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# NATO STANDARD

## AMedP-4.13

# NATO SPECIAL OPERATIONS FORCES (SOF) MEDICAL SUPPORT

**(Final Draft)** Edition A Version 1

**MONTH** 2020



**NORTH ATLANTIC TREATY ORGANIZATION**

**ALLIED MEDICAL PUBLICATION**

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Brigadier General, HUNAF  
Director, NATO Standardization

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**CHAPTER 1 - INTRODUCTION****1.1 GENERAL**

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150 1. The nature of special operations missions often requires small, highly  
151 skilled, self-contained operational elements capable of operating on short  
152 notice. They must function in remote and hostile locations, in all geographic  
153 environments, for prolonged time periods, and following insertion by land, air, or  
154 water. The requirements to provide medical support in this context differ  
155 significantly from those required to support conventional operations.

156

157 2. Effective Medical Support for NATO SOF operations is fundamental to  
158 mission success. SOF Medical Support is characterized by an austere structure  
159 and a limited number of personnel with enhanced medical skills. *SOF Medical*  
160 *Support includes, but is not limited to the prevention of disease, rapid treatment*  
161 *of the infirm, wounded or injured, medical evacuation and the eventual recovery*  
162 *and/or return to duty of NATO SOF's best.* The provision of appropriate and  
163 visible medical support demonstrates military resolve.

164

165 3. Military Committee Medical Standardization Board tasked NATO  
166 COMEDS SOF Medicine Panel with development of this standard with NATO  
167 Special Operations Headquarters (NSHQ) as the custodian in accordance to  
168 STANAG 6451.

**1.2 PURPOSE**

170

171 This publication aims to provide fundamental principles and commonly agreed  
172 standards to improve interoperability of *medical support of special operations*  
173 *forces (SOF) missions.* It explains principles, guidelines and responsibilities of  
174 joint medical support to SOF.

**1.3 SCOPE**

176

177 This document is intended for medical and non-medical personnel who provide  
178 or plan for medical support to SOF missions. The Publication focuses on  
179 medical planning and medical support requirements unique to the nature of  
180 special operations missions.

**1.4 STRUCTURE**

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183 AMedP-4.13 is structured with a main body and a series of annexes to provide  
184 greater coherence.

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**220 CHAPTER 2 - FOUNDATIONS OF SOF MEDICAL SUPPORT****221 2.1 NATO PRINCIPLES OF MEDICAL SUPPORT**

222

223 1. The underlying principles of military medical support are consistent  
224 regardless of the operating environment or the supported capability. The  
225 fundamental principles of timely medical treatment applied with continuity  
226 throughout the treatment and evacuation chain, creating a compatible medical  
227 support system that is able to contribute to a multinational medical support  
228 solution, should underpin any analysis of military medical support.

229

230 2. MC 0326, NATO Principles and Policies of Medical Support, outlines the  
231 NATO principles of operational medical support and presents the NATO medical  
232 polices that are derived from them. Military medical support is able to support  
233 the full spectrum of conflict from crisis prevention in peacetime military  
234 engagement to peace support operations and combat operations.

235

236 3. Health care standards are accountable to the ethical and legal  
237 requirements of a clinical profession. The aim of military medical care in  
238 operations is to achieve outcomes of treatment equating to best medical  
239 practice. The application of this principle must be guided by the principles  
240 embodied in the concepts of Clinical Governance and Evidence Based  
241 Medicine.

**242 2.2 SPECIAL OPERATIONS ENVIRONMENT**

243

244 1. Special operations differ from conventional operations because they are  
245 frequently executed on short notice, clandestinely, and for strategic purposes  
246 where risk is assumed because of mission importance. Special Operations units  
247 require flexibility, precision, speed and agility to be successful. Likewise,  
248 medical support must meet these same requirements. Medical care must move  
249 at the speed of the unit. It must be able to sustain casualties for extended  
250 periods because Special Operations Forces (SOF) frequently operate in areas  
251 outside the NATO doctrinal medical (planning) timelines.

252

253 2. A common misconception about SOF operations is that SOF units are  
254 essentially self-sufficient for most, if not all, support enablers. On the contrary,  
255 SOF frequently requires conventional force support. Whenever possible SOF  
256 will seek to link into available conventional medical support for operations. This  
257 potentially increases the risk to SOF by jeopardizing operational security. To  
258 mitigate this vulnerability, SOF elements must rely heavily on available surgical  
259 and transport resources. Ideally, SOF will have internal surgical and casualty  
260 evacuation capability. Accordingly, SOF operators have to be trained in  
261 advanced skills for emergency treatment of casualties according to  
262 standardized protocols. SOF medics will require additional medical education

263 and training to independently perform techniques and protocols typically  
264 reserved for medical professionals. This will often require specific waivers or  
265 endorsements by national authorities. Medical professionals assigned to SOF  
266 forces have to be selected, trained and equipped appropriately to operate within  
267 the challenging SOF environment and may need special expeditionary medical  
268 skills.

269  
270 3. SOF medical support must maintain high states of readiness in order to  
271 be rapidly deployable with the supported SOF units. The medical support must  
272 be trained and capable to operate independently in remote and hostile  
273 environments and to adapt efficiently to a variety of adversary and  
274 environmental threats and changing situations. The medical support should be  
275 able to use a wide variety of assets for insertion by land, air, or water into  
276 operational areas, maintain a low profile, and possess the mobility to support  
277 highly-mobile small-unit operations.

## 278 **2.3 SPECIAL OPERATIONS MISSIONS**

279 Special operations missions are divided into three principle tasks:<sup>1</sup> Direct Action  
280 (DA), Special Reconnaissance (SR) and Military Assistance (MA). Each mission  
281 set has specific environmental considerations that must be accounted for when  
282 planning and executing medical support to SOF operations.

### 283 **2.3.1 Direct Action**

284 1. DA missions are characterized by speed and violence of force hinging on  
285 surprise as a key combat enabler. The nature of injuries associated with DA  
286 missions tend to be high velocity penetrating trauma or orthopaedic in nature.  
287 The use of breaching explosives and other means of entry to denied areas  
288 increase the risk of injury for SOF operators. Thus, medical support must be  
289 focused toward tactical combat casualty care principles. History has proven that  
290 frequently in combat scenarios, the SOF medic is either injured or not  
291 immediately available to treat casualties because of the tactical situation.  
292 Therefore, *SOF medical support for DA missions hinges on the trained medical*  
293 *skills of the operator as much as it does the SOF medic.* Commanders must  
294 practice casualty response as an integrated battle drill for all operators to  
295 successfully support DA missions. Because penetrating trauma is a common  
296 injury in DA missions, Damage Control Resuscitation (DCR) and Damage  
297 Control Surgery (DCS) must be available as soon as possible. However, DA  
298 missions frequently occur in locations which may not be easily accessible to  
299 conventional surgical support. For this reason, highly mobile surgical  
300 capabilities that can insert near or on an objective to provide lifesaving  
301 resuscitation and surgery are necessary.

---

<sup>1</sup> MC 437 *Special Operations Policy*

302

303 2. Timelines given in AJP 4.10C are doctrinal planning guidelines and  
304 recommend delivery of Tactical Combat Casualty Care (TCCC) in less than 10  
305 minutes, DCR in less than one hour, and DCS in less than two hours. Medical  
306 research shows clear benefits for DCR and DCS as soon as possible after injury,  
307 with potentially survivable deaths from major trauma beginning within minutes  
308 from time of injury. In order to optimize survivability, **SOF should aim for a 0-  
309 30-60 timeline wherever tactically feasible,**<sup>2</sup> with TCCC delivery immediately  
310 or as soon as possible, DCR as soon as possible and no more than 30 minutes  
311 after injury, and DCS as soon as possible and no more than 60 minutes after  
312 injury. Likewise, advanced evacuation platforms capable of providing en-route  
313 medical care, particularly damage control resuscitation should be utilized in  
314 direct support of the mission. Both early surgical intervention and high level  
315 evacuation care are desirable elements of SOF medical support for these high-  
316 risk missions.

### 317 **2.3.2 Special Reconnaissance**

318

319 1. SR missions are typically longer duration missions characterized by  
320 clandestine insertion into an area or observation point, conduct of missions  
321 without detection and extraction from the area of operations. Medically  
322 supporting these missions is limited by what the medical provider can carry and  
323 the limited ability to communicate with higher medical support. Because these  
324 missions frequently require prolonged exposure in harsh uncomfortable  
325 conditions, particularly maritime special reconnaissance, early treatment  
326 intervention for disease and non-battle injuries (DNBI) becomes mission critical.  
327

328

329 2. To sufficiently support these missions, medical personnel must be able  
330 to make independent medical decisions consistent with their level of training and  
331 national policies, and be physically capable of keeping pace with the special  
332 reconnaissance element. To be successful, SOF units require special medical  
333 protocols for their providers and operators that may extend above the usual  
medical authorities and skills of their conventional counterparts. Leveraging

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<sup>2</sup> The recommended timelines of immediate TCCC, followed by DCR within 30 minutes and DCS within 60 minutes are based on research by Kotwal et al. (A descriptive study of US Special Operations Command fatalities, 2001 to 2018. *J Trauma Acute Care Surg.* 2019;87: 645–657.), Shackelford et al. (Association of Prehospital Blood Product Transfusion During Medical Evacuation of Combat Casualties in Afghanistan With Acute and 30-Day Survival. *JAMA.* 2017;318(16):1581-1591.), Kotwal et al. (The Effect of a Golden Hour Policy on the Morbidity and Mortality of Combat Casualties. *JAMA Surg.* 2016;151(1):15-24.), Remick et al. (Defining the optimal time to the operating room may salvage early trauma deaths. *J Trauma Acute Care Surg.* 2014;76: 1251-1258.), Eastridge et al. (Death on the battlefield (2001-2011): Implications for the future of combat casualty care. *J Trauma Acute Care Surg.* 2012;73: S431-S437. Tactical or medical reasons for deviating from the timeline should be part of every CONOP.

334 distance and telemedicine capabilities can be useful in supporting these  
335 missions.

### 336 **2.3.3 Military Assistance**

337 Medical support of SOF MA missions typically fall into two potential categories;  
338 medical engagement and medical partnering. In medical engagement, a SOF  
339 Commander leverages medical capability to engage an area or population for  
340 both operational and medical objectives. In medical partnering, a SOF  
341 commander uses his medical assets to train a partner force in medical skills to  
342 improve interoperability and medical capability to support operations. Both  
343 categories of military assistance medical support present unique challenges.

## 344 **2.4 TREATMENT CAPABILITIES AND ORGANIZATION IN SUPPORT OF** 345 **SPECIAL OPERATIONS**

346

347 1. In order to be able to provide immediate medical care when conducting  
348 discreet or clandestine operations in remote locations, advanced treatment  
349 capabilities need to be integrated at the lowest level of SOF operational  
350 elements.

351 2. A Special Operations Task Unit (SOTU) must have at least one NATO  
352 Special Operations Combat Medic (NSOCM) or Special Operations Medical  
353 Technician (NSOMT).<sup>3</sup> The availability of NSOCMs/NSOMTs may be a key  
354 factor in a SOTU's operational status. Depending on the type of mission, some  
355 SOF units may require two NSOCMs/NSOMTs within a single SOTU. The  
356 availability of more than one NSOCM/NSOMT within a SOTU may be a deciding  
357 factor in determining whether a SOTU is capable of split-team operations.

358 3. A Special Operations Task Group (SOTG) or Special Operations  
359 Component Command (SOCC) may have a Special Operations Surgical Team  
360 (SOST)<sup>4</sup> and/or a Special Operations Critical Care Evacuation Team (SOCCET)  
361 to mitigate medical risk, especially when operating outside recommended  
362 timelines.

363 4. For levels of care beyond the capabilities found within the initial surgical  
364 capability, conventional medical treatment capabilities, or host nation (HN) or  
365 national civilian health care systems should be considered.

---

<sup>3</sup> If national regulations do not allow the training of NSOCM/NSOMT, a NATO Special Operations Medical Provider (NSOMP) should be deployed with the SOTU.

<sup>4</sup> SOST and also a SOCCET are specially selected, trained and equipped to work in the SOF environment together with SOF units. Whereas medical capabilities may be similar to the capabilities of the Role 2F or the CCAST/CCATT, the capability to operate, move and communicate with the supported SOF unit is not present in all Role 2F/CCAST/CCATT. All SOSTs are Role 2Fs, but not all Role 2F are SOSTs.

366 5. Medical and surgical treatment capabilities (other than NSOCMs /NSOMTs)  
367 in support of Special Operations can either be organic, attached, or in support to a  
368 SOTG. When attached or in support, they can either be dedicated to SOF or be  
369 a dual-use capability, trained to support Special Operations in addition to  
370 conventional operations.

## 371 **2.5 CASUALTY MOVEMENT<sup>5</sup> CAPABILITIES AND ORGANIZATION IN** 372 **SUPPORT OF SPECIAL OPERATIONS**

373

374 1. The seriously injured or ill casualty must be evacuated as soon as  
375 possible to the most appropriate facility which may not necessarily be the  
376 nearest.

377

378 2. Casualty movement may occur under different tactical circumstances:

379

380 a. As a separate evacuation mission while the main force continues  
381 tactical operations.

382

383 b. Along with the main force following mission abort due to the  
384 requirement to evacuate one or more casualties.

385

386 c. Along with the main force as it exfiltrates from the objective after  
387 completion of the action at the objective.

388

389 3. Casualties can be moved from the battlefield to a higher level of care by  
390 any ground, air, or maritime platform able to transport personnel. SOF typically  
391 does not have an organic, dedicated medical evacuation (MEDEVAC)  
392 capability. Often the use of SOF tactical platforms will be required to conduct  
393 evacuation to medical treatment facilities within acceptable timelines. SOF  
394 ground, air, and maritime waterborne and amphibious tactical platforms should  
395 routinely carry medical kits and evacuation equipment without having to rely on  
396 medical kits carried by SOF providers.

397

398 4. Specific to SOF operations, the most important considerations are the  
399 ability to move casualties from a hostile and austere tactical environment to a  
400 more secure location capable of providing advanced medical care, and the  
401 availability of appropriate en-route care. This will often require the use of armed  
402 and protected tactical platforms.

403

404 5. When conducting casualty movement, additional medical personnel  
405 should arrive with the evacuation asset, if available. Even though medical

---

<sup>5</sup> The term "casualty movement" is used here in order to prevent confusion with the defined terms "casualty evacuation (CASEVAC)" and "medical evacuation (MEDEVAC)" and refers to movement of a casualty regardless of the movement being classified as CASEVAC or MEDEVAC.

406 personnel are often part of the SOF operation, certain situations may limit their  
407 ability to assist with evacuation:

408

409 a. The medical personnel may be among the casualties.

410

411 b. The medical personnel may need to continue on the unit's mission  
412 and be unavailable to escort the casualty.

413

414 c. The medical personnel may have been temporarily separated, and  
415 may not have been at the point of injury.

416

417 6. The continuum of care must be maintained throughout evacuation.  
418 Casualties taken initially to a forward surgical facility with only a limited holding  
419 capability (such as a SOST) will usually necessitate subsequent evacuation to  
420 a more capable facility before evacuation to definitive care. This transfer may  
421 be necessary within a few hours of surgery, depending on the condition of the  
422 patient and other circumstances, particularly intensive care capability and  
423 capacity as well as the security environment. If no separate critical care  
424 transportation personnel are available, a SOST may have to provide en-route  
425 critical care for patients being moved to a higher echelon surgical facility,  
426 following damage control surgery at a forward location.

427

428 7. Evacuation of casualties will be coordinated with the medical cell inside  
429 the SOCC Joint Operations Centre (JOC) and inside the operational-level  
430 headquarters Combined JOC.

431

432 8. SOTUs should have integral tactical rescue capabilities.<sup>6</sup> While not a  
433 purely medical capability, tactical rescue is an essential individual and team skill  
434 required to extract casualties.

## 435 **2.6 SOF LEADERS CASUALTY RESPONSE CAPABILITIES**

436

437 1. The occurrence of a casualty during Special Operations is not an isolated  
438 medical issue, but a tactical-medical problem in which there may be a direct  
439 conflict between what is best for the casualty and what is best for the mission.  
440 SOF leaders at all levels should be educated on the operational consequences  
441 of casualties and how to manage such events. Realistic leader-directed casualty  
442 battle drills should be embedded into SOF unit tactics and tactical training  
443 exercises.

444

445 2. In addition to the acute treatment priorities of a deployed task force, and  
446 depending on the operational situation and the overall Medical Support System

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<sup>6</sup> Tactical rescue capabilities refer to the ability to employ special rescue skills, techniques and equipment not usually available in standard medical or tactical teams and under combat conditions. It includes, but is not limited to extrication from vehicles, confined spaces, collapsed or damaged structures, heights, or difficult terrains.

447 in the Joint Area of Operations, a SOF medical support system may need to  
448 include a range of medical specialties such as nurses, dentists, veterinarians,  
449 psychiatrists, psychologists, physical therapists and Chemical Biological Radio  
450 Nuclear (CBRN) specialists etc.

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481 **CHAPTER 3 - SOF MEDICAL SYSTEM ORGANIZATION**482 **3.1 OVERVIEW**

483

484 1. SOF Medical support is characterized by the requirement to integrate  
485 tactical, security and medical aspects. A functioning SOF medical system is  
486 paramount to ensure mission success as well as health and wellbeing of SOF  
487 personnel. Core capabilities of every SOF medical system should include the  
488 eight pillars.<sup>7</sup>

489

- 490 • Leadership
- 491 • Personnel
- 492 • Planning
- 493 • Training
- 494 • Treatment
- 495 • Evacuation
- 496 • Communication
- 497 • Logistics

498

499 2. In addition, SOF specific Human Performance Programs (HPP) play an  
500 essential role in physical and mental preparation of SOF personnel who are  
501 healthy, injured or being rehabilitated.

502 **3.2 LEADERSHIP**

503

504 1. Effective medical Command and Control (C2) is critical in the overall  
505 success of SOF medical support. It must be integrated in all operational and  
506 tactical planning. As such, it is compulsory that SOF commands have a medical  
507 advisor and joint medical staff that are incorporated into headquarters at the  
508 tactical, operational and strategic levels.

509

510 2. A SOF medical leader must have a comprehensive understanding of  
511 military and medical aspects within the SOF environment.<sup>8</sup>

512

513 3. SOF medical leaders should strategically engage with medical and non-  
514 medical leaders. This includes but is not limited to civilian and military entities.

---

<sup>7</sup> Not all capabilities must be organic or permanently embedded within the SOF unit. However, if external capabilities are a conceptual part of a SOF medical system, they need to be tailored to the specific needs of the SOF unit supported and require close coordination with the SOF medical staff.

<sup>8</sup> Medical leadership on different levels can be by any medically trained person, whoever is responsible.

515 **3.3 PERSONNEL**

516

517 1. In order to provide immediate medical care when conducting SOF  
518 operations, advanced treatment capabilities must be integrated into the lowest  
519 level of SOF tactical elements. These efforts must be coordinated and  
520 supported by dedicated SOF medical leadership at all levels.

521 2. To ensure interoperability and comparable standards of care throughout  
522 NATO, roles and responsibilities in the SOF medical system must be clearly  
523 defined.

524 3. Special Operations First Responders<sup>9</sup> representing a DCR capability  
525 must have a minimum qualification as NSOCM or NSOMT.

526 **3.3.1 NATO Special Operations Combat Medics**

527

528 1. The NATO Special Operations Combat Medic (NSOCM) is a Service  
529 Member who provides TCCC and advanced tactical medical support directly to  
530 SOF. NSOCMs will be SOF operators with specific, standardized medical  
531 education and training as per NSHQ Directive 75-001.

532 2. In case a medic<sup>10</sup> is not a SOF operator (e.g. medical or support  
533 personnel), they must be appropriately trained. Civilian or conventional medical  
534 training on its own is not sufficient to support SOF operations. Such personnel  
535 must complete a NSHQ recognized NSOCM course and be trained and  
536 equipped appropriately to operate within the challenging SOF environment. A  
537 standardized selection and training program is mandatory. NSOCMs must be  
538 an organic asset of SOF units or have a dedicated supporting relationship to a  
539 SOF unit.

540 3. NSOCMs receive additional medical education and training to  
541 independently perform combat casualty care techniques and protocols typically  
542 reserved for medical professionals.

543 4. NSOCM qualification requires the graduation from an NSHQ recognized  
544 NSOCM training program or equivalent<sup>11</sup> and regular sustainment training,  
545 including recertification every two years. Training and sustainment requirements  
546 are defined within NSHQ Directive 75-001 Medical Standards and Training  
547 Directive.

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<sup>9</sup> AJP 4.10C

<sup>10</sup> The term "medic" is used in this context for a service member tasked with providing the first medical response capability beyond self and buddy aid, but who doesn't fall in the other categories.

<sup>11</sup> The training program can be conducted by a national or international training facility or within a SOF unit. Specifics of the process to recognize a program are defined in the NSHQ MedOps NSOCM NSOMT Course Certification SOP (NSHQ SOP Med-001).

**548 3.3.2 NATO Special Operations Medical Technician**

549

550 1. The NATO Special Operations Medical Technician (NSOMT) is medical  
551 personnel that have undergone a standardized selection and training program.  
552 Standards for selection, tactical training and equipment for personnel dedicated  
553 to directly support SOF missions are defined by the supported SOF units.  
554 NSOMTs must be an organic asset of SOF units or have a dedicated supporting  
555 relationship to a SOF unit. Some nations will also rely on SOF operators with  
556 specific, standardized medical education and training as per NSHQ Directive  
557 75-001 to the level of a NSOMT. The NSOMT closes the gap between NSOCM  
558 and credentialed medical providers by incorporating advanced medical  
559 techniques, as well as tactical capabilities.

560 2. The NSOMT must have a national civilian healthcare qualification as a  
561 paramedic, nurse or equivalent. This qualification can be acquired before or  
562 during the NSOMT training program.

563 3. NSOMT qualification requires the graduation from an NSHQ recognized  
564 NSOMT training program or equivalent<sup>12</sup> and regular sustainment training,  
565 including recertification every two years. Training and sustainment requirements  
566 are defined within NSHQ Directive 75-001 Medical Standards and Training  
567 Directive.

**568 3.3.3 NATO SPECIAL OPERATIONS MEDICAL PROVIDERS**

569

570 1. Special Operations Medical Providers are health care professionals who  
571 have undergone a national military selection and training program to function in  
572 the SOF environment as part of a SOF unit. They have the ability and authority  
573 to treat patients independent of the presence of a supervisor, including  
574 prescribing authority. Depending on their specific national tasks, they should  
575 have experience in emergency medicine and related specialties as well as SOF  
576 Medicine. These providers support Special Operation Units with the oversight  
577 and authority to develop, plan, mentor and train medical skills to organic support  
578 personnel, SOF operators, NSOCMs and NSOMTs.

579 2. NATO SOF medical providers must be an organic asset of SOF units or  
580 have a dedicated supporting relationship to a SOF unit. They must be  
581 operationally qualified to directly support SOF operations.

582 3. Training requirements are defined within NSHQ Directive 75-001 Medical  
583 Standards and Training Directive.

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<sup>12</sup> The training program can be conducted by a national or international training facility or within a SOF unit. Specifics of the process to recognize a program are defined in the NSHQ MedOps NSOCM NSOMT Course Certification SOP (NSHQ SOP Med-001).

**584 3.3.4 SOF Medical Advisor**

585

586 1. The SOF Medical Advisor (MEDAD) in a formation headquarters is part  
587 of the command group and responsible for ensuring that the commander and  
588 his staff are properly aware of the health and medical implications of their  
589 actions and any force health protection issues connected to the operation. This  
590 includes raising awareness of SOF medical capabilities and shortfalls. Direct  
591 access of the MEDAD to the commander is essential to ensure that all health  
592 and medical support related matters requiring the commander's attention,  
593 decision and action, can be addressed in time and based on professional  
594 expertise. Key responsibility are to oversee medical training, medical  
595 planning/execution/evaluation/LI&LL of operations and ensure medical  
596 readiness of the unit.

597 2. The MEDAD should be supported by the JMED branch.

598 3. A MEDAD should be appointed to all SOF Headquarters (e.g. battalion,  
599 group, regiment, SOCC, SOTG) and provide oversight and guidance in all  
600 medical matters.

601 4. The MEDAD should have a medical degree (e.g. physician, dentist,  
602 physicians assistant, nurse, public health expert, veterinarian, or pharmacist)  
603 and have completed a specific training pathway for medical advisors. In addition  
604 he or she must have experience working in the SOF environment and have a  
605 comprehensive understanding of military, SOF specific and medical aspects  
606 within the SOF environment. The JMED should include at least one individual  
607 with a clinical background.

**608 3.3.5 SOF Medical Planner**

609

610 1. The SOF medical planner must have a comprehensive understanding of  
611 military, SOF specific and medical aspects within the SOF environment. The  
612 SOF medical planner has to be proficient in staff planning processes,  
613 procedures and medical planning in particular. The SOF medical planner  
614 coordinates medical plans with higher levels of command and subordinate units.

615 2. SOF medical planners do not require medical-technical skills or a medical  
616 degree. They report to the MEDAD for all medical matters.

**617 3.4 PLANNING**

618

619 1. NATO has adopted a comprehensive approach to operational thinking.  
620 This reflects a culture of collaboration and integration. Special Operations needs  
621 to be integrated within all levels of staff planning within the joint task force.  
622 Operational and Strategic objectives are the SOF commander's end state. SOF  
623 medical planning must be integrated at every command level. An effective plan

624 reflects an understanding of the expected operating environment, task, force  
625 disposition and commander's end state.

626 2. Timely and thorough medical planning, including contingency and  
627 emergency planning, is essential for effective medical support and mission  
628 success.

629 3. SOF medical planning must be coordinated with overall medical plan for  
630 the AoR to ensure a proper continuum of care.

### 631 **3.5 TRAINING**

632

633 1. Medical training for SOF units must be mission oriented and focus on  
634 medical skills acquisition and sustainment, as well as casualty response  
635 training. It should include casualty scenarios that require collaboration and  
636 coordination between conventional medical support elements, SOF medical  
637 assets and SOF commanders.

638 2. All SOF operators and all non-operators deploying with or in support of  
639 SOF units, including staff personnel as well as base support personnel must be  
640 medically trained according to NSHQ Directive 75-001.

641 3. Medical scenarios must be incorporated in all tactical training to ensure  
642 adequate casualty response on all levels.

643 4. Mission specific medical support assets (e.g. MEDEVAC, SOST, or  
644 SOCCET) must be incorporated in unit training in order to perform integrated  
645 medical training scenarios. Military medical personnel require complementary  
646 skill sets that ensure they have the military and clinical proficiency required of  
647 them.

### 648 **3.6 TREATMENT**

649 Treatment is based on the general principles for medical support, outlined in  
650 MC-326 and AJP-4.10. SOF are often required to operate outside the area of  
651 medical coverage not being able to meet clinical timelines. To mitigate the  
652 resulting risks medical care provided is capability based, not facility based. This  
653 is often outside conventional planning guidelines and national regulations and  
654 thus requires specific waivers or endorsements by national authorities.

#### 655 **3.6.1 Lifesaving first response measures**

656 Every individual deploying with SOF must be capable of providing lifesaving first  
657 response measures based on TCCC principles. This includes at a minimum  
658 bleeding and airway control immediately or as soon as possible. Treatment  
659 protocols must be aligned with the unit's casualty response SOPs and take  
660 tactical as well as medical aspects into consideration.

### 661 **3.6.2 Damage Control Resuscitation (DCR)**

662 DCR is a systematic approach to dealing with major trauma combining the  
663 catastrophic bleeding, airway, breathing and circulation paradigm with a series  
664 of clinical techniques. This includes immediate lifesaving measures, invasive  
665 interventions and emergency blood transfusions, in order to minimize blood  
666 loss, maximize tissue oxygenation and optimize outcome. DCR is generally  
667 provided by emergency medical personnel and includes advanced skills and  
668 techniques that are usually reserved to military medical personnel. In SOF  
669 operations, DCR can be provided by NSOCMs, especially when it is tactically  
670 not feasible to deploy more advanced medical capabilities<sup>13</sup>. The goal for  
671 combat casualties who require it is to provide DCR as soon as possible and not  
672 more than 30 minutes after injury.

### 673 **3.6.3 Damage Control Surgery (DCS)**

674 DCS is a surgical approach where the completeness of immediate surgical  
675 repair might be sacrificed to achieve haemorrhage and contamination control  
676 and to restore circulation and perfusion, in order to avoid a deterioration of the  
677 patient's condition. It consists of emergency surgical procedures and treatment  
678 to stabilize casualties, in order to save life, limb or function. In SOF operations,  
679 DCS is usually provided by Special Operations Surgical Teams (SOST) that  
680 consist of specially selected, trained and equipped personnel that are able to  
681 work in austere and / or hostile operational environments. Depending on mission  
682 characteristics, it may be necessary to rely on conventional DCS assets or move  
683 a casualty directly to a Role 2/3. The goal for combat casualties who require it  
684 is to provide DCS as soon as possible and not more than 60 minutes after injury.

## 685 **3.7 EVACUATION**

686

687 1. Medical Evacuation (MEDEVAC) is the process of moving any person  
688 who is wounded, injured or ill under continuous medical supervision and care to  
689 or between medical treatment facilities as an integral part of the treatment  
690 continuum.<sup>14</sup> Additionally, it is conducted during military operations by  
691 designated assets able to provide in-transit care in accordance with prevailing  
692 medical standards at the same or a higher level as provided by the originating  
693 unit.<sup>15</sup> Casualty Evacuation (CASEVAC) means unplanned or occasional  
694 movements of casualties not employing dedicated or designated medical  
695 capabilities. The differentiation between MEDEVAC and CASEVAC needs to be  
696 consistent throughout NATO nations. SOF will often use means of casualty  
697 movement providing the same level of care as MEDEVAC using platforms that

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<sup>13</sup> Depending on national regulations it might be required to reserve certain procedures to NSOMTs or SOMP.

<sup>14</sup> Medical Evacuation and "Medically supervised" refers to tasking authority by a PECC and general oversight by the medical service, AJP 4-10.

<sup>15</sup> AJP 4-10.

698 may not fulfil MEDEVAC definitions. For SOF medical support, all medically  
699 escorted transportation of casualties on a designated platform will be  
700 considered "CASEVAC with qualified medical escort," as long as it provides the  
701 same or higher level care from the originating unit.

702 2. Appropriate and timely evacuation of casualties is essential for SOF  
703 medical support, whether via dedicated medical platforms or via designated  
704 tactical platforms. The principles lined out in AJP-4.10 and AJMedP-2 also apply  
705 for SOF operations. Especially for initial casualty movement, SOF will often rely  
706 on non-standard and/or non-designated assets to move casualties while still  
707 adhering to the principle of continuum of care. This can be achieved by en-route  
708 care provided by NSOCMs, NSOMTs, NSOMPs, Special Operations Critical  
709 Care Evacuation Teams (SOC CET) or a SOST with en-route surgical capability.

710 3. MEDEVAC or CASEVAC with qualified medical escort for SOF missions  
711 must be coordinated with the responsible Personnel Evacuation Coordination  
712 Centre (PECC) in the AoR, to ensure seamless transition of casualties from the  
713 SOF medical system to the conventional medical system. This will often require  
714 the weighing of Operations Security (OPSEC) versus medical requirements.

### 715 **3.8 COMMUNICATION**

716

717 1. Medical information management and communication in Special  
718 Operations requires many of the common characteristics of civilian and  
719 conventional force medical information systems. In fact, those shared  
720 characteristics are crucial to ensure interoperability and support of supporting  
721 medical assets.

722 2. The efficient management of medical information is a vital element of  
723 competent medical support planning and developing a comprehensive medical  
724 common operating picture (MEDCOP). This includes, but is not limited to  
725 medical intelligence, patient tracking, medical reporting, quality assurance,  
726 scientific evaluation and lessons learned. Therefore, specific protocols that  
727 consider OPSEC and medical confidentiality need to be developed on national  
728 and NATO level.

729 3. Telemedicine is an important tool to improve healthcare for deployed  
730 SOF. NSOCMs and NSOMTs must have the ability to reach back to an  
731 appropriate credentialed medical provider for support and guidance.  
732 Development of appropriate protocols and SOPs are essential for telemedicine  
733 capabilities.

### 734 **3.9 LOGISTICS**

735

736 1. SOF medical logistics can present significant challenges for medical  
737 support. Because space and weight are limited in SOF units, medical equipment  
738 and treatment supplies will compete with other operational requirements like

739 food, water, and ammunition for space. SOF medical equipment and supplies  
740 will frequently need to be dual purpose and capable of easy disposal, must  
741 withstand the extremes of temperature and field conditions, and be simple to  
742 use in high pressure situations. For this reason, SOF frequently rely on off-the-  
743 shelf technologies specially designed for the SOF environment that are not  
744 common to the conventional medical supply distribution chains of most nations.  
745 The flexibility to procure and the authority to use these items require senior  
746 medical leadership involvement, and are critical to maintaining the edge that  
747 gives SOF units the advantage over conventional forces.

748 2. Availability of blood and blood products is particularly important in the  
749 austere environment with prolonged evacuation timelines. The ability to  
750 administer blood far forward requires specific measures like international  
751 agreements, blood chain resupply, cold chain management, transfusion  
752 protocols and specialized equipment. SOF units may need specific waivers from  
753 national authorities to use products or protocols such as whole blood transfusion  
754 if they are to save lives in this challenging environment.

755 3. Since most nations do not have SOF specific logistic chains of supply,  
756 SOF medical logistics will frequently rely on the conventional medical logistics  
757 system for procurement and resupply of non-SOF specific medical supplies.  
758 SOF medical planners should coordinate with SOF J4 during early stages of the  
759 Crisis Response Planning Process or during the high level planning phase in  
760 order to facilitate the development of the LOG-MED Concept of Support to  
761 sustain SOF activities.

### 762 **3.10 HUMAN PERFORMANCE PROGRAMS**

763  
764 1. Human Performance (HP) programs are designed to improve operational  
765 readiness of the unit as a whole as well as individual operators. This includes  
766 improvement of physical and mental readiness resulting in a reduction of  
767 adverse occupational effects on health and well-being. Injury prevention and  
768 optimal rehabilitation can accelerate return to duty after injury and increase the  
769 operator lifecycle.

770 2. HP optimization is a holistic, multi-professional approach and not an  
771 exclusive medical responsibility.

772 3. SOF HP programs must address the unique characteristics of SOF  
773 culture and operational challenges. Conventional HP efforts rarely address the  
774 specific needs of SOF organizations as SOF operators are specially selected  
775 and trained for certain physical and mental attributes.

776 4. SOF HP staff must have comprehensive understanding of SOF culture  
777 and operational requirements. Different professions (e.g. physical training  
778 instructors, mental performance specialists, psychologists, medical



779 professionals, nutritionists) must closely cooperate and coordinate, but also  
780 respect professional boundaries.  
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## CHAPTER 4 - SOF MEDICAL PLANNING

### 4.1 PRINCIPLES OF MEDICAL SUPPORT TO SPECIAL OPERATIONS

1. Medicine is considered a SOF enabler. Admiral McRaven's Theory should be incorporated as background during the planning and execution phases of SOF medical missions.

- a. Simplicity: Simple, effective treatments; advanced scope of practice.
- b. Surprise: Embedded with force.
- c. Security: OPSEC sensitive, but coordinated with higher echelons.
- d. Purpose: Enhance mission success and save lives.
- e. Repetition: Practiced support (right time, right place, right treatment).
- f. Speed. Moving at the speed of tactical elements.

2. Adaptation of the six principles will allow SOF forces to gain relative superiority in a mission. Fundamental gaps in the principles will add to increase a Commanders vulnerability. For all these, "less" is preferred to "more" in terms of being able to adhere to the principles. For example, highly mobile, smaller footprint embedded teams are preferred over robust, high profile assets.

3. Medical support to SOF must be flexible, precise, agile, and having the velocity of the forces they support. A SOF operational plan is best when it maximizes the six principles of SOF: Surprise, Speed, Security, Purpose, Repetition and Simplicity. A SOF plan is most likely to be successful if it is a simple plan, carefully conceived, repeatedly and realistically rehearsed, and executed with surprise, speed, and purpose. When considering the type and scope of medical support for such operations, medical planners must create plans that meet the most serious threats without diminishing the principles of SOF operations. The medical plan will always be a balance between the desired medical standard and the effect of maximizing the 6 SOF principles.

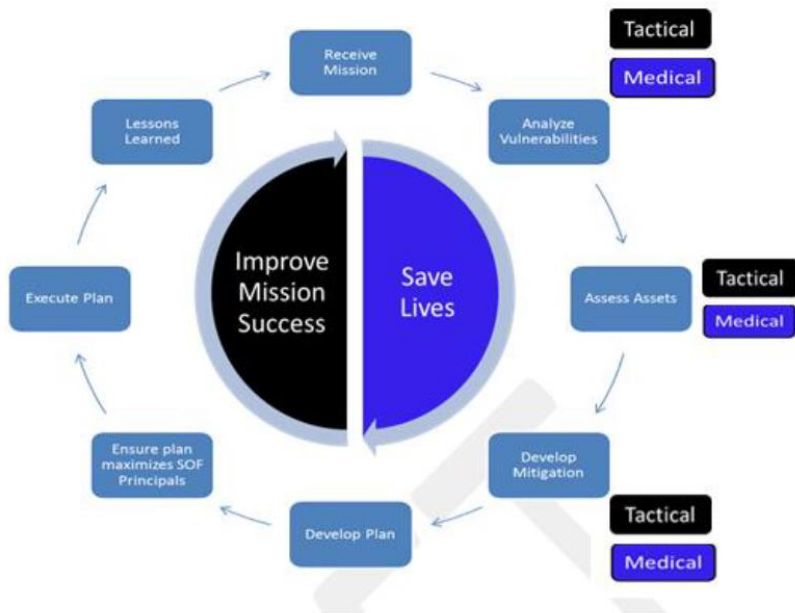
4. To this end medical planning must be integrated at every command level and must not be borrowed from conventional forces. The Medical Advisor is responsible for overseeing all planning and must be represented on all levels. Commanders must receive a comprehensive brief by trained SOF medical advisors and medical personnel on medical risks and mitigation strategies.

849 **4.2 SOF MEDICAL PLANNING CYCLE**

850

851 1. Many of the frictions of war and vulnerabilities associated with SOF  
 852 operations are medical in nature. Careful analysis of the commander’s plan with  
 853 an eye for tactical vulnerabilities and medical vulnerabilities can help identify  
 854 risk areas requiring mitigation. Good medicine can reduce the area of  
 855 vulnerability of assets and increase relative superiority, not only by minimizing  
 856 the impact of a casualty on the mission, but also by ensuring operators that they  
 857 will get the best care possible. Too much medicine or medicine at the wrong  
 858 time can increase the area of vulnerability and decrease relative superiority.

859 2. The key is to systematically analyse the developing plan to identify  
 860 vulnerabilities that can be mitigated through medical channels. Ensure that the  
 861 mitigation does not impede the unit’s ability to maximize SOF principles. Figure  
 862 1 below shows the SOF Medical Planning Cycle. This can aid the medical  
 863 planner to execute a medical plan for current and future SOF mission as well as  
 864 using it for the lessons learned process for previous SOF missions. Integrating  
 865 the SOF principles, the Eight Pillars (see chapter 3) and the Medical Planning  
 866 Cycle will ensure a well-structured medical plan. MC 326, MC 437, AJP-3.5,  
 867 AJP 4.10 and AMedP-1 will also aid medical planners to execute the medical  
 868 plan and present the medical plan during the orders process.



869

870 **Figure 1 – SOF Medical Planning Cycle**

871 **4.3 PLANNING CONSIDERATIONS FOR MEDICAL SUPPORT TO**  
872 **SPECIAL OPERATIONS**

873 **4.3.1** Principal tasks of SOF Forces. **SOF has three principle tasks, Military**  
874 **Assistance (MA), Special reconnaissance (SR), and Direct Action (DA).**  
875 Planning for medical support to SOF must take into account specific varying  
876 factors between them. These include but are not limited to:

877

878 1. Military Assistance. Planning consideration for medical support to MA  
879 may include the considerations for both SR and DA (see below), since these  
880 may be implied tasks in any MA mission. In addition, medical support to the  
881 assisted HN security forces or local guerrilla forces, as well as to their relatives  
882 or even their extended communities can be a direct or an implied task and must  
883 therefore be taken into consideration in the planning phase. This includes  
884 reliable information about local medical treatment capabilities.

885

886 2. Special Reconnaissance. Medical risks associated with SR missions are  
887 mainly related to environmental conditions prevalent in the often austere  
888 operational area, as well as to the physiological effects of prolonged inactivity  
889 during extended surveillance in confined spaces. A special reconnaissance  
890 missions are mostly conducted covert, weight and size limitations as well as  
891 evacuation difficulties contribute highly to the medical risk.

892

893 3. Direct Action. Medical risks associated with DA missions are mainly  
894 related to combat trauma. In addition to medical support to the SOF element  
895 conducting the operation, treatment of wounded non-combatants and adversary  
896 combatants may have to be planned for.

897

898 **4.3.2 Intelligence Preparation of the battlefield**

899

900 1. Intelligence is the product resulting from the processing (collection and  
901 analysis) of information concerning foreign nations, hostile or potentially hostile  
902 forces or elements, or areas of actual or potential operations. The intelligence  
903 (J2) staff is responsible for all intelligence activities.

904

905 2. Medical information incorporates all information on medical or  
906 environmental threats or on health infrastructure which has been gathered  
907 through non-intelligence channels and which has not been analysed for  
908 intelligence content.

909

910 3. Medical intelligence is the product resulting from the directed collection  
911 and assessment (processing) of medical, bio-scientific, epidemiological,  
912 environmental and other information related to human or animal health, to  
913 identify threats and offer opportunities for exploitation by decision-makers.  
914 Medical intelligence is not to be used, to take any advantage of medical

915 vulnerabilities of any party as this would be a serious violation of fundamental  
916 ethical and legal conventions and likely have deleterious effects.

917

918 4. SOF Medical expertise plays a significant role in intelligence preparation  
919 and force protection, in particular for the identification of health threats to  
920 deployed personnel. Proper intelligence preparation of the battlefield is the key  
921 element of medical planning.

### 922 **4.3.3 Operational safety context**

923

924 1. The operational context and safety thereof often dictates the assets  
925 which can be used on the mission.

926 a. Permissive. In the permissive environment the medical plan will  
927 often incorporate conventional assets. In these situations they will fit  
928 more easily in the operation while providing the highest level of care.

929 b. Semi-permissive. In this setting there has to be more negotiation  
930 between the level of care desired and the risk to the operation and core  
931 principles. The use of assets is mostly limited to Enablers and SOF  
932 personnel. Examples are SOSTs, SOF trained medical teams, SOMPS,  
933 NSOMT and NSOCMS.

934 c. Denied environment. Putting non-SOF personal in a denied  
935 environment, including enablers, is often not feasible nor effective. This  
936 may limit the use of even a SOST. Assets are mostly only NSOMT or  
937 NSOCMS with an expanded scope of practice. Evacuation will mostly  
938 include unconventional methods.

939 2. Even though the use of medical assets on the mission might be limited,  
940 there always needs to be a pre-planned connection or link to the conventional  
941 medical system to ensure continuum of care and access to levels of care that  
942 are outside the SOF medical system.

### 943 **4.3.4 Medical Threat Assessment**

944

945 1. SOF frequently operates in remote austere areas and may therefore be  
946 exposed to health risks not normally seen in other areas of the joint operations  
947 area. This factor, coupled with the fact that SOF is held on short response times,  
948 routinely require proactive planning for the provision of robust preventive  
949 medicine measures, such as immunizations against a wide variety of potential  
950 diseases. There is an essential requirement for specific expertise to address  
951 occupational and environmental factors relevant for SOF. This includes but is  
952 not limited to dive medicine, flight / altitude medicine, tropical medicine, medical  
953 implications of working in extreme climates or under CBRN exposure.

954 2. Effects of adversary tactics and associated weapons-munitions systems  
955 used affect planning of medical assets in terms of capabilities required to cope  
956 with likely injuries and in terms of recognizing the need for protected evacuation  
957 assets. In addition, SOF medical plans should anticipate the fact that changes  
958 in adversary tactics may require rapid changes in SOF medical capabilities,  
959 including the fielding of new and/or additional medical equipment and supplies  
960 to the lowest levels.

961 3. Medical Operations to Support Local Populations. When planning to  
962 conduct medical engagements with local populations, SOF planners should  
963 ensure that these medical outreach operations support SOCC and Joint Forces  
964 Command (JFC) overall objectives and do not undermine them through medical  
965 and tactical unintended consequences. In contrast to the term MEDCAPs,  
966 Medical Outreach is a planned medical engagement activity, which in its design  
967 and execution meets the principles described in Para 9 above. Such activities  
968 will be dependent on the needs of the operational situation, and should be  
969 agreed with the appropriate authorities and other civilian agencies, and be  
970 consistent with their policies, noting the principle of civilian primacy.  
971 Engagements may include capacity building, development of infrastructure  
972 projects and logistic support. Direct provision of healthcare would be by  
973 exception; examples might be veterinary projects to improve food production,  
974 but in co-operation with the local authorities and only where such interventions  
975 do not interfere with provision by local professionals, or the development of such  
976 capability and capacity. In all cases the intervention must address the health  
977 need, and be appropriate to the level of care that can be realistically and  
978 competently sustained.<sup>16</sup>

979 4. Casualty Estimates. Special operations missions are unique in a number  
980 of ways. For example, contact with the adversary is often sought, they are  
981 conducted using surprise, and prolonged force-on-force operations are avoided.  
982 As a consequence, producing, reliable, accurate casualty estimates is  
983 challenging. Exceptions to this are specific actions involving relatively large  
984 forces, such as a parachute insertion conducted by a large SOF unit. Here more  
985 accurate casualty estimates, based on specific factors related to the  
986 environment and the type of equipment used (but not related to adversary  
987 action), might be feasible. AJMedP-1 Allied Joint Medical Planning Doctrine  
988 provides an overview on the process of casualty rate estimation. Important here  
989 is that commanders and planners should not be lured into believing they have  
990 to meet higher commanders' expectations to provide casualty estimates. SOF  
991 should always be prepared for the scenario to go badly, and mostly be able to  
992 avoid taking casualty's altogether. It is however important for commanders and  
993 med-planners to let higher commanders understand the cost, time-consuming  
994 creation and scarcity of SOF operators. A SOF operator should be treated as a

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<sup>16</sup> ACO directive 83-2.

- 995 high-value strategic asset and treated accordingly for deployment-criteria and  
996 level of care provided.
- 997 5. Evacuation Timelines. NATO aims to provide appropriate life, limb and  
998 functions saving treatment within specific clinical timelines as described in AJP  
999 4.10. This has become known as the 10-1-2 Timeline. However, this timeline is  
1000 inadequate to save many combat casualties with life-threatening injuries.  
1001 Instead, SOF should aim to achieve the zero – 30 – 60 timeline as outlined in  
1002 section 2.3.1. As there may be situations unique to the SOF environment that  
1003 make it difficult or not feasible to adhere to these timelines, SOF should have a  
1004 comprehensive toolbox of assets and skills to mitigate the risks, aiming for the  
1005 best but robust medical planning to deal with every situation. This mandates that  
1006 every NSOCM, NSOMT and SOMP must be trained in prolonged field care.<sup>17</sup>
- 1007 6. Special Operations Surgical Teams Employment Criteria. The planning  
1008 for the employment of SOSTs will be made in the context of timely accessibility  
1009 of other hospital resources. SOSTs are a scarce resource and therefore should  
1010 be planned with a risk vs benefit approach. Factors which predispose for a  
1011 SOST are operations which carry a high trauma risk, for which the SOST is a  
1012 force multiplier or there is a “no fail” criterion (Examples include Hostage Rescue  
1013 Operations (HRO) for an High Value Target (HVT) or extraction of HVT asset).
- 1014 7. Redundancy of Evacuation Assets. Evacuation plans should routinely  
1015 include the use of alternate evacuation assets. Air evacuation should never be  
1016 the only evacuation option being planned for. There needs to be planning for  
1017 alternate or redundant evacuation options. These methods should be proven  
1018 and effectively in place before failure of the primary evacuation method.
- 1019 8. Medical Logistics. SOF medical logistics personnel should plan for and  
1020 ensure that adequate stock levels of medical supplies are maintained, and that  
1021 resupply of medical items can be conducted when needed. High operations  
1022 tempo may demand a push-pull system of pre-built resupply packages of  
1023 mission critical expendable medical items, such as blood products, bandages,  
1024 etc. Special consideration should be given to the provision of temperature-  
1025 sensitive blood and blood components far forward, to be used by the lowest-  
1026 level SOF tactical elements, i.e. maintain the necessary cold chain but provide  
1027 also proper warming tool for them. For extended operations in a resource-  
1028 constrained environment, SOF may require guidance on potential applications  
1029 of expired pharmaceuticals when no other options are available.
- 1030 9. The need for Operations Security (OPSEC) often requires access  
1031 restrictions on medical planning information to other components or higher-level

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<sup>17</sup> Prolonged field care is a mitigation strategy, not a solution, for situations where planned DCS or higher levels of care in general cannot be accessed in a timely manner and where medical and tactical risk allow for or require longer timelines. If the medical risk assessment concludes that a DCS capability is required for the most likely medical threats, then all efforts should be taken to provide the required level of care.



- 1032 conventional medical planners. The SOF medical planners should provide only  
1033 sufficient information to ensure the required conventional medical support is in  
1034 place, with the least opportunity of mission compromise.
- 1035 a. Regardless of the other criteria that determine the requirement to  
1036 use special operations surgical teams, there may be cases where  
1037 OPSEC requires their employment instead of a readily available  
1038 conventional medical treatment facility.
- 1039 b. Selected missions may have a requirement to safeguard the  
1040 patient's identity in order not to compromise a SOF unit's presence and  
1041 jeopardize its mission. In those cases, alias patient tracking systems may  
1042 have to be used to maintain accountability of injured SOF personnel  
1043 inside the conventional medical system.
- 1044 c. Patient tracking systems are not to breach or supersede OPSEC,  
1045 digital connected systems need to be used with great caution due to the  
1046 inherent weakness.
- 1047 10. Two primary populations to keep in mind when conducting the medical  
1048 pre-deployment and mission analysis in support of special operations.
- 1049 a. Friendly Forces.
- 1050 b. Local support / indigenous Population.<sup>18</sup>
- 1051 11. The needs of the host nation or indigenous population are a paramount  
1052 consideration when looking at the wide spectrum of the SOF medical interaction.
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<sup>18</sup> Facilities, infrastructure, and medical capabilities etc. are important and SOF should collaborate with host nation (HN) or local authorities, non-governmental organizations (NGO)s, agencies, and international organizations. AJP 3.5.

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1066 **CHAPTER 5 - MEDICAL SUPPORT TO SOF OPERATIONS IN MAJOR**  
1067 **COMBAT OPERATIONS**

1068 **5.1 SUPPORTING VERSUS SUPPORTED ROLES**

1069 SOF and conventional forces interdependence is best achieved when  
1070 requirements are determined early, commanders and their medical advisors and  
1071 medical planners, gain expanded understanding of each force's capabilities and  
1072 limitations, and units have the opportunity to develop relationships and  
1073 procedures in advance of executing missions.<sup>19</sup> Contrary to SOF's role in many  
1074 recent NATO Operations, such as a major joint operation, SOF may have a  
1075 supporting role to a conventional force's operation and will have to rely on  
1076 medical support from the conventional medical assets.

1077 **5.2 SOF MEDICAL COMMAND AND CONTROL**

1078 1. Horizontal and vertical communication. As a general rule, every level of  
1079 command will collaborate and coordinate their operational plans and medical  
1080 support plans with the next higher level command. Special Operations  
1081 Component Command combined joint medical branch (SOCC JMed) will  
1082 coordinate and synchronize planning and integrate SOF medical support plans  
1083 into Joint Task Force (JTF) medical support, within operational security  
1084 limitations. JTF must have sufficient understanding of SOF medical capabilities,  
1085 how they are tailored to mission requirements, medical roles and  
1086 responsibilities, and OPSEC considerations (at all levels) in order to support  
1087 with patient evacuation.

1088 a. SOCC JMED directly coordinates horizontally with Component  
1089 Command JMEDs to synchronize and coordinate medical support to  
1090 SOF land, air, or maritime operations.

1091 b. SOCC JMED coordinates with SOTGs – SOCC JMED must be  
1092 aware of the SOTG's medical support plan. SOTG medical support gaps  
1093 are communicated and coordinated with the SOCC JMED.

1094 c. SOCC JMED communicates and synchronizes with the Military  
1095 Treatment Facilities and theatre PECC for (awareness of) medical  
1096 support planning and patient status reporting and tracking within OPSEC  
1097 limitations.

1098 2. The Joint Logistic Support Group (JLSG) medical staff is part of the  
1099 overall medical command and control structure and responsible for the  
1100 coordination of medical support functions and medical assets SOCC JMED is

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<sup>19</sup> Par 4.1, AJP 3.5.

1101 responsible to define logistic interfaces to ensure timely and adequate logistics  
1102 support to the SOCC and subordinate units.

### 1103 **5.2.1 Roles and Responsibilities**

1104

1105 1. Joint Force Command (JFC) JMED – Responsible for the overall Medical  
1106 Support Plan (Annex QQ to the OPLAN), ensures medical command and control  
1107 and information management throughout the Joint Operational Area, and  
1108 assists the SOCC in meeting medical support requirements.

1109 2. SOCC JMED– develops a Medical Support Plan based on the JFC  
1110 Medical Support Plan. Coordinates medical evacuation to support the SOTGs.  
1111 Assists the SOTGs in meeting their medical support requirements.

1112 3. Special Operations Task Group (SOTG) MEDAD / JMED – develops a  
1113 Medical Support Plan based on the SOCC Medical Support Plan, coordinates  
1114 and synchronizes medical support for SOTUs.

1115 4. Special Operations Task Unit (SOTU) medical personnel<sup>20</sup>– develops the  
1116 tactical medical plan for specific missions or tasks in close coordination with the  
1117 SOTG.

1118 5. JLSG – facilitates rapid reinforcement of medical supplies in order to  
1119 ensure the sustainability of medical support under all operational conditions and  
1120 coordinates required medical resources in line with tasks and functions. The  
1121 joint logistic support group commander will receive command and control of  
1122 these medical support capabilities as long as they are assigned to the joint  
1123 logistic support group.

1124 6. SOCC Medical Advisor (MEDAD) – provide timely medical advice to the  
1125 Commander, ensuring that the commander and the commander's staff are  
1126 aware of all medical implications their actions and decisions might have as well  
1127 as of any health-related issues affecting the force or the operation. Direct access  
1128 of the MEDAD to the commander is essential to assure that all health and  
1129 medical support related matters requiring the commander's attention, decision  
1130 or action, can be addressed in time and based on professional expertise. The  
1131 SOCC MEDAD is responsible for deployment health surveillance and force  
1132 health protection.

1133 7. Medical Director –, the Medical Director serves as the Chief JMED. The  
1134 Medical Director maintains situational awareness of common operational  
1135 picture, medical support, and medical evacuation assets. Given the complexity  
1136 of SOF missions in major combat operations and the challenges providing  
1137 medical support, the Medical Director must be integrated into all stages of

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<sup>20</sup> Depending on the specific set up of the SOTU, this is usually the highest medically qualified person, e.g. NSOCM, NSOMT or SOMP, but also a Special Operations Medical Planner.

1138 planning at all times. The medical director reports to the medical advisor for all  
1139 medical issues.

1140 8. Medical Logistics – Medical logistics is a national responsibility but within  
1141 a multinational environment of major combat operations, in order to improve  
1142 logistical efficiency, the SOCC and JTF should assist coordinating medical  
1143 resupply through the JLSG. Close coordination with and guidance to the JLSG  
1144 Medical Branch on the specifics of SOF Medical Logistic requirements is  
1145 essential for timely and adequate logistics support.

1146 9. PECC – The coordination of patient evacuation should ensure the most  
1147 effective use of medical treatment and evacuation resources and that all  
1148 patients receive timely and appropriate care. The patient evacuation  
1149 coordination cell (PECC) monitors the current medical operational picture,  
1150 manages the flow of patients, and provides timely and accurate tracking  
1151 information throughout the entire continuum of care. The location of a PECC is  
1152 dependent on the size and complexity of the mission and area of operations as  
1153 well as national policy. In major combat operations a PECC may be necessary  
1154 at the SOCC level to manage multiple SOTGs and larger numbers of casualties.  
1155 It is imperative that the PECCs and MEDADs at different command levels  
1156 communicate effectively with each other.

## 1157 **5.2.2 SOCC JMed Branch Structure and Organization**

1158  
1159 1. JMED acts as the executing body of the medical organization supporting  
1160 joint operations. The JMED branch requires the following functions to  
1161 accomplish all medical support tasks:

1162 a. Medical Director (MedDir) – Physician or Medical Planner<sup>21</sup>,  
1163 ideally Special Operations Medical Provider or Special Operations  
1164 Medical Planner

1165 b. Medical Planner, Deputy Medical Director – Special Operations  
1166 Medical Planner

1167 c. Medical Operations - Special Operations Medical Planner

1168 d. Force Health Protection including Preventive Medicine –  
1169 Physician, Nurse, Veterinarian or specifically trained public health  
1170 specialists

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<sup>21</sup> Some nations do not have dedicated medical planners, but use medical providers (such as physicians, physician assistants or nurses) in this function. Wherever feasible, both services should be integrated in the JMED branch. For example, if the MEDAD is a physician, the JMED Chief should be a medical planner. This allows for mutual complementation of different skill sets.

1171 e. Patient evacuation coordination – patient tracking and casualty  
 1172 reporting is a J1 function. However, patient evacuation must be  
 1173 coordinated with the JMED. This function can be assumed by a Special  
 1174 Operations Medical Planner with clinical expertise available.

1175 f. Med Log – Med Log or Log NCO

1176 g. HN and civ-mil health liaison – Physician (either Force Health  
 1177 Protection and Preventive Medicine Physician or MedDir)

1178 2. For major combat operations it is not desirable to have individuals  
 1179 assuming multiple functions.

### 1180 **5.3 INTEROPERABILITY / INTEGRATION AND OPERATIONAL** 1181 **SECURITY**

1182  
 1183 1. Medical support for special operations must address the most serious threats  
 1184 without diminishing special operations forces operational principles and  
 1185 requirements. Usually SOF must rely on conventional force support for most if  
 1186 not all support enablers, even if this might increase the risk of compromising  
 1187 OPSEC. SOF will use conventional medical support capabilities where available  
 1188 and needed. Where possible, SOF will integrate medical service personnel  
 1189 specifically trained and selected to support SOF.

1190 2. The modular approach to medical support is a conceptual idea to enhance  
 1191 the efficiency and adaptability of medical support. It is based on pooling and  
 1192 sharing of standardized capability modules. A module typically consists of  
 1193 equipment and personnel necessary to provide a specific capability<sup>22</sup>. These  
 1194 modules can be rearranged, replaced, combined and interchanged according to  
 1195 mission needs. The modular approach could be an effective instrument to  
 1196 optimize operational medical support in special operations, especially when  
 1197 forces are required to operate outside the area of medical coverage, when  
 1198 appropriate medical support is not available, or other situations that impact the  
 1199 ability to meet clinical timelines.

1200 3. Modules can be used to augment, enhance or to complement the standard  
 1201 minimum requirement defined for the respective capability according to mission  
 1202 needs and operational requirements.

1203 4. Modules must be able to cooperatively work in concert with other modules  
 1204 irrespective of their origin and assure compatibility with equipment & supplies,  
 1205 communication and information technology, power and water supply from other  
 1206 providers.

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<sup>22</sup> SOF specific modules that could augment a SOTUs or SOTGs embedded medical capabilities could be an ICU module to add holding capacity of a SOST or a blood bank module to increase availability / utilization of blood far forward.

1207 5. Personnel of modules assigned to a special operations unit must be able to  
1208 effectively integrate, overcome language barriers and cultural differences and  
1209 operate with (unfamiliar) equipment and supplies (from other nations).

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1250 LEXICON		
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1252	AMedP	Allied Medical Publication
1253	AoR	Area of Responsibility
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1255	CASEVAC	Casualty Evacuation
1256	CBRN	Chemical Biological Radio Nuclear
1257		
1258	DA	Direct Action
1259	DCR	Damage Control Resuscitation
1260	DCS	Damage Control Surgery
1261		
1262	HN	Host Nation
1263	HPP	Human Performance Program
1264	HRO	Hostage Rescue Operations
1265	HVT	High Value Target
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1267	JLSG	Joint Logistics Support Group
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1269	MA	Military Assistance
1270	MEDAD	Medical Advisor
1271	MEDEVAC	Medical Evacuation
1272		
1273	NSOCM	NATO Special Operations Combat Medic
1274	NSOMT	Special Operations Medical Technician
1275		
1276	OPSEC	Operations Security
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1278	PECC	Personnel Evacuation Coordination Centre
1279		
1280	SOCC	Special Operations Component Command
1281	SOST	Special Operations Surgical Team
1282	SOTG	Special Operations Task Group
1283	SOTU	Special Operations Task Unit
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1285	TCCC	Tactical Casualty Combat Care
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