Features

Operation Desert Storm—a PA's Perspective

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A first person account by a Physician Assistant of his experience in a combat zone. He describes vividly how he slowly became confident in applying the training he had received by treating patients during Desert Shield and Storm.

On Feb 23, 1991 at 1502 hours, I crossed the border into Iraq. I had just invaded my first country. War was no longer a threat; it was a reality. I was attached to the 3rd Squadron, 2nd Armored Cavalry Regiment. Our mission was to spearhead the 7th Corps through nearly 200 kilometers of Iraqi desert, find the Republican Guard, engage and hold them until the rest of the corps came through to destroy them. A mission of this nature had never been attempted before, but those in charge believed that it could be accomplished and it was our job to prove them right.

It was hard to believe that the waiting had ended. Five months earlier, I didn't know who Saddam Hussein was; nor did I care. Now I was part of a force that would dismantle his military might, liberate the world from his egomaniacal rule and free the Kuwaiti people from his terror. This venture promised to be costly both in men and equipment. It was estimated that 220 casualties would come from our squadron of 1200 men, including 40 men who were expected to die. We were expecting to lose one of our tanks for every four of theirs. We faced not only conventional weapons but also the very real threat of chemical weapons.

Were we ready for this mission? I was confident that the scouts and tankers were ready. The command was ready and, of course, America was ready. But as a Physician Assistant (PA), I had never been faced with a mass casualty situation. In practice scenarios I had always performed well, but that was practice and this, real. I had never had patients that I was responsible for die. Would I be able to deal with that? I didn't know and it was too late to back out now.

There were many firsts in this conflict. European units were deployed for the first time since World War II. PAs for the first time would be filling positions normally held by physicians. National Guard and Army Reserve units were activated for the first time in years and many technological advances in weaponry would be tested.

Preparation for combat began as soon as I was attached to the unit. The aid stations were split and I was assigned 12 men to assist me with the treatment of the injured. We spent many long hours reviewing trauma scenarios. We changed the packing list for our trauma chests to enable us to retrieve any supplies needed for a particular procedure. These supplies were not only in the same chest, but were bundled together.

Both aid stations were configured to treat chemical casualties. The downwind treatment team would be the "dirty" aid station. We spent many of the 72 days prior to the ground war in MOPP IV practicing decontamination and treatment of mock patients. The training was made as realistic as possible and for the first time I was witnessing medics take chemical training seriously. They knew the threat was real.

Ground War

During the first two days of the ground war, we witnessed some very impressive bombing, artillery strikes and MLRS (Multiple Launch Rocket System) raids, but there were few patients to be treated. The treatment section of the squadron was divided into two aid Stations. Steve Sawyer, the PA normally assigned to 3/2 ACR, was in charge of the White aid station and I, the Blue. The first two casualties received were Iraqi. One had taken two 50 caliber rounds; one in the right elbow and the other in the right lower leg. He was treated by the White team and evacuated to the rear. The other received superficial lacerations and was processed with the other EPWs.

We were told at 6:00AM on Feb 25 that there were an undetermined number of injured EPWs enroute to our location. We had no idea what their injuries were. Everyone on the team contained their anxiety very well. After setting up the aid station I went through a mental checklist; everything was there. I briefed the medics again and, even though assignments were already made, had them tell me what their jobs were. All of our training was about to be tested. One NCO told me he couldn't believe that it was all coming back to him.

To battle the stress of the unknown, I went through every possible scenario. All the equipment was in place and there was nothing else to do but wait. We not only had injuries to worry us, but the injured

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were enemy soldiers. Would they panic when the "infidels" were treating them? I had no idea, so we assigned a guard.

After 15 minutes we were told that there were three patients, but still had no word on the types of injuries. Thirty minutes later when the track ambulance arrived, the senior medic briefed me on the extent of the injuries. All had taken shrapnel in the lower extremities and all were conscious. Two had morphine on board. (Someone later made the statement that the front line medics, in addition to learning the ABCs of trauma, had learned "morphine, ABC.") The most seriously injured patient had a large avulsion of his left gastrocnemius and missile wounds to his thighs. There were no apparent femur fractures and pulses were intact. The largest wound was badly contaminated with dirt. After several minutes of irrigation, only a minimal amount of dirt was removed. We stopped wasting our saline and dressed the wound, started 750mg of IV cefuroxime (Zinocf) and prepared our patient for evacuation. Patient 2 had shrapnel wounds to his legs. He too was stable and had been appropriately treated by a medic, who used the skills he learned at the Medical NCO course to care for the injuries. Our third patient had a single shrapnel wound to the gluteus maximus which was cleaned, dressed and bandaged. He, too, was evacuated.

Our concerns for our own safety while treating these patients were unfounded. All seemed very appreciative of the care given and were glad the war was finally over for them.

After our initiation, I gathered the medics together for a quick after-action review. We talked about what we had just accomplished and made suggestions for anything that might have been handled more efficiently. I thought the Blue team had handled the situation nicely and was very pleased when I asked them who we had treated and they all answered, "patients."

Later that night, we received word that an enemy soldier with an amputation was enroute. The "White" team was the working aid station but I walked over to see if they needed any help. The patient was an Iraqi who had been in a tank that had taken a round from an M1 Abrams. He was conscious and talking, but disoriented. His pulse was irregular and his sclera were injected. The second through fifth digits on his left hand were partially amputated and his left lower leg was partially amputated at the mid-tibia. Bone fragments were embedded in what remained of his gastrocnemius and bleeding was minimal. The patient was cachectic. His name was Sam and he kept repeating "Sam okay, Sam okay." He briefly lost consciousness, probably from the morphine, but a sternal rub brought him back. Our primary problem with Sam was the weather. It was dark, windy and raining. There was no way to care for all of his injuries in the vehicle, so we made a rain shield with a casualty blanket and treated him outside. I was stabilizing fractures while Steve tried to get an IV access. After several attempts he finally opted for a venous cutdown of the greater saphenous; not an easy task when a flashlight is the only light source. Once a half liter of fluids was on board, I easily started the second IV in his left cephalic vein. With two large bore IVs, Sam was doing well. His pulse was just over 100 and his blood pressure was 100/62. After we had done all we could do, Sam was ground evacuated; there would be no air evacuation in this weather.

I had dealt with my first real trauma, and my confidence level soared. I realized there was nothing magic about my job, since I needed only to stabilize and ship. Everything was so mechanical. The war was going great; we were getting very little resistance and we had yet to take an American casualty. I was ready to go home.

The aid stations traveled with the combat trains. On February 26, at 5:00AM when we were given the order to move, we knew that waiting for us was the Tawakalna Division, one of Saddam's elite Republican guard units. Even though they had been heavily bombarded for six weeks, we knew that this would not be an easily accomplished mission.

As we were preparing to move out, a call came in that there were five wounded EPWs on the way. Lt Starrs, our medical administrative assistant, stopped by my track and gave me a ride to the White aid station while the Blue aid station continued to move forward.

The first casualty had a partial amputation of the right arm and multiple shrapnel wounds. His airway was patent and his lungs were clear. Vital signs were stable. An IV access was started and his wounds dressed. The other four casualties had multiple shrapnel wounds and were stabilized and prepared for transport. As we were completing our care for these men, we were informed that our first American casualties were enroute, along with one EPW. We instructed the medics to bring them to the White aid station but soon learned that they were on the ground at the Blue aid station. I jumped in the Hummvee and within five minutes was back at my aid station. When I arrived, the medics had already triaged the patients and had started unloading them from the vehicle.

This was a SNAFU that corrected itself. The plan was that one aid station at a time would receive patients. If an ambulance brought patients to the wrong aid station, they would be directed to the correct one. This obviously didn't work, and the time for corrective action had long passed.

The patients' wounds were significant. Our first patient was a scout whose vehicle had been hit by a missile. His driver was killed instantly, and he suffered burns to the chest and face and took shrapnel to the right biceps. His lungs were clear and there was no indication of inhalation burns. His humerus was fractured and there was a weak radial pulse on the right. An IV was started and his

fracture splinted. The second patient was a 19-year-old engineer who had a small fragment wound to his abdomen. There was no exit wound. His abdomen was distended and bowel sounds were absent. His wounds were dressed after an IV was started. Our third patient had a shrapnel wound to his left thigh resulting in a femur fracture. There was a hare traction splint in place to stabilize the femur, and his fractured right humerus was also splinted. His vital signs were stable and the IV was running well. Morphine was already on board. We checked his vital signs. The initial 3rd Squadron line medics had already done all that needed to be done for him at the aid station level. The last American had superficial fragments in his back, but no neurological deficits, and was evacuated with the other patients.

As we were loading our patients onto the helicopters, the injured EPW arrived. He had a fractured femur with a large hematoma over the fracture site. His pulse was rapid and thready, BP 98/68. There was no IV access, and after three failed attempts I decided to attempt a cut down. PFC McNamara assisted me in the procedure while SPC Foster and SSG Dowridge applied the hare traction splint. I had practiced this procedure on a laboratory animal, but had never performed it on a man before. I had just bluntly dissected, exposed and isolated the vein when an MLRS battery, only 100 meters away, opened up on the enemy. The noise was deafening and I did not know whether it was incoming or outgoing. I kept my eyes on the vein and yelled, "Is that ... coming in or going out ... somebody talk to me!" My medics immediately informed me that the rounds were indeed moving down range, and I then successfully completed my first cutdown.

A few minutes after the MLRS barrage, we heard that a Bradley had been hit. There was one casualty and he was going to be taken to the White team. We loaded our gear and moved out to catch up with the rest of the combat trains. When we pulled in, I started walking to the White side. As I came close, I saw a mass of people surrounding the patient. A Lieutenant was waving his arms at me, so I ran over to help. The patient was a 19-year-old with a partial amputation of the right arm and multiple shrapnel wounds to the lower extremities. Most of the wounds had been dressed, but there was no IV. I was asked to start an IV, but I could not get a vein. We then attempted a cutdown, but the solution still would not flow. I tried the same vein and got the same result. The patients' blood pressure was 138/74 and his pulse was 90. We were out of options and decided to transport without a line. I was angry that I could not get an IV started, but I was convinced that I had done my best. At one of the conferences I attended prior to deployment, we were told, "Do your best, learn from your mistakes and don't repeat your mistakes." I guess that's all anyone could ask.

The events of the day had been very intense. My adrenalin had been pumping hour after hour. Never in my life had I seen so many injured people, much less been responsible for their care. And the end was not in sight. I could see the battle raging a few thousand meters away. There were burning tanks everywhere and the sky was full of fighters and helicopters. We received word that enemy vehicles were just two kilometers away; too close for us to run, so we had to dig in and wait. My rule was "when we stop, we dig." I jumped into my foxhole, and reached for my 45 caliber pistol. As I pulled it out of the holster, I laughed. What good would this little thing do against a tank! So I holstered it again and decided that the jets flying overhead could take care of the problem for me.

As I was surveying the situation, two of my medics jumped into my foxhole with me. I turned around and said, "It's getting a little crowded here, don't you think? Why don't you gentlemen go on over there and get a shovel and dig your own hole, and while you're digging, if the bad guys come, you can jump back in here with me." About the time they finished digging, the all clear was given. The distance that had been reported as two kilometers was actually 20.

Later that evening, we got word that another Bradley with a crew of five, had been hit; no word as to casualties. I moved over to the White aid station to help. Upon my arrival I was told that there were five patients, two urgent litter patients, injuries unknown; one patient with a fractured leg; and two with minor wounds. We initiated the medevac system.

The medevac pilots did a fantastic job. Because the weather was so bad, we didn't want to call in the helicopters unless it was an emergency, but the pilots had told us to call as soon as we got word that we had wounded soldiers coming in. If it turned out that they were not needed, then they could turn around. Because of their policy, more often than not they were on the ground before our patients arrived.

Our five patients were actually only three; two with burns and one with a puncture wound to the calf. The burn patient had first and second degree burns to the chest and arms. Neither were circumferential; his airway was patent and his lungs were clear. The other patient had burns on his back. Both were dressed with silvadine and burn packs and given a narcotic analgesic. The third patient's wound was cleaned and dressed, and he too was evacuated. As the choppers left with our patients, we learned that two badly wounded EPWs were enroute.

It took an hour and a half for the EPWs to arrive. While I waited, I sat outside and watched the night battle. We were still engaging the Tawakalna, but reports indicated we had control and the battle was about to end. Our front lines had stopped advancing to allow the First Infantry Division to pass through. The battle was spec-

tacular at night. The light given off by the explosions was brilliant, and the flares that marked boundaries painted green and red streaks through the night sky. The sky lit up with the rockets from the MLRS, and three artillery batteries added thunder. For a while, it was the most beautiful sight I had ever seen.

Then I saw the first vehicles from the 1st ID as they rolled through our position. I knew that the war would soon be over for the Second Armored Cavalry Regiment, and thus for me.

Two patients arrived at midnight. One was a 15-year-old Iraqi boy who had a gunshot wound to the right chest and shrapnel to the sternum. I took him while a medic took a patient who had an entrance wound from a 50-caliber round in the right anterior superior iliac spine and an exit wound through his left buttock. The boy had breath sounds on the left with decreased sounds on the right. His airway was patent, but he was tachypneic. His blood pressure was stable. Percussion of the right chest produced a dull sound. I inserted a chest tube, and more than 300 milliliters of blood returned. The patient's respirations immediately slowed. The medic, SGT Gordon, started an IV in the left arm and the patient was prepared for evacuation.

As I was finishing with my patient, the medic who was trying to start an IV in the other patient yelled that his patient was crashing. This man who seconds ago was talking suddenly started gasping for air and within seconds was apneic and pulseless. Steve intubated the patient, but his pupils had already fixed and dilated, and with the word that the choppers had been grounded because of a thunderstorm, we ceased all heroics. We postulated that because of his injuries he had thrown a fat embolus. We asked the S-4 what he would like for us to do with the body. He answered "We don't process dead Iraqis." We wrapped our patient in a casualty blanket and left him in the desert.

It was 1:30AM when I finally went back to my track to get some sleep. The 1st ID was still moving through our position, and I was sure that my services would not be needed again until morning. The Cav had done its part. We led 7th Corps 250 kilometers through Iraq, screening and patrolling for the enemy. We had engaged several small units and had met the Republican Guard head-on. We had destroyed over 150 tanks and 180 armored personnel carriers. We had evacuated nine wounded Americans, and the next day four families would be notified that their sons, fathers or husbands would not be coming home.

Early on the 27th, as we were about to move out, three injured EPWs were brought in for treatment. The first was a 15-year-old boy with a through and through missile wound to his left flank and a fractured right humerus. Bowel sounds were present and there was no distention of the abdomen. He was ready for transport after being splinted and bandaged and IV hydration initiated. The second patient had a laceration to his scalp and shrapnel to his left calf. While caring for his wounds, Steve asked him how he liked Americans. He replied, "I love Americans." It must have been the morphine talking. Our third patient had several fragment wounds to the lower extremities, the worst being an open calcaneus fracture. All three were ground evacuated to Med Troop.

These were the last patients we were to treat during the ground war.

On March 1, we moved into Kuwait. We remained there until we were ordered back to Iraq, where our mission would change from a combat role to a humanitarian function. Here we witnessed first hand the atrocities of the Iraqi forces against their own people. There were combat wounds: burns, bullet wounds and shrapnel. But there were also signs of torture, such as a 20-year-old male with burns to his cornea and a ruptured iris. There were people seeking help with old injuries; I saw two cases of gas gangrene. The local hospital evicted patients because they were afraid of repercussions from the Iraqi Army. One such patient was brought to us on the back of a pickup truck with a chest tube still in place.

The most heartbreaking aspect of the entire mission was the children. I took care of a 10-year-old boy with a partial amputation of his right hand, a 7-year-old girl with a puncture wound to her left back and a 15-year-old girl with shrapnel wounds to her chest, abdomen and all four extremities. There were several babies who were dehydrated from gastrointestinal diseases. Even with all this illness around me, I felt like I was one of the lucky medical officers. I was in a forward aid station where my job was only to stabilize and transport. I didn't have to watch these children die.

CONCLUSION

During the 131 days I served in Southwest Asia, I saw a group of men train hard and become a very proficient, life-saving team. I gained confidence in my abilities as a soldier, a leader, and a health care professional. I witnessed the devastation of two countries and realized that there may be other egomaniacs who would force our nation into combat. I know now that we must be prepared to deploy to any place at any time, and why training must be as realistic as possible. I am assigned to a combat unit. My medics and I must be prepared for combat. I owe this to myself, to my medics and to any soldier that might be evacuated to my aid station. ●