An Ongoing Series

Prolonged Field Care for the Winter 2017 Edition

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PFC has always been a grassroots effort. It is about you, medics and providers, seeing a problem and coming up with solutions. Long delays to definitive care due to long evacuations, Anti-Access and Area Denial {A2AD}, or nonpermissive operating environments continue to fuel the interest in PFC. Along the way, the PFC Working Group has sought guidance from some of the best operational and medical experts in military and austere medicine. Many thanks go out to our growing PFC community for their tireless efforts to solve our common problems!

We have made great strides answering tough clinical questions. Make note of the recent prehospital Clinical Practice Guidelines (CPGs) which tackle complex issues like traumatic brain injury (TBI), wound care, crush syndrome, burns, and pain control/sedation. These "field" CPGs provide medics and other point-of-injury providers the best available evidence for expert austere combat care and can be found at PFCare.org or at www.usaisr.amedd.army.mil/cpgs.html. Future topics include: eye injury, nursing care, DCR, sepsis, preparation for flight, and more. If you think of a PFC problem that has yet to be answered and reviewed by a community of experts, let us know. Aside from the CPGs, we continue to make other official recommendations such as our "Teleconsultation in Prolonged Field Care Position Paper" and call script, which appeared in the Fall edition of the JSOM.

Several members of the PFC Working Group recently attended the Military Health System Research Symposium (MHSRS) in August 2017. MHSRS is a venue for presenting new scientific knowledge resulting from military-unique research and development. At first glance at the agenda, it was disappointing to see the lack of PFC-oriented research being presented. But, after attending several sessions, it became clear how wrong that assumption was. PFC was everywhere! Most researchers and vendors were not only talking about PFC, but also focusing research and product development to answer questions like, "what happens to these patients or this intervention after 4, 8, or 24 hours?" The assumptions are changing. Researchers and leaders are no longer assuming all patients will reach a surgeon in less than an hour. In a huge win for our training goals, the JPC-1 portfolio manager agreed to include new PFC-oriented training methods as a line of research, along with simulations and tech. The message is getting around.

We continue to hear demand from the community for a PFC training course outside of the 18D and SOCM pipelines. While a formal course is nearly impossible to build and fund at this point, we recently posted the PFC Working Group–approved "Critical Task List" and podcast on our new training tab along with other resources to use in teaching, training, and evaluating PFC. This task list represents SOCM-level or higher medical tasks that are integral to successful PFC. We hope units can take these tasks and the resources on PFCare.org to craft mission-driven training for their unit. Just as there is no single mission, there is no one "right" way to train PFC. The best training is the training you can do with the time and money you have, supporting your unique mission and individuals' capabilities. As always, expert TCCC is a prerequisite for any PFC training. Keep up the great work, and I look forward to the ongoing conversation!

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