

CHAPTER 4

PATIENT EVACUATION AND MEDICAL REGULATING

4-1. Patient Evacuation

a. Patient evacuation is the timely, efficient movement of wounded, injured, or ill persons from the battlefield and other locations to MTFs. En route medical care is provided by medical personnel during patient evacuation. Precisely planned evacuation plays an important role in the carefully designed treatment sequence from the FLOT rearward. As the echelons of care become more sophisticated from front to rear, so do the means of patient evacuation.

b. The evacuation process continues for each person until he can be returned to duty or discharged from the Service. In keeping with the AMEDD mission, every effort is made, consistent with the evacuation policy, to rehabilitate patients and return them to duty at the lowest practicable echelon of care.

c. Evacuation of patients is the responsibility of the echelon of care to which patients are evacuated.

(1) Casualty collection evacuation from the point of injury or illness to the BAS is a unit responsibility.

(2) Evacuation from a BAS to a clearing station (division) is the responsibility of the forward support medical company. For those divisions not under the FSB/MSB design, separate brigades, and ACRs, evacuation is the responsibility of the supporting medical company.

(3) Evacuation from a clearing station to a MASH, CSH, or evacuation hospital is the responsibility of the corps medical brigade/group.

(4) Evacuation to a field, station, or general hospital in the COMMZ from a CZ hospital or from another MTF within the COMMZ is the responsibility of the TA MEDCOM in conjunction with the US Transportation Command (USTRANSCOM).

(5) Evacuation from the COMMZ to the ZI is the responsibility of the USTRANSCOM. (See paragraph 4-7c.)

4-2. Theater Evacuation Policy

a. Plans to provide theater evacuation must consider the theater evacuation policy. This policy is established by the Secretary of Defense, with the advice of the Joint Chiefs of Staff, and upon the recommendation of the theater commander. The policy establishes, in number of days, the maximum period of noneffectiveness (hospitalization and convalescence) that patients may be held within the theater for treatment. This policy does not mean that a patient will be held in the theater for the entire period of noneffectiveness. A patient who is not expected to be ready for RTD within the number of days established in the theater evacuation policy is evacuated to CONUS or some other safe haven. This is done providing that the treating physicians determine that such evacuation will not aggravate the patient's disabilities or medical condition. For example, a theater evacuation policy of 60 days does not mean that a patient is held in the theater for 59 days and then evacuated. Instead, it means that a patient will be evacuated as soon as possible after a determination is made that the patient is not projected to be returned to duty within 60 days following admission.

b. When unforeseen increases in the number of patients occur (due perhaps to an epidemic or heavy combat casualties), a temporary reduction in the policy may be necessary to adjust the volume of patients in the theater hospital system. A reduction in the evacuation policy increases the number of patients requiring evacuation out-of-theater, and it increases the requirement for evacuation assets. This action is necessary to relieve the congestion caused by the increased number of patients.

c. The time period established in the theater evacuation policy starts on the date the patient is admitted to the first hospital (CZ or COMMZ). The total time a patient is hospitalized in the theater, including transit time between MTFs, for a single uninterrupted episode of illness or injury should not exceed the number of days stated in the theater evacuation policy. Although convalescent centers are not hospitals, the time a patient spends in one is included in the calculation of the duration of his hospital stay. Though guided by the evacuation policy, the actual selection of a patient for

evacuation will be based on clinical judgment as to the patient's ability to tolerate and survive the movement to the next level of hospitalization.

4.3. Intratheater Evacuation Policy

a. Subordinate commands may establish intratheater patient evacuation policies within the limits of the theater patient evacuation policy and subject to approval by the theater commander. For example, a short evacuation policy may be established for corps hospitals to maintain their mobility and their capability to accommodate surges of patients. The intratheater evacuation policy, usually stated in days at the corps level, represents the maximum period of allowable hospitalization in corps hospitals. Any patient who can be expected to RTD within the stated policy is retained by a corps hospital for definitive care and subsequent RTD. Any patient who cannot be expected to be returned to duty within the stated policy is evacuated to the COMMZ as soon as his condition and transportation resources permit. Intratheater patient evacuation policies must be flexible and changed as dictated by the tactical situation. (These policies may be adjusted in the early days of a contingency operation as the availability of treatment facilities and evacuation means permit.) Intratheater evacuation policies may differ among hospitals depending on their location, facilities, staff, and the numbers and types of patients received.

b. When patients are received at a constant rate, the evacuation policy at a specific echelon may be adjusted to retain and subsequently RTD those patients who do not require specialized treatment in COMMZ GHs. However, when increased patient loads are anticipated, the intratheater evacuation policy must be adjusted downward to make additional beds available for current and anticipated needs. As a result, a larger proportion of patients admitted to hospitals in the CZ are evacuated to the COMMZ.

4.4. Acceptable Percentage of Fill for Available Hospital Beds

a. Another management tool available to the HSS planner is to establish a percentage

limiting the number of beds that may be occupied within a command at any given time.

b. This percentage, as a tool, is smaller in scope but more immediate in impact than adjusting the evacuation policy. The use of this factor within the overall limitations of the intratheater evacuation policy allows the planner to respond immediately to the course of action selected by the tactical commander. For example: A corps commander has been assigned a mission requiring offensive action. The senior medical headquarters commander (COSCOM surgeon) in coordination with the corps surgeon anticipates increased casualties as a result of this action. During the previous defensive operations, a 15-day evacuation policy, coupled with a 75 percent bed-fill level, was in effect. The corps commander anticipates initiating action within 48 hours. In this scenario the adjustment of the evacuation policy would not provide for that immediate flexibility necessary to support the operation. However, by reducing the percentage of bed-fill level within the command (after coordination with the TA surgeon), the brigade/group commander can rapidly achieve the availability of the beds necessary to meet casualty needs.

c. This adjustment of the percentage of fill factor is dependent on many support assets and may not be done without extensive coordination. Adequate evacuation capability must exist to support any adjustment.

4.5. Medical Regulating

a. Medical regulating is a system for coordinating and controlling the movement of patients through the various echelons of care. The system ensures the timely, efficient, and safe movement of patients, often over great distances, to the destination MTF. Medical regulating is executed in such a manner that the welfare of the patient is second only to the success of the tactical mission. The system entails identifying patients to be evacuated, locating available beds, and coordinating evacuation means so that each patient is moved to the proper MTF with the least possible delay.

b. Careful control of patient evacuation to hospitals is necessary to—

- Effect an even distribution of cases.
- Assure adequate beds for current and anticipated needs.
- Route patients requiring specialized treatment to the proper MTFs.

c. Rigid control is maintained over the evacuation of patients needing surgery to prevent surgical backlog in MTFs. Surgical backlog is the time, generally measured in hours, between the time a patient is delivered to a facility and the time that patient enters an operating room. Obviously, with a fixed number of operating tables in a hospital, if patients arrive at a facility faster than surgery can be completed on them, surgical backlog will increase. Supporting MTFs should express surgical backlog in terms of total patient operating hours divided by the number of operating tables in use.

d. Factors which influence the scheduling of patient movement include the—

- Tactical situation.
- Availability of transportation means.
- Locations of MTFs with special capabilities or resources.
- Current bed status of MTFs.
- Surgical backlog.
- Number and location of patients by diagnostic category.
- Locations of airfields (or seaports).
- Condition of each patient (Is the patient sufficiently stabilized to withstand travel?).

e. With a responsive communication system, the receipt of medical evacuation mission requests and the issuance of mission assignments are expedited.

4-6. Bypassing Triage and Medical Care

Routinely bypassing available triage and care will not be practiced. To do so risks further injury to the

patient and negates the effective use of medical resources. Routinely bypassing an echelon of care will also—

- Cause overevacuation of less critically injured soldiers which results in delaying their RTD.
- Remove the evacuation asset from its supporting position for longer periods of time.
- Cause more wear and tear of evacuation assets therefore requiring more maintenance on aircraft and vehicles.

4-7. Means of Evacuation

a. Within a theater of operations, patients may be evacuated by manual carries, litter teams, ground and air ambulances, other nonmedical ground and air transportation assets, watercraft, or any combination thereof. From the theater of operations to the ZI, patients are normally evacuated by aircraft, but surface means will be used when USAF transportation is not available or advisable. Regardless of the means used, patient evacuation under most battlefield conditions is a difficult, hazardous task. It becomes even more complex with problems created by bad weather, high altitude, inaccessibility to available roads, broken or rough terrain, NBC contamination of roads and vehicles, movement of other friendly elements, and enemy actions. Coordination of evacuation plans with those involving the flow of tactical and logistical traffic to and from the main battle area is essential to sound patient evacuation operations.

b. Army ground and air ambulances will be used in the CZ for the evacuation of patients.

c. The preferred means of evacuation from the CZ to the COMMZ is by USAF aircraft. These resources are controlled by USTRANSCOM. Aeromedical evacuation requirements are coordinated by the medical regulating officer assigned to the senior medical command in the CZ. If adequate air evacuation is not available, the medical regulating officer will coordinate for the use of ground transportation. In exceptional circumstances, Army ground or air ambulances may

be used. Evacuation of patients from the COMMZ to the ZI will normally be accomplished by the USAF.

d. The medical unit commander is responsible for coordinating additional emergency nonmedical transportation when requirements exceed the medical evacuation assets available. For example, the medical group coordinates with the area support group for additional resources.

e. The system of medical command and control headquarters, through their medical regulating (patient movement control) sections, provides the planning and coordination necessary for a successful patient evacuation system. This includes both air and ground ambulances. When there is an interruption in USAF AE from the CZ, movement of large numbers of patients to and from USAF mobile aeromedical staging facilities (MASFs) or aeromedical staging facilities (ASFs) and between hospitals and convalescent centers may be done by ambulance buses, ambulance trains, or tactical helicopters (CH-47) with medical attendants. These buses, trains, and helicopters with medical attendants have been modified to accommodate ambulatory and litter patients and are acceptable substitutes for unavailable USAF tactical aircraft normally used for patient evacuation.

4-8. Sorting of Patients for Evacuation

a. Sorting for evacuation is the methodical process of examining patients and identifying those who—

- Can receive the required treatment without evacuation.
- Must be evacuated to a higher level for needed treatment.

Patients are also sorted to route them to the proper element within a MTF. Sorting for these purposes must not be confused with the sorting of mass casualties into priority treatment and evacuation categories (Chapter 14).

b. Proper sorting is essential for effective patient management in the evacuation system.

Improper sorting can jeopardize the success of combat operations by creating the following unnecessary burdens:

(1) The patient's unit must go short-handed until the soldier is returned to duty or replaced.

(2) The replacement system must procure and deliver additional personnel unnecessarily.

(3) Medical treatment facilities in the rear will be unnecessarily burdened, thus decreasing the care and support that could be provided to more properly selected patients.

(4) Evacuation assets, already in short supply, will be used moving patients unnecessarily.

4-9. Evacuation Chain

a. Echelon I Evacuation.

(1) Wounded or injured casualties on the front lines rely on other unit personnel to perform basic evacuation carries. Carries such as the pistol-belt carry or the fireman's carry are used to evacuate the casualty to a point where a litter is available or where a litter can be improvised. The casualty is subsequently taken to the company aid post or a preplanned casualty collecting point. If possible, this evacuation is supervised by a combat lifesaver (whose primary responsibility is to fight the enemy) or a combat medic. Evacuation duties are performed when the situation permits. Casualty evacuation from the aid post to the BAS is accomplished by ambulances from the medical platoon.

(2) The BAS is not staffed and equipped to provide patient holding. It must be capable of moving on short notice. Only those emergency medical procedures which contribute to initial resuscitation and the preservation of life or limb, and which enable a patient to survive en route to the next MTF, are performed in the BAS.

b. Echelon II Evacuation.

(1) The ambulance platoon of the

medical company provides medical evacuation of patients on an area basis from—

- The forward BAS.
- Other BASs and units within the brigade area and division rear area.

(2) Air ambulances from the forward support evacuation teams of the direct support air ambulance company will assist the ambulances of the medical company. These teams are usually collocated with the forward support medical company in the brigade support area. They will normally evacuate patients to the medical company from as far forward as the tactical situation permits.

c. Echelon III Evacuation.

(1) The medical brigade or group commander, with the required resources at his disposal, must prevent any undue accumulation of patients in MTFs within the corps by their timely evacuation. Evacuation is accomplished by ground and air and involves patient movement from division and corps medical facilities.

(2) Corps-level medical units are responsible for evacuating patients from division clearing stations, separate clearing stations, nondivisional dispensaries in the corps area, and aid stations to hospitals of the corps. Evacuation is by ground and air ambulance.

(3) The evacuation units usually found in corps are the evacuation battalions; medical ambulance companies; medical companies, air ambulance; and air ambulance detachments. Some of these units are used in the COMMZ as well as in the CZ; however, when they are employed in the COMMZ, they are assigned to the TA MEDCOM rather than the corps medical brigade.

(4) There are several fundamental considerations concerning evacuation of patients in a theater of operations. For each patient that is moved to the rear, there must be a replacement brought forward. Therefore, it is essential that the HSS system avoid evacuating patients that can RTD within the set evacuation policy. However, the need to retain patients in forward areas for rehabilitation and early RTD must be weighed

carefully against the risk of immobilizing forward MTFs by accumulating large numbers of patients. The entire scheme of evacuation is based on—

- Providing adequate care en route.
- Providing the most rapid method of transport.
- Causing the least discomfort to the patient.

d. Echelon IV Evacuation. Patients are evacuated to locations and facilities where more definitive treatment is provided. The MEDCOM is responsible for coordinating and regulating both surface and air evacuation (Army and USAF) from the CZ to the COMMZ and between medical facilities within the COMMZ.

4-10. Medical Ambulance Company, TOE 08-127H410

This company consists of a company headquarters and 3 ambulance platoons of 12 ambulances each. It provides a single-lift capability for evacuation of 144 litter patients or 288 ambulatory patients from division medical units to supporting medical installations or evacuation points. This company also evacuates patients from area medical units within the CZ. It is assigned to the corps medical brigade on the basis of one per division supported. It is also employed in the COMMZ on the basis of one per two divisions supported. For control purposes, this company is attached to a headquarters and headquarters detachment, medical battalion or headquarters and headquarters detachment, evacuation battalion. The unit is employed to provide a ground evacuation means in areas of expected patient density. This ambulance company maintains liaison not only with the unit from which it evacuates patients, but also with the unit which is to receive the patients. In keeping with the field HSS principle of continuity, the company provides en route medical care for patients being moved. This unit may also be organized with 18 buses (36-45 passenger) in lieu of the 36 ambulances (normally bus units will be in the COMMZ). This gives it a single-lift capability for evacuation of 324 litter patients or 792 ambulatory patients.

4-11 Medical Company (Air Ambulance), TOE 08-137H200

a. Mission. The mission of this unit is to—

- Provide aeromedical support in the CZ.
- Provide emergency movement of medical personnel and accompanying equipment and supplies to meet a critical requirement.
- Ensure uninterrupted delivery of whole blood, biological, and medical supplies when there is a critical requirement.

b. *Assignment.* This unit is assigned to headquarters and headquarters detachment, medical brigade. It is normally attached to headquarters and headquarters detachment, medical group.

c. *Capabilities.* This unit provides the following:

(1) Aeromedical evacuation of critically wounded or other patients, extrication of personnel from crashed aircraft, and aeromedical evacuation of those patients from the crash site to the appropriate medical facility capable of providing required treatment.

(2) Emergency aid at air crash site, in-flight medical treatment, and/or surveillance for patients en route to MTFs.

(3) Aeromedical evacuation of patients from units in support of combat troops except from an airhead or airborne force objective area that is logistically supported by the USAF.

d. *Basis of Allocation.* This unit is allocated to the corps on the basis of one per four divisions and one per task force not supported by other air evacuation assets.

NOTE

Air ambulances evacuate all categories of patients, normally on an *on-call* basis, except battle fatigue unless no

other means is available. (Psychiatric cases are not usually evacuated by air; however, mission exigencies may require that a properly sedated, restrained psychiatric casualty be evacuated using AE assets.) Priority for this evacuation is given to the seriously wounded.

4-12. Medical Detachment (Helicopter Ambulance) and Medical Detachment (Ground Ambulance), Medical Evacuation Teams, TOE 08-660H0

a. *Mission.* The mission of the evacuation teams is to evacuate patients to and between MTFs, or to evacuate patients to airfields and airports for further evacuation out of the theater. Evacuation teams consist of Team RA, air ambulance (UH-IV); Team RG, air ambulance (UH-60A); and Team RE, ground ambulance.

b. *Assignment.* Medical evacuation teams are assigned to the MEDCOM or a medical brigade. They may be further attached to other AMEDD command and control units as required by the nature of operations and the forces being supported.

c. *Capabilities.*

(1) *Team RA, air ambulance.* This team—

- Provides immediate AE of all categories of patients except battle fatigue unless no other means is available. Evacuation is provided consistent with evacuation priorities and other operational considerations, from forward areas of the CZ to division clearing stations or further if medically indicated. When employed in the COMMZ, this team provides expeditious movement of patients, consistent with evacuation priorities and other considerations, to and between MTFs, or to airfields or seaports for further evacuation out of the theater.

- Operates 6 air ambulances (each normally configured to carry 3 litter and 4 ambulatory patients) for single-lift evacuation capabilities of 18 litter and 24 ambulatory patients. Depending on rigging, these aircraft can each carry

either 6 or 9 ambulatory patients for single-lift evacuation capabilities ranging between 36 and 54 ambulatory patients.

- Provides air crash rescue support less fire suppression; extricates personnel from crashed aircraft; provides emergency aid at the crash site; and aeromedically evacuates these patients to appropriate MTF's.

- Provides expeditious delivery of whole blood, biological, and medical supplies to meet recurring and critical requirements.

- Provides rapid movement of medical personnel and accompanying equipment and supplies to meet requirements of mass casualty and other emergency situations.

- Has a flight operations section which is staffed for 24-hour operations to receive and coordinate AE missions; other sections are staffed for normal operations.

- Can perform limited AVUM and organizational maintenance on all organic avionics equipment.

- Is dependent upon the supporting AVIM company for supplemental AVUM support and for AVIM.

(2) *Team RG, air ambulance (UH-60A).*

This team—

- Provides immediate AE of all categories of patients except battle fatigue unless no other means is available. Evacuation is provided consistent with evacuation priorities and other operational considerations, from forward areas of the CZ to the division clearing stations, or further if medically indicated. When employed in the COMMZ, this team provides for expeditious movement of patients, consistent with evacuation priorities and other operational considerations, to and between MTFs or to airfields or seaports for further evacuation out of the theater.

- Operates 6 air ambulances (each normally configured to carry 4 litter patients and 1 ambulatory patient) for single-lift evacuation

capabilities of 24 litter and 6 ambulatory patients. The kit litter may be reconfigured to carry 6 litter or 7 ambulatory patients for single-lift evacuation capabilities ranging between 36 litter, 42 ambulatory, or some combination thereof. If the kit litter is removed, the aircraft can carry 13 ambulatory patients. This team provides in-flight medical care or surveillance for patients during evacuation.

- Provides air crash rescue support. Extricates personnel from crashed aircraft. This team provides emergency aid at the crash site and aeromedically evacuates these patients to appropriate MTFs capable of providing required treatment.

- Provides expeditious delivery of whole blood, biological, and medical supplies to meet recurring and critical requirements.

- Provides rapid movement of medical personnel and accompanying equipment and supplies to meet requirements of mass casualty and other emergency situations.

- Has a flight operations section which is staffed for 24-hour operations to receive and coordinate AE missions; other sections are staffed for normal operations.

- Can perform limited AVUM on organic aircraft and organizational maintenance on all organic avionics equipment.

- Is dependent upon the supporting AVIM company for supplementing AVUM support and for AVIM.

(3) *Team RE, ground ambulance.* This team—

- Provides ground evacuation of patients to and between MTFs in the COMMZ as well as to airfields or seaports for further evacuation out of the theater. This team may also be used to provide ambulance support on an area basis primarily in high density troop population areas of the COMMZ.

- Operates 6, 1 1/4-ton field ambulances (each with a carrying capacity of 4 litter

or 8 ambulatory patients) for single-lift evacuation capabilities ranging between 24 litters and 48 ambulatory patients. This team provides medical treatment or surveillance of patients during evacuation.

- May be used to provide six 2-man short-haul or three 4-man long-haul litter teams to meet emergency evacuation requirements when ambulance evacuation cannot be accomplished or is otherwise contraindicated. This team provides emergency medical care prior to and during evacuation.

- May be organized with bus ambulances in lieu of truck ambulances to provide bulk ground evacuation of patients. When so organized, operates 3 ambulance buses (each with a carrying capacity of 18 litter or 42 ambulatory patients) for single-lift evacuation capabilities ranging between 54 litter and 126 ambulatory patients depending on the configuration of the ambulance buses.

d. Basis of Allocation. The evacuation teams are allocated as follows:

(1) *Team RA, air ambulance (UH-1V).* Two teams are allocated per division supported, one team per separate brigade-size task force not otherwise supported by an AE unit, one team per hospital center, and as required to meet AE needs of the theater when units of less than company size are indicated.

(2) *Team RG, air ambulance (UH-60A).* Two teams are allocated per division supported, one team per separate brigade-size task force not otherwise supported by an AE unit, one team per hospital center, and as required to meet AE needs of the theater when units less than company size are indicated.

(3) *Team RE, ground ambulance.* One team per division or equivalent of approximately 40,000 CZ troops supported from the COMMZ and as required to meet evacuation needs of the theater when units of less than company size are indicated.

4-13. Headquarters, Headquarters Detachment, Medical Battalion (Evacuation), TOE 08-446L000

(See paragraph 2-11d, Chapter 2, for a discussion on this unit.) Medical companies under the H-edition TOE will be converted (or are in the process of conversion) to L-edition TOE discussed in paragraphs 4-14 and 4-15.

4-14. Medical Company (Air Ambulance) (UH-1V or UH-60A Aircraft), TOE 08-447L100 and 008-447L200

a. Mission. The mission of the medical company (air ambulance) is to provide AE and support within the theater of operations.

b. Assignment. The medical company (air ambulance) is assigned to the medical brigade and is normally further attached to the headquarters and headquarters detachment, medical battalion (evacuation).

c. Capabilities. This unit provides—

- Fifteen helicopter ambulances to evacuate patients consistent with evacuation priorities and operational considerations, from points as far forward as possible, to division MTFs and corps-level hospitals. Single patient lift capability for the UH-1V units is 90 litter patients or 135 ambulatory patients, or some combination thereof. The UH-60A unit when used with kit AE K40878) installed has the capability to carry 90 litter patients or 105 ambulatory patients, or some combination thereof. When the UH-60A is configured in the troop carrier mode without the kit litter installed, the unit is capable of carrying 195 ambulatory patients.

- Air crash rescue support, less fire suppression.

- Expeditious delivery of whole blood, biologicals, and medical supplies to meet critical requirements.

- Rapid movement of medical personnel and accompanying equipment and supplies to meet the requirements for mass casualty

reinforcement, reconstitution, or emergency situations.

- Movement of patients between hospitals, ASFs, MASFs, seaports, or railheads in both the CZ and COMMZ.

d. Basis of Allocation. One in direct support of each division or equivalent force not supported by Teams RA or RG. Additionally, one in general support in the corps per two divisions or fraction thereof not supported by medical air ambulance company.

4-15. Medical Company (Ground Ambulance), TOE 08-449L000

a. Mission. The mission of the medical company (ground ambulance) is to provide ground evacuation of patients within the theater of operations.

b. Assignment. The medical company (ground ambulance) is assigned to the medical brigade and further attached to a headquarters and headquarters detachment, medical battalion (evacuation) for command and control.

c. Capabilities. This unit provides—

- Forty truck ambulances with a single-lift capability for evacuation of 160 litter patients or 320 ambulatory patients.
- Evacuation of patients from division medical companies to CZ hospitals.
- Evacuation of patients from area support medical companies to supporting hospitals.
- Reinforcement of division medical company evacuation assets when required.
- Reinforcement for patient evacuation from covering force and deep battle operations.
- Movement of patients between hospitals and ASFs, MASFs, seaports, or railroads in both the CZ and COMMZ.

- Area evacuation support beyond the capability of the area support medical battalion.

- Emergency movement of medical supplies.

d. Basis of Allocation. The medical company is allocated to the CZ on the basis of one per division or equivalent-size force supported, to the TA on the basis of one per TA and corps supported, and in the COMMZ as required.

4-16. Airspace Coordination

Airspace coordination maximizes joint force effectiveness without hindering the combat power of any of the Services. Friendly aircraft must be able to enter, depart, and move within the area of operations without undue restrictions, while supporting fires and remotely piloted vehicle flights continue uninterrupted. The tempo and complexity of modern combat rule out a system that requires time-consuming coordination. To be simple and flexible, our airspace coordination system operates under a concept of management by exception.

a. Each Service may operate its aircraft within the theater airspace. Army aircraft at low altitudes operate under the control of the Army airspace command and control (A2C2) system. The USAF aircraft at medium and high altitudes operate under control of the tactical air control system. Navy and Marine Corps aircraft may also provide mission support to the force and will, therefore, operate in theater airspace. The boundary between low- and medium-altitude regimes is flexible and situation-dependent. Coordination between the Services is continuous, but it is especially important when aircraft pass from one regime to another. Generally, Army aircraft operate with fewer restrictions below coordinating altitudes forward of the division rear boundary. Passing information about major movements or high concentrations of fire is necessary to avoid conflicts.

b. In practice, USAF support of strategic and operational plans is flown within airspace procedures established by theater or joint force commanders. These procedures may include aircraft of any Service or ally, all using rules and procedures appropriate to operational plans. Aircraft

supporting tactical plans (usually Army aviation) will adhere to theater-wide procedures as augmented by the tactical commander being supported. All airspace management rules and procedures will be standardized to the extent possible, but they will ultimately be applied in a particular theater in accordance with operational direction. The G3 air or S3 air ensures that staff elements in the A2C2 cell conduct the necessary coordination.

c. Medical evacuation pilots routinely cross divisional boundaries and may operate in and forward of the brigade support area. They need access to radio frequencies and call signs for all elements within their area of responsibility. To traverse the CZ safely, current situational updates must be available. The evacuation battalion staff has a responsibility to adequately brief their subordinate units on a recurring basis. The briefing of airspace hazards and restrictions must include information on hazards created by corps artillery units. The locations of friendly and enemy anti-aircraft units will become important flight planning factors for the safe entry and exit of medical evacuation aircraft to acquire casualties from supported units. Air ambulance companies will obtain A2C2 information from the division A2C2 section and will coordinate with the DMOC in the

divisions under the MSB/FSB design or with the medical battalion headquarters for other divisions.

d. The lethality and intensity of the modern battlefield will force medical evacuation aviators to invest the planning time required in ensuring avoidance of battlefield hazards. The ability to reach casualties far forward and survive will be improved by the preflight preparations. Although the natural tendency will be to respond immediately, the preflight preparation is necessary to complete the mission.

4-17. Enemy Prisoners of War

Sick, injured, or wounded EPW are treated and evacuated through normal medical channels, but remain physically segregated from US and allied patients. Enemy prisoners of war are evacuated from the CZ as soon as possible. Only those sick, injured, or wounded prisoners who would suffer a great health risk by being evacuated immediately may be treated temporarily in the CZ. Accountability and security of EPW and their possessions in MTFs are the responsibilities of the echelon commander. AMEDD resources are not used to guard EPW. (See FM 19-40 for further information concerning E P W evacuation and control.)