



Litter bearers prepare to carry patients to a medevac helicopter at the National Training Center at Fort Irwin, California. Mission authority and launch authority for air medevac assets are critical components of medical mission command. (Photo by Capt. David Draper)

Medical Mission Command: A Gap in Doctrine

■ By Capt. David W. Draper

While mission command is well-defined in the Army's dedicated doctrinal publications, the term medical mission command is poorly articulated. This is particularly true concerning how medical mission command relates to the Army's core competencies and warfighting functions.

Field Manual (FM) 4-02, Army Health System, is the Army Medical

Department's (AMEDD's) capstone doctrine. This doctrine puts medical mission command at the center of the 10 medical functional areas, just as Army Doctrine Reference Publication 6-0, Mission Command, makes mission command the center of the warfighting functions. (See figure 1 on page 10.)

The problem is that FM 4-02 reserves medical mission command

for medical commands, medical brigades, and multifunctional medical battalions. So how does it pertain to the modular force? What does medical mission command mean in a brigade combat team (BCT), and who exercises it?

In this article, I will use doctrine analysis and lessons learned from an armored BCT's decisive action rotation at the National Training Center

(NTC) at Fort Irwin, California, to address these issues.

Medical Doctrine 101

Any Medical Service Corps (MSC) officer worth his or her salt can quickly recite the 10 medical functions: medical mission command, medical treatment, hospitalization, medical evacuation, dental services, preventive medicine services, combat and operational stress control, veterinary services, medical logistics, and medical laboratory services. The 10 areas are essential to the health service support (HSS) and force health protection (FHP) plans.

If you asked that same MSC officer who recited the 10 medical functions where medical mission command belonged in an operation order, he or she would likely say Paragraph 4 (Sustainment) and Appendix 3 (Army Health System Support) to Annex F (Sustainment).

Although correct in the school house, I argue that it is fundamentally wrong. Just as mission command should not simply be pigeonholed into Paragraph 5 (Command and Signal) of an operation order, medical mission command should not be pigeonholed into Paragraph 4, or worse yet, relegated to an obscure annex.

Some would argue that medical mission command is not pigeonholed at all and declare that it is derived from the higher headquarters' mission and commander's intent. While this is a step in the right direction, it is still fundamentally flawed based on the definition of mission command.

Mission Command

Mission command is "the exercise of authority and direction by the commander using mission orders to enable disciplined initiative within the commander's intent to empower agile and adaptive leaders in the conduct of unified land operations."

Simply putting "medical" in front of "mission command" and keeping the definition is easy, but it is not

realistic. Mission command belongs to commanders. The HSS and FHP plans belong to staff officers and support the mission and commander's intent.

The term "medical mission command" implies that someone (for example, a brigade surgeon or medical planner) has authority and direction over all things medical in the brigade or battalion. Such an implication is not likely to be received well by the commander of a BCT.

Medical Mission Command

FM 4-02 describes, but does not define, medical mission command. The best understanding of the doctrinal definition of medical mission command comes from the opening paragraph of Chapter 2, which says, "The complexities of the range of military operations, the myriad of medical functions and assets, and the requirement to provide health care across unified land operations to diverse populations ... necessitate a medical mission command authority that is regionally focused and capable of utilizing the scarce medical resources available to their full potential and capacity."

FM 4-02 goes on to say that each medical mission command organization "plans, directs, executes and synchronizes Army Health System support across the range of military operations."

This description sounds like a re-gurgitation of the operations process (plan, prepare, execute, and assess) with a hint of medical flavor. It differs significantly from the Army's definition of mission command. And nothing is mentioned concerning disciplined initiative, commander's intent, or mission orders.

The Doctrine Gap

In AMEDD's defense, FM 4-02 was written from the point of view of echelons-above-brigade (EAB) medical units. Here is the problem: This is the only doctrine AMEDD has that defines medical mission command, and it limits the function to a handful

of medical organizations.

Brand new MSC officers are learning that medical mission command is the center of the 10 medical functions just as mission command is the center of the warfighting functions, but medical mission command is limited to EAB medical units. Medical mission command in a BCT is not mentioned. This is a gap in doctrine.

The limited description leaves an unclear understanding of medical mission command in BCTs. Who exercises it? Who is responsible for it? Does medical mission command belong to the brigade surgeon, brigade medical planner, support operations (SPO) medical planner, or the brigade support medical company (BSMC) commander?

If you asked 10 MSC officers in the same BCT this very question, you would likely get many different answers. This is certainly contrary to the concept of mission command.

Medical Roles in a BCT

Over the course of three years in the same BCT, I served first as the SPO medical planner, then as the brigade medical planner, and finally as the BSMC commander. During my first NTC rotation, I was the SPO medical planner, and during the second, I was the BSMC commander. Those rotations taught me just how important medical mission command really is. Here are some of my observations from working in these positions.

SPO medical planner. Similar to the brigade medical planner, the SPO medical planner is a staff officer. The one critical difference is that the SPO medical planner is co-located with the BSMC in the brigade support battalion (BSB). In other words, the SPO medical planner can simply pick up a radio or even talk face-to-face with the BSMC commander for situational awareness.

Distance and terrain at the NTC always impairs radio capability between the BSB and the brigade headquarters. As a result, the SPO medical planner becomes an intermediary between the BSMC,

medical platoons, and the brigade surgeon cell.

Brigade medical planner. The brigade surgeon and the brigade medical planner are the staff officers who plan, prepare, execute, and assess the brigade's Army Health System plan.

I used to think the ultimate responsibility for medical mission command in the BCT rested on the shoulders of the brigade surgeon—the special staff officer of the brigade commander. But in serving as the brigade medical planner, I quickly realized that the brigade surgeon section is inadequately manned and equipped to provide medical mission command for an entire BCT.

The brigade surgeon cell consists of only three Soldiers (the brigade surgeon, a medical planner, and a combat medic in the rank of sergeant first class). It has no equipment for battle tracking, such as Blue Force Tracking (BFT), Command Post of the Future (CPOF), or even FM radios. Everything the brigade surgeon section uses for situational awareness on the battlefield is provided through the brigade S-4 section, where it inevitably shares a CPOF.

How can the brigade surgeon have

medical mission command if direct communication with battalion medical platoons or the BSMC is not possible? It can be done with thorough coordination and synchronization, but the surgeon section relies on borrowing infrastructure through the S-4 to communicate.

BSMC commander. Because the BSMC has at least a dozen medevac vehicles with BFT and FM radio communications, the BSMC commander, who is located in the BSB, has a keen understanding of the medical situation at all times.

As I witnessed at my last NTC rotation, co-locating medevac vehicles with BFT at the back of each battalion's main aid station provides instant communication capability and situational awareness. The brigade surgeon cell simply does not have this capability and must instead relay messages down to the BSMC commander or SPO section in order to get medical situation reports. This is time-consuming and therefore impractical in a decisive action environment.

Interactions at the NTC

During NTC rotation 15-06, the primary plan for medical reporting

for the 2nd Armored Brigade Combat Team, 1st Infantry Division, was to submit medical situation reports via BFT messaging. Because the brigade surgeon had CPOF and not BFT, the SPO medical planner consolidated BFT medical situation reports and converted them to CPOF before submitting them to the brigade. This was an effective way to create and maintain a medical common operational picture (COP).

Information flowed in this way during the entire decisive action fight. Medical platoons and the BSMC used BFT to report to the SPO section, which consolidated these reports and converted them to CPOF to submit to the brigade surgeon.

The brigade surgeon was then responsible for creating the COP in CPOF and disseminating it throughout the brigade. Finally, the reporting loop was closed when the SPO medical planner converted the medical COP from CPOF to BFT and disseminated it to the BSMC and the medical platoons.

How does this NTC example relate to medical mission command in an armored BCT? None of the three key medical players in a BCT (the

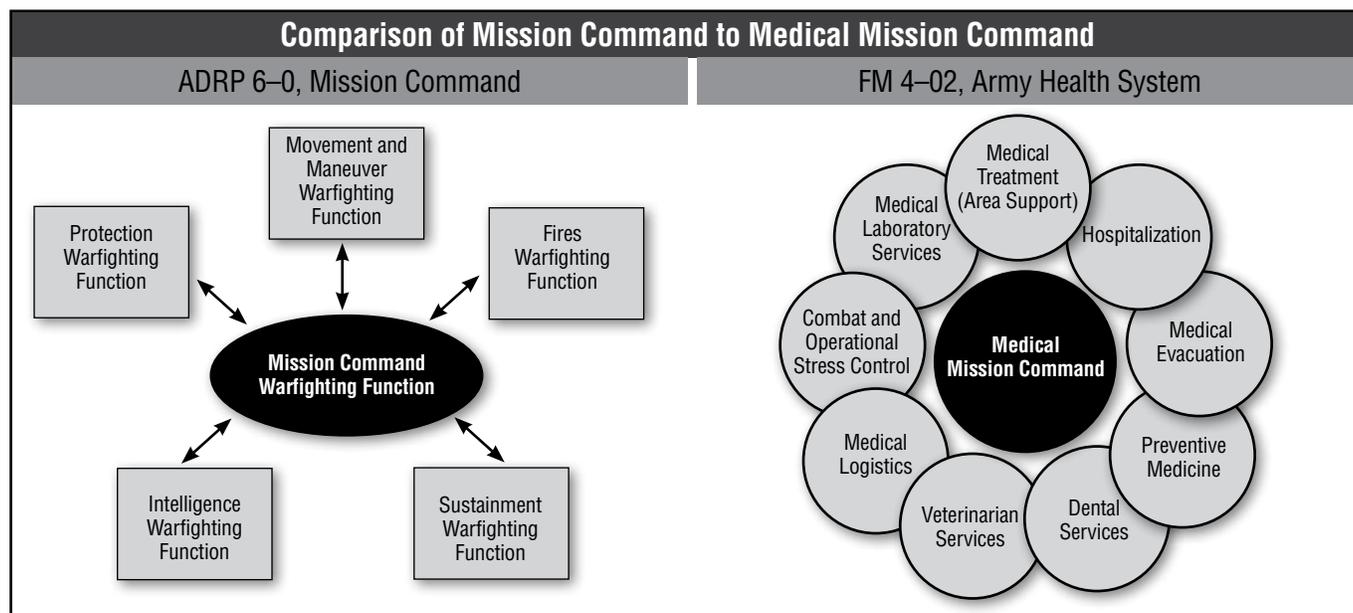


Figure 1. This figure compares the roles of mission command and medical mission command in doctrine. The chart on the left is from Army Doctrine Reference Publication 6-0, Mission Command, and the chart on the right is from Field Manual 4-02, Army Health System.

brigade surgeon, the SPO medical planner, and the BSMC commander) truly had medical mission command. The brigade surgeon and SPO medical planner did not attempt to direct the BSMC commander to launch ground medevac missions. Likewise the BSMC commander did not open or close ambulance exchange points without notifying higher echelons.

The concept of medical support was mutually understood and then combined with mission requirements. This is more in line with the definition of control rather than command. As defined in the principles of mission command, “Control is the regulation of forces and warfighting functions to accomplish the mission in accordance with the commander’s intent.”

Medical Mission Control

So what is the alternative, and how do we bridge the gap? It has taken me seven years as an active duty MSC officer and two rotations at the NTC to come to the conclusion that the best solution is to create a new term with a new definition to properly define authorities and responsibilities.

This may seem like semantics, but what if medical mission command became medical mission control? This would alleviate the seemingly forced correlation between mission command and medical mission command. Additionally, the term “medical mission control” better reflects the purpose of medical support in a BCT. We control the medical functions in a BCT in order to support the commander’s intent—as opposed to pretending to conduct mission command.

Changing the term provides the opportunity to change the definition. I propose defining medical mission control as, “The regulation of a modular force’s medical assets and medical functional areas by the unit’s senior medical planner to accomplish the commander’s intent.”

This definition applies specifically



A combat medic and combat lifesaver from the 2nd Armored Brigade Combat Team, 1st Infantry Division, treat a patient as their first sergeant monitors the radio at an ambulance exchange point during rotation 15–06 at the National Training Center at Fort Irwin, California, in March 2015. (Photo by Sgt. Enriqueta Fuentes)

to modular forces, including BCTs and their subordinate battalions. It specifies control, not command, of medical assets by the medical planner, who is a special staff officer of the BCT commander.

The term “medical mission control” alleviates the confusion of who is in charge of the Army Health System plan in the BCT—the BSMC commander, SPO medical planner, or the brigade medical planner. The BSMC commander is out of the running by nature of the definition; he or she is an executor, not a planner. The seniority aspect is the final consideration, which is black and white.

This is just one humble opinion about a term. Perhaps I should refrain from attempting to redefine doctrine, but I can’t help but notice the disparity in the doctrinal understanding of medical mission command in a BCT.

Medical mission command makes perfect sense in an EAB medical

unit. However, in today’s modular forces, all too often the brigade surgeon section, SPO medical planner, and BSMC commander are disenfranchised from each other because of a lack of understanding of roles and responsibilities. Changing “command” to “control” and emphasizing this paradigm shift in the AMEDD Center and School may fix the disparity and bridge the gap in doctrine.

Capt. David W. Draper is a Medical Service Corps officer and the commander of the Brigade Support Medical Company, 299th Brigade Support Battalion, 2nd Armored Brigade Combat Team, 1st Infantry Division, at Fort Riley, Kansas. He holds a bachelor’s degree in biology from the University of Wisconsin–La Crosse. He is a graduate of the Army Medical Department Captain’s Career Course and the Health Services Plans, Operations, Intelligence, Training, and Security Course.