

SPECIAL TALK: AN INTERVIEW

An Ongoing Series

From the Trails of Afghanistan to the Streets of America: COL (Ret) Andy Pennardt on Frontline Medical Care

Interviewed by COL Dan Godbee, MC, FS, DMO, FL-ARNG

Tell us about the operation in Kandahar in 2001? Briefly what happened and how did it happen?

US Special Forces personnel and their Afghan coalition partners were fighting Taliban forces near Kandahar. On



COL (Ret) Andy Pennardt

5 December, a US Air Force B-52 providing air support inadvertently dropped a 2,000-lb [joint direct attack munition] on our troops' position, resulting in the deaths of three US and five Afghan fighters, as well as dozens of injuries. Upon notification of the incident, a Special Operations medical team responded by C-130 from Oman, elements of the 274th

Forward Surgical Team responded by C-130 from Kazakhstan, and a rotary wing Combat search and rescue team responded with an embedded US Army SOF [Special Operations Forces] physician and Special Forces medical sergeant from Pakistan. The CSAR [combat search and rescue] element proceeded to the bombing scene and transported casualties to FOB [Forward Operating Base] Rhino, where the C-130s had landed and a Navy Shock Trauma Platoon (NSTP) was available.

What was your role? What other medical personnel were involved, and what were their roles?

En route to Afghanistan, our team set up resuscitation and surgical stations in the C-130 to be prepared for receiving casualties immediately upon landing. As soon as we were on the ground, I met with the 274th FST CDR (Dr Burlingame) and the NSTP leader at the ramp of our C-130. They both agreed that I would serve as the senior medical officer in charge of the overall incident. The plan was quickly developed to divide the casualties. All Afghan casualties would go to the NSTP. Urgent and priority US patients would go to our aircraft, which had both surgical teams and a resuscitative team aboard. Routine US

casualties and those minimally injured who did not evacuate from Afghanistan would go to the second C-130, which had nursing personnel aboard. We then established a casualty collection point where I performed triage to identify those casualties requiring urgent surgical intervention. Ultimately, we loaded the seven most serious casualties aboard the SOF C-130 and took off to fly back to Oman. All medical personnel worked as teams and were actively involved in the resuscitation, airway management, surgical stabilization, and postoperative care throughout the almost 6-hour flight. I additionally worked with a J1 representative to prepare a casualty list with an accurate list of injuries for transmission to the chain of command.

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Other involved medical personnel included the following SOF personnel: an emergency physician, two medics, a general surgeon, a CRNA [certified registered nurse anesthetist], and a physician assistant; and the following personnel from the 274th FST [Forward Surgical Team]: a medic, a general surgeon, an orthopedic surgeon, and a CRNA.

What were the casualties? What were their injuries?

Multiple extremity trauma including a near-complete amputation of the right forearm, subclavian artery laceration, and hemothorax. Severe traumatic brain injury with extensive scalp laceration. Penetrating chest trauma with left pneumothorax. Multiple victims with various blast injuries including pulmonary injuries, TBI [traumatic brain injury], and penetrating fragment wounds. All of these were also uniformly experiencing nausea and vomiting.

What treatment was provided on scene, en route, and at the MTF [military treatment facility]?

How well did the treatments performed in the field (by medics) work?

Treatments provided on scene included extremity tourniquets to control bleeding, NPAs [nasopharyngeal airways],

occlusive dressings, needle chest decompression, splinting, sternal IO [interosseous infusion (supplies)], limited fluid resuscitation, and analgesics. These treatments worked fairly well in helping to stabilize the patients long enough to reach our surgical teams. During the flight, treatments included establishing definitive airways using rapid-sequence intubation, ventilator management, surgical control of internal hemorrhage, placement of chest tubes, measures to reduce increased intracranial pressure, blood transfusion, fluid resuscitation, antibiotics, analgesics, and antiemetics. These treatments were continued at the Air Force hospital in Oman. The greatest challenge after arrival at the MTF was repair of the subclavian artery laceration, which involved multiple vascular surgeons and massive blood transfusion.

How were the patients evacuated, and is there anything about the evacuation that is memorable?

The patients were evacuated by MH-60 from the point of injury to Rhino and then by C-130 to Oman. This was a daylight mission and the C-130 engaged in significant evasive maneuvering due to anti-aircraft threat warnings while over Afghanistan, which resulted in a very challenging environment for patients and medical providers alike. I still have a very vivid memory of blood and vomitus sloshing back and forth as the aircraft rolled from side to side. Medical aid bags that were not properly secured or closed readily spilled supplies across the aircraft.

Were any changes implemented after the AAR [after-action review] on the incident?

A heavy emphasis was placed on developing better surgical packages, such as operating tables that could be rapidly employed with a minimum of setup and had supplies and equipment stored in integrated doors. From a planning perspective, there was a renewed focus on looking at ways to integrate far-forward surgical and resuscitative teams into the tactical plan.

What was the significance or impact on the unit, command (JSOC; Joint Special Operations Command) and task force (Sword) of executing this mission?

This was the first time that the concept of utilizing far-forward surgical teams aboard evacuation aircraft was validated under actual combat conditions. While SOF had practiced this capability for years during joint readiness exercises and other training missions, it was incredibly rewarding to see it save lives during real-world operations. The success of this mission provided compelling evidence that employing advanced medical assets as close to the point of injury as operationally feasible could have significant impact on casualty mortality and morbidity.

What lessons would you like to emphasize to our readers? Important take-homes that may still be relevant today?

From a medical perspective, the operation went very well because everyone involved was extremely familiar with unit SOPs [standard operating procedures] and TTPs

[tactics, techniques, and procedures]. We had rehearsed our actions numerous times. Our partners in the 274th FST were former SOF unit members, which gave them the same kind of familiarity with our equipment and setup. I think it is an important reminder that we have to train the way we expect to fight and that we should cross-train with supporting units to enhance interoperability. Medical planners also need to consider how to provide advanced resuscitation and surgical stabilization in remote areas without a strong medical support and evacuation system in place. This will have significant relevance in our ongoing combat operations and relates directly to the work SOF is doing to improve prolonged field care.

Tell us about your transition from military Special Operations medicine to civilian (law enforcement) Special Operations medical support.

I knew that when I left the military I wanted to continue professionally supporting those that keep our nation safe every day. During my last several years in the Army, I became involved in efforts by the National TEMS [Tactical Emergency Medical Support] Initiative and Council to establish minimum training standards for law enforcement Special Operations medical support, which introduced me to many of the leaders of the civilian tactical medicine community. I was fortunate enough during my final military assignment to have the opportunity to complete the 770-hour Florida law enforcement academy (5 nights a week for 10 months), followed by appointments as a reserve deputy and then medical director for a sheriff's department special response team. I made an effort to work with different agency elements (e.g., road patrol, aggressive driver enforcement, marine patrol, narcotics interdiction) to broaden my understanding of the challenges faced by law enforcement officers and completed a SWAT [Special Weapons and Tactics] officer course. I also always tried to apply what I learned in military SOF to advocate to law enforcement agencies the utility of universal training in tactical medicine. For example, I was able to [obtain] C-A-T tourniquets [Combat Application Tourniquet®; Composite Resources Inc., <http://combattourniquet.com/>] with holsters for all of my fellow cadets, and the academy made it a mandatory part of the uniform. Instructors and command staff took notice, the practice caught on, and today every deputy in that department carries a tourniquet. My goal today is to use my experience in both the military and law enforcement Special Operations communities to bridge the differences between them, increase dialogue, and encourage the exchange of ideas and knowledge.

What do you see as the primary difference between military Special Operations medics and law enforcement (civilian) Special Operations medics? Do you view them as equivalent in training, scope of practice, etc.?

There are a number of differences and similarities between the two. Both perform critical roles in extremely challenging and dangerous settings. I would say military

Special Operations medics receive significantly more training to manage trauma and operate relatively independently in very austere environments, often for extended periods. Military Special Operations medics, as a whole, generally also enjoy a broader scope of practice than their civilian counterparts, who, depending on jurisdiction, are often limited by state laws, agency policies, and medical direction protocols. Civilian medics, on the other hand, are likely more experienced in handling medical emergencies (e.g., cardiac, respiratory), managing special populations (e.g., elderly, children, pregnant women) that may require care during a tactical operation, and handling unique aspects such as evidence preservation. There is also a major difference between military and civilian Special Operations medics from a standardization perspective. The military benefits from a process that readily allows standardization of training and casualty care guidelines, which are directed from the top down. Civilian medics vary widely in how they are trained and allowed to function due to the complex system of authorities placed over them, including state, regional, and local EMS [emergency medical services] offices, laws and regulations, and medical directors.

Can you address the utilization differences between being “operators” as opposed to being medical support only? Are there any obstacles or significant considerations when arming tactical medics in the civilian (law enforcement) role?

Due to the inherent nature of their combat mission, military Special Operations medics are generally qualified as operators in the sense of your question. They are considered to be combatants and there is no question about them being armed and capable of engaging the enemy within the ROE [rules of engagement]. There is far greater variability among civilian Special Operations medics due to a number of factors. For example, are the medics sworn law enforcement officers [LEOs]? Sworn LEOs, as a rule, are armed. Nonsworn medics may sometimes carry for defensive purposes, if allowed by state law and agency policy. There are many considerations, such as liability protection, use of force restrictions, weapons qualification, and public scrutiny. Some states do not allow open carry except for sworn officers, and concealed carry may not be practical during a tactical operation. If not directly employed by the supported law enforcement agency, the tactical medic may be prohibited from being armed by the parent EMS/fire agency or hospital, usually due to liability concerns. Some medics may actually perceive a conflict between their role of saving lives versus being armed and possibly shooting someone. A consideration for agencies is also the necessity of providing security for unarmed medics, which can be a significant drain on available manpower during a tactical incident.

What would you recommend to others who are or will be making the same transition? How should they prepare for the transition? Any specific training or education you would recommend?

I highly recommend to anyone making the transition to seek out whatever law enforcement-specific training may be available to them, whether it is a full academy, reserve or auxiliary program, SWAT training, tactical medical provider, or similar. Obtaining experience in law enforcement will increase both one's credibility and ability to provide support for tactical operations. Don't assume that your military Special Operations background automatically makes you an expert in law enforcement tactical operations. There are a lot of organizations whose members provide tactical medicine support for law enforcement, such as the tactical medicine section of the American College of Emergency Physicians, the physician section of the International Association of Police Chiefs, the TEMS section of the National Tactical Officers Association, the operational medicine section of the National Association of EMS Physicians, and the Special Operations Medical Association, as well as other organizations seeking to further professionalize the specialty of tactical medicine, such as the Committee for Tactical Emergency Casualty Care and the National TEMS Initiative and Council. Seek out the advice of others who are already involved, network, contribute, and collaborate. And always remain the Quiet Professional. Law enforcement deserves the same caliber people as military SOF.

COL (Ret) Pennardt is board certified in both emergency medicine and emergency medical services. He served in numerous Special Operations assignments, including multiple combat deployments to Afghanistan and Iraq, during his 23 years of active duty Army service. Dr Pennardt is the current chairman of the USSOCOM Curriculum and Examination Board, the director of the National TEMS Initiative and Council, and the medical director for tactical medicine on the Board for Critical Care Transport Paramedic Certification, as well as serving on the Board of Advisors of the Committee for Tactical Emergency Casualty Care. He additionally works as a TEMS medical director and certified law enforcement and SWAT officer.

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and Sacrifices of
the SOF Medic*

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