MHSRS 2026 | SCIENTIFIC BREAKOUT SESSION

Role 0 Damage Control Procedures in Ukraine

A Model for Far-Forward Casualty Care in LSCO

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Session: Forward Trauma Care: Enhancing Semi-Fixed Role 1 Facility Capabilities for LSCO
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Disclosures

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Scope of practice and off-label content

Several interventions discussed fall outside the conventional scope of practice for non-surgeon providers in most peacetime systems. They are presented as workshop consensus priorities for austere, resource-constrained care, not as approved standards of practice. No commercial product is recommended, and all agents are referred to by generic name.

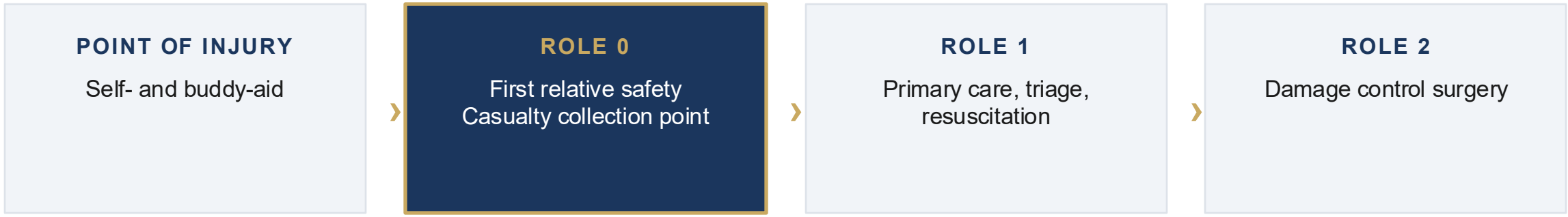
Learning objectives

1. Describe the Role 0 concept and how it extends damage control capability beyond traditional point-of-injury and Role 1 frameworks.

2. Analyse which Damage Control Procedures and Resuscitation interventions can be safely prioritised for trained non-surgeon providers in austere settings.

3. Discuss the governance, documentation, and training requirements needed to scale interoperable Role 0 capability across military and civilian response systems.

An echelon that practice created and doctrine has not named



Persistent threat · drone-contested evacuation · prolonged time to surgery

- Large-scale combat operations in Ukraine have disrupted the traditional prehospital chain of survival.
- Advanced interventions are being delivered by non-surgeon providers under persistent threat, at the first location of relative safety, before any formal echelon is reached.
- The same conditions define civilian mass casualty events with delayed evacuation and multi-agency response, so the problem is not specific to Ukraine.

Methods

KYIV

November 2025

25

Ukrainian military and volunteer medical stakeholders, with European faculty

Mixed-methods participatory workshop

1. **Structured problem framing**
   Shared definition of the operational gap
2. **Nominal Group Technique**
   Silent generation, round-robin, ranking to consensus
3. **Plenary discussion and mind-mapping**
   Capability mapped across point of injury, Role 0, Role 1, Role 2
4. **Post-event questionnaires**
   Confirmation and stability of prioritisation

Capability was mapped by echelon and stratified by provider type, so that scope of practice, not enthusiasm, set the boundary of what was prioritised.

CONSENSUS DEFINITION

Role 0 is the first location of relative safety where interventions beyond self- and buddy-aid can be delivered.

In Ukraine this is most commonly an improvised casualty collection point. It is defined by tactical condition, not by infrastructure, staffing table, or map symbol, which is precisely why it has escaped doctrine.

Prioritised DCP and DCR capability for trained non-surgeon providers

Intervention	Point of injury	Role 0	Role 1
Advanced airway management	—	●	●
Thoracic decompression and drainage	—	●	●
Low-titer O whole blood transfusion	—	●	●
Targeted analgesia	—	●	●
Point-of-care ultrasound-guided vascular access	—	●	●
Escharotomy	—	●	●
Fasciotomy	—	●	●

● prioritised for trained non-surgeon providers — — limited to self- and buddy-aid at point of injury

Consensus prioritisation is conditional on training, credentialing, and a governed scope-of-practice agreement. It is not a statement that any provider present may perform any listed procedure.

Capability is not the constraint. Governance is.

1

Harmonised documentation

A casualty record that survives the handover from volunteer to military to ministry system. Without it, Role 0 activity is invisible to analysis and to quality assurance.

2

Tiered governance

Scope of practice tied to demonstrated competence and to echelon, with named clinical authority, rather than to job title or unit of origin.

3

Context-specific training

Interoperable pathways that train the procedure and the decision to perform it under threat, with recertification that reflects the operating environment.

The workshop identified these three as prerequisites for safe implementation, not as follow-on work.

Why this generalises beyond Ukraine

- **LSCO and peer conflict**
  Any theatre with contested evacuation will hold casualties at a point of relative safety. Role 0 gives that space a name, a scope, and an owner.
- **Civilian mass casualty events**
  Active-threat and structural-collapse incidents create the same delay between injury and surgical care, with the same non-surgeon providers holding the casualty.
- **Remote and austere medicine**
  Maritime, expeditionary, and rural systems already operate with prolonged times to definitive care and no Role 1 to fall back on.
- **Multi-agency response**
  Shared scope-of-practice agreements and one casualty record are what make military, EMS, and ministry-level systems interoperable at the seam.

Limitations

- Single workshop, single theatre. Findings reflect Ukrainian operational experience in November 2025 and may not transfer to other conflict or disaster settings without adaptation.
- Consensus method. Nominal Group Technique establishes expert priority, not clinical effectiveness. No patient outcome data were collected.
- Purposive sample of 25 stakeholders, weighted toward practitioners already working far forward, which may over-represent confidence in non-surgeon delivery.
- Prioritisation was mapped for capability, not for logistics. Cold chain, resupply, and blood availability were out of scope and will constrain implementation.

Next step: prospective, documented Role 0 activity with linked outcomes, which is only possible once the record travels with the casualty.

Conclusions

01 **Role 0 is real and definable**

The first location of relative safety is where care beyond buddy-aid already happens. Naming it makes it resourceable and governable.

02 **Selected damage control procedures can be pushed forward**

Prioritised for trained non-surgeon providers, conditional on credentialing and governed scope of practice.

03 **The bridge is built from governance, not equipment**

Interoperable training pathways, standardised scope-of-practice agreements, and shared documentation across military, EMS, and ministry systems.

Questions

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