

Winds of war and military surgeon readiness: Commentary on 'Developing the Ready Military Medical Force: military-specific training in Graduate Medical Education'

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Military Graduate Medical Education (GME) stands at the intersection of healthcare and national defense, playing the dual role of developing an educational and operational force that is unique compared with civilian GME. While both military and civilian GME adhere to the Accreditation Council for Graduate Medical Education standards for medical competency, military GME lacks explicit requirements for military proficiency or deployability. This discrepancy raises concerns about varying skill levels among military physicians, given the diverse training across specialties and the absence of a standardized military unique curriculum (MUC). In this edition of *TSACO*, Baird *et al* address this difficult task of establishing a high-quality and functional MUC.¹ The authors identify multiple factors affecting a universal MUC. However, the necessity of its implementation remains—especially for surgical specialties.

Maintaining deployment readiness is difficult, and implementation across GME is wrought with significant barriers. For example, Hall and colleagues found little overlap between patients seen at military treatment facilities and patients seen on deployment.² To overcome this, GME experiences are often outsourced to civilian trauma centers. But these civilian experiences may not be reliable battlefield surrogates. Robust trauma centers have technology and capabilities not afforded in the austere environment, and many serve a primarily blunt trauma mechanism population. Attaining and maintaining military medical readiness is not feasible purely by osmosis; a deliberate and objective effort is warranted to ensure a deployable surgical force. Assuming our military graduates are competent to take care of patients in a military treatment facility is one thing, assuming they are competent to take care of the deployed warfighters is quite another, and by no means equivalent.³ While we have the tools to assess the prior, we fundamentally have ignored the opportunity to implement a regimented approach to ensure the latter.^{1,4}

Until a cohesive approach to address the specific military training requirements is ensured across specialties, some options are worth exploring. A standardized MUC for military personnel training in civilian GME positions may help provide some

relevant military experience. Adjunctive or 'just-in-time training' modules focused on deployability could be added across tri-service GME curricula. Examples of these would include the ASSET Plus course, the Extremity War Surgery course, and other core trauma exposure courses. Even these adjuncts fall short of the proposed benefits of a specific GME-level MUC. By investing in a specialized curriculum, military GME can enhance the readiness, competency, and professionalism required for the overall success of the armed forces in fulfilling their mission and their sacred responsibility of caring for our wounded servicemembers.

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REFERENCES

- Baird EW, Lammers DT, Betzold RD, Brown SR, Tadlock MD, Eckert MJ, Cox DB, Kerby JD, Gurney JM, Elster EA, *et al*. Developing the Ready Military Medical Force: military-specific training in Graduate Medical Education. *Trauma Surg Acute Care Open* 2024;**9**:e001302.
- Hall AB, Davis E, Vasquez M, Umberger J, Tadlock MD, Qureshi I, Walker A, Glaser J, McClendon H, Gurney JM. Current challenges in military trauma readiness: insufficient relevant surgical case volumes in military treatment facilities. *J Trauma Acute Care Surg* 2020;**89**:1054–60.
- Nealeigh MD, Kucera WB, Bradley MJ, Jessie EM, Sweeney WB, Ritter EM, Rodriguez CJ. Surgery at sea: exploring the training gap for isolated military surgeons. *J Surg Educ* 2019;**76**:1139–45.
- Neuman TJ, Johnson WR, Maciuba JM, Andrews M, O'Malley PG, Wilson RL, Hartzell JD. Updating the military unique curriculum for a ready medical force. *Mil Med* 2023:usad099.



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