

MEDEVAC vs. CASEVAC: Life Saving Decisions in the Field Artillery Battalion

By SFC Matthew Winners

As the Army transitions to Large-Scale Combat Operations (LSCO), casualty numbers will drastically increase from what we as an Army saw in the recent counterinsurgency (COIN) fight. Loss of air superiority, significant counterfire risk, increased casualty evacuation (CASEVAC) needs and prolonged medical evacuation (MEDEVAC) times will be constraints the modern warfighting organization must overcome.

“Medical evacuation is the timely and effective movement of the wounded, injured or ill to and between medical treatment facilities on dedicated and properly marked medical platforms with en route care provided by medical personnel.” (Army Techniques Publication 4-02.2)

“Casualty evacuation is the movement of casualties aboard nonmedical vehicles or aircraft without en route medical care.” (Field Manual 4-02)

Effective CASEVAC and MEDEVAC planning and execution begins with home station training. Too often, units at the National Training Center (NTC) struggle with casualty movement due to a lack of sets and reps throughout their home station training progression. The implementation of doctrinal MEDEVAC practices has been neglected due to personnel shortages and equipment maintenance issues. Unit tactics, techniques and practices (TTPs) have been the norm, rather than doctrinal MEDEVAC and CASEVAC practices. These TTPs may work at home station. However, units struggle at NTC due to the larger area of operations and the persistent enemy presence.

An example is the use of the M992 Carrier Ammunition Tracked (CAT) for CASEVAC operations. Units will train and develop TTPs to implement the CAT to transport casualties because of its ease of access and the typically lower amount of available ammunition at home station. However, at NTC, units will receive a full issue of ammunition, leaving the CAT unable to transport casualties. If units still choose to use CATs, their ammunition haul capacity will significantly decrease without that now occupied space. Implementing their available MEDEVAC platforms or a different CASEVAC platform allows the unit to maintain its ammunition capacity along with casualty movements. This planning must be driven from home station sets and reps.

This success greatly relies on deliberate health service support (HSS) planning at the battalion staff level that effectively incorporates battery medical assets, along with the organic battalion Role 1 and medical platoon. The battalion medical officer (MEDO) and the medical platoon sergeant must develop the MEDEVAC plan in conjunction with senior non-commissioned officers (NCOs) across the battalion. These senior NCOs will be directly responsible for implementing the CASEVAC plans and ensuring casualty movement from the point of injury (POI) to the casualty collection points (CCPs).

“Casualty evacuation and MEDEVAC are complementary capabilities, and when used efficiently and effectively, reduce Soldier mortality. Having CASEVAC capable platforms does not negate the need to plan for and use organic MEDEVAC assets. As complimentary capabilities, they enhance the maneuver commander’s options and ability to clear their wounded from the engagement area while ensuring that the more severely wounded have access to the increased lifesaving capabilities provided in the MEDEVAC platform”. (Army Techniques Publication 4-02.2)

As units progress through their artillery tables, implementing CASEVAC and MEDEVAC drills ensures success when operating as a battalion. The battalion medical platoon must be prepared to pull casualties from battery CCPs back to Role 1 while utilizing organic MEDEVAC assets. The batteries must be ready to pull their casualties from POI back to their designated CCP while maintaining the fight. For this to be successful in real-time, rehearsals need to be conducted. Pre-designated CASEVAC platforms, routes and functional communications equipment are all key to effective CASEVAC rehearsals. (Figure 2-2, ATP 4-02.2 below depicts effective patient flow from POI through the roles of care.)

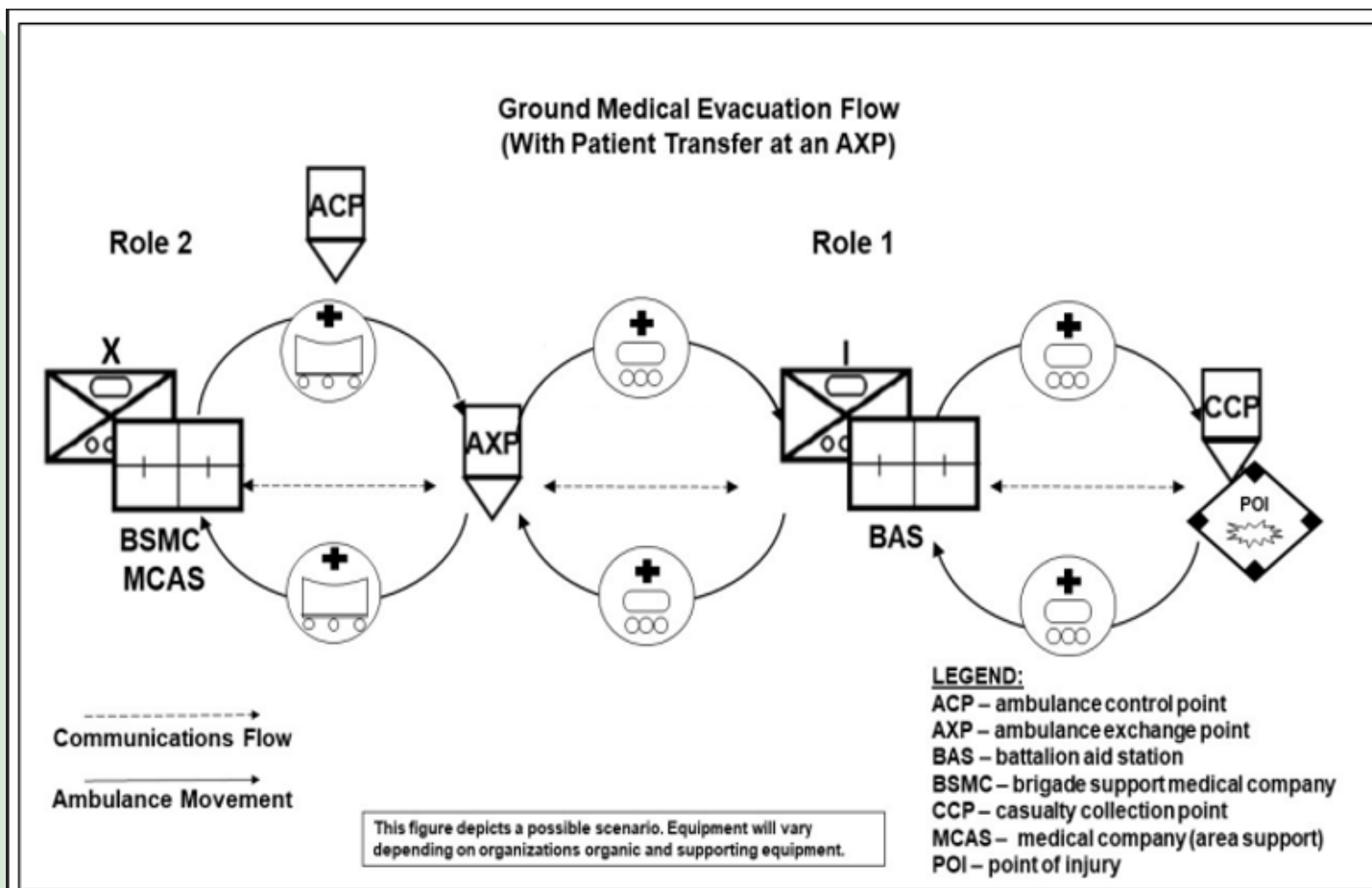


Figure 2-2, ATP 4-02.2: Effective patient flow from POI through the roles of care

Aggressive Role 1 posturing is critical to ensuring successful CASEVAC and MEDEVAC plans. The battalion Role 1 needs to be postured 3-5 kilometers, or one major terrain feature, from battery position areas for artillery (PAAs) in order to effectively provide emergency treatment and stabilization. Often, we see the Role 1 co-located with combat trains command posts (CTCPs) due to security concerns and ease of resupply. However, these CTCPs are typically 10-15 kilometers behind battery PAAs, leading to prolonged evacuation times and decreased survivability rates.

Moving forward, units should consider placing their Role 1 further forward in the vicinity of their main command post. This posturing allows for security coverage, presence with the battalion staff during planning and an overall decrease in casualty movement timelines. These benefits allow for an increase in survivability and a shared understanding of the HSS plan with key leaders across the battalion.

Ensuring that leaders at all echelons understand the CASEVAC plan is crucial to overall patient survivability and, ultimately, mission success. Timely CASEVAC—with the right equipment—leads to effective MEDEVAC. This, in turn, is directly correlated to patient survivability and a decrease in died of wounds (DOW) rates here at NTC. In the LSCO environment, time and distance kills patients. A well developed and rehearsed CASEVAC plan can make the difference between life and death.

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