

	CURTIS E. LEMAY CENTER FOR DOCTRINE DEVELOPMENT AND EDUCATION	
	<u>AIR FORCE DOCTRINE PUBLICATION (AFDP) 4-02</u> <u>HEALTH SERVICES</u>	

INTRODUCTION TO HEALTH SERVICES

Last Updated: 12 November 2019

The Air Force medical forces provide seamless health service support to the Air Force and the joint force. They also assist in sustaining the performance, health, and fitness of every Airman at home station and while deployed within the continental United States (CONUS) or outside the CONUS (OCONUS) in support of global operations. This capability is summarized by the phrase “global medical readiness,” which includes the full spectrum of medical operations, including expeditionary deployment operations, humanitarian assistance, all-hazards response, and global health engagement to support building partnerships and stability operations. Components of this global system are fully integrated, with forward-deployed health services, and en route care to facilities providing comprehensive, definitive medical specialty care. As we continuously improve our medical capabilities and capacities, our ability to revolutionize health services and incorporate new concepts and technologies will identify the new best practices that shape future health service support. The range of military operations, from peacetime through large-scale combat operations, is always a consideration when determining the best practices for our Air Force; consideration of peer and near-peer competition is a continuing necessity for doctrine as the Air Force supports the joint fight. Every Airman is an innovator and is integral to this continuous development process – we must all connect, share, and learn together to succeed.

Air Force Health Services

The [Air Force Medical Service](#) (AFMS) ensures medically fit forces, provides expeditionary medics and improves the health of all we serve to meet our Nation’s needs. First, Air Force health services are focused on life-saving expeditionary medical support. They ensure rapid casualty stabilization, treatment, staging, and evacuation to definitive care, while maintaining the standard of care and providing en route patient safety. Air Force medical forces leverage speed, range, and flexibility by using hub and spoke operations to quickly form and maneuver customized medical capabilities to forward operating sites. Intertheater air mobility forces move cargo and personnel to arrive at an enduring location (hub) within a theater. Intratheater air mobility forces then move the cargo and personnel to contingency locations (spokes) in the theater. Before placing medical teams at airlift hubs, medical planners should consider the feasibility of the airlift web supporting the established hub and spoke operations. See [Fundamentals](#)

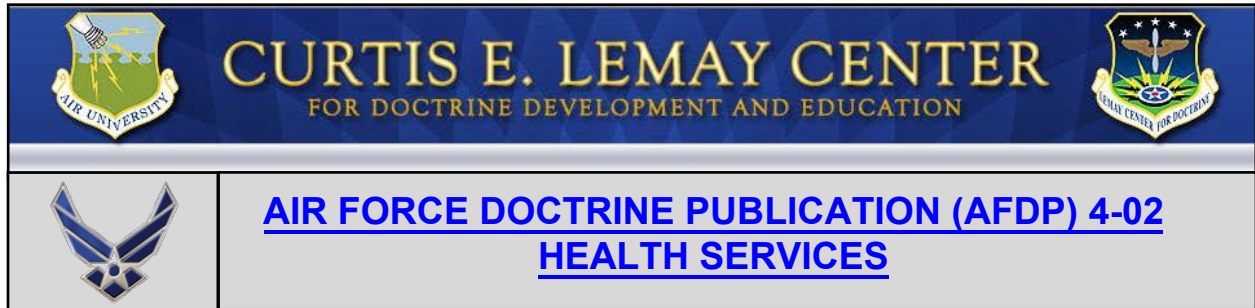
[of Air Force Health Service Support](#) for a detailed discussion of [Air Force medical forces support in joint operations](#), [patient movement](#), and [medical logistics](#).

Air Force medical forces consist of personnel from active duty, Air Force Reserve, and Air National Guard, as well as Air Force civilians, and contractors. Though regular, Reserve, and Guard medical forces are interoperable, each has distinctive mission areas. Command and organization of medical forces consist of both the internal command and operational relationships within the AFMS and the external command relationships for home station and expeditionary operations. See [Roles and Responsibilities](#) for detailed discussion of command and organization.

Health services provide force health protection, which is designed to support the combat force. These focal points promote and sustain a healthy and fit warfighter, prevent illness and injury, and provide casualty care and management. See [Force Health Protection](#) for in-depth discussion.

The global security environment is constantly evolving. No single nation can address every challenge and priority alone. With this in mind, the Air Force, as part of the joint force, actively partners with allies to further US and partner nation mutual interests. Air Force medical forces may be required to support stability operations, build partnerships, and improve partner capacity. They leverage military health engagement and training opportunities to enhance military capabilities necessary to achieve objectives for all operations. See [Health Support Operations](#) for in-depth discussion.

Responsive medical assistance within our borders is also vital to effective support of the Service as a whole. Air Force medical personnel support homeland operations as effectively as they do in an expeditionary environment. See [Home Station Planning and Execution](#) for in-depth discussion.



FUNDAMENTALS OF AIR FORCE HEALTH SERVICE SUPPORT

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Air Force medical forces provide [combat support](#) (CS) functional capability. They provide the force health protection capability of CS. Likewise, medical forces are by design not self-sustaining; they depend upon CS capabilities for security and infrastructure support. They are an integral part of forces employed to open, establish, and operate airbases.

Employment as Part of a Combat Support Force Module

During the planning stage leading up to an operation, force module elements are linked together in planning systems so they may be rapidly identified and tasked to deploy. Medical force capabilities are integrated into each air expeditionary task force module with specific capability types and quantities based on the population at risk in the force module and the typical force health protection threats found at most airbases. Medical forces in CS force modules are those required to provide direct support to an expeditionary unit conducting operations from one airbase. For additional information on force modules, see AFDP 4-0, [Combat Support](#).

When opening an airbase, medical teams assess the potential health impact of a beddown location, base configuration, and provide advice on mitigating health hazards. These teams also provide initial medical support to the fielded forces from the initial commencement date. Based on existing theater and local medical capabilities, they provide input into additional medical capabilities required to support the projected population at risk. Continual health surveillance and assessment of operational, disease, and environmental exposures and risks are part of total exposure health. This continual surveillance and assessment is essential for optimal health outcomes and operational performance.

Upon establishing the airbase, medical personnel and materiel assets continue to flow into the operational area and contingency locations to expand medical support capabilities. Medical forces remain focused on threats and countermeasures to sustain and optimize warfighter performance. Medical forces establish a theater health care system using the following assets:

- ✦ Theater Patient Movement is tied into the theater aeromedical evacuation (AE) system. This includes forward resuscitative care (FRC) assets like Role-2 Light-Maneuver surgical capabilities, such as ground surgical teams (GSTs) and special operations surgical teams (SOSTs). Initial AE and patient movement item assets to evacuate casualties.
- ✦ FRC provided as close to the point of injury as possible based on current operational requirements to attain stabilization, achieve the most efficient use of life-and-limb saving medical treatment, and provide essential care so the patient can tolerate evacuation.
- ✦ A theater contingency and disaster casualty management plan to integrate theater, host nation, and coalition medical services; expeditionary medicine platforms; and the AE network.

During expeditionary operations, Air Force medical capabilities are planned based on the Air Force population at risk and access to available AE using organic or contract aircraft. In a joint deployment, additional resources may be required to care for joint personnel. Air Force medical personnel also work closely with line of the Air Force personnel to monitor operational threats and provide risk management data for maximum operational effectiveness. The theater health care system is tied together with a robust network of local, host nation, joint, and coalition medical force capabilities linked by air, ground, and maritime evacuation platforms.

When redeployment commences, medical force resources should be used in the same manner as when deploying. Larger assets should be redeployed first with smaller elements providing ongoing care.

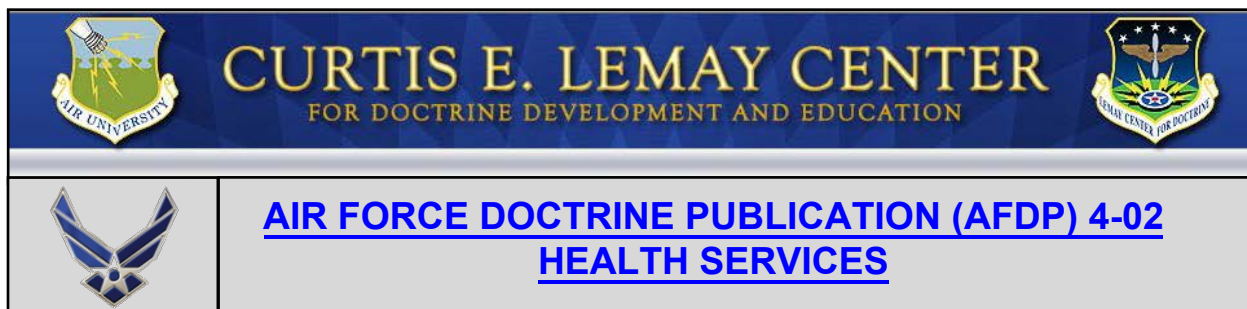
Employment Tailoring

Medical force employment tailoring includes population at risk support, rapid incremental employment, CS force module employment, hub and spoke employment, or flexible tasking of an in-place force. Each has benefits as well as risks to be weighed for the operation at hand. In practice, when considered at the theater level, medical forces use these employment methods to optimize a theater medical system characterized by speed, responsiveness, flexibility, and agility. The goal is to strike a balance in devising a medical operations plan that exploits the capabilities yet limits the risks that come with a light and lean system of capabilities. The plan should be designed to maximize the commander's capability to stabilize, treat, stage, and evacuate casualties and patients from points of injury to [definitive care](#) on a worldwide scale.

Rapid Incremental Employment

Air Force medical forces possess the ability to insert forces into forward areas with a team tailored to the specific operational mission. Tailored forces may include preventive medicine, primary care, trauma surgery, intensive care, and connectivity to the medical evacuation and AE system. Within this dynamic window of rapid deployment, combat and support forces compete for limited airlift into new airfields based on priority. This priority is not always an “all or nothing” decision for the deployment of combat support forces. Rather, the decision may be a balanced response to increase combat support capability as the airfield opens and begins operations, or as requirements change. During the period of medical vulnerability, en route critical care capabilities (e.g., critical care air transport team, etc.) are able to expedite evacuation while continuing active resuscitation and treatment of casualties from initial forward resuscitative care teams. When deploying, medical forces strive to ensure health protection capability arrives as early as the warfighters and minimizes the demand on limited airlift resources.

During the periods of opening and closing airbases, Air Force forces are at a high risk of injury or illness due to non-combat vulnerabilities such as poor food, water, or sanitation and industrial or occupational accidents. The use of tailored medical forces allows a tiered approach to flowing medical capabilities in or out to match changing medical support requirements, mission or threat scenarios, availability of airlift, or the population at risk. Flowing in only essential medical capability on the first available aircraft provides the necessary force health protection yet maximizes the limited airlift available for competing priorities. Additional medical capability flows in to meet requirements as operations dictate and airlift becomes available. When Air Force forces redeploy, medical force capabilities decrease incrementally as the population at risk decreases and the threat allows.



AIR FORCE HEALTH SERVICE SUPPORT IN JOINT OPERATIONS

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Medical support in the joint environment is a key component of expeditionary and operational planning. The following Air Force medical capabilities are provided to the [joint force commander](#):

- ✦ En route casualty support and responsiveness corresponding to the activities during the opening, establishing, operating, drawing down, and closing of airbases during the deployment, employment, and redeployment phases of operations. The capabilities of these medical forces allow precise insertion into forward areas with teams tailored to the specific medical mission (e.g., preventive or primary care medicine, trauma surgery, intensive care, humanitarian relief operations, en route critical care or [aeromedical evacuation](#) [AE]). These capabilities are designed to support military forces when they are historically most vulnerable to illness and injury, and are most likely to lack access to medical care.
- ✦ Responsive medical capability to support military or civilian medical requirements including those during stability operations. The rapidly deployable and near-immediate operational capability of air expeditionary medicine often makes the Air Force the most capable of all military Services to support such operations. The use of expeditionary medical forces from the beginning to the end of operations ensures the [commander, Air Force forces](#) (COMAFFOR) makes these limited forces available based upon priority and reconstitutes these forces for their primary mission once other Services' sustainment forces are able to deploy.

Air Mobility and Medical Forces

Air Force air mobility and medical forces provide Service assets, in conjunction with the other Services, to form the worldwide patient movement system. AE provides time-sensitive en route care of patients or casualties to and between medical treatment facilities using organic or contracted aircraft with medical aircrew trained explicitly for that mission. AE forces can operate as far forward as aircraft are able to conduct air operations, across the full range of military operations, and in all operating environments. Specialty medical teams may be assigned to work with the AE aircrew to support patients requiring more intensive en route care.

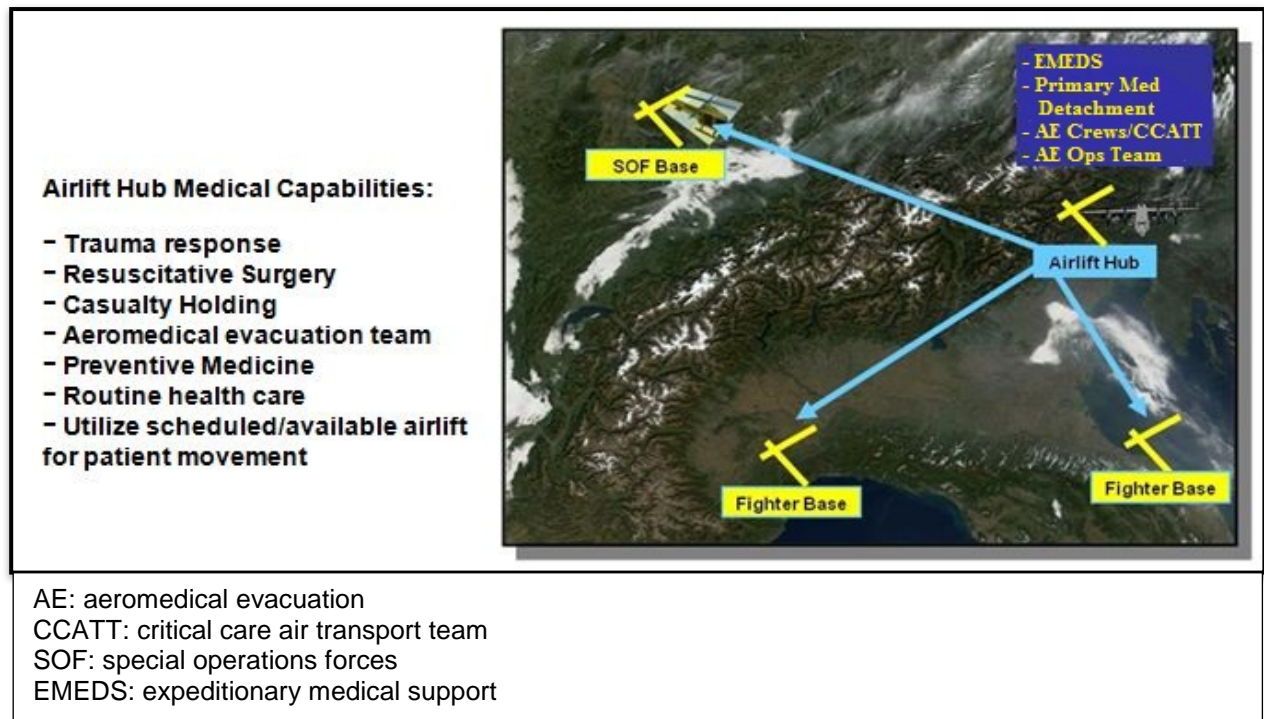
The Air Force description of AE supplements the joint definition--"AE is the movement of patients under medical supervision to and between medical treatment facilities by air transportation." To provide patient care in the aeromedical environment, Air Force AE crewmembers and specialty medical teams receive advanced training and education on the stresses of flight, altitude physiology, and medical equipment designed for AE. See AFDP 3-17, [Air Mobility Operations](#), for a detailed discussion of AE.

The Air Force AE system uses its capability to stabilize, prepare, and approve casualties or patients for regulated air transport to ensure they are transported to the right destinations. The [en route care \(ERC\) capability](#) provides commanders the ability to evacuate severely wounded or critically ill personnel to [definitive health care](#) while providing increasing levels of critical health care along the way and in the least amount of time. Other Services support key elements of the ERC capability by providing the majority of forward surgical care and rotary wing medical evacuation. The Air Force AE system is the backbone of the ERC capability, which is operated by air mobility and medical forces. Command and control over medical and mobility forces through the AE system resides in the COMAFFOR's [A-staff](#) and the [air operations center](#) (AOC) to enable near-immediate evacuation, strategic reach, and operational capability upon arrival.

Hub and Spoke Operations

The Air Force theater medical support network is based upon a hub and spoke concept. Deployed Air Force medical facilities are located at "hubs" and provide expanded theater medical and surgical support to treat and return joint personnel to duty or to stabilize them for AE to more definitive care as needed. The "spokes" are relatively small teams that provide life-saving medical care and continuous force health protection and prevention services to joint personnel. The figure titled, "Notional Hub and Spoke Operations Medical Capabilities" illustrates a notional hub and spoke operation. Air Force medical hub and spoke operations leverage the integration of inter and intra-theater airlift to optimize the use of low density, high demand medical forces and enable rapid response to emergent medical needs at forward operating sites (FOSs). The hub is the focal point for follow-on transshipment by intra-theater assets to FOSs via spokes. Hub and spoke operations enable the COMAFFOR, at the recommendation of the Air Force forces Surgeon (AFFOR/SG), to "push" medical capability to spokes based on anticipated or actual medical threats to the operational mission. Hub and spoke operations also allow commanders at spokes to "pull" medical capability when needed such as forward surgical and casualty staging capability, patient movement item, blood, and biomedical equipment maintenance.

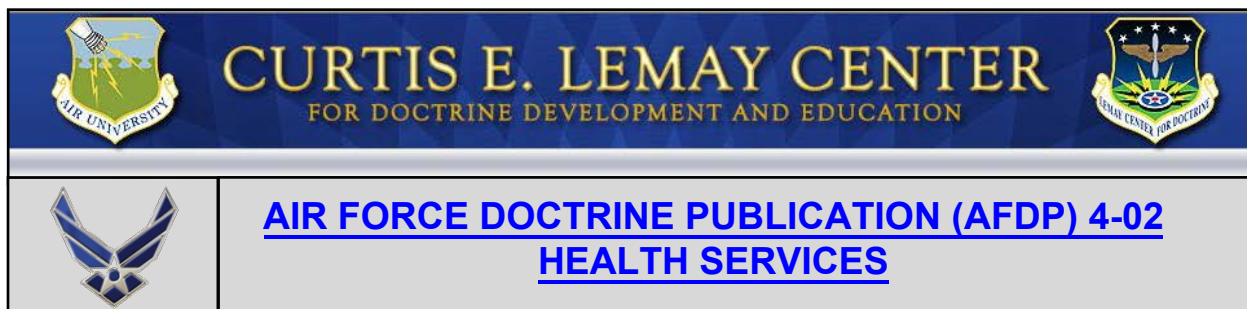
The interdependence and synergy between medical forces and air mobility are demonstrated by hub and spoke operations where trauma, casualty staging, and AE forces from the hub are pushed to a FOS in response to a mass casualty scenario. Casualties are stabilized, staged, and evacuated back to the hub for a higher level of care and possible strategic evacuation. Hub and spoke operations extend the ERC capability to at-risk FOSs that may not require full-time capability.



Notional Hub and Spoke Operations Medical Capabilities

Accommodating Changes in Employment Missions

Medical forces deployed in support of one unit may be tasked to support forces performing an unrelated mission. These missions are usually conducted by joint forces or component forces of another Service in the same operational area as the airfield. Accommodating changes to missions require planning and direction by the A-staff and the AOC in coordination with the unit commander, usually in support of short-notice, short-duration missions. Typically, these missions leverage the existing resuscitative surgical, critical care, and staging capability that offer immediate access to available AE organic or contracted aircraft. The tasked medical unit has a support relationship with the requesting commander while ensuring the unit commander retains [tactical control](#) of their organic medical capability. The unit commander assesses shortfalls in medical capability that should be augmented or presented to the supported commander as risks to be accepted. The supported commander may augment the medical unit with organic medical assets to enhance the overall capability and mitigate risk. In most cases, changes in employment mission tasking cannot be planned exclusively at the tactical level but require the AFFOR/SG and the A-staff to make AE plans in support of the mission. In-place medical forces tasked to support adjacent combat operations provide the supported commander the ability to rapidly plan and execute intense, short-duration combat missions supported by the immediate ability to stabilize, stage, and evacuate significant numbers of combat casualties and patients.



EN ROUTE CARE CAPABILITY

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[Patient Movement](#) provides the [joint force commander](#) the ability to ensure injured warfighters receive lifesaving care from the point of injury to definitive care in the least amount of time. [En route care \(ERC\) capability](#) is a critical component in all expeditionary planning. Medical forces are an integral piece of the [air mobility](#) and [combat support](#) forces which enable patient movement. This integration, plus the [command and control](#) (C2) through the [air operations center](#) (AOC) [air mobility division](#) (AMD), allows the Air Force to perform in the most rapid manner possible.

Patient movement begins at the first point of in-theater casualty or patient injury and is supported by available patient movement capability. Critical care support can be initiated at the entry into the ERC capability and continues through increased levels of care to definitive care en route to continental US (CONUS)-based [medical treatment facilities](#) (MTF).¹ Expeditionary medical support (EMEDS), medical treatment facilities (MTF), and Air Force theater hospitals (AFTH) are capable of simultaneously providing health services for deployed beddown locations and en route medical support. EMEDS and AFTHs are incrementally expandable to provide enhanced resuscitative surgery, critical care capabilities, and humanitarian support. EMEDS and AFTHs extend the reach of strategic casualty evacuation for en route care, and can be collocated and supported by the en route patient staging system (ERPSS). En route critical care teams (e.g., critical care air transport team (CCATT), lung team, etc.) are postured at en route locations and provide advanced care throughout transport. Using aeromedical evacuation (AE) crews supplemented with critical care specialists when needed, casualties and patients are moved via designated retrograde or in-system select aircraft through a facility with staging capability before being transferred by AE and patient movement item assets to definitive care en route or to CONUS-based MTFs.

En Route Patient Staging System

The [ERPSS](#) is a flexible, modular patient staging system able to operate across the spectrum of scenarios such as military operations, humanitarian assistance and disaster relief operations, and defense support to civil authorities. It is used for temporary

¹ Air Force Tactics, Techniques and Procedures 3-42.51, [Critical Care Air Transport Team](#), and US Army Field Manual 4-02, [Army Health System](#).

staging, casualty care, and administration support during contingency operations. It should be located at an airfield capable of supporting organic and contracted aircraft. An ERPSS is capable of sustaining 24-hour operations. It provides patient reception, complex medical-surgical nursing care, and limited emergent intervention. Employed ERPSS ensure patients are medically and administratively prepared for flight and coordinate with all Service medical and transportation elements to accomplish patient movement. Patients requiring extensive medical treatment or critical nursing care should remain in the MTF until arrangements have been made for transfer. Patient holding times may range from between 6 to 72 hours, range from 10-250 beds, and are very dependent upon the arrival of the earliest opportune aircraft for which a patient can be prepared for AE.

Air Force Theater Hospital

The AFTH provides dedicated in-theater and en route medical support. AFTHs are located at critical strategic airlift hubs to stage casualties from the operational area or en route airlift staging bases as patients move to definitive care. Several teams augment the AFTH to provide the appropriate level of medical support at or above a 25-bed capacity. Specialty and ancillary teams are generally centralized at one to three mature theater hospitals. Mature theater hospitals normally house 50 beds or greater with a full complement of medical specialties. Contingency-specific needs drive deviations.² In coordination with the geographical combatant command, AFTH may be designated a reintegration facility and will be prepared to receive recovered isolated personnel in support of the personnel recovery reintegration process.

En Route Fixed Medical Treatment Facilities

En route fixed MTFs provide dedicated medical support to casualties and patients en route to definitive care. These facilities are joint or Service-specific and are located at major air hubs in an operational area and in CONUS. Because of distances, patient acuity, stresses of AE to severely injured patients, en route fixed MTFs are designated to provide stabilization, resuscitative, and initial or definitive care to casualties transiting the AE system. Medical planners should also consider appropriate fixed civilian medical facilities depending on which services may be leveraged to fill gaps not available from the Air Force, joint, or coalition force.

En Route Critical Care Team

ERCCT is a global term that encompasses all medical teams that provide advanced clinical care by augmenting an evacuation platform medical crew during any portion of patient movement. The ERCCT is a specialty care or critical care team which is authorized operational support status. It can be added to the basic AE crew to provide a higher level of care to critically ill patients during AE staging and flight. ERCCTs may be unit type codes (UTCs), standing peacetime capabilities, permanently based at a single

² Air Force Instruction 41-106, [Medical Readiness Program Management](#).

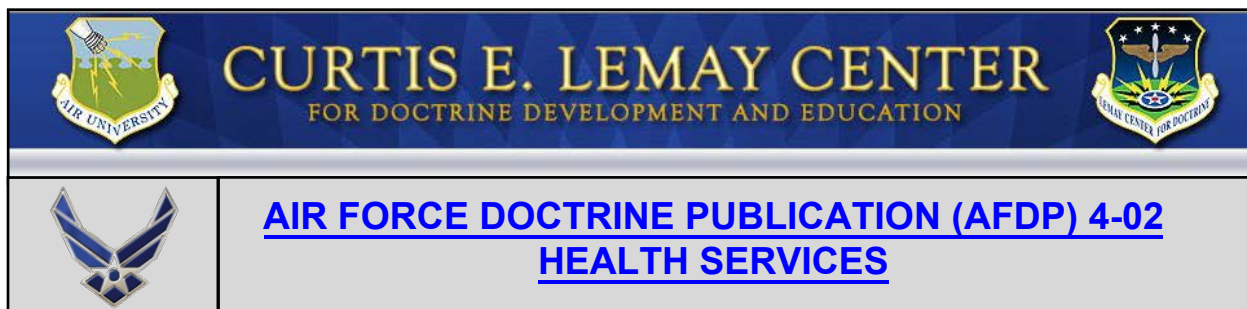
MTF, or created for a specific mission. Some examples include CCATT, Lung Team, Neonatal Team, US Army burn team, US Army en route critical care nurses and British Medical Emergency Response Team. When in flight, the ERCCT physician is responsible for clinical decisions and care concerning the critically ill patient(s) and works under the operational direction of the medical crew director for mission management and the aircraft commander for operational management. In the event of potential threats to the aircraft or crew, during most contingency operations, casualties will be brought quickly to the flightline where they will be assessed on or near the aircraft.

Critical Care Air Transport Team

CCATT is an Air Force UTC consisting of three persons (critical care physician, critical care nurse and respiratory therapist) that provide an advanced en route medical capability to evacuate critically ill, injured, or burned patients requiring continuous stabilization or advanced care during transport to the next level of care.

Aeromedical Evacuation Crew Member (AECM)

AECMs provide inflight patient care on any aircraft using medical equipment that meets airworthiness testing certification standards. Crewmembers have completed specific qualification and training requirements and are knowledgeable about the stresses of flight and effects of altitude on patients, basic trauma skills, and patient safety. AECMs are experts on the interface between aircraft systems and medical equipment to meet patient care requirements. The basic aeromedical evacuation crew may be tailored to support patient needs and requirements. If appropriately coordinated with their C2, crews can also augment aeromedical evacuation AE ground UTCs. During execution of the AE mission, AE crews and CCATTs are controlled by the AOC for intratheater missions or the 618th AOC (Tanker Airlift Control Center) for intertheater missions.



MEDICAL LOGISTICS

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[Medical logistics](#) underpins medical operations and is of utmost importance in operational and expeditionary planning. The medical logistics system provides support and sustainment to all [air expeditionary task force](#) medical forces.³ The medical logistics function includes planning for blood and other transfusion products. Medical planners and personnel implement the logistics and blood distribution processes to meet the deployment and sustainment challenges of deployed forces. For additional information, see Air Force Tactics, Techniques, and Procedures (AFTTP) 3-42.8, [Expeditionary Medical Logistics System](#).

Expeditionary Medical Logistics (EML)

The EML system provides tailored logistics packages to the deployed medical unit by using a predetermined supply chain.

The expected results of fielding focused logistics capabilities include a timelier and more precise delivery of mission-ready forces and their essential support to the [joint force commander's](#) specified destinations. Expected results also include a right-sized (and potentially reduced) support footprint in the operational area and more cost-effective logistics support for the warfighter.

The EML process uses a sustaining base to receive a deployed medical unit's requirements and to process orders to approved vendors or depots that meet strict Air Force availability, time, and shipping criteria. Commercial transportation should be used as far forward as possible and may connect with the military transportation system. The EML system is the linking process for a complex supply chain.

Air Force Medical Logistics Operations Center (AFMLOC)

The AFMLOC is central to Air Force medical supply chain management. It is the focal point for coordinating and integrating medical logistics planning and support. The AFMLOC functions as the supply chain manager and creates and maintains responsive,

³ Air Force Manual (AFM) 41-209, [Medical Logistics Support](#).

visible sustainment to deploying and deployed forces.⁴ The AFMLOC integrates information, commercial technology, logistics, and transportation strategies to meet the full spectrum of operational requirements.

Medical Logistics Management Center (MLMC)

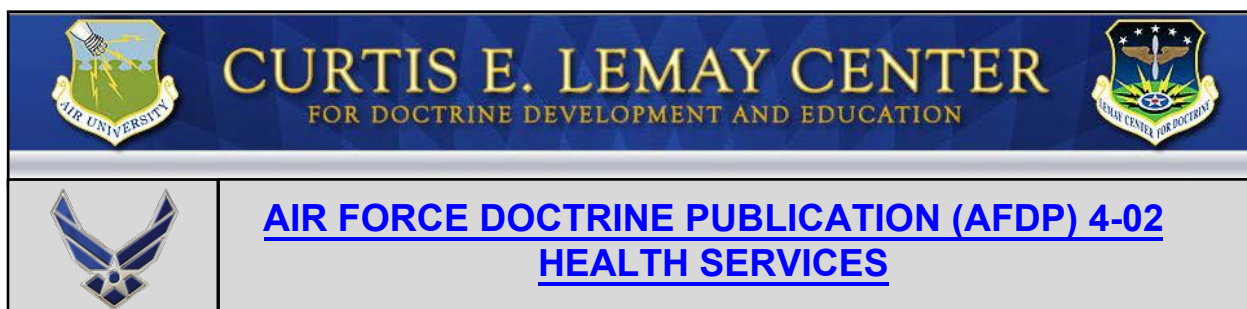
In theater, there may be a jointly staffed MLMC linked to the combatant commander (CCDR), joint task force Surgeon (SG), Air Force forces SG, deployed medical units, continental US sustaining base, or the AFMLOC. The MLMC supports the theater lead agent for medical materiel (TLAMM) by identifying supply chain planning. The TLAMM is responsible for providing theater customer support, materiel management, medical maintenance distribution, and assists CCDRs' MLMC with planning.

Patient Movement Items (PMIs)

[PMIs](#) are the jointly designated supplies and equipment necessary to support patient movement within the aeromedical evacuation (AE) system.⁵ Medical logistics and AE personnel manage inventory availability at PMI centers, cells, and nodes and ensure asset visibility and flow of PMI through available transportation methods to meet requirements. Asset visibility is provided via the PMI tracking system. Deployed PMI system teams collocate at key interface points and theater medical treatment facilities to provide initial AE operational capability, sustain AE operations, and minimize equipment turnaround time. During contingency operations, PMI assets and tracking system requirements are initially identified by the CCDR and pushed to support patient movement at key patient insertion points in the AE system. Steady-state PMI support is supplied by the combatant command as required. For additional information see Joint Publication 4-02, [Joint Health Services](#); AFTTP 3-42.5, [Aeromedical Evacuation](#); and AFTTP 3-42.8, [Expeditionary Medical Logistics System](#).

⁴ AFM [41-209](#).

⁵ AFM [41-209](#).



ROLES AND RESPONSIBILITIES

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Medical units are commanded by [Air Force Medical Service](#) (AFMS) officers with the majority of medical forces ultimately working for designated Line of the Air Force commanders at each echelon of the chain of command. High standards of medical care are met and sustained through the single chain of command. Though medical forces are generally organized and controlled like other Air Force forces, inherently unique medical mission requirements prompt distinct differences.

It is essential to understand the roles and responsibilities of key commanders and senior leaders involved in planning and executing medical operations. This section provides a concise overview of these roles and responsibilities.

Command and Control in Expeditionary Organizations

The [commander, Air Force forces](#) (COMAFFOR) normally exercises [operational control](#) (OPCON) over all Air Force forces assigned or attached to the Air Force component. Medical operators and planners are integrated into the COMAFFOR's [A-staff](#) and [air operations center](#) (AOC), providing the mechanism for [centralized control](#) over medical force capabilities on the ground and in the air. Centralized control permits the COMAFFOR to respond rapidly to emergent medical needs across a theater.

Air Mobility Division

The AOC's [air mobility division](#) (AMD) plans, coordinates, tasks, and executes air mobility operations for the COMAFFOR. As one of the five divisions of the AOC, the AMD provides integration of and support for all joint operational air mobility missions, to include aeromedical evacuation. The AOC commander provides policy and guidance to the AMD who tasks intratheater air mobility forces through wing and unit command posts when those forces operate from home bases and through applicable forward command and control nodes such as wing operations centers. The aeromedical evacuation (AE) control team is one of four teams within the AMD.

Aeromedical Evacuation Forces

Organizationally, an AFMS officer commands AE squadrons which may be assigned to the operations group of an air mobility wing. On employment, the critical care air transport team and en route patient staging system may be assigned to the expeditionary AE squadron. The AE squadron commander is responsible for administrative control, operational risk management, mission execution, and ensuring assigned personnel maintain qualification and training requirements.

Aeromedical Evacuation Control Team (AECT)

Medical personnel trained in AE command and control (C2) are attached to the AECT within the AMD of the AOC. The AECT is responsible for AE operational planning, scheduling, tasking, execution, and monitoring in coordination with air mobility controllers. The AECT coordinates airlift support and evaluates available air mobility airframes attached to or transiting the theater to meet theater AE requirements. The AECT coordinates with the J-4 medical branch on the joint task force staff and the Patient Movement Requirements Center (PMRC) on patient movement requirements and priorities. It also works closely with air mobility controllers for pre-planned and immediate intratheater/intertheater airlift requests.

United States Transportation Command (USTRANSCOM)

The Commander, US Transportation Command (CDRUSTRANSCOM), serves as the Department of Defense single manager and global synchronizer for patient movement policy in coordination with Office of the Assistant Secretary of Defense/Health Affairs, joint staff, secretaries of the military departments, and geographic combatant commands. USTRANSCOM develops, publishes and implements standardized patient movement item business practices and guidelines. USTRANSCOM Surgeon (SG) office manages all assigned personnel supporting patient movement requirements centers (PMRCs) in the global patient movement system in peacetime and contingency. USTRANSCOM/SG serves as the functional manager to maintain, operate, and provide joint training for existing and future patient movement automated information systems. USTRANSCOM/SG manages the global patient movement safety program and conducts event reviews and investigations of patient movement activities as required. USTRANSCOM/SG coordinates with theater components for designation of portions of theater-assigned transportation and bed assets for use by PMRCs. Theater PMRCs (TPMRCs) should be responsive to the geographic combatant command's patient movement requirements as well as oversee and approve joint task force--coordinated PMRC transport-bed plans and patient movement enablers as required. TPMRCs will oversee processes for management of the theater patient movement safety program and ensure patient safety from entry into the patient movement system to arrival at destination facility.

In the European and Indo-Pacific areas of responsibility (AORs), the PMRCs are permanently established functions responsible for coordination of joint patient

movement within the AOR. PMRCs operating in other geographic combatant commands are assigned to USTRANSCOM.⁶ The AFFOR/SG can request a joint PMRC (JPMRC) be established through the global force management process. CDRUSTRANSCOM may transfer [tactical control](#) of the JPMRC to the geographic combatant commander. PMRCs are responsible for coordinating with GPMRC for patient movement regulated back to the US. For more information, see Joint Publication 4-02, [Joint Health Services](#), Appendix A, [Patient Movement](#).

Air Force Forces Surgeon

Within an air expeditionary task force (AETF), the Air Force forces (AFFOR) Surgeon (AFFOR/SG) is a member of the COMAFFOR's special staff and is the Director of Medical Operations. The AFFOR/SG is the COMAFFOR's designated coordinating authority with all agencies affecting medical operations. The AFFOR/SG does not exercise command authority or direct control over medical forces, but provides planning, coordination, and oversight. The AFFOR/SG also advises how best to employ medical force capabilities in support of expeditionary Air Force forces and other joint forces. In addition, the AFFOR/SG uses direct liaison authority, when authorized, to coordinate medical support of the AFFOR staff and the AOC with other supported and supporting commands and agencies. The AFFOR/SG is responsible for overall medical personnel and materiel resource management and provides information on health surveillance and medical risk assessments, sustainment, and other force health protection issues. The AFFOR/SG typically deploys liaison officers to coordinate with Service, joint, and multinational force surgeons' staffs. These liaison officers maintain a common operating picture, anticipate operational requirements for medical capabilities support, assess impact on air component operations, deconflict issues that may degrade operations, and assist in achieving optimal unity of effort.

Medical planners should be integrated into the COMAFFOR's A-staff and the AOC. They plan en route casualty care and aeromedical evacuation (AE) missions. Centralized control over Air Force medical, AE, and airlift forces is essential. It enables seamless stabilization and worldwide evacuation of casualties or patients from forward airfields to definitive care hospitals. Decentralized execution provides flexibility for en route medical support and local health services.

Deployed Medical Commander

The deployed medical commander is the commander of the deployed medical organization, and is responsible to the deployed wing commander for the health service support of the deployed population. The deployed medical commander coordinates with the Air Force forces Surgeon on theater medical support issues.

⁶ Deputy Secretary of Defense memo dated 25 November 2011, *Assignment of the TPMRC to CDRUSTRANSCOM*.

Deployed Medical Forces

Most conventional medical forces are deployed as expeditionary medical groups or squadrons within an air expeditionary task force. Medical units are normally under the OPCON of the COMAFFOR and are attached to an air expeditionary wing (AEW) or air expeditionary group (AEG). The AEW (or AEG) commander exercises [administrative control](#) (ADCON) of all attached AEW (or AEG) assets, including medical support. A medical group commander is typically a member of the AEW (or AEG) commander's staff.

Joint Medical Missions

When the air component is tasked to provide medical capability in support of joint or other Service components, the provided Air Force medical forces should remain under the OPCON of the COMAFFOR, except when the air component falls under a joint theater special operations command and OPCON lies with the Commander, US Special Operations Command and subordinate line special operations commanders. Joint medical missions may span the range of Air Force medical capabilities. Examples of these missions may include a short-notice deployment of surgical capability to a forward operating base; an expeditionary medical squadron to support a nearby ground combat operation; or a preventive medicine team to assess and reduce adverse health effects to deployed personnel in occupational, environmental, and chemical, biological, radiological, and nuclear operations. These missions can rapidly close gaps in joint medical capability by using Air Force medical capabilities already employed nearby.

When medical forces already deployed in support of an Air Force expeditionary unit are tasked to support another mission, the forces are typically provided in a [support relationship](#). This commits the needed capability to the requesting commander while ensuring the Air Force expeditionary commander retains OPCON of their organic medical capability.

Command and Control in a Joint Environment

Medical forces may deploy to the AOR, to AE en route stops, to locations outside the AOR, or to sites within the continental United States (CONUS). The organization and C2 of these medical forces follow normal command relationships. However, when medical forces are assigned missions supporting joint forces, the organization and C2 differ. This situation occurs, for example, when the [joint force commander](#) (JFC) delegates the commander, Army forces (COMARFOR), in his or her role as the joint force land component commander, authority over medical operations involving theater-level medical assets. This most often applies to Air Force Theater Hospitals (AFTHs) in the combat zone.

The Army forces (ARFOR) Surgeon has the C2 capability to command, control, and support theater-level medical assets using the ARFOR staff. This C2 capability includes a tactical-level medical regulating function that directs ground and rotary-wing medical

evacuation of casualties and other patients to medical units in the combat zone for initial stabilization. It is usually at this interface that stabilized patients are entered into the theater AE system and further regulated for movement to definitive care by the PMRC. When this C2 arrangement exists and the JFC so designates, the ARFOR medical commander may exercise [tactical control](#) (TACON) of AFTHs as part of the [en route care \(ERC\) capability](#). However, the COMAFFOR retains OPCON of these AFTHs and other medical assets to ensure they are optimally organized and employed to meet assigned missions.

Air Force Theater Hospitals

The AFTHs are typically attached to an AEW or AEG commander responsible for airlift hub operations. Therefore, it is critical that medical force commanders and leaders clearly understand the established command relationships as well as the bounds of each command authority. The bounds of TACON warrant specific discussion regarding Air Force medical forces under the TACON of the COMARFOR. TACON is limited to the detailed direction and control of movements or maneuvers within the operational area necessary to accomplish missions or tasks assigned. TACON only provides sufficient authority for controlling and directing the tactical use of combat support forces within the assigned mission. Therefore, medical forces assigned the mission of en route casualty support at an airlift port cannot be directed to other missions in other locations except by the COMAFFOR. However, an Air Force combat casualty stress team assigned an area mission in support of joint forces can be maneuvered within that area as needed. Ultimately, it is critical that when TACON is transferred to a non-Air Force commander that the assigned mission be clearly defined and understood by all affected commanders to properly bind the authority being delegated. For more information on roles and responsibilities of Air Force medical agencies, major commands, and medical treatment facilities, see [Appendix C](#).

FORCE HEALTH PROTECTION

Last Updated: 12 November 2019

To sustain a fit and healthy force is the first of three focal points of [force health protection](#). Total Exposure Health (TEH) aims to accomplish this by creating a solution to capture workplace, environment, and lifestyle exposures and connect to the individual using advances in science, technology, and informatics to prevent disease and improve the health and well-being of Air Force personnel.

A fit and healthy force increases the Air Force's capability to withstand the physical and mental rigors associated with combat and other military operations. The ability to remain fit and healthy despite exposure to numerous health threats is a force multiplier at home station and in deployed settings.



Healthy Fit Force Concept

Concept for Fit and Healthy Force

Fit and healthy Airmen can deploy on short notice and operate effectively in austere environments. Using TEH for early identification and intervention of health conditions that could otherwise prohibit Airmen from being fully ready to deploy, increases the [commander, Air Force forces](#)' (COMAFFOR's) ability to [mass](#) forces. Fitness includes at least fitness for military service, for Air Force specialty code, for deployment, and special operational duties and implies abiding fitness for in garrison duties, periodic fitness for deployed duty, and on-demand fitness for emergency or disaster-response duties anyway.

Prevent Illness and Injury

To prevent illness and injury is the second of three focal points of force health protection. Illness and injury prevention is the framework by which Air Force leaders and individuals optimize health readiness and protect Airmen. The force health protection goal is to prevent illness and injury from the physical and mental stress caused by environmental, occupational, operational, and warfare; to include [chemical, biological, radiological, and nuclear](#) (CBRN) threats. Air Force medical personnel recognize and prepare for emerging man-made and natural threats. They make reasonable efforts to identify and protect our forces from emerging infectious diseases, as well as potential genomic/proteomic, directed energy, non-traditional agents, and other new technologies. Casualty prevention is a continuous process conducted throughout pre-deployment, deployment, and post-deployment phases. Illness and injury prevention requires the full commitment of commanders, leaders, and individuals.

Medical forces arrive early as an integral part of the [beddown](#) team to assess threats; mitigate hazards to acceptable levels for operations; and to protect Airmen. Medical forces conduct routine standardized exposure monitoring and tracking of disease and injury rates to assist commanders in taking data-driven corrective actions at all levels. Automation and data collection are conducted at the lowest echelon, and actionable data are transferred to each echelon of command. This enables a full health risk assessment for the operational missions and the development of risk-mitigating recommendations for commanders.

During deployment and follow-on operations, adversaries and the total environment generate threats to forces. Enemies produce combat-related casualties, commonly called battle injuries; while the environmental, safety, and occupational health threats, or total-environment threat, produce disease and non-battle injury (DNBI) casualties.⁷ DNBI's historically have accounted for three-quarters or more of battlefield casualties, although this proportion has decreased dramatically since the advent of modern medical practices. Casualty prevention historically has focused on reducing or eliminating the risk of food-, water-, waste-, and insect-borne illnesses, as well as heat and cold injuries during deployments. However, in today's environment, increased risk from covert

⁷ Department of Defense Instruction 6490.03, [Deployment Health](#).

chemical and biological contamination by terrorists has expanded casualty prevention to include the monitoring of food, air and water for chemical and biological agents. Recent operations demonstrated the need to emphasize environmental and occupational exposures and combat stress in addition to DNBI.

Medical capabilities include refined military medical surveillance and objective exposure measurements to identify threats, assess risk, and develop countermeasures to meet actual and potential threats. Considerations to prevent casualties include:

- ✦ **Total Exposure Health:** Includes workplace, environmental, and lifestyle exposures to the individual. TEH integrates exposure science and information technology to analyze and translate all data into clinically and personally actionable results.
- ✦ **Non-Adversary Threats:** These are naturally occurring in the environment or a result of past or present military operations and may include endemic diseases, motor vehicle accidents, sports or recreational injuries, body stresses due to wearing of personal protective equipment and other equipment, heat and cold exposure, biological exposures, and chemical and radiation exposures from industrial sources.
- ✦ **Adversary Threats:** The result of deliberate attack, which can include CBRN agents. As a mitigating tool, health surveillance may likely be the first indicator of a biological, chemical, or other attack.
- ✦ **Identifying Preventable Threats and Implementing Countermeasures:** Casualty prevention requires medical forces to identify preventable threats and for commanders, leaders, and individuals to implement countermeasures. Medical forces provide location and task-specific threat knowledge and casualty prevention lessons learned. Commanders mitigate casualties before operations begin by directing required immunizations or chemoprophylaxis, engineering solutions, managerial controls, or personal protective equipment that mitigates identified threats. Additionally, aerospace medicine functions directly support operations to ensure health and safety of the total force by conducting health risk assessments and pre- / post-mishap investigation of human factors that are causal or contributory in over 70 percent of mishaps. Medical experts coordinate with safety personnel to investigate and analyze unit safety culture and mishap human factors, with the goal of providing actionable safety information to operational commanders, acquisitions efforts and individual Airmen. During operations, medical forces use automated information support systems and equipment designed for detection, monitoring, and evaluation of occupational, environmental, and CBRN threats to assess risk and recommend mitigating actions to commanders.
- ✦ **Disease Prevention:** Medical forces use current medical information data to identify infectious disease threats to Airmen at home station and deployed locations.⁸ The Air Force tracks the vaccination status of all Airmen to ensure protection against

⁸ Air Force Instruction (AFI) 48-105, [*Surveillance, Prevention, and Control of Disease and Conditions of Public Health or Military Significance*](#).

vaccine-preventable diseases such as typhoid, meningitis, and influenza. At each airfield, medical forces assess disease threats and implement appropriate countermeasures, particularly in the areas of food and water vulnerability, waste disposal, and control of disease-carrying vectors.

- ★ **Dental Disease Prevention:** The Air Force Dental Service collects extensive risk assessment and dental readiness information to provide commanders an accurate picture of the dental fitness of their personnel.⁹ Severe dental pain rarely can be managed by self-care and most often requires professional intervention with specialized equipment.
- ★ **Mental Health Casualty Prevention:** The mental health of Airmen is critical to mission success. In the Air Force, the concepts of prevention and resilience are the two keys to mental health casualty prevention. In the deployed environment, medical forces identify mental health problems and provide appropriate care. Mental health personnel prepare the fighting force for mission readiness throughout the deployment cycle. Air Force members should be vigilant for signs of mental distress and act decisively to obtain assistance for themselves and others.
- ★ **Medical Intelligence:** Medical forces require seamless medical surveillance and intelligence integration with Air Force, Department of Defense, interagency and international agencies to maintain vigilance against emerging diseases and enemy threats.
- ★ **Global Vigilance:** Global vigilance is the ability to gain and maintain awareness anywhere in the world; provide warning; and determine intent, opportunity, capability, or vulnerability. Medical surveillance and information provide crucial support to medical operations and provide essential information to the [joint force commander](#). Included within this capability are medical information systems and processes to detect and warn of possible disease outbreaks.

Provide Casualty Care and Management

To restore health is the third of three focal points of force health protection. Medical forces use combined processes to rapidly restore each Airman to a combat ready status or arrange for the appropriate rehabilitative services. Restoring health requires a continuum of medical capabilities that includes first responders, forward resuscitative care (FRC), en route care, theater hospitalization, and definitive care.

- ★ **First Responder:** The first responder is the initial stabilizing medical care rendered to casualties at the point of injury or illness. Collectively, this includes self-aid / buddy care and immediate care and stabilization of individuals by medical personnel to return to duty or coordinate aeromedical evacuation.

⁹ AFMAN 47-101, [Managing Air Force Dental Services](#).

- ✧ **Emergency Responder:** Emergency responders are called upon if a specific incident dictates a particular need or hazard requires an immediate assessment. Air Force medical emergency responders, as defined by the Air Force Incident Management System, are members of the disaster response force elements that deploy after the first responders to expand command and control and provide additional support. Emergency responders include follow-on medical treatment and preventive medicine teams, with training in field sanitation; behavioral; environmental; occupational; operational; industrial; or CBRN warfare health assessment and management.
- ✧ **Forward Resuscitative Care:** The FRC is forward advanced emergency medical treatment performed as close to point of injury as possible. FRC makes extensive use of technology and advanced emergency medical treatment and surgical practice to increase initial surgical efficiency. Requirements for medical logistic support (blood and medical materiel) including varying re-supply, storage, and distribution capabilities, are intrinsically linked. The goal is stabilization. Properly designed, equipped, and employed, FRC capabilities can provide a decreased forward medical footprint while enhancing the capability to sustain life and limb and should be available as close to the point of injury as operational conditions permit.
- ✧ **En Route Care:** En route care is the continuation of care during movement (evacuation) within the health service support continuum of care without clinically compromising the patient's condition. En route care involves transitory medical care, en route critical care, patient holding, and staging capabilities during transport from the site of injury or onset of disease, through successive capabilities of medical care, to a medical treatment facility that can meet the needs of the patient. En route care consists of three phases:

 - ✧✧ **Casualty Evacuation** (CASEVAC) involves the unregulated movement of casualties aboard ships, land vehicles, or aircraft.
 - ✧✧ **Medical Evacuation** (MEDEVAC) refers to dedicated medical evacuation platforms staffed and equipped to provide en route medical care using pre-designated tactical or logistic aircraft, boats, ships, and other watercraft temporarily equipped and staffed with medical attendants for en route care.
 - ✧✧ **Aeromedical Evacuation** (AE) specifically refers to “the movement of patients under medical supervision to and between medical treatment facilities by air transportation” (JP 4-02, [*Joint Health Services*](#)). AE provides time-sensitive in-flight care of patients or casualties to and between levels of care using predominantly mobility air forces aircraft or contracted aircraft (civilian air ambulance) with medical aircrew trained specifically for this mission.
- ✧ **Theater Hospitalization:** Theater hospitals are designed to provide in-theater support. This includes all care and capabilities required to support the theater such as emergency, surgical, public health, dental, preventive, stress control, and

ancillary services. Air Force theater hospitalization capabilities deploy as modules or multiple individual capabilities.

- ✦ **Definitive Care:** Definitive care is rendered to personnel to conclusively manage the condition, injury, or illness. This normally leads to rehabilitation, return to duty, or discharge from the Service. Definitive care capability includes the full range of acute, convalescent, restorative, and rehabilitative care provided at definitive and rehabilitative care sites outside the operational area.

Air Force medical forces are designed, organized, and employed to stabilize sick and injured persons and expedite transport to definitive care while maintaining or increasing the standard of care en route. The nature of airpower provides Air Force medical forces with worldwide responsive operational reach between airfields in a theater of operations as well as the strategic reach to any global definitive care capability.

Roles of Medical Care

US doctrine uses roles of care to describe battlefield medical and health capabilities. Some of the North Atlantic Treaty Organization (NATO) definitions for roles of care are different from US doctrinal definitions. NATO roles consist of first / emergency responder (Role 1), forward resuscitative care (Role 2), theater hospitalization (Role 3), and definitive care (Role 4). See Joint Publication 4-02, [Joint Health Services](#), Chapter II, [Health Service Support](#), for specific details on each of these roles of medical care.

Optimize Human Performance

Personnel are the most important and valuable resource for the Air Force. Accordingly, [Air Force Medical Service](#) (AFMS) focuses on human performance in addition to health care as a primary means of supporting the COMAFFOR. Given the prerequisite need for health, addressing human performance requires achievement of the AFMS effects of “a healthy and fit force” and “prevent illness and injury”—two key focal points of force health protection.

The AFMS becomes a force multiplier by focusing on human performance in addition to TEH as the primary means of supporting Air Force and joint forces. Air Force medical personnel work to sustain the performance of Airmen, whether in the face of enemy conflict, environmental threats and stressors, or advancing age. Any activity that supports or encourages improvement in physical, mental, or emotional health and fitness contributes to sustaining human performance. Additionally, Air Force medical personnel develop risk mitigation approaches. They employ approved countermeasures to help Airmen maintain performance (or minimize performance degradations) during warfare or upon exposure to environmental threats such as climatic extremes, gravitational forces, fatigue, weapons effects, prolonged mental or physical stress, witnessing or participating in violent acts.

Management of Fatigue

Medical forces readily provide fatigue management training resources to aircrew and extend fatigue management capabilities to battlefield Airmen, security forces, critical care air transport teams, and other personnel that operate around the clock. Fatigue management, in all of its forms, is used by commanders as a means of sustaining and optimizing warfighter effectiveness.

Cognitive Performance

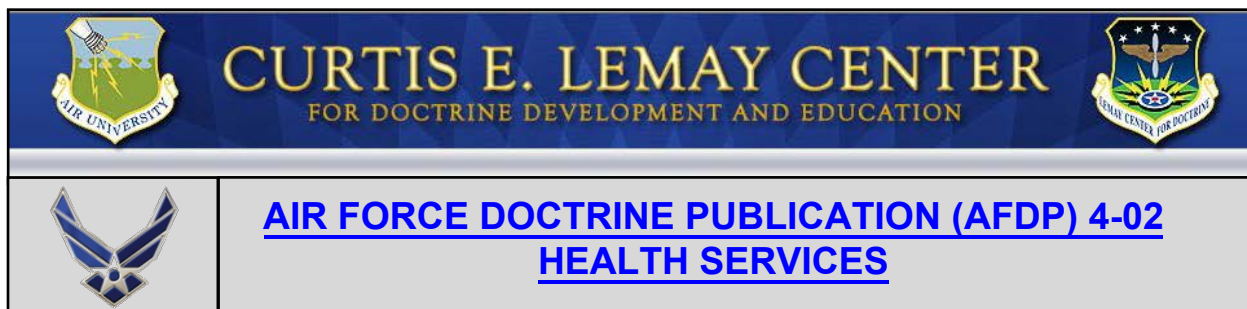
Optimizing and sustaining cognitive performance provides an advantage in the analysis, synthesis, and collation of information and timely action or reaction. Maintaining the highest degree of cognitive capacity improves information management quality and may attenuate fear, stress, or confusion.

Improved Physical Performance to Operate in All Environments

Air Force medicine optimizes and sustains the Air Force's ability to operate across the full [range of military operations](#). The goal is to reduce the physical demands on the warfighter and sustain the ability to complete the mission. Airman performance may need to be sustained regardless of adverse conditions due to unfavorable weather, temperature, or lightning; high altitude; rough terrain; gravitational effects; directed energy; or CBRN effects. The Air Force maintains an extensive array of methods and equipment to optimize and sustain warfighter performance under these conditions. These methods may range from sunscreen to spacesuits, medications to body armor, glasses to night vision goggles, and vaccines to rapid diagnostics. Cutting-edge efforts to enhance physical performance include manipulation of metabolic processes and addition of equipment or mechanical augmentation.

Weapons Effects on Human Performance and Health

Air Force medicine has a role in assessing weapons effects on human performance and health in an effort to advise commanders, support development of effective countermeasures against threats, and develop injury treatment. Assessing the effects of weapons against individuals or groups can supply information for the risk management process or developing defensive measures. Many performance and health impacts from traditional warfare methods such as kinetic and CBRN weapons are well known, and performance and health impacts of less traditional warfare methods such as directed energy systems, laser, less than lethal agents, psychological warfare, and thermobaric (heat pressure) weapons are being further assessed and investigated.



HEALTH SUPPORT OPERATIONS

Last Updated: 12 November 2019

The Air Force acknowledges that the current and future operating environments are extremely complex, and that these environments will continue evolving. In this environment, no single nation can address every challenge and priority alone. With this in mind, the Air Force should actively partner with the global community of airmen to further US and partner nation (PN) mutual interests in air, space, and cyberspace. These partnerships could act as a force multiplier in future crises. By relying on multinational cooperation and coordination, the sum of joint operations will usually be greater than if acting unilaterally. In addition, the USAF acknowledges that it should not limit itself to the relationships of the past and should broaden its scope to include partnerships for new situations and circumstances. This includes expanding the scope of the security cooperation focus to include building the security capabilities of at-risk and underdeveloped PNs so that these partners are able to defend themselves against the threats of today and tomorrow.

As the Air Force is increasingly called upon to conduct civil-military or humanitarian operations with interagency organizations or nongovernmental organizations (NGOs), Air Force medical forces may be required to support stability operations, build partnerships, and improve partner capacity. They accomplish this by leveraging military health engagement and training opportunities to demonstrate and enhance military capabilities necessary to achieve objectives for all operations.

Air Force medical forces use unique skill sets in facilitating interaction with world health care and supporting the [commander, Air Force forces](#) (COMAFFOR) in all areas of interest, executing global strategy and providing a smooth transition for forces deploying into a country or theater. Medical forces may be the initial or sometimes the only tool used to facilitate beneficial international relations and promote productive engagements with international partners and allies. International medical activities can range from humanitarian assistance and disaster relief (HA/DR) to peacekeeping operations to support for major conflicts. Air Force medical personnel can be embedded in any echelon to assist in planning, deploy on missions, support interoperability, and assist in developing appropriate health service support activities.

Global Medical Operations in Support of Security Cooperation

Seamless interoperability in military and civilian partnerships optimizes the health care of US and allied military personnel. Air Force medical personnel specializing in international health care support the COMAFFOR's missions and specific regional goals through their interface with world health care organizations. This includes accurate assessment of available medical resources and coordination with many military and civilian agencies.

Medical Stability Operations (MSO)

The Department of Defense (DOD) considers MSO a US military core mission.¹⁰ Air Force medical forces are prepared to conduct these operations throughout all phases of conflict and across the [range of military operations](#), including both combat and non-combat environments. Through these activities, security cooperation is strengthened; partner capacities are increased; Air Force global partnership strategies are enhanced; a safe and secure environment is reestablished; and security cooperation as a joint capability area is further enabled.¹¹

Air Force medical forces have robust capabilities to conduct MSO. They include, but are not limited to: the international health specialist (IHS) program; Defense Institute for Medical Operations, a joint agency for which the Air Force, through the Air Force Medical Service (AFMS), is the lead service; mobile training teams to train PN personnel; expeditionary medical support, for rapid ground and air support; personnel with foreign language skills; an IHS special experience identifier; Air Force Special Operations Command (AFSOC) irregular warfare / medical stability operations (IW/MSO) division; subject matter experts and strategic planning cell dedicated to the AFSOC IW/MSO program; and Air Force medical consultants as subject matter experts for reachback. See Appendix A, "Partnership Support Agencies" for additional information.

Global Health Engagement (GHE)

GHE is the primary means by which Air Force medical forces build the capacity of PNs and improve DOD visibility, access, influence, and interoperability in a host nation or region, in alignment with US Government (USG) objectives. The Air Force uses GHE, as part of an approved security cooperation program, to partner with other nations to achieve security cooperation objectives through medical-related stability activities, military and military-to-civilian consultation and training in public health and preventive medicine, disaster or outbreak response, exercises, disease surveillance, medical and dental civic action programs, and [force health protection](#).

To meet objectives, the AFMS continues to develop GHE capabilities to support MSO requirements. Personnel are prepared to work closely with relevant USG departments

¹⁰ Department of Defense Instruction (DODI) 6000.16, [Military Health Support for Stability Operations](#).

¹¹ Air Force Instruction (AFI) 41-106, [Medical Readiness Program Management](#).

and agencies, foreign governments and security forces, global and regional international organizations, US and foreign NGOs, and the private sector. For more details regarding MSO, reference DODI 6000.16, [Military Health Support for Stability Operations](#), and the AFMS GHE concept of operations.

To better enable the AFMS to meet stability operations tasks, the following new initiatives are currently under development: Synchronization of AFMS GHE through the medical readiness global health division and development of EMEDS health response teams (EMEDS-HRT) to provide rapid deployable modular patient care for humanitarian assistance and disaster relief. The EMEDS-HRT include capabilities for interagency coordination, regional health expertise, and cultural/language proficiency to establish and sustain relationships with PN military forces and key partners.

Air Force medical forces engaged in MSO enhance PN health capacity by providing appropriate health services and training, conducting HA/DR, or while improving the health surveillance/force health protection/AE capability of PN military forces. To meet these requirements, AFMS consultants advise PNs on GHE and MSO initiatives. They also identify and cultivate medical force personnel with IHS-specific competencies and unique language and culture skills. The gathering and disseminating of lessons learned from GHE and MSO is essential to developing suitable GHE and MSO exercises and operation plans in support of theater and Air Force campaign support plans.¹²

Humanitarian Assistance and Disaster Relief

HA/DR is a high profile foreign humanitarian assistance (FHA) mission that is executed upon the request of other nations, often through their ministries of health or equivalent organizations to US embassies. The request is coordinated through the Department of State (DOS) and the combatant commander (CCDR) for approval and mission prioritization, after which Services are tasked or volunteer to support the approved requirements. Air Force medical personnel support DR in typhoons, earthquakes, floods, complex post-conflict humanitarian operations, etc. DR operators should coordinate all efforts with the host nation, the US chain of command, the USG lead agent, other USG agencies, intergovernmental organizations, and NGOs involved in the response, especially when coordinating the use and need of supplies and equipment to ensure interoperability.

The US Agency for International Development Office for Foreign Disaster Assistance is usually the initial lead USG agency in a disaster response with DOD in support. FHA can be offered both in response to acute needs, such as the US role in the international community's response to an event, or as part of ongoing security cooperation activities. These activities support development of improved host nation health care infrastructure and interoperability. Other types of FHA missions include dislocated civilian support, security missions, technical assistance and support functions, and foreign consequence management, all of which will required unique global health input from Air Force medical personnel. The AFMS also plans, executes, and participates in humanitarian and civic

¹² [AFI 41-106](#).

assistance to host nations that include medical readiness training exercises. The humanitarian benefits of these missions may be integral to security interests of the US and the host nation and should fit cleanly into CCDR and COMAFFOR security cooperation objectives.

Operations in a Chemical, Biological, Radiological and Nuclear (CBRN) Environment

Air Force installation commanders can leverage the MTF's medical CBRN incident response capability to respond to an incident or disaster. Air Force installation commanders at foreign locations will follow DOS, theater, and major command guidance when assisting local authorities. This capability can minimize loss of life and human suffering as well as mitigate great property damage. Air Force medical forces support the installation commander within the following team capabilities: patient decontamination team, pharmacy team, bioenvironmental engineering team, laboratory biological detection team, field response team, triage team, clinical team, mental health, nursing services, and manpower / security team.

Integration with Special Operations Forces

Operational medical forces are provided in direct support of special operations forces (SOF) through AFSOC. Training is unique and extensive, and deployments do not typically follow the usual medical force construct. Because organic capabilities are limited, reliance and integration with rear echelon support medical care or collocated medical facilities is critical.

Special Operations Forces and Conventional Forces Planning Considerations

SOF may be equipped with a small medical contingent designed to rapidly stabilize casualties for transload of their assets to quickly return to the fight. In addition to providing medical support to SOF operators in forward areas, SOF medical forces perform casualty evacuation (CASEVAC) missions, assist with personnel recovery, and support infiltration and exfiltration missions. AFSOC medical personnel fall under the command and control of the Commander, US Special Operations Command and subordinate line special operations commanders. SOF and conventional planners are responsible for identifying requirements for, and obtaining conventional AE support at forward airbases, aligning the SOF CASEVAC and the conventional en route care capability. It is imperative that SOF and conventional planners identify en route medical and aeromedical evacuation (AE) support requirements to ensure appropriate patient transfer during transition to the conventional medical system.

AFSOC Operational Medical Capabilities

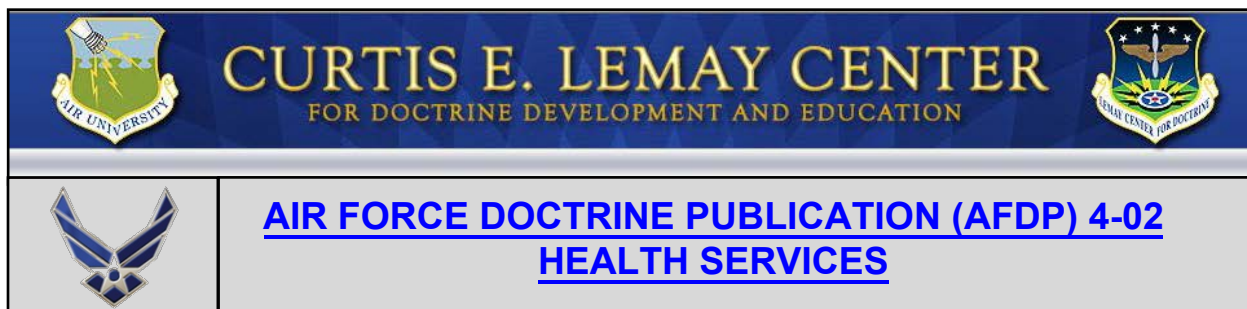
Deployed medical capabilities are primarily aligned with Air Force special operations forces (AFSOF) operational units and consist of SOF medical elements composed of flight surgeons, independent duty medical technicians, and specialized aeromedical and

physician assistants. AFSOF medical elements, frontline trauma specialists, provide first responder and forward resuscitative care for AFSOF and other SOF. AFSOF flight surgeons and independent duty medical technicians provide primary care, force sustainment, advanced trauma life support, advanced cardiac life support, preventative and aerospace medicine, and casualty evacuation support from forward areas. AFSOC can readily increase its medical capability at a staging base by adding AFSOC specialty operation teams (i. e., forward resuscitative care [including surgical capability], medical element augmentation, or other medical unit type codes). Conventional medical and/or - care evacuation capability may also be integrated with organic SOF medical capabilities to enhance medical and medical evacuation support as requirements dictate.

Pararescue Jumpers (PJs)

PJs are line combatants with training to render trauma medical support during personnel recovery missions and in environments and threats that would be too high-risk for noncombatant medical personnel. AFSOC PJs are specifically trained for supporting combat surface operations, either independently or in conjunction with other SOF teams. PJs may also provide casualty evacuation support from forward areas to the SOF air-ground interface point, and casualty evacuation support from forward areas to the SOF air-ground interface point, usually at the SOF intermediate or forward staging base under night or day operations.

For more information, see Joint Publication 4-02, [Joint Health Services](#), Chapter V, [Health Support Operations](#).



HOME STATION PLANNING AND EXECUTION

Last Updated: 12 November 2019

A key component of expeditionary and operational planning is the employment of Air Force medical forces. Medical forces deploy in capability-based modules that are flexible and tailored to each contingency operation to provide the appropriate level of medical support to an operational area.

The [Air Force Medical Service](#) (AFMS) provides responsive medical platforms to support local, state, tribal, and federal contingency operations. The flexibility of these platforms, whether using expeditionary, home station medical capabilities, or medical contingency response teams, is the key to enabling a quick and decisive response to any disaster.

Air Force installation commanders have the authority to develop mutual aid agreements for partnership with the surrounding communities when incidents or disasters occur. This partnership enables the indigenous capabilities of a base to survive an incident and, when available and authorized, to project mutual aid and support to the local community to minimize loss of life and human suffering, mitigate property damage, and be prepared to provide full participation of all appropriate base first responders and maintain readiness for the warfighting mission. Installation commanders should request full participation of all appropriate base first responders and, in coordination with local, state, tribal, and federal authorities, respond to local disasters consistent with their authority in Air Force Instruction 10-801, [Defense Support of Civil Authorities](#). Participation from all designated installation resources is paramount to ensure success.

Air National Guard medical force capabilities are available to support state responses to all hazard events at the direction of their governors. State-to-state agreements allow governors from other states to respond very quickly to offer civil support.

During larger incidents, such as hurricanes, tornados, floods, or terrorist attacks, local resources can be quickly overwhelmed. National Guard response capability to a [chemical, biological, radiological, and nuclear](#) (CBRN) incident at the state level includes the weapons of mass destruction-civil support teams, and the CBRN enhanced response force packages. The National Guard has homeland response forces, which provide lifesaving capabilities, search and rescue, decontamination, emergency medical, security, and command and control (C2). Homeland response forces are a

regional capability that remain under the C2 of their respective governor while in state active duty or US Code Title 32, [National Guard](#), status, but can be federalized as a component of the Department of Defense when requested. Collectively, protected expeditionary medical support systems provide scalable national and deployable medical capability to bridge the gap between initial National Guard response and active duty Air Force capabilities.

Air Force medical forces may be tasked to provide support in accordance with the National Response Framework, to include defense support of civil authorities. AFMS supports validated lead federal agency requests for assistance as identified in FEMA mission assignments through the joint task force commander. For additional information, see AFDP 3-27, [Homeland Operations](#).

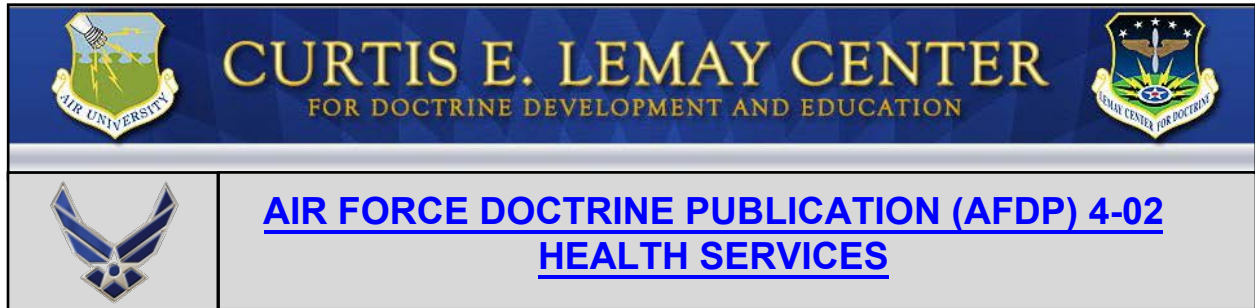
Air Force medical forces coordinate the development and implementation of relevant homeland operations with several oversight committees or agencies. These committees and agencies may include: other Services (joint); the North Atlantic Treaty Organization; United States Northern Command; regional contingency response working groups such as Department of Veterans Affairs, Department of Homeland Security, Department of Health and Human Services, the National Disaster Medical System Service Director (transferred to Air Force Medical Operations Control); and a plethora of oversight committees such as the Department of Defense Installation Protection Steering Group and the Security Enterprise Mission Assurance Steering Group.¹³

Medical force planning requires an understanding of the joint and component plans for the supported mission. After considering the following planning factors, planners should develop a medical estimate of the threat and a supporting medical plan of operations. The plan should be developed in collaboration with medical planners from the supported [joint force commander](#), as well as from the other Service and functional component commands. The interdependent nature of patient regulation and movement, medical logistics, and available blood support require planners to consider medical force operations from theater and global perspectives. Planning considerations include:

- ★ Supported mission.
- ★ Threat scenarios.
- ★ Planned and existing airfield locations.
- ★ Airlift availability and routes.
- ★ Population at risk for each location.
- ★ Host nation medical capabilities and existing relationships.
- ★ Medical capabilities of Service and coalition partners.

¹³ Department of Defense Instruction 6010.22, [National Disaster Medical System](#).

★ Environmental factors (weather, terrain, endemic disease, etc.).



APPENDIX A: PARTNERSHIP SUPPORT AGENCIES

Last Updated: 12 November 2019

- ✦ **International Health Specialists (IHS).** The IHS program¹⁴ develops Air Force medical personnel to support global operations throughout the range of military operations. IHS medical personnel have international and operational medical skills, civil-military and interagency medical knowledge, cultural expertise, and language proficiency. They foster partnerships with military, civilian, coalition, or interagency personnel and they advise combatant commander, numbered Air Force (NAF) Surgeon (SG) or the Air Force forces Surgeon (AFFOR/SG) on the role of Air Force medicine in support of global health engagement initiatives.
- ✦ Air Force medical forces use unique skill sets in facilitating interaction with world health care and supporting the [commander, Air Force forces](#) in all areas of interest, executing global strategy and providing a smooth transition for forces deploying into a country or theater. Medical forces may be the initial or sometimes the only tool used to facilitate beneficial international relations and promote productive engagements with international partners and allies. International medical activities can range from humanitarian assistance and disaster relief to peacekeeping operations in support of major conflicts. Air Force medical personnel can be embedded in any echelon to assist in planning, can deploy on missions, support interoperability, and assist in developing appropriate health service support.
- ✦ **Defense Institute for Medical Operations (DIMO).** DIMO provides training for host nations (HNs) using medical experts in a variety of medical topics and health care education and training, improving medical capabilities of both military and civilian agencies, and strengthening international coalition capabilities and partnerships. HNs improve their national health care system infrastructure through acquiring the needed theory, concepts, and educational tools that focus on areas of improvement which support their national goals.
- ✦ **Advanced Aerospace Medicine for International Medical Officers (AAMIMO).** The AAMIMO program offers international medical officers an in-depth training experience in aerospace medicine that supports the development of partner nation

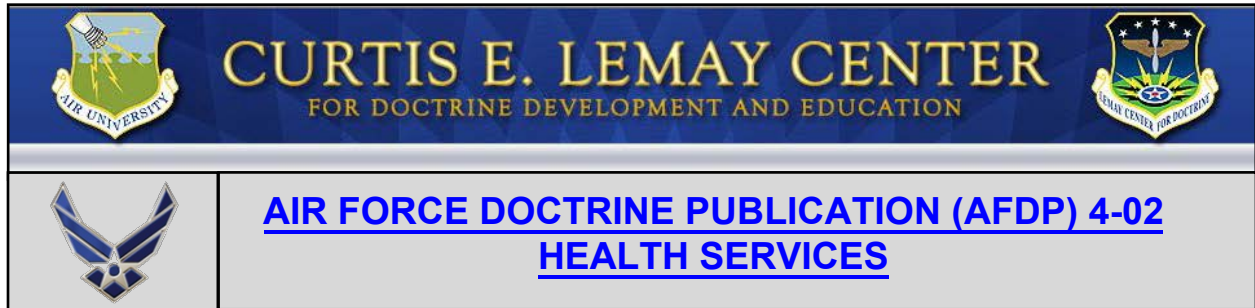
¹⁴ Air Force Instruction 44-162, [International Health Specialist Program and Global Health Engagement](#).

military medical systems and provides [Air Force Medical Service](#) (AFMS) medics a unique opportunity to learn from and interface with participating medical personnel.

- ★ **Combat Aviation Advisors.** The Air Force combat aviation advisor mission includes a cadre of medical personnel who focus on medical training and health services support. Although the focus often centers on aerospace medicine, several other areas of medicine can be primary areas of interest, such as casualty evacuation, aeromedical evacuation, and field or deployed medicine. The result is an improved PN aerospace and military medicine program and a group of AFMS experts able to provide focused advice to the US command structure.
- ★ **Theater Special Operations.** [Special operations](#) forces support a wide-range of military medical activities. Medical planners are postured in various combatant commands, providing direct Air Force medical support to the planning and execution of special operations involving health care.
- ★ **Military Personnel Exchange Program (MPEP).** AFMS personnel play an integral role developing a requirement for a specific MPEP in a HN with the goal of working towards interoperability with that country. Medical personnel help establish the need for a MPEP and develop a plan for future exchanges. This allows Air Force medical personnel to deploy to other nations and gain a full understanding of their capabilities. This experience enhances interoperability and complements medical care given during military operations. Additionally, AFMS personnel are exposed to international medicine when international participants integrate into US organizations as part of the exchange process.
- ★ **International Academic Training.** Medical personnel deploy with teams who assess health services support in a country or region, develop a strategic cooperation plan to support educational or academic requirements, and recommend training or other activities to the country team or military group who coordinates efforts throughout the operational area. Several AFMS organizations support international training at continental US-based locations through processes that allow security assistance officers to send coalition nation military medics to the US.
- ★ **Foreign Humanitarian Assistance (FHA).** FHA programs are long-term activities conducted to relieve or reduce conditions presenting a serious threat to life or that can result in great damage to or loss of property. Conditions may be the result of natural or manmade disasters or the prevailing socioeconomic climate. FHA programs are normally the responsibility of the HN civil authorities. However, AFMS personnel have knowledge of regional assets and the ability to coordinate disaster management response activities with surrounding countries per US Embassy or other US governing agency direction. Examples include consulting on the construction of health clinics or fresh water wells, or educating HN personnel in preventive medicine and public health principles.

- ✦ **Countries of Transition and Post-Conflict.** AFMS personnel play a major role in transition operations through the planning process and assisting civilian organizations to develop their roles and responsibilities in health care. Transition operations may include rebuilding hospitals and establishing supply warehouses. The AFMS role in rebuilding the health care system in Afghanistan and Iraq are good examples of this transition requirement. The AFMS team members support provincial reconstruction teams and embed training teams as they implement joint military medical goals. Subject matter expertise is provided and experts interface directly with HN medics to help them establish a self-sufficient health care system. Understanding health care principles and culture impacts are essential to avoid trying to impose a US solution on a HN situation.

 - ✦ **Peace Operations.** The deployed medical commander should be aware of special technical agreements with other Services and agencies regarding emergency care services and health care logistics. Medical and dental civic action programs can generate a positive response from the local populace towards military personnel if they are properly integrated into the US government security cooperation plans.
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APPENDIX B: LAW OF WAR

Last Updated: 12 November 2019

The law of war is part of the international law that regulates the conduct of armed hostilities and consists of treaties, regulations, rulings from international courts and tribunals, as well as the accepted practices of nations referred to as “customary international law.” Violations of the law of war are punishable under the Uniform Code of Military Justice. The law of war is also sometimes referred to as the law of armed conflict or international humanitarian law. Medical forces are subject to special protections and obligations under the law of war.

The law of war serves to protect members of the civilian population from the direct effects of battle by making a distinction between those who take part in the fighting, (commonly referred to as combatants) and those who do not, primarily individual civilians and the civilian population as a whole. It further provides for the protection of military wounded, sick, and shipwrecked, and respect for military medical personnel, medical units, and transports. Certain categories of medical and religious personnel should be respected and protected during military operations. The categories of medical personnel who are entitled to respect and protection during military operations include:

- ✦ Military medical personnel exclusively engaged in medical duties.
- ✦ Administrative staff exclusively engaged in support to medical units.
- ✦ Auxiliary medical personnel, if they are carrying out their medical duties at the time when they come into contact with the enemy or fall into the enemy’s hands.
- ✦ Authorized staff of voluntary aid societies.
- ✦ Staff of a recognized aid society of a neutral country.
- ✦ Religious, medical, and hospital personnel of hospital ships and their crews.

Medical facilities are protected from attack provided they are exclusively engaged in their humanitarian function. However, if they are used in a manner inconsistent with their function (e.g., used to store weapons or as a staging area to launch an attack from) they may forfeit their protected status and may be attacked. Commanders should

ensure medical forces resources and facilities, including mobile units, are situated in such a manner that attacks against military objectives cannot imperil their safety. In an international armed conflict, the Geneva Conventions define captured permanent medical forces personnel as “retained personnel,” not as prisoners of war (POWs). However, performance of combat-related functions, such as ambulance drivers ordered to carry ammunition to a forward unit, would result in such personnel being POWs upon capture. POWs may be detained until the end of hostilities, whereas retained personnel are held by the enemy to perform their medical duties for as long as the state of health and the number of POWs require. By contrast, medical retained personnel are repatriated when their services are no longer indispensable and operational circumstances permit.¹⁵

There is a further category, “auxiliary” medical force personnel, defined as those members of the armed forces who are specially trained to act, when the need arises, as “temporary” hospital orderlies, nurses, litter-bearers, etc. In this context, “temporary” means the exclusive discharge of medical duties or functions for limited periods. Auxiliary medical force personnel should wear a brassard (armband) displaying the distinctive emblem (e.g., Red Cross) only while carrying out medical duties. Auxiliary medical forces personnel are entitled to protection as noncombatants only if they are executing medical duties at the time contact is made with the enemy and are not otherwise engaged in acts harmful to the enemy. Auxiliary medical forces personnel should not be targeted while carrying out their medical duties, but if captured during international armed conflict they become POWs rather than retained persons. Consequently, they have no expectation of repatriation prior to the end of hostilities. For more information, see Air Force Instruction 51-401, [The Law of War](#), and Department of Defense (DOD) Directive 2311.01E, [DOD Law of War Program](#).

Geneva Conventions

The US is a party to the four Geneva Conventions of 1949 and all medical and line of the Air Force forces should thoroughly understand the provisions that apply to medical activities. Violations, which can result in the loss of the law of war protection, occur when medical forces, or their distinctive emblem(s), are used or engaged in any activities inconsistent with a noncombatant role. For example, performing entry control point and static resource guard duties for non-medical units are both duties inconsistent with noncombatant status. Other examples include guarding or helping to defend the perimeter of non-medical facilities, such as unit trains, logistics areas, or base clusters; the manning of any offensive-type weapons or crew-served weapons systems; or being ordered to engage enemy forces other than in self-defense or in the defense of patients, facilities, and the supplies and medicines used to treat those patients.

Current and future conflicts may pose additional issues because adversaries within non-state organizations are neither signatories nor adherents to the Geneva Conventions. Some irregular tactics of adversaries include deliberate attacks against military and

¹⁵ Joint Publication 3-63, [Detainee Operations](#).

civilian medical, health, and humanitarian personnel and assets. Even within this environment the US military adheres to and honors the law of war at all times. For more information on law of war, see [Department of Defense Law of War Manual](#); [The Military Commander and the Law](#); [Air Force Operations and the Law](#); JP 4-02; [Joint Health Services](#); JP 3-63, [Detainee Operations](#); and US Code Title 10, [Armed Forces](#).

Possible Consequences of Violating Geneva Conventions

- ✦ Risk that protected status for the medical unit and personnel will be forfeited.
- ✦ Risk that medical facilities and evacuation platforms (including aircraft on the ground) are attacked and destroyed by the enemy.
- ✦ Risk that medical personnel being treated as POWs rather than retained personnel and risk of them possibly being tried and punished for war crimes.
- ✦ Criminal prosecution for grave breaches of the Geneva Conventions.

Examples of Violations of the Geneva Conventions

- ✦ Making medical treatment decisions for the wounded and sick on any basis other than medical priority, urgency, or severity of wounds.
- ✦ Marking non-medical unit facilities and vehicles with the distinctive emblem (e.g., Red Cross) or making any other unlawful use of this emblem.
- ✦ Using medical vehicles marked with the distinctive emblem for transporting non-medical related troops, equipment, and supplies.

Detainee Operations

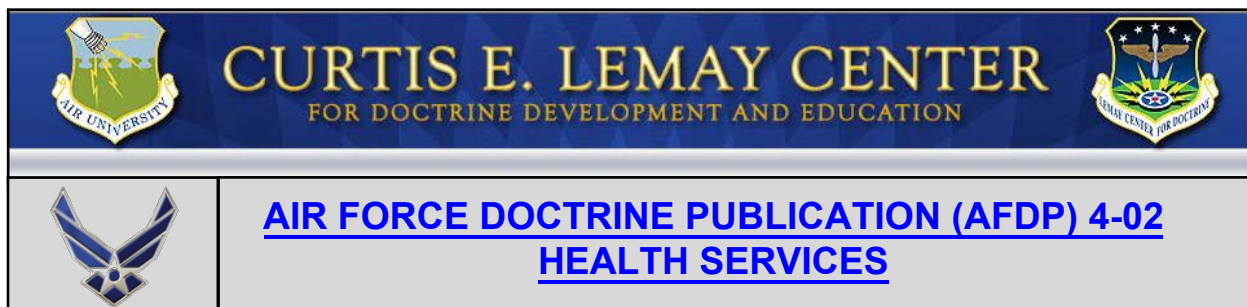
Medical forces should be prepared to provide medical care and treatment to a variety of individuals being detained by US forces on operations. Wounded and sick detainees should be cared for. They should receive the medical care and attention required by their condition. Medical or biological experiments on detainees are prohibited.

- ✦ **Consent.** Medical care should, wherever possible, be undertaken with the consent of the wounded or sick detainee. However, medical actions to preserve the health of the detainee may be justified, even when the detainee refuses to provide consent. For example, it is not prohibited to administer vaccinations to detainees in order to preserve their health and to prevent epidemics. Similarly, it is not prohibited to order detainees to be fed, if they undertake a hunger strike.
- ✦ **Blood Donation and Skin Grafting.** Detainees may voluntarily consent to give blood for transfusion or skin for grafting for therapeutic purposes; such procedures, standards and controls are designed for the benefit of both the donor and the

recipient. See Department of Defense Instruction 2310.08E, [Medical Program Support for Detainee Operations](#).

Self-Defense

Medical forces may carry only light individual arms for their own defense and the defense of the sick and wounded in their charge. This does not mean they may fire on an advancing enemy. However, if the enemy is attacking and ignoring the marked medical status of the personnel or facility, personnel may consider using force (though the dangers of being viewed as a combatant should be self-evident). In addition, medical forces may defend medical personnel, facilities, and patients from violent criminal elements, and even from unrest within the facility. For more detailed information on the law of war and the Geneva Conventions, please refer to the following publications: [The Military Commander and the Law](#); [Air Force Operations and the Law](#); Joint Publication 4-02, [Joint Health Services](#), and US Code Title 10, [Armed Forces](#).



APPENDIX C: ROLES AND RESPONSIBILITIES OF MEDICAL AGENCIES

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Air Force Medical Service (AFMS)

The AFMS, led by the Air Force Surgeon General (AF/SG), is the Air Force agency responsible for medical planning, programming, policy, and execution of Service medical operations.¹⁶ Unlike the medical functions in other Services, the AFMS is not in itself an organization with its own chain of command, but is an enterprise architecture within the Air Force chain of command ensuring unity of effort. This architecture is necessary to optimize medical operations in support of Air Force missions within the legal, policy, and resource constraints imposed by the Assistant Secretary of Defense for Health Affairs (ASD [HA]). The AFMS is comprised of the AF/SG and staff, major command Surgeons (MAJCOM/SGs) and staff, a field operating agency, and AFMS Airmen assigned to line organizations as medical subject matter experts.

Air Force Medical Readiness Agency (AFMRA)

AFMRA supports Air Force Surgeon (AF/SG) General for policy development and execution while supporting the MAJCOMs and base-level unit mission execution. AFMRA assists in the development of, and execute operational policy, plans, and decisions impacting the AFMS operational readiness mission. AFMRA supports AF full-spectrum medical readiness capability and AF mission in support of the joint force in both contested and uncontested environments. AFMRA supports capability development through requirements management, medical test and evaluation and integration with the Air Force Materiel Command and Defense Health Agency (DHA) Directorates for Acquisition and Research and Development. AFMRA will be the single field operating agency reporting to the AF/SG and will liaise with the DHA and the market to provide direct Service support to medical treatment facilities (MTFs) in the execution of AFMS and DHA policies and programs. In addition, AFMRA will support the AF/SG and the MAJCOMs in the execution of the operational medical mission, provide program support for a medically-ready force and medical force readiness in

¹⁶ Air Force Instruction (AFI) 41-106, [Medical Readiness Program Management](#).

support of the AEF construct, Joint Staff taskings, and related Request for Forces from combatant commanders.

Major Command Surgeons

MAJCOM/SGs have a role to ensure medical forces are organized, trained, equipped, and packaged to execute medical capabilities in war, peacetime disasters, homeland defense, counterterrorist activities, or any other domestic or worldwide mission requiring medical force expertise.¹⁷ Training should include principles of tactical combat casualty care to ensure medical personnel understand and meet the requirements of this standard of care.

Military Medical Treatment Facilities (MMTF)

At the installation level, the Department of Defense establishes the organizational structure for the Defense Health Agency's management of MMTFs according to mission. Medical forces are generally organized into the following MsMTFs:

- ★ **Clinics/Ambulatory Care Centers** provide direct medical support to an installation and are primarily tasked to ensure assigned Airmen are fit and healthy to deploy. Clinics are organized as medical groups or squadrons and are assigned to an installation's host wing.
- ★ **Hospitals** are medical facilities with in-patient capability, some of which have trauma capability. In addition to direct medical support to an installation, hospitals provide regional specialty care to eligible beneficiaries. Most importantly, hospitals are strategic nodes in the en route care capability. Hospitals are organized as medical groups with squadrons and are assigned to an installation's host wing.
- ★ **Medical Centers** are major medical treatment facilities providing trauma and specialty care as well as training platforms for medical forces. They are both strategic nodes and definitive care endpoints in the en route care system and are organized as medical groups assigned to the installation's host wing or as a medical wing assigned to a MAJCOM.

Reference <https://www.law.cornell.edu/uscode/text/10/1073d>, Section 703 of 10 USC 1073d for statutory discussion on Ambulatory Care Centers, Hospitals, and Medical Centers.

¹⁷ [AFI 41-106](#).