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*Dedicated to the
Indomitable Spirit
and Sacrifices of
the SOF Medic*

A Peer-Reviewed Journal that Brings Together the Global Interests of Special Operations' First Responders

PROLONGED FIELD CARE

Deconstructing the Definition of Prolonged Field Care

Sean Keenan, MD

What is this PFC thing exactly? The accepted definition is “field medical care, applied beyond ‘doctrinal planning time-lines’ by a SOCM (Special Operations Combat Medic) or higher, in order to decrease patient mortality and morbidity. Utilizes limited resources, and is sustained until the patient arrives at an appropriate level of care.”

This definition necessarily assumes that the care is delivered in an austere or field environment. It also acknowledges that the care is provided outside the planning guidance of usual military medical doctrine; therefore, the usual medical force structure and related assumptions cannot be relied on.

When we consider time factors, operational situations vary greatly. It has been said by some in Special Operations Forces (SOF) medicine that “an 18D can take care of a patient for 72 hours,” and still others have used this as strict operational planning guidance. The experienced medical practitioner, however, will quickly dispel this myth, having managed patients who may live for many weeks with serious injuries and illness and still others who quickly exhaust a full Forward Surgical Team in only hours. Instead, the community should accept the operational reality of military operations in austere locations and instead focus on the preparation and training of those tasked to provide comprehensive medical care in these difficult situations.

It should be acknowledged that PFC focuses on a relatively small subset of patient care. It specifically is meant to include only the most serious and critical casualties. Additionally, PFC assumes the patients are US or partner military forces and that the end-state is *evacuation* to higher-level medical treatment facilities.

A key point in understanding PFC principles is the concept of reduction in *morbidity*. We know that some patients are at risk for such complications as sepsis, multiorgan system failure, respiratory compromise, and other serious conditions. Contrast this with Tactical Combat Casualty Care (TCCC), where the protocols are aimed primarily at preventing mortality in the first hours of treatment, prior to arrival at surgical resuscitative care. PFC patient management necessarily begins with the sound principles of TCCC, but in situations where care is extended over hours or days, we must evaluate and reevaluate all treatments, being diligent to minimize the morbidity of potentially harmful interventions and prevent, recognize, and treat medical conditions that may develop over time.

Last, medics most likely will prepare for CASEVAC on a diverse array of potential platforms, whether land, sea, or air. The continued movement to an appropriate referral center presents a level of operational challenge not experienced in static patient care scenarios. Only through practice, reviewing basic patient care capabilities, and continuous learning will SOF medics be ready to provide medical coverage in the diverse and austere situations found in today’s global medicine challenges.

For these difficult patient care situations, the SOCOM PFC Working Group is working to identify needs and knowledge gaps. Additionally, our goal is to provide educational tools and references to meet the challenges of managing the most complex patients, in the most austere environments.

Please join the discussion at prolongedfieldcare.org.