

# Combat Medic Allocation:

## Doctrine Works

by Captain Jeffery S. King

*Task Force 1-67th Armor is conducting a movement to contact. As the lead team in the diamond formation, A Company is the first to come within direct fire range of the enemy. Although the team is doing well, they are taking losses. The first sergeant needs to get his injured off the battlefield and back to the medics at the aid station. His M113 and his maintenance track are picking up wounded and bringing the wounded back to his company casualty collection point (CCP). He has five soldiers on the ground and more are expected. The medics with their M113 ambulance are collocated with him and have treated the wounds. Now he must evacuate the soldiers to the aid station. What will he use to move them back? If he sends the medics, then he will have no medical treatment at his CCP. He has no other vehicles to use because they are forward evacuating to him. He finally calls the aid station requesting evacuation. He now waits for a vehicle to move to his location, pick up his patients, and return to the aid station so his soldiers can receive definitive medical care from a physician or physician's assistant. Time is running out, and his soldiers are nearing death. If only he could save some time.*

This is an all too common scene at the National Training Center (NTC) at Fort Irwin. Although company/teams develop good maneuver plans and supporting logistical plans, they tend to start their rotation behind the power curve when it

comes to medical treatment and evacuation. Most task forces improve in their medical evacuation and treatment by the end of the rotation. For the last 14 rotations, the Died of Wounds (DOW) rate tended to drop from an average of 48% to 35%. In researching the reason behind the DOW rates, "time" and "left on the battlefield" account for the preponderance of soldiers, as seen in Figures 1 and 2. The other categories for died of wounds are "improper treatment," "improper evacuation," and "ROE violators/lost MILES cards." Of all of the categories of DOW, time, and left on the battlefield are the most affected by improper planning and execution of the medical evacuation system. If units can master the planning early, they will evacuate all soldiers off of the battlefield in proper time to save lives and conserve the fighting strength.

Most units that come to NTC plan on using the senior medic riding in the supporting pre-positioned M113 ambulance as the company medic. This is the concept which causes first sergeants a great deal of frustration, as seen in the previous example. The time spent trying to acquire evacuation assets results in the urgent patients losing time and becoming DOW casualties.

To counter this problem, units only need to research their MTO&E and aggressively use doctrine. In armor and mechanized infantry battalions, the medical platoon is divided into four sections or

paragraphs by the MTO&E. (See Figure 3)

The intent is to use the combat medic section as the treatment for the company teams. The company medics are attached to those companies and are with them 24 hours a day. The senior medic rides with and works alongside the first sergeant and provides the medical expertise to the company's logistics plan. The combat medic ensures that all combat lifesavers are trained and fully stocked with Class VIII. It is the combat medic's responsibility to run the company CCP and provide lifesaving care to patients awaiting transportation to the aid station. The company relies on the combat medic to synchronize evacuation with the aid station. In this role, the company combat medic will become the "ad hoc squad leader" for the company's medical team, which includes the pre-positioned M113 ambulance. As the squad leader, the combat medic will brief the ambulance team on the company's mission and concept of operations. This medic will conduct the pre-combat inspections of the ambulance team to ensure that all company PCIs are completed.

Should the battalion cross-attach the company to another heavy task force, the combat medic will stay with the company. The new task force will position another M113 ambulance forward for evacuation. If the company is attached to a light task force, the M113 ambulance should then become part of the attach-

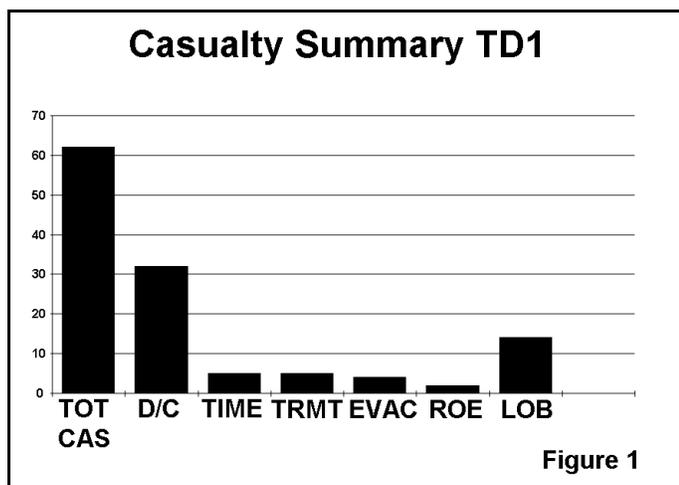


Figure 1

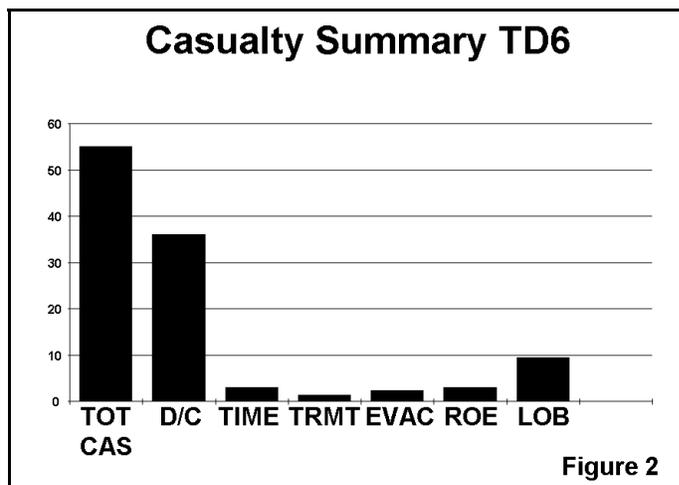
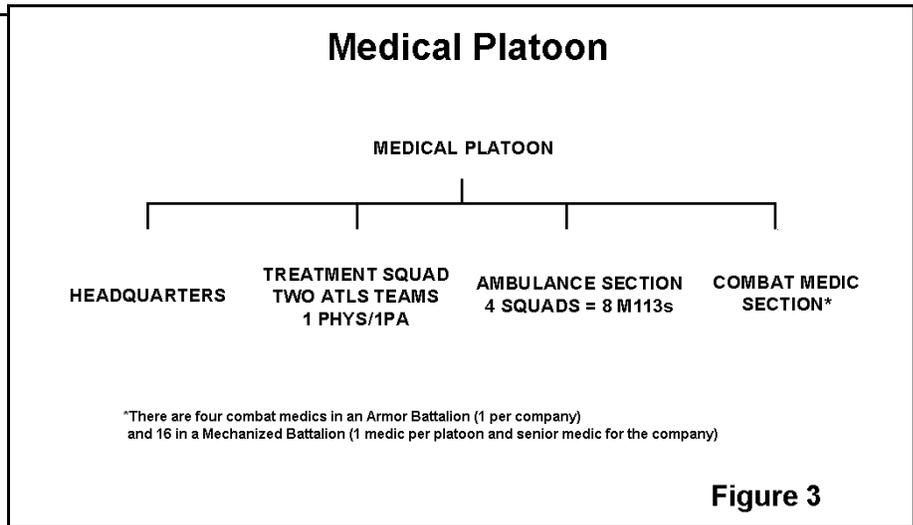


Figure 2

ment. Using this concept of the combat medical section, the evacuation of soldiers should become less trouble for the first sergeant. The pre-positioned evacuation vehicle can now transport patients to the aid station while the senior combat medic runs the CCP. There is no loss of medical care at the company/team level.

The above technique secures the command and control of evacuation vehicles moving within a task force's maneuver space. The assigned medical platoon must understand their task force's Standard Operating Procedures (SOPs) for marking and movement during offensive and defensive operations. There will then be less likelihood of fratricide due to direct fire and obstacles. Again, the senior combat medic, working with the first sergeant, is the key to coordinating the evacuation with their new supporting medical platoon. This provides the ability to rotate evacuation assets to the company/team. As the evacuation M113 moves to the aid station, they can call in a casualty report which could be the trigger for the aid station to send another ambulance forward to the company team. Using this technique, the medical platoon will shorten the time that the first sergeant does not have standard evacuation assets in the company/team. (See Figure 4)

Using the combat medic section in this way also provides the medical platoon leader more flexibility in his support of the task force. In the scenario, each company/team had an evacuation vehicle which was used as its company medic transportation vehicle. This strips the medical platoon of four ambulances and, as a result, the task force of fifty percent of its standard evacuation assets. As a result, the task force would only have four standard evacuation platforms to transport patients from the company/teams to the aid station. This is a total of 16 litter patients prior to nonstandard assets being



utilized. This also limits the ability of the platoon leader to position his assets to the area of casualty densities. A technique to help the medical platoon leader to better manage his assets is by anticipating the casualty densities through participating in the task force's wargaming process. From this, the medical platoon leader can identify which company/team is expected to receive the most casualties at the outset of hostilities, and he can position more ambulances with that company's first sergeant. With the use of all eight evacuation vehicles, the medical platoon greatly enhances its ability to conduct proactive pre-positioning to a specific unit without jeopardizing the support to the rest of the task force.

Most units that come through the National Training Center say that they do not have the manpower to fill the combat medic section. The platoon has the personnel to use the combat medic section, but priority goes to filling the driver and TC positions in the evacuation vehicle positions. The combat medic section is the first one to be stripped. A technique to fill the medical platoon and maintain the combat medic section is to

prioritize the combat medic section first and then the drivers and TC position. Those that are left open are priority fills for the task force.

Should deployments or critical training events occur, these positions should be on the critical shortage list. The task force should request augmentees from the support-

ing forward support medical company. In this technique, the combat medic will already be positioned with the company/team. The first sergeant will have his point of contact for medical information and medical evacuation.

This relationship should not only exist in tactical environments, but should maintain strength in garrison. The combat medic should take an active role in the unit's training and everyday life while conducting daily routines at the unit. During this time, the combat medic could continue the education of the combat lifesavers and conduct necessary classes requested by the first sergeant. The combat medic should also keep the first sergeant informed on the medical status of the company for deployments. In this way, the combat medic will become an integral part of the company/team.

By properly using the combat medic section of the MTO&E, task forces can aggressively attack the problem of treating and evacuating all soldiers from the battlefield to the battalion aid station. In using the combat medic in the planning and execution of the medical fight, the DOW rate will drop for both time and left on the battlefield. The combat power will stay ready to face the enemy. And the will to fight and win will increase because soldiers know that they will be taken care of should they get injured.

*CPT Jeffery S. King received his commission in the Medical Service Corps from Texas Tech University in 1987. He has been a medical platoon leader in the 82nd Airborne Division, and a forward support medical company commander in the 10th Mountain Division. Since September 1996, he has been the medical platoon Armor and Cavalry trainer at the National Training Center.*

