

becomes critically ill and precious seconds will make the difference in saving a life, the HAC will divert to the closest facility, not necessarily the one with the most sophisticated care available.

The aircrew play a pivotal role in the mission by directing the placement of patients inside the aircraft. They must know how to safely load them, with the most critical patients being placed in an accessible spot with easy egress. With mass casualties, aircrew direct the loading of patients in the most sensible and safe order. To my knowledge, the only time a patient ever was injured during a mission was when one of the corpsmen failed to listen to the direction of a crew chief. The crew chiefs are in charge of the back of an aircraft, and a CasEvac mission is no exception.

The brunt of the medical mission, however, falls on the backs of the CasEvac corpsmen. These young Sailors, who make up for in heart

anything they may lack in refined medical knowledge, have duties among the toughest. Very few of them have had advanced lifesaving training, and, for many, this is their first assignment in the Navy.

We had a mere 40 CasEvac corpsmen with our squadron, and they manned aircraft 24 hours a day for seven months. They flew in extreme weather and daily risked their lives without complaint. If necessary, they ran to rescue the wounded on the ground, while rounds were being fired overhead. They flew despite many internal emotional battles with the ghosts of traumatic experiences. They witnessed some of the most horrifying acts of violence our generation ever will see. They are true heroes. The only reward they ever asked for was the honor of looking a wounded Marine in the eye, holding his hand, and telling him, "You did a great job; now we're going to get you home."

Lt. Matthews is a flight surgeon with HMM-161.

## A Corpsman's Perspective

By HM3 Jefferoy Kennedy

After checking in to HMM-161 for duty as a squadron corpsman, I was sent to Yuma, Ariz., for the Desert Talon course. I was joined by another squadron corpsman scheduled to fly CasEvac missions for OIF-II. We were put on a regular rotation for flights that, among other tasks, practiced taking-on and off-loading patients. This syllabus was geared toward flight duties, and we practiced taking care of patients in a training setting in the back of the CH-46E. The aircrew also got experience having patients on board while working alongside corpsmen.

The class reviewed the types of injuries that had been reported during OIF-I, how we would treat them, and what we could or couldn't do. Each CasEvac mission is different, and we discussed what to do in a variety of situations. At the end of the week, we were given a complete tour of the CH-46E, and received emergency-procedures training.

We then went to the dunk tank at MCAS Miramar, where we received swimming training. We earned the same swim qualifications required of all aircrew, including getting checked out in emergency-ditch procedures.

We then joined the last of HMM-161, and left for Al Taqqaddum, Iraq. A couple of months later, we took over the CasEvac mission from the Army. I regularly was paired with a highly qualified corpsman, HM3 (now HM2) Christopher Pair. He helped continue my training in emergency medicine and procedures.

The setup for each day was routine: After morning muster, the previous crew took all the gear off the aircraft and staged it at a designated spot. We then went over what gear each section would need. A section consisted of two aircraft, with three sections total. We would have the oncoming CasEvac team leader for the next shift attend the aircrew brief and note the aircraft and section assignments. We also made sure we had the right medical equipment on board.

In the first couple months, when the sections and aircraft would change their lineup, the corpsmen would trade out the required gear (usually just from one section leader to another). Later, when the temperature rose to around 120 F to 130 F, or higher, we noticed the batteries on the suction machine and vital-signs monitor would start to die toward the middle and end of the day shift, even though they were fully charged the night before



and sometimes not used. We decided to keep both machines on a rotating charge with their respective charging devices.

If a CasEvac mission was called, the CasEvac bell would be rung, and the maintenance chief would notify everyone on the radio. Our objective was to make sure the turn up and takeoff was fast, efficient and safely done. That first hour after the injury occurs is extremely vital to the patient.

The night shift also included a regular mission, later to be known as the milk run. Before the night shift aircrew got their brief, patients who needed transport or those who later might need to be moved to a higher level of care (but were stabilized enough to wait a few hours), would be identified. The section leader would be given a time by the direct-air-support center (DASC) to start the milk run. Injured patients from TQ SSTP, Blue Diamond, Camp Fallujah, and Camp Ramadi medical would be transported to the CACH in Baghdad, or to the Army surgical center in Ballad, depending on the patient's needs. We also would transport personnel who had finished medical treatment in theater and needed to return to their respective units. They would get dropped off at any of the medical units mentioned above for further transport via ground units. The milk run would last anywhere from an hour to six hours, depending on the patient load and how many places and trips it took to get the mission done.

When we were not flying, Cdr. Boyle, a surgeon from the SSTP, liked to visit once or twice a week and show us new and better ways of doing emergency medicine. We welcomed his training, knowing it would help us become better corpsmen.

HM3 Kennedy was with HMM-161.