We Dare Not Fail: Preparing Junior Military Medical Officers for 21st-Century Conflict

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'The mothers and fathers of America will give you their sons and daughters…with the confidence in you that you will not needlessly waste their lives. And you dare not. That's the burden the mantle of leadership places upon you… It is an awesome responsibility. You cannot fail. You dare not fail…' – General H Norman Schwarzkopf, USMA Corps of Cadets, May 15, 1991

Just as General H Norman Schwarzkopf addressed the US Military Academy at West Point in 1991, reminding cadets that *character* and *competence* are inseparable pillars of leadership for the 21st-century battlefield, we currently face a similar inflection point. Then, the First Gulf War had just ended. Now, we again confront geopolitical uncertainty: the Russo-Ukraine conflict, continued instability in the Middle East and tension in the Indo-Pacific.

Yet, at an incredible pace, warfare is evolving. The future 21st-century fight will not mirror the wars in Iraq or Afghanistan. Instead, the next large-scale conflict is predicted to resemble a convergence of advanced weaponry and technology, leading to massive casualty numbers, prolonged casualty care and ethical ambiguity.[1] Military medical leaders will be expected to perform in the most austere environments, under constant stress and with limited resources, while simultaneously providing optimal combat casualty care to wounded warfighters. For military medical leaders, the mission remains the same: to conserve fighting strength. However, the tools, tempo and nature of warfare have changed. Therefore, junior military medical officers must be prepared to be clinically *competent* and have the *character* to lead through ethical adversity on the 21st-century battlefield.

The 'Walker Dip' and the Peacetime Paradox

Compounding these challenges during this interlude period is the unfortunate reality that military medicine is experiencing the 'Walker Dip' or 'Peacetime Effect'.[2] This phenomenon describes how trauma care capabilities and innovations surge during conflict and decline in peacetime due to reduced exposure and training opportunities. After decades of counterinsurgency operations, many trauma skills were refined and institutionalised. However, with decreased combat deployments and fewer casualties returning from abroad, there is now a growing concern about a perceived decreased proficiency among junior medical trainees.

This concern is not hypothetical. Future large-scale combat operations (LSCO) are expected to generate casualty volumes not seen since World War II, often in environments without reliable air evacuation or communication. Junior military medical officers may be called upon to deliver prolonged casualty care with minimal resources, far from definitive surgical assets and under direct threat. Without deliberate, realistic training in such conditions, the Walker Dip could leave our future leaders unprepared for the operational, clinical and ethical demands of LSCO. Overcoming this gap requires more than just classroom instruction—it calls for immersive experiences, trauma-informed readiness and leadership development embedded throughout medical education.

Character, competence and the future fight

While technology continues to transform warfare, the human element remains central to military medicine. The operational 'kill chain' may be accelerated by drones and artificial intelligence. However, the medical 'survival chain' still demands human judgement, compassion, and moral courage.[3] High-tech weaponry may shorten the time between identification and strike, but saving lives still depends on the steady hands and sharp minds of medics, corpsmen and military medical professionals operating in unpredictable environments.

Future military medical officers, therefore, must be prepared not only for clinical complexity but also for moral asymmetry. In modern conflicts, such as those in Ukraine and Gaza, adversaries have violated long-standing norms of warfare by targeting hospitals, attacking humanitarian corridors and disregarding

the Geneva Conventions. In a future large-scale combat operation, US military medical officers may be forced to operate in similar environments, where their commitment to medical ethics will be tested against battlefield chaos, resource scarcity, and the failure of adversaries to honour international law.[4]

Combat casualty care will no longer be defined by rapid evacuation and golden-hour surgical interventions. Instead, military medical officers must prepare for prolonged casualty care in environments marked by actual resource scarcity. Although moral complexity has always existed in trauma care, such as making decisions based on limited blood products or responding to reports of additional casualties who never arrive, LSCO introduces a fundamentally different challenge. In this context, medical providers may need to withhold life-saving interventions, not because the injuries are unsalvageable, but because the system cannot support the care required. Mass casualty triage may involve denying treatment to patients who would have survived under previous standards. The boundary between life-saving and life-sustaining care becomes even more challenging to navigate when decisions must account for both medical urgency and operational sustainability. Questions such as who should receive the final ventilator, whether a patient can be moved safely without air support, and when to initiate advanced care while anticipating additional casualties will define the ethical complexity of future warfare.

Moreover, junior officers will be expected to lead through these crises—navigating tactical uncertainty, guiding interdisciplinary teams, communicating with line commanders, and maintaining the moral and operational integrity of their unit. These responsibilities cannot be taught solely through textbooks or classroom lectures; they must be practised, challenged and developed through immersive simulation and ethical reflection. As the battlefield evolves, so too must our definition of readiness: one that accounts not only for clinical competency but for moral leadership, adaptability and character under fire.

As stewards of military medicine, we must ensure that these officers are equipped not only to stop the bleeding—a fundamental requirement—but also to lead with integrity when values and violence collide. They cannot rely solely on character, nor can they depend solely on competence. One without the other is not enough. In the words of General Schwarzkopf, they 'dare not fail'. To succeed on the 21st-century battlefield, they must have both.

Uniformed Services University: A military medical education and training case study

The Uniformed Services University (USU) provides a unique case study in preparing junior military medical officers for the demands of future LSCO. Often referred to as the 'West Point of Military Medicine', USU integrates military culture, operational readiness, and medical science into a cohesive and longitudinal curriculum. Its mission, to develop clinician-leaders of character prepared to serve across the continuum of military operations, is operationalised through an educational model that embeds military-specific training alongside rigorous clinical instruction.

At the core of this model is the Military Unique Curriculum (MUC), a longitudinal framework that scaffolds operational content across four years of undergraduate medical education. The 750+ hour MUC incorporates modules on expeditionary medicine, military medical ethics, health service support planning and joint force interoperability. Throughout the MUC, more than 400 mission-critical Knowledge, Skills and Abilities (KSAs) have been identified and strategically placed to ensure the readiness of junior officers as a part of the Joint Expeditionary Medical Officer (JEMO) project.[5,6] These components are intentionally aligned to develop both clinical competence and leadership capacity within the unique ethical, logistical and tactical demands of the operational environment.

One of the signature experiences in USU's MUC is Operation Bushmaster, a five-day, field-based capstone exercise designed to simulate the realities of combat casualty care during LSCO.[7] Students operate in a simulated austere, far-forward environment characterised by mass casualties and limited resources. Under conditions of stress, fatigue and moral complexity, they are expected to lead medical teams and make high-stakes decisions within the fog of war. Students are assessed not only on their clinical competency but also on their leadership, adaptability and character. The inclusion of allied and international partners in these scenarios further prepares students for joint operations in coalition environments.

USU also emphasises ethical preparation for warfare through case-based learning on combat decision-making, dual loyalty, and medical responsibilities in complex and contested environments. These discussions underscore the imperative for moral clarity and ethical reflexivity in future conflicts that are likely to involve prolonged casualty care, triage under fire and shifting mission priorities.[8]

Graduates of USU enter the Military Health System not only as licensed physicians but also as commissioned officers equipped to practice medicine in austere, high-threat and ethically ambiguous settings.[9] Their training reflects a deliberate investment in readiness: clinical competence, leadership under pressure and the capacity to deliver care in the face of uncertainty. As such, USU offers a model of military medical education tailored to the operational realities of LSCO and the evolving character of 21st-century warfare.[10] This model is well-positioned to inform the next phase of military medical education by shaping Graduate Medical Education programs that sustain a ready pipeline of military medical officers for the battlefield. For example, the Walter Reed/USU Department of Surgery residency program includes an MUC with a cadaver-based procedural curriculum, point-of-care ultrasound training, hands-on bowel and vascular anastomosis simulation courses, and combat craniofacial trauma courses. These initiatives are being refined for expansion across all military GME programs, providing a scalable model to sustain a battlefield-ready pipeline of military providers aligned with the demands of LSCO and 21st-century conflict.

Conclusion: We dare not fail

The preparation of junior military medical officers is not a peacetime luxury—it is a wartime necessity, undertaken in advance of conflict. As new threats loom on the horizon, military medicine must anticipate and adapt. This includes preserving combat casualty care skills, embedding ethical leadership throughout training, and embracing simulation-based training that mimics the complexity of LSCO.

General Schwarzkopf's warning still resonates: 'You dare not fail'. For military medical leaders, failure is not an option—not because perfection is expected but because lives will depend on their preparation, judgement and integrity. In shaping the next generation of military medical officers, we must match that urgency. We dare not fail.

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