APPENDIX N

COMBAT HEALTH SUPPORT OF SPECIAL OPERATIONS FORCES

N-1. Special Operations

a. Special operations (SO) are operations conducted by specially trained, equipped, and organized DOD forces against strategic or tactical targets in pursuit of national military, political, economic, or psychological objectives. These operations may be conducted during periods of peace or hostilities. They may support conventional operations or they may be prosecuted independently when use of conventional forces is either inappropriate or not feasible.

b. Because one of the missions of SO involves training HN military to be self supportive, an exception to the normal funding source is provided under Section 2011 of Title 10, US Code, permitting the use of operation and maintenance funds when SO units are practicing their training skills in a HN. The benefit that the HN derives as a result of this instruction is considered by Congress as a consequential benefit.

c. The medical capabilities and requirements for support of each Service's SO component are discussed in Joint Pub 3-05.3.

N-2. Department of the Army Special Operations Forces

The five component elements of the Army special operations forces (ARSOF) are:

- Special Forces.
- Rangers.
- Psychological operations (PSYOP).
- Special operations aviation (SOA).
- Special operations support.

N-3. The Threat to Special Operations Forces

The threat to SOF varies with the environment, geographic area, mission, and level of hostilities. The specific threat to SOF encompasses the same threat facing conventional forces. Further, from the moment SOF are inserted in small groups into an area by land, sea, or air, they must be able to survive; operate deep in opposing force-held areas without being detected; and work closely with friendly, indigenous personnel.

N-4. Special Operations Forces Missions

a. Special operations forces missions are normally conducted as joint or combined operations across the full range of military operations.

(1) In accordance with Section 167, Title 10, US Code, the following are the principal SOF missions:

- Counterproliferation.
- Special reconnaissance (SR).
- Psychological operations.
- Direct action.
- Foreign internal defense.
- Civil affairs.
- Combatting terrorism.
- Information warfare.
- Unconventional warfare.

(2) Special operations forces collateral activities are—

- Coalition support.
- Counterdrug operations.
- Countermine operations.
- Humanitarian assistance.
- Security assistance.
- Special activities.

b. Special operations forces can provide an extra dimension to the battlefield through their unique and flexible capacity to affect operations in the deep, close, and rear battle areas.

N-5. Command and Control

a. Special operations forces are theater-level assets when deployed into an AO. Operational- and tactical-level commanders request SOF through the unified CINC. The SOF C2 element is established at any headquarters, combined or US, employing SOF. This ensures that unique mission requirements and employment procedures are met.

b. The CINC directs theater SO and the employment of SOF through his subordinate special operations command (SOC). The theater SOC is a joint command that controls ARSOF, USN, and USAF SOF. As strategic assets, SOF elements are deployed to the TO and placed under SOC operational control.

c. Special operations forces units do not have an organic combined arms capability and are not designed for sustained combat operations. Special operations forces require the support or attachment of other combat, CS, and CSS resources (units/elements/personnel). Special operations forces units are entirely dependent upon the resources of the theater to support and sustain their operations.

N-6. Army Special Operations

a. The SF group is a unique combat arms organization capable of planning, conducting, and supporting SO activities in all operational environments and in peace, conflict, and war. Special Forces units are characterized by the quality, motivation, training, and individual skill of their members. These characteristics produce units with superb collective skills, able to adapt well to dynamic, complex situations.

(1) The SF group consists of a group headquarters and headquarters company, a group support company, and three SF battalions. The group can operate as a single unit, but normally the battalions plan and conduct operations from widely separated locations.

(2) The SF company consists of a company headquarters ("B" detachment) and six operational detachments ("A" detachments or ODAs). The ODA (twelve-man team) is the basic SF unit and is specifically designed to conduct SO activities in remote areas. This unit can operate for extended periods with a minimum of external direction and support. The high-grade structure and experience level of the ODA is required to permit it to develop, organize, equip, train, and advise or direct indigenous military and paramilitary organizations of up to battalion size. For other SO activities that do not require its full capabilities, the ODA serves as a manpower pool from which SF commanders organize tailored SF teams to execute specific missions.

b. The Ranger regiment is a unique light infantry unit capable of planning, conducting, and supporting SO activities. The Ranger regiment provides the NCA with the capability to deploy a credible military force quickly to any region of the world. The primary Ranger mission in SO is to conduct direct action operations best accomplished by light infantry forces using special techniques. Ranger direct action operations may support or may be supported by other SO activities, or they may be conducted independently or in conjunction with conventional military operations.

c. The SOA regiment is a unique Army aviation unit that provides dedicated combat aviation support to Army and other SOF. This support is provided in all operational environments and in peace, conflict, and war. Because of current force structure and contingency requirements, the regiment does not operate as a single unit. Instead, it tailors the SOA battalion or company task forces to perform specific missions. The primary mission of SOA assets is to clandestinely penetrate hostile and sensitive airspace to conduct and support SO activities.

d. United States Army Reserve CA units have public welfare teams with various medical specialties. These teams can train, advise, and assist US and indigenous forces in the conduct of medical assistance to command operations and facilitate their integration due to their training.

e. Psychological operations are planned operations to convey selected information and indicators to foreign audiences to influence their emotions, motives, and objective reasoning. These operations ultimately influence the behavior of foreign governments, organizations, groups, and individuals. Army PSYOP units may be employed by the NCA in pursuit of national security objectives or by a theater-level commander in pursuit of operational objectives. These PSYOP may be designed to maintain the support of groups and nations friendly to the US; gain support and cooperation of neutral countries; strengthen or alter alliances; deter a nation from aggression; and induce the surrender of hostile forces.

N-7. Organic Combat Health Support Capability

The organic CHS capability of SOF units is limited. Consequently, SOF are dependent upon the conventional CHS structure for medical support in theater. Special operations forces missions rely on organic assets to perform Echelon I medical care. Echelon II, (division level), Echelon III (corps level), and Echelon IV (echelons above corps [EAC] level) medical care must be provided to the force.

a. Special Forces.

(1) The SF group has the capability to perform enhanced Echelon I medical care. Individual care consists of self-aid and buddy aid, combat lifesaver, and aidman (SF medic [MOS 18D]) care. There are two SF medics assigned to each ODA. The SF medic is extensively trained to act independently, often as the sole source for medical, veterinary, dental, and PVNTMED care for his ODA and the indigenous personnel (and their families) with whom his ODA interfaces. The SF medic is also uniquely qualified to act as a trainer for indigenous and civilian medical personnel. The SF medic and other more specialized medical assets within the SF group can provide limited support in the following areas:

- Preventive medicine.
- Medical intelligence.
- Veterinary and dental medicine.
- Laboratory support for clinical diagnosis.

- Minor surgery.
- Short-term trauma management.
- Training for HN health care workers in medical, veterinary, dental, and PVNTMED skills.

(2) A flight surgeon and physician assistant (PA) are assigned to each SF battalion. At the forward operating base (FOB), the flight surgeon and PA can perform ATM procedures and provide limited resuscitative care. Further, the FOB has a PVNTMED noncommissioned officer (NCO) capable of providing medical threat evaluation and limited direct PVNTMED support.

(3) The Special Forces operating base (SFOB) has a flight surgeon, dental officer, veterinary officer, medical operations officer, CHL officer, and an environmental science officer assigned. At this level, the medical officers perform primarily as staff advisors to the group commander and provide medical staff assistance to the deployed SF battalions. They can also assist in the training of HN medical assets.

(4) The medical platoon of the ARSOF special operations support battalion (SOSB) provides Echelon I medical care to its supported ARSOF units. (The full range of Echelon II through Echelon IV support must be provided to the force.)

- It also provides—
  - Limited ground evacuation of the sick, injured, and wounded.
  - Limited medical intelligence capability.
  - Communications capability.
- The platoon is organized into a headquarters and treatment section, an ambulance section, and a medical logistics section.
- For additional information, refer to FM 8-10-1.

b. Rangers.

- The Ranger regiment has the capability to perform Echelon I and limited Echelon II care. Echelon III care must be provided to the force by conventional CHS resources.
- Rangers have organic CHS assets, but they do not have an aid station (treatment squad) capability.
- A general medical officer and a PA are assigned to each Ranger battalion. The Ranger regiment, battalion, and company headquarters are each assigned one MOS 18D, SF medical sergeant. Platoons are each assigned MOS 91B, medical specialists.

c. Special Operations Aviation.

- Special operations aviation has a flight surgeon and a psychiatrist assigned at group level.

- Special operations aviation is dependent on area CHS from units it is supporting (typically the SFOB).

- Special operations aviation units do not have specifically designated medical aircraft with a primary mission of medical evacuation. Evacuation by nonstandard aircraft is emphasized and augmentation from supporting Echelon II assets is encouraged.

- Like other SO medical assets, SOA medical personnel can provide limited flight medical training for HN aviation personnel.

d. Psychological Operations.

- Psychological operations units have no organic CHS. They are dependent on area CHS from the theater medical command (MEDCOM).

- Psychological operations units also require timely and accurate information on all public health and HN support initiatives to accomplish their mission.

e. Civil Affairs. United States Army Reserve CA battalions have public welfare teams with various skills. Their expertise gives them unique qualifications to provide guidance on the HN health care infrastructure, as well as PVNTMED issues.

N-8. Planning for Combat Health Support of Special Operations Forces

Special operations forces units require CHS similar to other combat, CS, and CSS units. They also need medical intelligence to counter the medical threat. The support should include all of the medical functional areas.

N-9. Patient Evacuation and Medical Regulating

Aeromedical evacuation of SOF is indicated only when it will not compromise the mission. Combat health support planners must ensure there is adequate medical evacuation capability, both intertheater and intratheater. If SOF assets are used, as will probably be the case in intratheater evacuation, medical assets must be on board to provide medical care en route. Combat health support planners must ensure that SOF have their own evacuation policy to allow return of critical SOF MOSs to their units instead of being evacuated out of theater. Early coordination must be made with in-theater USAF assets or supporting SOA assets to ensure timely intertheater evacuation capability. The SOSB has a limited ground evacuation capability within the staging base. Echelons I through III medical care is a service responsibility. Intratheater medical regulating of ARSOF is normally an Army function. The transfer of patients from an Echelon III

Army MTF to an Echelon IV facility is a theater (or joint) function; therefore, intratheater and intertheater medical regulating is usually a function of the TPMRC and GPMRC. Medical regulating is not an ARSOF function since units are neither staffed nor equipped to accomplish this mission. It is essential that surgeons at all levels understand how patients are regulated within and between theaters, and how they can track them through the system.

N-10. Hospitalization

Special operations forces do not have an organic Echelon III capability. They rely on the theater MEDCOM hospitalization system for their patients in the combat zone and EAC; in an underdeveloped theater or AO, SOF may rely on the HN to provide hospitalization. When the sensitivity of a particular mission dictates strict OPSEC, the SOC must coordinate with the MEDCOM to establish facilities capable of handling patients on a classified basis.

N-11. Combat Stress Control

a. Combat fatigue cases should be managed as far forward as possible to preclude unnecessary loss of personnel, hasten RTD, and prevent overburdening the medical evacuation system.

b. Army SOF do not have organic CSC teams; support is required from the theater MEDCOM.

N-12. Preventive Medicine

A major shortfall of SOF CHS is the lack of PVNTMED assets for extensive PVNTMED area support (such as aerial spraying and larviciding). Although SF medics are trained in the basics of PVNTMED, the SF group has limited assets and capabilities to plan, coordinate, and supervise PVNTMED programs to the extent that is required. Other SOF units have even less PVNTMED capabilities. Given the nature of SOF operations which places personnel at serious risk for disease and environmental injury, a full-time PVNTMED commitment may be required, necessitating the use of theater PVNTMED support. Education and thorough indoctrination to the risks, surveillance procedures, and PMM are continually required to safeguard the health and readiness status of the operational force. The PVNTMED NCOs in the SF battalions and the SOSB provide technical assistance to the unit field sanitation teams and advise the commander on the control measures required to protect the force.

N-13. Medical Intelligence

Research specialists are dedicated to researching and compiling medical threat information in all foreign countries and disseminating this information to all deploying SOF elements. The United States Special Operations Command (USSOCOM) medical intelligence section is the interface between SOF and AFMIC. Medical intelligence maintains comprehensive classified and unclassified hard copy and electronic data bases in support of SOF deployments for training and security assistance commitments. It also maintains

extensive liaison with intelligence and medical networks within USSOCOM, AFMIC, Defense Intelligence Agency (DIA), and other agencies. This section compiles new critical elements of information received from teams operating in the field for dissemination in future deployments. After-action reports (AARs) containing medical information have proven to be critical in planning operations. The PVNTMED branch and medical intelligence section work together in recognizing the threat and recommending countermeasures to this threat.

N-14. Veterinary Services

Special Forces groups have limited veterinary services. When veterinary services are required in more than one location or when the SOF are larger than two deployed FOBs, veterinary support must be augmented. Veterinary personnel must perform the majority of the food source inspection mission.

N-15. Medical Laboratory Services

The SF group ODA is the only SOF unit with a limited laboratory capability. The SO medical sergeant (MOS 18D) is trained to provide basic clinical laboratory tests and procedures in support of UW or FID missions. Echelon III laboratory support is required from the theater.

N-16. Combat Health Logistics and Blood Management

The medical sections of all SOF units maintain a Class VIII (medical supply) basic load to support initial operations. The SF group, SOSB, special operations support command (SOSCOM), and battalion medical sections are the only SOF elements with organic medical supply personnel. The SOSCOM provides the medical equipment support in SOF. No SOF unit has an organic medical equipment maintenance capability. These units receive routine CHL through their supporting medical logistics battalion. This support includes Class VIII supplies, oxygen, resuscitative fluids production, optical fabrication, medical equipment maintenance support, and blood management. To fill operational requirements in support of UW or FID, SF medical supply personnel at the SFOB and FOB requisition bulk Class VIII supplies directly from the supporting MEDCOM medical logistics battalion or installation CHL activity. Army SOF may also supplement their CHL effort with foreign national medical supplies, particularly during UW operations, if approved by the Food and Drug Administration (FDA) and theater surgeon.

N-17. Dental Services

The group's medical section includes a dental team (dental officer and dental assistant) who can provide emergency or sustaining dental care. The SF medics have limited dental training and equipment and can provide only emergency dental care.

N-18. Interrelated Missions

As previously stated, SOF units conduct nine basic missions and have a number of collateral capabilities (paragraph N-2 above.). Special operations forces elements conduct UW, FID, counterterrorism, direct action, and SR operations in peace, conflict, and war. Mission priorities vary from theater to theater. These elements are specifically tailored to organize, equip, train, direct, control, and support indigenous forces in FID and UW operations. They also perform SR, direct action, and counterterrorism operations and other missions requiring their collateral capabilities. Although each mission is treated separately, they are all interrelated. Some situations will dictate that a committed SOF element conduct more than one mission at the same time.

N-19. Unconventional Warfare

a. Unconventional warfare is a broad spectrum of military and paramilitary operations, normally of long duration, predominantly conducted by indigenous or surrogate forces who are organized, trained, equipped, supported, and directed in varying degrees by an external source. Unconventional warfare includes guerrilla warfare and other direct offensive, low-visibility, covert, or clandestine operations. Unconventional warfare also includes the indirect activities of subversion, sabotage, intelligence collection, and evasion and escape.

b. The goals of CHS in support of UW are to conserve the guerrilla force's fighting strength and to assist in securing local population support for US and insurgent forces operating within unconventional warfare operations area (UWOA).

c. Medical elements supporting the insurgent forces must be mobile, responsive, and effective in preventing disease and restoring the sick and wounded to duty. There is no safe rear area where the guerrilla takes his casualties for treatment. Wounded and ill personnel become a tactical rather than a logistical problem.

d. In a UW situation, indigenous medical personnel may provide assistance during combat operations by establishing casualty collecting points, thus permitting the remaining members of the insurgent force to continue to fight. Casualties at these collecting points are later evacuated to the guerrilla base or guerrilla medical facility. As the operational area develops, more seriously injured or diseased personnel are evacuated to friendly areas. Clandestine evacuation nets are established if security does not permit using aeromedical evacuation.

e. Medical requirements within the UWOA differ from those posed by conventional forces. Battle casualties are normally fewer and the incidence of disease and malnutrition is often higher.

N-20. Foreign Internal Defense

a. Foreign internal defense is the invited participation by civilian and military agencies of a government in any of the action programs taken by another government to free and protect its society from

subversion, lawlessness, and insurgency. These operations which may be international in makeup and involve more nations than the US are aimed at supporting a friendly government. The purpose of these operations is to protect internal development efforts that focus on the economic and social aspects of the nation's structure. Special operations forces are frequently deployed in regions where FID is a major DOD mission and, by virtue of their unique skills, language capability, and cultural knowledge, SOF medical assets are easily integrated into a HN support role. However, FID is not exclusively a SOF mission. It is a joint and interagency activity in which SOF participate. The primary SOF mission in this interagency activity is to organize, train, advise, and assist HN military and paramilitary forces.

b. Civil-military operations that focus on the relationship between US military forces and the indigenous population are critical for FID operations. Combat health support has proven to be one of the most effective ways to gain support for the HN government. Medical assistance is constructive in nature and is generally welcomed, rather than feared. Medical assistance programs are requested by the HN government. They are aimed at—

- Improving basic standards of living and health.
- Involving the local population.
- Enhancing the prestige of local authorities.

c. Combat health support may include, but is not limited to—

- Providing medical treatment.
- Providing education in basic sanitary procedures, hygiene, and PVNTMED.
- Providing sanitary facilities and waste disposal and controls.
- Improving the quality of drinking water.
- Conducting immunization programs.

N-21. Counterterrorism

a. Counterterrorism operations are offensive measures taken by civilian and military agencies of a government to prevent, deter, and respond to terrorism. The primary mission of SOF in this interagency activity is to apply specialized capabilities to preclude, preempt, and resolve terrorist incidents abroad.

b. Counterterrorism operations are either overt or covert in nature. They are characterized, in contrast to UW, as being of short duration and specifically targeted. During counterterrorism operations, tailoring of units and equipment is required. Medical personnel are needed at all levels of the operation, and medical equipment is selectively chosen for the operation.

c. Combat health support planning involves studying the mission and the AO to determine CHS requirements. Equipment is kept to a minimum to support emergencies and routine illnesses. Special packing of the equipment is considered, especially for raid-type missions, to make essential items immediately accessible. Pre-mission medical training concentrates on EMT, ATM, and treatment of mass casualties.

N-22. Direct Action

a. Special operations forces direct action missions are combat operations conducted or directed primarily by SOF in hostile or denied areas beyond the operational capability of tactical weapon systems and conventional maneuver forces. Direct action operations are normally limited in scope and duration, but they may include long-term stay-behind operations. These operations typically involve the interdiction of critical LOC or other target systems and the abduction, rescue, or recovery of selected personnel or sensitive items of material.

b. Combat health support of SOF direct action operations is generally directed toward providing evacuation and hospitalization. Since the majority of SOF direct action missions are conducted beyond the forward line of own troops (FLOT), aerial medical evacuation is required to remove casualties from the field when OPSEC is not endangered. Echelons II and III CHS are required on an area support basis from the theater MEDCOM.

N-23. Special Reconnaissance

a. Special reconnaissance is an intelligence collection activity conducted beyond the operational capabilities of tactical collection systems to obtain or verify information about the activities and resources of a target, organization, or group. Special operations forces SR missions are generally of short duration and involve small elements (squads, teams, split-teams). Special reconnaissance missions are "deep" operations conducted beyond the FLOT primarily in support of intelligence requirements of strategic importance.

b. Since SR missions are conducted deep in hostile or denied territory, CHS is limited. As aerial medical evacuation of SOF casualties would compromise the mission, the units rely on Echelon I (self-aid and buddy aid, combat lifesaver, and SF medic) until the mission is accomplished and the team is extracted.

c. Comprehensive medical intelligence is critical for SOF SR missions. The medical threat requires evaluation of PMM to counter the threat and to protect SR elements from exposure to disease and injury.