



MINISTRY OF DEFENCE

Joint Doctrine Note 2/10
Medical Doctrinal Update

JOINT DOCTRINE NOTE 2/10

MEDICAL DOCTRINAL UPDATE: MEDICAL EMERGENCY RESPONSE TEAM, ROLE 2 AND ROLE 4

Joint Doctrine Note 2/10 (JDN 2/10), dated April 2010,
is promulgated as directed by the Chiefs of Staff

A handwritten signature in black ink, appearing to read "Ray Lor". The signature is written in a cursive style with a long horizontal stroke at the end.

Head of Doctrine Air and Space (Development, Concepts and Doctrine)

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JOINT DOCTRINE PUBLICATIONS

The successful conduct of military operations requires an intellectually rigorous, clearly articulated and empirically-based framework of understanding that gives advantage to a country's Armed Forces, and its likely partners, in the management of conflict. This common basis of understanding is provided by doctrine.

UK doctrine is, as far as practicable and sensible, consistent with that of NATO. The development of national doctrine addresses those areas not covered adequately by NATO; it also influences the evolution of NATO doctrine in accordance with national thinking and experience.

Endorsed national doctrine is promulgated formally in Joint Doctrine Publications (JDPs).¹ From time to time, Interim Joint Doctrine Publications (IJDPs) are published, caveated to indicate the need for their subsequent revision in light of anticipated changes in relevant policy or legislation, or future lessons arising out of operations.

Urgent requirements for doctrine are addressed in Joint Doctrine Notes (JDNs). JDNs do not represent an agreed or fully staffed position, but are raised in short order by the Development, Concepts and Doctrine Centre (DCDC) to establish and disseminate current best practice. They also provide the basis for further development and experimentation, and a doctrinal basis for operations and exercises.

Details of the Joint Doctrine development process and the associated hierarchy of JDPs are to be found in JDP 0-00 *Joint Doctrine Development Handbook*.

¹ Formerly named Joint Warfare Publications (JWPs).

PREFACE

1. **Purpose.** Joint Doctrine Note (JDN) 2/10 *Medical Doctrinal Update: Medical Emergency Response Team, Role 2 and Role 4* provides guidance for operational and tactical commanders and their medical staff. The definitions within this JDN and their associated notes will be incorporated into the 3rd edition of JDP 4-03, following its review.
2. **Context.** Medical Emergency Response Team (MERT) is an important capability component of the forward medical evacuation pathway from point of wounding to entry into secondary care. Role 2 Resuscitation, Surgery and Transfusion is an essential element of hospital emergency care and a continuation of the overarching care pathway following injury. The provision of Role 4 care in the UK is the final stage of the medical care pathway leading to rehabilitation and appropriate rehabilitation of the casualty.
3. **Structure.** JDN 2/10 is divided into 3 parts:
 - a. Part 1 – MERT.
 - b. Part 2 – Resuscitation, Surgery and Transfusion.
 - (1) Section I – Context.
 - (2) Section II – Resuscitative Processes.
 - (3) Section III – Definitions.
 - (4) Section IV – Commanders' Considerations.
 - c. Part 3 – Role 4 Medical Treatment Facilities.
4. **External Assistance.** Joint Medical Doctrine Working Group, Joint Medical Command and the Military Pre-Hospital Emergency Care Facility were consulted throughout the writing of this publication.

LINKAGES

5. This Joint Doctrine Note (JDN) should be read in conjunction with JDP 4-03 *Medical Support to Joint Operations*, JDP 4.03.1 *Clinical Guidelines for Operations* and Surgeon General's Operational Policy Letter 08/09 *Management of Massive Haemorrhage on Operations*.

MEDICAL EMERGENCY RESPONSE TEAM, ROLE 2 AND ROLE 4

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PART 1

MEDICAL EMERGENCY RESPONSE TEAM

1. Paragraph 224 of Joint Doctrine Publication (JDP) 4-03 2nd Edition *Medical Support to Joint Operations* refers to the process of forward medical evacuation. An additional component within this process is the Medical Emergency Response Team (MERT), an element of the Incident Response Team. MERT provides medical care and resuscitation in direct support of frontline activity.

Definition

2. MERT is defined '*as the medical component of an Incident Response Team where the capability may be delivered in the maritime, littoral, land or air environments. MERT is used when the clinical situation dictates the need for specialist Pre-Hospital Emergency Care (PHEC) interventions during Medical Evacuation (MEDEVAC)*'.

3. MERT operates within the tactical environment and its members will be specifically trained in PHEC to operate in this environment.² The team will be based on paramedics³ and/or emergency medicine nurses but may be augmented by medical officers, medical assistants, combat medical technicians or Royal Air Force medics as the clinical and operational situation dictates. Intelligent tasking is required to decide the most appropriate MERT to deploy as well as facilitating appropriate asset management across the area of operations.

Configuration of a MERT

4. Amongst other factors, MERT will be configured to provide the best medical response in light of the nature of the incident, severity of the injuries and number of casualties. The decision on the composition of the MERT will ultimately rest with Commander Medical, on whom the responsibility for the provision of healthcare rests within theatre. This decision making process may be passed along the medical chain of command. Using intelligent tasking the aim will be to bring the optimal mix of PHEC skills to the incident, within timeline guidelines, in order to give the best treatment within the constraints of the operational situation. To enable the decision making process it is vital that as much information as possible is made available in the initial reporting of the incident or transmission of the initial casualty report.

² As with any operational environment, it is expected that the members of MERT will have apposite and thorough military skills to support their function within the operational environment.

³ State Registered Paramedic.

Commanders' Considerations

5. Commanders and medical commanders at all levels need to consider the following important factors:

a. The clinical requirements of the incident; this will dictate the composition of the MERT.

b. Accurate and timely casualty reporting occurs from point of wounding; this will ensure that the decision on the composition of the MERT is made using the optimal information.

6. Medical personnel on operations within Surgeon General's Department and frontline commands need to be aware of current and future MERT requirements and its changeable nature. This will ensure appropriate manning and resources to this element of medical support in the forward environment.

PART 2

ROLE 2 RESUSCITATION, SURGERY AND TRANSFUSION

SECTION I – CONTEXT

7. With the inception of the Massive Transfusion Protocol (MTP)⁴ clarification is required regarding its place within Role 3 and Role 2 Enhanced Medical Treatment Facilities (MTFs). Consequently Role 3 (R3), Role 2 Enhanced (R2E) and Role 2 Light Manoeuvre (R2LM) need to be re-defined. Damage Control Surgery (DCS), Damage Control Resuscitation (DCR) and Haemostatic Resuscitation will also be clarified. These definitions provide the doctrinal basis to support MTP, or elements of it, as far forward of R2E as practicable within the bounds of technology, sustainability, capability and mobility. While there are discrete definitions for the specific areas of resuscitation it should be noted that resuscitation covers an arc of care from point of wounding to return to duty where practicable.

8. The provision of the MTP is intended to reduce mortality and morbidity alongside appropriate and accessible resuscitation procedures (damage control surgery or damage control resuscitation) with the best quality of care applicable within the constraints of the military situation at the time. Blood products are essential components of operational surgery and make a significant contribution to the reduction of mortality in the hospital emergency care environment.

9. It should be remembered that Joint Doctrine Publication (JDP) 4-03.1 *Clinical Guidelines for Operations* contains the current MTP details and is maintained through its agreed system by the Academic Department of Military Emergency Medicine (ADMED) in association with the Development Concepts and Doctrine Centre. Neither this Joint Doctrine Note (JDN) nor 3rd Edition of JDP 4-03 will provide tactical detail on MTP. Rather they give the doctrinal underpinning based upon accurate definition of the roles and facilities required to support MTP as far forward as practicable.

⁴ Surgeon General's Operational Policy Letter 08/09 *Management of Massive Haemorrhage on Operations*, DMSD/29/15/01 dated 10 June 2009. Joint Doctrine Publication (JDP) 4-03.1 *Clinical Guidelines for Operations*.

SECTION II – RESUSCITATIVE PROCESSES

10. The aim of resuscitation is the restoration of the endogenous homeostatic physiological processes of the patient. This can be achieved through the multi-layered interventions of resuscitation from point of wounding back to Role 4 medical treatment facilities. Resuscitation can take many forms and may encompass multiple specialities to ensure the best possible outcome for the patient concerned within the resources and limitations of the operational arena.

11. DCS was first coined by Rotondo in 1993 and relates to the naval term that describes the emergency actions taken to prevent a badly damaged ship from sinking.⁵ DCS represents the surgical (abdominal, thoracic, orthopaedic or neurosurgical) interventions to counter the anatomical and physiological disruption caused by trauma.

12. Elements of DCS encompass the more physiological processes that take place within the intensive care unit and final, definitive surgical repairs. The physiological processes will inevitably be greatly disrupted before the patient arrives at an intensive care unit so some measure of resuscitation must take place. This usually affects the coagulation pathway as well as other physiological effects, so the restoration of the circulating volume of blood and the provision of appropriate clotting capability is vitally important. The technology and techniques required for this *haemostatic resuscitation* are progressing rapidly but have now been set out in the MTP under the Surgeon General's Operational Policy Letter 08/09 *Management of Massive Haemorrhage on Operations*.⁶ MTP has the ability to enhance the survivability of major trauma⁷. It requires a large volume of red cell concentrate, fresh frozen plasma, cryoprecipitate and platelets which have to be stored at specific temperatures. This may form a logistic constraint on their provision in theatre and MTFs; a move to freeze-dried plasma products would alleviate this burden.

13. Current logistic capability and technology constrains the provision of blood components within certain MTFs. The ultimate aim is to provide MTP as far forward as practicable within the limitations of technology, logistics and sustainability. Within the prevailing conditions it is accepted that full support of

⁵ Parker PJ, *Damage Control Surgery and Casualty Evacuation: Techniques for Surgeons, Lessons for Military Medical Planners*, J R Army Medical Corps 2006 Volume 152, pages 202-211.

⁶ Surgeon General's Operational Policy Letter 08/09, *Management of Massive Haemorrhage on Operations*, *op. cit.*

⁷ Holcomb J B et al., *Increased Plasma and Platelet to Red Blood Cell Ratios Improves Outcome in 466 Massively Transfused Civilian Trauma Patients*, *Annals of Surgery* 2008 Volume 248, pages 447-458.

MTP is integral to R2E and R3 MTFs. Apheresis⁸ cannot, at the moment, be delivered at R2LM and the anticipated transfusion capability at R2LM would be red cells and fresh frozen plasma. Platelets may be delivered forward from a R2E/R3 hub if present. Novel technological and logistic solutions may allow for assured provision of platelets or apheresis at R2LM in the near future.

14. DCR may be viewed as the overarching principle, combining both processes within the entire resuscitative arc. The specific aim of DCR is to deal with the 'lethal triad' of hypothermia, acidosis and coagulopathy.⁹ This allies the practice of DCS with the correction of coagulopathy in the early stages of the resuscitative process. This certainly holds true for the military variant of damage control resuscitation.

SECTION III – DEFINITIONS

Role 2 Light Manoeuvre

15. R2LM '*conducts triage and advanced resuscitation procedures up to damage control surgery*'. It will usually evacuate its post surgical cases to Role 3 (or R2E) for stabilisation and possible primary surgery prior to evacuation to Role 4.¹⁰ The clinical capability of R2LM is based upon Role 1 capabilities being augmented by consultant-led resuscitation (with the elements to support it). R2LM provides DCS with post-operative care. This would require a field laboratory, basic imaging capabilities and the means to receive, regulate and evacuate patients. There will be limited holding capacity.

Role 2 Enhanced

16. R2E is a '*basic secondary care facility built around primary surgery, intensive care unit and beds with nursing support; a R2E facility is able to stabilise post-surgical cases for evacuation to Role 4 without the need to put them through Role 3 first*'.¹¹ R2E is built upon the basis of R2LM with the addition of primary surgery capability that includes surgical and medical intensive care assets and beds with nursing support. There will be an enhanced field laboratory with blood component provision. Additional capability in terms of decontamination facilities may be included in response to the operational risk assessment. The provision of preventive medicine, environmental health, psychiatry, tele-medicine and evacuation coordination will also be integrated.

⁸ Apheresis is '*a technique by which a particular substance or component is removed from the blood*'. Concise Oxford English Dictionary.

⁹ Holcomb J B, Jenkins D, Rhee P, Johannigman J, Mahoney P, et al., *Damage Control Resuscitation: Directly Addressing the Early Coagulopathy of Trauma*; J Trauma, 2007, Volume 62(2) pages 307-310.

¹⁰ Joint Doctrine Publication (JDP) 4-03, *Medical Support to Joint Operations*, 2nd Edition, paragraph 2-7.

¹¹ *Ibid*, page 2-7.

Role 3

17. Role 3 is *'provision of theatre secondary healthcare within the restrictions of the Theatre Holding Policy (THP), offering a range of clinical services not available elsewhere in the theatre of operations.'*¹² Role 3 represents the force hospital with the provision of primary surgery, intensive care, surgical and medical beds with dedicated nursing and diagnostic support. The facility can include: mission specific clinical specialities (specialist surgery, neurosurgery, burns and plastics as well as oral maxillofacial surgery); advanced diagnostic capabilities to support clinical specialities (for example CT scanning or sophisticated laboratory tests); and major medical and nursing specialities.

Damage Control Surgery

18. DCS has been defined as a *'an operative strategy that sacrifices the completeness of the immediate surgical repair to that required to achieve haemorrhage and contamination control, in order to address the physiological consequences of the combined trauma of the injury and surgery.'*¹³ DCS represents elements within the continuum of care under the wider definition of DCR – both DCR and DCS are an integrated process and approach to trauma.

19. DCS is extremely resource-intensive and, when conducted in a hospital setting with the full range of secondary healthcare support, will have a reduced mortality risk to that undertaken in the more fragile environment normally associated with Role 2 LM. It represents the best chance of survival following significant, penetrating trauma, especially that encountered within the operational environment.

Haemostatic Resuscitation

20. Haemostatic Resuscitation is the *'attempt to reduce hypothermia, maintain normovolaemia (or permissive hypovolaemia) and reduce the physiological burden of injury'*. Blood loss and concomitant coagulopathy are corrected by component replacement therapy (red cells, fresh frozen plasma and platelets).¹⁴

¹² *Ibid*, page 2-8.

¹³ Consensus definition from Medical Director Joint Medical Command and Defence Professors, e-mail communication dated 15 February 2010.

¹⁴ Defence Consultant Adviser (Transfusion), e-mail communication dated 14 September 2009.

21. Massive haemorrhage is the most immediate threat to the injured Service person, with procedures and equipment being used that cover the 2 critical areas of resuscitation – control of bleeding and replacement of lost blood. The successful management of acutely haemorrhaging patients requires prompt and appropriate action to reduce mortality and morbidity.¹⁵ Equipment must be suitable to safely administer large volumes of blood components rapidly; the blood should be warm, un-haemolysed and be compatible with other resuscitation fluids and drugs.

Damage Control Resuscitation

22. DCR is *'a systematic approach to major trauma combining the <C>ABC (catastrophic bleeding, airway, breathing, circulation) paradigm with series of clinical techniques from point of wounding to definitive treatment in order to minimise blood loss, maximise tissue oxygenation and optimise outcome.'*¹⁶

23. DCR involves the use of multiple techniques drawn from technical and organisational advances in combat casualty care. It is consistent with and encapsulates the established concept of DCS, providing an overarching approach to resuscitation in order to reduce the physiological as well as surgical impact of major trauma.¹⁷

SECTION IV – COMMANDERS' CONSIDERATIONS

24. **Resource Implications.** DCR brings the maximal contribution to life saving capability (following major trauma) within the operational environment provided that apposite medical resources are available to support such a resource-intensive process. Given the intent of the Defence Medical Services to provide the best possible care within the constraints of the operational environment, compromising on the provision of these resources is seldom justified. Thus every effort needs to be made to keep the most optimal surgical and haemostatic capability as far forward as physically, technologically and logistically possible.

25. **Logistic and Personnel Burden.** Commanders need to remain aware of the logistic and personnel burden that resuscitative processes place on the system throughout the spectrum of activity. Investment in Laboratory Information Management Systems (LIMS), large scale automated chemistry and haemostasis analysers will afford an increase in capacity and patient safety within MTFs. The introduction of alternative transfusion products and

¹⁵ Surgeon General's Operational Policy Letter 08/09 – *Management of Massive Haemorrhage on Operations.*

¹⁶ Hodgetts TJ, Mahoney PF, Kirkman E, *op. cit.*

¹⁷ Holcomb JB, Jenkins D, Rhee P, Johannigman J, Mahoney P, et al., *op. cit.*

the greater use of point of collection testing should permit the wider use of massive transfusion capability.

26. **Moral Component.** The moral component provided by the assured presence of the best possible resuscitation processes should not be underplayed. It will have an important impact upon the morale of the population at risk.

PART 3

ROLE 4 MEDICAL TREATMENT FACILITIES

27. Paragraph 220 of Joint Doctrine Publication (JDP) 4-03 2nd Edition *Medical Support to Joint Operations* refers to the current UK Role 4 process as follows:

'The NHS in the UK provides UK Role 4 medical care for all British casualties who require specialist or prolonged (beyond THP) inpatient care, definitive treatment and rehabilitation. The seamless reception, triage, tracking and secondary care of military patients requires close cooperation between MOD and the Department of Health. Entitlement to evacuation to Role 4 should be a feature of the Permanent Joint Headquarters' (PJHQ) eligibility matrix.'

28. The UK approach to Role 4 provision has significantly changed since the promulgation of the 2nd Edition of JDP 4-03. This section will clarify the doctrinal changes that will be incorporated into the next edition. To ensure that the force generation and establishment processes are appropriate and assured; an early, endorsed, exposition of the doctrinal requirement for Role 4 treatment is required.

Definition

29. Role 4 *'provides the full spectrum of definitive medical care that cannot be deployed to theatre or is too time consuming to be conducted there'*.¹⁸ This would normally include definitive care, specialist surgical and medical procedures, reconstructive surgery and rehabilitation. This care is highly specialised, time consuming and normally provided in the casualty's country of origin. The acute phase of this is provided within the main receiving hospital at University Hospitals Birmingham Foundation Trust (UHBFT) in combination with the Royal Centre for Defence Medicine (RCDM). Subsequent rehabilitation is provided according to clinical need with less severe cases going to Primary Care Rehabilitation Facilities (PCRFs) or Regional Rehabilitation Units (RRUs) and the majority of the complex cases going to the Defence Medical Rehabilitation Centre (DMRC) at Headley Court. RCDM and DMRC are collectively known as the UK Role 4 Medical Group (although elective and acute Force Generation patients are also admitted to and treated in both locations). During an individual patient's care pathway he or she may return to Birmingham or be referred to other NHS or third party specialist centres. The overall partnership with the NHS is therefore fundamental to the

¹⁸ Allied Joint Medical Support Doctrine (AJP-4.10(A)), p.1-13.

provision of Role 4 care in the UK but is not necessarily tied to one specific Trust or Strategic Health Authority.

Royal Centre for Defence Medicine

30. The RCDM was established in 2001 and is now the focal point for the military reception of operational casualties. RCDM supports UHBFT through the provision of Defence Medical Services command and control, manpower and specialist military expertise in order to facilitate the Patient Care Pathway. This is a logical extension of operational care provision. Thus, RCDM is an operational unit in the Home Base responding to the operational tempo of deployed formations. Therefore, during operations, it must not be constrained by peacetime business, timelines and activities. This demands manning and establishment support from the single Services and MOD as well as opening up Command, Control, Communication and Intelligence (C3I) tasks.

31. The critical contribution that the tri-Service uniformed Role 4 Medical Group staff provide is the visible, sustained and continuing military presence within UHBFT to work alongside NHS colleagues. The skill-mix of the military personnel should be appropriate to the tasks. They must be sufficient in number to allow deployment as required without compromising patient care. This Joint and cross-government approach that has been developed between RCDM and UHBFT meets the duty of care expectations of the patient group,¹⁹ the chain of command, ministers and the nation. It delivers military effect – first class clinical care supported by comprehensive military administrative and welfare provision which are all necessary to the well-being of the operational casualty. In doing so, RCDM directly supports the conceptual, moral and physical components of fighting power as articulated in British Defence Doctrine (BDD).²⁰

Defence Medical Rehabilitation Centre

32. DMRC's core function is as part of the force generation process, returning injured military personnel to their functional lines. The rehabilitation of seriously injured casualties also contributes to force generation within the physical component of BDD but in addition is of great significance to the moral component. While complex trauma rehabilitation is currently perceived to be of core importance, its high profile is a function of the current operational climate. In a similar vein to RCDM, DMRC must be viewed as an Operational Unit (again at the home base) having a duty to respond within an operational timeline without being constrained by peacetime business processes.

¹⁹ The patient group encompasses both the patient and next of kin.

²⁰ *British Defence Doctrine* (JDP 0-01), 3rd Edition, August 2008, Chapter 4. Conceptual, Moral and Physical components.

33. The subordinate RRUs and PCRFS facilitate the flexible and responsive management of those injured operational casualties that are either in the later stages of recovery or less seriously injured, allowing them to be rehabilitated in an environment appropriate to their needs. They form an integral part of the patient care pathway and so are part of the manning and establishment requirement for DMRC.

34. Balancing the numbers of uniformed to civilian staff within the rehabilitation lines of both DMRC and the RRUs is an important element of fulfilling the duty of care. Again, this is a function of the single Services and wider MOD rather than being a purely DMS role.

35. The rehabilitation function goes beyond the clinical duty of care and includes the requirement to maintain and instil military ethos with all personnel acting as exemplars. Supporting this process will be the clinical, social, mental, spiritual, administrative and general welfare support services provided from within DMRC and its associated RRUs. These functions should be aligned with both the moral and physical components of BDD and raise the profile of DMRC's vital and supportive role within the operational environment.

Command Considerations

36. The assured provision of apposite personnel to fulfil the establishment and force generation of Role 4 capability must be recognised as an MOD-wide responsibility. It must be supported by the single Services, Surgeon General's Department and the Joint Medical Command.

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LEXICON

The Lexicon contains acronyms/abbreviations and terms/definitions relevant to this Joint Doctrine Note. For fuller reference to extant terminology see the current edition of JDP 0-01.1 *The UK Glossary of Joint and Multinational Terms and Definitions*.

PART 1 – ACRONYMS AND ABBREVIATIONS

AAP	Allied Administrative Publication
ADMEM	Academic Department of Military Emergency Medicine
AJP	Allied Joint Publication
C3I	Command, Control, Communication and Intelligence
DCDC	Development, Concepts, Doctrine and Development Centre
DCR	Damage Control Resuscitation
DCS	Damage Control Surgery
DMRC	Defence Medical Rehabilitation Centre
DMS	Defence Medical Services
JDN	Joint Doctrine Note
JDP	Joint Doctrine Publication
LIMS	Laboratory Information Management System
MEDEVAC	Medical Evacuation
MERT	Medical Emergency Response Team
MOD	Ministry of Defence
MTF	Medical Treatment Facilities
MTP	Massive Transfusion Protocol
NHS	National Health Service
PHEC	Pre-Hospital Emergency Care
PJHQ	Permanent Joint Headquarters
R2E	Role 2 Enhanced
R2LM	Role 2 Light Manoeuvre
RCDM	Royal Centre of Defence Medicine
RRU	Regional Rehabilitation Unit
THP	Theatre Holding Policy
UHBFT	University Hospital Birmingham Foundation Trust

PART 2 – TERMS AND DEFINITIONS

Damage Control Resuscitation

A systematic approach to major trauma combining the <C>ABC (catastrophic bleeding, airway, breathing, circulation) paradigm with series of clinical techniques from point of wounding to definitive treatment in order to minimise blood loss, maximise tissue oxygenation and optimise outcome. (JDN 2/10)

Damage Control Surgery

Damage Control Surgery is an operative strategy that sacrifices the completeness of the immediate surgical repair to that required to achieve haemorrhage and contamination control, in order to address the physiological consequences of the combined trauma of the injury and surgery. (JDN 2/10)

Haemostatic Resuscitation

Haemostatic Resuscitation is the attempt to reduce hypothermia, maintain normovolaemia (or permissive hypovolaemia) and reduce the physiological burden of injury. (JDN 2/10)

Medical Emergency Response Team

Medical Emergency Response Team (MERT) is defined as the medical component of an Incident Response Team where the capability may be delivered in the maritime, littoral, land or air environments. MERT is used when the clinical situation dictates the need for specialist Pre-Hospital Emergency Care (PHEC) interventions during Medical Evacuation (MEDEVAC). (JDN 2/10)

Role 2 Enhanced

Role 2 Enhanced is a basic secondary care facility built around primary surgery, intensive care unit and beds with nursing support; a R2E facility is able to stabilise post-surgical cases for evacuation to Role 4 without the need to put them through Role 3 first. (JDN 2/10)

Role 3

Role 3 is provision of theatre secondary healthcare within the restrictions of the Theatre Holding Policy (THP); offering a range of clinical services not available elsewhere in the theatre of operations. (JDN 2/10)

Role 2 Light Manoeuvre

Role 2 Light Manoeuvre conducts triage and advanced resuscitation procedures up to damage control surgery. (JDN 2/10)

Role 4

Role 4 provides the full spectrum of definitive medical care that cannot be deployed to theatre or is too time consuming to be conducted there. (JDN 2/10)