Stellingen
behorend bij het proefschrift

Battlefield Casualties Study

Task Force Uruzgan, Afghanistan 2006-2010:
medical aspects and challenges

1. Studying combat injuries contributes to data driven development of protective equipment and thus to injury prevention (this thesis).

2. A NATO wide trauma registry should be implemented (this thesis).

3. Military surgery should be recognized as an official surgical subspecialty (this thesis).

4. The Netherlands role 2 "single surgeon concept" needs reconsideration given the current stream of more narrow specialization (this thesis).

5. The role of buddy and social network support in treating combat casualties must have a prominent place in the aftercare program (this thesis).

6. The most substantial opportunity to improve battle casualty outcomes seems to be in the pre-hospital phase (Eastridge, J Trauma Acute Care Surg 2012).

7. Endografting for blunt traumatic aortic disruption is feasible in military role 3 hospitals (Clouse, Mil Med 2009).

8. Temporary vascular shunting used as a damage control adjunct in management of wartime extremity vascular injury does not lead to worse outcomes (Rasmussen, J Vasc Surg 2009).

9. Finding biomarkers as a predictor of vulnerability for developing PTSD could have unwanted side effects, when used as employment criteria for recruitment of service members.
10. Multi organ donation procedures should be part of the training of future visceral trauma surgeons.

11. Decompression diving tables rely too much on mathematics and not on physical parameters.

12. He who wishes to be a surgeon, must first go to war (Hippocrates, ca. 460-377 B.C.).