Committee on Tactical Combat Casualty Care (CoTCCC) Position Statement on Prolonged Casualty Care (PCC)

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"REMEMBER, THE GOAL OF PCC IS TO GET OUT OF PCC!"

Background

In 2009, Secretary of Defense Robert M. Gates mandated that all casualties receive rapid handoff to a surgical team within 60 minutes of injury.[1] In addition to tourniquets and blood transfusion, this Golden Hour mandate and subsequent reduction of transport time contributed to historically low case fatality rates and increased survival rates for U.S. military personnel during the low-intensity conflicts in Afghanistan and Iraq.[2] The Golden Hour may prove challenging in large-scale combat operations (LSCOs) without air superiority. Although the military departments recognize that high casualty numbers and delayed casualty transport may occur during LSCOs, contingency planning and preparation for this eventuality has been difficult.[3] The delayed evacuation of casualties during LSCOs will force Role 1 (prehospital) responders to contend with the medical, logistical, and operational challenges associated with providing Prolonged Casualty Care (PCC). This may result in an increase in the percentage of casualties killed in action (KIA; prehospital deaths).[4] To mitigate an increase in casualties KIA, substantial time and effort should be spent on PCC.[5]

PCC is defined as:

> "The need to provide Role 1 casualty care for extended periods of time when the tactical situation may limit or prevent prompt and/or optimal medical care."

PCC is care provided by any responder to non-regulated casualties in the Role 1 environment. PCC ends when the casualty is evacuated to a medical system under medical mission command within a medically regulated environment. Therefore, PCC solutions across all Joint capabilities and development system domains (doctrine, organizational, training, material, leadership/education, personnel, facilities, and policy) must be focused on Role 1 care. In contrast, *prolonged care* begins when the planned evacuation of a medically regulated casualty is delayed, resulting in the need for a non-doctrinal increase in patient holding capacity.[6]

The willingness to adopt PCC across the full range of military operations demonstrates an unwavering commitment to continually improve battlefield survivability for our force and unwillingness to accept any gaps in the continuum of care. Furthermore, the DoD's clinical and research communities have recognized the need to improve PCC capabilities; however, there remain substantial shortfalls and misconceptions among framed PCC problems. As such, the DoD must continue to develop Joint capable solutions for the delivery of PCC across all force development domains and institutionalize PCC best practice principles outlined within the Joint Trauma System's (JTS) PCC guidelines.[7]

The PCC guidelines are a consolidated list of casualty-centric best practices that provide all Servicemembers with "what to consider next" after all Tactical Combat Casualty Care (TCCC) interventions have been effectively performed. The PCC guidelines were developed to inform DoD education and training programs that build confidence, interoperability, and common trust among those caring for casualties in a PCC environment. However, PCC should only be trained after mastering the principles and techniques of TCCC.

Facts and Principles

- Nonmedical responders will likely provide a substantial portion of PCC interventions and assist with care.
- Once a Role 1 casualty becomes medically regulated (at the next role of care), returned to duty, or die they are no longer in PCC.

- Completion of TCCC is a prerequisite to PCC.
- The PCC guidelines provide a role-based set of best practices for Role 1 nonmedical and medical responders that build upon TCCC.

Given the operational requirement for PCC, the CoTCCC, and JTS *endorse* the following:

1. TCCC is the foundation for any care in PCC and any Servicemember who receives PCC training should be fully qualified in the appropriate role-based level of TCCC.[8]
2. PCC training should be given to all Servicemembers and expeditionary civilians who will be in operational scenarios where evacuation is likely to be delayed.
3. Role 1 nonmedical and medical responders need PCC education, training, and equipment in accordance with the JTS PCC guidelines.
4. To decrease KIA rates and improve casualty outcomes, the DoD must maximize existing or establish new medical proficiency opportunities within military treatment facilities or established medical military-civilian partnerships, to enhance all Role 1 nonmedical and medical responders' clinical experience and critical thinking skills.

Given the operational requirement for PCC, the CoTCCC, and JTS *recommend* the following:

1. PCC-related research, development, testing, evaluation, and recommendations should focus on realistic interventions that can be used within the Role 1 environment.
2. The minimum standards published by the JTS for a Joint PCC curriculum should be integrated into all common military training and PCC pre-deployment training courses, regardless of course nomenclature.
3. The military departments should develop medical assemblage sets using the PCC planning paradigm for subsequent time-based Role 1 care, for use across the full range of military operations.
4. Review and update all DoD component policy, publications, definitions, terms, and lexicons to communicate PCC best practices to the Secretaries of the Military Departments, Joint Staff, and Defense Health Agency.

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