

The Texas A&M University System Health Science Center

Office of Homeland Security

John B. Connally Building
301 Tarrow Street, 7th Floor
College Station, TX 77840-7896
979 458-7246 • fax 979 458-7202

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Subject: SACCO Triage Method

I have been involved in trying to improve the current triage method since 1983. I was the Chief of Surgery for the Marine Barracks bombing in Beirut, Lebanon in 1983 and outlined my concerns at that time with the MIDE system. Minimum, Immediate, Delayed, and Expected was part of the START system (Simple Triage and Rapid Transport) that had been promoted by the NATO Countries for a long time. When I ran out of fingers and toes for casualties, it no longer worked for me. I felt it was not reproducible, not scalable, had no scientific basis, and did not lend itself to computer applications.

I stayed in the service and tried to fix the system from that time on. We spent a fair amount of money to examine new ways to do business. What we found was that the new measurements did not help us and the old methods of pulse, motor activity, and respiratory rate were still key. We continue to accumulate patients in our data base through the Institute of Surgical Research in San Antonio and currently have over 900 patients in our data base. Pulse, respiratory rate, and motor response are the only variables that seem to matter in survival.

In November of 2003 I was presented the SACCO method of triage. This system had everything that I had identified as important-- it was reproducible, scalable, scientific in its origin, and lended itself to computer applications. It also had a resource allocation mode to tell you which patient should go to what hospital and by what conveyance. This answered all my concerns about the old MIDE system in the START protocol and then some!

It is usable everyday so is not something we dust off and try to learn in the heat of a major casualty producing event. It is very reproducible since it is science based. It factors in survival and deterioration rates to allow us to focus our resources on those most likely to survive. It automatically does the resource allocation part of mass casualty events and tells us best how to utilize scarce resources.

Tom McCord and his group of experts have improved the system in its ease of use since I first saw it and is now receiving rave reviews from the first major area to adopt it-- Okaloosa County in the panhandle of Florida.

I think this is a system that is just right for our current challenges! Who goes to the Level I Trauma Center and how? If the event is large, how do we do resource allocation and what transportation do we use? Can we defend decisions made in the field by non-surgeons in a court of law? How do we optimize survival? When do we go regional? National? The SACCO package gives us a great method to answer all these questions and move into the future!

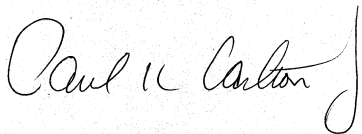
I currently think it is the best investment for improving survival in injured patients that I have seen in my lifetime!

My background is trauma surgery, military surgery, long range planning, and I am a former Surgeon General of the Air Force. I designed the current medical system in Iraq that has produced the lowest died of wounds rate in the history of war! Today, 90% of our wounded warriors survive their wounds compared to 76% in the previous Gulf War--so I know a little about the subject!

Adopting and utilizing the SACCO method of triage for peacetime usage makes great sense to me so that we will truly be ready for our mass casualty event!

I have no financial interest in this company but feel so strongly that this is the proper path to go on that I am happy to write such letters for them!

Sincerely,

A handwritten signature in cursive script that reads "Paul K. Carlton, Jr." The signature is written in black ink on a white background.

Paul K. Carlton, Jr., M.D., FACS
Lt. General, USAF (Ret.)
Director, Homeland Security