

FM 4-02.10

# THEATER HOSPITALIZATION

HEADQUARTERS, DEPARTMENT OF THE ARMY

**JANUARY 2005**

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THEATER HOSPITALIZATION

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\*This publication supersedes FM 4-02.10, 29 December 2000.

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## PREFACE

The Army Medical Department (AMEDD) continues to pursue the transformation vision. To achieve complete alignment with the transformation process, the AMEDD is committed to a Current and Future Force. Until the transition from Current Force to Future Force is completed, the AMEDD will have a mixed Level III and IV hospital support base.

Under the current Medical Force 2000 (MF2K) concept, theater hospitalization is provided by three hospitals, the combat support hospital (CSH), the field hospital (FH) and the general hospital (GH). These hospitals were designed and based upon the North Atlantic Treaty Organization (NATO) scenario and workloads. Current MF2K hospital doctrine is provided in Field Manual (FM) 8-10-14 for the CSH and FM 8-10-15 for the FH and the GH.

Under the current Medical Reengineering Initiative (MRI), theater (corps and echelons above corps [EAC]) hospitalization is provided by a single CSH. The CSH is designed based on lessons learned from Desert Shield/Desert Storm, recent contingency operations, and the requirements of the future war fighting. In particular, hospital size and bed mix are based upon these experiences as well as the casualty rates, disease and nonbattle injury (DNBI) rates, and projected evacuation policy for the major regional conflict scenarios.

To support the transforming Army to the Future Force, the MRI corps CSH has been redesigned into adaptive medical increments (AMI). The AMI, with its modular design, enhances the ability to tailor health service support (HSS) to adapt to mission requirements of a smaller magnitude when a complete CSH is not required.

The purpose of this publication is to describe the Current (MRI) Force CSH and the redesigned corps CSH in support of the Future Force. The CSH incorporates doctrine based on the A-edition Table(s) of

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Organization and Equipment (TOE) 08945A000 (corps CSH) and 08855A000 (EAC). The organizational structures presented in this publication reflect those established in the A-edition TOE in effect on the date of this publication. For a copy of your modified TOE (MTOE), contact the Authorizations Documentation Directorate, 9900 Belvoir Road, Suite 120, ATTN: MOFI-FMA, Fort Belvoir, Virginia 22060-2287.

This publication incorporates the Universal Joint Task List (UJTL) (see Chairman, Joint Chiefs of Staff Manual [CJCSM] 3500.04C) and the Army Universal Task List (AUTL) (see FM 7-15) that are applicable to HSS commanders throughout the operational continuum. These task lists are used to form the doctrinal foundation for the Army tactical task (ART) in support of mission operations and collective tasks.

The following AUTL ART are incorporated into this FM and will be discussed in depth as to their applicability across the operational continuum.

### AUTL ART

ART 5.3	Conduct Survivability Operations
ART 6.1	Provide Supplies
ART 6.2	Provide Maintenance
ART 6.8	Provide Religious Support
ART 6.13	Conduct Internment and Resettlement Activities
ART 7.8	Conduct Continuous Operations
ART 7.9	Develop and Implement Command Safety Program
ART 8.4	Conduct Support Operations

The use of the term *level of care* in this publication is synonymous with the terms *echelon of care* and *role of care*. The term echelon of care is the former NATO term. The term *role of care* is the current NATO and American, British, Canadian, and Australian Armies term.

The information presented in this FM is consistent with and supports FM 4-02 (Force Health Protection in a Global Environment). Throughout this publication, the term HSS is synonymous with Force Health Protection in a Global Environment.

This publication is designed primarily for the hospital commander, his staff, assigned personnel, and medical planners. The structural layout of the hospital is flexible and situationally determined (for example, mission requirements, commander's guidance, and terrain features). It requires intensive prior planning and training of all personnel to establish the facility. Users should be familiar with FM 3-0.

The proponent of this publication is the United States (US) Army Medical Department Center and School (AMEDDC&S). Users of this publication are encouraged to submit comments and recommendations to improve the publication. Comments should include the page, paragraph, and line(s) of the text where the change is recommended. Comments and recommendations should be forwarded directly to Commander, AMEDDC&S, ATTN: MCCS-FCD-L, 1400 East Grayson Street, Fort Sam Houston, Texas 78234-5052, or by using the e-mail address: [Medicaldoctrine@amedd.army.mil](mailto:Medicaldoctrine@amedd.army.mil).

This publication implements or is in consonance with the following NATO International Standardization Agreements (STANAGs) and American, British, Canadian, and Australian (ABCA) Quadripartite Standardization Agreement (QSTAG):

STANAG	QSTAG	TITLE
2068		Emergency War Surgery
2931		Orders for the Camouflage of the Red Cross and Red Crescent on Land in Tactical Operations
	2026	Principles and Procedures for Tracing and Tracking Personnel in an ABCA Coalition Force

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

The use of trade names or trademarks in this publication is for illustrative purposes only and does not imply endorsement by the Department of Defense (DOD).

## CHAPTER 1

**HOSPITALIZATION SYSTEM IN A  
THEATER OF OPERATIONS****1-1. Health Service Support in a Theater of Operations**

*a.* A theater of operations (TO) is that portion of an area of conflict necessary for military operations, either offensive or defensive, to include administration and logistical support. The scenario depicts the size of the TO and the US forces to be deployed. The theater is normally divided into a combat zone (CZ) and a communications zone (COMMZ). The CZ begins at the Army/corps rear boundary and extends forward to the extent of the commander's area of influence. The COMMZ begins at the corps rear boundary and extends rearward to include the area(s) needed to provide support to the forces in the CZ. In some instances, the COMMZ may be outside the TO and located in offshore support facilities, third country support bases, or in the continental United States (CONUS).

*b.* The Army Service Component Command (ASCC) is responsible for providing HSS for the Army component in a TO.

*c.* The medical command (MEDCOM) commander or the senior medical commander in the theater functions as the deputy chief of staff for medicine (DCSMED) for the ASCC. As the DCSMED, he provides information, recommendations, and professional medical advice to the ASCC commander and special staffs. He also maintains current data regarding the status, capabilities, and requirements for HSS. As the DCSMED, he is responsible to the ASCC commander for staff planning and coordinating and developing policies for HSS of the theater Army forces.

*d.* The mission of the AMEDD is to conserve the fighting strength. This mission of HSS is a continuous and integrated function throughout the TO. It extends from the CZ back through the COMMZ and ends in CONUS. Health service support maximizes the system's ability to maintain presence with the supported soldier, to return injured, sick, and wounded soldiers to duty, and to clear the battlefield of soldiers who cannot return to duty (RTD). Patients are examined, treated, and identified as RTD or nonreturn to duty (NRTD) as far forward as is medically possible. Initial identification is performed by the treating primary care provider and continues in the evacuation chain with constant reassessment. Patients requiring evacuation out of the division who are expected to RTD within the theater evacuation policy are evacuated to a corps and/or COMMZ hospital. Those patients classified as NRTD follow the evacuation chain for evacuation out of the theater.

*e.* The HSS system is a continuum from the forward edge of the battle area through the CONUS sustainment base. It is a system that provides medical management throughout all levels of care. The challenge is to simultaneously provide medical support to deploying forces; provide health care services to the CONUS base; and establish an HSS system within the theater. Additionally, there will be a requirement to provide medical support to redeployment and demobilization operations at the conclusion of military combat operations. Furthermore, HSS requirements will surface in support of stability operations and support operations. The basic tenets of HSS for a Force Projection Army involve strict adherence to Army medical battlefield rules. These battlefield rules provide the basis for the development of medical organizations and force structure. Table 1-1 lists these rules in order of precedence.

Table 1-1. Army Medical Battlefield Rules

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BE THERE (MAINTAIN A MEDICAL PRESENCE WITH THE SOLDIER)  
MAINTAIN THE HEALTH OF THE COMMAND  
SAVE LIVES  
CLEAR THE BATTLEFIELD OF CASUALTIES  
PROVIDE STATE-OF-THE-ART MEDICAL CARE  
ENSURE EARLY RETURN TO DUTY OF THE SOLDIER

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**1-2. Principles of Health Service Support**

*a. Conformity.* Conformity with the theater plan is the most fundamental element for effectively providing HSS. Only by participating in the development of the theater operation plan (OPLAN) can the medical planner ensure adequate HSS at the right time and at the right place.

*b. Continuity.* Health service support must be continuous since an interruption of treatment may cause an increase in morbidity and mortality. Procedures are standardized at each organizational level to ensure that all required medical treatment is accomplished. No patient is evacuated any farther to the rear than his physical condition or the military situation requires. In the COMMZ, patients are not evacuated to the CONUS support base if they can be returned to duty within the provisions of the theater evacuation policy.

*c. Control.* Control of medical resources must rest with the medical commander. Health service support staff officers must be proactive and keep their commanders apprised of the impact of future operations on HSS assets. The medical commander must ensure that the HSS system is responsive to the requirements of the theater. He must be able to tailor his HSS resources and direct them to focal points of demand throughout the area of operations (AO). Since HSS resources are limited, it is essential that their control be retained at the highest HSS level consistent with the tactical situation.

*d. Proximity.* In the CZ, the location of HSS assets in support of combat operations is dictated by the tactical situation (mission, enemy, terrain and weather, troops and support available, time available, and civil considerations [METT-TC] factors) and the availability of evacuation resources. In the COMMZ, the hospitals should be located to facilitate access to medical evacuation (MEDEVAC) resources (Army, United States Air Force [USAF], and Navy, if available), host nation (HN) rehabilitation resources (if applicable), and command and control (C2) facilities.

*e. Flexibility.* A change in tactical plans or operations may require redistribution or relocation of medical resources. No more medical resources should be committed nor medical treatment facilities (MTFs) established than are required to support the expected patient densities.

*f. Mobility.* Mobility is measured by the extent to which a unit can move its personnel and equipment with organic transportation. When totally committed to patient care, the CSH can retain its limited mobility only by immediate patient evacuation. The hospital's limited mobility severely restricts its capability to relocate assigned personnel and equipment. It is imperative that medical planners program transportation requirements into the system and coordinate with management nodes to ensure adequate transportation assets are requested. Each hospital must have contingency plans to affect a move should one be required; they should routinely do those administrative measures that will enhance the facilities' ability to move. For example, load plans must be developed, maintained, and updated as necessary to ensure that all necessary equipment and supplies are included in the move. The medical planner will identify transportation requirements that exceed the hospital's capability and coordinate requirements with the supporting transportation element.

### **1-3. Levels of Health Service Support**

The HSS system is organized into five levels of support. The TO is normally organized into four levels of support that extend rearward throughout the theater. The fifth level is located in CONUS. Each level has the same capabilities as the level before it, but adds a new treatment capability that distinguishes it from the previous level. In the TO, HSS is tailored and phased to enhance patient acquisition, treatment, evacuation, and RTD as far forward as the tactical situation will permit. Hospital resources located at Levels III and IV will be employed on an area basis to provide the utmost benefit to the maximum number of personnel in the AO. Wounded, sick, or injured soldiers will normally be treated, returned to duty, and/or evacuated to CONUS (Level V) through the theater's four levels. For an additional discussion on the levels of medical care, see FM 4-02.

*a. Level I*—The first medical care a soldier receives is provided at this level. This care includes immediate lifesaving measures, emergency medical treatment (EMT), advanced trauma management (ATM), disease prevention, stress prevention, casualty collection, and evacuation from supported unit to supporting MTF. Level I elements are found in divisions, corps, and at EAC units. These elements include the trauma specialist assisted by first aid (self-aid/buddy aid) and enhanced first aid (combat lifesaver) and the Level I MTF (battalion aid station [BAS]). Some or all of these elements are found in maneuver, combat support, and combat service support (CSS) units. When a Level I medical capability is not present in a unit, this support is provided, on an area support basis, to that unit by the supporting Level II medical unit.

*b. Level II*—Capabilities duplicate Level I and expand available services by adding operational dental care, laboratory, x-ray, and patient holding capabilities. Some Level II facilities also have mental health and preventive medicine (PVNTMED) capabilities. Emergency medical treatment and ATM is continued. If necessary, additional emergency measures are instituted; however, these measures do not exceed those dictated by the immediate needs. Level II units are located in the CZ (brigade, division, corps support areas) and at EAC. Forward support, brigade support, main support, division support, area support medical companies, and medical troops provide Level II medical care. The forward surgical team (FST) from the corps collocates with a medical company/troop and provides emergency resuscitative surgical capability. The combined medical company and FST are generally considered to be Level II+. This capability is organic to the medical company/troop, main support battalion, division support command, airborne and air assault divisions, and the support squadron, armor cavalry regiment (light).



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*c. Level III*—This level of support expands the support provided at Level II. Level III characterizes the care that is provided by the CSH in the corps. Minimum operational functions required for a Level III hospital include: command, control, and communications; patient administration; nutritional care; supply and services; triage; emergency medical treatment; preoperative care; orthopedics; general surgery; operating rooms and central materiel and supply services; anesthesia, nursing services (to include intensive and intermediate care wards); pharmacy; clinical laboratory and blood banking; radiology services; and hospital ministry team services. Operational conditions may require Level III units to locate in offshore support facilities, third country support bases, or in other locations. Level III hospitalization provides hospital care to all classes of patients and with medical resupply can indefinitely sustain care. The Level III hospital in some environments may be augmented with specialty teams, such as head and neck or renal hemodialysis team.

*d. Level IV*—This level of care is provided at an EAC CSH that is normally augmented with additional and specialized medical and surgical capabilities and with additional patient holding capabilities. The EAC CSH is staffed and equipped for general and specialized medical and surgical treatment. This level of care provides further treatment to stabilize those patients requiring evacuation to CONUS.

*e. Level V (CONUS Support Base)*—This definitive level of care is provided in the CONUS support base. The patient is treated in hospitals staffed and equipped to provide the most definitive care available. Hospitals used to provide this care are not limited to US Army hospitals. Hospitals from the other military Services, the Department of Veterans Affairs (VA), and the civilian health care systems may also be included. Civilian hospitals include those hospitals that are members of the National Disaster Medical Systems (NDMS).

### 1-4. Medical Evacuation and Medical Regulating

#### *a. Definition.*

(1) Medical evacuation is the timely, efficient movement and en route care provided by medical personnel of wounded, injured, and ill soldiers from the battlefield or other locations within the TO. Evacuation begins when medical personnel receive the injured or ill soldier and continues as far rearward as the patient's medical condition warrants or the tactical situation allows. The higher level is responsible for coordinating for the evacuation of patients from the lower level of care.

(2) Medical regulating entails identifying the patients awaiting evacuation, locating the available beds, and coordinating the transportation means for movement. Careful control of patient evacuation to the appropriate hospital is necessary to—

- Effect an even distribution of cases.
- Ensure adequate beds are available for current and anticipated needs.
- Route patients requiring specialized treatment to the appropriate MTF.

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