The nice thing about being at a Role 3 (R3) combat support hospital (CSH) is that there are multiple general surgeons and frequently there is a trauma surgeon, vascu- lar surgeon, and sometimes a neurosurgeon. Just out of residency, a busy R3 deploy» ment is like a trauma fellowship — there is always someone available to help, which is a luxury not always appreciated until you are deployed as the sole surgeon. Just like at the R2, success depends on communication, understanding team and facility limitations, having excellent and frequently trained MASCAL and whole blood plans, and of course being a well—traincd, well—practiccd surgeon.

During the recent Iraq and Afghanistan wars, strategic placement of surgical capabilities in the battle space was not a priority; instead, a warm body with a “sur- geon“ designation was sufficient — this may have been secondary to the deployment tempo. A pitfall for a young surgeon recently out of residency is the assumption that an experienced surgeon is experienced in trauma management. For example, you may know more about trauma than a senior cardiothoracic surgeon who hasn't oper~ ated in the abdomen or pelvis in over a decade. Do not assume that seniority equates to experience, although it frequently does. It can be a challenge to have to inform a senior ranking officer that they are taking too long to do a damage control 1aparot— omy, but patients’ lives will necessitate that you speak up, communicate effectively, and do the right thing for the patient. Professional respect and communication are paramount at a CSH. Future R3 hospitals will likely include a Trauma Medical Director as current Air Force CSHs already do.