



ORGANIZATION, COMMAND, AND CONTROL

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Expeditionary Organization, Command, and Control

Air Force medical forces have complementary missions to provide restorative health care and to remain postured for rapid deployment. To this end, medical force teams are configured using a constant deployer model, which is the bundling of like teams into one [military treatment facility](#) (MTF) to meet both home station missions and deployment taskings.⁹ Teams are available to provide clinical care in the MTF while other teams are in a training window or are extractable for deployment without crippling the MTF's ability to function as a health care facility.

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.¹⁰ [Centralized control](#) permits the COMAFFOR to respond rapidly to emergent medical needs across a theater.

Aeromedical Evacuation Forces

Organizationally, an [Air Force Medical Service](#) (AFMS) officer commands [aeromedical evacuation](#) (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 ensuring assigned clinicians meet clinical currency training requirements as established by the Air Mobility Command Surgeon.

Aeromedical Evacuation Control Team (AECT)

Medical personnel trained in AE command and control (C2) are attached to the AECT within the [Air Mobility Division](#) (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

⁹ Air Force Instruction (AFI) 41-106, [Medical Readiness Program Management](#).

¹⁰ Annex 3-17, [Air Mobility Operations](#).

and priorities. It also works closely with air mobility controllers for pre-planned and immediate intratheater/intertheater airlift requests.

Deployed Medical Forces

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 or group (AEW/G). The AEW/G commander exercises [administrative control](#) (ADCON) of all attached AEW assets, including medical support. A medical group commander is typically a member of the AEW/G commander's staff.

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.

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. 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 through flexible and sustainable force health protection recommendations. 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.

En Route Casualty Care System (ERCCS) Command and Control in Joint Operations

In support of the ERCCS, medical forces may deploy to the area of responsibility (AOR), to AE en route stops, to locations outside the AOR, or to sites within the continental US (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 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.¹¹

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/patients to medical units in the combat zone for initial stabilization. It is usually at this interface that stabilized casualties/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 Air Force theater hospitals as part of the ERCCS. However, the COMAFFOR retains OPCON of these AFTHs and other medical assets to ensure they are optimally organized and employed to meet assigned missions.

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.

¹¹ AFI 41-301, [Worldwide Aeromedical Evacuation System](#).