The Medicanic Defeat Strategy:

How Small Changes Can Make a Huge Impact

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What if every infantry platoon in every brigade combat team (BCT) in the active duty Army had a second 68W combat medic permanently assigned? What if an infantry company's casualty collection point (CCP) also had a second combat medic to assist the company senior medic? A bridge too far, you say. But is it?

Medicanic: (noun) Term in common use for a 68W combat medic who spends considerably more time in the unit motor pool maintaining evacuation vehicles than actually treating real patients or training perishable medical skills.

From October 2001 to June 2011, more than 24 percent (976 service members) died of battlefield wounds that were deemed potentially survivable during Operation Enduring Freedom and Operation Iraqi Freedom.[1]

The above statements are actually linked. One directly influences the other. Fixing the first issue may well fix the more important issue and save thousands of American lives in future combat operations.

There are many benefits to this plan. Eliminating the dreaded "medicanic" will substantially increase training time availability. Recouping this lost training time will build experience, knowledge, and better execution of critical 68W skills sets. Additionally, two combat medics working a single casualty poly trauma, as a trauma team, is far better than one alone. Many casualties exsanguinate within six minutes before their platoon medic can even reach them on the battlefield. Doubling your manpower also doubles the Class VIII immediately available for multi-patient or mass casualty (MASCAL) scenarios.

Unit tactical flexibility will be enhanced with the assault and the support-by-fire elements each supported by a medic. One moving with the platoon leader and one with the platoon sergeant. During high operations tempo (OPTEMPO) mission sets, the current modified table of organization and equipment (MTOE) cannot support conducting three squad-sized dismounted patrols daily. This is unsustainable with only a single platoon combat medic. With two, they can alternate and every patrol will have coverage. If one is injured and evacuated, the mission continues. Improved platoon-level medical readiness, sick call operations, and first responder/combat lifesaver (CLS) training

Soldiers assigned to the 1st Cavalry Division Resolute Support Sustainment Brigade perform tactical combat casualty care on a mannequin during a training exercise at Bagram Airfield in Afghanistan on 17 January 2017. (Photo by CPL Michael Smith)

are all positive by-products. When deploying to combat, what leader would not want twice the combat medics for his or her element?

How do we get there? In an airborne infantry battalion, for example, the magic number to make this work is 16. The medical platoon has eight ground evacuation platforms/field litter ambulances (FLAs). Every FLA is crewed with three medical personnel. For safety, no vehicles operate without a truck commander (TC). However, the driver and TC positions are not required to be 68W personnel. These two duty positions are listed as the ambulance aide/driver within the evacuation section MTOE. By re-tasking these two positions on each FLA, we free additional combat medic resources which were not previously available. These 16 68Ws fill the second combat medic positions in the 12 rifle platoons and four company CCPs.

Optimally, the eight actual driver positions would be filled by motor transportation specialists (88Ms). This would mitigate our "medicanic" issue of 68Ws logging "Motor Pool Mondays" and endless motor stables details, etc. The 88Ms are experienced drivers who are thoroughly trained to safely conduct preventive maintenance checks and services (PMCS), fueling, operator-level maintenance, and all vehicle dispatch documentation. The TC position, riding shotgun, is best performed by the unit primary Military Occupational Specialty (MOS) holders, i.e., an Infantryman (11B). TC duties focus on vehicle/crew safety, routes/navigation, and tactical radio communications. The 16 personnel could be tasked through intra-unit borrowed military manpower (BMM) or by an MTOE change. From a medical perspective, there are four basic prerequisites for these front-seater personnel:

1. Licensed and trained to operate the vehicle safely,
2. First responder/CLS qualified to assist the combat medic,
3. Qualified on their assigned weapon to provide security for the 68W, and
4. No physical profile from wearing body armor/personal protective equipment (PPE) or from carrying/lifting a litter casualty to a top litter berth of a medical evacuation platform.

These personnel changes will re-focus 68Ws on their primary mission — patient care and not vehicle care. Combat medic mission readiness is a direct reflection of training.

The only certainty in combat operations are casualties. Training saves lives. More training saves more lives; less training saves fewer lives.

In Extremis — It's only life and death...

Notes

[1] Brian J. Eastridge, MD, Robert L. Mabry, MD, Peter Seguin, MD, Joyce Cantrell, MD, Terrill Tops, MD, Paul Uribe, MD, Olga Mallett, Tamara Zubko, Lynne Oetjen-Gerdes, Todd E. Rasmussen, MD, Frank K. Butler, MD, Russell S. Kotwal, MD, John B. Holcomb, MD, Charles Wade, PhD, Howard Champion, MD, Mimi Lawnick, Leon Moores, MD, and Lorne H. Blackbourne, MD, "Death on the Battlefield (2001-2011): Implications for the Future of Combat Casualty Care," *Journal of Trauma and Acute Care Surgery*, 73 (Number 6, Supplement 5, 2012), S431.

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