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EMPLOYMENT OF THE COMBAT SUPPORT HOSPITAL TACTICS, TECHNIQUES, AND PROCEDURES

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PREFACE

Throughout history, much has been written on the confrontations and wars between nations. From the beginning, a major concern of the commander has been the health and fitness of his forces. Following all confrontations, an improvement in tactics and techniques has been sought to enhance the force's ability to win the decisive battle. Over the years, advancements in technology have given our commanders weapons with the lethality to destroy or generate casualties once thought to be impossible. These advancements in technology and battlefield strategy have caused support elements to strive to improve the effectiveness of their services. The Army Medical Department (AMEDD) has maintained the pace in the development and employment of battlefield medical techniques to provide responsive, quality combat health support (CHS) for the military forces.

The purpose of this publication is to describe the functions and employment of one of the CHS assets, the combat support hospital (CSH). This publication is designed for the hospital commander, his staff, and assigned personnel. It embodies doctrine based on Medical Force 2000 and the L-edition Table of Organization and Equipment (TOE) 08-705L000. 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. The staffing and organizational structure presented in this publication reflects those established in the L-edition TOE 08-705L000, effective as of this publication date. However, such staffing is subject to change to comply with Manpower Requirements Criteria outlined in Army Regulation (AR) 570-2 and can be subsequently modified by your modification TOE (MTOE).

This publication is in concert with Field Manual (FM) 8-10, FM 8-55, and Training Circular (TC) 8-13. Other FM 8-Series publications will be referenced in this publication. Users should be familiar with FM 100-5 and FM 100-10.

Echelon is a North Atlantic Treaty Organization (NATO) term used to describe levels of medical care. For the purposes of this publication, the terms "level" and "echelon" are interchangeable.

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This publication implements the following NATO International Standardization Agreements (STANAGs):

STANAG	TITLE
2068 Med	Emergency War Surgery (Edition 4) (Amendment 3)
2931	Orders for the Camouflage of the Red Cross and Red Crescent on Land in Tactical Operations

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

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

This chapter implements STANAG 2068 Med.

CHAPTER 1

HOSPITALIZATION SYSTEM IN A THEATER OF OPERATIONS

1-1. Combat Health Support in a Theater of Operations

a. A theater of operations (TO) is that portion of an area of war necessary for military operations and for the administration of such operations. 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). 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). 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.

b. The mission of the AMEDD is to conserve the fighting strength. This mission of CHS is a continuous and an integrated function throughout the TO. It extends from the CZ back through the COMMZ and ends in CONUS. Combat health support maximizes the system's ability to maintain presence with the supported soldier, 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. Early 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 trauma care and stabilization for evacuation out of the theater.

1-2. Echelons of Combat Health Support

The CHS system within a TO is organized into four echelons of support which extend rearward throughout the theater (see Figure l-l). The system is tailored and phased to enhance patient identification, evacuation, treatment, and RTD as far forward as the tactical situation will permit. Hospital resources will be employed on an area basis to provide the utmost benefit to the maximum number of personnel in the area of operations (AO). Each echelon reflects an increase in capability, with the function of each lower echelon being contained within the capabilities of the higher echelon. Wounded, sick, or injured soldiers will normally be treated, returned to duty, and/or evacuated to CONUS (Echelon V) through these four echelons:

a. Echelon 1. This echelon is also known as unit level. Care is provided by designated individuals or elements organic to combat and combat support (CS) units and elements of the area support medical battalion (ASMB). Major emphasis is placed on those measures necessary to stabilize the patient (maintain airway, stop bleeding, prevent shock) and allow for evacuation to the next echelon of care.

(1) *Combat medic.* This is the first individual in the CHS chain who makes medically