Chapter 2

Roles of Medical Care (United States)

Introduction

Military doctrine supports an integrated health services support system to triage, treat, evacuate, and return the casualty to duty in the most time-efficient manner. The system begins with the casualty on the battlefield and ends in hospitals located within the continental United States (CONUS) and other safe havens. Care begins with first responder (self-aid/buddy aid and combat lifesaver), rapidly progresses through tactical combat casualty care (TCCC; care under fire, tactical field care, and tactical evacuation care) and advanced trauma management to stabilizing surgery, followed by critical care transport to a higher taxonomy of care where more sophisticated treatment can be rendered.

A basic characteristic of organizing modern health services support is the distribution of medical resources and capabilities to facilities at various levels of command, diverse locations, and progressive capabilities. This is referred to as the **four roles of care (Roles 1–4)**. As a general rule, no role will be bypassed except on grounds of medical urgency, efficiency, or expediency. The rationale for this rule is to ensure the stabilization and survivability of the patient through advanced trauma management and far-forward resuscitative surgery prior to movement between medical treatment facilities. Different roles denote differences in capability of care. Each higher role has expanded capabilities.

Role 1

- The first medical care military personnel receive is provided at Role 1 (also referred to as unit-level medical care). This role of care includes:
  - Immediate lifesaving measures.
  - Disease and nonbattle injury prevention and care.

- Combat and operational stress preventive measures.
- Patient location and acquisition (collection).
- Treatment provided by designated combat medics, treatment squads, or animal care specialists for working animals. (Major emphasis is placed on those measures necessary for the patient to return to duty or to stabilize them and allow for evacuation to the next role of care. These measures include maintaining the airway, stopping bleeding, preventing shock, protecting wounds, immobilizing fractures, and other emergency measures, as indicated.)

- **Self-Aid and Buddy Aid.** All military personnel are trained in a variety of basic first-aid procedures. These procedures include aid for chemical casualties with particular emphasis on lifesaving tasks. This training enables the military personnel to apply first aid to alleviate potential life-threatening situations.
- **Combat Lifesaver.** The combat lifesaver is a nonmedical military personnel selected by their unit commander for additional training beyond basic first-aid procedures. A minimum of one individual per squad, crew, team, or equivalent-sized unit should be trained. The primary duty of this individual does not change. The additional duty of the combat lifesaver is to provide enhanced first aid for injuries based on his or her training before the medical care arrives. Combat lifesaver training is normally provided by medical personnel assigned, attached, or in sustainment units. The senior medical person designated by the commander manages the training program.
- **Medical Personnel.** Role 1 provides primary healthcare, specialized first aid, triage, resuscitation, and stabilization. Normally included within the basic Role 1 capabilities are routine sick call and the management of minor sick and injured personnel who can immediately return to duty. Role 1 also includes casualty collection and preparation of casualties for evacuation to the rear. Expanded medical treatment is provided by medical personnel with enhanced medical skills (eg, the expeditionary combat medic [ECM], Special Forces medical sergeant [18D], Special Operations combat medic [SOCM W1/W4], independent duty corpsman/medical technician [IDC/IDMT], pararescueman [PJ], physician assistant, or physician).

Role 2

- Role 2 provides advanced trauma management and emergency medical treatment including continuation of resuscitation started in Role 1. Role 2 provides a greater capability to resuscitate trauma patients than is available at Role 1. If necessary, additional emergency measures are instituted, but they do not go beyond the measures dictated by immediate necessities. Role 2 care has the capability to provide packed blood products, limited x-ray, laboratory, dental support, combat and operational stress control, PVTMED, and Role 2 veterinary medical and resuscitative surgical support. Role 2 has a limited hold capability (i.e., no bed capacity). Role 2 is classified into Role 2 light maneuver (2LM) and Role 2 enhanced (2E).
  - Role 2LM are light, highly mobile medical units designed to support land maneuver formations (normally brigade level). A Role 2LM medical unit is able to conduct advanced resuscitation procedures up to damage control surgery. It will evacuate its post-surgical cases to Role 3 (or 2E for stabilization and possible primary surgery) before evacuation to Role 4.
  - 2E provides basic secondary healthcare, built around primary surgery, intensive care unit, and ward beds. A 2E MTF is able to stabilize post-surgical cases for evacuation to Role 4 without the requirement to first route them through a higher Role 3 facility.

Role 3

- In Role 3, the patient is treated in an MTF or veterinary facility (for working animals) that is staffed and equipped to provide care to all categories of patients, to include resuscitation, initial wound surgery, specialty surgery (general, orthopedic, urogenital, thoracic, ENT, neurosurgical) and post-operative treatment. This may include definitive surgery for local nationals depending on the current rules of engagement. This role of care expands the support provided at Role 2. Patients who are unable to tolerate and survive movement over long distances receive surgical care in a hospital as close to the supported unit as the tactical situation allows. This role includes provisions for:

- Evacuating patients from supported units.
- Providing care for all categories of patients in an MTF with the proper staff and equipment.
- Providing support on an area basis to units without organic medical assets.

Role 4

- Role 4 medical care is found in US base hospitals and robust overseas facilities. Mobilization requires expansion of military hospital capacities and the inclusion of Department of Veterans Affairs and civilian hospital beds in the National Disaster Medical System to meet the increased demands created by the evacuation of patients from the area of focus. The support-base hospitals represent the most definitive medical care available within the medical care system.

For Clinical Practice Guidelines, go to http://jts.amedd.army.mil/index.cfm/PI_CPGs/cpgs