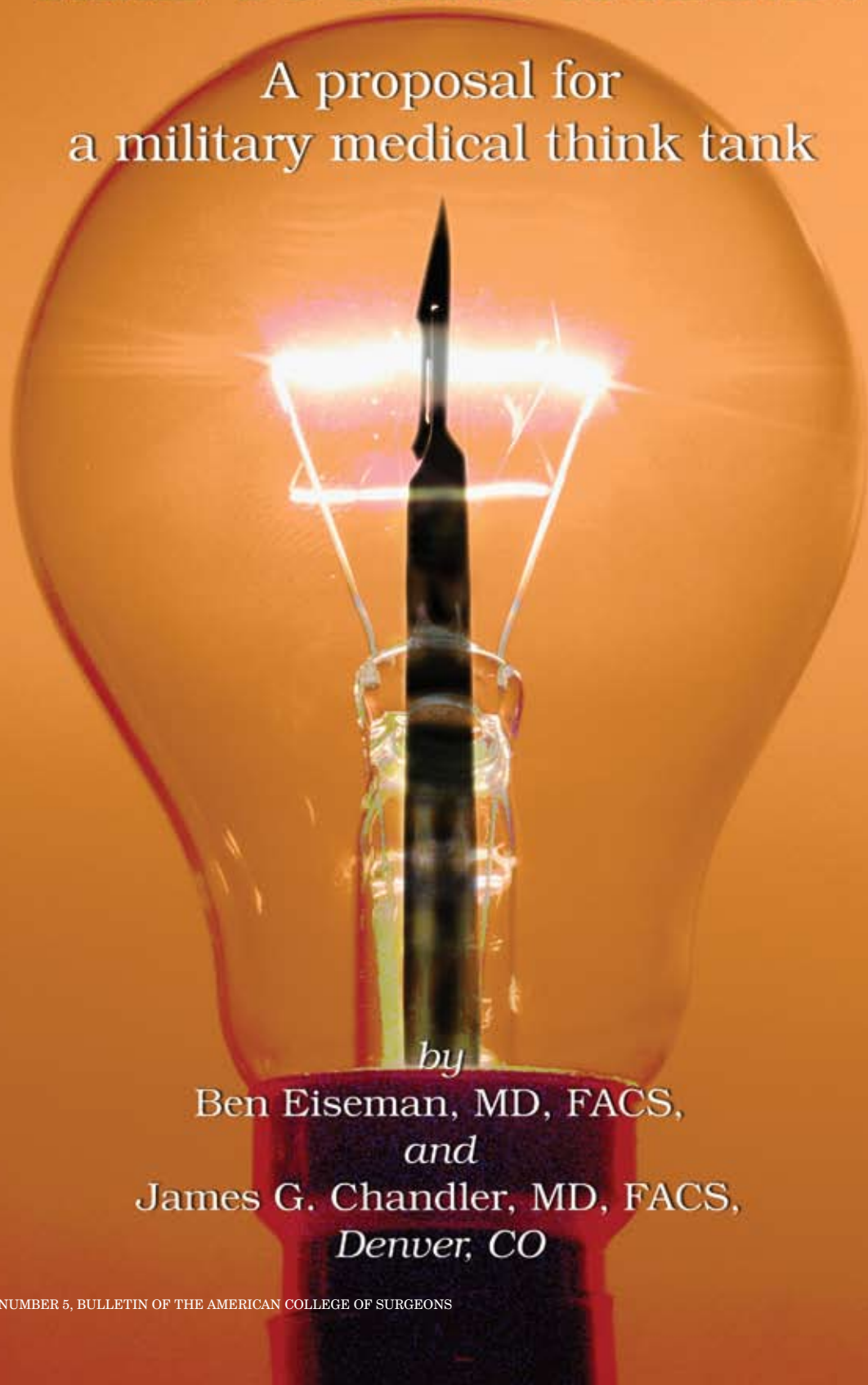


TIME TO LEND A HAND:

A proposal for
a military medical think tank



by

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The Revolution in Military Affairs, wherein overlapping wars are fought with unequal and often stateless antagonists in widely disparate terrains, is in the process of overrunning the three U.S. military medical departments.¹ They are stretched thin; tightly budgeted; and facing novel, critical operational and planning decisions for evolving responsibilities at home as well as abroad.

The disaster wrought by Hurricane Katrina brought two operational issues into sharp focus: Federal force has to take charge when states flounder, and military and civilian critical care and trauma surgeons work well together in tough situations, as exemplified by the displaced Charity Hospital trauma surgeons working side-by-side with Navy surgeons on active duty on the naval ship USNS *Comfort*. The disarray and disconnect between real need and well-equipped, expert help that kept North Carolina's State Medical Assistance Team and its mobile surgical hospital wandering about Louisiana until they found work in Mississippi could have been avoided if they simply could have reported for duty to a coordinated command.²

As the world's only current superpower, the U.S. has effectively become the "world's sheriff."¹ The sheriff is often criticized as being too rough, too self-interested, and sometimes capricious, but detractors and admirers alike look to the sheriff to maintain world order and hunt down the bad guys. Inextricably, by training and professional intent, we are the sheriff's surgeons, as the College has recognized through its Operation Giving Back program and, on an individual basis, through Fellows' participation in religious and secular humanitarian private organizations.

The bad news is that many civilian trauma surgeons are underemployed and undercompensated.³ But the good news is twofold: (1) the military medical services need to develop a limited-term, trauma-care, surge capacity, and (2) several auspicious events are conspiring to bring us all together for the common good.⁴ The Walter Reed Army Medical Center is going to be rebuilt near the National Naval Medical Center in Bethesda, MD, which is likely to be an engulfing merger of unequals but also a substantial step toward triservice medical care.⁵ The Uniformed Services University (USU) is on the same campus

and headed by a Fellow, a trauma surgeon and a former active duty naval medical officer, Charles L. (Chip) Rice, MD, FACS.

We believe the time is right for the College's Committee on Trauma (COT) and others to step up and get behind the sheriff. To facilitate this, we have proposed that a military medical think tank be incorporated into USU's postgraduate division to provide a structured framework for the best minds in trauma, critical care, health care management, and military medicine to formulate new ideas and forge new paths.⁶ This think tank will be modeled after the Rand Corporation and the Brookings Institute, within the structure of the university, to provide evidence-based staff support to the Surgeons General and the Assistant Secretary of Defense for Health Affairs through the Senior Military Medical Advisory Council (SMMAC).

The SMMAC was established within the U.S. Department of Defense (DoD) in 2002 to systematize DoD health care decisions and is the ideal command structure to task such a think tank and to receive its work product. USU's dual credibility within both the Department of Defense health care and the civilian academic community uniquely qualifies the school as the ideal academic administration to oversee the think tank and facilitate its work. The scope of the think tank should encompass both policy and operational issues, with a primary focus on improved care of the sick and injured in both instances.

There are many issues appropriate for think tank deliberations, but the general tenor can be illustrated by considering options for developing a trauma care surge capacity, absent committing to a permanent expansion of the military medical services or putting more burden on the Reserves and National Guard as they are currently constituted. In order of progressive discomfort for the establishment, the options are as follows:

- Integration of military medical personnel from allied nations as individuals or, perhaps more effectively, as a medical battalion or companies into the U.S. Medical Corps as noncombatants, subject to the U.S. military medical command structure. It may be necessary, or even desirable, to limit the activities of an allied nation's medical unit to humanitarian care of the

local population, as this workload component has proven to be substantial in Iraq.

- The DoD sponsors surgical residents and Fellows in both military and civilian training programs. These surgeons are already ranked in the military and have eventual active duty commitments. Temporary assignment to a combat zone or civilian disaster, particularly if mentor pairing were included, would be a valuable part of their training—but to be real contributors, they would need to be of senior rank and activated on short notice, which is unlikely to be popular with their program directors.

- Special trauma/critical care reserve units have always had a certain appeal, as they imply built-in camaraderie and coworker confidence. Surgeons might sign up through a multidisciplinary umbrella in the model of university units of World Wars I and II. Today's health care structure offers several alternatives, including Level 1 trauma centers; individual Veterans Administration (VA) Medical Centers or VA centers of an entire region; or large civilian health maintenance organizations—which could serve as contracting units and manage the added obligation by rotating personnel assignments to the on-call reserve military unit, assuming all substitutions would be in kind; and annual training commitments. Academic trauma departments, in particular, could offer considerable flexibility in return for DoD funding of a cadre of Fellows rotating between clinical care and research.

- Private military firms could easily adapt to provide a trauma/critical care surge capacity.



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They are traditional, for-profit business organizations that provided special-forces-type combat units in Afghanistan and in pre-invasion Iraq and are now major suppliers of foodservice, bulk transport, housing construction, and interpreter resources in U.S. combat and peacekeeping efforts.⁷ Trauma/critical care specialists from other countries, as well as those in the U.S., would be likely participants in a medical private military firm, attracted by very competitive salaries and being free of the fetters imposed by the political stance of various countries and the military bureaucracy. The principal issues are quality control (the COT and ACS's National Surgical Quality Improvement Program), integration, and intelligence security.

This proposal is meant to proselytize. We already see steps in the right direction: the COT's appointment of David Hoyt, MD, FACS, to coordinate its efforts with the military medical departments and the Association for the Surgery of Trauma's Military Medical Liaison Committee, led by C. William Schwab, MD, FACS, another trauma surgeon and former active duty naval medical officer. These appointments suggest that these could be preliminary events leading to the establishment of a regular, productive working relationship.

In the past, military medical leaders—such as Walter Reed, Leonard Heaton, Robert Brown, and Basil Pruitt—freely sought help from their civilian counterparts, and the likes of Evarts Graham, Edward Churchill, Isidore Ravdin, Michael DeBakey, and Tom Shires regularly responded with helpful largess. However, this fruitful civilian–military, collegial medical relationship eventually eroded—not by design, but by simple neglect. This is a propitious moment for both parties to renew the spirit of the past and harvest their joint potential for meeting the widely varying demands that all know are a part of the game, and the think tank should be an ideal venue for restoring this relationship. The issues that merit “out of the box” thinking have been given just a light touch here. Each potential solution has substantive pros and cons that require in-depth and expeditious exploration for the immediate need, but the nature of the issues is such that they will also engender worthy clinical research projects. We are convinced that

the collective knowledge is available and up to the task, and will flourish within the academic framework of the USU. [Q]

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