

**NATO STANDARD**

**AMedP-8.12**

**MILITARY ACUTE TRAUMA CARE  
TRAINING**

**Edition A Version 2  
AUGUST 2020**



**NORTH ATLANTIC TREATY ORGANIZATION**

**ALLIED MEDICAL PUBLICATION**

**Published by the  
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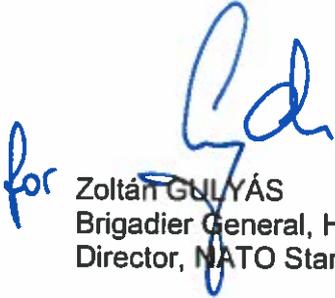
**NORTH ATLANTIC TREATY ORGANIZATION (NATO)**

**NATO STANDARDIZATION OFFICE (NSO)**

**NATO LETTER OF PROMULGATION**

5 August 2020

1. The enclosed Allied Medical Publication AMedP-8.12, Edition A, Version 2, **MILITARY ACUTE TRAUMA CARE TRAINING**, which has been approved by the nations in the MCMedSB is promulgated herewith. The agreement of nations to use this publication is recorded in STANAG 2544.
2. AMedP-8.12, Edition A, Version 2, is effective upon receipt and supersedes AMedP-8.12, Edition A, Version 1, which shall be destroyed in accordance with the local procedure for the destruction of documents.
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4. This publication shall be handled in accordance with C-M(2002)60.

  
for Zoltán GULYÁS  
Brigadier General, HUNAF  
Director, NATO Standardization Office

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## RECORD OF SPECIFIC RESERVATIONS

[nation]	[detail of reservation]
BGR	The standard requirements will be applied fully for physicians' training. For nurses' training they will be implemented with limitations: not to apply para. 2.2.2 E (1), (3), (4), (6), (12), (13) and para 2.2.3 K due to legal restrictions on their qualification. The standard will not be applied for paramedics' training since, currently, there are no established positions for paramedics in the Bulgarian Forces.
CZE	CZE applies the following reservations to AMedP-8.12(A): 1. Chapter 2.2.2 Primary Survey, point f(6): CZE does not use Tranexamic acid during Primary Survey. Training of Tranexamic acid application is not provided. 2. Chapter 2.2.3 Secondary Survey, point k(3): CZE does not train Paediatric trauma score assessment.
DEU	Due to the German division of labor between medical specialists, German nurses, with exception of E.R. and anesthesiological personnel, are not primarily trained to provide traumatologic first-aid as laid down in this STANAG. They receive the same training as every other soldier concerning first aid. Further training, e.g. acute trauma care, is provided if necessary for the planned assignment in theatre.
FRA	France will not implement in extenso the training content of Chapter 2, but will focus on tactical care, and the content of Chapter 3 will be limited in keeping with combat rescue training reference standards, including within the context of mass casualties (MASCAL). France recalls that STANAG 2122, referenced in AMedP-8.12, was ratified with reservations.
HRV	The Croatian Armed Forces accept the principles of this standardization document, but retain the right to determine the scope and type of training for military personnel, in particular for doctors, as well as nurses and medical technicians, in accordance with national healthcare regulations.
LVA	LVA National Armed Forces will reference STANAG 2544 requirements for qualification of Latvian physicians, nurses, medics and other military personnel in accordance with NATO requirements and guidance in Military Medicine. Requirements of nurses in the STANAG 2544 exceeds limits set by Latvian legislation therefore LVA nurses are entitled only partially apply STANAG 2544.

NLD	The Netherlands agree with the intention of the STANAG. The Netherlands will not be able to apply all standards and requirements for all military medical personnel as mentioned.
SVN	STANAG requirements will be fully applied for physicians training. For registered nurses and nurses, the training will be implemented in line with legal restrictions on their assigned competences. Restrictions are in paragraph 2.2.2. E(1), (3), (4) and (12).
<p>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.</p>	

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**CHAPTER 1****INTRODUCTION****1.1. BACKGROUND**

Military medical personnel (i.e. physicians, nurses and medics) at all levels must possess certain individual skill sets in Acute Trauma Care to be able to participate in most of the multinational Medical Modules described in STANAG 2560. To improve interoperability, acute trauma care training for NATO forces must meet standards acceptable to all participating nations, as opposed to national support to national contingents, which only requires national acceptance. In a multinational setting, medical personnel at different levels must be able to provide an acceptable standard of acute trauma care and demonstrate outcomes of skill sets enabling them to give treatment equating to best medical practice.

NATO military operations have become increasingly multinational. This allows more nations to participate and also to use their medical assets more efficiently. However, international medical cooperation also poses challenges due to differences between nations' medical standards and due to legal constraints. To improve the outcome of acute trauma care treatment in a multinational scenario, common standards and procedures are essential for the outcome of treatment of patients, especially in a Major Incident/MASCAL situation. This raises a demand for standardized training of medical personnel in military acute trauma care.

**1.2. AIM**

The purpose of this AMedP is to standardize the skills in acute trauma care and medical management in a major incident/MASCAL situation by all medical personnel and any other military personnel, who are going to participate in peace supporting missions and/or armed conflicts, and to produce guidance for the training of such personnel.

As training should lead to the systematic acquisition of knowledge and psychomotor skills, this publication addresses both contents and format of that training.

**1.3. SCOPE AND LIMITATIONS**

Training in military acute trauma care should be made available to medical personnel and any other military personnel, adapted with respect to depth and extent to each category of personnel, that might take part in peace supporting missions and/or armed conflicts.

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**CHAPTER 2**

**REQUIREMENTS FOR TRAINING OF GENERAL TRAUMA SKILLS AND KNOWLEDGE**

## **2.1. PSYCHOMOTOR SKILLS**

All medical health care personnel delivering acute trauma care should be able to assess an Acute Trauma Patient and deliver appropriate care in a logical sequence.

Depending on the level of previous training and on legal constraints all personnel will not be able and/or allowed to apply all skills below.

## **2.2. KNOWLEDGE/THEORY**

### **2.2.1. List of subjects**

The following list of subjects should be taught and adapted with respect to depth and extent to each category of personnel:

- a. Introduction:
  - (1) Background and aims for standardized trauma treatment
  - (2) The phases and principles in management of the injured
  
- b. Basics:
  - (1) The influence of the environment in the widest sense on "what is possible and what is not", "what should be done and what should be avoided"
  - (2) The necessity of having a system of care that is adaptable to actual circumstances
  
- c. Triage:
  - (1) Reasons for, principles and categories of the triage system
  - (2) Triage for treatment vs. Triage for evacuation
  - (3) Difficulties in applying the triage system
  - (4) Allocation of priorities to casualties and factors to be taken into account
  
- d. Assessment/treatment:
  - (1) Primary Survey

### **2.2.2. Primary Survey**

The following list of subjects should be taught and adapted with respect to depth and extent to each category of personnel.

- C. Catastrophic external bleeding
  - (1) Correct application of tourniquet and pressure dressing
  
- a. Airway and C-spine:
  - (1) Symptoms, signs and treatment of (partial) obstruction (internal/external)
  - (2) C-spine protection
  
- b. Breathing:
  - (1) Signs of impaired breathing
  - (2) Oxygen, mouth-to-mouth/mouth-to-mask breathing, Cardiopulmonary Resuscitation (CPR) and Bag-Mask ventilation
  - (3) Symptoms, signs and treatment of:
    - (a) Tension pneumothorax
    - (b) Flail chest
    - (c) Open pneumothorax
    - (d) Massive haemothorax
    - (e) Blastlung
    - (f) Cardiac tamponade
  
- c. Circulation:
  - (1) Shock
    - (a) Definition

- (b) Symptoms and signs
  - (c) Treatment
  - (d) Response
- d. Disability/neurologic status:
- (1) Glasgow Coma Scale
  - (2) AVPU
  - (3) Pupillary reaction
  - (4) Major motor defects
- e. Adjuncts:
- (1) Pulsoxymetry
  - (2) AMPLE history
  - (3) Tourniquets
  - (4) Field dressings
  - (5) Splint systems
  - (6) Intraosseous devices
- f. Medication:
- (1) Analgesia
  - (2) Antibiotics
  - (3) Intravenous fluids incl. blood products
- g. Hypothermia/Patient Warming

h. Special considerations:

- (1) Handling of impaled patients and evisceration
- (2) Spinal immobilisation
- (3) Splinting of fractures and dislocations
- (4) Emergency handling of eye injuries:
- (5) Hyperthermia
- (6) Burns
- (7) Freezing injuries

**CHAPTER 3****REQUIREMENTS FOR TRAINING OF TACTICAL TRAUMA SKILLS AND KNOWLEDGE****3.1. PSYCHOMOTOR SKILLS**

1. All military medical health care personnel delivering acute trauma care should be able to assess an acute trauma patient and deliver appropriate care in a systematic way.
2. It should be understood that the actual circumstances in which acute trauma care is delivered will influence what care can or should be delivered. The following differentiation can be made:
  - a. Care under fire.
  - b. Tactical field care (care in the field with limited equipment in possibly unsafe circumstances).
  - c. Care during casualty evacuation (CASEVAC). Medical Evacuation (MEDEVAC) is a medically controlled process of moving patients, while CASEVAC stands for moving of patients without medical support.
  - d. Major Incident/MASCAL scenarios.
3. *Depending on the level of previous training and on legal constraints all personnel will not be able and/or allowed to apply all skills mentioned here.*

**3.2 KNOWLEDGE/THEORY****3.2.1. General subjects**

The following list of subjects should be taught and adapted with respect to depth and extent to each category of personnel:

- a. Introduction:
  - (1) Differences between the military and the civilian trauma scene
  - (2) Background and aims for standardised trauma treatment in certain tactical scenarios
- b. Basics:

- (1) The influence of the environment in the widest sense on "what is possible and what is not", "what should be done and what should be avoided"
  - (2) The necessity of having a system of care that is adaptable to actual circumstances
- c. Kinetics:
- (1) Refreshing basic principles of kinetics – including blunt, penetrating and blast injuries
  - (2) Special focus on damage caused by high energy weapons
- d. Triage:
- (1) Principles for triage for treatment with respect to the tactical situation
  - (2) Principles for triage for evacuation with respect to the tactical situation

### **3.2.2. Care under fire**

The following list of subjects should be taught and adapted with respect to depth and extent to each category of personnel:

- a. Protection:
  - (1) Return fire
  - (2) Do not get shot yourself
  - (3) Prevent additional injuries of the wounded (if possible)
- b. Stop life-threatening haemorrhage:
  - Temporary tourniquet
- c. Put unconscious casualty in recovery position

### **3.2.3. Tactical field care**

The following list of subjects should be taught and adapted with respect to depth and extent to each category of personnel as regards depth and width:

- a. Applying previously acquired general trauma skills and knowledge to the tactical situation

- b. Applying previously acquired knowledge regarding principles for triage (triage for treatment) to the tactical situation

#### **3.2.4. Tactical Evacuation Care**

The following list of subjects should be taught and adapted with respect to depth and extent to each category of personnel:

- a. Applying previously acquired general trauma skills and knowledge to a tactical medical evacuation scenario
- b. Applying previously acquired knowledge regarding principles for triage (triage for evacuation) to a tactical medical evacuation scenario

#### **3.2.5. Major Incident/MASCAL scenarios**

The following list of subjects should be taught and adapted with respect to depth and extent to each category of personnel:

- a. Applying previously acquired general and tactical trauma skills and knowledge to a Major Incident/MASCAL scenario
- b. Applying previously acquired knowledge regarding principles for triage for treatment and triage for transport to a Major Incident/MASCAL scenario.

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**CHAPTER 4****FORMAT OF TRAINING****4.1 GENERAL REMARKS**

1. How to adapt treatment as a consequence of the actual circumstances should be explicitly taught, and parts of the courses for physicians, nurses and medics can be taught together; the course for other personnel should be separate
2. For teaching theory, psychomotor skills and other subjects a combination of short lectures, skills stations and discussions is recommended for all categories of personnel

**4.2 LECTURES, SKILLS STATIONS, DISCUSSIONS**

1. Short lectures will deal with the majority of knowledge items.
2. Skills stations for physicians, nurses and medics should include working on simulation mannequins.
3. For making triage and the consequences of different circumstances as regards assessment and treatment understood, discussion of cases/scenarios is necessary.

**4.3 EXERCISE**

1. A course is followed by a scenario-based field exercise.
2. Different categories of personnel should be exercised together.
3. During the exercise the medical Major Incident/MASCAL team(s) should be evaluated in accordance with STANAG 2560.

**4.4 HANDS-ON TRAINING**

Skill stations training are valuable in enabling a trainee to do the same skill many times. It is strongly recommended that to those trainees (physicians, nurses, medics), who will not have an almost daily contact with trauma victims, training opportunities are offered in a civilian emergency room, or operating theatre and with civilian ambulance service.

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**CHAPTER 5****GLOSSARY**

This Glossary contains abbreviations used in this document.

AAP	Allied Administrative Publication
AMedP	Allied Medical Publication
AMPLE	Allergy, Medication, Past history, Last meal, Events
AVPU	Alert, Verbal, Pain, Unresponsive
CASEVAC	Casualty Evacuation
CPR	Cardiopulmonary Resuscitation
DPL	Diagnostic Peritoneal Lavage
EAR	Exhaled Air Resuscitation
ECG	Electrocardiogram
MASCAL	Mass Casualty
MEDEVAC	Medical Evacuation
METHANE	My call sign, Exact location of incident, Type of incident, Hazards at the scene, Access, Number and type of casualties, Emergency services required
NATO	North Atlantic Treaty Organisation

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<p><b>ANNEX A      REFERENCE PUBLICATIONS</b></p>
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MC 326/3 – NATO Principles and Policies of Medical Support

STANAG 2228 – AJP 4.10 - Allied Joint Medical Support Doctrine

Bi-SC 75-2 – Education and Training Directive

STANAG 2560 – AMedP – 27 - Medical Evaluation Manual

STANAG 2122 – Requirement for Training in First-Aid, Emergency Care in Combat Situations and Basic Hygiene for all Military Personnel

STANAG 2879 – Principles of Medical Policy in the Management of a Mass Casualty Situation

STANAG 7179 – Planning Guidelines for Fire and Emergency Services Response to Major Fire and Emergency Incidents

**AMedP-8.12(A)(2)**