



# Highlights from the Committee on Surgical Combat Casualty Care (CoSCCC) Meeting

03-05 March 2026 – San Antonio, Texas



**Defining the Role 3, Deployed, and Operational Trauma Medical Director (TMD).** A Tri-service panel explored TMD definitions, responsibilities and command relationships, emphasizing that effective TMDs must have inside the tent (clinical) and outside the tent (leadership, operational planning, and communication of risk) expertise. Preliminary consensus concluded:

1. **TMD must be defined in Joint Doctrine.**
2. **Role 3 TMD is the recommended standardized terminology:** Other Service-specific terms (Czar/Chief) should be avoided.
3. **Other TMD types identified requiring doctrinal definitions:** Combatant Command TMD, Deployed/Theatre TMD, and Type Commander/Operational TMD (e.g., commands responsible for man, train, equip mission).
4. **Key Deployed/Operational TMD Skills Identified:**
  - **Operational coordination:** TMDs often serve as advisors on casualty estimates, logistics planning, capability modernization efforts and system design during Phase 0 shaping operations.
  - **Trauma system development:** Efforts include regional advisory councils, teleconsultation networks, trauma registries, supporting training exercises to educate operational elements on the trauma system and quality improvement programs.
  - **Command integration:** Successful TMDs build relationships with operational commanders and medical leadership to influence system readiness.
  - **Deployed/Theater TMD: Unify the medical system** through the JTS performance improvement and JTS Medical Performance Optimization process. Communicate about risk in the deployed trauma system. Integrate teams to focus on casualty care and the **right patient, right place, right time, right care**. Communicate gaps back to the JTS.
5. **Identified Gaps:** Limited institutional memory, lack of formal TMD training, inconsistent expectations between commanders, poorly defined roles, responsibilities and command relationships, and restricted mobility to assess forward units.
6. **Next Steps:**
  - **Develop TMD Position Statement.** Define the types of TMD and associated roles, responsibilities, and relationships. Identify required training courses.
  - **Create TMD/Trauma Program Manager Seminar curriculum** planning committee.
7. **Completed 2025 and Ongoing CoSCCC Work Products:**
  - Complete: [Role 2 Orthopedic Needs Assessment for LSCO](#)
  - Complete: [Fighting to Train – Implementation of a Train Like you Fight Joint Role 2 Austere Surgical Care Curriculum](#)
  - Complete: [The incidence, outcome, and treatment of advanced organ failure and support after trauma: A review with implications for future LSCO](#)
  - Complete: [2025 Update to Committee on Surgical Combat Casualty Care Research Gap Analysis: Top 10 Research and Development Priorities for Battlefield Surgical Care](#)
  - Revision of Austere Resuscitative Surgical Care (ARSC) CPG, ongoing. Lead: CAPT Jack Brandau, MC, USN
  - Revision of Emergency General Surgery CPG, ongoing. Lead: CAPT Anthony Strawn, MC, USN
  - Bioethics Clinical Practice Primer, submitted for adjudication. Lead: Maj Marguerite “Maggie” Spruce, USAF, MC
  - ARSC Handbook – Operational & Planning Guidance, will publish on Deployed Medicine. Lead: CAPT Matthew Tadlock, MC, USN
  - Point of Care Ultrasound Clinical Practice Primer, nearly ready for adjudication. Lead: LCDR Daniel Berman, MC, USN
  - Role 1 Procedural Training Gap Manuscript, nearly complete. Lead: LCDR Brittany Hout, PA-C
  - CoSCCC 10-year Retrospective, under peer review. Lead: COL Linda Benavides, MC, USA

## CoSCCCC Working Group Updates

1. **CPG Work Group: Symptom Management of Severely Injured Casualties in Resource Constrained Environments** – Lead: LtCol Curtis. CPG Goal: To provide symptom management guidelines without hastening death for prehospital, Role 1 and 2 caregivers and medical directors. The Defense Committee on Trauma (DCoT) consensus was reached on CPG clinical guidance. Next Steps: Higher Level DCoT Review and consensus on title; [2026 NATO SOFMedP consensus statement defines this kind of care as: “Care of the Dying Patient During Conflict.”](#)
2. **Role 1 Work Group:** Near-peer operations without air superiority will place unprecedented demands on Role I caregivers. The group reviewed 16 advanced surgical procedures identified by the DCoT to determine if they should be expected of Role 1 caregivers (consensus is fasciotomy should not, but dental procedures should be included). Discussed listing these as good, better, and best and that these should guide training and resourcing but not impose limitations on Role 1 providers. Expanding Role 1 caregiver capabilities will be essential for casualty survival.

**The Joint Trauma System and the Defense Committees on Trauma – Saving Lives with Data!**

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