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ALLIED JOINT MEDICAL DOCTRINE FOR MEDICAL EVACUATION

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AUGUST 2018

NORTH ATLANTIC TREATY ORGANIZATION

ALLIED JOINT MEDICAL PUBLICATION

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NORTH ATLANTIC TREATY ORGANIZATION (NATO)

NATO STANDARDIZATION OFFICE (NSO)

NATO LETTER OF PROMULGATION

29 August 2018

1. The enclosed Allied Joint Medical Publication AJMedP-2, Edition A, Version 1, ALLIED JOINT MEDICAL DOCTRINE FOR MEDICAL EVACUATION, which has been approved by the nations in the Military Committee Medical Standardization Board, is promulgated herewith. The agreement of nations to use this publication is recorded in STANAG 2546.

2. AJMedP-2, Edition A, Version 1, is effective upon receipt and supersedes AJMedP-2, which shall be destroyed in accordance with the local procedure for the destruction of documents.

4. This publication shall be handled in accordance with C-M(2002)60.

Zoltán GULYÁS
Brigadier General, HUNAF
Director, NATO Standardization Office

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RESERVED FOR NATIONAL LETTER OF PROMULGATION

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RECORD OF RESERVATIONS

CHAPTER	RECORD OF RESERVATION BY NATIONS

Note: The reservations listed on this page include only those that were recorded at time of promulgation and may not be complete. Refer to the NATO Standardization Document Database for the complete list of existing reservations.

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RECORD OF SPECIFIC RESERVATIONS

[nation]	[detail of reservation]
DNK	The Danish forward ambulances are not trained to provide advanced prehospital emergency care, but to provide emergency medical care.
FRA	France will implement in part only Chapter 1, paragraph 0106-3: the patient evacuation policy must not be influenced by "welfare considerations" and "public expectations".
GBR	• Paragraph 0101.4 infers that "MEDEVAC is the medically supervised process of moving a [patient]…..aboard dedicated and appropriately marked medical transports…." The United Kingdom reserves the right not to use either dedicated and/or appropriately marked platforms. Both of these factors will be driven by the operational environment and conditions (threat in particular) and their use is a commander's decision. The United Kingdom will in the main use the term "designated" as opposed to "dedicated". Furthermore, where a threat exists from non-state actors, United Kingdom commanders are empowered, subject to legal and policy advice, to remove the Red Cross insignia, and to fit a mounted weapon system for the protection of that platform and those within their care. However, such a platform will no longer be recognizable as an ambulance and it, and its occupants, will lose the protection that the distinctive emblem would otherwise confer. Under no circumstances may the Red Cross emblem be displayed on an ambulance platform at the same time as a weapon system is mounted on it. • Paragraph 0102-4 refers to the "10-1-2 evacuation timeline", the United Kingdom operates to "10-1-2(2)+2" medical planning guidelines; this takes into account the time required to conduct DCS "(2)" and, further in-theatre surgery "+2". • Paragraph 0202-2 refers to the use of passive protection under Article 35 of the Geneva Conventions (Protection of Medical Transports). Where a threat exists from non-state actors, United Kingdom commanders are empowered, subject to legal and policy advice, to remove the Red Cross insignia, and to fit a mounted weapon system for the protection of that platform and those within their care. However, such a platform will no longer be recognizable

	as an ambulance and it, and its occupants, will lose the protection that the distinctive emblem would otherwise confer. Under no circumstances may the Red Cross emblem be displayed on an ambulance platform at the same time as a weapon system is mounted on it.
GRC	Blue-light matrix and MedCIS development will be progressively embedded within the national medical evacuation planning policy due to financial constraints and within national legal framework, including further enhancement of national equivalent to CCART and SOST team capability. Hellenic Armed Forces dispose MEDEVAC rotary and fixed wing assets (manned by qualified personnel) but no dedicated Aeromedical evacuation unit for the nonce. Hellenic Army Blue-Light matrix for ground assets (non-armored ambulances and armored stretch bearing vehicles), will be progressively embedded within the Army medical evacuation planning. Furthermore, there is a standing reservation regarding shortfalls in MEDEVAC capabilities for CBRN contaminated casualties.
USA	(1) Paragraph 0101, 3. Evacuation of casualties is a fundamental aspect of medical support however, there is a distinction between CASEVAC and MEDEVAC. CASEVAC is a command responsibility that refers to, in general terms, □clearing the battlefield□□of all casualties by available means, in this case, using opportune evacuation platforms. MEDEVAC (NATO definition revision ongoing) is a medical responsibility. Also, the following sentence, (1) “At no point in the chain of evacuation ….previous MTF“ does not take into account emergent evacuations that may require dispersion of casualties to any MTF with the capacity to receive patients. (2) Paragraph 0403. In the US Army and concerning US Army MEDEVAC platforms, the Army retains command, control and launch authority unless otherwise agreed or directed.
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SECTION I – INTRODUCTION

The purpose of this document is to describe a medical evacuation system to enable nations to maintain their national evacuation procedures as far as possible and to plan for reliable, cost-effective Medical Evacuation (MEDEVAC) by facilitating bi- or multilateral agreements and promoting common planning, programming and training. These principles must all comply with International Humanitarian law (comprising the relevant Geneva conventions and principles and The Hague convention).

0101 General

1. The purpose of medical support in military operations is to conserve manpower, preserve life, and minimize residual physical and mental disabilities. Appropriate medical support makes a major contribution to both force protection and morale by the prevention of disease, rapid evacuation and treatment of the sick, wounded and injured and the return to duty of as many individuals as possible.

2. The medical support to a force must be capable of maintaining the necessary quality and quantity of treatment and evacuation activities during peace, crisis, and conflict. This requires having on hand or in reserve appropriate medical equipment, supplies, and Medical Evacuation (MEDEVAC) capacity, as well as having the ability to resupply and to replace medical personnel on a continuous basis.

3. Evacuation of casualties is a fundamental aspect of medical support. Movement of casualties is not just transportation to a suitable medical treatment facility (MTF) but is part of a continuum of patient treatment and care, and is therefore, a medical responsibility.[1] At no point in the chain of evacuation must the level of care be reduced below that received at the previous MTF.

4. MEDEVAC is the medically supervised process of moving any person who is wounded, injured or ill to and/or between medical treatment facilities as an integral part of the treatment continuum. This should be in accordance with modern medical standards, aboard dedicated and appropriately marked medical transports to and between MTFs. For example, medical aircraft, employed for the removal of wounded and sick and for the transport of medical personnel and equipment. All dedicated assets shall bear, clearly marked, the distinctive emblem prescribed in Article 38 Geneva Conventions.

0102 Aim

The aim of this document is to describe a concept of MEDEVAC, for Allied combined joint operations, which is consistent with the principles and policies dictating the organization and capabilities of the MEDEVAC system whilst taking into account the development of multinational operational integration.

[1] ALLIED JOINT DOCTRINE FOR MEDICAL SUPPORT AJP-4.10

0103 Principles and Policies of Medical Evacuation

MEDEVAC is the capability of transporting patients during military operations under continuous medical care. These transports (medical) must all comply with International Humanitarian law (comprising the relevant Geneva conventions and principles).

Successful patient care depends on timely evacuation, which can be influenced by many factors, such as the operational environment, the weather, the length and quality of evacuation routes and sufficient MEDEVAC assets.
It is a responsibility of command to ensure an effective medical evacuation system is in place 24/7and capable, as far as possible, to:

- **a.** evacuate patients at day and night, in all weather and sea conditions, in any terrain and any operational circumstances
- **b.** provide appropriate emergency and critical care throughout the evacuation
- **c.** direct the flow of patients and their disposition to the most appropriate MTF
- **d.** track patients accurately throughout evacuation[2]

1. MEDEVAC needs to be planned prior to any operations. The responsibility for planning and executing an effective MEDEVAC system lies with the Force's medical staff in close coordination with Nations, operational and logistics staff and CJ3 Ops and CJ3 Air Ops.

2. The provision of evacuation assets occurs via national contributions or multinational arrangements, such as bi- and multi-lateral agreements, utilizing of assets from lead nations, and host nation or a specialized contribution from other NATO countries

3. The pooling of assets will allow smaller contributions from participating nations to be combined into a larger multinational organization. Centralization of these assets, may allow for economies of scale, effective operational management and timely intervention throughout the JOA.

4. Coordination of the assets requires an integrated sea-air-land MEDEVAC system with close coordination of the components.[3]

5. It is important to state that the term Casualty Evacuation (CASEVAC) is **not** a part of medical evacuation. When used it means the non-medically supervised process of moving a person who is wounded, injured or ill. This type of movement will unavoidably happen, but is **not** a factor in planning of the medical footprint and, therefore, can have **no** influence on the medical estimate process and should **not** be regarded as a medical capability.

0104 Linear Medical Evacuation

1. MEDEVAC doctrines and capabilities differ substantially by nations; however, the move towards combined operations increases the need for flexibility in these structures. While these differences do not exclude close cooperation, it requires thoroughly

[2] AJP-4.10
[3] AJP-4.10

coordinated procedures to ensure the smooth transfer and treatment of patients within a multinational medical support chain.

2. The robustness of the evacuation chain is directly related to and depends on the quantity and capability of the treatment assets that will be required in theatre. A robust MEDEVAC system requires the following qualities[4]:

Timeliness of Treatment (10-1-2)[5] [6]**.** Time is a fundamental factor in the effectiveness of medical care. Treatment and evacuation timelines in operations are determined by medical doctrines.

10: Advanced First Aid within 10 minutes after injury, wounding or onset of acute symptoms consisting of immediate life saving measures based on the paradigms of tactical combat casualty care applied by non-medical military personnel at the point of injury (POI).

1: Prehospital Emergency Care within 1 hour after injury, wounding or onset of acute symptoms consisting of Damage Control Resuscitation (DCR) or Damage Control Surgery (DCS) measures as of Prehospital- and Advanced Life Support [7] commenced by medical professionals trained in emergency care.

2: Life, limb and function-saving Surgery, i.e. Damage Control Surgery (DCS) within 1 hour, but not later than 2 hours after injury or wounding.[8]

Availability[9]. The aim of the medical evacuation system is to evacuate casualties 24/7 day and night, in (as far as possible) all weather and sea conditions, in any terrain and any operational circumstances. Operations of Special Forces or at sea may require specific solution.

Continuity[10]. A casualty's recovery will depend on continuing appropriate care. Continuity of care means uninterrupted and appropriate medical attention throughout the chain of their medical treatment and evacuation.

Multinational interoperability[11]. Multinational medical solutions have considerable potential to reduce the burden of medical capability provision upon individual nations.

Civilian providers. Solutions may be sourced from civilian providers to support operations for which military capabilities are not available or when their use is impractical.

3. MEDEVAC may move patients throughout the continuum of care from the POI / Role 1 in the AOR to any Role 4 in the patients home Nation. The underlying principle is to transport every patient to the most appropriate MTF as quickly as possible, based primarily on clinical imperatives, but also tempered by the operational environment,

[4] MC 326/3 NATO Principles and Policies of Operational Medical Support.
[5] AJP 4.10 Allied Joint Medical Support Doctrine. In the future AJP-4.10C this will change to 10-1-2 +2
[6] MC 326/3 NATO Principles and Policies of Operational Medical Support.
[7] Advanced skilled medical aid that is provided by the military medical services (e.g. doctors, nurses or paramedics), using personnel with competences that include awareness and experience of the pre-hospital environment and the equipment needed to apply those skills.
[8] Regarding the patient's condition as the result of the initial trauma combined with possible physiological consequences of surgery.
[9] AJP 4.10 Allied Joint Medical Support Doctrine.
[10] MC 326/3 NATO Principles and Policies of Operational Medical Support.
[11] MC 326/3 NATO Principles and Policies of Operational Medical Support.

which may necessitate direct transport to a higher level of care. Whereas, medical treatment is generally described in terms of Roles/Echelons, according to their capabilities, MEDEVAC assets are defined by the area in which they operate along the chain of evacuation in three main categories:

a. Forward MEDEVAC is the movement of casualties in a platform with medical personnel from point of injury and/or illness to the first MTF. It should be conducted by the most expedient method to the most appropriate level of care but not necessarily the closest MTF within the timelines (10-1-2). This is most commonly achieved with Rotary assets. Forward MEDEVAC assets need to meet similar protection levels as the forces operating in the area they cover. Forward MEDEVAC teams should be equipped and trained to provide advanced pre-hospital emergency care.

b. Tactical MEDEVAC is the intra-theatre movement of patients in a platform with medical personnel between medical treatment facilities. from one MTF to another MTF within the Joint Operational Area (JOA). It can be conducted by ground, rotary or fixed wing assets along the Lines of Communication in the JOA. Patients will routinely have been stabilized prior to evacuation.

c. Strategic MEDEVAC from the JOA, to the home nation, to other NATO countries or to a temporary out of theatre safe area is a national responsibility that can be fulfilled by multi-national agreements; in general, it is a shared responsibility between the Force Commander and the Contributing Nations (CN). In case of non-availability of military means, consideration should be made for the use of civilian charter aircraft with the caveat on their ability to fly into the operational theatre.

4. Medical Emergency Response[12].

Under combat conditions the flow of casualties and acute medical cases usually follows the continuum of care. However, this is a medical organizational pattern and not a linear pathway that has to be followed in a sequence. One or more emergency response capabilities may be bypassed due to patients' needs and the availability, capacity and workload of MTFs, and the capacity and capability of MEDEVAC assets.

0105 The Blue-Light Matrix

1. Based on operational requirements and the timelines for emergency care, the blue-light matrix provides a dynamic overlay, highlighting the footprint of and the coverage by medical support in the Area of Operations (AOO), thereby determining the location of medical assets on the ground, their capabilities, capacity and readiness status.

2. The aim of the matrix is to respond to incidents along Lines of Communication or within the AOO in order to achieve the initial response timeline to advanced trauma life support for a casualty.

[12] AJP 4.10

0106 The Theatre Patient Evacuation Policy:

1. The theatre patient evacuation policy[13] will be established by the operational commander on advice of the medical staff, indicating the maximum length of time in days that a patient will be allowed to remain in theatre to receive treatment, recover and return to duty.

2. If recovery will take longer than the limit set by the evacuation policy, the patient should be evacuated to his home base as soon as it is considered appropriate.

3. The theatre patient evacuation policy will be primarily influenced by the availability of assets, constraints on movement, particular operational imperatives, distances, weather and topography.
   This will also be affected by factors such as welfare considerations, public expectations, national policy and the cost of strategic evacuation.

4. The theatre patient evacuation policy needs to be dynamic and able to respond to changes in the operational situation. It has to ensure that

   a. appropriate medical capacities and capabilities can be maintained in theatre to rapidly meet operational imperatives, such as surges in casualty numbers as a result of enemy action.

   b. less seriously sick and injured patients are managed at the appropriate level of care and potentially returned to duty.

   c. seriously ill or injured patients are evacuated to appropriate MTFs as rapidly as possible.

[13] AJP-4.10

SECTION II – ELEMENTS OF MEDICAL EVACUATION

0107 Medical Evacuation Assets

1. Within the range of ambulance vehicles available, there is considerable variation in terms of capabilities and patient capacity. Minimum essential equipment is described in STANAG 2342. There are no restrictions to add further medical equipment according to national requirements. The medical equipment should reflect the level of expertise of personnel staffing the ambulances.

2. The ambulance system capability is to
   a) provide pre- hospital care and life support
   b) evacuate and manage severe casualties
   c) provide patient tracking and transfer
   d) evacuate CBRN patients, preferably decontaminated
   e) provide and apply medical evacuation treatment guidelines
   f) ensure rapid and efficient medical transport
   g) respond to MASCAL

3. Meeting evacuation requirements demands a range of transportation assets for both intra- and inter-theatre movement.

4. **Intra-Theatre assets**[14] are used for **forward-** and **tactical evacuation** of patients. They must be appropriate to the mission they support. This includes:

a. **Ground assets** armoured and non-armoured, wheeled or tracked, are used to transfer casualties from POI to or between MTFs within the JOA, and finally from MTFs to the port of debarkation, be it sea or air.
   a. Ambulances are the most common type of ground evacuation transportation; these vehicles must have the same mobility and protection as the force they are supporting,
   b. Ambulances will also differ in capabilities (medical personnel and equipment) depending on the level of care the patient requires. For example; MEDEVAC from POI will require personnel capable of performing Prehospital Emergency Care where as a ventilated, post-surgical patient being transferred from one MTF to another will require critical care personnel.

b. **Air assets** (fixed and rotary wing) are an increasingly essential element to assist timeliness of MEDEVAC. In the absence of dedicated evacuation assets, command must give consideration to preparation for medical use of the air frame. Different levels of dependency of patients for all stages of AE lead to the requirement to enhance the standard AE crew with teams providing intensive or critical care during the AE. For fixed wings these specialised teams are referred to as Critical Care Air Transport Team (CCATT) or Critical Care Air Support Team (CCAST). Such teams should be available throughout the evacuation chain.

c. **Maritime, littoral and non-tidal water assets** (depending on the geographical constraints of the operation) range from small boats with limited capabilities to evacuate casualties, to full-scale hospital ships with Role 3/4 capability.

[14] AJP-4.10

0108 Responsibilities

1. Nations have the responsibility for ensuring provision of medical support to their forces allocated to NATO. Duplication of medical functions should be minimized and options of multinational cooperation should be evaluated. Nations and NATO authorities have a collective responsibility for medical support in NATO's multinational operations. Standardization, cooperation and mutual assistance among nations together form the basis for flexible and efficient use of medical support thereby contributing to the operational success.

2. At the strategic level, the key MEDEVAC tasks of the Allied Command Operations (ACO) include:

   a. Definition of the MEDEVAC element in the Combined Joint Statement of Requirements (CJ SOR).

   b. Development of strategic level MEDEVAC support plans.

   c. Development of the MEDEVAC concept of operations.

   d. Assistance in negotiation of mutual MEDEVAC agreements and host Nation support.

   e. Assessment and analysis of Theatre medical information and data.

3. At the operational level, the Combined Joint Force HQ Medical Director (MEDDIR) takes overall responsibility for:

   a. The coordination of medical support, including MEDEVAC throughout the JOA.

   b. Identification of medical information requirements to include MEDEVAC reporting and tracking.

   c. Assessment of the Theatre medical situation.

   d. Identification of medical shortfalls and initiation of coordinated actions to remedy the situation.

   e. The conduct of multinational evacuation training in periodical exercises.

4. The overall responsibility for planning and executing an effective MEDEVAC system lies with the Force's medical staffs in close coordination with the Nations and the operational and logistics staffs and close cooperation with J3 Ops and J3 Air Ops and the Patient Evacuation Coordination Cell (PECC).

Detailed air, ground and maritime evacuation concepts should be established at the differing levels of Command for a respective AOO applying the following principles:

a. Evacuation from POI to Role 1 facility is in principle a National responsibility. Whenever possible multilateral solutions should be considered.

b. Evacuation from Role 1 to Role 2 and/or Role 3 is a National or Multi-national responsibility.

c. Evacuation to Role 4 is a National responsibility that can be fulfilled by multi-national agreements, in a Combined Joint Medical Staff (CJ MED).

0109 Command and Control

1. In the NATO environment today, most operations are combined, joint operations. Measures that enhance the overall efficiency of medical support include the whole range of multinational support options, industrial contracts, leasing, common or multinational procurement, pre-positioning, pooling and sharing with other nations, and arrangements for the cooperative acquisition. Detailed air, ground and maritime evacuation concepts need to be established at the differing levels of Command for a respective AOO to ensure that medical support is in balance with the force strength and the exposure to risk. MEDEVAC can mitigate the need for intra-theatre medical support capacities and capabilities to some extent, but is a dynamic process. Additionally, peaks of demand must be taken into account and both intra-theatre support and MEDEVAC capacity adjusted accordingly[15]

2. To accomplish the mission, activities such as preventive medicine, first aid, resuscitation, stabilization of vital functions, evacuation and definitive specialized care are required. Specific medical support principles and policies are laid down in MC 326/3 NATO principles and policies of operational medical support, AJP-4.10 (Allied Joint Medical Support Doctrine), MC 0551 Medical support concept for NATO Response Force operations and the AJMedP series of documents.[16]

3. A dedicated and structured command and control system is the essential foundation of an efficient medical support structure. This system, supported by a reliable and secure communications and information management system must be capable of planning, executing, controlling, supporting and auditing the full spectrum of medical support functions.

4. The medical command system should ideally provide all resources required to support treatment, evacuation and flow of information from initial point of wounding, injury or sickness through evacuation to definitive treatment and final disposition.[17] To achieve this requires a Combined Joint Medical Staff (CJ MED) with a modular structure usually encompassing a medical ops/plans cell, a Patient Evacuation Coordination Cell (PECC) and if required also a Force Health Protection (FHP) cell.[18]

5. The function of the ops/plans cell is to coordinate current medical operations and develop medical support planning for future medical operations. It develops and updates the theatre-level MASCAL plan and cooperates with the PECC in case of its execution.[19]

6. In most circumstances Strategic evacuation is by air. Strategic AE is controlled by the National Aeromedical Evacuation Control Centre (AECC) from the Nation providing the aircraft and AE teams. It requires close liaison with the Air Evacuation Coordinating

[15] AJP-4.10
[16] ALP 4.2
[17] AJP-4.10
[18] AJP-4.10
[19] AJP-4.10

Officer (AECO) to ensure the correct personnel and equipment are matched to the patient load.

0110 Multinational Aspects

1. Nations are advised to establish National Medical Liaison Teams (NMLT) with a national senior medical officer (SMO) in lead, collocated with their National Support Element (NSE) and deploying, if required, to medical facilities in order to assist in the administration, tracking, and repatriation of their Nation's patients. Details on the overall concept including command and control or coordination for MEDEVAC in the specific theatre, national or multinational lines of control and accountability, as well as co-ordination of MEDEVAC assets must be given in the Operational Plan (OPLAN).[20]

0111 Patient Evacuation Coordination Cell (PECC)

The PECC is integrated into the Joint Operations Centre (JOC) and provides the theatre level MEDEVAC coordination for all patients, moving beyond formation boundaries, in conjunction with force components and theatre logistic and movement control agencies.[21,22] In addition to the Theatre-level PECC there may be PECCs at Regional, Component, Sector headquarters.

1. The PECC is expected to be operational 24/7 and will be manned in accordance with the operational requirements. Expertise within will likely include medical operations and plans officers, clinical advisors and aviation staff. In circumstances where the PECC has no embedded clinical advisor or aviation staff, it must have access to urgent clinical and aviation advice. It is responsible for patient tracking and the maintenance of the MTF capability database and MEDEVAC assets availability. It has the following tasks:

    a. Receive patient evacuation requests and input into automated support system.
    b. Coordinate patient flow management.
    c. Coordinate receipt or bed assignment with receiving MTFs or Nations.
    d. Coordinate evacuation during MASCAL situations.
    e. Provide in-transit tracking of patients in AOO.
    f. Coordinate with the patient releasing MTF and the receiving evacuation asset concerning:
        - fitness of the patient for movement; in case of fixed wing AE in consultation with a physician appropriately trained in aviation medicine
        - requirements for medical attendants
        - management issues necessary to support the patient in flight
        - clinical management issues and special needs of the patient
        - administrative patient information to be provided to the body responsible for patient tracking
        - development of a load plan for patient movement, if needed
    g. Coordinate all ambulance requirements directly with the appropriate Theatre Headquarter and movement coordination centre.

[20] AJP-4.10
[21] AJP-4.10
[22] AJP-4.10

h. Coordinate AE pick-up and delivery with nations or organizations providing the aircraft support.
i. Coordinate AE pick-up with the Originating Medical Facility (OMF) and delivery with the Receiving Medical Facility.
j. Verification of aircraft itinerary.
k. Compile a patient manifest for patient transfer missions.
l. Pass manifest to nations or organizations supporting the mission.
m. Track and monitor missions for destination arrivals and departures.
n. Coordinate with the receiving MTF patient estimated time of arrival.
o. Keep ground support aware of inbound missions and their estimated time of arrival.
p. When necessary, coordinate requirement for special medical equipment supporting AE missions.

2. Key to successful medical support for operations is the establishment of clear and responsive medical consultation command and control, which must include patient tracking and patient flow management capabilities. Access to robust and secure data communications is essential, which is particularly difficult during highly mobile land operations, in environments not conducive to radio communications or over long distances.[23]

0112 Medical Communications and Information System (MEDCIS)

1. A MedCIS is a collective term for communication systems and information systems used in the provision of healthcare and in providing the commander with medical situational awareness. There is a need for interoperability between a NATO MedCIS and those of the nations, based on the ability to enable controlled data transfer. A robust MedCIS will ensure that commanders at all levels are provided with accurate and timely medical data to inform decision making processes.[24]

2. The efficient management of medical information, particularly regarding the status and location of patients, is a vital element in the effective execution of medical support. It is essential that this information is distributed rapidly to all authorized personnel[25]. Key medical information management concerning medical evacuation will be:

a. **Passage of Information**. Medical decision-making is dependent on the efficient processing and distribution of environmental, tactical, and casualty data.[26,27]
b. **Patient Tracking and Patient Flow Management**. Both patient tracking and patient flow management require up to date and accurate information about individual casualties and the availability of appropriate treatment and evacuation assets.[28,29]
c. **Patient Data**. In a multinational environment medical documentation should be interoperable throughout the theatre of operations and in all national contingents.

[23] AJP 4.10
[24] AJMedP-5, 1-1
[25] AJP-4.10
[26] AJMedP-5, 1-4
[27] AJP-4.10
[28] AJMedP-5, 1-4
[29] AJP-4.10

Medical data must move with the patient through the evacuation system to definitive care.[30]

3. **Dedicated MedCIS** assets should provide adequate connectivity within the medical functional area, both vertically and horizontally in the command and control architecture.[31] There is a requirement to provide NATO commanders, at all levels, with non-patient identifiable medical information needed to ensure medical situational awareness and patient tracking.[32]

4. **Medical Confidentiality** regarding patient Information which refers to a specific patient (i.e., non-anonymized data) requires special handling, and generally will not be transmitted by a NATO MedCIS.[33]

5. **Direct signal communications support**, in the form of terrestrial and satellite networks, is required to provide a reliable and timely verbal communications architecture comprising radio, fax, telephone, and web based capabilities being particularly important for evacuation- and treatment-assets located in theatre, as well as providing support to similar assets located out-of-theatre.

6. The PECC must have its own dedicated communication links to the key nodes of the evacuation system.[34] The patient flow management component of the MedCIS will be integrated with patient tracking that must be able to maintain a current record of the location of patients and utilization of MTFs. The objective of patient flow management component of the MedCIS is to provide an automated software platform for the PECC.[35]

7. All MEDEVAC assets should have communications on board to allow:
   - **a.** Appropriate assets to be directed to incidents and subsequently directed to the most suitable medical support capability.
   - **b.** Reduced response times.
   - **c.** Be able to precise tasking and re-tasking of assets, thus reducing the numbers of medical evacuation assets required.
   - **d.** Direct communications between in-transit medical staff and receiving clinicians. This allows advice to be given and permits the receiving facility to prepare appropriate staff and equipment.[36]

8. In order to direct appropriate assets, reduce response times and have direct communications, an overarching communication plan must be in place, exercised and tested periodically. The Theatre Medical Director coordinates this plan.[37]

9. **Patient Documentation**
   Medical documentation is the recording and processing of medical information on a patient to include personal details and clinical history. The documentation includes the

[30] AJP-4.10
[31] AJMedP-5, 3-1
[32] AJMedP-5, 1-5
[33] AJMedP-5, 2-7
[34] AJMedP-5, 2-6
[35] AJMedP-5, 2-6
[36] AJP-4.10
[37] AJP-4.10

medical care and treatment during the evacuation system to definitive care and must be interoperable throughout the Theatre of Operation.

Copies of patient's documentation must move with the patient through the evacuation system to definitive care. Medical documentation is also fundamental part of clinical evidence for official national and international inquiries.[38]

0113 Special Considerations (factors)

1. Location: Geographic and climatic factors have a crucial impact on movements. MTFs and evacuation assets should be carefully located in order to facilitate patient transfers through the medical chain.

2. MEDEVAC of infectious patients: The basic principles of medical evacuation of patients with infectious diseases are the same as those for any medical condition. However specialized medical advice needs to be taken on the risk of transmission of the illness. If circumstances dictate that patient movement is essential, then this can be undertaken provided that appropriate infection control measures are adopted.

3. Prisoners of War (POW): as described in the Geneva Conventions and AJP-4.10, POW are the responsibility of the capturing Nation and are to be treated, evacuated and returned to POW MTF using the same clinical and evacuation principles that are applied to the Nation's own sick and injured personnel.

4. Disaster Relief Operations: During non-Article V Crisis Response Operations (CRO) such as Disaster Relief Operations, the overall responsibility for producing a MEDEVAC system for local patients lies with their own medical authorities. Patients should normally not be evacuated from the country without their nation's authority.

5. CBRN factors: Planning should include contingencies for chemical, biological, radiological, and nuclear (CBRN) factors. More details concerning CBRN and medical evacuation will be found in AJMedP-7.

0114 Patient Categorization

1. Patients requiring evacuation are categorized based on their clinical condition. However, a large number of factors must be balanced for MEDEVAC to be successful, including clinical timelines. The decision to treat patients on route is based on clinical decisions. Patient in the forward evacuation phase are prioritized using the T classification or the 9-liner report for AE. In the tactical and strategic evacuation phase they are prioritized using the P classification[39].

2. Dependency degrees[40]

38 AJMedP-5 2-7 Edition A Version 1

39 STANAG 3204, AJP 4.10(C), AMEDP-1.10

40 STANAG 3204

The assessment of dependency recognizes the need to move patients who have been stabilized but whose condition remains unstable, possibly requiring intensive support enroute or in-flight.

The clinical condition of patients may either allow them to be evacuated seated or necessitate them to be evacuated lying down.

3. Classification[41]

The classification defines the patient's requirement for space in the aircraft and for physical assistance. In addition, it describes any requirement for the physical restraint or supervision of psychiatric patients.

0115 Patient Flow Management

1. **Patient flow management** is the active process of directing, controlling and coordinating the transfer of patients within and outside a JOA from the point of wounding or onset of disease through the continuum of care, in order to

a. facilitate the most effective use of medical treatment and evacuation resources, and
b. ensure that the patient receives appropriate care in a timely manner.

2. In any JOA the active management of patients through the continuum of care is a dynamic process, based on an evacuation plan that has to be closely related to the medical footprint, the casualty rate and theatre patient evacuation policy, taking into consideration factors such as:

a. Availability of evacuation capabilities and assets at the tactical and strategic level.
b. MTF availability, their specialist capabilities, medical equipment status and staffing levels.
c. Current bed occupancy status at each MTF including any surgical backlog.
d. Location of airport / seaport of embarkation (APOE / SPOE).
e. Location, number and clinical condition of patients.
f. Current tactical situation and associated threats from movement to patients or evacuation assets.
g. Although usually preferred, AE may not always be available or appropriate, so other means of evacuation must always be considered.
h. Communication status in the regulating chain.
i. Theatre holding and evacuation policy.
j. Restrictions due to patients with infectious diseases[42]

[41] STANAG 3204
[42] A command decision, indicating the maximum period of non-effectiveness that patients may be planned to be held within the command for treatment.

0116 Patient Tracking Management

1. **Patient tracking management** is the precise and continuous monitoring of the location and intended destination of the patient within the continuum of care, but also in terms of the individual's clinical condition, readiness implications to the unit of origin, as well as media and family sensitivities to casualties.

2. A patient tracking system (PTS) should be near-real time (ideally real time), accurate and dynamic, using standardised procedures, enabling exchange and interchange of data and available to HQ J1 and Medical staffs. Such systems should be integrated to a Medical Command and Information System (MedCIS). Such systems can significantly reduce J1 administrative efforts and relieve distress for both, patients and relatives.

3. Continuous monitoring and notification of patient location and status is a great challenge and of significant importance in a multinational environment, involving transfer of information between and among nations. Practical issues of language differences, communication system compatibility, legislation and record keeping practices combine to complicate multinational patient tracking functions. These challenges make interoperability evaluation and training tasks of paramount importance as well as the provision of trained and experienced liaison officers.

4. A patient tracking capability contains two key elements: in-treatment and in-transit visibility. NATO and National medical staffs report all in-transit information to the manpower and personnel (J1) staff, which has the overall responsibility for patient tracking. If appropriate, data links are made available so that on-line visibility is possible. Identification, collection and dissemination of relevant patient information together with connectivity amongst theatre MTFs and NATO and national medical staffs is paramount to develop a seamless and comprehensive patient tracking and in-transit visibility capability.

5. The purpose of a MedCIS PTS is to:

a. Support NATO and the nations with an overview of the location of the patients within the multinational medical support chain;
b. Contribute to the Common Operational Picture;
c. Serve as the basis for patient regulation.

6. Every nation should have only one point of data exchange at any time. Alternate points of data exchange are allowed only for the case of communication problems using the primary point.

7. An integrated PTS will provide the following information:

a. Who is the patient?
b. When was the patient status changed? (This will apply on admission, on transfer and on discharge)
c. Where is the patient currently located?
d. What is the patient's destination (in case of transfer)?
e. Additional information e.g. nationality and status

8. The medical in confidence principle must be adhered to at all times during the patient tracking process. No personnel outside the medical chain has a right to know patient names and medical protected information in order to conduct patient tracking.

9. The patient tracking tasks which must be met by a MedCIS can be summarized as:

a. Receive messages from national PTS;
b. Receive messages from NATO tracking systems for transport assets;
c. Ensure that patients in transit are mapped to transport assets in the NATO transport asset tracking system.
d. Provide a template for the PTS operator to enter data from incoming non-electronic messages as stated in STANAG 2231.
e. Log the tracking history.

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CHAPTER 2 GROUND MEDICAL EVACUATION

0201 General

1. The land component support concept is designed to ensure the support of either national or multinational forces, taking their different structures and multinational composition into account. Medical support will be based on national provisions and may include degrees of multinational support as agreed by those nations.

2. Ground evacuation assets normally are comprised of armored and non-armored wheeled or tracked MEDEVAC assets. They are used to convey patients from POI or wounding to a MTF, or between MTFs within the JOA, and finally from MTFs to the point of departure.

0202 Assets

1. The availability and type of evacuation assets to be utilized, the length and difficulty of the evacuation route, the operational environment and its limitations, the Theatre Holding Policy and the medical status of the patient will all have an effect on the MEDEVAC decision process.

2. Military ambulances for forward ground MEDEVAC should have the same passive protection status as the combat unit they are supporting, this usually includes armored protection. The personnel may carry light individual weapons for self-protection and for the defense of their patients within the regulations of the International Humanitarian Law.

0203 Command and Control

1. The Land Component Command (LCC) has overall responsibility for MEDEVAC assets in support of ground maneuver forces; however, in joint operations, he is subordinate to the Combined Joint Task Force (CJTF) Commander and coordination with the CJTF and contributing nations for appropriate MEDEVAC asset support of all forces is required.

2. Planning and executing an effective MEDEVAC system is a medical responsibility. The Force medical staff will co-ordinate such activity with all appropriate staff elements in theatre. The provision of resources will be coordinated by medical planning staff (JLSG/MEDCC/PECC) but may comprise assets from a number of sources, including HNS and local resources.

3. Launch authority for MEDEVAC is usually vested in the Executive chain of command. Medical C2 should be aligned with the operational command in the Combined Joint Operations Centre (CJOC) in order to perform a MEDEVAC risk assessment.

0204 Responsibilities

1. **The Land Component Medical Director (MEDDIR)** takes overall responsibility for:

a. Coordination of NATO and National component medical planning including evacuation with delegated authorities.

b. Promotion and coordination of bi- or multinational medical support agreements for evacuation.

c. Establishment of land component requirements and priorities covering all areas of medical support including evacuation.

d. Identification of evacuation medical shortfalls and coordination of remedial actions with MEDDIRs of subordinate formations.

e. Development of land component MEDEVAC support plans, mission-tailored and optimizing use of available assets.

f. Direction and coordination of the land component MEDEVAC mission in accordance with ACO/Joint Forces Command (JFC) medical plans and policy.

2. **Formation MEDDIR** is responsible for the execution of the medical mission within the AOO. They should ensure the bi- or multinational arrangements for medical support including evacuation to contingents and units are established if required. Specifically, they are responsible for:

a. Ground and forward/tactical AE- system for land forces.
b. Medical reporting.
c. Medical regulating and patient tracking responsibilities.
d. Capability and location of MTFs.

3. **Medical Coordination Cell** (**MEDCC)** the MEDCC co-ordinates multinational, joint and multifunctional medical issues, including medical evacuation under the technical input of the MEDDIR.

   Key tasks may include:
   a. Co-ordination of medical logistics issues as directed,
   b. Tasking of those medical assets assigned to NATO by nations for the overall benefit of the joint force that do not fall under direct control of other agencies,
   c. On behalf of the Medical Director, co-ordinate, further develop, and execute when necessary and directed, the theatre-level Mass Casualty (MASCAL) Plan,
   d. Liaison with civilian medical agencies and organizations providing medical services and resources,
   e. Assessment and monitoring of relevant HN medical facilities,
   f. Maintenance of a medical facility capabilities database,
   g. Co-ordination of tactical and strategic medical evacuation through liaison with the applicable MED BDE Medical Regulating Office, Air Lift Co-ordination Centre (ALCC) and the respective Aeromedical Evacuation Control Centers (AECC) by the PECC,
   h. Conducting patient tracking and regulation through the PECC.

CHAPTER 3 MARITIME MEDICAL EVACUATION

0301 General

1. **Maritime Vessels**
   Maritime vessels can carry different levels of MTFs. As a minimum each ship should have a Role 1 MTF. In addition, surgical capabilities may be present (Role 2 Level 3-4 or Role 3 Level 5). MEDEVAC can be performed between different MTFs afloat or ashore. Evacuation of casualties between MTFs of a similar Role/Level should be avoided except in extremis (such as during MASCAL when low priority casualties could be evacuated to different Role 1 Level 2 facilities in order to prevent an MTF being overwhelmed).
2. **Environment**
   Weather conditions, sea state and distances may influence achieving the timelines for medical evacuations, by air or by surface. Movement of vessels continuously alters the distance between MTFs both afloat and ashore.
3. **Missions**
   Maritime operations range significantly from high intensity warfighting to humanitarian operations. Maritime units are highly mobile. A task force can include a vast array of vessels that have specific medical needs; submarines, amphibious, aircraft, mine warfare. Maritime operations can occur in isolation or in support of littoral activities and may be expected to support operations ashore.
4. **Nature of injuries**
   Casualties in maritime operations can differ from those seen in Land operations. Incidents on board are more likely to result in MASCAL. The most frequent injuries seen are burns and smoke inhalation, alongside blast and blunt trauma. Due to the confined nature of accommodation onboard, outbreaks of infectious diseases can occur.

0302 Maritime MEDEVAC Assets

1 Medical treatment facilities

MEDEVAC requirements depend of the medical level on board:

	Emergency Healthcare Provision	Holding capacity[43]	Medevac
Role 1 Level 1	Enhanced First Aid (EFA)	Single patient (no ICU)	Forward
Role 1 Level 2	EFA + Damage Control Resuscitation (DCR)	Single patient (No ICU)	Forward
Role 2 Level 3	EFA+DCR + Damage Control Surgery (DCS)	Single patient (ICU capable)	Forward/Tactical

[43] According to MMPG 2017

Role 2 Level 4	EFA+DCR+DCS	ICU and ward	Forward/Tactical
Role 3 Level 5	EFA+DCR+DCS Specialized Surgery	ICU and ward	Forward/ Tactical

2 MEDEVAC assets

Medical evacuation can be undertaken either by aviation assets or surface vessels:

a. **Aviation**. Although larger vessels maybe able to accept fixed wing (FW) aviation assets, the majority of casualties are moved using RW assets. In the maritime environment, the operational constraints are unlikely to allow dedicated medical rotary wing (RW) assets to be available for MEDEVAC. These will be assigned on a priority basis. It is important that a full evaluation of all available RW assets is performed to identify appropriate MEDEVAC platforms.

b. **Boats**. Small rigid hull inflatable boats (RHIBs) or Amphibious Landing Craft may be utilized to move casualties short distances. This operation can be hazardous due to weather conditions and difference in height between vessels or wharf. Operating limitations of the equipment can also introduce difficulties in loading the patient in and out of boats.

c. **Ships**. If transfer of patients by air is not possible, larger MTFs (Role 2 Level 3 and above) can provide in-transit care for patients. Hospital ships can be used, but this must comply with The Hague Convention.

0303 Responsibilities

1. The Maritime Component MEDDIR has overall responsibility for medical support to maritime operations, including maritime casualty evacuations; however, he/she is subordinate to the CJ HQ MedDir, when applicable.

2. Maritime Component MedDir Responsibilities:

a. to coordinate with the strategic and tactical level concerning NATO and National component medical planning, and bi- or multinational medical support agreements, including evacuation with delegated authorities.

b. to establish maritime component requirements and priorities covering all areas of medical support including evacuation. This includes the responsibility for the component PECC function.

c. to assist the development of medical reporting procedures regarding evacuation for use through the three phases of evacuation (forward, tactical and strategic).

0304 Medical Reporting

1. Reports for MEDEVAC request and patient tracking according to chapter 0119 Medical Reporting.

CHAPTER 4 AEROMEDICAL EVACUATION (AE)

0401 General

1. By definition, AE is the movement of patients under medical supervision by air transport to and between medical treatment facilities as an integral part of the treatment continuum. .AE will be carried out as forward medical evacuation, tactical medical evacuation or strategical medical evacuation.

0402 Aeromedical Evacuation Assets

1. An AE asset is a military or civil, rotary or fixed wing aircraft, designated crewed and utilized for aeromedical missions and, as appropriate, should be appropriately marked according to the Geneva Convention. It is provided as a complete package with a NATO stretcher fit, and must be medically equipped and crewed in line with the minimum requirements of STANAG 2342, 3204 and national standards.
2. CCAST are specialist teams with intensive care expertise for AE of critically ill patients by air, including those ventilated.

0403 Command and Control

1. The Air Component Commander has overall responsibility for air operations, including AE of casualties; however, he is subordinate to the CJTF Commander in joint operations.
2. The Forward AE assets are usually under the control of the component commanders. The overall coordination of tactical and strategic air movement is the responsibility of the relevant NATO theatre movement agencies and air commands, such as the Allied Movement Coordination Centre (AMCC), Joint Transportation Coordination Centre (JTCC), National Movement Coordination Centre (NMCC), or Regional Airlift Control Centre (RALCC) or Patient Evacuation Coordination Cell (PECC). Air commands will normally establish an AECC within their staffs.

0404 Responsibilities

1. Aeromedical Evacuation Control Cell (AECC).
2. As defined by STANAG 3204, the AECC is the control facility established by the Commander of an air transport division, Air Force or Air Command. It operates in conjunction with the command movement control centre and coordinates overall medical requirements with airlift capability. It also assigns medical missions to the appropriate AE elements in the system and monitors patient movement activities.

3. Their responsibilities include

a. Liaise with the PECC. These two functions may be collocated.

b. Liaise with the OMF that the patient is fit to fly.

c. Report all the information required to coordinate AE as per SOP.

d. Liaise as appropriate with National Medical Liaison Team(NMLT).

e. Coordinate each AE patients' prioritisation, classification, and administration in accordance with STANAG 3204.

f. Coordinate CCAST assets.

Aeromedical Evacuation Coordinating Officer (AECO) /Aeromedical Evacuation Liaison Team (AELT)

An AECO is a person qualified and experienced in aviation and transportation medicine who may be collocated at each OMF. The AECO will normally be provided by the Nation(s) providing the OMF. The AECO responsibilities listed below include those responsibilities, which in some Nations are carried out by an Aeromedical Evacuation Liaison Team (AELT).

a. Have overall coordination responsibility for all fixed-wing AE transport medicine matters, and will provide a unique interface between the OMF, CSU, JTCC or equivalent, and the receiving medical facility.

b. Provide a communication link between affected unit(s) and the OMF.

c. Ensure physiological and other patient movement requirements, have been considered including all special equipment needs or altitude restrictions.

d. Closely coordinate with personnel preparing patients for transfer to the CSU or to Airframes.

e. Provide timely reporting of patients as per SOP.

f. Keep all other AE components aware of mission progress and coordination of patient movement issues.

Casualty Staging Unit (CSU).

This is a temporary patient holding facility on or near the flight line. However, patients may be taken straight from the OMF to the airframe.

In-transit Evacuation Facility (IEF).

Operational factors, such as the length of the Lines of Communication (LOC) or lack of strategic lift capability, may generate the requirement for AE mission to be staged over a number of flight legs. It is therefore necessary to provide In-transit Evacuation Facility (IEF) at these interim staging points.

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CHAPTER 5 SPECIAL OPERATIONS

1. Special operations contain specific tasks to the conduct of casualty evacuation. Once patients are sustained, the management may be complicated by extraction and evacuation difficulties compounded by long evacuation routes that may challenge acceptable treatment timelines (10-1-2).
2. Removal of patients from austere or secretive locations can be difficult and time-consuming. It may require special equipment and training. Often, SOF patients will be pulling out with available transportation, requiring enroute prolonged medical care. Preferably, MEDEVAC will be provided by dedicated rotary wing assets, specially equipped and manned for combat rescue and advanced enroute medical care. Since this is not always feasible, SOF units should have SOF trained easily deployable evacuation teams, Specialized Special operations surgical teams (SOST) capable of providing appropriate medical care enroute on a variety of air, land or sea platforms that can be place prepositioned to support the mission.

3. Evacuation of patients will be coordinated with the medical desk inside the SOCC joint operations centre (JOC) and inside the operational-level headquarters' CJOC.

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ANNEX A GLOSSARY OF ABBREVIATIONS AND ACRONYMS

ABBREVIATIONS AJMedP-2

ACO Allied Command Operations

AE Aeromedical Evacuation

AECC Aeromedical Evacuation Control Cell

AECO Aeromedical Evacuation Coordinating Officer

AELT Aeromedical Evacuation Liaison Team

ALCC Air Lift Coordination Centre

AMCC Allied Movement Coordination Centre

AOO Area of Operation

APOE Airport of Embarkation

C2 Command and Control

CBRN Chemical, Biological, Radiological and Nuclear

CCAST Critical Care Air Support team

CIS Communications and Information Support

CJTF Combined Joint Task Force

CJFLCC Combined Joint Force Land Component command

CJSOR Combined Joint Statement of Requirement

CN Contributing Nations

COP Contingency Plan

CRO Crisis Response Operations

CSU Casualty Staging Unit

DCS Damage Control Surgery

POW Enemy Prisoners of War

FHP Force Health Protection

HN Host Nation

HNS Host Nation Support

IEF In-Transit Evacuation Facility

IRT Incident Response Team

JOA Joint Operations Area

JTCC Joint Transportation Coordination Centre

LCC Land component Command

LCCLN Land Component Command Lead Nation

LOC Line of Communication

MASCAL Mass Casualty

MC Military Committee

MEDCC Medical Coordination Cell

MedCIS Medical Communications and information systems

MEDDIR Medical Director

MEDCC Medical Coordination Cell

MTF Medical Treatment Facility

NMCC National Movement Coordination Centre

NMLT National Medical Liaison Team

NSE National Support Element

OMF Originating Medical Facility

OPLAN Operational Plan

PECC Patient Evacuation Coordination Cell

PTS Patient Tracking System

RALCC Regional Airlift Coordination Cell

SOF Special Operations Forces

SMO Senior Medical Officer

SOP Standing Operating Procedure

SOR Statement of Requirement

STANAG Standardization Agreement

TCN Troop Contributing Nation

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ANNEX B *LIST OF REFERENCES*

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