Train to Failure

MSG Dennis Lyons of USASOC on Medical Training and Learning

Interviewed by John F. Kragh, Jr.

How did you enter Special Operations?

I was an infantry medic, came back from Korea to Fort Bragg's emergency room. SOF docs there recommended me, and I tried out for a job, and it worked out pretty well.

You were in JSOC for 9 years and Civil Affairs (CA) for 2 years?

Yes, I learned early the value of joint operations planning, which is even more important now and will be more so in the next couple of decades. CA was challenging, as well. They are Special Operations Combat Medics with additional skills in veterinary, agricultural, and public health and preventive medicine for civil military operations. We had a very wide scope of practice. We focused on improving the sustainment training and the pre-mission validation of medics and refined the SOF CA Medical Sergeants Course.

Dennis loves whitewater kayaking in western North Carolina, the Mecca of southeast whitewater.

Where were you in CA?

I spent 2 years in CA, which included time in the 98th Civil Affairs Battalion, which was oriented toward Southern Command, and in the 95th Civil Affairs Brigade (Airborne) as the Senior Enlisted Medical Advisor.

What does your job "CMF 68 Coordinator/Med Training NCO" mean?

Advisor for SOCM medics within USASOC for professional development and training development. There are about 360 SOCM medics within USASOC. I try to focus on developing medics for future positions of responsibility to look at how they can provide input not only to their current unit and teams, but to the larger SOF medical community so we continue to evolve our medical capabilities and training. Within the training cell we also provide input to the DOD Joint Program Committee for Medical Simulations and Training (JPC1).

What advice do you have for the* JSOM (Journal of Special Operations Medicine) *community?

Lessons learned are to be re-learned, and often they are not so innovative but have to be refound and incorporated in to training. Look closely, objectively, and honestly at failure for the opportunities for growth and improvement. Our goal of training should be for our skill level in the next conflict to start better than where we ended the last.

What training priorities do you have today?

Train to fight the way you're going to fight. Perform in training how you're going to perform in war. Wear in training what you're going to wear to war. Pack what you are going to use in war. Don't treat the grade sheet; treat the patient. Try to mimic mission conditions as closely as possible with the correct operational stressors. A great example is how in training I often see people yelling over a trainees shoulders. The reality is medics are often working in silence with little outside feedback. A medic once summed up his experience with "the silence was eerily deafening and stressful".

What training strategies seem best for you?

Train to failure. You rarely learn by getting a 100% on a test. Real learning comes from failure. As human beings we have been at war for thousands of years. Current lessons learned are rarely innovative, but just relearned from past events, which then have new technology applied to an old problem.

What problems do you anticipate in training in the next 2 to 4 years?

Medics have perishable skills, which degrade quickly. Sustainment training starting the day after graduation is key to preserving those skills. Hands-on training takes a lot, and computer-based training takes very little. Online training seems to be the new answer to most training gaps, but delegating our sustainment training responsibility to computer-based will be a costly mistake.