to evaluate size.

• Put up a new 25-meter target after firing four shot groups.

When finished with these steps, move the elevation knob on the M16A2 down one click to ensure that sights are aligned for 300 meters. At this point, the rifle sights are battlesight zeroed for 300 meters; the AN/PAQ-4A is zeroed for 100 meters; the AN/PAQ-4B is zeroed for 250 meters.

These procedures will result in better aim points, better aiming light zeros, and more target hits at range. They will also save time and ammunition during the zeroing process. Fewer errors will be made in adjusting the aiming light. Do not omit steps; each is critical.

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CASEVAC for Light Infantry Units

At a Combat Training Center

CAPTAIN JAMES SISEMORE

The evacuation and treatment of casualties on the battlefield is one of the most frustrating and difficult missions for a light infantry unit during a rotation at a combat training center (CTC). It is also one of the most important.

Each unit that prepares for a rotation understands that it will suffer casualties. Most units try to prepare for casualties by implementing training that incorporates casualty evacuation (CASEVAC) into the scenario. But these units often find during a CTC rotation that they are not prepared to handle the large number of casualties they experience. And leaders do not realize the way these casualties affect the ability to complete a mission, or even continue it.

The techniques and options I cover here will not solve all the problems you encounter, but I believe they will help you prepare for a CTC rotation, or for combat.

Integrate evacuation and available medical treatment assets into your battalion planning sequence. The battalion S-1 and medical platoon leader play an important part in wargaming and should be included in the decision making process. It is during this process that the medical platoon leader can use his ability to support the mission. By including medical support in the wargaming process and later in developing the synchronization matrix, you can tailor medical assets to support the tactical scheme of maneuver and increase the plan's effectiveness.

Using the course of action decided upon, the medical platoon leader should plan his support on the basis of the main effort. Medical support needs to focus on the point at which the commander, S-3, and S-2 plan for the main effort to encounter strong enemy resistance.

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Tailor the medical support to the mission. There are several ways to plan and conduct medical support during an operation. Depending on the assets available, a single or a dual aid station can be established to support the mission. The benefit of either type varies with the category of mission. The important thing to remember in developing a plan is to tailor medical coverage to mutually support all company teams in both offensive and defensive operations.

The use of a single aid station may be beneficial in operations where large numbers of casualties are expected in a single operational area. With a single station, the complete assets of the medical platoon are available in one location, its sustainment and resupply are easier; and, since it is often located with the combat trains, it is easier to defend. A single station may also be necessary if medical crewmen have become casualties and you cannot man more than one.

The use of dual or mobile treatment teams can be an advantage in the treatment of casualties in offensive operations. A mobile team can move quickly to the site of the battle and treat the casualties on the objective (once it is secure or the fighting has advanced beyond the initial contact site). This "follow and support" concept assists triage forward, which in turn improves the treatment of casualties at the main aid station.

Most light infantry units, depending on the table of organization and equipment, are authorized a "professional doctor" (an active Army physician dedicated to the

battalion) and a physician's assistant (PA) assigned. The physician seldom deploys on operations short of real combat. With prior coordination, however, observer-controllers at a CTC will often allow a unit to put a senior soldier in MOS 91B in the PA position and to promote the PA to doctor status.

When task organizing the aid station, you can either designate the staff as separate treatment teams (Teams 1 and 2), or designate a main aid station and a forward (mobile) aid station. If you plan to use a mobile station, you can assign the PA to the forward station, the maneuver station. The doctor can remain at the main aid station, the stationary one, normally located near the combat trains. A mobile team (often dismounted with only a triage ruck sack) will not be able to carry as much as a stationary team (normally vehicle supported), but "on-site" treatment can save far more lives.

Either concept adds flexibility to the treatment plan. If your battalion is moving on two separate axes of advance, you can cover both advances by making both treatment teams mobile, thereby giving each element maximum medical coverage forward.

When attacking over a single axis of advance, designating a forward and a main aid station will increase the effectiveness of medical coverage. The forward station can travel dismounted at the tail of the maneuver element or, if given an adequate defensive force, can maneuver forward by phase line behind the trail combat elements, ready to come forward once the objective is secure. The main aid station can set up with the combat trains and prepare to treat casualties and control ambulance movement to evacuate casualties from the forward aid station.

The use of dual or mobile treatment teams can be an advantage in the treatment of casualties in offensive operations.

When evacuating casualties to these two sites, it is important to send to the forward station only those casualties classified as *Immediate* (need medical assistance within two hours) and *Delay* (need medical assistance within four hours). Those classified as *Minimal* (needing medical assistance within 24 hours) can be evacuated directly to the main aid station. The forward station, in its mobile status, and depending on the number of casualties, should be used only to treat casualties whose survival may depend upon prompt attention.

While the use of dual treatment stations will greatly assist in the medical coverage of the maneuver element, the danger is that the mobile or dual treatment teams are not as well protected from the effects of both direct and indirect enemy fire. Depending on the enemy threat, the danger of losing an aid station may preclude the use of forward or maneuver treatment teams.

Consider defensive operations. When planning medical support for a defensive battle, remember that enemy initiative will decide where the attack will come. The establishment of one or two aid stations in the defense should be based on the size of the area of coverage. Dual treatment stations in the defense offer the advantage of redundancy in case either station is overrun or destroyed in an enemy attack. The use of forward and main aid stations may be favorable in the defense, with the forward station mounted on a vehicle, ready to move to the vicinity of the main enemy attack and offer forward medical treatment. The main aid station can be established out of imminent danger of the attacking forces, ready to receive incoming patients.

Plan for CASEVAC. The key to all successful CASEVAC is to rehearse it at home station under all possible conditions. If you do not already have a standing operating procedure (SOP) that addresses CASEVAC, you must include specific guidance in the operations order.

Once you have developed an SOP for CASEVAC, you must then include it in your training. Briefing the way your platoon, company, or battalion plans to conduct CASEVAC, and then ending an exercise as soon as the objective has been cleared or the enemy attack has been defeated, will set your unit up for failure. Your soldiers need to understand the hardship of carrying a casualty 300 meters to a collection point. Leaders need to experience the handicap that CASEVAC imposes on their ability to reconsolidate and continue the mission. The medics in your unit need to endure the anxiety of treating multiple casualties while the company first sergeant or executive officer is trying to coordinate evacuation for those who need immediate treatment to the battalion aid station, and while the unit is still under indirect fire.

The depth and dispersion of the objective area may create time and distance problems for medical evacuation planning. No one can be sure where casualties will first occur on the battlefield. During the wargaming phase of a mission, a best guess of enemy action and reaction can be developed, and from that estimation, casualty collection points (CCPs) can be planned.

Leaders need to experience the handicap that CASEVAC imposes on their ability to reconsolidate and continue the mission.

Casualty evacuation exercises must be incorporated into all training events at platoon and company level. The use of a poleless litter is not easy if it has not been taught to the new soldiers in the unit. Platoon leaders and company commanders should continually press to have combat lifesaver courses taught within the battalion. The goal should be to have two lifesaver qualified soldiers in each rifle squad and one in each antiarmor vehicle. Equally important, combat lifesaver bags must be carried and used. The habit of including one soldier with a lifesaver bag on every attack and on every patrol must be trained and enforced.

Locate and mark casualties. Once reconsolidation on the objective has begun, locating casualties can be time-consuming, especially at night or in dense woods. Depending on the size of the objective and the number of casualties, it can take from several minutes to several hours to find every wounded soldier in a training center environment. One tech-

nique that has been used effectively at night is to have an injured soldier, once he knows he has been hit, break out a chemical light and mark his position. In daylight, a visual signaling panel (VS-5 or VS-17) can be used to mark casualties, which will help the casualty collection teams as they sweep the objective.

The use of a CCP in day and night training has to be exercised. Platoon and company medical personnel have to practice their trade as often as possible. These are the soldiers who will save the most lives at a CTC. A senior company medic needs to ensure that each platoon medic and combat lifesaver understands the company SOP for marking casualties for evacuation.

Standardized marking and separation procedures will assist in a rapid evacuation of the time-urgent casualties. An easy way to separate casualties is the "ID-ME" system: I for *Immediate,* D for *Delay,* M for *Minimal,* and E for *Expectant* (those not expected to live long enough for evacuation). Each category of casualty is placed in a cardinal direction from the center of the CCP, with the expectant casualties removed from the view of the others. Any system will work so long as every member of the company casualty collection team understands his part in it.

The medical platoon leader, in addition to planning for the establishment of the aid station, is also responsible for the movement and coordination of his ambulances. It is important that each ambulance team be provided with maps. Although every ambulance dispatched should have a security element to escort it to the company CCP, this is not always the case. Each medic in an ambulance needs to be prepared to move individually and be proficient at dismounted and mounted navigation.

The reconnaissance of evacuation routes, while usually possible only in defensive operations, will assist in the rapid evacuation of casualties. And a face-to-face coordination between the medical platoon leader and the company first sergeant or executive officer will ensure that the medical platoon knows the company plan, and that company leaders understand the medical platoon's evacuation plan.

The medical platoon leader is also responsible for the coordination of ambulance exchange points. These are designated points, usually on an operational boundary, where the brigade medical support element is responsible for pushing evacuation assets forward. These points become critical during mass casualty operations, where the number of casualties quickly overloads the abilities of the battalion aid station.

Casualty evacuation and treatment are an important part of sustaining the force. The average number of died-of-wounds casualties at a combat training center is 50 percent. All of these are due to a lack of a timely evacuation or effective triage procedures.

The techniques listed here may help your unit decrease the number of its died-of-wounds casualties. Whatever evacuation and treatment technique your unit uses, it is the rehearsal, conducted to standard, that will achieve the most effective results and save the most lives.

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Information Systems

Let's Go Beyond Computer Literacy

LIEUTENANT COLONEL DONALD J. WELCH, JR.

Computers are everywhere. As we enter a new age—the Information Age—the magnitude of the changes we see will be similar to that of the changes when the Industrial Age replaced the Agricultural Age.

Computers and computer-related technologies are transforming the battlefield, much as the introduction of mechanization remade the battlefield earlier this century. As we can see from efforts such as Force XXI, there are few officers today who think that computers don't have a place on the modern battlefield. One critical question is, "What does an officer need to know about computers to be successful now and in the next century?" "Computer literacy" is not enough; an officer must understand information systems.

Most officers have learned how to use computers and have become computer literate. Computer literacy means knowing how to use the tools—computers and software. A person who is computer literate can use a computer to help with many different tasks. But to thrive in the next century, our Army will need officers who know more about computer technology than just how to use a spreadsheet