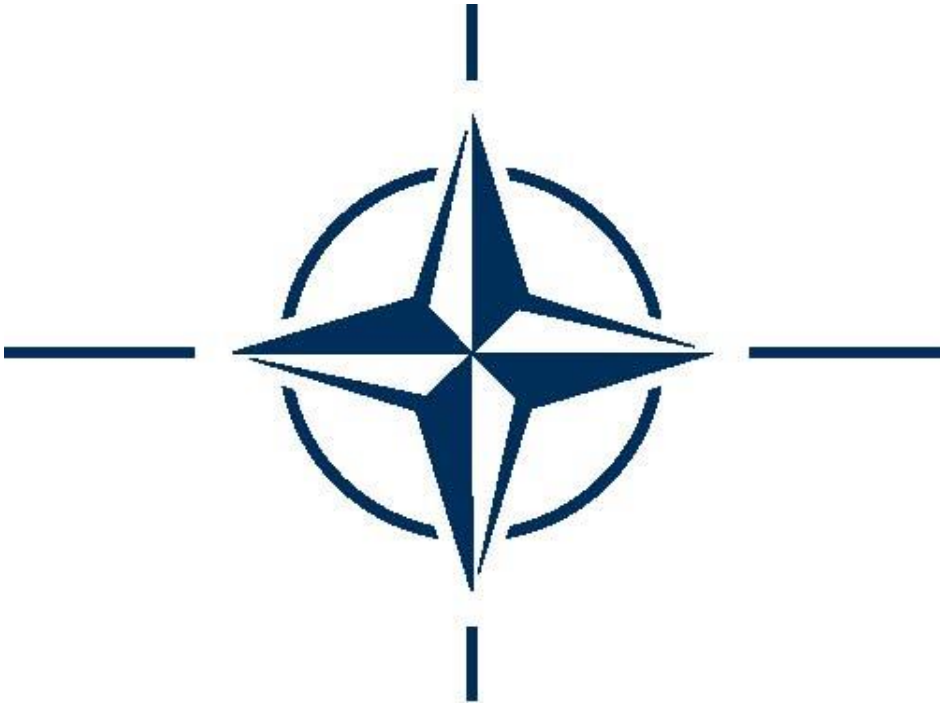
NATO STANDARD

AMedP-4.13

NATO SPECIAL OPERATIONS FORCES (SOF) MEDICAL SUPPORT

Edition A, Version 1

FEBRUARY 2021



NORTH ATLANTIC TREATY ORGANIZATION

ALLIED MEDICAL PUBLICATION

Published by the
NATO STANDARDIZATION OFFICE (NSO)

INTENTIONALLY BLANK

NORTH ATLANTIC TREATY ORGANIZATION (NATO)

NATO STANDARDIZATION OFFICE (NSO)

NATO LETTER OF PROMULGATION

19 February 2021

1. The enclosed Allied Medical Publication AMedP-4.13, Edition A, Version 1, NATO SPECIAL OPERATIONS FORCES (SOF) MEDICAL SUPPORT, which has been approved by the nations in the Military Committee Medical Standardization Board, is promulgated herewith. The agreement of nations to use this publication is recorded in STANAG 6541.

2. AMedP-4.13, Edition A, Version 1, is effective upon receipt.

3. This NATO standardization document is issued by NATO. In case of reproduction, NATO is to be acknowledged. NATO does not charge any fee for its standardization documents at any stage, which are not intended to be sold. They can be retrieved from the NATO Standardization Document Database (https://nso.nato.int/nso/) or through your national standardization authorities

4. This publication shall be handled in accordance with C-M(2002)60.

Zoltán GULYÁS
Brigadier General, HUNAF
Director, NATO Standardization Office

INTENTIONALLY BLANK

RESERVED FOR NATIONAL LETTER OF PROMULGATION

INTENTIONALLY BLANK

RECORD OF RESERVATIONS

CHAPTER	RECORD OF RESERVATION BY NATIONS

Note: The reservations listed on this page include only those that were recorded at time of promulgation and may not be complete. Refer to the NATO Standardization Document Database for the complete list of existing reservations.

INTENTIONALLY BLANK

RECORD OF SPECIFIC RESERVATIONS

[nation]	[detail of reservation]
CAN	Reservations: Canada does not have a Special Operations Critical Care Evacuation Team. The MSRT performs elements of this task while CMERT and Strat MEDEVAC are used to support special operations when additional capability is required.
GBR	UK SFMs do not hold national civilian recognised qualifications and are trained, to various levels, using bespoke non-vocational healthcare provider courses.
LVA	LVA will implement this capability gradually by 2025
NLD	The Netherlands approves only military medical assistance activitities within the Guidelines on The use of Foreign Military and Civil Defence Assets in Disaster Relief - (Oslo Guidelines), International Laws of Armed Conflict and national health legislation
PRT	Portuguese Navy does not have Damage Control Surgery capability. Portuguese Air Force does not have SOF, for this reason the structure and training of health personnel does not include these scenarios. Air Force in its aeromedical evacuations strand may be called to participate in the evacuation of military SOF from other Branches, but not in the primary approach to the victim.
USA	a. Paragraph 2.3.1.2. Edit paragraph to read: In order to optimize survivability, SOF should aim for a 0-30-60 timeline wherever tactically feasible, with Tactical Combat Casualty Care (TCCC) delivery immediately or as soon as possible, DCR as soon as possible and no more than 30 minutes after injury, and DCS as soon as possible and no more than 60 minutes after injury. Timelines given in AJP-4.10(C) are doctrinal planning guidelines and recommend delivery of TCCC in less than 10 minutes, DCR in less than one hour, and DCS in less than two hours. Medical research shows clear benefits for DCR and DCS as soon as possible after injury, with potentially survivable deaths from major trauma beginning within minutes from time of injury.

	b. Paragraph 3.7.1, includes wording that is not noted in the NATO terminology definition for MEDEVAC. The words “under continuous medical supervision and care” are not contained in the NATO definition implying that some MEDEVAC platforms may not afford the capability to provide “continuous medical supervision and care.” The NATO definition is specified as follows: “MEDEVAC: The medically supervised process of moving a person who is wounded, injured or ill to and/or between medical treatment facilities. Notes: Medical evacuation is an integral part of the treatment continuum and will be conducted in accordance with rules of eligibility.”
Note: The reservations listed on this page include only those that were recorded at time of promulgation and may not be complete. Refer to the NATO Standardization Document Database for the complete list of existing reservations.	

TABLE OF CONTENTS

REFERENCES

A.	MC 0326/4	NATO Principles and Policies of Medical Support
B.	MC 0437/2	Special Operations Policy
C.	AJP-3.5	Allied Joint Doctrine for Special Operations
D.	AJP-4.10	Allied Joint Doctrine for Medical Support
E.	AJMEDP-1	Allied Joint Medical Planning Doctrine
F.	AJMEDP-2	Allied Joint Medical Doctrine for Medical Evacuation
G.	ACO DIR 83-2	Allied Command Operations (ACO) Guidance for Military Medical Services Involvement with Humanitarian Assistance and Support To Governance, Reconstruction And Development
H.	NSHQ DIRECTIVE	75-001 Medical Standards and Training Directive
I.	NSHQ DIRECTIVE	30-001 SOF Medical Leaders Handbook
J.	NSHQ SOP Med-001	NSHQ MedOps NSOCM/NSOMT Course Certification SOP
K.	Eastridge et al.	Death on the battlefield (2001-2011): Implications for the future of combat casualty care. J Trauma Acute Care Surg. 2012;73: S431-S437.
L.	Kotwal et al.	The Effect of a Golden Hour Policy on the Morbidity and Mortality of Combat Casualties. JAMA Surg. 2016;151(1):15-24.
M.	Kotwal et al.	A descriptive study of US Special Operations Command fatalities, 2001 to 2018. J Trauma Acute Care Surg. 2019;87: 645–657.
N.	Mc Raven	Spec Ops: Case Studies in Special Operations Warfare: Theory and Practice. William McRaven. Presido Press 1996.
O.	Shackelford et al.	Association of Prehospital Blood Product Transfusion During Medical Evacuation of Combat Casualties in Afghanistan With Acute and 30-Day Survival. JAMA. 2017;318(16):1581-1591.
P.	Remick et al.	Defining the optimal time to the operating room may salvage early trauma deaths. J Trauma Acute Care Surg. 2014;76: 1251-1258.

INTENTIONALLY BLANK

CHAPTER 1 - INTRODUCTION

1.1 GENERAL

1. The nature of special operations missions often requires small, highly skilled, self-contained operational elements capable of operating on short notice. They must function in remote and hostile locations, in all geographic environments, for prolonged time periods, and following insertion by land, air, or water. The requirements to provide medical support in this context differ significantly from those required to support conventional operations.

2. Effective Medical Support for NATO SOF operations is fundamental to mission success. SOF Medical Support is characterized by an austere structure and a limited number of personnel with enhanced medical skills. *SOF Medical Support includes, but is not limited to the prevention of disease, rapid treatment of the infirm, wounded or injured, medical evacuation and the eventual recovery and/or return to duty of NATO SOF's best.* The provision of appropriate and visible medical support demonstrates military resolve.

3. Military Committee Medical Standardization Board tasked NATO COMEDS SOF Medicine Panel with development of this standard with NATO Special Operations Headquarters (NSHQ) as the custodian in accordance to STANAG 6451.

1.2 PURPOSE

This publication aims to provide fundamental principles and commonly agreed standards to improve interoperability of *medical support of special operations forces (SOF) missions*. It explains principles, guidelines and responsibilities of joint medical support to SOF.

1.3 SCOPE

This document is intended for medical and non-medical personnel who provide or plan for medical support to SOF missions. The Publication focuses on medical planning and medical support requirements unique to the nature of special operations missions.

1.4 STRUCTURE

AMedP-4.13 is structured with a main body and a series of annexes to provide greater coherence.

INTENTIONALLY BLANK

CHAPTER 2 - FOUNDATIONS OF SOF MEDICAL SUPPORT

2.1 NATO PRINCIPLES OF MEDICAL SUPPORT

1. The underlying principles of military medical support are consistent regardless of the operating environment or the supported capability. The fundamental principles of timely medical treatment applied with continuity throughout the treatment and evacuation chain, creating a compatible medical support system that is able to contribute to a multinational medical support solution, should underpin any analysis of military medical support.

2. MC 0326, NATO Principles and Policies of Medical Support, outlines the NATO principles of operational medical support and presents the NATO medical polices that are derived from them. Military medical support is able to support the full spectrum of conflict from crisis prevention in peacetime military engagement to peace support operations and combat operations.

3. Health care standards are accountable to the ethical and legal requirements of a clinical profession. The aim of military medical care in operations is to achieve outcomes of treatment equating to best medical practice. The application of this principle must be guided by the principles embodied in the concepts of Clinical Governance and Evidence Based Medicine.

2.2 SPECIAL OPERATIONS ENVIRONMENT

1. Special operations differ from conventional operations because they are frequently executed on short notice, clandestinely, and for strategic purposes where risk is assumed because of mission importance. Special Operations units require flexibility, precision, speed and agility to be successful. Likewise, medical support must meet these same requirements. Medical care must move at the speed of the unit. It must be able to sustain casualties for extended periods because Special Operations Forces (SOF) frequently operate in areas outside the NATO doctrinal medical (planning) timelines.

2. A common misconception about SOF operations is that SOF units are essentially self-sufficient for most, if not all, support enablers. On the contrary, SOF frequently requires conventional force support. Whenever possible SOF will seek to link into available conventional medical support for operations. This potentially increases the risk to SOF by jeopardizing operational security. To mitigate this vulnerability, SOF elements must rely heavily on available surgical and transport resources. Ideally, SOF will have internal surgical and casualty evacuation capability. Accordingly, SOF operators have to be trained in advanced skills for emergency treatment of casualties according to

standardized protocols. SOF medics will require additional medical education and training to independently perform techniques and protocols typically reserved for medical professionals. This will often require specific waivers or endorsements by national authorities. Medical professionals assigned to SOF forces have to be selected, trained and equipped appropriately to operate within the challenging SOF environment and may need special expeditionary medical skills.

3. SOF medical support must maintain high states of readiness in order to be rapidly deployable with the supported SOF units. The medical support must be trained and capable to operate independently in remote and hostile environments and to adapt efficiently to a variety of adversary and environmental threats and changing situations. The medical support should be able to use a wide variety of assets for insertion by land, air, or water into operational areas, maintain a low profile, and possess the mobility to support highly-mobile small-unit operations.

2.3 SPECIAL OPERATIONS MISSIONS

Special operations missions are divided into three principle tasks:[1] Direct Action (DA), Special Reconnaissance (SR) and Military Assistance (MA). Each mission set has specific environmental considerations that must be accounted for when planning and executing medical support to SOF operations.

2.3.1 Direct Action

1. DA missions are characterized by speed and violence of force hinging on surprise as a key combat enabler. The nature of injuries associated with DA missions tend to be high velocity penetrating trauma or orthopaedic in nature. The use of breaching explosives and other means of entry to denied areas increase the risk of injury for SOF operators. Thus, medical support must be focused toward tactical combat casualty care principles. History has proven that frequently in combat scenarios, the SOF medic is either injured or not immediately available to treat casualties because of the tactical situation. Therefore, *SOF medical support for DA missions hinges on the trained medical skills of the operator as much as it does the SOF medic*. Commanders must practice casualty response as an integrated battle drill for all operators to successfully support DA missions. Because penetrating trauma is a common injury in DA missions, Damage Control Resuscitation (DCR) and Damage Control Surgery (DCS) must be available as soon as possible. However, DA missions frequently occur in locations which may not be easily accessible to conventional surgical support. For this reason, highly mobile surgical capabilities that can insert near or on an objective to provide lifesaving resuscitation and surgery are necessary.

[1] MC 0437 *Special Operations Policy*

2. Timelines given in AJP-4.10(C) are doctrinal planning guidelines and recommend delivery of Tactical Combat Casualty Care (TCCC) in less than 10 minutes, DCR in less than one hour, and DCS in less than two hours. Medical research shows clear benefits for DCR and DCS as soon as possible after injury, with potentially survivable deaths from major trauma beginning within minutes from time of injury. In order to optimize survivability, **SOF should aim for a 0-30-60 timeline wherever tactically feasible,**[2] with TCCC delivery immediately or as soon as possible, DCR as soon as possible and no more than 30 minutes after injury, and DCS as soon as possible and no more than 60 minutes after injury. Likewise, advanced evacuation platforms capable of providing en-route medical care, particularly damage control resuscitation should be utilized in direct support of the mission. Both early surgical intervention and high level evacuation care are desirable elements of SOF medical support for these high-risk missions.

2.3.2 Special Reconnaissance

1. SR missions are typically longer duration missions characterized by clandestine insertion into an area or observation point, conduct of missions without detection and extraction from the area of operations. Medically supporting these missions is limited by what the medical provider can carry and the limited ability to communicate with higher medical support. Because these missions frequently require prolonged exposure in harsh uncomfortable conditions, particularly maritime special reconnaissance, early treatment intervention for disease and non-battle injuries (DNBI) becomes mission critical.

2. To sufficiently support these missions, medical personnel must be able to make independent medical decisions consistent with their level of training and national policies, and be physically capable of keeping pace with the special reconnaissance element. To be successful, SOF units require special medical protocols for their providers and operators that may extend above the usual medical authorities and skills of their conventional counterparts. Leveraging distance and telemedicine capabilities can be useful in supporting these missions.

[2] The recommended timelines of immediate TCCC, followed by DCR within 30 minutes and DCS within 60 minutes are based on research by Kotwal et al. (A descriptive study of US Special Operations Command fatalities, 2001 to 2018. J Trauma Acute Care Surg. 2019;87: 645–657.), Shackelford et al. (Association of Prehospital Blood Product Transfusion During Medical Evacuation of Combat Casualties in Afghanistan With Acute and 30-Day Survival. JAMA. 2017;318(16):1581-1591.), Kotwal et al. (The Effect of a Golden Hour Policy on the Morbidity and Mortality of Combat Casualties. JAMA Surg. 2016;151(1):15-24.), Remick et al. (Defining the optimal time to the operating room may salvage early trauma deaths. J Trauma Acute Care Surg. 2014;76: 1251-1258.), Eastridge et al. (Death on the battlefield (2001-2011): Implications for the future of combat casualty care. J Trauma Acute Care Surg. 2012;73: S431-S437. Tactical or medical reasons for deviating from the timeline should be part of every CONOP.

2.3.3 Military Assistance

Medical support of SOF MA missions typically fall into two potential categories; medical engagement and medical partnering. In medical engagement, a SOF Commander leverages medical capability to engage an area or population for both operational and medical objectives. In medical partnering, a SOF commander uses his medical assets to train a partner force in medical skills to improve interoperability and medical capability to support operations. Both categories of military assistance medical support present unique challenges.

2.4 TREATMENT CAPABILITIES AND ORGANIZATION IN SUPPORT OF SPECIAL OPERATIONS

1. In order to be able to provide immediate medical care when conducting discreet or clandestine operations in remote locations, advanced treatment capabilities need to be integrated at the lowest level of SOF operational elements.

2. A Special Operations Task Unit (SOTU) must have at least one NATO Special Operations Combat Medic (NSOCM) or Special Operations Medical Technician (NSOMT).[3] The availability of NSOCMs/NSOMTs may be a key factor in a SOTU's operational status. Depending on the type of mission, some SOF units may require two NSOCMs/NSOMTs within a single SOTU. The availability of more than one NSOCM/NSOMT within a SOTU may be a deciding factor in determining whether a SOTU is capable of split-team operations.

3. A Special Operations Task Group (SOTG) or Special Operations Component Command (SOCC) may have a Special Operations Surgical Team (SOST)[4] and/or a Special Operations Critical Care Evacuation Team (SOCCET) to mitigate medical risk, especially when operating outside recommended timelines.

4. For levels of care beyond the capabilities found within the initial surgical capability, conventional medical treatment capabilities, or host nation (HN) or national civilian health care systems should be considered.

5. Medical and surgical treatment capabilities (other than NSOCMs/NSOMTs) in support of Special Operations can either be organic,

[3] If national regulations do not allow the training of NSOCM/NSOMT, a NATO Special Operations Medical Provider (NSOMP) should be deployed with the SOTU.

[4] SOST and also a SOCCET are specially selected, trained and equipped to work in the SOF environment together with SOF units. Whereas medical capabilities may be similar to the capabilities of the Role 2F or the CCAST/CCATT, the capability to operate, move and communicate with the supported SOF unit is not present in all Role 2F/CCAST/CCATT. All SOSTs are Role 2Fs, but not all Role 2F are SOSTs.

attached, or in support to a SOTG. When attached or in support, they can either be dedicated to SOF or be a dual-use capability, trained to support Special Operations in addition to conventional operations.

2.5 CASUALTY MOVEMENT[5] CAPABILITIES AND ORGANIZATION IN SUPPORT OF SPECIAL OPERATIONS

1. The seriously injured or ill casualty must be evacuated as soon as possible to the most appropriate facility which may not necessarily be the nearest.

2. Casualty movement may occur under different tactical circumstances:

   a. As a separate evacuation mission while the main force continues tactical operations.

   b. Along with the main force following mission abort due to the requirement to evacuate one or more casualties.

   c. Along with the main force as it exfiltrates from the objective after completion of the action at the objective.

3. Casualties can be moved from the battlefield to a higher level of care by any ground, air, or maritime platform able to transport personnel. SOF typically does not have an organic, dedicated medical evacuation (MEDEVAC) capability. Often the use of SOF tactical platforms will be required to conduct evacuation to medical treatment facilities within acceptable timelines. SOF ground, air, and maritime waterborne and amphibious tactical platforms should routinely carry medical kits and evacuation equipment without having to rely on medical kits carried by SOF providers.

4. Specific to SOF operations, the most important considerations are the ability to move casualties from a hostile and austere tactical environment to a more secure location capable of providing advanced medical care, and the availability of appropriate en-route care. This will often require the use of armed and protected tactical platforms.

5. When conducting casualty movement, additional medical personnel should arrive with the evacuation asset, if available. Even though medical personnel are often part of the SOF operation, certain situations may limit their ability to assist with evacuation:

[5] The term “casualty movement” is used here in order to prevent confusion with the defined terms “casualty evacuation (CASEVAC)” and “medical evacuation (MEDEVAC)” and refers to movement of a casualty regardless of the movement being classified as CASEVAC or MEDEVAC.

a. The medical personnel may be among the casualties.

b. The medical personnel may need to continue on the unit's mission and be unavailable to escort the casualty.

c. The medical personnel may have been temporarily separated, and may not have been at the point of injury.

6. The continuum of care must be maintained throughout evacuation. Casualties taken initially to a forward surgical facility with only a limited holding capability (such as a SOST) will usually necessitate subsequent evacuation to a more capable facility before evacuation to definitive care. This transfer may be necessary within a few hours of surgery, depending on the condition of the patient and other circumstances, particularly intensive care capability and capacity as well as the security environment. If no separate critical care transportation personnel are available, a SOST may have to provide en-route critical care for patients being moved to a higher echelon surgical facility, following damage control surgery at a forward location.

7. Evacuation of casualties will be coordinated with the medical cell inside the SOCC Joint Operations Centre (JOC) and inside the operational-level headquarters Combined JOC.

8. SOTUs should have integral tactical rescue capabilities.[6] While not a purely medical capability, tactical rescue is an essential individual and team skill required to extract casualties.

2.6 SOF LEADERS CASUALTY RESPONSE CAPABILITIES

1. The occurrence of a casualty during Special Operations is not an isolated medical issue, but a tactical-medical problem in which there may be a direct conflict between what is best for the casualty and what is best for the mission. SOF leaders at all levels should be educated on the operational consequences of casualties and how to manage such events. Realistic leader-directed casualty battle drills should be embedded into SOF unit tactics and tactical training exercises.

2. In addition to the acute treatment priorities of a deployed task force, and depending on the operational situation and the overall Medical Support System in the Joint Area of Operations, a SOF medical support system may need to

[6] Tactical rescue capabilities refer to the ability to employ special rescue skills, techniques and equipment not usually available in standard medical or tactical teams and under combat conditions. It includes, but is not limited to extrication from vehicles, confined spaces, collapsed or damaged structures, heights, or difficult terrains.

include a range of medical specialties such as nurses, dentists, veterinarians, psychiatrists, psychologists, physical therapists and Chemical Biological Radio Nuclear (CBRN) specialists etc.

INTENTIONALLY BLANK

CHAPTER 3 - SOF MEDICAL SYSTEM ORGANIZATION

3.1 OVERVIEW

1. SOF Medical support is characterized by the requirement to integrate tactical, security and medical aspects. A functioning SOF medical system is paramount to ensure mission success as well as health and wellbeing of SOF personnel. Core capabilities of every SOF medical system should include the eight pillars.[7]

- Leadership
- Personnel
- Planning
- Training
- Treatment
- Evacuation
- Communication
- Logistics

2. In addition, SOF specific Human Performance Programs (HPP) play an essential role in physical and mental preparation of SOF personnel who are healthy, injured or being rehabilitated.

3.2 LEADERSHIP

1. Effective medical Command and Control (C2) is critical in the overall success of SOF medical support. It must be integrated in all operational and tactical planning. As such, it is compulsory that SOF commands have a medical advisor and joint medical staff that are incorporated into headquarters at the tactical, operational and strategic levels.

2. A SOF medical leader must have a comprehensive understanding of military and medical aspects within the SOF environment.[8]

[7] Not all capabilities must be organic or permanently embedded within the SOF unit. However, if external capabilities are a conceptual part of a SOF medical system, they need to be tailored to the specific needs of the SOF unit supported and require close coordination with the SOF medical staff.

[8] Medical leadership on different levels can be by any medically trained person, whoever is responsible.

3. SOF medical leaders should strategically engage with medical and non-medical leaders. This includes but is not limited to civilian and military entities.

3.3 PERSONNEL

1. In order to provide immediate medical care when conducting SOF operations, advanced treatment capabilities must be integrated into the lowest level of SOF tactical elements. These efforts must be coordinated and supported by dedicated SOF medical leadership at all levels.

2. To ensure interoperability and comparable standards of care throughout NATO, roles and responsibilities in the SOF medical system must be clearly defined.

3. Special Operations First Responders[9] representing a DCR capability must have a minimum qualification as NSOCM or NSOMT.

3.3.1 NATO Special Operations Combat Medics

1. The NATO Special Operations Combat Medic (NSOCM) is a Service Member who provides TCCC and advanced tactical medical support directly to SOF. NSOCMs will be SOF operators with specific, standardized medical education and training as per NSHQ Directive 75-001.

2. In case a medic[10] is not a SOF operator (e.g. medical or support personnel), they must be appropriately trained. Civilian or conventional medical training on its own is not sufficient to support SOF operations. Such personnel must complete a NSHQ recognized NSOCM course and be trained and equipped appropriately to operate within the challenging SOF environment. A standardized selection and training program is mandatory. NSOCMs must be an organic asset of SOF units or have a dedicated supporting relationship to a SOF unit.

3. NSOCMs receive additional medical education and training to independently perform combat casualty care techniques and protocols typically reserved for medical professionals.

[9] AJP-4.10(C)

[10] The term "medic" is used in this context for a service member tasked with providing the first medical response capability beyond self and buddy aid, but who doesn't fall in the other categories.

4. NSOCM qualification requires the graduation from an NSHQ recognized NSOCM training program or equivalent[11] and regular sustainment training, including recertification every two years. Training and sustainment requirements are defined within NSHQ Directive 75-001 Medical Standards and Training Directive.

3.3.2 NATO Special Operations Medical Technician

1. The NATO Special Operations Medical Technician (NSOMT) is medical personnel that have undergone a standardized selection and training program. Standards for selection, tactical training and equipment for personnel dedicated to directly support SOF missions are defined by the supported SOF units. NSOMTs must be an organic asset of SOF units or have a dedicated supporting relationship to a SOF unit. Some nations will also rely on SOF operators with specific, standardized medical education and training as per NSHQ Directive 75-001 to the level of a NSOMT. The NSOMT closes the gap between NSOCM and credentialed medical providers by incorporating advanced medical techniques, as well as tactical capabilities.

2. The NSOMT must have a national civilian healthcare qualification as a paramedic, nurse or equivalent. This qualification can be acquired before or during the NSOMT training program.

3. NSOMT qualification requires the graduation from an NSHQ recognized NSOMT training program or equivalent[12] and regular sustainment training, including recertification every two years. Training and sustainment requirements are defined within NSHQ Directive 75-001 Medical Standards and Training Directive.

3.3.3 NATO Special Operations Medical Providers

1. Special Operations Medical Providers are health care professionals who have undergone a national military selection and training program to function in the SOF environment as part of a SOF unit. They have the ability and authority to treat patients independent of the presence of a supervisor, including prescribing authority. Depending on their specific national tasks, they should have experience in emergency medicine and related specialties as well as SOF Medicine. These providers support Special Operation Units with the

[11] The training program can be conducted by a national or international training facility or within a SOF unit. Specifics of the process to recognize a program are defined in the NSHQ MedOps NSOCM NSOMT Course Certification SOP (NSHQ SOP Med-001).

[12] The training program can be conducted by a national or international training facility or within a SOF unit. Specifics of the process to recognize a program are defined in the NSHQ MedOps NSOCM NSOMT Course Certification SOP (NSHQ SOP Med-001).

oversight and authority to develop, plan, mentor and train medical skills to organic support personnel, SOF operators, NSOCMs and NSOMTs.

2. NATO SOF medical providers must be an organic asset of SOF units or have a dedicated supporting relationship to a SOF unit. They must be operationally qualified to directly support SOF operations.

3. Training requirements are defined within NSHQ Directive 75-001 Medical Standards and Training Directive.

3.3.4 SOF Medical Advisor

1. The SOF Medical Advisor (MEDAD) in a formation headquarters is part of the command group and responsible for ensuring that the commander and his staff are properly aware of the health and medical implications of their actions and any force health protection issues connected to the operation. This includes raising awareness of SOF medical capabilities and shortfalls. Direct access of the MEDAD to the commander is essential to ensure that all health and medical support related matters requiring the commander's attention, decision and action, can be addressed in time and based on professional expertise. Key responsibility are to oversee medical training, medical planning/execution/evaluation/LI&LL of operations and ensure medical readiness of the unit.

2. The MEDAD should be supported by the JMED branch.

3. A MEDAD should be appointed to all SOF Headquarters (e.g. battalion, group, regiment, SOCC, SOTG) and provide oversight and guidance in all medical matters.

4. The MEDAD should have a medical degree (e.g. physician, dentist, physicians assistant, nurse, public health expert, veterinarian, or pharmacist) and have completed a specific training pathway for medical advisors. In addition he or she must have experience working in the SOF environment and have a comprehensive understanding of military, SOF specific and medical aspects within the SOF environment. The JMED should include at least one individual with a clinical background.

3.3.5 SOF Medical Planner

1. The SOF medical planner must have a comprehensive understanding of military, SOF specific and medical aspects within the SOF environment. The SOF medical planner has to be proficient in staff planning processes, procedures and medical planning in particular. The SOF medical planner coordinates medical plans with higher levels of command and subordinate units.

2. SOF medical planners do not require medical-technical skills or a medical degree. They report to the MEDAD for all medical matters.

3.4 PLANNING

1. NATO has adopted a comprehensive approach to operational thinking. This reflects a culture of collaboration and integration. Special Operations needs to be integrated within all levels of staff planning within the joint task force. Operational and Strategic objectives are the SOF commander's end state. SOF medical planning must be integrated at every command level. An effective plan reflects an understanding of the expected operating environment, task, force disposition and commander's end state.

2. Timely and thorough medical planning, including contingency and emergency planning, is essential for effective medical support and mission success.

3. SOF medical planning must be coordinated with overall medical plan for the AoR to ensure a proper continuum of care.

3.5 TRAINING

1. Medical training for SOF units must be mission oriented and focus on medical skills acquisition and sustainment, as well as casualty response training. It should include casualty scenarios that require collaboration and coordination between conventional medical support elements, SOF medical assets and SOF commanders.

2. All SOF operators and all non-operators deploying with or in support of SOF units, including staff personnel as well as base support personnel must be medically trained according to NSHQ Directive 75-001.

3. Medical scenarios must be incorporated in all tactical training to ensure adequate casualty response on all levels.

4. Mission specific medical support assets (e.g. MEDEVAC, SOST, or SOCCET) must be incorporated in unit training in order to perform integrated medical training scenarios. Military medical personnel require complementary skill sets that ensure they have the military and clinical proficiency required of them.

3.6 TREATMENT

Treatment is based on the general principles for medical support, outlined in MC 0326 and AJP-4.10. SOF are often required to operate outside the area

of medical coverage not being able to meet clinical timelines. To mitigate the resulting risks medical care provided is capability based, not facility based. This is often outside conventional planning guidelines and national regulations and thus requires specific waivers or endorsements by national authorities.

3.6.1 Lifesaving first response measures

Every individual deploying with SOF must be capable of providing lifesaving first response measures based on TCCC principles. This includes at a minimum bleeding and airway control immediately or as soon as possible. Treatment protocols must be aligned with the unit's casualty response SOPs and take tactical as well as medical aspects into consideration.

3.6.2 Damage Control Resuscitation (DCR)

DCR is a systematic approach to dealing with major trauma combining the catastrophic bleeding, airway, breathing and circulation paradigm with a series of clinical techniques. This includes immediate lifesaving measures, invasive interventions and emergency blood transfusions, in order to minimize blood loss, maximize tissue oxygenation and optimize outcome. DCR is generally provided by emergency medical personnel and includes advanced skills and techniques that are usually reserved to military medical personnel. In SOF operations, DCR can be provided by NSOCMs, especially when it is tactically not feasible to deploy more advanced medical capabilities[13]. The goal for combat casualties who require it is to provide DCR as soon as possible and not more than 30 minutes after injury.

3.6.3 Damage Control Surgery (DCS)

DCS is a surgical approach where the completeness of immediate surgical repair might be sacrificed to achieve haemorrhage and contamination control and to restore circulation and perfusion, in order to avoid a deterioration of the patient's condition. It consists of emergency surgical procedures and treatment to stabilize casualties, in order to save life, limb or function. In SOF operations, DCS is usually provided by Special Operations Surgical Teams (SOST) that consist of specially selected, trained and equipped personnel that are able to work in austere and/or hostile operational environments. Depending on mission characteristics, it may be necessary to rely on conventional DCS assets or move a casualty directly to a Role 2/3. The goal for combat casualties who require it is to provide DCS as soon as possible and not more than 60 minutes after injury.

[13] Depending on national regulations it might be required to reserve certain procedures to NSOMTs or SOMPs.

3.7 EVACUATION

1. Medical Evacuation (MEDEVAC) is the process of moving any person who is wounded, injured or ill under continuous medical supervision and care to or between medical treatment facilities as an integral part of the treatment continuum.[14] Additionally, it is conducted during military operations by designated assets able to provide in-transit care in accordance with prevailing medical standards at the same or a higher level as provided by the originating unit.[15] Casualty Evacuation (CASEVAC) means unplanned or occasional movements of casualties not employing dedicated or designated medical capabilities. The differentiation between MEDEVAC and CASEVAC needs to be consistent throughout NATO nations. SOF will often use means of casualty movement providing the same level of care as MEDEVAC using platforms that may not fulfil MEDEVAC definitions. For SOF medical support, all medically escorted transportation of casualties on a designated platform will be considered ”CASEVAC with qualified medical escort,” as long as it provides the same or higher level care from the originating unit.

2. Appropriate and timely evacuation of casualties is essential for SOF medical support, whether via dedicated medical platforms or via designated tactical platforms. The principles lined out in AJP-4.10 and AJMedP-2 also apply for SOF operations. Especially for initial casualty movement, SOF will often rely on non-standard and/or non-designated assets to move casualties while still adhering to the principle of continuum of care. This can be achieved by en-route care provided by NSOCMs, NSOMTs, NSOMPs, Special Operations Critical Care Evacuation Teams (SOCCET) or a SOST with en-route surgical capability.

3. MEDEVAC or CASEVAC with qualified medical escort for SOF missions must be coordinated with the responsible Personnel Evacuation Coordination Centre (PECC) in the AoR, to ensure seamless transition of casualties from the SOF medical system to the conventional medical system. This will often require the weighing of Operations Security (OPSEC) versus medical requirements.

3.8 COMMUNICATION

1. Medical information management and communication in Special Operations requires many of the common characteristics of civilian and conventional force medical information systems. In fact, those shared characteristics are crucial to ensure interoperability and support of supporting medical assets.

[14] Medical Evacuation and “Medically supervised” refers to tasking authority by a PECC and general oversight by the medical service, AJP 4-10.
[15] AJP 4-10.

2. The efficient management of medical information is a vital element of competent medical support planning and developing a comprehensive medical common operating picture (MEDCOP). This includes, but is not limited to medical intelligence, patient tracking, medical reporting, quality assurance, scientific evaluation and lessons learned. Therefore, specific protocols that consider OPSEC and medical confidentiality need to be developed on national and NATO level.

3. Telemedicine is an important tool to improve healthcare for deployed SOF. NSOCMs and NSOMTs must have the ability to reach back to an appropriate credentialed medical provider for support and guidance. Development of appropriate protocols and SOPs are essential for telemedicine capabilities.

3.9 LOGISTICS

1. SOF medical logistics can present significant challenges for medical support. Because space and weight are limited in SOF units, medical equipment and treatment supplies will compete with other operational requirements like food, water, and ammunition for space. SOF medical equipment and supplies will frequently need to be dual purpose and capable of easy disposal, must withstand the extremes of temperature and field conditions, and be simple to use in high pressure situations. For this reason, SOF frequently rely on off-the-shelf technologies specially designed for the SOF environment that are not common to the conventional medical supply distribution chains of most nations. The flexibility to procure and the authority to use these items require senior medical leadership involvement, and are critical to maintaining the edge that gives SOF units the advantage over conventional forces.

2. Availability of blood and blood products is particularly important in the austere environment with prolonged evacuation timelines. The ability to administer blood far forward requires specific measures like international agreements, blood chain resupply, cold chain management, transfusion protocols and specialized equipment. SOF units may need specific waivers from national authorities to use products or protocols such as whole blood transfusion if they are to save lives in this challenging environment.

3. Since most nations do not have SOF specific logistic chains of supply, SOF medical logistics will frequently rely on the conventional medical logistics system for procurement and resupply of non-SOF specific medical supplies. SOF medical planners should coordinate with SOF J4 during early stages of the Crisis Response Planning Process or during the high level planning phase in order to facilitate the development of the LOG-MED Concept of Support to sustain SOF activities.

3.10 HUMAN PERFORMANCE PROGRAMS

1. Human Performance (HP) programs are designed to improve operational readiness of the unit as a whole as well as individual operators. This includes improvement of physical and mental readiness resulting in a reduction of adverse occupational effects on health and well-being. Injury prevention and optimal rehabilitation can accelerate return to duty after injury and increase the operator lifecycle.

2. HP optimization is a holistic, multi-professional approach and not an exclusive medical responsibility.

3. SOF HP programs must address the unique characteristics of SOF culture and operational challenges. Conventional HP efforts rarely address the specific needs of SOF organizations as SOF operators are specially selected and trained for certain physical and mental attributes.

4. SOF HP staff must have comprehensive understanding of SOF culture and operational requirements. Different professions (e.g. physical training instructors, mental performance specialists, psychologists, medical professionals, nutritionists) must closely cooperate and coordinate, but also respect professional boundaries.

INTENTIONALLY BLANK

CHAPTER 4 - SOF MEDICAL PLANNING

4.1 PRINCIPLES OF MEDICAL SUPPORT TO SPECIAL OPERATIONS

1. Medicine is considered a SOF enabler. Admiral McRaven's Theory should be incorporated as background during the planning and execution phases of SOF medical missions.

a. Simplicity: Simple, effective treatments; advanced scope of practice.

b. Surprise: Embedded with force.

c. Security: OPSEC sensitive, but coordinated with higher echelons.

d. Purpose: Enhance mission success and save lives.

e. Repetition: Practiced support (right time, right place, right treatment).

f. Speed. Moving at the speed of tactical elements.

2. Adaptation of the six principles will allow SOF forces to gain relative superiority in a mission. Fundamental gaps in the principles will add to increase a Commanders vulnerability. For all these, “less” is preferred to “more” in terms of being able to adhere to the principles. For example, highly mobile, smaller footprint embedded teams are preferred over robust, high profile assets.

3. Medical support to SOF must be flexible, precise, agile, and having the velocity of the forces they support. A SOF operational plan is best when it maximizes the six principles of SOF: Surprise, Speed, Security, Purpose, Repetition and Simplicity. A SOF plan is most likely to be successful if it is a simple plan, carefully conceived, repeatedly and realistically rehearsed, and executed with surprise, speed, and purpose. When considering the type and scope of medical support for such operations, medical planners must create plans that meet the most serious threats without diminishing the principles of SOF operations. The medical plan will always be a balance between the desired medical standard and the effect of maximizing the 6 SOF principles.

4. To this end medical planning must be integrated at every command level and must not be borrowed from conventional forces. The Medical Advisor is responsible for overseeing all planning and must be represented on all levels. Commanders must receive a comprehensive brief by trained SOF medical advisors and medical personnel on medical risks and mitigation strategies.

4.2 SOF MEDICAL PLANNING CYCLE

1. Many of the frictions of war and vulnerabilities associated with SOF operations are medical in nature. Careful analysis of the commander's plan with an eye for tactical vulnerabilities and medical vulnerabilities can help identify risk areas requiring mitigation. Good medicine can reduce the area of vulnerability of assets and increase relative superiority, not only by minimizing the impact of a casualty on the mission, but also by ensuring operators that they will get the best care possible. Too much medicine or medicine at the wrong time can increase the area of vulnerability and decrease relative superiority.

2. The key is to systematically analyse the developing plan to identify vulnerabilities that can be mitigated through medical channels. Ensure that the mitigation does not impede the unit's ability to maximize SOF principles. Figure ***1*** below shows the SOF Medical Planning Cycle. This can aid the medical planner to execute a medical plan for current and future SOF mission as well as using it for the lessons learned process for previous SOF missions. Integrating the SOF principles, the Eight Pillars (see chapter 3) and the Medical Planning Cycle will ensure a well-structured medical plan. MC 0326, MC 0437, AJP-3.5, AJP-4.10 and AMedP-1 will also aid medical planners to execute the medical plan and present the medical plan during the orders process.

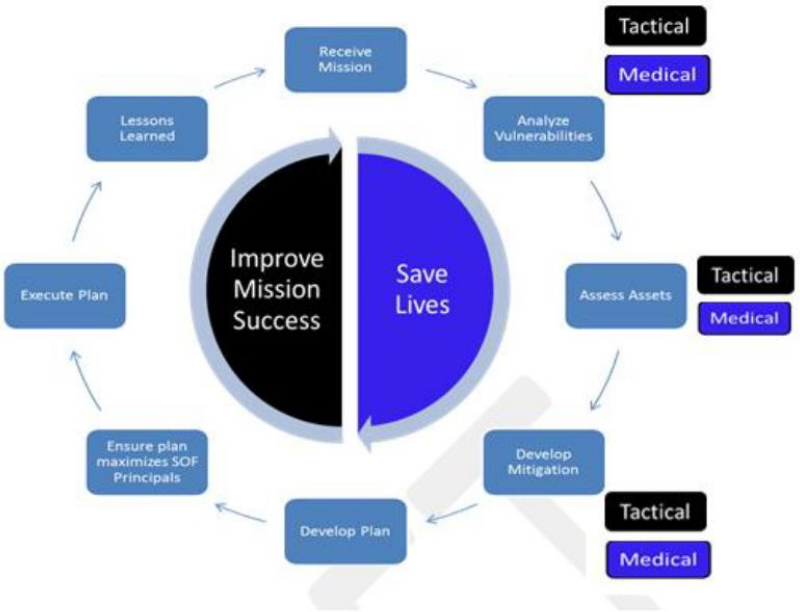


Figure 1 – SOF Medical Planning Cycle

4.3 PLANNING CONSIDERATIONS FOR MEDICAL SUPPORT TO SPECIAL OPERATIONS

4.3.1 Principal tasks of SOF Forces. **SOF has three principle tasks, Military Assistance (MA), Special reconnaissance (SR), and Direct Action (DA).** Planning for medical support to SOF must take into account specific varying factors between them. These include but are not limited to:

1. Military Assistance. Planning consideration for medical support to MA may include the considerations for both SR and DA (see below), since these may be implied tasks in any MA mission. In addition, medical support to the assisted HN security forces or local guerrilla forces, as well as to their relatives or even their extended communities can be a direct or an implied task and must therefore be taken into consideration in the planning phase. This includes reliable information about local medical treatment capabilities.

2. Special Reconnaissance. Medical risks associated with SR missions are mainly related to environmental conditions prevalent in the often austere operational area, as well as to the physiological effects of prolonged inactivity during extended surveillance in confined spaces. A special reconnaissance missions are mostly conducted covert, weight and size limitations as well as evacuation difficulties contribute highly to the medical risk.

3. Direct Action. Medical risks associated with DA missions are mainly related to combat trauma. In addition to medical support to the SOF element conducting the operation, treatment of wounded non-combatants and adversary combatants may have to be planned for.

4.3.2 Intelligence Preparation of the battlefield

1. Intelligence is the product resulting from the processing (collection and analysis) of information concerning foreign nations, hostile or potentially hostile forces or elements, or areas of actual or potential operations. The intelligence (J2) staff is responsible for all intelligence activities.

2. Medical information incorporates all information on medical or environmental threats or on health infrastructure which has been gathered through non-intelligence channels and which has not been analysed for intelligence content.

3. Medical intelligence is the product resulting from the directed collection and assessment (processing) of medical, bio-scientific, epidemiological, environmental and other information related to human or animal health, to identify threats and offer opportunities for exploitation by decision-makers. Medical intelligence is not to be used, to take any advantage of medical

vulnerabilities of any party as this would be a serious violation of fundamental ethical and legal conventions and likely have deleterious effects.

4. SOF Medical expertise plays a significant role in intelligence preparation and force protection, in particular for the identification of health threats to deployed personnel. Proper intelligence preparation of the battlefield is the key element of medical planning.

4.3.3 Operational safety context

1. The operational context and safety thereof often dictates the assets which can be used on the mission.

a. Permissive. In the permissive environment the medical plan will often incorporate conventional assets. In these situations they will fit more easily in the operation while providing the highest level of care.

b. Semi-permissive. In this setting there has to be more negotiation between the level of care desired and the risk to the operation and core principles. The use of assets is mostly limited to Enablers and SOF personnel. Examples are SOSTs, SOF trained medical teams, SOMPS, NSOMT and NSOCMS.

c. Denied environment. Putting non-SOF personal in a denied environment, including enablers, is often not feasible nor effective. This may limit the use of even a SOST. Assets are mostly only NSOMT or NSOCMS with an expanded scope of practice. Evacuation will mostly include unconventional methods.

2. Even though the use of medical assets on the mission might be limited, there always needs to be a pre-planned connection or link to the conventional medical system to ensure continuum of care and access to levels of care that are outside the SOF medical system.

4.3.4 Medical Threat Assessment

1. SOF frequently operates in remote austere areas and may therefore be exposed to health risks not normally seen in other areas of the joint operations area. This factor, coupled with the fact that SOF is held on short response times, routinely require proactive planning for the provision of robust preventive medicine measures, such as immunizations against a wide variety of potential diseases. There is an essential requirement for specific expertise to address occupational and environmental factors relevant for SOF. This includes but is not limited to dive medicine, flight/altitude medicine, tropical medicine, medical implications of working in extreme climates or under CBRN exposure.

2. Effects of adversary tactics and associated weapons-munitions systems used affect planning of medical assets in terms of capabilities required to cope with likely injuries and in terms of recognizing the need for protected evacuation assets. In addition, SOF medical plans should anticipate the fact that changes in adversary tactics may require rapid changes in SOF medical capabilities, including the fielding of new and/or additional medical equipment and supplies to the lowest levels.

3. Medical Operations to Support Local Populations. When planning to conduct medical engagements with local populations, SOF planners should ensure that these medical outreach operations support SOCC and Joint Forces Command (JFC) overall objectives and do not undermine them through medical and tactical unintended consequences. In contrast to the term MEDCAPs, Medical Outreach is a planned medical engagement activity, which in its design and execution meets the principles described in Para 9 above. Such activities will be dependent on the needs of the operational situation, and should be agreed with the appropriate authorities and other civilian agencies, and be consistent with their policies, noting the principle of civilian primacy. Engagements may include capacity building, development of infrastructure projects and logistic support. Direct provision of healthcare would be by exception; examples might be veterinary projects to improve food production, but in co-operation with the local authorities and only where such interventions do not interfere with provision by local professionals, or the development of such capability and capacity. In all cases the intervention must address the health need, and be appropriate to the level of care that can be realistically and competently sustained. [16]

4. Casualty Estimates. Special operations missions are unique in a number of ways. For example, contact with the adversary is often sought, they are conducted using surprise, and prolonged force-on-force operations are avoided. As a consequence, producing, reliable, accurate casualty estimates is challenging. Exceptions to this are specific actions involving relatively large forces, such as a parachute insertion conducted by a large SOF unit. Here more accurate casualty estimates, based on specific factors related to the environment and the type of equipment used (but not related to adversary action), might be feasible. AJMedP-1 Allied Joint Medical Planning Doctrine provides an overview on the process of casualty rate estimation. Important here is that commanders and planners should not be lured into believing they have to meet higher commanders' expectations to provide casualty estimates. SOF should always be prepared for the scenario to go badly, and mostly be able to avoid taking casualty's altogether. It is however important for commanders and med-planners to let higher commanders understand the cost, time-consuming creation and scarcity of SOF operators. A SOF operator should

[16] ACO directive 83-2.

be treated as a high-value strategic asset and treated accordingly for deployment-criteria and level of care provided.

5. Evacuation Timelines. NATO aims to provide appropriate life, limb and functions saving treatment within specific clinical timelines as described in AJP-4.10. This has become known as the 10-1-2 Timeline. However, this timeline is inadequate to save many combat casualties with life-threatening injuries. Instead, SOF should aim to achieve the zero – 30 – 60 timeline as outlined in section 2.3.1. As there may be situations unique to the SOF environment that make it difficult or not feasible to adhere to these timelines, SOF should have a comprehensive toolbox of assets and skills to mitigate the risks, aiming for the best but robust medical planning to deal with every situation. This mandates that every NSOCM, NSOMT and SOMP must be trained in prolonged field care.[17]

6. Special Operations Surgical Teams Employment Criteria. The planning for the employment of SOSTs will be made in the context of timely accessibility of other hospital resources. SOSTs are a scarce resource and therefore should be planned with a risk vs benefit approach. Factors which predispose for a SOST are operations which carry a high trauma risk, for which the SOST is a force multiplier or there is a “no fail” criterion (Examples include Hostage Rescue Operations (HRO) for an High Value Target (HVT) or extraction of HVT asset).

7. Redundancy of Evacuation Assets. Evacuation plans should routinely include the use of alternate evacuation assets. Air evacuation should never be the only evacuation option being planned for. There needs to be planning for alternate or redundant evacuation options. These methods should be proven and effectively in place before failure of the primary evacuation method.

8. Medical Logistics. SOF medical logistics personnel should plan for and ensure that adequate stock levels of medical supplies are maintained, and that resupply of medical items can be conducted when needed. High operations tempo may demand a push-pull system of pre-built resupply packages of mission critical expendable medical items, such as blood products, bandages, etc. Special consideration should be given to the provision of temperature-sensitive blood and blood components far forward, to be used by the lowest-level SOF tactical elements, i.e. maintain the necessary cold chain but provide also proper warming tool for them. For extended operations in a resource-constrained environment, SOF may require guidance on potential applications of expired pharmaceuticals when no other options are available.

[17] Prolonged field care is a mitigation strategy, not a solution, for situations where planned DCS or higher levels of care in general cannot be accessed in a timely manner and where medical and tactical risk allow for or require longer timelines. If the medical risk assessment concludes that a DCS capability is required for the most likely medical threats, then all efforts should be taken to provide the required level of care.

9. The need for Operations Security (OPSEC) often requires access restrictions on medical planning information to other components or higher-level conventional medical planners. The SOF medical planners should provide only sufficient information to ensure the required conventional medical support is in place, with the least opportunity of mission compromise.

a. Regardless of the other criteria that determine the requirement to use special operations surgical teams, there may be cases where OPSEC requires their employment instead of a readily available conventional medical treatment facility.

b. Selected missions may have a requirement to safeguard the patient's identity in order not to compromise a SOF unit's presence and jeopardize its mission. In those cases, alias patient tracking systems may have to be used to maintain accountability of injured SOF personnel inside the conventional medical system.

c. Patient tracking systems are not to breach or supersede OPSEC, digital connected systems need to be used with great caution due to the inherent weakness.

10. Two primary populations to keep in mind when conducting the medical pre-deployment and mission analysis in support of special operations.

a. Friendly Forces.

b. Local support/indigenous Population.[18]

11. The needs of the host nation or indigenous population are a paramount consideration when looking at the wide spectrum of the SOF medical interaction.

[18] Facilities, infrastructure, and medical capabilities etc. are important and SOF should collaborate with host nation (HN) or local authorities, non-governmental organizations (NGO)s, agencies, and international organizations. AJP-3.5.

INTENTIONALLY BLANK

CHAPTER 5 - MEDICAL SUPPORT TO SOF OPERATIONS IN MAJOR COMBAT OPERATIONS

5.1 SUPPORTING VERSUS SUPPORTED ROLES

SOF and conventional forces interdependence is best achieved when requirements are determined early, commanders and their medical advisors and medical planners, gain expanded understanding of each force's capabilities and limitations, and units have the opportunity to develop relationships and procedures in advance of executing missions.[19] Contrary to SOF's role in many recent NATO Operations, such as a major joint operation, SOF may have a supporting role to a conventional force's operation and will have to rely on medical support from the conventional medical assets.

5.2 SOF MEDICAL COMMAND AND CONTROL

1. Horizontal and vertical communication. As a general rule, every level of command will collaborate and coordinate their operational plans and medical support plans with the next higher level command. Special Operations Component Command combined joined medical branch (SOCC JMed) will coordinate and synchronize planning and integrate SOF medical support plans into Joint Task Force (JTF) medical support, within operational security limitations. JTF must have sufficient understanding of SOF medical capabilities, how they are tailored to mission requirements, medical roles and responsibilities, and OPSEC considerations (at all levels) in order to support with patient evacuation.

a. SOCC JMED directly coordinates horizontally with Component Command JMEDs to synchronize and coordinate medical support to SOF land, air, or maritime operations.

b. SOCC JMED coordinates with SOTGs – SOCC JMED must be aware of the SOTG's medical support plan. SOTG medical support gaps are communicated and coordinated with the SOCC JMED.

c. SOCC JMED communicates and synchronizes with the Military Treatment Facilities and theatre PECC for (awareness of) medical support planning and patient status reporting and tracking within OPSEC limitations.

2. The Joint Logistic Support Group (JLSG) medical staff is part of the overall medical command and control structure and responsible for the

[19] Par 4.1, AJP-3.5.

coordination of medical support functions and medical assets SOCC JMED is responsible to define logistic interfaces to ensure timely and adequate logistics support to the SOCC and subordinate units.

5.2.1 Roles and Responsibilities

1. Joint Force Command (JFC) JMED – Responsible for the overall Medical Support Plan (Annex QQ to the OPLAN), ensures medical command and control and information management throughout the Joint Operational Area, and assists the SOCC in meeting medical support requirements.

2. SOCC JMED– develops a Medical Support Plan based on the JFC Medical Support Plan. Coordinates medical evacuation to support the SOTGs. Assists the SOTGs in meeting their medical support requirements.

3. Special Operations Task Group (SOTG) MEDAD/JMED – develops a Medical Support Plan based on the SOCC Medical Support Plan, coordinates and synchronizes medical support for SOTUs.

4. Special Operations Task Unit (SOTU) medical personnel[20]– develops the tactical medical plan for specific missions or tasks in close coordination with the SOTG.

5. JLSG – facilitates rapid reinforcement of medical supplies in order to ensure the sustainability of medical support under all operational conditions and coordinates required medical resources in line with tasks and functions. The joint logistic support group commander will receive command and control of these medical support capabilities as long as they are assigned to the joint logistic support group.

6. SOCC Medical Advisor (MEDAD) – provide timely medical advice to the Commander, ensuring that the commander and the commander's staff are aware of all medical implications their actions and decisions might have as well as of any health-related issues affecting the force or the operation. Direct access of the MEDAD to the commander is essential to assure that all health and medical support related matters requiring the commander`s attention, decision or action, can be addressed in time and based on professional expertise. The SOCC MEDAD is responsible for deployment health surveillance and force health protection.

7. Medical Director –, the Medical Director serves as the Chief JMED. The Medical Director maintains situational awareness of common operational picture, medical support, and medical evacuation assets. Given the complexity of SOF missions in major combat operations and the challenges providing

[20] Depending on the specific set up of the SOTU, this is usually the highest medically qualified person, e.g. NSOCM, NSOMT or SOMP, but also a Special Operations Medical Planner.

medical support, the Medical Director must be integrated into all stages of planning at all times. The medical director reports to the medical advisor for all medical issues.

8. Medical Logistics – Medical logistics is a national responsibility but within a multinational environment of major combat operations, in order to improve logistical efficiency, the SOCC and JTF should assist coordinating medical resupply through the JLSG. Close coordination with and guidance to the JLSG Medical Branch on the specifics of SOF Medical Logistic requirements is essential for timely and adequate logistics support.

9. PECC – The coordination of patient evacuation should ensure the most effective use of medical treatment and evacuation resources and that all patients receive timely and appropriate care. The patient evacuation coordination cell (PECC) monitors the current medical operational picture, manages the flow of patients, and provides timely and accurate tracking information throughout the entire continuum of care. The location of a PECC is dependent on the size and complexity of the mission and area of operations as well as national policy. In major combat operations a PECC may be necessary at the SOCC level to manage multiple SOTGs and larger numbers of casualties. It is imperative that the PECCs and MEDADs at different command levels communicate effectively with each other.

5.2.2 SOCC JMed Branch Structure and Organization

1. JMED acts as the executing body of the medical organization supporting joint operations. The JMED branch requires the following functions to accomplish all medical support tasks:

a. Medical Director (MedDir) – Physician or Medical Planner[21], ideally Special Operations Medical Provider or Special Operations Medical Planner

b. Medical Planner, Deputy Medical Director – Special Operations Medical Planner

c. Medical Operations - Special Operations Medical Planner

d. Force Health Protection including Preventive Medicine – Physician, Nurse, Veterinarian or specifically trained public health specialists

[21] Some nations do not have dedicated medical planners, but use medical providers (such as physicians, physician assistants or nurses) in this function. Wherever feasible, both services should be integrated in the JMED branch. For example, if the MEDAD is a physician, the JMED Chief should be a medical planner. This allows for mutual complementation of different skill sets.

e. Patient evacuation coordination – patient tracking and casualty reporting is a J1 function. However, patient evacuation must be coordinated with the JMED. This function can be assumed by a Special Operations Medical Planner with clinical expertise available.

f. Med Log – Med Log or Log NCO

g. HN and civ-mil health liaison – Physician (either Force Health Protection and Preventive Medicine Physician or MedDir)

2. For major combat operations it is not desirable to have individuals assuming multiple functions.

5.3 INTEROPERABILITY/INTEGRATION AND OPERATIONAL SECURITY

1. Medical support for special operations must address the most serious threats without diminishing special operations forces operational principles and requirements. Usually SOF must rely on conventional force support for most if not all support enablers, even if this might increase the risk of compromising OPSEC. SOF will use conventional medical support capabilities where available and needed. Where possible, SOF will integrate medical service personnel specifically trained and selected to support SOF.

2. The modular approach to medical support is a conceptual idea to enhance the efficiency and adaptability of medical support. It is based on pooling and sharing of standardized capability modules. A module typically consists of equipment and personnel necessary to provide a specific capability[22]. These modules can be rearranged, replaced, combined and interchanged according to mission needs. The modular approach could be an effective instrument to optimize operational medical support in special operations, especially when forces are required to operate outside the area of medical coverage, when appropriate medical support is not available, or other situations that impact the ability to meet clinical timelines.

3. Modules can be used to augment, enhance or to complement the standard minimum requirement defined for the respective capability according to mission needs and operational requirements.

4. Modules must be able to cooperatively work in concert with other modules irrespective of their origin and assure compatibility with equipment &

[22] SOF specific modules that could augment a SOTUs or SOTGs embedded medical capabilities could be an ICU module to add holding capacity of a SOST or a blood bank module to increase availability/utilization of blood far forward.

supplies, communication and information technology, power and water supply from other providers.

5. Personnel of modules assigned to a special operations unit must be able to effectively integrate, overcome language barriers and cultural differences and operate with (unfamiliar) equipment and supplies (from other nations).

INTENTIONALLY BLANK

LEXICON

AMedP	Allied Medical Publication
AoR	Area of Responsibility
CASEVAC	Casualty Evacuation
CBRN	Chemical Biological Radio Nuclear
DA	Direct Action
DCR	Damage Control Resuscitation
DCS	Damage Control Surgery
HN	Host Nation
HPP	Human Performance Program
HRO	Hostage Rescue Operations
HVT	High Value Target
JLSG	Joint Logistics Support Group
MA	Military Assistance
MEDAD	Medical Advisor
MEDEVAC	Medical Evacuation
NSOCM	NATO Special Operations Combat Medic
NSOMT	Special Operations Medical Technician
OPSEC	Operations Security
PECC	Personnel Evacuation Coordination Centre
SOCC	Special Operations Component Command
SOST	Special Operations Surgical Team
SOTG	Special Operations Task Group
SOTU	Special Operations Task Unit
TCCC	Tactical Casualty Combat Care

AMedP-4.13(A)(1)