

**FM 8-55**

**PLANNING  
FOR  
HEALTH SERVICE SUPPORT**



**HEADQUARTERS, DEPARTMENT OF THE ARMY**

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## PLANNING FOR HEALTH SERVICE SUPPORT

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## PREFACE

This manual provides guidance to health service support (HSS) planners at all echelons of care within a theater of operations (TO). It contains a digest of the accepted principles and procedures pertaining to HSS planning. Information in this publication is applicable across the spectrum of military operations. It is compatible with the Army's combat service support (CSS) doctrine. Readers should have a fundamental understanding of Field Manuals (FMs) 8-10, 100-5, 100-10, 100-15, 100-20, 101-5, and 101-10-1/1 and -1/2. The planner must supplement or replace the data in this manual with any known factors to meet the needs of his particular situation.

The staffing and organizational structure presented in this publication reflect information in the most current living tables of organization and equipment (LTOE) as of calendar year 1992. However, staffing is subject to change to comply with manpower requirements criteria outlined in Army Regulation (AR) 570-2. Your table of organization and equipment (TOE) can be subsequently modified.

A series of FMs currently under development will provide techniques and procedures for specific HSS organizations and activities in the TO. These manuals will be published over the next several years.

This publication implements the following North Atlantic Treaty Organization (NATO) and American, British, Canadian, and Australian (ABCA) International and Quadripartite Standardization Agreements (STANAGs and QSTAGs, respectively):

<b>NATO STANAG</b>	<b>ABCA QSTAG</b>	<b>TITLE</b>
2068	322	Emergency War Surgery
	291	Interface of Medical Materiel Procedures
	815	Blood Supply in the Area of Operations
	909	Principles of Prevention and Management of Combat Stress Reaction
2135		Procedures for Emergency Logistic Assistance
2500		NATO Handbook on the Medical Aspects of NBC Defensive Operations— AMedP-6(A)
2873		Concept of Operations of Medical Support in Nuclear, Biological, and Chemical Environments—AMedP-7(A)
2874		Planning Guide for the Estimation of Battle Casualties (Nuclear)— AMedP-8
2939		Medical Requirements for Blood, Blood Donors, and Associated Equipment

The proponent of this publication is the United States (US) Army Medical Department Center and School (AMEDDC&S). Send comments and recommendations on Department of the Army (DA)Form 2028 directly to Commander, AMEDDC&S, ATTN: HSMC-FCD, Fort Sam Houston, Texas 78234-6123.

Unless this publication states otherwise, masculine nouns and pronouns do not refer exclusively to men.

## CHAPTER 1

**HEALTH SERVICE SUPPORT IN ARMY OPERATIONS****1-1. The Army's Keystone Doctrine**

Field Manual 100-5, the Army's keystone doctrinal manual, describes how the Army thinks about the conduct of operations. It is a condensed expression of the Army's participation in diverse environments in terms of what the force does in operations other than war (OOTW) and how the Army conducts war.

**1-2. Range of Military Operations**

*a.* The US seeks to achieve its strategic aims in three diverse environments.

(1) *Peacetime.* During peacetime, the US attempts to influence world events through those actions which routinely occur between nations. Typical peacetime operations include—

- Disaster relief.
- Nation assistance.
- Security and advisory assistance.
- Counterdrug operations.
- Arms control.
- Treaty verification.
- Support to domestic civil authorities.
- Peacekeeping.

(2) *Conflict.* Conflict is characterized by confrontation and the need to engage in hostilities short of war to secure strategic objectives. Although the American people, our government, and the US Army prefer peace, hostile forces may

seek to provoke a crisis or otherwise defeat our purpose of deterring war by creating a conflict. At the point where diplomatic influence alone fails to resolve the conflict, persuasion may be required, and the US could enter a more intense environment in which it uses the military to pursue its aim.

**NOTE**

The Army classifies its activities during peacetime and conflict as OOTW.

(3) *War.* The most violent and high-risk environment is that of war, with its associated combat operations.

*b.* Regardless of the specific type of operation, a return to the environment of peace is a major component of the desired strategic end-state.

**1-3. Army Operations**

*a.* Often the Army will find itself operating in all environments at once. The Army's mission is that of—

(1) Projecting land power to distant theaters, The Army supports power projection through force projection. This is a demonstrated ability to rapidly alert, mobilize, deploy, and conduct operations anywhere in the world. Forces are moved from the continental United States (CONUS) or a theater in response to requirements of war or OOTW. Force projection spans from mobilization and deployment of forces to distant theaters, to their redeployment to CONUS or their home theater and, subsequently, to their demobilization. Force projection involves the entire Army, as a forward presence or CONUS-based, both active



and reserve components, and supported by Department of Defense (DOD) civilians and civilian contractors.

(2) Conducting operations in several environments, sometimes simultaneously, and maintaining forces to operate across the spectrum of war and OOTW as part of joint and combined forces. The Army does not fight alone. It integrates its efforts in joint operations with its sister services, with other national agencies, and will usually be in conjunction with allies in operations outside the US.

(3) Supporting our allies in nation assistance and peacetime competition. Army forces routinely conduct peacetime activities outside continental United States (OCONUS) in OOTW as the potential for conflict escalates.

*b.* The Army must focus on deterring aggression through strength with a smaller force. It must also foster initiative in its leaders so that they will be able to adjust to the dynamics of the battlefield. It is important to realize that the Army's keystone doctrine discussed in FM 100-5 represents an evolution, not a revolution, in our military thinking.

#### **1-4. Need for a Health Service Support System**

*a.* The dynamics of our global responsibilities require a HSS system that is flexible to support the diversity of operations.

*b.* Providing comprehensive HSS to Army Operations requires continuous planning and synchronization of a fully integrated and cohesive HSS system. The system must be responsive and effective across the full range of possible operations. Medical unit commanders and HSS planners must be proactive in changing

situations, applying the medical battlefield rules as the situation requires.

#### **1-5. Medical Battlefield Rules**

*a.* The HSS planner and operator applies the following rules, in order of precedence, when priorities are in conflict:

- (1) Maintain medical presence with the soldier.
- (2) Maintain the health of the command.
- (3) Save lives.
- (4) Clear the battlefield.
- (5) Provide state-of-the-art care.
- (6) Return soldiers to duty as early as possible.

*b.* These rules are intended to guide the HSS planner to resolve system conflicts encountered in designing and coordinating HSS operations. Although medical personnel seek always to provide the full scope of HSS in the best manner possible, during every combat operation there are inherent possibilities of conflicting support requirements. The planner or operator applies these rules to ensure that the conflicts of HSS are resolved appropriately.

*c.* The rationale for the battlefield rules is based on prevention of disease and injury and the evolving clinical concept which demonstrates that with good medical care the trauma victim will probably survive the injury.

- (1) Good medical care, to be precise, means that the injured soldier receives prompt

medical care: he is adequately resuscitated, he is stabilized, and stabilization is maintained during evacuation.

(2) The goal of resuscitation and stabilization is the restoration of vascular volume with adequate oxygen delivery to the cells. This condition means that the patient's bodily systems have available the amount of oxygen demanded to ensure viability. The patient can then be evacuated over a greater distance to a rearward medical treatment facility (MTF) with time being less of a major concern to save life or limb.

(3) Good medical care and stabilization prior to evacuation is a major aspect in determining whether the patient survives provided stabilization is sustained during evacuation. Early medical care with the ability to adequately stabilize must be available with less delay from the time of injury than it has ever been in the past. An enhanced capability to sustain stabilization during evacuation must also be provided.

*d.* By way of illustration, consider a rapid assault of short duration where the composition of the task force precludes deployment

of a definitive medical care facility. A medical support conflict now arises between supporting the commander's intent and providing optimal care to the soldiers. The conflict can be resolved appropriately by applying the battlefield rules. Planners must increase the medical presence with the soldiers to resuscitate casualties and maintain stabilization pending evacuation. Greater reliance on forward medical presence compensates for the inability to employ hospitals near the battlefield, supports the commander's intent, and still provides the patient with state-of-the-art medical care within the limitations imposed by the battlefield. The battlefield rules are thereby used as a means of conflict resolution.

#### **1-6. The Health Service Support Planning Goal**

The planner, by carefully applying medical doctrine and the principles outlined in this manual, will strive to provide the best possible HSS system for all Army operations. Proper planning enhances the capability of medical units to provide effective HSS which is a key factor in conserving combat power.

## CHAPTER 2

**HEALTH SERVICE SUPPORT ESTIMATES, PLANS, AND ORDERS****Section I. PRINCIPLES OF PLANNING****2-1. Health Service Support Planning**

*a.* Current HSS planning addresses the management of normal day-to-day operations, while short- and long-range planning cover projected operations of successively longer periods. Planning is a continuous process. The planner must remain sensitive to the demands for HSS based upon constantly changing situational and operational requirements. During current operations, staffs at all levels (especially higher command levels) must continuously plan for subsequent operations. Regardless of the type of military operation being supported or the level of command providing the support, HSS plans must be made. These plans may be either formal written plans or informal thought processes. Either plan must be well-communicated to be effective. The planner must proceed in an orderly, progressive manner to ensure maximum effort and completeness. The specific time required to plan varies with the type, size, and level of the command concerned. The amount of detail required to plan will also vary with the—

- Type of command.
- Experience of all personnel in the command.
- Complexity of the operation.
- Factors of combined, joint services, or interagency participation.
- Time available.

*b.* Planners must develop well-thought-out plans and validate the plans through field training exercises and command and staff simulations. The process of thinking through a plan

and conducting "What if?" drills by changing critical variables is especially useful. This process allows the HSS planner to envision potential results and to anticipate problems. Consequently, the planner can become proactive instead of being reactive. The proactive planner can eliminate potential problems before they cause adverse consequences. He has more time to accomplish the required synchronization to adjust operations when adverse consequences arise because he has anticipated problems and has already considered potential solutions. The proactive planner has more time to address unanticipated problems and more time to plan HSS for future operations.

*c.* Effective and timely planning is essential to operate successfully on the battlefield. Failure in the planning process will result in commanders, their staffs, and subordinate units finding themselves unprepared to function in military operations. The modern, mobile battlefield is the wrong place to be operating precariously. That approach will cost soldiers' lives. Planners must have the initiative to ask questions that may affect the performance of their units, and they must know their units well enough to answer questions when asked.

**2-2. Planning Sequence**

The planning sequence is a series of steps representing a logical progression of command and staff actions required to develop plans. The planning sequence attempts to prepare for all developments that can reasonably be anticipated. Although some actions ordinarily occur sequentially, others take place concurrently. Field Manual 101-5 provides an in-depth discussion of the planning process.

**2-3. Current Plan**

A plan developed in the planning sequence described in FM 101-5 is not necessarily implemented on completion. As new information becomes available or as events occur, the plan is reviewed and updated accordingly. This action continues until the plan is implemented or until no requirement exists for the plan.

**2-4. Coordination of the Plan**

a. Coordination is one of the most essential elements in successful planning. From the beginning, the planner must continuously coordinate the various types of operations with the commander and his assistants. With a knowledge of the mission, the current situation, and the objectives, the planner can better plan for the support that will be required. This method enables him to begin the planning for support early and allows him time for more thorough planning. He must ask questions such as, *What resources will I need to do the job? Where will Z obtain them?*

b. The planner must also coordinate with those staff representatives at the various headquarters who can furnish him needed information and who must coordinate their plans with his. He must begin early coordination in those areas requiring close HSS interface within the CSS community.

c. Building the HSS interface as part of the CSS community is critical. Health service support depends on the CSS system for a multitude of support services such as—

(1) Class I (Subsistence, including medical B rations and gratuitous health and welfare items).

(2) Class II (Clothing, individual equipment, tentage, tool sets and tool kits, hand

tools, and administrative and housekeeping supplies and equipment). This class includes items of equipment (other than principal items) prescribed in authorization/allowance tables, and items of supply (not including repair parts).

(3) Class III (Petroleum, oils, and lubricants [POL]: Petroleum fuels; lubricants, hydraulic and insulating oils, preservatives, liquid and compressed gases, chemical products, coolants, deicing and antifreeze compounds, together with components and additives of such products, and coal).

(4) Class IV (Construction: Construction materials including installed equipment and all fortification/barrier materials).

(5) Class V (Ammunition, individual small arms ammunition, and pyrotechnics for defense of self and patients).

(6) Class VI (Personal demand items).

(7) Class VII (Major end items such as vehicles and aircraft which are ready for their intended use).

(8) Class IX (Maintenance repair parts for associated support items of equipment [ASIOE]).

(9) Class X (Material to support nonmilitary programs).

(10) Other support services such as—

(a) Nonmedical transportation.

(b) Potable water resupply.

(c) Liquid waste disposal.

(d) Direct support(DS)/general support (GS) maintenance backup.

(e) Trash/solid waste disposal.

(f) Medical intelligence dissemination.

(g) Rear operations.

(h) Mortuary affairs.

(i) Site support by engineer units.

(j) Movement control.

(k) Reconstitution.

(l) Delivery of Class VIII supplies.

(m) Assistance in movement of medical units.

(n) Nonmedical augmentation, such as personnel and air and g-round transportation from nonmedical units, to medical evacuation assets in mass casualty situations.

*d.* Commanders and staff (planners) within units must know how, when, and with whom to coordinate (synchronize) both internally and externally. Proficient synchronizers tend to think about what is happening and what will be happening two levels down, two levels up, and on each side.

*e.* Just as HSS commanders must be multifunctional to recognize CSS requirements, so too must future multifunctional CSS commanders recognize medical requirements to integrate CSS effectively across the spectrum of military operations. They will have to understand what the HSS system is all about as they will have an

inherent responsibility for ensuring that HSS is planned and provided in a timely, responsive, and effective manner.

## 2-5. Characteristics of the Plan

A good HSS plan—

- Provides for accomplishing the mission.
- Is based on facts and valid assumptions. All pertinent data have been considered for their accuracy, and assumption have been reduced to a minimum.
- Provides for the use of existing resources. These include resources organic to the organization and those available from higher headquarters.
- Provides for the necessary organization. It clearly establishes relationships and fixes responsibilities.
- Provides for personnel, materiel, and other arrangements for the full period of the contemplated operation.
- Provides for decentralized execution of the plan. It delegates authority to the maximum extent consistent with the necessary control.
- Provides for direct coordination during execution between all levels.
- Is simple. It reduces all essential elements to their simplest form and eliminates those elements not essential to successful action.
- Is flexible. It leaves room for adjustments because of operating conditions and, where necessary, stipulates alternate courses of action (COA).

- Provides for control. Adequate means exist, or have been provided, to carry out the plan according to the commander's intent.
- Is coordinated. All elements fit together, control measures are complete and understandable, and mutual support requirements are identified and provided for.

## 2-6. Planning Guidance

The commander provides planning guidance to the staff as required. The frequency, amount, and content of planning guidance will vary with the mission, time available, situation, information available, and experience of the commander and staff. The commander may choose to issue initial planning guidance to the staff when the mission to be supported is announced; however, he must take care not to unduly bias staff estimates. This guidance is used to direct or guide the attention of the staff in the preparation or revision of staff estimates and serves to expedite the decision-making process. Planning guidance should include all elements of the commander's intent.

## 2-7. Basic Planning Considerations

The commander's intent and the mission assigned to the combat forces must be the basic consideration of all components in their planning for HSS.

*a.* Health service support preparations and planning must be initiated early and designed specifically to support the operation.

*b.* Certain basic factors and premises must be used for sound HSS planning. Among the most important are—

(1) Preparing a HSS estimate and a concept of the HSS operation.

(2) Coordinating the efforts of the health services of the component forces to make maximum use of available resources.

(3) Planning to assure flexibility for unforeseen contingencies such as nuclear, biological, and chemical (NBC) and directed-energy (DE) warfare.

# Section II. THE HEALTH SERVICE SUPPORT ESTIMATE

## 2-8. Surgeon's Responsibility

*a.* After the commander provides planning guidance, the surgeon should prepare estimates of requirements and descriptions of projects to be undertaken for establishing adequate HSS systems to support the mission. He prepares this in his role as a special staff officer. The surgeon makes a health service estimate that may stand alone, or that may be incorporated into the personnel estimate. This estimate forms the basis

for the subsequent HSS plan. All HSS possibilities that could affect the successful support of an operation must be considered. (See FM 8-42 for additional discussion.)

*b.* The surgeon must determine what basic load modifications are required, what additional people skills are required, and any mission unique training that must be conducted. The surgeon must know his intelligence element, how medical information requirements are made

known to the appropriate intelligence element, what medical intelligence is available, how medical intelligence is disseminated, and how to integrate intelligence in general and medical intelligence in particular into HSS operation plans (OPLANs)/operation orders (OPORDs). (See Appendix F and FM 8-10-8.)

*c.* The commander uses the HSS estimate, along with estimates of other individual staff members, in the preparation of his own estimate. He uses the information in the HSS estimate to select the best COA for the command, and for inclusion in the operational and logistics support plans.

*d.* After considering all the staff estimates, the commander completes his own estimate and makes his decision. In the case of a medical command (MEDCOM) or medical brigade headquarters, the estimate is made by the commander, assisted by his staff, and normally results in the publication of the HSS plan for the command. At lower echelons, the estimate is a continuous mental process integrated in the planning process.

## **2-9. Format for the Estimate**

The process followed in preparing a HSS estimate of the situation is the same as that followed in preparing an operational estimate.

*a.* Staff estimates may be presented orally, or in writing. Often, only the staff officer's conclusions or recommendations are presented to the commander.

*b.* An example for a health service estimate is found in Appendix B. This format is applicable to any echelon of command and can be used under any operational condition. It is lengthy and includes many more details than may be needed in some situations. Each HSS planner

must vary it according to his needs. There is no beginning or end to the estimate. It must be continuously and constantly revised as circumstances change, so that planned support can be provided to the command from the time it is mobilized until it is inactivated.

*c.* The estimate is intended to be a timesaving and integral part of providing adequate support for all types of operations. If the estimate is prepared by the command surgeon (corps surgeon/corps support command [COSCOM] surgeon), it must support the tactical commander's intent. If prepared by a command such as a MEDCOM, medical brigade, or medical group, it becomes the estimate of the medical commander assisted by his staff. Normally, estimates at the division surgeon's level are not formal written documents; however, health service considerations may appear in a written personnel estimate prepared by the G1/S1 (Personnel/Adjutant, respectively). The commander or the staff officer should use the format as a guide and checklist.

## **2-10. Mission**

*a.* The senior medical commander/command surgeon is responsible—

(1) For analyzing the mission of the command from the HSS perspective.

(2) For outlining the concept of HSS operations, assigning taskings, and providing guidance for a casualty care system in support of the commander's intent and concept of operations.

(3) For coordinating HSS with civil affairs, other Services, and/or alliance and coalition partners, and other government agencies.

(4) For coordinating HSS with host nations by providing medical liaison teams to countries with which the US has HSS agreements

or with relief agencies participating in the operation in concert with civil affairs.

(5) For anticipating the lack of HSS infrastructure in a host nation and determining the impact upon refugee management.

b. The HSS mission is the basis for the estimate and is stated clearly in paragraph 1 of the estimate. It always conforms to the operations in which the supported personnel are engaged. For example, the mission might be to *provide HSS to the 52d Mechanized Division in a deception operation on 10 and 11 June 92. The division attacks on 110310 June to secure high ground on Hills 123, 456, and 789. 3d Brigade makes the main attack on the west.* In another example, the mission may be to *save lives by providing basic medical care, medical evacuation, and preventive medicine (PVNTMED) sanitation enforcement and education.*

## 2-11. Situation and Considerations

The health service situation will consist of HSS facts, assumptions, and deductions that can affect the operation. In this logical and orderly examination of all the HSS factors affecting the accomplishment of the mission, the HSS planner must be familiar with the commander's intent. The information required includes medical intelligence which is obtained through supporting intelligence channels. (See FM 8-10-8 for a discussion on information requirements and priority intelligence requirements.) The planner must conduct a thorough evaluation of the enemy situation and the area of operations (AO) from the standpoint of their effects on the health of the command and HSS operations. These are enumerated as follows in paragraph 2 of the estimate:

a. *Enemy Situation.* From his specialized point of view, the surgeon must consider

the enemy's ability to adversely affect the HSS operations of the command.

(1) The enemy's attitude toward the Geneva Conventions could alter HSS if he is likely to attack the friendly HSS system, or if he is known to have attacked it. It could also determine the type of medical care friendly prisoners of war can expect.

(2) The enemy's strength, disposition, probable movements, logistic situation, and combat efficiency must be considered to estimate the number of patients requiring hospitalization and evacuation.

(3) The enemy's ability to inflict conventional and unconventional (NBC and DE warfare) casualties is a concern. The type of enemy weapons employed will influence the number and type of combat casualties. Heavy artillery bombardment, air attack, surprise weapons and tactics, and continuous operations increase battle fatigue casualties, while guerrilla or terrorist attacks cause other combat stress reactions. Supplementary hospitalization and evacuation resources may be required.

(4) The enemy's medical capabilities, sanitation discipline, and the health of potential enemy prisoners of war (EPW) can be expected to influence the command's medical work load as well as the EPW patient work load.

b. *Friendly Situation.* A preliminary estimate of medical work loads can be made when the friendly forces' strength, combat efficiency, position, weapons, and plan of action are compared with those of the enemy.

(1) This comparison considers the tactical plan of the commander to determine the location of areas of casualty densities and the best placement of HSS units.



(2) He must consider the enemy's ability to disrupt the rear operations of the command. Medical units in the rear must be incorporated into base clusters. Units must be positioned logically to ensure maximum security. These facilities are so numerous that in many cases the ideal type of security may not be available. The threat to these units must not be aggravated by positioning them near areas of high attack probability such as ammunition or nuclear storage facilities. To successfully defeat enemy deep operations, clear-cut lines of authority for security must be established. These lines of authority must be clearly identified at all echelons before any plans or operations are initiated. (See FM 100-15 or FM 71-100 for detailed discussions.) Field Manual 8-10 addresses Article 24 of the "Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field (GWS)." It also discusses US Army policy on the use of Article 24 personnel in perimeter defense.

(a) Article 24 of the GWS 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 the administration of medical units and establishments. . . . [Emphasis added.]"

(b) The GWS does not itself prohibit the use of Article 24 personnel in perimeter defense of nonmedical units such as unit trains logistics areas or base clusters under overall security defense plans, but the policy of the US Army is that Article 24 personnel will not be used for this purpose. Adherence to this policy should avoid any issues regarding their status under the GWS due to a temporary change in their roles from noncombatant to combatant. Medical personnel may guard their own unit without any concurrent loss of their protected status.

c. *Characteristics of the Area of Operations.* The HSS planner should obtain medical

intelligence regarding the AO from the supporting intelligence element (FM 8-10-8). This information must be considered in the planning process. The characteristics of the AO influence the number of patients, as well as their collection and evacuation.

(1) *Terrain.*

(a) Topography has the same bearing on HSS planning as it does on tactical planning. Using terrain to one's advantage may reduce combat casualties therefore decreasing the anticipated patient work load.

(b) Natural conditions may favor large populations of arthropods (insects, arachnids, and crustaceans) which commonly are vectors of many diseases and therefore could directly increase the incidence of disease.

(c) Mountains, forests, and swamps can be expected to hamper HSS. Altitude exposure at high terrestrial elevations frequently results in reduced military performance and can result in acute mountain sickness. Transfer of patients from shore to ship is particularly dependent upon coastline and harbor conditions. Availability of roads, landing strips, and railroads will be important in developing evacuation alternatives. Terrain factors such as protection, shelter, and water supply are considered in consonance with evacuation alternatives and with the selection of medical treatment facility locations. Evacuation resources must be augmented when using difficult terrain.

(d) An increase in the hospital bed allocation should be considered if the terrain analysis suggests a significant increase in battle injury (BI), wounded in action (WIA), disease admissions, or difficulty in evacuating patients. Preventive medicine detachments should be tasked to reinforce forward deployed units if disease potential warrants.

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