



## 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.<sup>6</sup> 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.

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<sup>6</sup> 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](#).

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