

PROLONGED FIELD CARE WORKING GROUP POSITION PAPER:

OPERATIONAL CONTEXT FOR PROLONGED FIELD CARE

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We propose a universal approach to operational planning and logistical preparation for Prolonged Field Care (PFC) missions, in the form of 4 stages. In the past, we have been accustomed to view missions in terms of patient treatment stages, such as seen in TCCC. This is less useful when planning for Prolonged Field Care, due to the more comprehensive list of capabilities needed to consider across a wider spectrum of operational realities. Instead of echelons of patient care, we propose to use a system of mission or evacuation stages to simplify and standardize our language, utilizing the following terminology: RUCK-TRUCK-HOUSE-PLANE (RTHP). We believe that the RUCK-TRUCK-HOUSE-PLANE format is useful, being simple as well as easily transferable and relatable, across all branches of service.

The stages are explained below:

RUCK - the gear carried to the furthest point on a mission, generally carried by medical personnel dismounted.

TRUCK - whatever additional equipment will be carried in mission-specific transportation, whether that is trucks, boats, ATVs, kayaks, etc.

HOUSE - gear available to the medic, but which is only feasible to be maintained at a team house, firebase, or other mission support site. It represents the highest level of care the operational element has organic to it.

PLANE - planning stage included to allow the medical providers to consider how they will move patients on aircraft, whether MEDEVAC aircraft (those designated and equipped to move casualties as a primary mission) or CASEVAC (pre-planned non-medical mission support aircraft, opportunity or "slick") aircraft.

These stages are conceptual, and not necessarily linear, but should be used as guidelines only. An operational example could include:

A unit operating out of their vehicles on an extended desert mission may not have any higher level of organic care than that which is contained on their trucks. They may not operate out of a fixed facility or team house. The trucks would therefore represent the highest level of capability the unit has organic to them, or HOUSE. However, when they split up into patrols, the vehicles on each patrol will normally be stocked with resupply bags, and perhaps heavier medical equipment, such as oxygen bottles. These patrol vehicles now represent the TRUCK stage. The most specialized capabilities may only be retained by the command and control element or mission support site (MSS), representing HOUSE. The individual medic and the

equipment on his person represent RUCK.

In the above scenario, if the Special Operations team is engaged apart from their vehicles they will only have the capabilities in their RUCK. If possible, they may move back to the vehicles and evacuate the patient with the additional capabilities in TRUCK to their command and control or MSS (HOUSE). Alternatively, if available, they may call for air evacuation of a patient. Consequently they may go from the capabilities of RUCK or TRUCK directly to PLANE.

The point of the above illustration is the flexibility of the language to describe operational context of care. It should be noted these stages are always defined according to assets available, mission and unit. There is no expectation that a TRUCK or HOUSE is the same across the board.

A useful operational planning diagram would be to develop a matrix with 4 horizontal rows labeled with the 4 operational stages, and the vertical columns labeled with the PFC capabilities. This allows for easier visualization and decision-making with respect to capabilities and equipment available throughout stages of the mission, with respect to casualty treatment and transport. A partial example is below:

	Monitor	Resuscitate	Vent/oxy	Airway	...
RUCK	Pulse ox, BP Cuff, Steth	NS/hespan	BVM with PEEP	SGA/cric	...
TRUCK	Monitor	NS/hespan/FWB kit	BVM with PEEP/O2 x2 bottles	SGA/cric with ketamine drip	...
HOUSE	Monitor	LR cases/hypertonic saline/FWB	O2 concentrator	RSI capability	...
PLANE	Monitor	LR	BVM with PEEP	SGA/cric with ketamine drip	...

There are several further advantages to considering this model. Most importantly, after identifying stages in this manner, it is easy to identify which capabilities and which specific equipment you will have at any point on a mission or during evacuation of a patient. This then helps the medic to visualize gaps, and areas which lack important capabilities along the proposed evacuation chain.

Space is a planning constraint on almost all SOF missions. From the moment a unit

loads out from their home station, decisions are made to prioritize the allocation of space; in shipping containers, on vehicles, and on the person of the individual combatants. The framework RTHP can be of utility by simplifying prioritization here as well.

Using this verbiage, it is much easier for the medic to explain to his leadership what his concerns are, and to pack an appropriate amount of equipment for a realistic expectation of needs. A medic can use the operational context and stages to better visualize the equipment needs, and communicate this to his team. For example, the medic's explanation would include the operational need to support a house, four trucks, and possibly the capabilities to outfit an aircraft to some degree. Using this example, it becomes easier to see that instead of one or two oxygen bottles, perhaps the team needs two more, with another solution, such as an oxygen concentrator, at the HOUSE.

Finally, one of the strategic advantages of the community using this lexicon, is homogenizing our research, development and procurement of equipment, and improve our overall capabilities in the long run. Since part of the emphasis on PFC is to effectively evaluate equipment to support capabilities, we can better evaluate equipment in our numerous sets, kits and outfits, and objectively compare common equipment in the standardized operational phases. It will also quickly identify capability gaps and focus future research and development needs in the community.

To summarize, the application of a standardized operational context naming convention system such as RTHP in the context of medical operational planning, and specifically in PFC, provides several immediate benefits:

1. It provides a framework for planning your mission support and personal load out.
2. It provides a clear system to explain to leadership where your patient care and holding capability shortfalls lie.
3. It is flexible language, applicable to any mission.
4. It gives the community common language, and allows all SOF medical providers and planners to easily share best practices, or equipment suggestions.
5. It provides a simple lens through which to consider necessary research, development, or acquisition.