THE ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, DC 20301-1200

13 MAY 1997

MEMORANDUM FOR: THE SURGEON GENERAL OF THE ARMY
THE SURGEONS GENERAL OF THE NAVY
THE SURGEON GENERAL OF THE AIR FORCE
PRESIDENT, UNIFORMED SERVICES UNIVERSITY OF HEALTH SCIENCES

SUBJECT: Combat Trauma Surgery

The attached Combat Trauma Surgery Committee (CTSC) report was approved by each of your offices. Within this process, two noteworthy comments were presented; the Navy identified the need to identify a mechanism for record keeping and the OASD (RA) was concerned with the lack of inclusion of reference to the Reserve Components (RC). A mechanism for accurate record keeping is an absolute necessity and will be incorporated in all future actions. The Reserve Components are an integral part of the MHSS and a critical asset in our wartime capability. The concepts, programs and standards delineated by the CTSC and follow-on workgroups should be viewed from the Total Force perspective. The methods of achieving the results, however, may require differing methods of implementation depending on Service or Component.

To move this initiative forward, I am directing the Services develop a phased implementation plan for trauma surgical skill training of Active Component (AC) personnel, initially focused on surgeons, based on the approved recommendations of the CTSC report. The Services must determine the number of surgeons, by the CTSC tiered categories, they require and the number they currently have in each of these categories. The plan should address the availability of inservice programs and use of outservice programs in acute and recuperative trauma care and include the training of entire teams. The Services should submit their plans in 60 days for review by the Defense Medical Readiness Training Education Committee (DMRTEC).

The Uniformed Services University of Health Sciences (USUHS) is tasked to develop military specific trauma courses to meet operational training goals. This military specific training is intended to bridge the gap between the experience gained in trauma centers and the expected military requirements. The USUHS will coordinate development of this military specific training with the Services.

I will use the Defense Medical Readiness Training Education Committee (DMRTEC) as the senior oversight body to coordinate, monitor progress and provide guidance. The DMRTEC will review the Service plans and the USUHS military specific trauma courses to ensure maximum efficiencies are gained through eliminating redundancies and integrating and consolidating where possible. In addition, the DMRTRC will undertake development of a mechanism for accurate record keeping, and the development of a RC program that incorporates the CTCC's concepts and standards. The DMRTEC will provide the Tricare Readiness Committee with periodic progress reports as required.

Edward D. Martin
Acting Assistant Secretary of Defense

Attachment:

Combat Trauma Surgical Committee Report

HA POLICY 97-050

Combat Trauma Surgical Committee

Background and Purpose:

The United States General Accounting Office Reports [1,2,3] to the Chairmen, Subcommittees on Military Forces and Personnel, Committee on Armed Services, House of Representatives, following the Gulf War, recognized that many physicians and other health care professionals were not adequately trained for their wartime mission. Of significant concern was that many surgeons lacked sufficient training or experience in trauma surgery.

The Combat Trauma Surgical Committee (CTSC) was organized in August of 1996 to study policy options for the Department of Defense (DoD) to best sustain wartime trauma surgery capability, and to recommend measurable standards for assessing and reporting of individual surgeons, surgical teams and field medical units.

Assumptions:

1. DoD should have sufficient expertise and personnel to ensure capable trauma surgical care in the earliest stages of combat.
2. Individual services should possess the ability to track trained trauma personnel.
3. A trauma leadership should be in place to enhance training opportunities and the teaching of trauma surgery/treatment in a combat environment.
4. Most Military Treatment Facilities (MTF's) do not routinely see enough trauma admissions to train all personnel internally.

Recommendations:

Military surgeons should be placed in one of three tiered categories:

Category 1 (Trauma Leadership)
Category 2 (Ready Forces)
Category 3 (Need Exposure)

Category 1 surgeons would form a core of trauma experienced/trained individuals who have demonstrated a long term, career commitment to trauma leadership. They would serve as subject matter experts to various commands. Requirements for a category 1 surgeon include:

1. Board certification in a primary surgical specialty and current skills & training evidenced by completion of a trauma/critical care fellowship or equivalent experience.
2. Recognition by the service Surgeon General as a Trauma Leader
3. Fully trained operationally
4. Ongoing active participation in the trauma assessment, resuscitation, decision, decision making and continuum of care with a goal of at least 20 patients per year.
5. Ongoing involvement in trauma care evidenced by educational efforts, membership in trauma societies and publications or research in the field and Completion of 20 hours of trauma related CME I biannually or 30 hours of CME II. By the year 2000, 50% of those CME's should be in military specific topics.
6. Assume and provide ongoing leadership in integrating a team approach to combat trauma sustainment training.

Category 2 surgeons would be those who have completed a variety of trauma related courses and military specific training modules during initial training and periodically over the course of their career. Most, if not all, surgeons should obtain a 'ready' status once their residency is completed. Requirements include:

1. Board certified or eligible in a surgical specialty
2. Active clinical privileges in their specialty
3. Initial ATLS certification or equivalent
4. Clinical rotation of a minimum of 2 weeks every other year at a level 1 trauma center with active participation in the trauma assessment, resuscitation, decision making and continuum of care with a goal of at least 20 patients during that time. Clinical observerships may not be used to meet this requirement.
5. Completion of 20 hours of trauma related CME I biannually or 30 hours of CME II. By the year 2000, 50% of those CME's should be in military specific topics.
6. Completion of service specific/platform specific training as determined by mission or billet requirements.

Category 3 surgeons are those with initial residency training who need additional exposure prior to deployment.

Implementation:

1. The Combat Trauma Surgical Committee's (CTSC's) recommendations are submitted for approval by appropriate authorities.

2. Once standards for surgeons are approved, the newly designated trauma leadership should be tasked to coordinate the development of combat surgical readiness standards for other surgical subspecialties, non surgeons, nurses and support personnel.

3. Individual services determine requirements for the numbers and platform assignments of personnel at each level and category of expertise. Requirements should be written into service Unit Status Requirements (USR's)

4. A Combat Trauma Capability and Skills database should be instituted and maintained by the services for tracking trained personnel.

5. Trauma surgical skill training should be available through both outservice and inservice programs: Inservice training at MTF's would have the advantage of training entire teams, in both acute and recuperative trauma care. Outservice training through civilian trauma centers is likely to be limited to surgeons and anesthesiologists only. A sufficient number of in and outservice training programs should be created to meet the needs established by the services.

6. Didactic - The Uniformed Services University of Health Services (USUHS) lead development of military specific trauma courses to meet operational training goals. Experience gained, even in most active trauma centers, is not equivalent to that gained in an actual combat situation. Military specific training should bridge the gap between civilian experience and expected military requirements.

7. Additional training requirements will have an associated cost, in both money and manpower. It is requested that language be added to the DoD Medical Program Guidance requiring the services to resource the necessary training.

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[i] Report to the Chairman, Subcommittee on Military Forces and Personnel, Committee on Armed Services, House of Representatives. *Operation Desert Storm, Full Army Medical Capability Not Achieved*, United States General Accounting Office report GAO/NSIAD-92-175, August 1992.

[ii] Report to the Chairman, Subcommittee on Military Forces and Personnel, Committee on Armed Services, House of Representatives. *Operation Desert Storm, Problems With Air Force Medical Readiness*, United States General Accounting Office report GAO/NSIAD-94-58, December 1993.

[iii] Report to the Chairman, Subcommittee on Military Forces and Personnel, Committee on Armed Services, House of Representatives. *Operation Desert Storm, Improvements Required in the Navy's Wartime Medical Care Program*, United States General Accounting Office report GAO/NSIAD-93-189, July 1993.