Highlights from the Committee on Surgical Combat Casualty Care Meeting

24-25 August 2023

EXPERIENCE SAVES LIVES

1. Lack of clinical volume and case complexity within our medical treatment facilities (MTFs) is an existential threat to military medicine and joint medical force generation. BLUF: Military MTFs must recapture complex patient care.
   a. MTFs are failing in their role as skill sustainment platforms – the Committee on Surgical Combat Casualty Care (CoSCCC) recognizes the importance of supporting MTFs for clinical currency and force preservation.
   b. There is a need for continued transparency for the challenges with deployed healthcare skill sets / clinical currency.
2. Initial clinical training/certification or specialty label does not equate to currency. *There is a substantial clinical experience gap within military medicine to provide combat casualty care*. 'Experience saves lives' was a theme in the discussions.
3. MTF based Graduate Medical Education (GME) programs are heavily dependent on civilian hospitals to meet national residency requirements. Limited military physician mentorship will negatively impact operational readiness for trainees.
   a. Given distinct deployed clinical requirements; a military unique curriculum (MUC) is necessary to support military medical training. Military GME requires a MUC to help mitigate the Walker Dip and improve battlefield outcomes.
   b. The CoSCCC recommends a Capabilities Bases Assessment (CBA) to define GME MUC requirements at all levels.
4. Orthopedic surgeons are critical wartime specialists (75% of combat casualties have orthopedic or soft tissue injures); their expertise are force multipliers for many Role 2 (R2) capabilities. The CoSCCC identified a need for a R2 Orthopedic Surgery Statement led by the military Orthopedic Subject Matter Experts (SMEs).
5. The War in Ukraine has demonstrated that the misuse of tourniquets (TQ) has been life and limb threatening. In recent wars, short transport times to surgical capability prevented the negative consequences of TQ misuse. Feedback from the UKR battlefield resulted in the Committee on Tactical Combat Casualty Care (CoTCCC) voting to have *TQ conversion and replacement as a Combat Life Saver skill*. This is an excellent example of an adaptive and responsive trauma system.
6. CoSCCC members discussed the necessity for a Role 1 (R1) Procedures Position Statement that would identify types of procedures R1 providers should be prepared to perform during Large Scale Combat Operations (LSCO) and prolonged holding situations. There was not concurrence on the need for this statement, but most felt it would be helpful and empowering for R1 providers. This topic will be further discussed at the CoTCCC meeting in Sept 2023.

INDOPACOM (IPC) Area of Responsibility (AOR) Review

1. Global Health Engagement (GHE) overlaps with Irregular Warfare and is an opportunity to increase clinical competency. GHE includes the State Partnership Program, led by the National Guard, whose mission is to improve capability and capacity at contingency locations. Relationship building with allies and partners is a critical element to promoting regional stability and disaster response capacity, as well as enhancing our theater readiness posture for crisis or conflict.
   a. Forward deployed caregivers and those who may deploy to Indo-Pacific (IPC) need a resource capability that describes Partner Nation medical capabilities.
   b. Understanding cultural history of a region(s) is a mission essential task prior to deployment/partnering in war and during humanitarian assistance/disaster relief.
   c. JTS must formally integrate and engage in IPC Combatant Command (CCMD) work groups. The IPC Surgeon will identify WG and Lines of Effort where JTS can best support the CCMD Surgeon cell.
2. Large Scale Exercises (LSE) PACIFIC SENTRY 23 and TALISMAN SABER 23 demonstrated limited blood availability and resupply capacity and substantial gaps in IPC medical capabilities, logistics pre-positioning and coordination in the IPC AOR.
   a. JTS SMEs must be involved in CCMD level Joint and Service specific exercises. An opportunity exists to measure current medical/surgical capabilities against predicted number of casualties for LSCO in IPC.
   b. JTS SME participation is recommended in developing Commander Estimates during mission analysis for OPLANS.
   c. During LSCO, Fresh Whole Blood (FWB) will save lives and return casualties to the fight. There is an urgent need for standardization of pre-conflict transfusion protocols and novel approaches to increase FWB availability and Freeze-Dried Plasma across R1/R2 platforms throughout IPC to bridge this capacity gap.
3. Critical care capability gaps exist for R1/R2 teams. A diverse panel of providers underscored the lack of clinical experience and critical care gaps at every echelon. CoSCCC members and SMEs will write a review article delineating current critical care gaps for deployed teams, including En Route Care (ERC) teams in current operations and future LSCO.
4. ERC Capability Gaps exist for inter/intra-theater patient transport. The CoSCCC and Committee on En Route Combat Casualty Care (CoERCCC) should be leveraged as SME consultants to assist with recommendations in addressing these gaps and identifying joint training requirements.

The Joint Trauma System and the Defense Committees on Trauma – *Saving Lives with Data*. Contact us:

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