FM 4-02.10

THEATER HOSPITALIZATION

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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

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.

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.

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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.