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