CHAPTER 5

DEPLOYMENT AND EMPLOYMENT OF THE FIELD AND GENERAL HOSPITALS

5-1. Threat

a. The military threat facing the US Armed Forces is massive. For years, the Communist military forces were considered to be our major adversary. Not only must we remain cognizant of the potential threat of major global powers, we must also maintain an awareness of the various threats and trouble spots of Third World countries. Once considered not to be a major threat, the Third World regional powers pose a threat to US security and interests worldwide. These countries now have the capability of conducting hostile activities, and during wartime or periods of crisis, of supporting espionage, subversion, and sabotage operations. Highly destructive regional wars remain a danger. Potential aggressors will be well-armed with modern aircraft and armored forces. They will likely be equipped with highly sophisticated and state-of-the-art weaponry systems. The proliferation and use of NBC weapons by developing nations will continue to pose a threat. They could attack using NBC weapons, powerful conventional weapons, or an assortment of both. The US Army will most likely face regional threats attempting to expand their sphere of influence by force.

b. Another major threat to US forces deployed outside continental United States (OCONUS) is that of a medical threat. Elements of the medical threat include naturally occurring infectious diseases (also referred to as endemic diseases), environmental extremes, and combat stress. For a detailed discussion of medical threat elements, see FM 8-10.

5-2. Planning Combat Health Support Operations

Combat health support is an integral part of the force structure and is vital to all contingencies for the sustainment of forces. Planning CHS is a continuous and demanding process. The hospital commanders and their staffs must constantly assess new information for its impact on current and future support requirements. Hospital commanders must understand how their actions should complement their higher headquarters plan. Misinterpretations can lead to counterproductive actions and potentially disastrous results. Two primary factors hospital planners must be knowledgeable of are the higher commander's intent and the METT-T. The planning process for future missions should not be isolated from current support actions. The planning process should be flexible and adaptive to the situation and the hospitals' mission. Combat health support elements should be deployed in the appropriate mix, in a logical sequence, based on the supported forces.

5-3. Mobilization

a. *Concept of Operations*.

(1) In the event of contingencies in support of war, peace, or conflict, the DOD initiates appropriate action for the deployment of forces in response to the scenario. Based on the situation, selected Active Component (AC) and Reserve Component (RC) hospitals and other units are alerted through command channels. For those units located in CONUS, the United States Army Forces Command (FORSCOM) uses

the Time-Phased Force Deployment Data List (TPFDDL) based on the theater commander's requirements, and the air and sea resources available. For deployable AC hospitals, an increase in readiness posture (DEFCON) is directed by the post or installation commander, or by higher headquarters. For RC hospitals, mobilization notification constitutes an increase in readiness posture.

(2) Deployment operations for hospital readiness validation are controlled through the post or installation emergency operations center (EOC) according to established plans and regulations. The EOC plans and coordinates all deployment preparation support for the deploying hospital and monitors and controls all facets of the deployment operation, to include reporting to higher headquarters.

(3) The hospitals may deploy by land, sea, or air (or a combination of these modes) from locations designated by higher headquarters. Priority of effort is given to those modes of movement outlined in current plans.

(4) Active Component hospitals maintain the capability for emergency deployment on short notice to execute assigned missions.

(5) Mobilizing RC hospitals must attain and maintain the capability for mobilizing on short notice and arriving at their designated mobilization site according to unit mobilization plans.

(6) Once mobilization is validated, hospitals prepare for deployment on short notice (72 hours or less). During validation, appropriate status reports are submitted to higher headquarters.

b. Conduct of Operations.

(1) Commanders of deploying hospitals develop movement plans and TSOPs to accomplish the necessary preparations for deployment. Provisions for accomplishing all required training and other requirements to be accomplished during all phases of the deployment are identified. The checklists contained in Appendix F can be used as a guide for developing deployment operation procedures in support of movement by air and surface modes, or a combination thereof. The checklists are applicable to both AC and RC units. **The checklists are detailed only as a guide for commanders**. Installation mobilization stations and/or higher headquarters may prescribe different procedures for your unit.

(2) Active Component hospitals maintain the capability necessary to achieve a deployment posture in the time required by any alert warning order or deployment instructions received. For planning purposes, the readiness posture maintained is consistent with the shortest notification period presented in the mobilization plan.

(3) Reserve Component hospitals maintain the readiness posture necessary to meet planned deployment dates contained in current FORSCOM and mobilization documents. Upon arrival at the designated mobilization site, hospitals are placed in an increased or advanced deployability posture based on the published priorities of plans for which the hospitals are listed. The hospitals are managed through the RC chain of command, with input by the mobilization installation commander during the premobilization period.

(4) All hospitals are scheduled for deployment validation by unit line number based on the published validation schedule. Hospitals can be expected to deploy within 72 hours following validation. Actual deployment date and times are as directed by higher headquarters.

5-4. Deployment

a. When directed by higher headquarters through the port call or airlift message, the FH/GH will move to the port of embarkation (POE) for deployment. Deployment from the POE will be as directed by the United States Transportation Command. Upon arrival at the theater point of entry, it is essential that contact with the assigned MEDCOM or medical brigade be made immediately. Normally, the MEDCOM or medical brigade has liaison personnel to meet and assist the hospital staff with coordination and movement to its AO. As equipment and supplies are off-loaded, they are moved to a designated receiving area for consolidation and movement. An inventory for accountability and damage assessment is conducted. Vehicles are serviced and necessary repairs are made, or coordination is made with the supporting maintenance element for the repairs. Documentation for replacement of unusable supplies or equipment damaged beyond repair is initiated through the MEDCOM or medical brigade headquarters element. Vehicle loads are adjusted for convoy operations. For equipment that was transported separately from the hospital, coordination is made for receiving and transporting it upon arrival. Once the hospital has moved to its AO, the MEDCOM or medical brigade staff elements conduct formal personnel in-processing and an orientation on current operating policies and procedures. The orientation includes information on the following:

- Mission update, to include geographical support area.
- Combat health support issues.
- Host-nation support.
- Local laws and customs.
- Threat update.
- Security requirements.
- Personnel restrictions.
- Personnel replacements.
- Uniform requirements.
- Emergency warning signals.
- Religious support.

- Vehicle and unit movement requirements.
- Geneva Conventions (see Appendix G).
- Supply support activities and procedures (all classes).

b. In a force projection Army, METT-T will drive the amount of supplies required to support the force. For planning purposes, the hospitals normally deploy with 10 days of medical supplies; the medical assemblage for each work area contains a basic load of 3 days of supply; the medical supply set maintained by the supply and service division contains a 7-day basic load for the entire hospital. In a maturing theater, medical resupply is accomplished by preconfigured resupply packages until the MEDLOG battalion (rear) has been established. These "push packages" are throughput directly to the hospital via the transportation system. These packages may be pre-positioned "mobilization stocks," or may be built and shipped from the Defense Logistics Agency (DLA) depot system. Hospital logistics personnel coordinate with their next higher command headquarters for all logistical support to include resupply. Early deploying hospitals that arrive prior to their higher medical C2 headquarters must coordinate with port transportation personnel for shipment and receipt of supplies and equipment. Once the MEDLOG battalion (rear) has been established, hospital logistics personnel coordinate directly with the MEDLOG battalion for resupply of Class VIII materiel. (For a detailed discussion on Class VIII resupply, see FM 8-10-9.) All other resupply is requisitioned through higher headquarters with the appropriate supporting organization. Effective coordination is the key to responsible logistical support. To be effective it must be early and it must be often.

c. For maximum use of the FH/GH, the entire hospital should deploy together. However, due to their limited mobility and the availability of transportation support requirements, it may be necessary to deploy by echelons. If required to move by echelons, the number and composition of each echelon is a command decision. The following is a recommended sequence:

(1) *Field hospital*.

(*a*) *First echelon*. Advanced/quartering party.

(*b*) *Second echelon*. This echelon should include—

- Hospital Headquarters HUB
- Triage/Preoperative/EMT HUB
- Operating Room/CMS Control Team HUB
- Operating Room E Module HUB
- One ICU Ward HUB
- Two ICWs HUB

- Laboratory HUB
- Blood Bank HUB
- X-Ray HUB
- Pharmacy HUB
- CMS HUB
- Ortho Cast Clinic HUB

Elements of the following should also be included to provide necessary support: company headquarters (HUB), supply and service division (HUB), PAD, and nutrition care division. It is critical to the operation of the hospital that the first echelon include a heavy complement of utilities personnel and equipment.

(*c*) *Third echelon*. This echelon should include—

- Neuropsychiatric Service and Ward HUB
- Inpatient Medicine—Module A HUB
- One ICU Ward HUB
- Two ICWs HUB
- Two Minimal Care Wards HUB
- Three Patient Support Sections HUH
- Physical Therapy/Occupational Therapy Service HUB
- Dental Service HUB

Elements of the following should be included in this echelon: company headquarters (HUB), supply and service division (HUB), and PAD.

(*d*) *Fourth echelon*. All remaining elements of the hospital.

(2) *General hospital*.

(*a*) *First echelon*. Advanced/quartering party.

(*b*) *Second echelon*. This echelon should include—

- Hospital Headquarters HUB
- Supply and Service Division HUS
- Triage/Preoperative/EMT HUS
- Operating Room/CMS Control Team HUS
- Operating Room A/B Module HUB
- Inpatient Medicine—Module A HUB
- Three ICU Wards HUB
- Four ICWs HUB
- Laboratory HUB
- Blood Bank HUB
- X-Ray HUB
- Pharmacy HUB
- Two CMSs HUS
- Ortho Cast Clinic HUS
- Litter Bearer Section HUB

Elements of the following should also be included to provide necessary support: company headquarters (HUB), supply and service division (HUB), PAD (HUB), and nutrition care division (HUB). It is critical to the operation of the hospital that the first echelon include a heavy complement of utilities personnel and equipment.

(*c*) *Third echelon*. This echelon should include—

- Neuropsychiatric Service and Ward HUB
- Operating Room C/D Module HUS
- Inpatient Medicine—Module B HUM
- Two ICU Wards HUS

- Two ICWs HUB
- Four ICWs HUM
- Two Minimal Care Wards HUB
- Two CMSs HUB

Elements of the following should be included in this echelon: company headquarters (HUS), supply and service division (HUB/HUS), and PAD (HUB/HUM).

(*d*) *Fourth echelon*. All remaining elements of the hospital.

5-5. Employment

a. The FH/GH are employed in the COMMZ (with exception of the FH as noted in Chapter 2). A COMMZ is defined as the rear part of the TO (behind but contiguous to the CZ) that contains the logistics routes (lines of communication [LOC]) established for supply and evacuation and other agencies required to immediately support and maintain the field forces.

b. The FH/GH provide hospitalization for patients originating in the COMMZ and for those received from the CZ. Patients are received by air and ground ambulance. The patients are triaged, treated, and RTD or stabilized for further evacuation. Patients who cannot RTD within the theater evacuation policy are normally stabilized at the GH for evacuation to CONUS. Those patients identified as RTD are hospitalized and receive rehabilitative care at the FH.

c. The hospitals should be located where they can best acquire patients from the CZ and COMMZ. By virtue of their dependency on COMMZ support units, their location should be in an area where they can be easily supported by elements of the TAACOM ASGs, the theater signal brigade, the district contingency engineer manager, and the TAMCA and its associated regional movement control battalions and movement control teams (MCTs). If the FH is deployed in the corps area, it should be located where it can be readily supported by elements of the corps support group, the corps signal brigade, the corps contingency engineer manager, and the COSCOM movement control center (MCC). Each hospital will require a large area to establish and operate (see Appendix B). The total area is dependent upon the hospital's mission and the terrain features.

d. Appendix H depicts an example of a functional layout for each hospital using the DEPMEDS tent, extendable, modular, personnel (TEMPER) and international organization for standardization (ISO) system. See TC 8-13 for a recommended design of these systems for hospital operations. When possible, these hospitals should use existing buildings in the area. Because of their size and support requirements, relocating these hospitals should be limited.

e. The size and composition of health services in support of military operations will be tailored based on—

- Mission.
- Size of force being supported.
- Projected patient work loads.
- Anticipated civic action programs.
- Availability of evacuation assets.
- Evacuation policy.

f. During the initial stages of military operations, CHS to the US forces will be austere and limited to the unit's organic medical capabilities. A short theater evacuation policy is normally established; tailored hospital support is required. Projected patient work loads will dictate the composition of these hospitals. The modular design of these hospitals allow augmentation as needed.

5-6. Hospital Displacement

a. *Concept of Operations*.

(1) The MEDCOM or medical brigade commander moves the FH/GH in support of sustainment operations. Hospital displacement may be in response to forward moves in support of tactical operations, or rearward moves during a retrograde operation. The MEDCOM or medical brigade normally issues orders, either verbally or in writing, to the hospital commander. Frequently, the time to respond to orders may be short; therefore, the hospital commander must disseminate his guidance to his staff in the most expedient method. Upon receiving the commander's guidance, the hospital staff conducts the mission analysis, incorporating changes based on new information or situation. The hospital saves time by rehearsing moves, using knowledge from past experience, and maintaining a detailed TSOP.

(2) The hospital operations section develops the OPORD IAW the MEDCOM's or medical brigade's plan, FM 101-5, FM 8-55, and the TSOP. The hospital commander, in consultation with the hospital XO, approves the OPORD. The hospital commander ensures that the move is coordinated with higher headquarters and all supported elements. All supported elements must be aware of when medical operations at the current location will be curtailed and the date and time of opening of the operation at the new site. Hospital displacement necessitates the transfer of patients and medical operations to other MTFs. To minimize hospital operations disruption, the hospital should move in echelons. Displacement by echelons is contingent upon the higher commander's intent, the tactical situation, and the availability of support requirements.

b. *Conduct of Operations*.

(1) *Warning order*.

(*a*) A move is usually initiated by a warning order issued by the MEDCOM or brigade headquarters. The warning order serves notice of a contemplated action or order that is to follow. The amount of detail included in a warning order depends on the time available, the means of communications, and the information necessary for the hospital commander. Warning orders are brief oral or written orders.

(*b*) Upon receiving the warning order, the hospital commander analyzes the mission and provides planning guidance to his staff. Using the MEDCOM's or medical brigade's service support annex, status reports, and other appropriate documents, the hospital staff formulates the hospital service support estimate for the commander's approval. (Field Manual 8-55 discusses staff estimates and functions in greater detail.) With the acceptance and approval of the staff estimates, the hospital commander provides his decision and concept of operations. Concurrently with the staff estimate sequence, other hospital personnel conduct preliminary equipment checks and equipment loading procedures. Based on the commander's decision, the PAD coordinates with the MEDCOM or medical brigade to effect the transfer of patients to other MTFs.

(*c*) In preparation for displacement, the hospital commander should organize the hospital into manageable echelons, preserving hospital integrity as much as possible. Preparation for displacement requires—

- Identifying external support requirements; for example, MHE.
- Phasing down and transferring hospital operations.
- Performing map, ground, and/or air reconnaissance of the routes, and selecting the new site when possible.
- Selecting routes (coordinate with local MCT).
- Designating start points (SPs) and release points (RPs).
- Reconnoitering the route to the SP.
- Providing for security, maintenance, supply, and evacuation.
- Determining the march order (echelons), rate of march, maximum speed of vehicles, and distance between vehicles.
- Establishing checkpoints and halts.
- Establishing COMSEC procedures.
- Issuing strip maps.
- Dispatching reconnaissance and advanced parties.

- Controlling traffic.
- Issuing orders.

(2) *Operation orders*.

(*a*) The operations officer has staff responsibility for formulating, publishing, and obtaining the commander's approval of and distributing the OPORD. The OPORD provides hospital staff and personnel the information needed to carry out an operation. Preparation of this order normally follows the completion of area reconnaissance and an estimate of the situation. When time is available and the existing tactical situation conditions prevent detailed planning or area reconnaissance, the MEDCOM or brigade conducts coordination and prepares an initial march plan and issues fragmentary orders (FRAGOs) to modify these plans as needed. If conditions and time permit, information in the OPORD includes—

- Destination and routes.
- Rate of march, maximum speeds, and order of march.
- Start points and SP times.
- Scheduled halts, vehicle distances, and RPs.
- Required communications.
- Strip maps.

(Appendix I provides a sample OPORD with annexes; FM 8-55 and FM 101-5 contain more detailed OPORD information.)

(*b*) Each hospital division or section reports its supply, vehicle, equipment, work load, and maintenance status to the operations officer. This information is used in coordination with higher headquarters to finalize the convoy organization, compute additional transportation and external support requirements, and perform march computations. (For additional information on march computations, see FM 55-30.)

(3) *Area reconnaissance*.

(*a*) The MEDCOM or medical brigade headquarters normally coordinates unit movement with adjacent maneuver forces and prescribes the reconnaissance route. The hospital operations section uses a map reconnaissance in such cases to confirm checkpoints, identify problem areas, and begin planning positions of the hospital in the new area. If the route is not prescribed and the hospital reconnaissance team is not included as part of a reconnaissance party with other units, the operations section briefs the reconnaissance team on the displacement plan. The operations section provides the team with a map with graphic control measures, radio frequencies of adjacent units for coordination, and the designated

MOPP level and then notifies higher headquarters of the route selected. The composition of the reconnaissance team is directed by the hospital commander.

(*b*) The reconnaissance party wears the designated MOPP gear and monitors all radiological and chemical detection devices. It performs duties to—

- Verify map information.
- Note capabilities of road networks.
- List significant terrain features and potential problem areas.
- Verify travel times and distances.
- Draw/design a power configuration plan to the proposed layout of the hospital complex which will identify the power generation equipment, routes of electrical power dispersion, and fuel requirements to meet necessary electrical demands to various portions of the DEPMEDS hospital.
- Estimate hospital site preparation. (See TC 8-13 for a detailed discussion on site selection, layout, and support requirements.)

(4) *Advanced party*. The advanced party moves before the main body and is dispatched as directed by the hospital commander. Its composition is recommended by the medical operations officer and approved by the hospital commander. The advanced party normally consists of representatives from Echelon II of the convoy organization (see paragraph 5-4*c*[1] and [2]). It prepares the new site for arrival of the main body. The advanced party performs duties to—

- Conduct a security sweep of the new site to ensure the area is free of enemy activity. This is normally done by security support forces.
- Position chemical alarms.
- Establish communications with higher headquarters and old location.
- Designate boundaries of hospital elements based on unit defense plan and consistency with types of weapons and personnel availability.
- Increase security by manning key points along the perimeter.
- Establish a command post.
- Complete hospital site preparation layout (see TC 8-13).
- Establish land-line communications for critical areas.

- Ensure personnel follow dispersion and other measures.

- Position personnel to guide main body from the RP to designated locations.

(5) *Main body*. The main body moves as directed in the OPORD. The last echelon normally closes out any remaining operations, ensuring the old site is clear of evidence of intelligence valuable to the enemy, and moves to the new site. This echelon includes maintenance elements to deal with disabled vehicles from the rest of the convoy. It also picks up guides and markers along the route. As the main body arrives at the new site, it is met by the advanced party and guided to designated positions. Erection of the hospital and the establishment of hospital operations follows the priorities set by the commander.

(6) *Crossing a nuclear, biological, and/or chemical contaminated area*. When the hospital commander is directed by higher headquarters, or when the tactical situation dictates, the hospital may have to cross a contaminated area or an area designated as a contaminated area. Should this situation occur, the following are recommended procedures:

(*a*) *Operations section*.

- The operations officer conducts a map reconnaissance of the area and briefs the commander on the best possible route.

- Based on the commander's approval, a route reconnaissance is conducted prior to moving the convoy through the contaminated area.

- The reconnaissance team wears the appropriate MOPP level and carries monitoring equipment.

- The route selected should minimize hospital exposure when crossing the area.

NOTE

In a nuclear environment, the turn-back dose rate will be identified.

(*b*) *Convoy operations*.

- The convoy travels at a maximum safe speed with no scheduled stops within the contaminated area.

- Prior to convoy operations, the commander designates the MOPP level.

- The lead vehicle of each serial of the convoy has monitoring capabilities and survey instruments, with a map indicating areas of contamination. The map includes data from the reconnaissance party report. Continuous monitoring is conducted through the contaminated area.

- Spacing of vehicles should take into consideration dust generated by the next forward vehicle.

- Disabled vehicles will be collected IAW the maintenance collection plan (like vehicles can tow like vehicles). Coordination must be made with the unit providing recovery support.

(*c*) *Decontamination*.

- Immediately upon completion of the move, personnel and equipment are decontaminated. The hospital is responsible for decontaminating its personnel and equipment (see FM 3-5). Decontamination beyond the capability of the hospital will be requested from the supporting chemical company.

- The decontamination site is annotated on the map.

(*d*) *Reports*. Upon completion of the move, the operations officer reports immediately to the hospital commander and higher headquarters any contamination acquired during the move. Other required reports are also included.

5-7. Emergency Displacement

When confronted with an adverse tactical situation and/or when directed by higher headquarters, the hospital may be required to relocate expeditiously. Movement procedures identified above may be modified to accommodate the situation. As soon as the threat appears inevitable, all available means are used for evacuation of casualties, hospital personnel, and equipment. Wounded soldiers have priority on transportation assets. The critically wounded who cannot be moved are left behind with medical personnel, supplies, and equipment. The decision to leave patients behind is made by the tactical commander. Medical supplies and equipment are not intentionally destroyed, even to prevent them from falling into enemy hands. Paragraph 5 of Article 12, Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field, provides that if we must abandon wounded or sick, we have a moral obligation to, "as far as military considerations permit," leave medical supplies and personnel to assist in their care.

5-8. Nuclear, Biological, and Chemical Operations

As stated earlier in the threat, the corps' and division's sustainment capabilities are prime targets for the enemy's NBC weapons. Although the hospital may not be specifically targeted, locating it close to other CS and CSS units, major airfields, and road junctions makes it vulnerable to NBC weapons. The hospital's TEMPERs are relatively permeable. Without increased protection, hospital assets can be expected to experience a significant amount of contamination and damage when exposed to NBC strikes. The distance of the hospital from other support units and interposed terrain features as protective factors must be balanced against accessibility and time required for patient transport. Prompt notification of, and reaction to, downwind messages in the event of NBC employment will enhance hospital operations and patient and

individual protective measures. However, NBC defense includes all measures to minimize casualties and enhance the effectiveness of hospital operations under NBC conditions. These measures may be proactive or reactive in nature. They include contamination avoidance and control, protection, and decontamination. For a comprehensive discussion on hospital operations in a NBC environment, see FM 8-10-7 and FM 8-285.