

LETTER to the EDITOR

To the Editor:

We would like to thank N. L. Boyer, et al. ["Casualty Evacuation (CASEVAC) Platform Review and Case Series of US Military Enroute Critical Care Team With Contract Personnel Recovery Services in an Austere Environment," Volume 21, Edition 4/Winter 2021] for their recent article on contracted personnel recovery services, highlighting the capabilities of and lessons learned while utilizing civilian contracted air medevac in the US Africa Command (USAFRICOM) area of operations. We agree with the authors that contracted air MEDEVAC can provide our US forces in economy of force missions or remote geographic regions with essential capabilities. However, as the authors described, using contractors for medical care and evacuation is not without challenges. We propose that, in addition to the operational level challenges of ground force familiarization described by the authors, there are also several enterprise-level challenges that hinder the ability to fully integrate contracted medical support into the US expeditionary health system. While using contracted capabilities should not be the primary plan for providing expeditionary health services, the ability to quickly and effectively resource and integrate contracted health capabilities into our expeditionary system expands the decision space. Specifically, it expands the decision space for our nonmedical and medical leaders when faced with missions that cannot be sourced by military medical teams.

Nonmedical contracting officers operating in the Combatant Commands (COCOM) lack the training and expertise in writing and managing medical contracts, such as air MEDEVAC and other personal services contracts. This expertise currently resides in the Department of Defense's (DoD) care delivery organizations focused on nontactical care. As these specialized types of contracts to provide medical capabilities to expeditionary forces are still in their infancy, there are no standardized "off-the-shelf" contracting vehicles for expeditionary contracted medical capabilities. Instead of leveraging the expertise of our medical system that commonly contracts care in the US and abroad to support nonexpeditionary care, individual combatant commands or organizations, like Special Operations Command Africa (SOCAFRICA), are left to develop their own solutions and statements of work. This can lead to different standards and decreased efficiencies.

One such example with significant implications in terms of care quality is the lack of policy or guidance on who is responsible for credentialing oversight of contracted medical

professionals. Unlike the DoD's non-tactical care delivery organizations, COCOM's do not have organic credentialing entities to investigate and conduct prime verification to ensure the quality of contracted medical practitioners.

Lastly, North Atlantic Treaty Organization (NATO) doctrine specifically discusses the potential use of contracted medical care in Allied Joint Publication-4.10-Allied Joint Doctrine for Medical Support. Troop contributing nations may provide contracted medical resources as part of a NATO mission. US forces must be prepared to integrate these resources if they are the framework nation or lead nation in charge of health services during a NATO mission. This would include integrating contracted capabilities into the health system in an expeditionary environment. As medical capabilities supporting Special Operations above Role 1 are predominantly provided by non-SOF organizations except for very specific units, the current lack of US medical contracting policy and support to expeditionary forces is a direct risk to mission.

We appreciate the authors bringing the important topic of contracted medical care to the attention of this journal's readership, and we hope these additional points contribute to realizing the full opportunity of contracted expeditionary medicine for our SOF.

2LT A.J. Steinlage*

MD Candidate, Class of 2024
Uniformed Services University, Bethesda MD

COL Ramey Wilson

Medical Corps, US Army
Deputy Director, Military Internal Medicine
Uniformed Services University, Bethesda, MD

*Correspondence to arnold.steinlage@usuhs.edu

Disclaimer

The opinions and assertions contained herein are those of the authors and do not reflect those of the Uniformed Services University or the Department of Defense.

KEYWORDS: CASEVAC; critical care team; personnel recovery; USAFRICOM; MEDEVAC; contractors; medical care; evacuation POSTER RESEARCH AWARD



J^SO^M

JOURNAL of SPECIAL OPERATIONS MEDICINE™



Fall 2022
Volume 22, Edition 3

THE JOURNAL FOR OPERATIONAL MEDICINE AND TACTICAL CASUALTY CARE



Inside this Issue:

- › FEATURE ARTICLES: Effect of Airdrop on Fresh and Stored Whole Blood
- › Nursing: Mild TBI Inpatient Rehab › Whole Blood Storage in Austere Environments
- › Active Warfighter Resilience › Unorthodox Training Methods
- › Military GME Special Operations Clinicians
- › Stressful Simulation Training in Swedish Special Forces
- › Solo-T and the Combat Application Tourniquet Evaluation › Deployed Helicopter Crashes
- › Pioneer: Edith Nourse Rogers › Training Military Nurses for Point-of-Care Ultrasound
- › CRITICAL CARE MEDICINE: Acute Kidney Injury
- › IN COMMEMORATION OF: Women in US Military History
- › CASE REPORTS: Walking Quadriplegic › Operational Consideration for Airway Management
- › Bilateral Pneumothoraces in a Tandem Parachuting Passenger › Hypertonic Saline for Severe TBI
- › EDITORIALS: Military Physician Leadership › Neurological Directed-Energy Weapons for Military Medicine
- › Letter to the Editor › 2022 SOMSA Abstracts
- › ONGOING SERIES: Human Performance Optimization, Infectious Diseases, Psychological Performance, TCCC Updates, and more!

*Dedicated to the
Indomitable Spirit,
Lessons Learned &
Sacrifices of the
SOF Medic*