

The EPIC

Operation Iraqi Freedom: A Reservist's Perspective

Brad S. Goldman, Maj. USAF(R), MC, FS

It was a typical “day” for me, about 3:30 P.M., when I woke up from the night shift and was getting ready to begin anew. I kissed Ruby, my nearly somnolent mini dachshund on the pillow next to me, and headed to the kitchen. I grabbed a snack and checked the answer machine. Something caught my eye. There was a “10” flashing under Messages Waiting. Somebody is *really* trying to reach me. After playing the messages, eight were from my unit urging me to call ASAP on “important matters.” It was February 26th.

The ensuing 24 hours were a nervous blur of hectic packing, shopping, sending e-mails, calling people and saying goodbye. I was being activated. I had had a good idea that activation and deployment were possibilities considering current world affairs and my UTC. Within those 24 hours, with tremendous support from family, friends and especially my employers/partners, I was on base, in uniform and ready to go wherever they needed to ship my team. Now, this is where the old saying, “Hurry up and wait,” comes into play. For the next four months, my team was assigned to home station awaiting further deployment orders.

One weekend a month and two weeks a year. Perhaps you've seen the somewhat flip e-mail attachment from a transport truck in the AOR with that admonition in the front windshield. I guess this is what I had coming to me when I finished active
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During many of our missions into Iraq we take US flags to give later as gifts of appreciation. Here is my team: (L to R) Maj. Brad S. Goldman, Maj. Kimberly Heller and TSgt Ernie Lilly Jr. Note our flight suits are sanitized for travel into the AOR.

Day-by-Day in Iraq

*By CPT. Robert Blankenship, MD, MC, USA
President Elect, GSACEP*

In February, I received orders to deploy with the 4th Infantry Division, 1st Brigade, 66th Armor Battalion – the “Iron Knights.” I became assigned to the unit on the 25th of February, but we didn't start deploying to theater until the 4th of April – exactly six days after the birth of my youngest child.

We left Kuwait and entered Iraq at 0300 on the 17th of April. Our unit rapidly moved deep into Iraq stopping at Baghdad to download our tanks. We moved north to Tikrit and within hours moved even further north to Mosul to help the 101st Airborne secure the airfield there. After that, weeks went by, and I decided the worst scars from the battlefield I would see would be those from our smallpox immunizations. I was wrong. My unit moved from Mosul down to Samarra on the 5th of May. It only took one day before my medical platoon was tested.

The morning of May 6 went by like most: we ate what we could of our MREs, and we started working on setting up our aid station in our new hardstand. At noon, a truck pulled up to our gates with a man who was in an
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President's Column: What A Year!

By CDR. David S. McClellan, MD, FACEP, USNR

Wow! What a year. Six months into my term as your President, it has so far been a tumultuous year. When faced with the realities of our current status, we, the leadership, have had to make some tough decisions. I hope they've been the right decisions.

This year has seen a large percentage of our membership deployed to Iraq, Afghanistan or other theaters. Those of us left behind were faced with extra duties supporting those deployed physicians. We were required not only to provide patient care, but to cover extra clinical work shifts
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We welcome advertising queries as well.

Don't Miss Our Panel at Scientific Assembly

Emergency Medicine on the Frontlines: Lessons Learned and Future Implications

Tuesday, October 14

4:00-5:50 PM

2 credit hours

TU-319

Throughout history several important advances in medicine have come from the battlefield. In this panel discussion, a group of military emergency physicians who participated in Operation Iraqi Freedom will share some of the highlights from this recent battle. They will describe the vital role emergency physicians played in providing medical support from the Special Forces at the heart of the battle to the movement of critically injured patients back to the US by the Critical Care Air Transport Team. Medical treatments that have relevance to your practice such as the use of Chitocin dressing, fentanyl lollipops, and the new tourniquet will be discussed.

Describe the impact of emergency medicine during Operation Iraqi Freedom. Identify treatments from the battlefield with potential implications to the everyday practice of emergency medicine.

Course Instructors

Troy R. Johnson, MD, MAJ, MC, FS, USA

Linda L. Lawrence, MD, FACEP, LtCol, USAF, MC

Lynn Welling, MD, FACEP, CAPT, MC, USN

Robert Wood, MD, Capt., USAF, MC

GSACEP at Scientific Assembly

GSACEP will hold a Board of Directors Meeting open to all members at ACEP's Scientific Assembly on Monday, October 13, from 0730 to 0900 Orleans Room, Boston Marriott. Please look in the ACEP onsite program.

Be sure to visit us at the GSACEP Booth at Scientific Assembly as well.

Save Monday evening, October 13th, from 1800 to 1930 for the GSACEP Reception at SA Regis Room, Boston Marriott. (ED. Note: This may change. Please watch our website and check our booth to confirm.)

Operation Iraqi Freedom: A Reservist's Perspective

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duty without ever being deployed.

In my unit (445th ASTS) at Wright-Patterson AFB, OH, I wear two hats: I'm a Flight Surgeon and a Critical Care Air Transport Team (CCATT) physician. I've found, in my travels, many ED docs wear these hats as well. For those who may not be familiar, CCATT in essence is "military medflight". About 10 years ago, the Air Force realized that more mobile critical care capabilities were required to augment the Aeromedical Evacuation (AE) system. CCATT was the solution to that



My CCATT Tech and Nurse preflighting two ventilated RPG ambush victims from Iraq. Notice close quarters.

problem. A CCAT Team consists of a respiratory therapist, nurse and physician. All team members have extensive ER or ICU experience. Additional training is given to provide critical care in the potentially hostile environment of military aircraft during flight and familiarization with the AE environment. All equipment and supplies are to be carried by the team. CCATT has been used operationally for almost a decade in both military ops and military operations other than war (MOOTW). Mostly the active duty CCATT's were used for this purpose.

My team had known and trained with each other on UTAs [Unit Training Assemblies] for at least three years. This would prove to be a huge advantage when we actually did deploy to "the box" as the Operation Iraqi Freedom AOR is affectionately known. We had trained extensively and flew many missions with mannequins and simulated patients but not one actual "live" mission was under our belt. Each CCATT member is trained to perform the functions of the entire team should one of us be busy, unavailable or injured/killed during combat operations. Trust and communication are fundamental to mission readiness. A lot of issues I've heard about in the AOR are a direct result of a problem with either of these. Being an emergency physician, I am a "naturally born" team player. This was right up my alley, and working and flying as a team fit perfectly. We only needed a place to go and missions to fly. Soon enough, this would happen.

The EPIC

I guess the prospect of being deployed didn't really hit me until I was tucked onto a rotator heading to the Middle East for 120 days. Luckily, I read, re-read and shared the Spring 2003 Deployment Issue of The EPIC with my team and unit. There is much wisdom in those pages; heed it well.

Despite a short two-day stint in a locale which we were expecting to settle in for the duration, we were moved to Camp Wolf, Kuwait, as our base of operations. We got off the C-130 (my first time flying in one), greeted the admin folks, were shown a tent and dropped off for a quick afternoon nap. Within less than six hours and with all our gear still packed, our team was alerted that we were to fly our first "real-world" mission into Iraq. My mind was racing. We had the proper training; we also all had the proper civilian experience. However, this was still something new and different. That day was alarming, exciting and stressful just like internship, except compressed into a few short hours. The mission went smoothly and my team performed flawlessly. I'm so proud of them. They made me look good and gave me time to focus on the patients.

We have since flown many missions into Iraq and to Germany. Most of our patients are intubated and multi-trauma from IED (Improvised Explosive Devices) or RPG (rocket propelled grenade) attacks. There are some patients with a diagnosis of pneumonia of unclear etiology. We have endured long waits, flightline temps exceeding 140+ in idling planes (affectionately known as "the tube of pain"), communication snafus, extra patients springing up from nowhere, enemy fire, equipment failures, lack of paperwork, etc. Yet, our teams in the



Patience is a virtue. Nowhere will that be truer than in the AOR. Here troops deal with a 10-hour flight from Germany to Kuwait on a C-17.

AOR have managed to provide top quality care to these troops and wounded/ill civilians. This is especially true with the recent UN headquarters bombing in Baghdad. One day you are looking at a CNN newscast in the dining tent. Next day, you're flying a

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Iraq: A Reservist's Perspective

mission picking-up the critically injured UN workers.

Being busy is vital to your physical and mental wellbeing. The time passes quicker and you feel more productive. Below are a few cogent observations this flight doc has made during our 47 out of 120 days deployment to the desert.

Everyone—and I do mean everyone—counts! We count the days in the AOR, we count the days until we can go home. It's almost a pick-up line anywhere in the AOR, "Hey, how long you been in country?"

Be patient and flexible. Despite having the perspective of a "spoiled" Air Force doc, there are many things that require adjustment. This is more so since we are stationed with the Army. Different rules, but all in all, we play along well together.

Respect privacy, share your goodies from home and find out who is in charge of the air conditioning. All are vital to a smooth and more comfortable deployment.

Never, NEVER complain about how hard a time you feel you're having to anyone besides your team. There are always folks out there in the AOR who have it much worse, much hotter, more Spartan and more dangerous. I respect them and we see them when we fly into "the box". We provide care packages on every flight possible. It's our way of saying thanks to those closer to the war than we are.

Tent life is like sleep-away camp for those of us whose parents flushed us out of the house for two months during the summer. But there are no counselors! Ponchos, clothespins and blankets make nifty walls. Empty water bottles with ends cut off make fabulous air ducts for the central tent vent. Digital cameras and laptops are everywhere, and many Bx's, even tactical bare-base ones, have batteries and some sort of essentials.

Like many others, I packed way too much stuff. Lighten the load, contact folks deployed before you and find out what the mission and weather really dictate you need to bring. Moving several times is a huge hassle with a ton of stuff.

Consider reviving the lost art of writing. Write real letters and postcards. They are free when mailed in the AOR. Keep a daily journal. This will serve you well for personal reasons as well as a record of what you did and accomplished during your deployment (OPR's, medals, unit presentations, etc).

Bring only a few books; most folks will swap with you. CDs are easier to carry than a lot of books/manuals. Most units here have computers and all tents have somebody with a laptop who will share (this is where the goodies come into play). If there is any PME lingering, this is the perfect time to do it. I finished ACSC tests 3-6 in less than one month before finally deploying. Catch up on journals and professional CME readings.

I would like to close with perhaps the strangest personal realization I've made in the past 15 years. I've been activated for seven months and deployed for one and one-half. In this time, I have gone through extraordinary financial and personal challenges. I have been sent to hot desert climes, lived in tents, used latrines in all shapes and configurations, flown into combat zones, donned body armor in 125 degree weather, carried weapons while treating injured

military and civilians alike. I have endured separation from family, loved ones and friends. Yet, I have never felt more alive, more at peace and less stressed.

I know. I hear you saying—"What, are you crazy?" Maybe. Maybe not. Until this time, I've been so busy building a career, home and family that I've never taken the time to just sit, think and ponder the great mysteries of life and love. Deployment forced me to look at myself and re-evaluate what is truly important. Don't get me wrong, I'm no Hemingway in search of the glory of combat and war, but serving here and now has truly given me a perspective I otherwise would never have. There is an amazing sense of inner peace that many here have come to know and share (they just don't talk about it freely).

Just like in our ER residency training, a deployment is what you make of it. Come prepared with an open mind, and a willingness to work. Everything else will truly take care of itself. I don't know how the other half of our deployment will go, but the camaraderie and friendships I've made here will endure long after I put down the Kevlar and pick up the white lab coat. I'm proud of my team, unit and all the armed forces here in the AOR. The medical care given here is second to none.

A weekend a month and two weeks a year, indeed.



Ensuring all your equipment and gear is ready before the mission is critical to its success. Here we load and stow weapons preflight for mission into Iraq. (Maj. Goldman & TSgt Lilly)

New Members

Moved into Chapter	Institution	From
Peter E. Clemens, MD	SAUSHEC	San Antonio, TX
Scott Dickson, DO	Malcolm Grow Med. Ctr.	Andrews AFB, MO
Thanh Do, DO		Ft. Hood, TX
Robert Donovan, MD	Naval Medical Center	Portsmouth, VA
Andrew L P Houseman, MD		
Michael D. Jones, MD	SAUSHEC	San Antonio, TX
Robert Kulantzick, MD, FACEP	Walter Reed	Washington, D.C.
Greg Lepkowski, MD	Naval Medical Center	San Diego, CA
John Mastalski, DO,FACEP		Florida
Michael Miller, MD	Darnall	Ft. Hood, TX
Devin Rickett, MD		San Antonio, TX
Jon K. Riggs	Wright State Univ.	Kettering, OH
Alex Rosin, MD	Darnall	Ft. Hood, TX
Steven Ross, MD	Nellis AFB	Nevada
Vance Rothmeyer		Bethesda, MD
Dustn Shawcross, MD	Darnall	Ft. Hood, TX
Joel Schofer	Naval Medical Center	San Diego,CA

President's Column: What A Year!

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and other responsibilities of the deployed. It was true even in the reserves as one of my partners was deployed.

Understanding that a majority of our committee members and some of our Chairs and Board members were directly effected, we had to reduce our activity level. But don't despair. We're gearing up again on a number of committees, such as the Research Committee, under the leadership of LTC. Bob Gerhardt, MD, FACEP.

Perhaps the most painful decision was to cancel the Joint Services Symposium 2003, scheduled for March, in San Antonio, TX. We had never canceled this meeting, but we knew our members wouldn't be able to attend due to the situation at that time. We thank the St. Anthony Hotel for being so understanding of our unique circumstances. We do have an excellent program in the works for Spring 2004 again at the St. Anthony in San Antonio. I urge everyone to set aside March 22-March 25th for this outstanding conference. MAJ. John McManus and his program committee have blended cutting edge medical care with review of Topics on the ConCert exam while still focusing on operational aspects of military emergency medicine. For many, our next annual conference will be the first time in two years they'll even see each other. This is very, very special. I urge you to help us make this the best meeting ever.

On a related topic, most of you are aware that we have been able to keep our dues among the lowest in ACEP. Apart from very, very tight fiscal management, the chief reason we have been able to do this is because of the income we utilize from our conferences. We did raise dues a few years ago, and branched out to other income-producing areas, to help make us less dependent on conference income. (Incidentally, there is still no fee to our resident or candidate members which is not true of other chapters). However, we still need conference income to fully fund our operations.

We would love to fund more members to come to our Board and Strategic Planning Meetings, and to develop our young leadership

in other ways as well, but we simply haven't had the money this year. If we get a good result from JSS 2004, I anticipate restarting this process.

I also want to note that we're currently trying to get funding for our reception at Scientific Assembly, scheduled for Monday evening, October 13. As we go to press, we have not yet gotten a sponsor. If we don't get one, we'll hold a reception off site. Please watch the GSACEP web site (www.gsacep.org) and visit our booth at SA for confirmation of the reception location.

Over the past year, we have also had a slight decline in membership. We have been working hard to reverse this trend. We've discovered, for example, that most resident non-members have heard of GSACEP, but don't really know anything about it. It's our job to get that message out. We're doing that through residency visits, but I would also ask every member of GSACEP to talk to a co-worker or friend who is not a member. Please explain to them why it's important that there be a military chapter of ACEP, and what this chapter provides them. We have excellent resources on our web site or through the GSACEP office extolling the virtues of our group. I know it can be hard at times to do this, but it is very important.

On our part, we're contacting everyone we can whose membership has expired, or who has been transferred to another chapter. It's understandable if you've left the military, but this could also just be a glitch in the ACEP computer. If it is, let them know that the fact that you transferred to another state doesn't mean that you've left the military.

I want to thank all of our deployed members, some of whom speak of their experiences in this issue of EPIC. The people of the United States and your fellow military members appreciate your sacrifices and the sacrifices of your families. We all understand that, if these problems are not addressed in other parts of the world, we will be facing them to a greater extent here at home. We're proud to be part of your effort, in whatever way we serve.

Day-by-Day in Iraq

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automobile accident. He had significant thoracoabdominal trauma. Despite all our efforts, he died. For many of my medics this was the first time they had even seen a chest tube or intubation. They also saw a person who came in talking and died a few minutes later. It was a tough day, but it was just beginning.

Four hours later an Iraqi ambulance brought a child who had been playing with unexploded ordinance. It had exploded causing many injuries including a penetrating skull injury. We quickly prepared him for a MEDEVAC flight. The birds came in, but as they were flying over the river one helicopter went into the water. We rushed a medical team down to the river, but the injuries sustained by the crew were immediately fatal. The other helicopter, containing the boy, dropped him off. We then decided to evacuate him via ground to Baghdad, but he died enroute. Hours went by as our unit's soldiers and medics retrieved our soldiers from the downed helicopter in the middle of the river and brought them ashore. We were exhausted both mentally and physically – surely the night would bring us the rest we needed.

0300 I was awakened by a runner from the battalion TOC. There were four badly burned Iraqi children at the Samarra Hospital and the doctor there was requesting I come out to help.

The scouts got a convoy together and we raced to the hospital. Upon arrival, I met a father of six children – five boys and one girl. His children had brought unexploded ordinance into their home and it went off. Two children were immediately killed in the house, and his remaining four children were at the hospital. While evaluating the children at the hospital, one child died. We radioed back to our Forward Operations Base to have a bird come for the three remaining children. While waiting at the LZ we lost another child. It was a frustrating experience because we had no pediatric equipment in our aid station so all we could do was treat the pain and pray the bird came quickly. We evacuated both remaining children, but only one survived to the next day. We understand the daughter – the sole survivor – was ultimately evacuated to the United Arab Emirates. She is still in rehabilitation there.



CPT. Rob Blankenship, MD, at left, 25 lbs. thinner then when he left the States, with SFC Garcia (med platoon sergeant) and GEN. Peter J. Shoomaker, Army Chief of Staff.

“
...one helicopter went into the water... the injuries sustained by the crew were immediately fatal.
”

I wish I could tell you this is all we have seen in my little aid station here in Samarra, but it is not. All together we have seen over 38 traumas involving civilians, US soldiers, and the paramilitary forces. In addition to the deaths noted above, we had another three die of injuries in our aid station – the most recent being a two-year-old girl. It is so sad to see these children die. However, most of the deaths we see were in paramilitary forces trying to kill us.

Back in the spring, as I prepared to deploy with 1-66 Armor, many senior medical officers told me this would be the most rewarding experience of my career as a physician. I thought they were crazy. I already had many rewarding experiences such as serving as the chief resident of Darnall Army Community Hospital Emergency Medicine Residency Program, publications, national lectures, and was currently serving as the Assistant Program Director for Darnall's EM residency. I was proud of the accomplishments in our residency the past few years – how could this deployment top all of that?

Well, my senior medical officers were right. The experiences of the last few months, while very difficult, have helped me realize what is

really important in my life – God, my marriage, my family, and the freedom I enjoy as an American. It doesn't take long here to realize just how expensive that freedom is. So, how exactly is this freedom obtained? It's not in writing book chapters that we secure our freedom. It's not in serving as the assistant program director or in lecturing at conferences. It's the grunts who risk their lives day in and day out on patrols, raids, and checkpoints that secure our freedom for us. And, when they get injured in the line of duty, they come to me. Of all the things I've accomplished as a physician, nothing has been more rewarding than caring for our soldiers in a combat zone. I doubt anything ever will be.

Resident Rep From SAUSHEC Elected

In a very close election, in which over 45% of all resident or candidate members voted, Capt. Julio Lairer, DO, USAF, of the San Antonio Uniformed Services Health Education Consortium (SAUSHEC) was elected GSACEP Resident Representative. Dr. Lairer was opposed by CPT. Andrew Morgan, MD, USA, of Madigan Army Medical Center at Ft. Lewis, WA. Capt. Lairer's term of office begins immediately and is a two-year position. He will join the Board of GSACEP at its meeting in Boston during ACEP's Scientific Assembly.

In his campaign statement, Dr. Lairer, who is also active in EMRA, said that he believes the GSACEP position enables military residents in the chapter to have a strong voice in GSACEP. In addition, echoing past resident reps, Dr. Lairer said that it was his goal to help bring all military emergency residents closer together. One of the ways he hopes to achieve this is by starting a newsletter with contributors from all residencies.

"I believe that we have a very talented group of individuals within all the emergency medicine residency programs," Dr. Lairer said. "Unified, we can address all the issues which affect us not only as residents, but as future staff within the different services."

Dr. Lairer began his military career in 1989 when he enlisted in the Oklahoma Air National Guard and served as an in-flight Medical Specialist for eight years. Last year, he completed a Transitional Internship at Malcolm Grow Medical Center at Andrews AFB. He is currently an EM-2 at SAUSHEC.



ACEP Bookstore To Carry Core Lecture Series

At this year's Scientific Assembly, look for GSACEP's Core Lecture Series to be on sale at the ACEP Bookstore. ACEP is offering it at the rate of \$50.00 to ACEP members. We'll also be accepting orders for the product at our GSACEP Booth.

Congratulations To:

LTC. (sel) Frank Christopher, MD, named Division Surgeon to the 82nd Airborne Division. The 82nd was being deployed to Iraq at the time we went to press.

Have You Signed In on the Web?

A few months ago, GSACEP introduced a new sign-in form at our website which enables members to supply an email address and check off areas of interest in order to receive helpful information. We promised that we would not SPAM you and would not sell the list. The service was designed to make us more helpful to you and keep us current with the things that are important to you on a continuing basis. So, why is that only half of all GSACEP members are signed in? Probably, it's because of deployments which sent more than 50% of all members overseas, or possibly it's because you didn't even know about it.

If you can, go to our website now at www.gsacep.org and fill out the sign-in form. This could be a fantastic service, but you have to help make it one. Thanks.

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