

A Day in the Life

**Major Shawn T. Buller,
APA-C, MPH**



The author in front of a Blackhawk helicopter

The US Army has recognized the importance of meeting the health care needs of aviators, who must maintain a high standard of physical fitness, since creation of the Army Air Corps before WWII. The *flight surgeon* is a clinician whose primary responsibility is the health care of personnel on flight status. An aeromedical physician assistant (APA-C) is a clinician who can fill the role of flight surgeon.

The training program for flight surgeons is designed to develop the clinician's ability to recognize potential medical problems or the sudden incapacitation of an aviator. Flight surgeons also fly a minimum number of hours in order to understand the effects of fatigue, vibration, and noise on an aviator. This is my second tour to Iraq but my first tour "on flight status."

Shawn Buller is an aeromedical physician assistant with the Army National Guard and was deployed to Iraq at the time this article was written. When not on active duty, he practices emergency medicine in Charlotte, North Carolina. He has indicated no relationships to disclose relating to the content of this article.

■ 2200 HRS

I am just back from flying a mission north of Baghdad. I am barely able to stand, and a wave of fatigue and nausea comes over me as I egress the Blackhawk helicopter. I am close to being a heat casualty after flying over the combat zone for 6 hours in 130-degree heat. I sit down on the edge of the runway and recall the events of the day, thankful to be back in familiar surroundings.

I remember one small forward operating base (FOB) we landed at for a short stay; the FOB was located along the border of Iran. Like every other combat outpost, it was blanketed with dust and surrounded by 15-foot-high cement walls.

I learned that the medics at this FOB were available only for sick call and emergent care issues. I walked around in an attempt to link up with the medics. A sergeant at the base heard I was there and asked me to help the medics evaluate incoming injured coalition troops who had been involved in a motor vehicle rollover. I was directed to the medic tent and waited for the patients. I quickly triaged the patients' injuries, and the medics got to work treating their wounds, which appeared to be non-life-threatening orthopedic injuries. Nonetheless, the patients were stabilized and packaged up for medevac. I waited for the medevac helicopters to circle above and handed the situation over to the FOB medics, as my crew was waiting for me. I could see the patients being loaded onto the medevac helicopters as we lifted off and circled above the base. Watching the scene below, I smiled to myself, knowing that I had really made a difference today.

■ 0800 HRS

Back at my base in southern Iraq, I've dragged myself out of my bunk and now I'm evaluating routine sick-call patients. Sick call includes almost everything you would see in the States, conditions as mundane as athlete's foot to a sprained ankle. I give the medics some quick on-the-go tips on everything from pathophysiology to pharmacology while evaluating patients, which works out great because the patients appreciate the education as well.

■ 1130 HRS

Before going to lunch, I double-check the list of soldiers given influenza immunizations. On arrival in Iraq, many soldiers were quarantined with flulike symptoms and subsequently tested positive for the flu. The remaining asymptomatic soldiers didn't want to get sick or be stuck in quarantine, so they all got their shots.

■ 1300 HRS

When I return from the chow hall, I check the afternoon patient schedule; only two patients require a flight surgeon. One is an unmanned aerial vehicle (UAV) operator/pilot, and the other is a crew chief. The UAV pilot is an easy flight physical; he is healthy and the evaluation is quick. Although pressed for time, I like to find out information, so I ask, "Anything interesting out there to see?" All the UAV pilots give the same answer: "No." I know they have to be pretty tight-lipped because of operational security, so I don't press the issue.

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“The ER phone rings, and a medic relays the call. At once, everyone is alert.”

The crew chief presents for a recheck of what at first appeared to be some ulnar-nerve symptoms. I had initially inquired about his positioning in the Blackhawk, which included sitting at the side of the helicopter holding onto a machine gun while leaning on his elbows out a side window. He was advised to use elbow pads and attempt a different position, one that does not involve leaning on his elbows; now he is returning to let me know this seemed to help and his symptoms are improved.

The medic reminds me that I am scheduled to work the emergency room (ER) by myself, which supports a base with more than 7,000 soldiers, sailors, marines, and airmen. The ER is supported by an on-call forward surgical team (FST) capable of handling most trauma that comes through the door. Little did I know that this would be a night I would call for their help.

■ 1500 HRS

I examine a group of soldiers who are ready to redeploy back to their home station. They have been in Iraq anywhere from 10 to 12 months and are here for a mandatory post-deployment health assessment (PDHA), which requires a face-to-face encounter with the clinician. The PDHA is designed to screen soldiers for disease, illness, or injuries that may have occurred during their deployment.

This group, Desert XI, is a military transition team that helps train the local Iraqi and Afghan populations. The teams are typically made up of 10 to 14 soldiers from different job specialties and locations who are trained to be advisors. This particular group was based at the infamous Chemical Ali's house. Their common complaint is that the chemical fumes from the basement were so strong that no one could enter the area. Months earlier, a mass grave had been discovered in the front yard. The soldiers wanted to document that they had been exposed to fumes from burning trash and oil refineries or possibly chemical weapons that might pose long-term adverse health effects.

The consistently humid air in southern Iraq creates a thick early morning fog of burning trash fumes and the smell of oil refineries that burns your eyes and nostrils. Some soldiers present with asthmalike symptoms after trying to exercise. It makes me think about how awful it must

be to grow up in this kind of pollution and what the long-term effects of exposure to these toxic fumes will be for us.

■ 1700 HRS

After sending up reports and sitting through the unit's battle update briefing—a biweekly meeting that helps the commanders and staff catch up on the latest changes—I find myself once again dreading my impending shift in the ER. I make my way to the dining facility and eventually back to my hooch to get ready for my long night.

■ 2000 HRS

The night starts out quietly. The medics are meeting for the first time. Some have just arrived from the States and have been in country for less than a week, and others were brought in from all over Iraq to help beef up the base's medical capabilities. Most are new graduates of medic school and have never been deployed to the combat zone.

■ 0400 HRS

It's Sunday morning, and I am nearing the end of my shift. I have used the precious time to catch up on some paperwork. Suddenly, radio chatter begins: “Roger. We are in flight to your location.” The ER phone rings, and a medic relays the call, “Sir, we have two casualties. One is urgent surgical and one is priority ... both gunshot wounds ...” At once, everyone is alert and looking at me. I sit up and tell the medic, “Call the surgical team, lab, and x-ray. NOW! One of you stay next to the radio, the rest come with me.”

The medics follow me into the trauma room, which is a tent across from the ER. Our “hospital” is a bunch of tents hooked together. I start assigning the medics to different tasks. “I want everyone to put on a trauma gown and gloves.” All the medics are very quiet, intent on not looking like they just graduated from medic school. They are wide-eyed and their faces look expressionless, but they move with anticipation; each movement is deliberate, as if they are on the edge of panic. I then point to different medics, “I want you to check the monitors. You get the fluids ready. Get this place cleared and ready to accept patients.”

At that point, the overworked FST starts to filter in; surgeons, nurses, x-ray, and lab all quietly get their equipment prepared for the incoming patients. The patients, having arrived by helicopter, are soon transferred to the care of the trauma team. Everyone works diligently to stabilize the patients. I step aside and head back to the ER clinic, which is much quieter, and watch from a distance while the others work on the patients.

■ 0800 HRS

My relief has arrived, and I put on my protective vest and helmet, grab my pistol, and head for the door. The fatigue sets in again as the adrenaline wears off. Another day gone by brings me another day closer to home. **JAAPA**