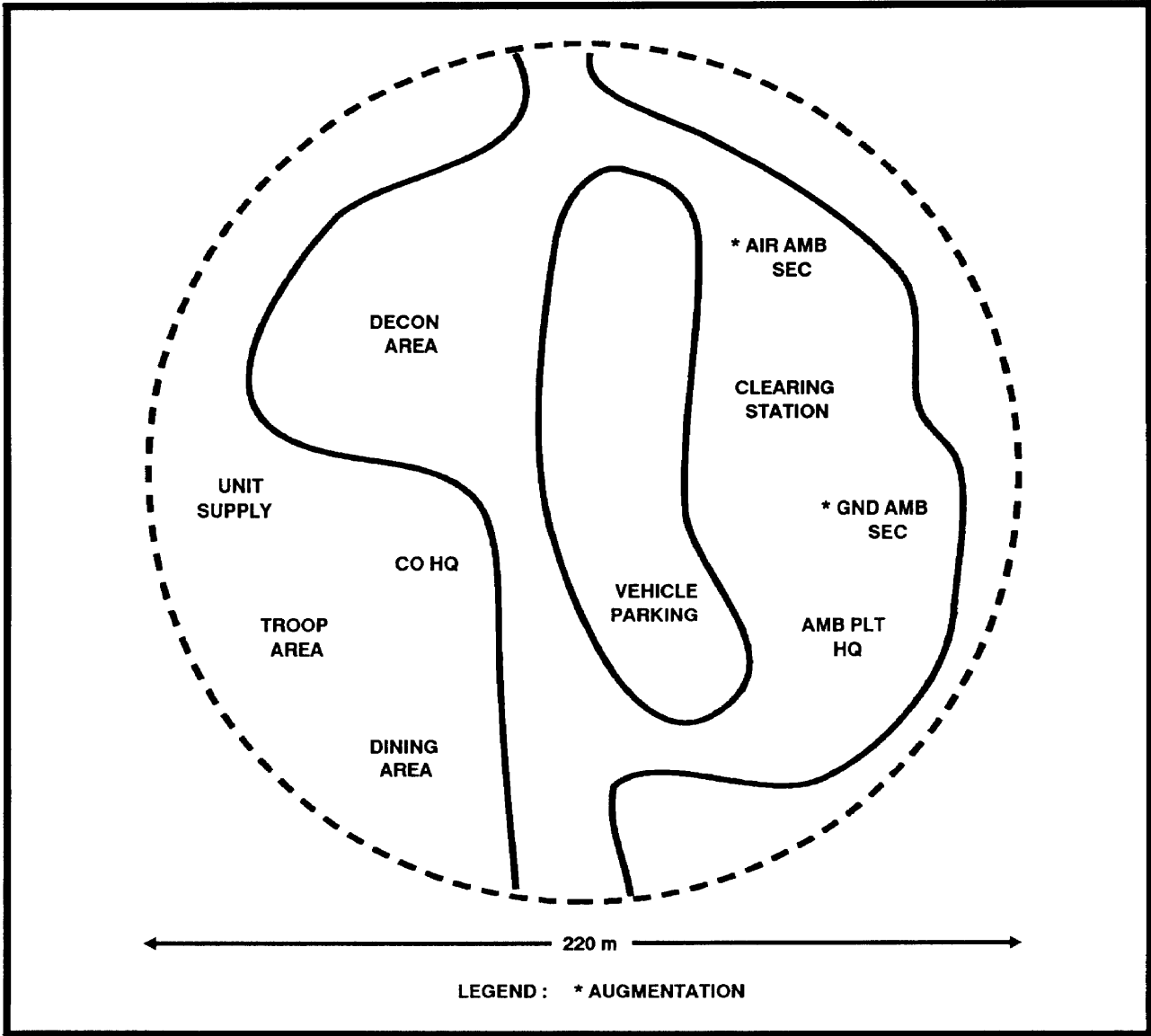


Figure 10-6. Sample medical company layout.

medical company commander ensures that the medical annex of the OPLAN includes –

- Procedures to handle and treat NBC casualties and provision for chemical protective shelter systems and decontamination augmentation.
- Provision for A2C2 for supporting air ambulances and for road clearances and MSR priorities for ground ambulances.
- Augmentation of medical support assets for contingency operations. This may include ground and air evacuation assets, modular trauma treatment squads/teams, and combat stress control augmentation.
- Provision for medical representation on casualty damage assessment elements.

Several provisions of the Geneva Conventions affect HSS operations in the brigade sector. HSS personnel treat and evacuate the sick, injured, and wounded prisoners through normal channels. Medical personnel do not guard prisoners. The echelon commander provides the guards. However, personnel physically segregate prisoners from US and allied patients. Medical personnel evacuate EPW patients from the combat zone as soon as possible. HSS personnel retain only those EPWs whose medical condition renders them nontransportable. They retain them temporarily in the combat zone until their condition permits further evacuation. Medical personnel are required to treat civilian casualties. These patients are transferred to civilian facilities at the earliest possible time. The Geneva Convention protects properly identified personnel performing medical duties in medical units. Details are in DA Pamphlet 27-1 and FMs 8-10 and 27-10.

The medical company, in coordination with the support battalion S2/S3, also develops a combat lifesaver program for support battalion personnel. Training is most critical for elements which deploy separately such as MSTs, contact teams, and truck drivers. However, the program covers all elements of the support battalion.

CLEARING STATION OPERATIONS

The treatment platoon of the medical company operates the clearing station. It collocates with the mental health, preventive medicine, and optometry sections. Also operating at the clearing station are any elements of the FSMC treatment section not deployed forward. In addition to providing Level II support for units in the brigade area, the clearing station provides unit-level

support to units in the BSA without organic medical assets. The clearing station also serves as the backup for the BAS. During static situations, ambulance teams are also stationed at the clearing station. They provide routine sick call runs and emergency standby support to units operating in and around the BSA. A suggested layout of a typical clearing station with surgical squad capability is shown in Figure 10-7.

The clearing station performs the functions discussed for the area support section of the treatment platoon. HSS personnel give necessary treatment to seriously ill or wounded patients arriving at the station. They also stabilize the patients for movements. Medical and dental officers treat patients with minor injuries and illnesses within their capability. They hold these patients for continued treatment or observation for up to 72 hours. They treat and immediately RTD or they evacuate them to the appropriate MTF for further treatment or evaluation. Other functions of the clearing station include –

- Providing consultation and clinical laboratory and X-ray diagnostics for unit physicians and physician assistants.
- Recording all patients seen or treated at the clearing station and notifying the brigade S1.
- Verifying the information contained on the field medical card of all patients received at the MTF.
- Monitoring casualties when necessary for NBC contamination before medical treatment. Details are in FMs 8-9 and 8-10-4 and TM 8-215.
- Ensuring NBC casualties are properly handled according to the guidance in Chapter 2 of this manual.

After an attack on the BSA, a treatment team of the treatment section and an ambulance team may be OPCON to the BCOC as part of the ADC element. Units are responsible for collecting casualties. They provide first aid and get casualties to a medical facility.

The preventive medicine section and unit field sanitation teams use preventive medicine measures to protect against food- and water-borne diseases. They use such measures to protect against arthropod-borne diseases and environmental injuries (such as heat and cold injuries). The section emphasizes preventive measures. In past conflicts, more soldiers have become ineffective from DNBI than as a direct result of combat. The section cannot wait until problems appear to take action. For example, it cannot wait for the first case of

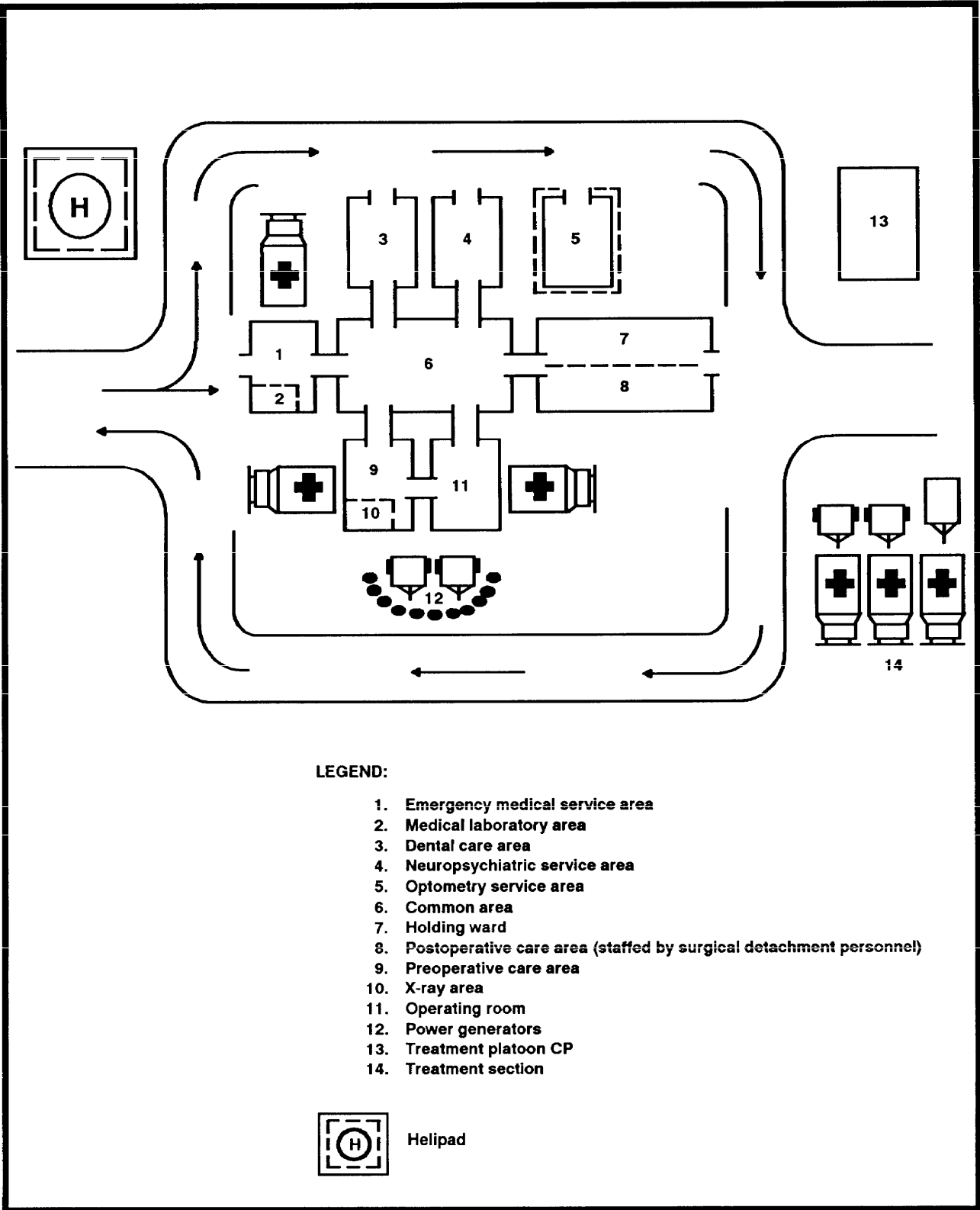


Figure 10-7. Suggested layout of a brigade clearing station.

malaria or sandfly fever to suppress mosquito or sandfly populations in troop assembly areas. The section may coordinate with the designated civil-military officer and the local population. See AR 40-5 for more on preventive medicine.

In the mental health team, the brigade combat stress control coordinator advises the brigade surgeon on mental health considerations. He keeps abreast of the tactical situation and plans for BF/NP care when maneuver units are pulled back for rest and recuperation. He assists in patient triage and ensures BF/NP patients are handled properly. Normal treatment follows these guidelines:

- HSS personnel give mild (duty) cases a brief respite of one to six hours of comfort and reassurance and return them to their units.
- HSS personnel may assign moderate (rest) cases to work at a logistics facility in the BSA for one to two days. During this time, however, they are under medical supervision. The medical company remains responsible for such services as feeding the patients. Moderate cases may also be held at the holding facility if space is available.
- HSS personnel hold serious (hold) cases in the clearing station holding facility for up to 72 hours if behavior is not too disruptive. The brigade CSCC provides guidance to clearing station personnel on treating BF/NP patients. Treatment consists of sleep, hydration, quality food, hygiene, general health measures, and restoration of confidence. It also includes soldierly work details and individual counseling. The attending physician prescribes medication only to briefly aid in sleep or to control disruptive behavior. The CSCC also helps the attending physician to coordinate RTD of patients fit to perform normal duties.
- HSS personnel evacuate more serious (refer) cases beyond the ability of the clearing station to manage to the supporting division MSB medical company. If the brigade is not operating with a division, HSS personnel evacuate the soldier to the corps. Ambulance aides use physical restraints during transportation when necessary. HSS personnel do not use air ambulance unless no other alternative is feasible. The physician, in coordination with the brigade CSCC, transfers soldiers who cannot RTD in three days directly to a corps reconditioning facility. In such cases, the physician annotates the patient's field medical card as "battle

fatigue" unless a specific neuropsychiatric disorder has been formally established.

EVACUATION

The ambulance platoon of the support battalion medical company provides evacuation. This platoon's ground ambulance assets normally provide evacuation to the FSMC clearing station from forward sites. Figure 10-8 shows the flow of patient evacuation.

The FSMC ambulance platoon and a forward air ambulance team of the supporting corps air ambulance company normally provide evacuation from the BAS. These assets also support other units in the brigade area on an area basis. Typically, the FSMC field sites one team from the ambulance platoon at each BAS. The ambulance platoon locates the other ambulances at AXPs. They also locate them at designated patient collecting points or at the clearing station. Within the BSA, units are responsible for getting wounded, injured, and sick soldiers to the clearing station.

An ambulance exchange point is a point where patients are exchanged from one ambulance to another. Planners normally designate these points as a part of the HSS plan. Support battalion tracked and wheeled vehicles carry patients from the BAS to an AXP where wheeled or tracked ambulances take over for the trip to the brigade rear. Use of AXPs returns evacuation assets to their support positions faster because the crews are familiar with the road net and the supported unit's tactical situation.

Another form of ambulance shuttle system involves the use of ambulance loading points and relay points. In this type of system, ambulance loading points are stationed ready to receive patients. Medical personnel station ambulances at relay points ready to replace ambulances leaving loading points to evacuate patients. They also require control points at crossroads or junctions to direct empty ambulances from relay points to loading points.

An air ambulance team of the corps air ambulance company is normally field sited at the BSA. Administrative and logistics responsibilities, discipline, internal organization, and training are the responsibility of the parent air ambulance company. The team leader knows the tactical planning process well enough to ensure appropriate employment of the air evacuation assets. He also obtains the required airspace management information. He coordinates aviation support requirements and airspace C2 matters with the brigade S3 (air). When

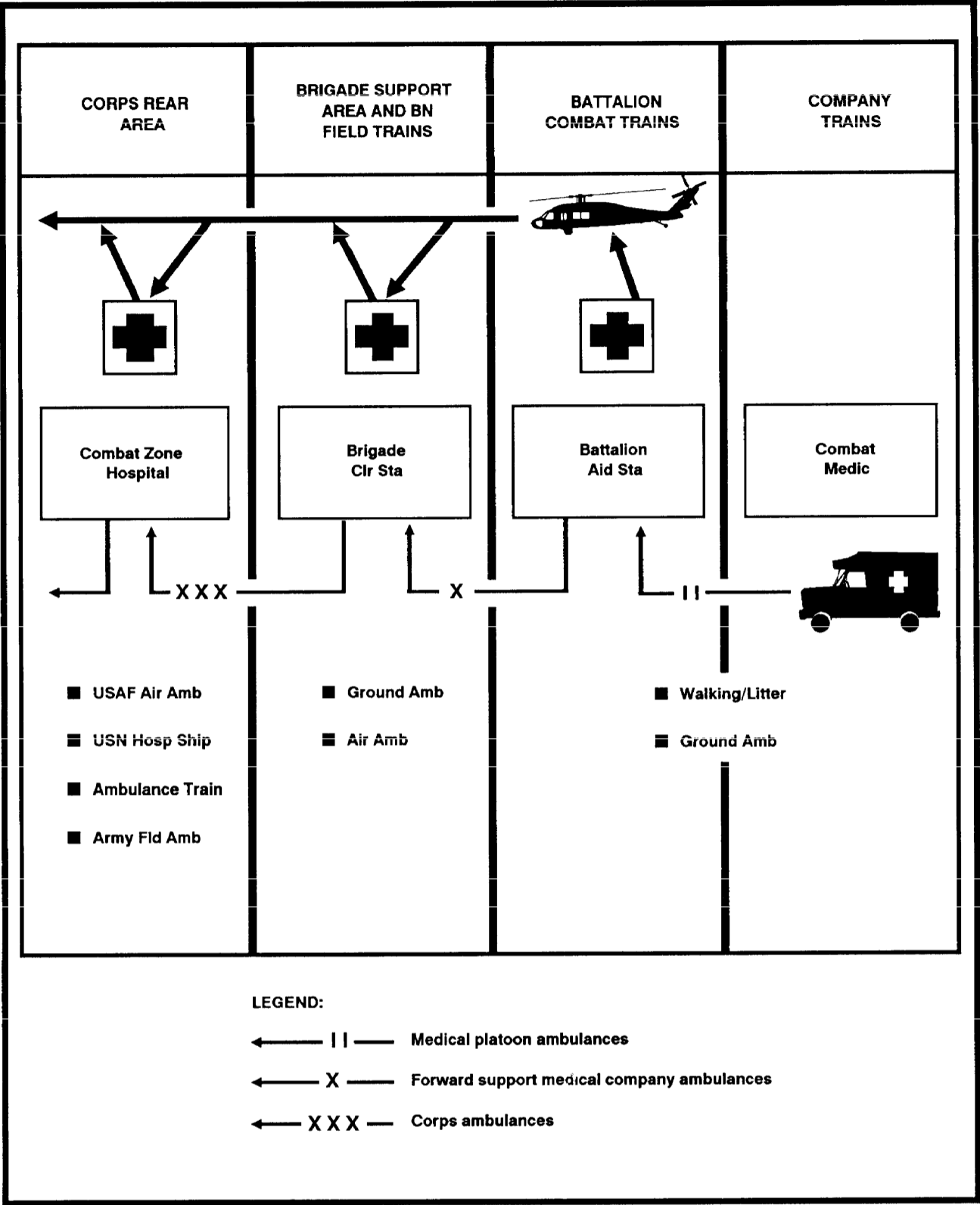


Figure 10-8. Patient evacuation flow.

air superiority exists, the team evacuates urgent patients from battalion aid stations to the BSA clearing station. The treatment platoon sets up and marks the helicopter landing zone at the forward triage site.

In determining which of the available means of evacuation (air or ground) is the most appropriate, the treating physician specifies the mode of transportation which best supports the clinical condition of the patient. As a minimum, he considers the following factors:

- The clinical condition of the patient, with the principal consideration being which mode of transportation contributes least to the patient's morbidity.
- The current tactical situation as it impacts upon the safety of the patient and the evacuation means.
- The geographical and climatic conditions.
- The time and distance to a supporting treatment facility as these relate to a patient's condition.

Patients' units normally keep ammunition and individual weapons belonging to patients to be evacuated out of the brigade. If they do not and patients arrive with weapons or ammunition, the clearing station collects and disposes of them according to command SOP. Options include giving them to the brigade S4, the support battalion S4, or the supported unit's designated representative.

CLASS VIII SUPPLY

Medical logistics systems provide medical supplies, equipment, and repair parts. The brigade medical supply section manages Class VIII items. This function includes the management of medical maintenance for the brigade.

The brigade's mission, its location, and guidance from the brigade surgeon and the COSCOM surgeon determine the number of days of supply and additional items for the BMSS to maintain. Brigade units normally stock two days of medical supplies. The BMSS maintains five days of supplies. During the initial deployment, lodgment, and early buildup phases each FSMC receives preconfigured push-packages of medical supplies. The LOGPLAN defines preconfigured medical supply packages tailored to meet the mission. Supply personnel normally send these packages directly to the brigade until the MEDLOG battalion sets up line item requisitioning. While preconfigured packages are intended for use during the initial phase, operational needs may dictate continued use in exceptional cases. Brigade planners coordinate such support with the MEDLOG battalion.

Once the routine supply system is established, the BMSS issues from stocks on hand or sends the requisition to the MEDLOG battalion. The BMSS coordinates shipment of materiel from the corps to the forward area with the brigade transportation office. Returning evacuation assets also carry supplies forward.

Trauma and sick call sets make up most of the sets in the brigade. The commonality of these sets allows the supply system to satisfy the brigade's major medical resupply need through a simple resupply process. Corps medical logistics units prepackage supplies to reconstitute the sets. Each set has three to five days of supplies for the brigade. The bulk of the BMSS stocks consist of these sets.

UNIT MEDICAL MAINTENANCE AND OPTICAL SUPPORT

The biomedical equipment specialist provides medical maintenance. The corps MEDLOG battalion provides higher level support.

The medical company provides single-vision lens optical fabrication support. The corps MEDLOG battalion provides multivision lens fabrication support.

SUPPORT IN SPECIFIC TACTICAL SITUATIONS

Offense

The basic characteristics of HSS in offensive operations are –

- As areas of casualty density move forward, the routes of evacuation lengthen, requiring forward movement of medical assets.
- Heaviest patient loads occur during disruption of enemy main defenses, at terrain or tactical barriers. They also occur during assaults on final objectives.
- Initially, the medical company locates as far forward as combat operations permit. This tactic allows maximum use of facilities at the initial location, thus enhancing overall effectiveness of support.

Two basic problems confront the medical company in the offense. First, communications contact with supported units must be continuous. Also, the medical company must maintain the mobility of treatment elements. It maintains contact through evacuation elements operating between the unit-level facilities and the clearing station. Treatment elements are minimally staffed consistent with the patient work load. Medical personnel evacuate

patients as promptly as possible. Therefore, the medical company positions available ambulance assets forward.

The BMSS issues treatment elements maximum allowable loads of medical supplies before the start of the attack. From the clearing station, supplies move forward via ambulances in response to informal requests from supported medical elements and through exchange of medical equipment received from BASS.

Defense

HSS of defensive operations is more difficult than of offensive operations. Casualty rates are lower, but forward acquisition is complicated by enemy action and the initial direction of maneuver to the rear. Increased casualties among HSS personnel reduce treatment and evacuation capabilities. HSS personnel expect the heaviest casualties, including those produced by enemy artillery and NBC weapons, during the initial enemy attack and in the counterattack. Insecure ground routes permit evacuation only periodically. The enemy attack disrupts ground and air communications routes and delays evacuation of patients to and from aid stations.

The probability of enemy penetration requires locating treatment elements farther to the rear than in the offense. However, their locations should not interfere with the maneuver of reserve forces.

The depth and dispersion of the mobile defense create significant time and distance problems in evacuation support to security and fixing forces. Security forces are forced to withdraw while simultaneously carrying their patients to the rear.

Retrograde

HSS in retrograde movements varies widely. It depends upon the operations, the enemy reaction, and the situation. Firm rules for all retrograde operations are difficult to set, but planners consider certain factors:

- Time is extremely important in retrograde operations. With less time available, the brigade surgeon

carefully evaluates the capability to collect, treat, and evacuate all patients.

- The enemy disrupts command, control, and communications. SOPs delineate measures to counteract factors impeding evacuation.
- Sorting of patients is critical. Planners consider the type of transportation available for evacuation. The ambulance platoon evacuates seriously wounded patients as quickly and comfortably as possible. Proper sorting and rapid evacuation of patients lessen the need to setup complete medical clearing stations.
- When a patient's condition precludes movement or when the patient load exceeds the means to move them, the tactical commander decides whether or not to leave patients behind. The surgeon ensures that the tactical commander understands the need to reach a timely decision in this regard. HSS personnel and supplies stay with patients left behind.
- Planners identify locations for successive positions. Generally, movement is toward existing medical elements. Initial locations are farther to the rear than in other types of operations. For continuity of support, medical personnel occupy and prepare the next rearward location before closing the forward facility.
- The rate of movement, the distance involved, and the tactical situation determine the frequency of displacement. Support battalion medical elements move before there is danger of involvement in the action of forces conducting the retrograde.

A rearward passage of lines requires detailed planning between surgeons of the units concerned. Planning covers patient collection points and AXPs with corps assets. It also covers Class VIII resupply. Medical elements remain mobile. This permits their rapid movement without the need to abandon patients. The medical planner helps maintain mobility by keeping the patient load low by coordinating evacuation with supporting medical elements.