My day started early. Hell, my days always started early. It was 0400hrs on COB Speicher in the middle of an extremely hot, dry Iraqi summer. My class was all assembled and conducting their stretching exercises before we got down to the nitty gritty. My assistant was leading the group while I evaluated their physical capabilities and attempted to gauge who would stand out the most in this class. The class had 20 Soldiers. Soldiers from all over, different MOSs, different genders, different ages and certainly different physical capabilities. A good diverse group. I had four females, two male officer LTs, three office pukes, two Air Force Tech Sgts (impressive), one mechanic, one medic (awesome!) and the rest were 11B’s. This was going to suck! So many differences meant that I would have to modify my training just a bit for each Soldier. I can’t yell, scream or berate the office POGs the same way I would knife hand the 11B’s to make my point. I didn’t have any worry about the LTs giving me any grief over rank, not here.

Here I was in charge. The uniform for training was your military issue t-shirt, ACU bottoms, no duty belt, socks were optional and no boots on the mat, only when we were outside. We were on wrestling mats in the gym, so we weren’t wearing boots. I was teaching Army Combatives to anyone who wanted to learn. To anyone who thought their lives might someday depend on them fighting in hand to hand, to the death. Army Combatives. The Army’s response to MCMAP, the Marine Corp Martial Arts Program. I knew that Army Combatives created by Matt Larsen was a great place to begin hand to hand fight training. I also know that the Marine’s MCMAP was a little bit better.

After stretching, I had one of my assistant instructors demonstrating a rear takedown. No big deal. Easy peasy. We were all practicing this technique when one of the females, a sergeant from the motor pool, fell to the floor with her opponent landing on her leg. She winced in obvious pain. I helped her over to the bleachers where she was almost crying by now. Crap, what a sucky way to start the day. I looked at her training partner and quickly noticed a smug look on his face. Mother fucker! I bet he threw her hard on purpose to prove his male superiority. Damn it!

I sat her down and administered the proper first aid. As a 68W40, Medical Platoon Sergeant, I had better damn-well know my basic first aid skills. I sent for some ice and got out the medic kit. After asking some questions about pain, OPQRST and getting a SAMPLE history, I examined the leg. Seemed like a nasty sprain. Not too bad. I had her rest the remainder of the class and apply ice for 10 to 15 minutes at a time while keeping the knee and leg elevated. We continued the class without her participating, just watching. I made a mental note to remember the asshole who threw her for later. I had something special planned for his ass.

After the class, I finished putting an ace wrap on her knee. Her name was Sgt. Willis. Air Force. I checked her circulation distal to the injury and reminded her that she needs to remove and reapply the ace wrap to make sure the knee doesn’t swell up and cut off her circulation due to the ace wrap being too tight. Then I helped her hobble to my HMMV and I drove her to her hootch for some rest. I got her unit’s contact info and I would relay what was going on. I did not anticipate any long-term issues.

As I pulled up to her hootch, another female Airman came out to help. This roommate was wearing a half shirt, and her 34B’s were clearly unrestrained showing their pale underside. Short shorts completed the outfit with some buttcheek showing. Air Force. Bless their hearts. After helping get Sgt. Willis get situated inside, ensuring she had some 800mg ibuprofen on hand, I explained her self-care protocol before I took my leave. I reminded her to be at the gym in the morning to continue her Combatives training, as I went out the door. It was 0630 hrs.

My cell phone rang. It was the ER. We were up. MEDEVAC was enroute, 15 mikes (minutes for you civilians). 6 wounded. GSW’s and other traumatic injuries. Marines. I was 2 minutes from the ER. I sped down the road, kicking up dust, going over my Rapid Trauma Assessments, all thoughts of Air Force cuties gone. It was time to earn my money.

A few moments later, I joined the unit in the ER. It was a Trauma unit from Louisiana. They were good. Really good. I was the Triage nurse and this was my week to be assigned to help in the CASH. It was my job to triage and sort the wounded as they came off the chopper. I was nervous. I was always nervous. I knew I worked with a great team and they wouldn’t let me make any mistakes. These Marines would be in good hands if they could get to us alive. Luckily for everyone, my Medics in the field were among the best. I did not second guess them. They would not second guess me. We supported the decisions made and things usually worked out just fine.

My team stood just inside the ER doors with our little wheeled litter rickshaws ready. Here came the bird. Loud as all get out. Dust clouds filling the helicopter’s LZ. I quickly checked to make sure we all had in our ear pro and goggles on. We were good to go. The chopper set down, the whine of the engines did not slow. All bad. This meant the chopper was doing a quick drop off and going back for more injured Soldiers. We had better hurry and make room. Our Small CASH was designed for 12 emergency patients. We had 4 Docs. It was about to be busy.

We wait patiently for the chopper’s MEDEVAC nurse to wave us in. The dust was still swirling violently through the air when we noticed the dusty silhouette of the nurse waving us in. We were stationed behind a hesco barrier peeking around the corner waiting for the signal. That was it. We stayed hunched over, low, just in case a strong gust of wind might force the rotating blades lower than they were. Our most common urban myth was that they would dip low in a high wind environment, cutting off your head, so you stayed low. In a combat zone, you don’t take any chances. Even superstition has some blade of reality.

So, we went in from a forty-five degree angle where the pilot could easily keep us in his field of vision. We were spaced out at 5 meter intervals, I was in the lead. I would get the most seriously injured Marine off the bird first. As I quick-stepped up to the side of the UH-60 the flight nurse was yelling into the dust, trying to get his voice heard over the roar of the rotors. I craned my neck towards his face hoping beyond reality that I would be able to hear his valuable words. No such luck. It was too loud. He knew it. I knew it. The dust was just another distraction, just like the ungodly heat bearing down on us. The sweat was flowing freely down into my eyes. We don’t dare try to wipe it out. The dusty grit would cause irritation and could even scratch our corneas. Hence the goggles. But he still tried to relay the life-saving information. It was vitally important. Marine was unstable. I did hear that.

I was trying to read his lips as he spoke. I think I heard the word Surgery. I couldn’t make out the rest. Maybe hemopneumothorax, maybe…Stat, I heard clearly. I hoped the field medics wrote out a tag. I quickly helped unlatch the injured Marine from the litter tray and the flight nurse helped me get him on my rickshaw gurney. Then I was off! I passed the next medic bringing in his own two wheeled rickshaw. Perfect spacing, perfect timing! No bottle neck and congestion here. We knew what we were doing. I looked down ay my Marine and noticed the triage tag flapping in the wind. It was half sticking out of his bloody chest bandage. His pale chest bare, bloody, dusty and yes, it was moving as he breathed! Thank God! As we moved out from under the rotor wash, a huge surge of chopper wind blew over us. My heart sank as I saw the small four-by-six Field Medical Card fly off and disappear in the wind. Fuck! Fuck, fuck, fuck! Don’t stop running. Don’t despair. Keep the faith. Without that medical card to tell me his injuries, I would have to use my detective skills and figure out his immediate life threats. I can do this. I had fifty meters through the landing zone and another 10 meters to the ER doors to figure it out. At a steady jog, with a patient on the rickshaw, I had about ten seconds, maybe fifteen to figure shit out.

I looked at his face now for the first time. I usually try not to look at their faces until they get through the worst of it. Just in case. I have enough ghosts when I sleep. But I needed to see his face. His face might tell me how bad off he is. Ten meters went by. He was actually awake, grimacing in pain. Difficult to tell through the dust if he was pale or not. I noticed he was canted just a bit onto his right side. Bandages to the chest, not actively bleeding, but soaked with blood. Good and bad. No bandaging to his back. Good. But no exit wound. Bad. Twenty meters. I noticed his neck, veins were slightly distended. Noticeable. Bad. Thirty meters. He had the grip of death on his litter he was strapped to. Good. He had marks on his arm where his IV should be. Looks like the field medic could not get a line started. Bad. My field medics were good. Forty meters. His boots were still on, laces loosened all the way, one leg slightly bent for comfort. Good. Fifty meters. And I turned at the hesco barrier, the wind suddenly blocked, dust and sticks were still swirling through the air. But definitely much better.

As I sprinted for the double doors, my mind raced. Sucking chest wound, right side. This is why he is canted to his right side. To keep the good lung, the left lung above the blood and the air can still readily find it’s way in. It can still function quite well. Shock, definitely in shock. How much blood has he lost, no one knew for sure. SPC Navarette was at the first set of double doors and opened them for me so I never stopped until I was inside. Then he quickly closed them. Navarette was my go-to guy. Solid and focused on his task at hand. Never faltered or hesitated when it came to making the hard decisions. He was an excellent Medic. I was glad to have him on my team. As soon as they were closed the inner set of double doors opened. This system kept out the majority of the dust and debris. This was also where we would decon patients, if need be. I quickly made my way through the inner doors where I parked next to the farthest litter stands. The ones closest to the x-ray room doors. SGT Collins helped me quickly stabilize my rickshaw gurney because we weren’t done with it just yet. I quickly glanced at the clock on the wall. 0655 hrs. I was hungry.

One of Lousiana’s finest trauma surgeons paused long enough to ask. “Whatawegot”? As he was looking for the FMC, which had blown away just thirty seconds ago.

“Pneumo-hemo thorax. Shock”. I quickly informed him without glancing up. I was looking for the succinylcholine to put him out. I estimated this Marine to be about two hundred pounds. Big as me. Equates to about ninety-five kilograms. That’s one milligram per kilogram. Comes to about ninety-five milligrams. Easy Peasy. But I was cheating. I memorized estimates rather than figuring out the math. I hated math. Small adults get ninety milligrams, medium sized adults get ninety-five while big guys get one hundred milligrams. It is a rough estimate, but that’s why it’s called practicing medicine, right? Right?

SGT Collins was already getting the oxygen turned on and placing the O2 mask over his face then placing the small D tank between the Marine’s legs. SGT Young was coming up with the I.V. cart and gloves. I quickly donned some nitrile gloves. SGT Collins continued to assist by taking vital signs. Pulse, respirations, skin color, condition and temperature. He added a small pulse ox to the left index finger.

“Chest x-rays, then prep him for surgery” Instructed the Battalion Surgeon. There was no need to add anything more. We all knew our standing protocols for trauma patients. Oxygen at fifteen liters a minute, consider bagging or intubation. Two large bore I.V.s, meaning use a 16 ga needle and don’t fuck it up. Push at least five hundred cc’s bolus of Lactated Ringers, maybe one thousand cc’s. Depends on how the patient is presenting. Draw blood for a quick “smac” panel (basic metabolic panel or chem 7 as the lab rats called them) and a CBC (complete blood count). I have no idea why we called it a smac panel. “What’s the MOI”? He added. Pausing for effect.

“Not sure, Doc.” I solemnly replied. “The FMC blew away with the bird”. I turned to find a needle for a quick chest decompression. “I’ll find out real quick”. I glanced to the next bed over. SPC Ngyuen was getting the next Marine settled into the litter stands. “Hey, Ngyuen”. I caught his attention. “What’s the MOI for these guys”? I quickly asked.

“IED, then an ambush with small arms fire”. He replied without looking up. He began setting up the oxygen for his patient. Johnson was getting I.V.s ready for him also.

“Shit”. I breathed. No way to tell if this is from a GSW (gunshot wound) or shrapnel from the IED. It made a difference here in the CASH, kinda. A GSW would be the easier to figure out while in surgery while a IED blast would be more difficult to discern and may have some primary blast injuries, maybe some secondary injuries and for sure some tertiary injuries. Could also be some TBI going on (traumatic brain injury). I quickly checked his pupils for PERLA. Do the pupils react equally to light and accommodation (Meaning can he follow your fingers with his eyes and not move the head? Are the pupils unequal? They looked fine to me. I was holding one of the Marine’s eye open with one hand as I shined my pen light towards his eyes with the other. Judging from the pupil’s reactions, I determined that he was not showing signs of a TBI at this time.

I began to talk to the Marine. “Hey, Jarhead. Don’t sweat it. I got you”. He made eye contact and gave a weak smile. He was having some trouble breathing. I quickly wiped a povidone/iodine swap in circular motions on his upper chest. Swiped a line through it with an alcohol pad at the mid-clavicular line. Then finding my landmarks, I located his second rib down and smoothly slid the fourteen ga needle and catheter unit in about an inch or so, over the top of the rib. I smoothly pulled out the catheter and a little hiss of air accompanied by a few little pink bubbles came bubbling out. A 14 ga needle is not ideal, but it would get us through the next 10 minutes while he waited for surgery.

I kept talking to him. “What’s your name, Buddy”? I asked as I got his I.V.s all put together and ready for insertion. I left the two I.V. sets on the tray stand.

“Lance Corporal Sully”. He squeaked out. He was tired. He was in pain. I was causing some of that pain. I wasn’t finished causing him pain.

“Well, Lance Corporal Sully”. I began with a smile. “We’re gonna get you an x-ray real quick. When you get back, I’m gonna start your I.V.s then we will get you into surgery so Doc Carter and his team can sew you up”. I quickly gave him a 15 on the Glascow Comma Score and felt some relief. For now. I put my two fingers into his hands at the same time. “Now squeeze my fingers, Sully. Squeeze hard”. I instructed. “Good. Relax for”-I was interrupted.

“I’m ready for him”. SGT Johnson piped in as he stuck his head out of his x-ray room door. Perfect timing. Johnson helped me wheel him into the x-ray room next to the x-ray table. We slid him over from the litter to the table. I quickly left and let Johnson work. Going back out into the ER, I helped where I could. Noting that we had four patients, everyone was busy. The patients were being tended to. Organized chaos. One patient had a tourniquet on his left leg. Big bulky bandages soaked through with blood. That looked bad. Another patient had multiple bandages on his legs. Another had bandages on his lower back, right where the body armor stops. That sucks.

“Ok, Top. He’s ready”. Johnson calls from his door. Satisfied that my guys have the ER under control, I hurry to the x-ray table and Johnson helps me to get Sully back in my rickshaw. From there we move him back to my spot before going to pre-op. I quickly apply constricting bands to both biceps. I wipe down both cephalic veins, one on each arm. As the povidone-iodine is drying, I check my bag and tubing set up. Good to go. I wipe the vein with an alcohol prep pad and secure the base of the vein with my left hand while I smoothly slide the catheter and needle unit in at a forty-five degree angle and I feel a slight “pop” as the needle pokes through the vein. A flash of blood can be seen in the needle’s clear flash chamber. I advance the needle unit a bit more ensuring the catheter is seated in the vein. Then I use my left hand to slide the catheter into the vein while my right hand remains motionless. I secure the I.V. with a clear Tegaderm I.V. dressing. Loop the tubing and secure it with tape. I open the I.V. all the way. Then I do the same on the other arm. This one I opened the I.V. at about 60 gtts a minute.

I check over everything I have done so far. Dressing is in place. Effective. Needle and catheter is still in place in the chest. Effective. Oxygen is in place. Needle is in the yellow. I just need 5 more minutes! Another quick set of vital signs before I hand him over to the cajun boys from Louisiana and they handle business.

The PA system comes to life. “MEDEVAC inbound. Ten Mikes. MEDEVAC inbound. Ten Mikes”.

I throw my gloves away and wash my hands. Everyone is making sure their patients are stable. Lining them up for surgery. We get more rickshaws and go wait by the hesco barriers. Seems like we were just here, I laugh.

The next round of injured are the easier ones who were not as severely wounded as the first group. Small injuries. Fractured humerus. Grazing gunshot to the thigh. Headache, possible concussion. Too easy. As I am finishing up in the ER and dotting all our I’s and crossing our T’s, Doc Nelson pokes his head out from the pre-op area.

“Hey, Tack”! He whispers very loudly.

I look up and smile. I notice a wicked gleam in his eye.

“Hey, Doc”. I break out in a big grin ear to ear. This is gonna be good, my mind starts to race. “I was gonna grab some chow. You want me to bring you something”? I casually ask.

“Naw, I’m good”. Doc Nelson replies. “You wanna cut off a guy’s leg”???...

Chow can wait.