Ministry of Defence

bite-size doctrine

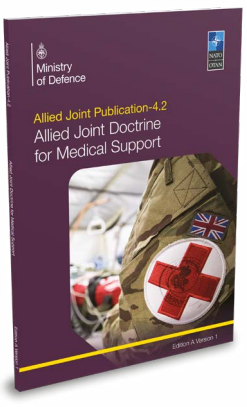
Executive summaries of UK joint doctrine

Allied Joint Doctrine for Medical Support

Allied Joint Publication (AJP)-4.2, *Allied Joint Doctrine for Medical Support*, is NATO's level-2 doctrine for planning, preparing and conducting medical support to Alliance operations. It provides commanders and their staff with a common framework for the medical contribution to NATO operations, clarifying NATO's approach to medical organisation, procedures and responsibilities.

Core philosophy and approach. AJP-4.2 treats medical support as a key force enabler, central to Alliance force preparedness, readiness, resilience and sustainability. Health is understood broadly to be a state of complete physical, mental and social well-being, rather than merely the absence of disease; the preservation of this wider state of health is recognised as a shared responsibility of commanders, other staff functions such as logistics and personnel, and individuals themselves, as well as medical staff. Following a fundamental restructuring to improve coherence with AJP-01, AJP-3, AJP-4, AJP-5 and AJP-10, the doctrine is now organised into eight chapters. The first two establish the fundamental principles of medical support and medical planning, emphasising the integration of the joint medical staff into the commander's joint operations planning group from the earliest stages. The remaining six chapters are structured around the six components of medical support: command and control; communication and information management; force health protection; military health care; medical evacuation; and medical logistics.

All-hazard approach. A recurring theme throughout the doctrine is the all-hazard approach, which is captured in the chemical, biological, radiological, nuclear, explosive, environmental and endemic threats, alongside trauma (CBRNE3T) framework. The CBRNE3T framework provides a comprehensive and threat-agnostic basis for assessing risk to the force and to the wider population at risk. This framework underpins force health protection, which must be proactive and collaborative, integrated into planning before deployment and sustained through to the post-deployment period. It requires working closely with force protection, CBRN, environmental health, veterinary and intelligence functions to build a shared situational picture.



Multinational and civil-military dimensions. The doctrine places strong emphasis on collective responsibility, encouraging nations to share the operational burden through standardisation, cooperation and the pooling of scarce medical resources. National contributions can range from purely national elements to fully integrated multinational medical units, with responsibilities governed by memoranda of understanding or similar arrangements. Civil-military interaction is framed as a strategic necessity

rather than an optional extra, recognising that host-nation and non-NATO medical systems may be unable to meet demand, and that security, legal or political constraints may limit the extent of achievable cooperation. Mortuary affairs, patient-return policy and the balance between operational imperatives and individual patient care are identified as areas requiring close coordination between medical advisers and operational commanders.

Continuous improvement and people. The doctrine stresses continuous improvement in health care support to operations, driven by risk management, lessons identified and learned, research and innovation, and digital transformation. Medical units and headquarters staff are expected to identify lessons clearly (within routine reporting), with the chain of command ensuring these are properly staffed and fed into the wider analysis process, supported by the Centre of Excellence for Military Medicine and the Joint Analysis and Lessons Learned Centre. Education and training remain a national responsibility, but nations are expected to align with NATO medical standards, and leaders of medical units are expected to be trained and exercised in critical incident management, coordination and planning. Gender perspective and a 'One Health' approach, linking human, animal and environmental health, are both identified as factors that strengthen the effectiveness of medical support.

UK application. Within the UK, planning, mounting and executing medical support is primarily the responsibility of the Permanent Joint Headquarters (PJHQ), drawing on medical force elements generated by the Military Commands and the Joint Hospital Group, and integrated throughout the operations planning process described in AJP-5 and AJMedP-1. Where an operation sits wholly within one operational domain or environment, the relevant Military Command may provide the operational headquarters in place of PJHQ, a model known as componency. UK national elements, identified throughout the text by a union flag symbol, supplement the NATO text, addressing matters such as health care governance arrangements and national legal obligations around patient data.

Conclusion. AJP-4.2 provides the overarching framework for medical support to Allied joint operations, positioning medical capability as a force multiplier that must be flexible, interoperable and resilient against a contested and evolving threat environment. By integrating force health protection, civil-military interaction, continuous improvement and robust command and control, it enables commanders to deliver effective medical support across the full spectrum of NATO operations while safeguarding the health of the force.

Want to read more?

AJP-4.2 is written for commanders and their staff engaged in medical planning and support, and provides a useful reference for coalition partners, host nations and civilian actors involved in medical support to operations.



Find out more about joint operational-level doctrine at gov.uk. For UK Defence staff search for the Joint Doctrine homepage on defnet.