Medical Evacuation Policies in NATO

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ALLIED JOINT DOCTRINE FOR MEDICAL EVACUATION

ABSTRACT

This article concentrates on the policy that is available within NATO to support and coordinate the medical evacuation (MEDEVAC) process, for both NATO forces and for those agencies and bodies that choose to interact and operate alongside NATO personnel. NATO doctrine is coordinated and crafted by Allied Command Transformation (ACT) who provide custodianship of Allied Joint Publications.

Within the hierarchy of NATO doctrine, medical doctrine begins at Level 2. For the purposes of this publication our key policy document is AJMedP-2 which was previously known as AJP-4.10.2.

The NATO Joint Medical Evacuation Concept can be considered a distillation of the best practice of the contributing nations, in the service of the casualties generated within the NATO operational environment.

The use of appropriately-trained medical staff and equipment for the sustainment of the casualty throughout the MEDEVAC chain (in doctrine referred to as continuity of care) is the difference between MEDEVAC and CASEVAC. This is described in STANAG 3204.

The article specifies and explains the different categories of medevac as well as the different levels of medical care. It dwells on Command and Control issues and emphasizes that a variety of options is available and that the routes for the patient reflect the conditions that may be encountered in operations.

As with the process of medical evacuation itself, the doctrinal direction is working within a constantly changing environment and thus in a constant process of development.

1.0 General

This article concentrates on the policy that is available within NATO to support and coordinate the medical evacuation (MEDEVAC) process, for both NATO forces and for those agencies and bodies that choose to interact and operate alongside NATO personnel.

2.0 Levels of Doctrine

NATO doctrine is coordinated and crafted by Allied Command Transformation (ACT) who provide custodianship of Allied Joint Publications.

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3.0 Concept of Evacuation

The NATO Joint Medical Evacuation Policy provides a general concept of evacuation.
This concept can be considered a distillation of the best practice of the contributing nations, in the service of the casualties generated within the NATO operational environment.

The concept addresses LAND, SEA and AIR environments and seeks to provide a framework for interoperability between the many potential contributing nations. As it can be imagined, within the NATO operational environment there is a huge risk that if nations were to operate independently, chaos could result.

Casualties can be generated anywhere within the battle space, even outside the area of an individual nation's area of responsibility.

A common and predictable system for the evacuation of casualties enables all contributing nations to plan for the transfer and recovery of the patients, eventually to the home nation.

The movement of casualties in all weathers, over all terrains, at any time (subject to the situation of the moment) is a key capability.

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throughout the MEDEVAC chain (in doctrine referred to as continuity of care) is the difference between MEDEVAC and CASEVAC. This is described in STANAG 3204.

Tracking the movement of the casualty through the continuum of care is a basic planning requirement. The regulation of the treatment and the flow of casualties within the evacuation chain is an essential prerequisite to ensure, treatment meets the needs of the patient and the movement of the patient is executed in the most effective and efficient manner.

4.0 Categories of Medevac

NATO policy describes these 3 categories of MEDEVAC. There is a general recognition that many nations may choose to describe their MEDEVAC activity in different ways but we must remember that NATO must provide the common framework, that can be appreciated and contributed towards by all NATO national elements.

FORWARD MEDEVAC is described as being from the POINT-OF-WOUNDING to the initial Medical Treatment Facility (MTF), which could be any of the medical ROLE types Role 1, Role 2 Light Manoeuvre, Role 2 Enhanced or Role 3. As you will hear during this Conference, it is this area of MEDEVAC that is currently receiving a great deal of study as this represents the first opportunity for resuscitative intervention. The movement of the casualties in Forward MEDEVAC is, as you might expect, predominantly provided by the ground-based, “blue light matrix” ambulance fleets, or the rotary wing airframes.

TACTICAL MEDEVAC is coordinated transfer of patients within the Joint Operational Area (JOA), between the available MTFs. The aim of the movement is to advance the casualty to greater care levels to meet the needs of the patient, with the ultimate aim of achieving transfer of the patient to the Casualty Staging Units (CSU) and into the final category of MEDEVAC – the STRATEGIC MEDEVAC. The transport methods are very much dependent upon distances, numbers for transfer and what is actually available. However, it could include ground ambulance, rotary wing helicopter of even fixed wing airframes.

STRATEGIC MEDEVAC. Also known as STRATEVAC, this is categorised as the repatriation of the patient out of the Joint Operational Area. The intent is for the patient to be ultimately returned to the home nation, but the category includes the concept of Intermediate Evacuation Facilities (IEFs) which can act as care-staging facilities on the routing back to home nation (such as Cyprus for some GBR/NLD patients in the Gulf conflict and Ramstein for many nations in the ISAF mission).

5.0 Levels of Medical Care

Doctrine describes the inter-relationship between the different levels of medical care and the MEDEVAC options that may (dynamically) be available. The most difficult issue with providing this doctrine is to clearly explain the options available as part of medical planning without having this doctrine interpreted as absolute and prescriptive routes to treatment.

There are a number of options available across the continuum of care and that these options can be coordinated and mobilised in a planned fashion that sustains and maintains the medical health of the casualty. One doctrinal issue that NATO has had to contend with is the description of “linear medical evacuation”. The intent was to describe the continuous nature of medical care from point of wounding to final repatriation. However, there has been some “literal” translations of this intent into a rigid adherence of Role 1, followed by Role 2LM, followed by Role 2E, etcetera. The following diagram, whilst a little overwhelming, shows that a variety of options is available and hopefully gives the impression that the routes for the patient can reflect the conditions that may be encountered in operations.
Role 1 is doctrinally described as being a national responsibility, so one could consider the recovery of personnel from point of wounding (forward MEDEVAC) as a national responsibility. For nations lacking such capability, memoranda of understanding (MOU) with nations that DO have the capability, are normally arranged. From Role 2 to Role 3 (tactical MEDEVAC), both NATO and the nations share responsibility for patient care. Eventually, when the patient is released to STRATEGEVAC, national responsibility is again resumed.

But as not many nations can afford these expensive airframes with highly sophisticated state of the art medical equipment, NATO vigorously encourages multinational cooperation. This can reach from bilateral MOUs up to a NATO agency, comparable to AWACS, with a NATO fleet of suitable aircrafts.

The CSU provides the holding capability at the airhead (APOD) to meet the STRATEGEVAC. This capability may be provided by the Role 3 (depending on beds available and location) but ideally should be separate.

6.0 Command and Control (C2)

C2 for medical is of paramount importance. Not only does this provide the overview of the operation and the medical deployment of assets, but it also ensures that individual component efforts are coordinated and working collectively for the benefit of the patients. The Medical Advisor (MEDAD) as the focus for medical C2, provides the ultimate role of maintaining a dialogue on medical issues with the operational commander.

The PECC is the key to the coordination of movements of the patients. Each component of an operation will have at least one PECC (they may have more to ensure regional cover). They receive the patient movement requests which include the details necessary to ensure the most effective movement such as medical priority (P1, P2, P3) and this is coordinated with transport means available within their area of responsibility. In critical situations the PECC will often serve as the medical CJOC.
This slide is not intended to be a description of all doctrine and policy available.

Instead it merely highlights that there is a large body of experience and advice available that underpins the higher level doctrine for medical evacuation procedures. As with the process of medical evacuation itself, the doctrinal direction is working within a constantly changing environment (as it should).

As an example the recent experience may serve, that most of the forward Aeromedevac missions flown in Afghanistan go to so called hot landing zones. The border between forward Aeromedevac and Combat Search And Rescue blurs, NATO doctrine will have to react on this challenge. It will have to unify or amalgamate the two doctrinal approaches.

Groups such as the RTO-Meeting are key to the advancement of the art of evacuation. Advances in medical techniques, operational challenges to current direction and the relentless questioning of medical assumptions are the essential lifeblood of doctrine development.