

SPECIAL TALK: AN INTERVIEW

An Ongoing Series

"It Always Starts With the Heart."

Ricardo "FLO" Flores on personal pushes in moving current care toward best care.

Interviewed by John F. Kragh Jr, MD

How did you come to Special Operations?

My dad went to Ranger school, so I knew that I wanted to be in the Ranger Regiment from some of the stories and knowledge that he shared with me. Because I knew that Ranger Medics did a lot of the same things as the rest of the Rangers, such as shooting the same weapons, jumping out of planes, and other extreme tasks, I felt like it would be a fit for me. I went ahead and passed through Basic Training and then graduated high school. My dad gave me the great advice that if I didn't like being a Medic, then I could always switch out later on.



Ricardo "FLO" Flores

He also advised that being a Medic would give me some additional options when I retired from the military—options that I may not have if I was just an infantry guy while in the service.

I learned early on that I loved the satisfaction of helping other guys when they need it the most—there's just something exhilarating about having a capability that you are competent in and being able to apply that knowledge and skill at the critical moment. I found out that if you're a good Medic living in the Ranger Regiment, that these guys will take care of you—basically there's nothing that you will lack. (laughs) I didn't have a vehicle until I'd been in the Regiment for 5 years because every time one of the guys went off to Ranger school they would give me the keys to their car!

When I arrived at 3d Batt[alion] in September '91, I felt like I was more of an infantryman than a Medic. The Ranger school training was just so much fresher in my mind. I remember graduating from Ranger school, when immediately the Sergeant Major put us on lockdown. We packed that weekend and headed out to link up with the rest of 3rd Ranger Battalion in Texas. Bravo Company had

launched out just that morning to Somalia. I only missed that first flight to Somalia because I didn't arrive until the afternoon. On October 3, 1993, while Bravo Company was in the middle of that fierce firefight, we were in the air—flying over to support them. The biggest worry that I had was whether or not I would remember all of my medical skills, or if I had forgotten anything critical during Ranger school and would let someone die from something that I could have prevented if my skills and memory were sharper.

When I arrived in Somalia I heard that Dr Holcomb—I had never met him before then—had held live-tissue training for Bravo Company in order to sharpen their Medics. I had

never participated in live-tissue training but was confident that as the Alpha Company Senior Medic, it could be a powerful asset for my Medics and [me]. As soon as I was able to track him down, I approached him and said, "Sir, I've been told that you conducted live-tissue training with Bravo Company. I just graduated Ranger school and I was wondering if you would be willing to

do the same training with our guys?" Dr [John] Holcomb calmly replied, "No problem," left to get us some equipment, and coordinated with the task force. That training was a huge boost in confidence. Later, I was able to tell Dr Holcomb, "You'll never understand the appreciation that I have for your willingness to help someone that you had never met before by coordinating that live-tissue lab. The confidence it left me with made me a better Medic." I've been privileged to reiterate that to him on several occasions since that day. The fact that he recognized the value of the Medic on the ground and was willing to help us was huge. I can't honestly say whether or not I could have performed a [cricothyroidotomy] or chest tube in the heat of the moment without that training, but after the live-tissue lab, I was confident that I could competently complete the task should it be required.

"FLO loves people, travel, and *The Gates of Fire*, a book by Steven Pressfield about the 300 Spartans in battle at Thermopylae against the Persian army."

You were in the [Ranger] Regiment when?

I was in the Ranger Regiment from '91 to 2005. From '91 to 2003, I was at 3d Ranger Battalion and I had every position you could have from platoon medic to Battalion Senior Medic. Rob Miller was my Battalion Senior Medic while he was there and then I took over after he left Battalion. I had the privilege to be part of that historical time right after [Frank] Butler introduced the concepts of TC3 [Tactical Combat Casualty Care]. We immediately knew that TC3 made sense and started adapting it into our training. It rapidly highlighted issues that we needed to address.

The first issue that we recognized was that the TC3 program needed to be tailored to the Operator audience. The original TC3 course included in-depth medical science. This actually became a hindrance because the Operators just wanted to be hands on. They needed to understand basic concepts and how medicine was blended into the different phases of care, but other than that, they just needed to be skilled at applying treatments based on the signs and symptoms presented by the casualty.

By modifying the course content, we were able to condense the original 5-day course down to a 2-day course. This helped a lot because the 5-day course was difficult to coordinate due to time, location, travel, and equipment coordination. When we reduced it to a 2-day course, we were able to get buy-in from the leadership at 3d Ranger Battalion so that every Ranger was scheduled to complete a 2-day course annually.

The second gap that we identified was learning to speak the language of the leadership and not just using a medical vocabulary. Medical plans were an afterthought to leadership, but once they understood how medical emergencies affected the operational tempo, they endorsed the need to be practiced and capable of efficiently responding to casualties. Previously, the leadership hadn't grasped what we were trying to accomplish, which was a huge limitation, as they control the logistics of moving patients and aircraft. When leadership wasn't on board, the tempo was interrupted at the CASEVAC [casualty evacuation] phase.

We were able to develop a course for the Ranger leadership, not so that they could be providers but so that they would understand the TC3 principles and be empowered to better manage us based on understanding what our capabilities were. This was another big win for us because the buy-in from the leadership increased our ability to do proper training. We had their endorsement because they understood the intent and expectations. That endorsement also provided approval for funding to purchase or develop equipment that was optimized for the operational environment.

That was the third gap that we identified—the need to have equipment that was ruggedized for use in the field. Only a few days after I arrived in Somalia, I lost a significant

portion of my medical gear when a rain storm hit and the old wooden crates that stored my equipment became soaked. Many of the items in there were not waterproof or in packaging that could withstand the environment. With the leadership funding for optimized gear, we were able to develop our own solutions or start working with vendors to close this gap.

At 3d Ranger Battalion, we started implementing these advancements for ourselves first. Later on, the Regimental Commander had a conference with all the Battalion Commanders, and they came down to Fort Benning and he showed them what we were doing. After reviewing the program, the other Battalion Commanders asked why their medics weren't doing what 3d Battalion's medics were doing. The conclusion was that the Regimental Commander mandated our process and it became a Regimental Program. It was incorporated by COL [Stanley] McChrystal, making medical one of the top four priorities for training. This paradigm shift really changed things around for us. COL McChrystal escalated medical to the same level as physical conditioning and firing at the range, granting significant credibility to the program. So now, not only were Rangers highly lethal they were also highly survivable!

To be "survivable" required empowering the Operator to have the ability to save his own life or his buddy's life without having to wait for the Medic. This was really the turning point for the Ranger Regiment. Many times after we instituted the program, by the time I got to a wounded Ranger, there was little I needed to do except reassess the casualty. What that did was free the Ranger Medic to focus more on the advanced procedures: the [cricothyroidotomies], the chest tubes, and other procedures [that] we were not training the Operators to do. Additionally, that allowed the Ranger [Medic] to grow because he didn't have to do just the basics. Now the Medic could be the advanced care provider.

The biggest lesson that we learned during this time was that in order to be successful you have to have the right training, the right equipment, and command endorsement. I think that is a three-legged stool, but without command endorsement you don't have the time to train (or the prioritization for training), and you also don't get the financial support and the logistics to get the equipment that you need.

Of those changes, what are you most proud of?

When we went outside of the fence. It was Rob Miller that started what we called "cross-pollination." We saw that other SOF [Special Operations Forces] units like the PJs [US Air Force Pararescuemen] were doing great things, but we were not using some of the techniques and equipment that these units were employing, and SOF guys tended to be pretty innovative. The Rangers weren't necessarily known for being innovative at the time, so when we saw what the PJs and the SF [Special Forces] were

doing, we made it a point to learn the best practices that SOF was utilizing and then we started incorporating them into our training. Bringing in the knowledge from other experts allowed us to grow by seeing what worked for us and leap-frogging ideas to better meet our specific needs. There were all these guys in Special Operations doing great things, but they weren't generally allowing for synergy by sharing ideas and solutions. Miller broke down those barriers and said, "Those guys are doing some smart things. Just because they aren't Rangers doesn't mean we can't learn from them. Let's see if that works for us." We experimented.

One of the big wakeup calls for us was when we started to do medical simulation. We trained ourselves. We developed the Ranger Medic Assessment and Validation Program (RMAV) in order to really challenge the medics. We put them in real-world-like conditions and as they were doing all these procedures we exposed training gaps and equipment gaps. We had guys begin the simulation confident that they could do a chest tube, or a [cricothyroidotomy]. Then they opened their aid bag and we found out they were missing their scalpel or they were missing their chest tube. We realized that we needed to put validations in place for our training, and a place to start was with validating our packing list. There were a lot of guys that had this sense that they were good to go, and unless you challenged them by submitting them to a situation that required confirmation of their readiness or capability, they didn't learn whether or not they were truly prepared.

At the time, the medic didn't have any requirements for medical sustainment. We recognized that we needed to know how to really confirm if our medics were ready. They didn't have any required training or credentials, so we mandated in the Ranger Regiment that all of our medics had to be EMT (Emergency Medical Technician)-basic certified. Later on, we made it a requirement that they go to the Special Operations Medic Course. That was the evolution of how we reached the quality of medic that the Ranger Regiment attained—by developing a success path that required going through a pipeline [that] verified training knowledge and confirmed capabilities. Mandating this pipeline really gave us a standard, basic medical capability that we had previously been projecting but were not able to validate. Finally, we had all these guys that were SOF medics in capability, not just SOF medics in title. Once someone completed the course, they possessed a standardized medical capability that everybody could understand and would be consistent across the Regiment.

You rewrote the book!

Yes. We wrote the *Ranger Medic Handbook*. Again, we had a great team of Medical NCOs [noncommissioned officers], medical officers, and junior enlisted that came together to focus on improving survivability. We started realizing that we were expecting the medics to perform, but we didn't have a reference that outlined our drug

list—a list of what drugs we needed the medics to know. We had TC3 as a guideline, but that didn't break down the details of protocols. We wanted a pocket reference so all the medics knew the standard they needed to execute. Now people are using the *Ranger Medic Handbook* internationally. Raising the standardization to include medications and putting everything down in the Handbook really took the Ranger Medic from the Stone Age to being a leader in trauma. That's something that gives me great pride—when I see where the Rangers are at now and how they are continuing to improve best practices. I think it's hard for a lot of people to truly understand the evolution that we have gone through, but it's been a significant journey.

The whole thing is changed.

Yeah. You see a lot of the things that the Rangers are doing and people are still adopting. They look to the Rangers as a source because they are validating their decisions. They're not just writing protocols and going out there without first verifying the success and accuracy of those protocols in real-world-like conditions.

How do you look at the challenge of giving best care?

There's a common mistake we make. When I was a young medic who had just graduated from the schoolhouse, I thought I knew everything. I was able to succeed at this course, and then I started to think I was super-smart—I knew everything. Yet, the more you learn, the more humble you become because you realize there's so much you don't know. You still get to see the example set by guys like Dr Holcomb and all my previous Battalion Surgeons like Dr Pappas, Dr Kragh, and Dr Kotwal. All of my mentors have this incredible base of knowledge, and they're still continuing to learn.

I think that is one of the strengths for the members of this community—many of us have realized that we should always be aware that you can never learn enough. Our experiences in real-world situations have trained us to be conscious that all you have available in a tight spot is what you brought with you. How long can you sustain somebody with the equipment and training you have right now? Even in the Ranger Regiment, when we conducted a combat parachute insertion into Afghanistan (Objective Rhino), we were told that we would have to complete that mission within a single cycle of darkness. If we didn't, we might be there for another day or two. We brought extra medical equipment to sustain our guys to address the potential of prolonged field care. On another mission, we ended up bringing three donkeys for [ammunition], water, and medical gear. I was thinking, "Here we are with all of this modern gear, vehicles, and high-speed technology, but in 2012 we're resorting to solutions they had in [the Second] World War." You have to always be prepared to go back to the basics. You may have all these lasers on your rifles, scopes, and stuff, but you have also got to be prepared to use iron sights—iron sights don't require batteries.

Trauma is the blood-and-guts stuff where individuals see themselves coming in to save the day, but nursing skills are part of the sustainment phase that combine to make you a great medic. It's not just the adrenaline heroic skills. You have to look at the problem holistically and be prepared to learn something new that will make you better equipped to help your team when they need it the most.

You went from 3d [Ranger Battalion] to Regiment?

Yeah, Ranger Reconnaissance Detachment [RRD]. They were doing incredible missions that were different than the standard Ranger missions. These guys were going out in small groups without any medical support. They were going to these high-speed shooting, communications, and survival courses, but they weren't doing any medical training.

Unfortunately, we had a team hit in RRD that resulted in all of them being injured. They didn't have a medic on the team and their medical training was not where it should have been. When you hear the story of these guys, you find out they took shelter under a train overpass. The hard question was, why didn't they all have the self-aid training? There was a single infantryman that was acting as the medic treating everyone, but his medical training wasn't focused on as much as it should have been.

When I went to RRD, they were in the process of updating their training course. It was the perfect opportunity for me to develop the RRD Medical Course and have it integrated into the training course. Because of their unique profile, we had to adapt certain things to give them a skill set above and beyond the basic TC3 course. They had the potential to be doing continuous operations with limited resources, so I really challenged them. Initially, they looked at medical training like NBC [Nuclear, Biological, and Chemical casualty] training: no one really wanted to do them. They would have rather gone to shoot at the range or gone to workout. By employing a good imagination and integrating medical into all the operational training, I was able to more successfully engage them.

A shift in paradigm was required so that medicine was not just thought about as an initial medical training course. Instead, I was able to shift the way of thinking to consider how to incorporate medical training into time shooting at the range or when they would go out to do other operations. By thinking this way, new questions started exposing gaps in preparation: How are you going to [evacuate] these guys? What medical assets do you have available? How much equipment can you take with you? Training their minds to think this way had high dividends for the RRD as they started realizing that previous solutions had not been challenged thoroughly. When they started taking it out to the field, they had to adapt solutions to be realistic.

I was there until 2005, and then COL [AI] Moloff gave me a position at the Defense Medical Readiness Training

Institute [DMRTI]. I had the opportunity to start out as the training NCO for the Combat Casualty Care Course [C4]. Later, I became the NCOIC [NCO-in-Charge] of the course. My Company Commander was Troy Vaughn and I had two SF Ranger-tabbed leaders at Fort Sam Houston. It was the kind of leadership that I was used to, so I understood their way of working. They came down there, and started implementing tactical medicine for the course and other programs at DMRTI.

It was eye-opening for me, going from the Ranger Regiment culture to the medical culture of Fort Sam Houston. The different styles of teaching and different expectations of instructors presented me with a new set of challenges as a leader than what I had experienced in the Ranger Regiment. It was a time of some of my highest personal accomplishments as a leader, because of the leadership challenges required to navigate these differences.

One time, in order to ensure that the students had a quality class, I took over presenting for an instructor who was struggling. I felt that changes were needed in order to optimize the instructor presentations and determined that an instructor boot camp could significantly assist with these goals. Implementing an instructor boot camp was not easy. During the slow summer season, I wanted to take the opportunity to have all the instructors present their classes to me. That idea was not an easy sell to the leadership, so it took me a year-and-a-half to institute the instructor boot camp. [Student] critiques identified the problems beforehand and verified the complete turnaround afterward. The instructors were [then] ready to present their courses.

It was Troy Vaughn who told me this: "Think how much you are learning here, how much you're growing as a leader [here] because of the challenges you have that you didn't have in Special Operations." It was true. In Special Operations, we took for granted that people were motivated, disciplined, and knew that this was life-and-death.

From DMRTI, I went on to the John F. Kennedy Special Warfare Center at Fort Bragg, where I became the Medical Operations Sergeant. I helped develop a couple of the USASOC [US Army Special Operations Command] First Responder Courses. Retiring from there, I started getting job offers from all these different companies, so I figured I would venture out for these good opportunities. By working with corporations tied to the SOF community, I would still be given the opportunity to work with SOF guys [and] still do some of the medical stuff. So going way back to when I decided to join the Army, I was still following the advice that my dad gave me and seeing that being a medic truly gave me opportunities that an infantry guy wouldn't have had.

Your dad was right.

Yeah, he was! He gave me good advice. When you see or hear the story, you have guys like Holcomb, Monty, Miller,

Russ, Pappas, you—my first doc in the Ranger Regiment way back when I showed up as a Private in '91. I still remember you grilling me on questions, and I was like, "They didn't teach me that in AIT [advanced individual (medic) training]!" I was in survival mode; I had just arrived at the Regiment.

When you first get there, you're in a probationary period. There are a lot of guys getting kicked out. Attrition rate back then was that out of the 15 guys to make it through RIP [Ranger Indoctrination Program], only five or six would still be around 6 months later. We had a high attrition rate. That first year, I was just focused on making sure that I didn't get kicked out of Ranger Regiment. I was following what my squad leader told me to do. I loved it!

In the 2001 initial insertion into Objective RHINO, TC3 principles allowed for the collection of data that [were] later published in Dr Kotwal's *Eliminating Preventable Death [on the Battlefield]*. Those TC3 principles equipped the Ranger Regiment with the capability of producing those results—eliminating preventable deaths. But that success hinged on the fact that we had the training, the equipment, and the command endorsement prior to going to war.

One of the most powerful things that was done (though it may not seem as glorious as some other things because nobody else wants to take the time to do the paperwork), was the work that Sergeant Montgomery did to make sure that those programs became legacy programs that are still in effect today. Prior to these lessons learned, we were seeing the first friction point in a mission occur when we started sustaining casualties. We got bogged down. We didn't have a good plan, because we had only conducted medical rehearsals for actions on the target. It happened in Somalia: we had not planned casualties in the other phases of the operation. So when PFC Blackburn fell during fast-roping, it became an unforecasted requirement. We had not war-gamed taking a casualty during [infiltration].

Somalia was a catalyst. We learned that we couldn't just focus on casualties [on] the objective. We needed to look at casualties from the moment we left until the moment we came back. Those were the things that made us better, because we were honest with each other and we didn't try to hide our faults. We identified and fixed them.

When we jumped into Objective Rhino, one of the main missions where I was on target, we had minimal resistance. It was the one they showed on TV [television]. I was on the third bird going in. I never expected that this was going to be in the news. I thought it was just going to be another Ranger mission that nobody would ever hear about because that's just the nature of the stuff we did. We came back from the mission, and they had it in the chow hall on the big screen. I was surprised and thought to myself, "They didn't even tell us that we were going to be on TV!" We had a sense of pride.

Later that night, I was getting ready to go take a shower and I was walking in the dark. From a nearby tent I heard some young Rangers talking. One of the Rangers was complaining because he was getting his combat scroll and he didn't get into a big firefight or engage the enemy. So he felt that he didn't deserve his Ranger scroll [combat patch]. I couldn't help but think that at the other target we had a brown-out when one of the birds flipped over on the target and two Rangers got crushed and killed. I remember thinking when I was a young Ranger that I wanted to go to combat to see what it was about. I realized that once you've been to combat and you've had a serious experience, you go to combat because it's your job, not because you want to do it. Most of the time, war's boring, but when it's high intensity and you lose people, you don't want that again. The first time is naiveté. The second time—that's bravery. It doesn't matter how badass you are, sometimes you're just in the wrong spot. I wasn't going to say anything to the young Rangers but it kept bugging me, so I stepped into the tent. I told them, "You know what? You might think that you didn't do anything to earn that scroll. There were two guys that died on this operation that gave their lives for that. So when you're thinking and you're looking at that scroll, just keep in mind that two Rangers died. Maybe that will give you a better sense of what that scroll on your shoulder really means and you can be proud that you earned it."

I remember in 1993, Private First Class Marcus Muralles [a peer PFC Ranger Medic of FLO] . . . died in Operation Red Wings [mentioned in the book, *Lone Survivor*]. He was the SFC 160th SOAR medic in the Chinook helicopter.

He took me under his wing. I was really impressed with his intelligence. He was a smart guy and he had a happy, smiling, laughing personality. He had such a big presence. I remember that I tried to talk him out [of leaving]. We were doing a fixed-wing [bilateral operation]. We were on Lawson Army Airfield. He was sitting there, and he told me he was thinking of going to Task Force 160. I tried to talk him out of it because I didn't want him to leave the Ranger Regiment. He told me, "I'm tired of road-marching everywhere. I just want to get into a helicopter and fly around." When I last saw him, I was down on the [San Antonio] Riverwalk and I ran into him while he was at [Advanced Noncommissioned Officer Course]. He was getting ready to deploy—his last deployment. The funny thing was that he had a few beers and got the great idea to call our old Battalion Surgeon, Dr Kotwal, at [0200] so that we could have lunch with him the next day. His sense of humor is one of the things that Marcus was known for.

The quality of people that I have been privileged to work with—to me, it's humbling. I feel fortunate that I can call guys like Rob [Miller], John [Holcomb], Russ [Kotwal], John [Detoro], and you, friends. Think of all the things that these guys have accomplished! Their hearts have been in the right place and I think that's what sets them apart. It always starts with the heart. Some guys want to do stuff,

but it's all about their egos. They want their names to be important; the true accomplishment is secondary. Then there are the guys that truly care about the guys on the ground: what can we do to bring those guys back alive? They have a sense of duty to do everything we can to bring our guys back alive.

When you look around [at the Special Operations Medical Association (SOMA)], it's like a brotherhood reunion. Every time you come back here, you meet these guys and get to have a couple of beers. If it wasn't for SOMA, I wouldn't get to see probably half of these guys throughout the year. After I retired from the military, I think that's part of why I didn't have withdrawal symptoms. A lot of people leave the military, and the biggest thing they miss is being around the SOF guys. SOMA is where you get a high concentration of the same caliber of quality individuals in one place. It's hard to find that anywhere else. It's hard to explain to somebody who has never been out there in the middle of the desert when it's 120°F+. When you've been out there for a couple of days and you have somebody that is injured and it's the middle of the night and you're trying to work to save them—you can only discuss that with someone that's been in that situation. That's

why warriors only talk to other warriors. Because they understand what they've been through and they really relate to some of those details. So I can tell you about what it feels like to do a 30-mile road march, but only someone else that has done it, been in those boots, knows how their joints feel, and how tired they feel after that, can really get it. That's the only way you really appreciate what somebody has accomplished.

Thanks for bringing that memory back.

Hahaha! See? Immediately when I said it, the experience flashes back in your mind! If you talk to somebody [who] has not had those experiences, they don't connect to that level, but you get flashbacks. Just like that grueling type of event—only someone [who] has worked to help stabilize an injured brother [who] was headed downhill fast can appreciate the exhilaration of knowing that saving lives is an amazing thing—something that I'm proud to have been a part of.

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