Editorials

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I read with interest the article "Damage Control Resuscitation for the Special Forces Medic: Simplifying and Improving Prolonged Trauma Care" (JSOM 2009, Vol 9, Eds 3-4) by Dr. Risk and Mike Hetzler, 18D. I agree that resuscitation of the trauma patient is of paramount importance, and is an equal partner with the surgical procedure. Perfect surgery on a poorly resuscitated patient is just as fruitless as failed surgery on a well resuscitated patient.

I am excited to see this information being pushed out as far as possible. I am concerned, however, that this will put the SOF medic in a difficult position. I was a paramedic for many years before getting my medical degree and I understand the capabilities, and limitations, of medics. In my current assignment I work closely with the Pararescue community and, while deployed, have treated patients with NSW Corpsmen and SF 18Ds. I have great admiration for these dedicated medical Operators and am honored to serve with them.

However, we are not providing good leadership for these men by adding another extensive skill set to their already exhaustive credentials. Given the current deployment cycle and high ops tempo, it is a challenge for the PJ/SOCM/18D/NSW Corpsman to maintain currency in their operational skill sets (weapons, MFF, etc). It is not reasonable to expect a medic, no matter how capable and motivated, to maintain another "critical care" skill set.

The authors assert "The scope and duration of care provided by SF medics may equate to that of a physician at more than one conventional level." If this is the case, then we need to provide field medical officer support for these operations. I propose that a tactical evacuation model with a medical officer and SOCM be designed to move casualties from the point of injury to a surgical facility, providing experienced critical care en route.

TACEVAC puts a medical officer/SOCM team on a QRF platform. This is not unlike the crew configurations in several foreign militaries (e.g., Australia, Israel) and some civilian helicopter EMS systems in the U.S. This is where damage control resuscitation can have the greatest impact. The more extensive skill set and seasoned experience of a critical care medical officer here can make all the difference down the chain of care.

Rangers have long sent their battalion surgeons to Ranger school. Special Forces is again sending some of their medical officers through the SFQC. The Air Force has developed and deployed Special Operations Critical Care Evacuation Teams (SOCCET) led by a critical care medical officer. We have in the Special Operations medical community, a group of rigorously selected, well trained, board certified physicians with extensive downrange combat experience. We must use them in innovative ways to address the evolving nature of medical care in this long war.

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