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Admiral's Log

Surgeon General VADM Michael Cowan's Insights on Military Medicine

Interviewed by COL (Ret) Andre Pennardt, MD

Please provide our readers a brief summary of the highlights of your military career.

I entered the military courtesy of the Selective Service ("doctor's draft") in 1971 in the closing years of the Vietnam Conflict. I didn't want to be in uniform any more than did many of the young Marines I cared for at Camp Lejeune, NC. But I quickly realized that treating those who were serving their country added another layer of purpose to my professional life—that I enjoyed practicing medicine without having to worry about someone's insurance status. All I had to do was deliver the best care I could, and I liked that.

VADM Michael Cowan

Fast forward a third of a century, and that's pretty much the story. I entered the military at the close of our last war and became Surgeon General of the Navy on August 10, 2001, a mere month before the start of our next.

During that time, I both watched and participated in the transformation of three "Cold War" military medical departments into a modern "post–Cold War" unified and effective healthcare system implementing the concepts of "Force Health Protection" to a level never before seen in any health system.

"I am proud that I got drafted and had the good sense to ditch my antimilitary attitude and spend my entire professional career caring for those who care for America."

Our nation has been at war continuously for longer than 15 years. What do you view as the most important lessons learned by those practicing military medicine during that time?

- Battlefield and deployment medicine depends on the full spectrum of Force Health Protection: fielding a healthy and fit Warrior who is resilient psychologically and physically. Protecting that Warrior from both environmental and warfare dangers and rapid mobile treatment and patient movement for the injured and, equally important, at the same time providing effective care for that Warrior's family—finally, for the Warrior and his/her family on departure from the service.
- The "brass ring" for American military medical systems is that the first casualty of the next war has the same chance of survival as any casualty who follows, because we deploy a highly capable team with the first Warrior on the first day. That is the promise military medicine makes to the nation and the reason the system exists.

How do you see those lessons learned applying to the civilian community?

Two principles have marked military medicine during the past two decades: the first is science-based casualty care based on the trauma registry established back in the later stages of the Vietnam Conflict. The use of tourniquets, the value of stabilization and rapid evacuation, and a number of surgical innovations have all flowed from that experience.

The second—and, in my opinion, even more valuable—principle has been the concept of family-based care. During the Vietnam era, we treated the amputee's wound, and when the wound was healed, the patient was separated from service, given a disability rating, and generally expected by both society and the individual to spend the rest of his life as a "cripple." That sounds harsh, but it's true.

Today, the first face a wounded Warrior sees when he/she wakens is often a spouse or mother. The entire family is the focus of treatment and rehabilitation from day 2, and the stated expectation is that that valuable Warrior and family will achieve a "new normal" of productive and happy life. We've come a long way, baby.

Any medical system caring for any population will do well to emulate both of these contributions to American

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medicine. And my observation is that some do and more are following.

Do you think that military medicine as a whole has learned anything of value from the Special Operations community during recent combat operations?
Certainly. The experience of combat care and healthcare support in small isolated units has been a valuable lesson that I believe has been applied as large field facilities have morphed into the small highly mobile units that increasingly rely on frontline providers as well as the basic survival skills of each Operator. We would be highly unlikely to have advanced so far so fast without the model of Special Operations Forces.

Tactical Combat Casualty Care has significantly contributed to reducing battlefield mortality. What, if any, impediments do you see to TCCC principles being used by law enforcement, fire, and emergency medical services (EMS) responders during tactical incidents such as active shooter events in our nation?
I have always seen TCCC as an enhanced set of EMS skills for the specific circumstances of prolonged care in austere environments and/or under direct kinetic conflict. Most civilian EMS care lasts moments to a few hours and, only in the rarest of cases, under fire. That may change as the world becomes increasingly unstable.

Further, having the skills for the rare occasion adds a level of value to any emergency response system. So . . . the short answer is, yes. I see the value. Through the eyes of a cost-constrained EMS department, I expect implementation to be less than universal.

What do you see as the greatest challenge facing military medicine now and in the future?
The biggest challenges for military medicine today are the efforts of Congress, among others, to impose dramatic and drastic changes on a system that is already working very well.

Through 15 years of war, the cost of the Military Health System/TRICARE program has grown as a grateful Congress added benefits and categories of benefits to the system. Now that the guns have (temporarily) stopped firing, the system they built looks too expensive to the same Congress and even to many leaders in the Pentagon.

Military medicine now must again effectively remake its case for its value proposition. Military health systems have their problems and weaknesses to be sure. These are solvable. But the benefit is special, the quality of care compares favorably with the best systems in the nation, and we have the readiness capability to protect that first casualty.

The military, and especially the Special Operations community, is likely to be deployed into increasingly austere environments that lack the robust medical care and evacuation systems that existed during the Iraq and Afghanistan wars. How should military medicine respond to best support our Servicemembers in those remote regions?
Military medicine must hold as its first principle a high level of medical readiness. When Warriors go out the door to defend our nation, capable and just as well-trained medics must go out that same door to defend them. Period. That is the Alpha and Omega of military medicine.

Is there anything else that you would like to share with our readers?
Yes. I am proud that I was drafted and had the good sense to ditch my antimilitary attitude and spend my entire professional career caring for those who care for America. All who serve in any branch of military medicine can be justly proud of themselves and their organizations. And we should remember that each of us owes any success to the giants who went before and brought us up to their standards. There is no other healthcare organization like it.

And as I continue to serve in my small way as director of AMSUS, I note that even on retirement, we never take off the uniform entirely. . . .

"Sending Charlie Papa" are the signal flags that have flown from every US naval hospital since 9/11/2001. "Charlie Papa" translates into "steaming to assist," signifying a ship running on all burners to provide relief. These flags were run up the Navy Bureau of Medicine and Surgery flagpole within hours of the attacks on that fateful day and have since flown worldwide to emphasize the mission to every hand every day.

The opinions or assertions contained herein are the private views of the author and are not to be construed as official or as reflecting the views of the Department of the Navy or the Department of Defense.

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