CHAPTER 9

Medical Company

CONTENTS

ORGANIZATION AND MISSION

The forward support medical company plays a vital role in the manning task by providing division- and unit-level health service support to all units operating in the supported brigade area on an area basis. As shown in Figure 9-1, the company consists of a company headquarters, treatment platoon, and ambulance platoon.

The company performs the following functions:

- Treatment of patients with minor diseases and illnesses, triage of mass casualties, initial resuscitation and stabilization, advanced trauma management, and preparation for further evacuation of patients incapable of returning to duty.
- Ground evacuation for patients from battalion aid stations and designated collection points.
- Emergency dental care.
- Emergency medical resupply 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.
- Coordination with the UMT for required religious support.

PRINCIPLES

MODULAR MEDICAL SUPPORT SYSTEM

The modular medical system standardizes all medical treatment subunits within the division. Modules are duplicated at different levels of health care to allow the medical

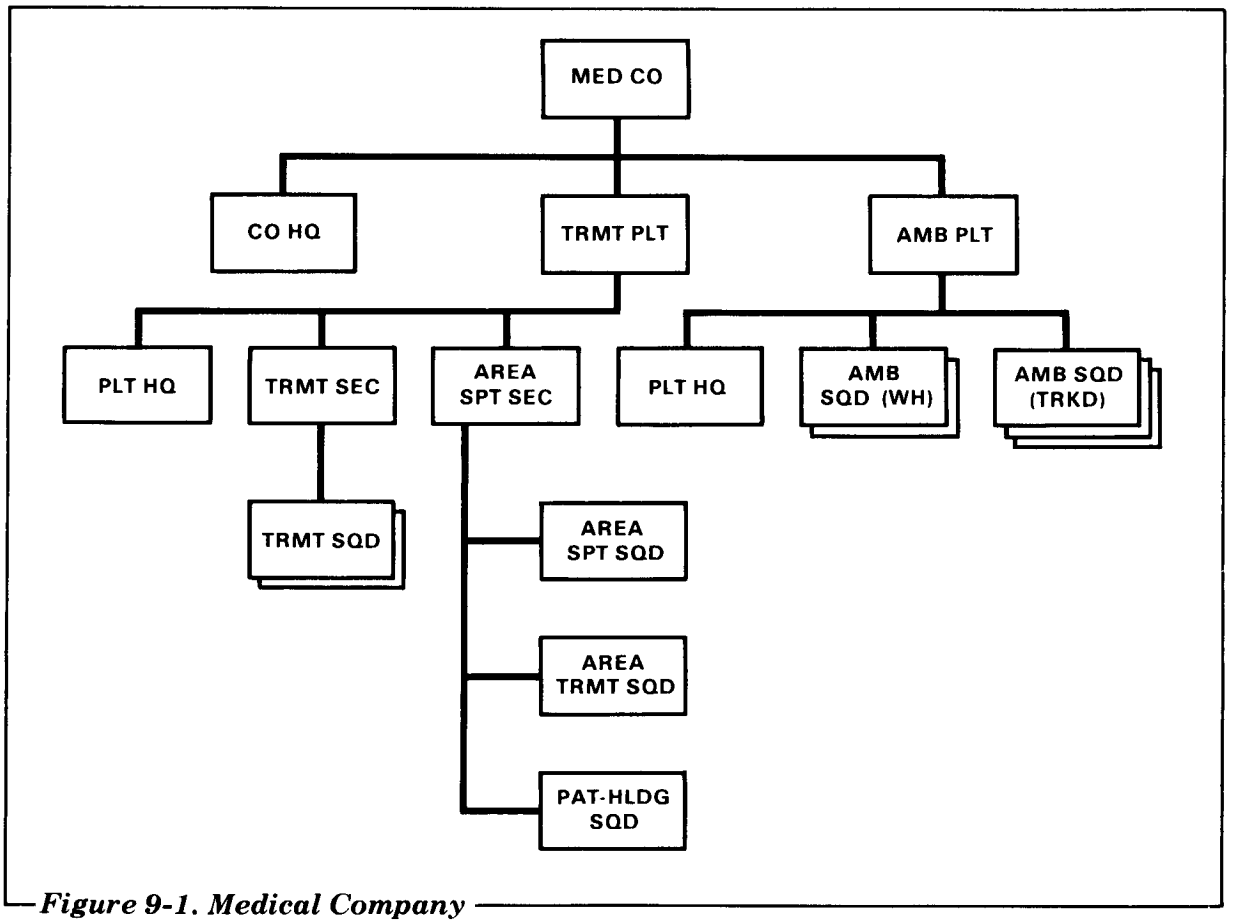

Figure 9-1. Medical Company

managers to rapidly tailor, augment, or reinforce medical units where the need is most critical. So if the FSB medical company cannot handle the work load in the brigade sector, additional modules may be sent forward from the MSB or corps. The system is oriented to patient acquisition, emergency medical treatment, initial resuscitation, patient holding, returning soldiers to duty, and patient evacuation. The five modules are—

- *Combat medic.* The combat medic is the first person in the health services support 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 ATM to battlefield casualties. ATM is emergency care designed to resuscitate and stabilize patients for evacuation or to treat and return to duty. Squads are organic to medical platoons of maneuver battalions and to FSB medical companies. When not engaged in ATM, these squads provide routine sick call on an area basis.
- *Area support squad.* The area support squad provides emergency dental care

and basic medical laboratory and X-ray diagnostic support. The squad is colocated with a treatment team and patient-holding squad. The three form an area support section. This section provides medical support on an area basis.

- *Patient-holding squad.* This squad can hold and provide minimal care for up to 40 patients who will return to duty within 72 hours. The squad is organic to the FSB and MSB medical companies.

TREATMENT PHASES

Only four phases of medical treatment are normally performed in the brigade area. These four—self-aid/buddy -aid, advanced first aid, EMT, and ATM—are collectively referred to as far forward medical care. This care maximizes return to duty of soldiers at the lowest possible level. It also provides stabilization and care for injured soldiers not expected to return to duty and allows for their rapid evacuation.

- Self-aid/buddy-aid is the lifesaving care given to an ill, injured, or wounded person by a nonmedical soldier. All soldiers are expected to know the lifesaving measures discussed in FM *21-11*.

- Advanced first aid is performed by the combat lifesaver. The combat lifesaver is a member of a combat, CS, or CSS unit who is not a medic but has received medical training beyond basic first aid. This function is an additional duty for the soldier.

- Emergency medical treatment involves medically substantiated decisions based on medical MOS-specific training. It is provided by the combat medic or EMT NCO. It includes emergency lifesaving measures, management of the airway, control of bleeding, and administration of intravenous fluids and medicinal drugs.

- ATM requires a higher degree of medical skill and judgment. It is performed at both the unit and division level by physicians assisted by physician assistants and EMT NCOs. ATM involves use of intravenous fluids and antibiotics, preservation of the airway by insertion of a breathing tube, and the application of more secure splints and bandages. This phase also involves laboratory and X-ray capabilities; a wide range of drugs, equipment, supplies, and intravenous fluids (including expander blood products); and a patient-holding capability.

FORWARD SUPPORT AND 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. Forward support is provided by medical company treatment elements working at battalion aid stations, reinforcing treatment capabilities before expected casualty-generating operations. It includes the positioning of tracked ambulances with battalion combat trains to maintain contact with the BAS during movement. Also, it involves establishing predetermined ambulance exchange points to reduce ambulance turnaround time and fuel consumption of tracked ambulances.

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. The categorization and scope of treatment are based on clinically sound criteria 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 (battalion aid station to division 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

Control of the medical company assets is retained by the medical company commander. Medical resources are limited. Therefore, the medical company commander must be able to employ medical elements to respond to the brigade commander's plans in a timely manner.

SECTION FUNCTIONS

COMPANY HEADQUARTERS

The company headquarters provides command and control for the company and other medical units that may be attached. It provides unit-level administration, general supply, and NBC operations and communications support. It also provides supply point distribution of class VIII items for the brigade. Unit supply operations are discussed in FM 10-14, unit maintenance in FM 43-5, and unit GRREG functions in FM 10-63-1. Unit biomedical maintenance is provided by the division medical supply office of the MSB medical company. C3 considerations for the headquarters are covered in Chapters 3 and 4. The headquarters may be organized into command, supply, operations and communications, dining facility, and maintenance elements.

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

- Assure implementation of the health service section of the division SOP.
- Determine the allocation of medical resources within the brigade.
- Supervise technical training of medical personnel and the combat lifesaver program in the brigade area.
- Determine procedures, techniques, and limitations in the conduct of routine medical care, EMT, and ATM.
- Monitor and coordinate requests for aeromedical evacuation from supported units.
- Ensure implementation of automated medical systems.
- Inform the division surgeon on the brigade's medical support situation.
- Monitor the health of the command and advise the commander on measures to counter disease and injury threats.
- Assume operational control of augmentation medical units when directed.
- Exercise technical supervision of subordinate battalion surgeons.
- Advise physician's assistants of artillery and engineer battalions as required.
- Assume technical supervision of physician assistants organic to subordinate units in the absence of their assigned physicians.

- Provide the medical estimate and medical threat input for inclusion in the commander's estimate.

TREATMENT PLATOON

The treatment platoon operates the division clearing station in the BSA and provides assets to reinforce supported unit medical elements. Platoon elements receive, triage, treat, and determine disposition of patients. The platoon consists of a platoon headquarters, an area support section, and a treatment 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 with the ambulance platoon.

The area support section operates the division clearing station. It consists of an area support treatment squad, an area support squad, and a patient-holding squad. These elements operate as a single medical unit and are not normally used to reinforce or reconstitute other units. The area support treatment squad is the base treatment element of the clearing station. The squad consists of two teams which provide troop clinic services, trauma treatment, and tailgate medical support. When the clearing station moves, one of the treatment teams 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 returned to duty within 72 hours. A temporary surgical capability can be given the clearing station by augmenting the area support section with a surgical detachment from corps assets.

The treatment section consists of two treatment squads. Each squad employs treatment vehicles with medical equipment sets—two trauma sets and two general sick call sets. These squads provide troop clinic services, trauma treatment, and tailgate medical support. This section is oriented toward augmenting or reinforcing supported units medical elements and alleviating mass casualty situations. Each squad may be split into two treatment teams.

AMBULANCE PLATOON

The ambulance platoon performs ground evacuation from battalion aid stations and designated collection points to the BSA clearing station. The platoon has a platoon headquarters and five ambulance squads. 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, 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

PLANNING

Planning for medical operations within the brigade area is done by the medical company commander/brigade surgeon and support operations section of the FSB in coordination with the medical operations center. In addition, the company XO (the field medical assistant) is the principal assistant to the company commander on the tactical employment of the company assets. A sample medical company layout is shown in

Figure 9-2. 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.

Medical planners use these factors to forecast the anticipated evacuation requirements in the main battle area and adjacent sectors. Having a single manager of health service support in an area of operations, enables shifting scarce medical resources. The medical company commander must also ensure that the medical annex of the OPLAN includes—

- Procedures to handle and treat chemical casualties and provision for chemical protective shelter systems and decontamination augmentation.
- Provision for surgical augmentation.

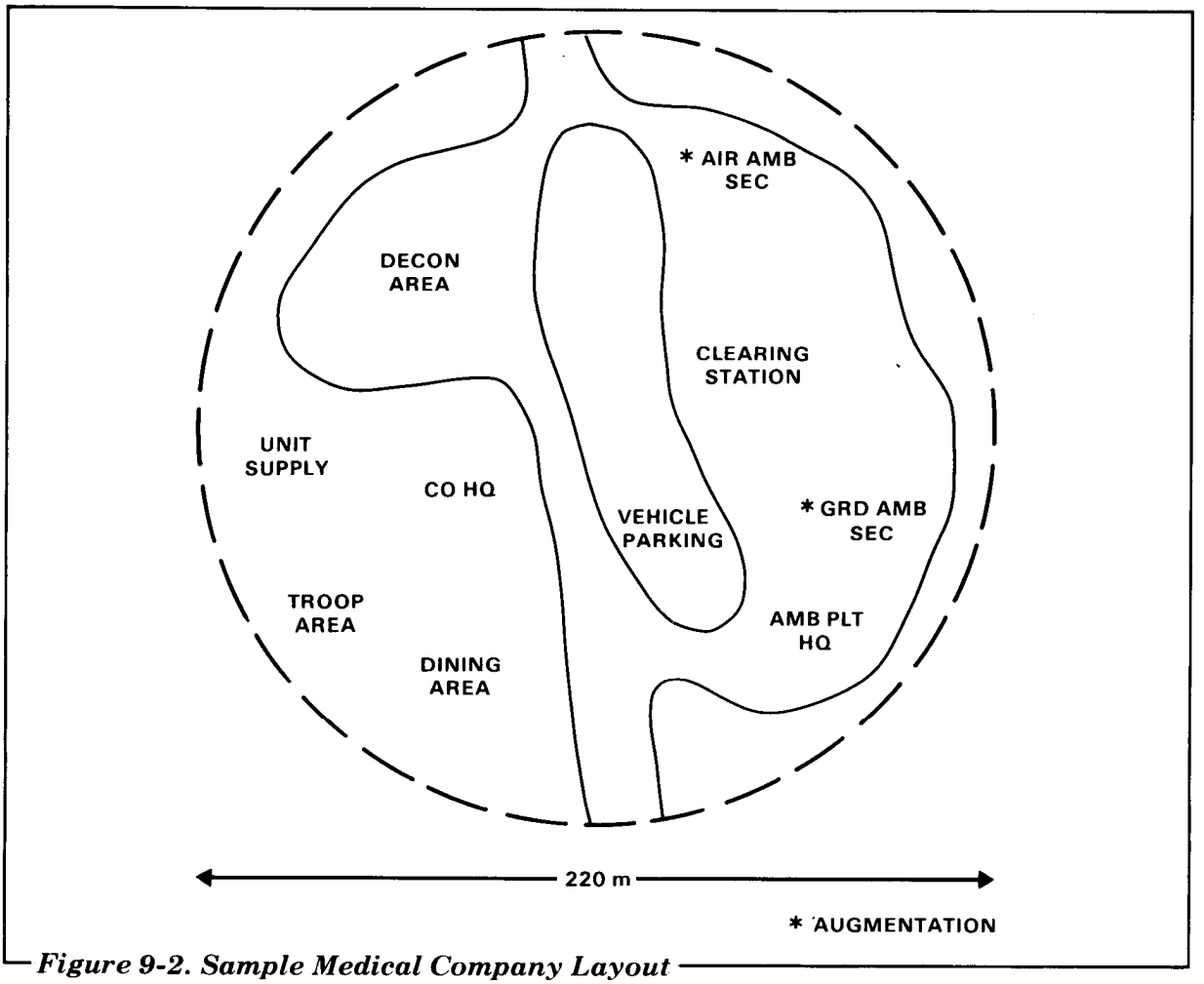

Figure 9-2. Sample Medical Company Layout

- 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.

Mass casualty situations arise when the number of casualties exceeds the capabilities of supporting medical treatment and evacuation elements. Mass casualties in the main battle area can be expected in close operations. Large numbers of casualties are likely in mid- and high-intensity conflicts, particularly among brigade-size forces employed against an enemy with high-yielding weapon systems. The medical planner must establish and thoroughly coordinate medical contingency plans for the handling of mass casualty work loads. Other battlefield operating systems must be synchronized to alleviate the situation. Planning should include—

- Immediate deployment of available treatment and evacuation elements in direct support of the affected force for triage and evacuation.
- On-call designated MSB medical assets to reinforce the forward medical company so it can continue to support forces not affected.
- On-call available corps medical assets to be provided to stabilize the situation.
- Division and brigade SOPS for the use of nonmedical vehicles and aircraft to alleviate Level II medical evacuation backlog.

In mass casualty situations, nonmedical personnel will have to perform first aid, rescue operations, and other medical tasks. Effective self-aid/buddy-aid will be critical.

Several Geneva Conventions affect medical operations in the brigade sector. Sick, injured, and wounded prisoners are treated and evacuated through normal channels. However, they are physically segregated from US and allied patients. EPW patients are evacuated from the combat zone as soon as possible. Only those who run a greater health risk by being evacuated may be temporarily kept in the combat zone. Civilians wounded or sick as a result of military operations are treated and transferred to civil facilities when required. Properly identified personnel performing medical duties in medical units are protected under the Geneva Convention. Details are in DA Pamphlet 27-1 and FM 27-10.

The medical company, in coordination with the medical operations center and the FSB S2/S3, must also develop a combat lifesaver program for FSB personnel. Training is most critical for elements which will be deployed separately such as MSTs, contact teams, and truck drivers. However, the program should cover all elements of the FSB.

CLEARING STATION OPERATIONS

The division clearing station in the BSA is principally operated by the medical company treatment platoon. In addition, a team from the MSB medical company preventive medicine section and a behavioral science NCO from the MSB company mental health section may augment the capability of the BSA clearing station. Also operating at the clearing station are any elements of the

155-991 O -94-5

FSMC treatment section not deployed forward. During static situations, ambulance teams may also be stationed at the clearing station and provide routine sick call runs and emergency standby support to units operating in and around the BSA.

The clearing station maintains its integrity at all times. Considerations for positioning this MTF within the BSA are given in Chapter 5. Figure 9-3 shows a sample clearing station layout in a field environment.

The functions performed at the clearing station are those discussed for the area support section of the treatment platoon. Seriously ill or wounded patients arriving at the station are given necessary treatment and stabilized for movement. Patients with minor injuries and illnesses are treated within the capability of the attending medical and dental officers. These patients are held for continued treatment or observation for up to 72 hours; evacuated to the appropriate MTF for further treatment, evaluation, or disposition; or treated and immediately returned to duty. Resupply of personal equipment for return-to-duty soldiers is addressed in Chapter 7. 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 radiological contamination before medical treatment. Details are in FM 8-9 and TM 8-215.
- Ensuring NBC casualties are properly handled according to the guidance in Appendix B.

In addition to providing division-level support for units in the brigade area, the clearing station provides unit-level support to units in the BSA. This is provided on an area basis. 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 area damage control element. Units are responsible for collecting casualties, providing first aid, and getting casualties to a medical facility. However, if the BSA is badly hit, the area is secure, and medical assets are available, sweeps of the BSA may expedite discovery, treatment, and evacuation of casualties.

The preventive medicine team attached from the division preventive medicine section of the MSB ensures that preventive medicine measures are implemented to protect against food-, water-, and vector-borne diseases and environmental injuries (such as heat and cold injuries). Specifically, the team—

- Performs environmental health surveys and inspections.
- Monitors water production and distribution within the brigade area.
- Investigates incidents of food-borne, water-borne, insect-borne, zoonotic, and other communicable diseases.
- Helps train unit field sanitation teams.

The team emphasizes preemptive action. In past conflicts, more soldiers have become ineffective from DNBI than as a direct result of combat. The team cannot wait until problems appear to take action. For example, it cannot wait for the first case of malaria or sand fly fever to suppress mosquito or sandfly

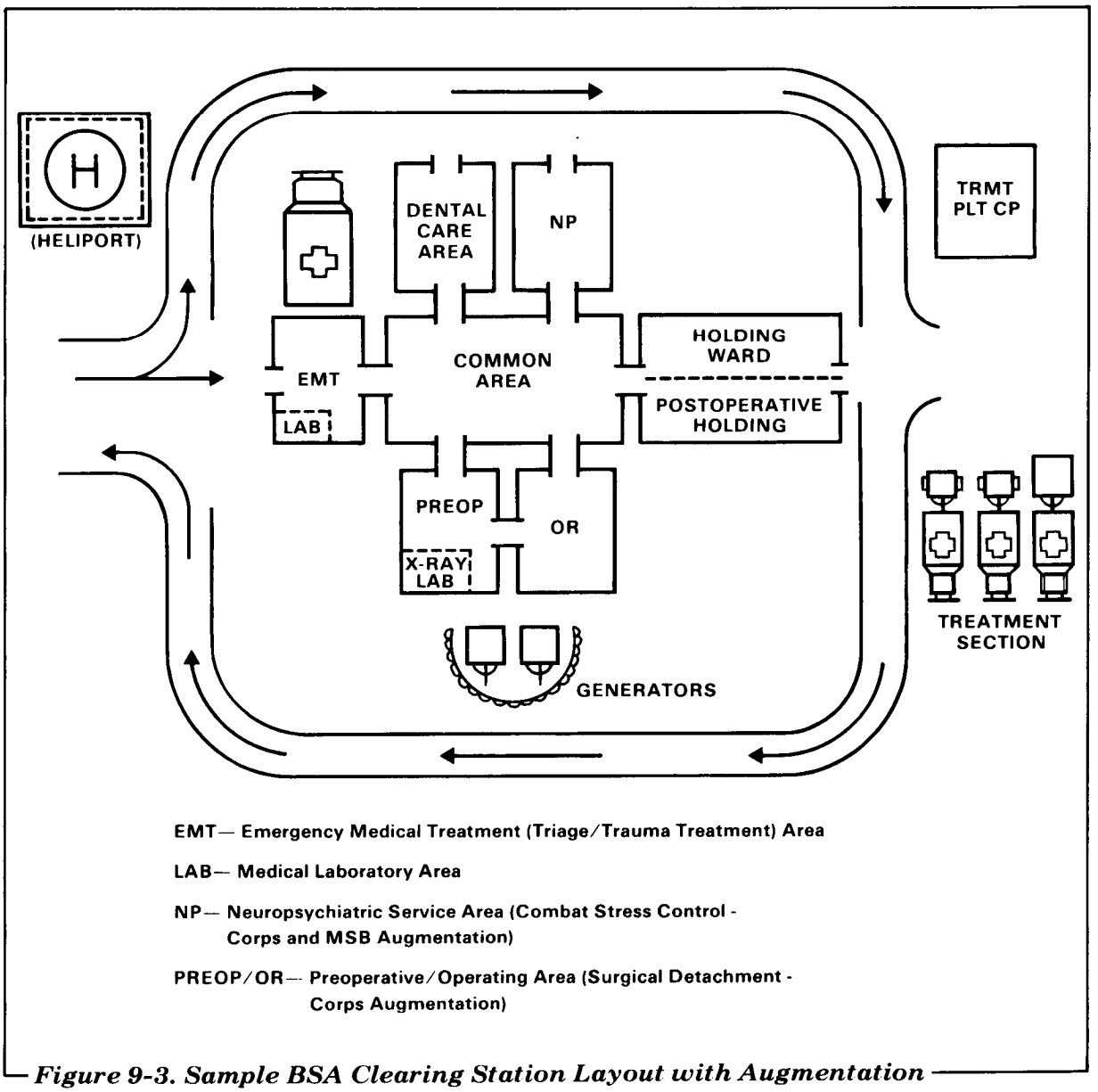

Figure 9-3. Sample BSA Clearing Station Layout with Augmentation

populations in troop assembly areas. The team may coordinate with the designated civil-military officer and the local population.

The representative from the division mental health section of the MSB functions as the brigade combat stress control coordinator. He is normally attached to the FSB medical company and operates from the BSA clearing station. He advises the brigade surgeon on mental health considerations. He keeps abreast of the tactical situation and plans for battle fatigue/neuro-psychiatric 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:

- Mild cases are given a brief respite of 1 to 6 hours of comfort and reassurance and are returned to their units.
- Moderate cases maybe assigned work at a logistics facility in the BSA for 1 to 2 days. During this time, however, they must be under medical supervision, and 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.
- Severe cases may be held in the clearing station holding facility for up to 72 hours if behavior is not too disruptive. The 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. Medication is prescribed by the attending physician 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.
- Severe cases beyond the ability of the clearing station to manage are evacuated to the DSA clearing station as conditions permit. Physical restraints are used during transport when necessary. The physician, in coordination with the CSCC, may evacuate the patient directly to a corps facility only if long-term care is required. In such cases, the patient's field medical card should be annotated to reflect a psychiatric illness.

Ammunition and individual weapons belonging to patients to be evacuated out of the division are normally kept by the patients' units. If they arrive at the clearing station, they are collected and given to the brigade S4, the FSB S4, or the supported CS/CSS unit's designated representative, or they are disposed of according to command SOP.

EVACUATION

Evacuation from the BASS is normally provided by the FSMC ambulance platoon and a forward air ambulance team of the supporting corps air ambulance company. These assets also support other units in the brigade area on an area basis. Typically, one team from the ambulance platoon is field sited at each BAS. The other ambulances of the platoon are located at AXPs, designated collection points, or at the clearing station. Within the BSA, units are responsible for getting wounded, injured, and sick soldiers requiring treatment to the clearing station.

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 should be involved with the tactical planning process enough to ensure appropriate employment of the air evacuation assets and to obtain the required airspace management information. He coordinates aviation support requirements and airspace C2 matters with the brigade S3 (air). When air superiority exists, the team evacuates urgent patients from forward sites in the brigade area to the BSA clearing station. The treatment platoon sets up and marks the helicopter landing zone at the forward triage site. The support operations section and brigade surgeon plan the air evacuation routes to and from the forward triage site with the air ambulance team leader.

If medical company evacuation assets are overwhelmed, additional assets may be requested from the MSB medical company or

the corps through the medical operations center of the DISCOM. Another alternative is the use of nonmedical air or ground transportation assets. This support is normally coordinated by the company XO with the FSB support operations section. Whenever possible, these assets are augmented with medical personnel and supplies to provide en route care.

When necessary to keep tracked ambulances from having to spend too much time evacuating patients to the BSA, an ambulance shuttle system may beset up between the clearing station and BASS. Such a system uses ambulance exchange points. AXPs are positions where patients are exchanged from one ambulance to another. They are normally preplanned and moved often. Using AXPs allows ambulances to return to their supporting positions more rapidly. This is desirable since the crews are more familiar with the roads and the tactical situation near their bases of operations.

Another form of ambulance shuttle system involves the use of ambulance loading points and relay points. In this type of system, ambulances are stationed at loading points ready to receive patients. Ambulances are also stationed at relay points ready to replace ambulances leaving loading points to evacuate patients. Control points may also be required at crossroads or junctions to direct empty ambulances from relay points to loading points.

CLASS VIII SUPPLY

Medical supplies, equipment, and repair parts are provided through medical logistics channels. Unit- and division-level medical elements carry a 5-day stockage of medical supplies. During combat operations, the medical section/platoon and the FSB medical company receive preconfigured medical supply packages pushed forward from the division medical supply office. Push resupply operations will continue until the situation stabilizes. At that time, if METT-T permits, line-item requests will begin. Resupply requests are sent through the class VIII supply point at the FSMC. Items will be issued from supply point stocks if available. If a request cannot be filled at the supply point, it is passed to the DMSO. Truckload delivery for one unit may be delivered directly by division transportation assets. The normal method of moving class VIII supplies forward is by ambulance backhaul. This is preferred since it maximizes use of transportation assets and because Geneva Convention markings of ambulances afford some protection from attacking aircraft.

CONSIDERATIONS FOR VARYING TACTICAL SITUATIONS

OFFENSE

The basic characteristics of medical support 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, and during assaults on final objectives.
- Medical elements of the brigade and FSB treat indigenous and displaced

persons that become sick or wounded as a result of military operations. In coordination with the division G5, these people are moved to civilian treatment facilities immediately after being treated.

- The main attack normally receives the greatest medical support.

Initially, company treatment assets are located as far forward as combat operations permit. When the brigade is assigned an independent mission or one likely to disperse its elements over unusually long distances, assets from the FSMC maybe attached to the brigade.

Two basic problems confront the medical company in the offense. First, contact with the supported units must be continuous. Also, the mobility of treatment elements must be maintained. Contact is maintained through evacuation elements operating within and between the unit-level facilities and the clearing station. Treatment elements should be minimally staffed consistent with the patient work load, and patients must be evacuated as promptly as possible. Therefore, available ambulance assets are positioned forward.

Treatment elements are issued 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 aid stations.

In fast-moving situations, patient collection points are predesignated along the axis of advance. The points operated by FSMC assets also provide units lacking organic medical support with areas for patient disposition in high mobility situations.

DEFENSE

Medical support of defensive operations is more difficult than in the offense. Casualty rates are lower, but forward acquisition is complicated by enemy action and the initial direction of maneuver to the rear. Increased casualties among medical personnel will reduce treatment and evacuation capabilities. Heaviest casualties, including those produced by enemy artillery and NBC weapons, may be expected during the initial enemy attack and in the counterattack. The enemy attack may disrupt ground and air communication routes and delay 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 must 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 may be forced to withdraw while simultaneously carrying their patients to the rear.

RETROGRADE

Medical support in retrograde operations varies widely. However, certain factors should always be considered:

- Time available for medical operations is likely to decrease. The brigade surgeon must evaluate the company's capability to collect, treat, and evacuate patients.
- Patient evacuation will be complicated by movement of troops and materiel on evacuation routes and by enemy disruption of C3. Plans for evacuation in such conditions should be included in tactical SOPs. Mobility of the clearing station may be increased by evacuating

patients directly from the BASS to corps MTFs whenever possible.

- Sorting of patients becomes more critical. Proper sorting and rapid evacuation lessen the need for establishing complete clearing stations.
- When patient loads exceed the means to move them, the brigade commander must decide whether to leave patients behind. The brigade surgeon assists in such decisions. Medical personnel and supplies must be left with patients who cannot be evacuated.
- Medical company assets displace by echelon and hold patients for the shortest possible time. Locations of successive positions must be planned in advance. Initial locations are further to the rear than in other types of operations. For continuity of support, the next rearward locations are operational before the forward MTFs are closed.