

Chapter 4

RECOLLECTIONS FROM THE FRONT

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INTRODUCTION

This chapter collects the thoughts and reminiscences of the active duty Air Force, Army, and Navy otolaryngologists who have deployed to Iraq and Afghanistan (emails from each otolaryngologist to Dr. Brennan,

July–September 2013). These combat surgeons were given no guidelines or recommendations but were asked to freely express their thoughts regarding their deployments to the war zone in their own words.

OTOLARYNGOLOGISTS

Lieutenant Colonel Jonathan “Luke” Arnholt, US Air Force

Pediatric trauma—specifically pediatric airway management, I had to trach [place a tracheotomy tube] in a few children and was incredibly fortunate to have all of the required endoscopic equipment and an excellent supply of 2.5 and 3.0 trachs available (credit to those that came before me). NO one understands pediatric airway other than ENT.

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Along the same line of thought above my opinion is that ENT should be involved in ALL airway management decisions from the OR to the ICU and beyond. It is a lesson that is continuously being relearned—but when in doubt trach the Patient especially if they are going aerovac (8+ hrs) to Germany.

Ensure that the great vessels are thoroughly evaluated. Although CTA [CT angiography] has a reported 99% sensitivity for vascular trauma this is downgraded if there are multiple metal fragments around the great vessels. Even if the vessels have been “explored” at an FOB [forward operating base] the Pt should get a CTA when the test becomes available and if you think the Pt should be explored they should be explored. I saw 3 cases of missed carotid injuries on initial evaluation prior to the Pt arriving at BAF [Balad Air Field] including one SM [service member] who had undergone a neck exploration at an FOB. 2 coalition members died. . . . Small holes can hide catastrophic vascular injuries—the great vessels can be injured with relatively minor external signs and symptoms.

Hypopharyngeal injuries can be managed conservatively—NG [nasogastric tube] and Abx [antibiotics]. (No surprise).

Things that I wish I had been more knowledgeable about prior to deploying would be applying the syntheses ex-fix [external fixator] device for comminuted/skeletonized (NO overlying soft tissue coverage) mandible FXRs and regional myocutaneous flaps (latissimus/trapezius) in a couple of cases Pt’s had undergone prior reconstructions with pec [pectoralis major] flaps that had failed presenting a real challenge in terms of reconstruction.

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As you taught us—being able to use the EGD [esophagoduodeno] scope for flexible esophageal evalu-

ation is a skill worth its weight in gold. Trauma, specifically H&N, trauma is a team effort.

Lieutenant Colonel Carlos Ayala, US Air Force

Highs—Overall amazing experience, tons of operating and exponential growth of surgical experience. Speaking to family via Skype, and morale phone calls, watching Afghan children recover from injuries because of the care we provided. Great surgical experience.

Lows—Watching our heroes injured and dying, watching children die or experience devastating injuries. Reality of Bagram base bombed regularly by Taliban. Many on base casualties from these bombing sleeping in areas very close to hospital. Observing the dismal depressing conditions the Afghan families live in.

Lessons learned—For our active duty service members do what you can and get them out of theater ASAP. Afghan nationals and Afghan people do as much as you can over a longer period of time. Poor hygiene conditions outside of hospital and such poor nutrition that you need to take your time treating their wounds for them to heal properly or your hard work will be ruined.

Lieutenant Colonel Richard J Barnett, US Air Force

My 6.5-month deployment to Bagram, Afghanistan, could be summed up as the best of times and the worst of times. The best would include the incredible fulfillment I experienced by caring for our troops and allies and the local Afghan population. Providing medical care to those who are in need and otherwise will never receive it is to me the greatest gift one can offer. I will cherish the opportunity forever. I would also add that I have never worked with a finer group of people in any setting than my fellow deployed colleagues. They were professionals in every way and every day. The hardest aspect of the deployment would be having to see our troop’s extensive injuries. Amputations were a daily occurrence on some of the most motivated and patriotic soldiers I have ever seen. I never got used to seeing it but will always remain impressed by their ability to persevere. I am forever humbled by their sacrifice.

Lieutenant Colonel Jose E Barrera, US Air Force

Thank you for giving me the opportunity to speak on my deployment as one of many ENT Surgeons and Facial Plastic Surgeon at Craig Joint Theater Hospital (CJTH) in Bagram, Afghanistan. I deployed on 10 May 2010 until 13 November 2010. While at Bagram, I served as the Flight Commander for Surgery and Anesthesia working alongside 17 physicians, key to the survival of 98% of airmen, soldiers, and marines that arrived on our doorsteps at Craig [Craig Joint Theater Hospital, Bagram Airfield, Afghanistan or CJTH]. Advanced head and neck and plastic surgery care was integral to providing outstanding care as 25% of injuries involved the head and neck. During my deployment we operated on over 120 facial and head and neck injuries with 35 patients necessitating complex craniofacial reconstruction and flaps. There was no general plastic surgeon assigned to CJTH, thus many of the burn and complex wound cases needing plastic surgery care were provided by the ENT/Facial Plastic Surgeon and General Surgeons.

I had the honor to see the transition of General Petraeus to command and the surge take place to a total troop strength of 120K in Afghanistan. With the surge came an increased amount of casualties and further stabilization of Helmand Province and the Kandahar region. We also experienced the first invasion of a US base since the Vietnam War. At 0400 hours on 18 May 2010, over 50 insurgents entered into the base half a kilometer from Craig after an insurgent detonated an IED through the sand bag and concertina wire wall. Sadly, a contractor was killed while driving on the road just south of the hospital. I woke up to live fire and the sound of Blackhawks over the shanty medical compound adjacent to the hospital. The insurgents were clothed in US military issued uniforms and were tasked to blend in to the base. They were either killed or retreated back to Bagram. Unfortunately, we did see three of our soldiers lose limbs as they chased the insurgents through a mine field in Bagram. The remaining 6 months saw scattered scrimmages and gun fires near and around Bagram with mortar attacks landing almost weekly near the hospital.

During my time at Craig, we evaluated and treated local Afghan national citizens on a humanitarian basis. In the period from November 2009 to November 2010, seventeen patients with cleft lip and palate (CL/P) deformities were treated. Thirteen patients were treated with CL/P, while four were deemed to be of too poor health to undergo surgery due to low weight. These patients were offered nutritional support and one patient received a nasogastric tube with feedings. The average age at presentation was 5.9 years old with a range from 1 month to 20 years. Eight patients presented with an isolated cleft lip or cleft palate, while the remainder (nine) presented with cleft lip with palate. Of the remaining nine pa-

tients, four patients received staged operations starting with a modified Millard rotation-advancement repair followed by the cleft palate repair. In addition, we performed both surgical and prosthetic rehabilitation of ear deformities. Dr Ian Zlotolow, DDS, from Stanford University visited Craig upon invitation as a visiting professor. We were able to offer 10 ocular prosthetics and three prosthetic auricular implants while two patients also received microtia repair. The Humanitarian mission was of high importance to the surge and intelligence on the ground. After operating on a 10 yo boy with an orbital tumor and achieving a good result, the father surrendered 3 tons of HME [homemade explosives] and 2 weapons caches.

As a surgeon, I learned that I was an integral part of the fight. My contribution to restore and save the warfighter, lead in an austere environment, and work alongside my fellow warfighters on the Provincial Reconstruction Teams and my surgical brothers in arms taught me that we could truly win hearts and minds.

Lieutenant Colonel Chester P Barton, III, US Air Force

We provided the injured US and coalition forces with top-notch care, and I felt privileged to serve them. We provided the Iraqi citizens with care and support which would have been impossible for them to obtain otherwise . . . it was nothing short of miraculous from their perspective. Our patients provided us with priceless medical knowledge, skills and experience—all at a great cost to them. Let's make sure their suffering was not in vain, by sharing the lessons learned and improving care for the future.

The foundation built during residency served me well in Iraq. My initial anxiety and self-doubts were soon replaced by increasing confidence as I realized that the principles I learned as a resident could be applied to the complex cases I was encountering. It's all about the building blocks.

If there was one exception to my statement above, it would be in the area of penetrating laryngeal trauma. I recommend covering this topic during any pre-deployment assessment or readiness skills courses.

The camaraderie among our deployed trauma surgeons was invaluable. We assisted each other and, in the process, learned from each other. The profession of medicine/surgery was combined with the profession of military officers—it created a great working environment which fostered mutual respect, developed trust and ensured a solid work ethic. I was honored to serve in the 332nd Expeditionary Medical Group at Balad Air Base, Iraq.

Lieutenant Colonel Nici Eddy Bothwell, US Army

Without question, my deployment with the 115th CSH [combat support hospital] to Camp Dwyer,

Afghanistan, is my most valued military endeavor, and I am grateful to have had this short, yet epic, chapter in my life. Not a single day passes that I am not reminded of something I learned, felt or experienced while deployed. There is an unexpected and refreshing opportunity to work side-by-side with other specialists and cross-pollinate our techniques and skills. Out of necessity, I adopted a urologic cystoscope as an esophagoscope, and I borrowed the C-arm from the OR to perform esophagograms. Out of curiosity, I performed a tibial external fixation with orthopedics and scrubbed in on numerous exploratory laparotomies with the general surgeons. And out of amity, I staffed a general surgeon through a maxillo-mandibular fixation and an orthopedic surgeon through an elective tracheostomy. This unique sense of camaraderie is seemingly exclusive to the deployment experience and just one of many reasons why these memories are everlasting.

Colonel Joseph A Brennan, US Air Force

See Chapter 48, Afterword.

Major Nathan Christensen, US Air Force

I was deployed from May to November of 2012 and overall I would describe the experience as professionally fulfilling and personally challenging. The highlights of my deployment were all related to episodes where I was able to use my unique skills as an otolaryngologist to help patients in need. Two such examples include identifying and repairing a persistent CSF [cerebrospinal fluid] otorrhea injury in a young afghan boy who had suffered a Taliban GSW [gunshot wound] to the head and identifying and repairing a penetrating pharyngeal and laryngeal wound in a coalition soldier who had been injured by an IED [improvised explosive device] blast. It was difficult being separated from my family, and I am thankful for their sacrifices. However, in retrospect, I am a proud that I had an opportunity to serve injured soldiers and patients in a tangible and rewarding way.

Lieutenant Colonel Robert L Eller, US Air Force

As one of my fellow medics said, being a well-equipped surgeon in a war is the best role one can have in the military. My experience in Iraq is the highlight of my professional career. It was truly an honor to serve our troops and the people of Iraq. I went to Iraq a year and a half after finishing my fellowship training, and I consider it to be the place where my surgical skills and knowledge solidified. I had a fantastic surgical experience there, performing over 700 procedures on more than 250 patients in nearly 5 months. While there were many technical lessons, I returned home with two principles that

have stayed with me: (1) When stress levels soar and chaos abounds, stay calm and be bold to do the right thing, and (2) build your skills into others and allow them to build their skills into you.

Colonel Jeffrey A Faulkner, US Army

During the summer months, the surge was beginning and the daily work-load increased with each month. Iraqi death squads were roaming the cities and often instead of killing their victims, the squads would shoot them laterally through the eyes, leaving the victims blinded, with a traumatic brain injury and disfigured faces. Consequently I often found myself working with the neurosurgeons to repair the anterior skull base and orbital complexes followed by a second operation the next morning to repair the rest of the maxillofacial or mandibular injuries. The pace of the operations was pretty grueling but I maintained a routine of exercise and fragmented sleep that allowed me to meet the demand.

In my personal assessment, I was just doing a lot more of the same work that I did at Brooke Army Medical Center prior to deployment. A while after redeployment I understood that the experience had a greater emotional effect than I was willing to admit. I think it was because in the combat zone all I ever saw every day were the losses, I never saw the victories. In the news at that time there was a constant drumbeat from the press of the deaths without any mention of the many victories that were happening. Later, grudgingly the press acknowledged the progress. When my friend Col Dave Hayes came into theater with his team to replace ours, I was very happy to see him and the team, but I felt a real reluctance to relinquish control. I felt a very strong obligation to stay until the job was done and of course that job would not be finished for another four or more years. Then one night a complex cervical, laryngeal injury came into our OR and we worked together reconstructing the damaged airway of one of our soldiers. At the end of the case I extended my hand across the field and shook his hand effectively transferring the responsibility to him. It was an emotional moment for me. Even though I knew he was most capable of taking care of "my soldiers," it wasn't until that moment that it felt right for me to step down and walk away.

Captain A Kristina E Hart, US Navy

I was the only Otolaryngologist to deploy out of Bremerton Washington with Fleet Hospital (FH) 8 in February 2003 in support of the then pending Operation Iraqi Freedom and the eventual OEF. We were not only the last Navy Fleet Hospital ever to deploy, we were also the largest, starting with physically building a 116 bed hospital and subsequently starting all over again several weeks later with a second (new site, new tents), "from the ground up" 250 bed

(expandable to 500 bed) hospital on the grounds of joint Naval base Rota Spain. Our mission was to care for the other half of the casualties coming from Afghanistan and Iraq as a counterpart to Landstuhl in Germany.

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The aforementioned aside, the one thing that really stood out was how exceedingly well everyone, most of whom had never directly worked with each other (many of us, myself included, had also recently arrived at the command), pulled together, regardless of service branch, rank or usual role, to take the best possible care of all the wounded, from all the branches (US Coast Guard excepted) of the military who landed on our doorstep. Even bedpan assistance wasn't beneath us as surgeons. Talk about learning to truly appreciate each other! War is, as you too know firsthand, an awful thing, particularly when its aftermath is seen with one's own eyes—it truly becomes personal and makes an indelible mark on anyone who's involved. The experience of this particular deployment (I was involved in many during my career though largely as part of the Naval fleet at sea) was far and away among the most remarkable, life-altering, memorable, ones of my life (almost up there with flying onto and off of aircraft carriers). It continually reinforces the pricelessness of life, the resilience of people in the face of adversity, and the need to be adaptable and creative.

Colonel David K Hayes, US Army

This is a special Christmas for me. It is the first time I have spent the entire holiday apart from my wife in 24 years.

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It is a strange season in Balad—tragic and hopeful, filled with rage and great kindness; painfully awakening and often surreal. It is a strangeness that soldiers have felt for a thousand years and more. I have stood for hours on end in the midst of carnage, practicing what we now call damage control surgery; and watched as the line of broken lives is reduced to numbers on a slide in some bizarre reckoning each morning. It is a place that makes one hope to wake up to find yourself in bed at home at the end of a dream. It is a place that pulls you in so you can't look away. I long to believe that if I simply left, the bloodshed would stop. We all do. And if it doesn't, what will happen when we are gone? It is a place of twisted feelings and conflicting emotions.

Home is sometimes hard to imagine, but is never far from my thoughts. I am sad to be away from each of you this year, but comforted in knowing that the small part I have the honor of playing here will ease the suffering of many—including a few of the wonderful young servicemen and women whose fate has led them through this place. I would not trade that for

all the wealth of Nations.

So there is sadness here, as in any war. But there is more. There are smiles from new friends, and there is caring for strangers. There are small unprompted favors from each of us toward our workmates, which come without the asking. There are helping hands offered freely, and words of encouragement. Here, there is something of a family, and something of the season, that is difficult to convey but easily recognized—something basic, and good, and sometimes overlooked at home. Perhaps it stems from a deeper appreciation of each other, and of our common beliefs in our country and the flag that flies over this place.

Lieutenant Colonel Lakeisha Henry, US Air Force

I consider my deployment to Bagram one of the most important and rewarding highlights of my military career. Although I was reassured by my training, I was challenged almost daily and had to be creative especially when it came to pediatric patients. There were so many more pediatric trauma patients than I expected. I am humbled by and forever grateful for the opportunities the experience provided the ability to volunteer to deploy, to care for our nation's and allies' wounded warriors, for the humanitarian surgical opportunities, and ability to demonstrate why I am a military otolaryngologist.

Captain Michael E Hoffer, US Navy

I was deployed twice to Iraq. The first time was a short deployment from October–December of 2005 where I worked in three Role 2 medical facilities in Western Iraq (Al Taqqedum, Al Asad, and Fallujah). My job on that deployment was to help stabilize head and neck trauma and to deploy field audiometers to these centers so that hearing loss could be monitored. My second deployment was from August 2008–March of 2009. During that deployment I was deployed as a staff surgeon for the Marine Group. I served in a very remote FOB near the Syrian border at Al Taqqedum). My job was to stabilize head and neck trauma. During that deployment I also performed some smaller cases and ended up doing the most procedures of any of the surgeons in our group (there were 5 general surgeons, three orthopods, and an OBGYN doctor with me). We also performed a study on the use of NAC in individuals with mTBI secondary to blast.

The highs of the deployments were begin able to treat our brave American Men and Women and our allies. Whether that treatment was being part of a lifesaving surgery or simply treating a sinus infection—providing quality care in an austere environment should always be a source of pride. The lows, of course, were seeing American's severely wounded or dead—I will never fully recover from that and nobody should.

It should be noted that NAC [N-acetyl cysteine] works phenomenally well for mTBI and our research work was truly groundbreaking in helping us understand and better treat mTBI. . . .

Colonel G Richard Holt, US Army

The 36th Combat Aviation Brigade, which deployed to OIF in 2006 with me as the Brigade Surgeon, was a composite (patchwork) brigade of over 4,000 personnel from the Army National Guard and Army Reserve. The various aviation battalions, companies, and support units included attack helicopters, light lift troop carriers, heavy lift helicopters, and casualty evacuation helicopters. The aeromedical technicians, medics and physician assistants, and the flight surgeons under my responsibility were all well-trained, and it didn't take us long to become a well-functioning medical team. I especially enjoyed working with the pilots and crew from Deep South states who were professional, yet at the same time humorous and gregarious. Unfortunately, I lost several new friends in a helicopter crash. But, we saved many more.

Colonel Christopher Klem, US Army

Deployment to Afghanistan as an Otolaryngologist offered some of the most challenging, yet rewarding experiences of my career. Working in the austere environment of a combat zone definitely brings out the best in many people, but also the worst in some. I was reminded how important excellent, supportive leadership is and what toxic leadership can do to the morale and effectiveness of a unit. Deployment also confirmed to me that military and civilian trauma are incredibly different and that the military should maintain an experienced active duty military medical component to ensure that lessons learned from OIF and OEF are passed on.

Lieutenant Colonel Philip D Littlefield, US Army

Deployment was the most satisfying thing I ever did in the Army, even though I counted the days until I could be back with my family. The politics of the war in Iraq were messier than any of us would like, but they did not detract from what I did. I was helping people who needed it badly, and it did not matter to me who they were. The Army put me there, and I was proud to be there for them when they needed it most. We don't think about it much as physicians because we usually don't have to, but it is a great blessing that we don't—and should not have to—take sides. We are only on the side of humanity.

I was amazed how well I bonded with people completely unlike me. I now keep in touch with people that I never would have met or started a conversation with at home. That taught me a lot. On the other hand, the people that in principle were most

like me could drive me crazy.

Anyone who spends time in the military quickly learns that it is full of brilliant and dedicated people mixed in equal measure with incompetents. Yet it somehow works. I don't know how we pulled it off, but the Army just moves on. I am in continuous wonder and awe. But, don't think I like things the way they are.

Lieutenant Colonel Manuel Lopez, US Air Force

After completing my fellowship in FPRS [facial plastics and reconstructive surgery], I arrived to WHMC [Wilford Hall Medical Center] on July 15, 2004, to be the chief of facial plastic surgery. On my first day at the hospital I was informed that otolaryngology was being deployed to Iraq and that I was going to be deployed within a year. Welcome to the Air Force! I was one of only two fellowship-trained facial plastic surgeons in the air force. I can't deploy, I am too important to the residency program so I thought. Turns out that 2 of the first 3 otolaryngologists to deploy were facial plastic surgeons, which included me as the third to go. I deployed on May 2, 2005, and honestly I went with little if any enthusiasm. My wife was pregnant and I knew I would miss the birth of my second child in July. I believed that the patients could be transported back to the states for their care so as not to put vital assets such as myself at risk. How arrogant was that thinking? Quickly into my deployment I realized how wrong I was. Soldiers were being injured and injured bad. Improvised explosive devices (IEDs) are some powerful weapons. Russ Linman, the oral surgeon at Balad, and I worked very closely as a team to treat the numerous patients with head and neck injuries. The injuries we saw were like the traumas we saw in the states but on steroids.

As I reflect back on my time deployed I think about how pure that time was. My only mission was to treat patients with head and neck injuries. It was medicine at its purest as there was wonderful comradery among the surgeons using their unique skills to provide the best medical care to our troops. . . . Our soldiers deserve to have the best medical care possible at their disposal where they are at and the best care includes a head and neck team with an otolaryngologist. The greatest highlight of my career has been and I am sure will always be the 5 months that I spent in Balad, Iraq, treating our American heroes that risked their lives to protect our freedom.

Captain Michael Maddox, US Navy

The mission for "Marine Medical" in Al Anbar Province in Iraq in 2008 was different than in prior years. Previously, doctors and corpsmen treated Marines and soldiers injured during the intense battles of Fallujah, Ramadi, and other towns. By the time we arrived, those days of furious combat were over.

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To accomplish our part of the job, the doctors and corpsman of our Regimental Combat Teams and Battalion Aid Stations engaged with local Iraqi doctors, sheikhs, and villagers in order to benefit villagers and to help rebuild the Iraqi medical system so that its doctors could care for its people. Five projects stand out:

Clinics in Villages:

Regimental and battalion commanders capitalized on the "Al Anbar Awakening," . . . Medical clinics in towns and villages were one means to engage the populace.

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Fallujah Hospital:

My first impression of the Fallujah Hospital was, "There's nothing here." The intensive care unit had no monitors, no suction, no resuscitative equipment . . . nothing . . . just one large oxygen bottle, some cots, and dedicated young house officers who were caring for their patients. And that big pile of trash behind the hospital: a smelly collection of medical refuse. So our civil military operations folks obtained a trash contract, which then helped to set the refurbishing of Fallujah Hospital on a positive course.

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Books for the Ramadi Medical School:

The laboratory at the Ramadi medical school had only two microscopes. The anatomical lab had two plastic models, and the newest book in the medical library was twenty years old. However, sixty medical students were there—half of them women—and they were quite serious and professional about their medical education. Working with the school's director, we purchased thirty copies of fifteen different medical textbooks.

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Eyeglass Distribution:

Many villagers could not see well. We contacted the Rotary Club at Camp Pendleton, and that club coordinated with local churches and schools to collect eyeglasses.

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Case-study Discussions:

These started out in the far west, near the Syrian border, at Camp Korean Village. The Marine battalion aid station doctor sponsored a case-study discussion at the local Iraqi Hospital.

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It was a unique and worthwhile year. We treated the

injured, helped to prevent illness, and we used our medical skills to engage with the Iraqi populace and the Iraqi doctors.

Major Lee Miller, US Air Force

I deployed to the Air Force Theater Hospital at Joint Base Balad, Iraq, in the spring of 2008. The strategy known in popular media as "the surge" had just begun. Although it would ultimately lead to victory, at that time its success was still far from assured. Throughout my deployment, I was struck by the incredible bravery of our men and women in uniform who intentionally placed themselves in harm's way. Seven years after 9/11, our brave Soldiers, Airmen, Seamen, and Marines knew full well what they were signing up for and what awaited them in the desert. My deployment remains the high point of my medical career. The exhilaration of being an integral part of a comprehensive in-theater trauma care team, ensuring that as many of our wounded as possible made it back to their families and loved ones, is unlike anything I have ever experienced in medicine. The pace was exhausting, at times a grind, and the constant flow of trauma, twenty-four/seven call, and the inevitable mortality that follows war wore down even the most experienced surgeons. Low points include "Fallen Star Ceremonies," hushed, solemn events in the hallways of the operating room where the medical staff with a chaplain said goodbye to one of our best with an American flag laid over the gurney. The separation from my wife and two daughters, each under the age of 3 at the time, was incredibly difficult, but made the reunion even sweeter. Despite the difficulties, if given the opportunity, I would do it again in a second. My deployment remains the most consequential period of my medical career.

Major Justin E Morgan, US Air Force

What an honor it was to serve in Afghanistan at Bagram Air Base from January to May 2009. Due to the incredibly rugged terrain there, enemy activity had slowed during the winter. We averaged about 1 head and neck trauma case daily, ranging in severity from mild abrasions to massive open laryngotracheal injuries and seemingly everything in between. Most were IED injuries, the likes of which I had not experienced in training or practice. We saw a few airway and ear humanitarian cases which were pleasant surprises I did not expect before deploying. Even during busy periods, there was more free time than at home. Filling it with exercise and reading was an effective way to cope with the battlefield injuries of the brave soldiers we were there to serve. Except for being separated from my precious wife and girls, it was definitely one of the best experiences of my life.

Many of you have probably heard the following powerful poem, "It Is The Soldier," by Charles Province:

It is the Soldier, not the minister

Who has given us freedom of religion.

It is the Soldier, not the reporter

Who has given us freedom of the press.

It is the Soldier, not the poet

Who has given us freedom of speech.

It is the Soldier, not the campus organizer

Who has given us freedom to protest.

It is the Soldier, not the lawyer

Who has given us the right to a fair trial.

It is the Soldier, not the politician

Who has given us the right to vote.

It is the Soldier who salutes the flag,

Who serves beneath the flag,

And whose coffin is draped by the flag,

Who allows the protester to burn the flag.

Copyright Charles M Province, 1970, 2005 (reproduced with permission).

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Remember the fallen soldiers who have given us our American freedoms, and the fallen & risen Soldier who has given us freedom from sin and death.

Colonel Mitchell J Ramsey, US Army

Excitement and apprehension—that's what I felt as I tried to manage my three duffle bags across the airfield at Camp Dwyer, Helmond Province, Afghanistan. I was assigned to the 31st CSH as an otolaryngologist/head and neck surgeon. Without prior deployment or combat experience, I was unsure of the role I would play or the benefit I could provide. Within hours, the unit was engaged in a mass casualty and I was placed in charge of one of the ER [emergency room] bays to managing an injured soldier; I had hoped for a slower transition.

It quickly became apparent that I was working with a skilled and seasoned group in an environment much different than I had ever experienced. In a matter of minutes, the pace would shift from zero to 100 miles per hour and quick assessment, quick decisions, and quick action were often required.

Despite my earlier apprehension, it was quickly apparent that I would be contributing, a lot, to the team and more importantly to the soldiers. Some of my skills were complimentary, but the majority was unique, and not surprisingly, there was tremendous demand for them. The range of injuries that became my turf included the ubiquitous blast-induced hearing loss, tinnitus and dizziness, complex airway management, orbital and ocular injuries, head trauma and neurologic injuries, head and neck gunshot wounds, and complex maxillofacial reconstructive problems. At the conclusion of my tour, a few things were apparent; the role of an otolaryngologist/head and neck surgeon is paramount at any level three facility. I was not the most important provider in the team, but I know that my participation helped expand the capabilities of the 31st CSH for the better.

Captain Charles A Reese, US Navy

I deployed with the Navy's Fleet Hospital 3 from Pensacola in March of 2003 as the Director of Surgical Services and the staff otolaryngologist. We were supporting the USMC 1st FSSG and staged in northern Kuwait until 25 March 2003, at which time our advance party moved by convoy up to a site near LSA Viper. . . . We saw our last new patient sometime after mid-May and retrograded with 1st FSSG to northern Kuwait and then home shortly after President Bush said "Mission Accomplished." We got back to the states on 9 June 2003.

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We saw a wide range of injuries, from amputations to ruptured eyeballs as well as non-battle injuries and illnesses. Because of the force structure and the way that we were used, all but a few of the injured personnel had already been evaluated by at least one other facility (BAS, FSST and/or Surgical Company) and many of them had already had one surgical procedure to stabilize them. We did get a few "fresh" injuries, but not many. For the most part we were a staging facility for the USMC personnel that we received. Within a day or two of getting to FH3 they were on their way to Germany. Occasionally they needed another procedure for debridement or stabilization. I had one midface degloving injury from a rollover accident in a young female Marine who had not received prior care and a couple Marines with some shrapnel injuries that I explored. One of these was in the neck and the vascular surgeon and I did it together.

Colonel Scott B Rooft, US Army

The most striking aspect of the experience was the camaraderie and collegiality. Despite our varied backgrounds and training, surgeons were surgeons in this setting and everyone from each of the specialties worked closely together for hours on end on any num-

ber of cases. Distractions of day to day life went away as the entire team was focused on patient care. But despite the sometimes long hours, at the end of almost every day, we gathered together to walk to the dining facility for dinner or to the theater for a bad movie and stale popcorn. I was deployed near the end of the Iraq war and the injuries were less frequent, which created long periods of boredom punctuated by occasional episodes of excitement. Still, the intense working environment created the opportunity to develop deep bonds. The people at Balad were like a family and there is rarely a day that goes by that I don't think of at least one of them. It was an incredible honor to serve.

Major Peter R Sabatini, US Air Force

My experience in Bagram was very rewarding. I gained satisfaction from being part of a team that took care of the men and women on the front lines. I also did a lot of humanitarian work, I ran three clinics a week for the Korean and Egyptian humanitarian hospital. My trauma experience there was excellent, it was very collegial with the different services and we performed some very complex facial reconstructions. I will always remember my experience there with pride.

Lieutenant Colonel Cecelia E Schmalbach, US Air Force

An extremely important lesson learned during my deployment was the value of collaborative efforts among surgeons in the operating room. Checking egos at the door and truly valuing each surgeon for her/his unique skill set enabled patients to receive a higher level of care, in an extremely efficient manner. Two surgeons working together, even if they were from different surgical backgrounds, significantly decreased the operative time. Consequently, more patients were treated in a single day. This efficiency is imperative, not only because of the limited number of operating rooms, but also because of the manner in which combat trauma ebbs and flows. Unlike the relatively low, steady stream of patients presenting to a civilian trauma center, head and neck trauma down range presents in waves. A combat surge will bring multiple, high-acuity trauma patients all at once, followed by a lull. This cyclical trauma pattern necessitates a team approach to maximize the successful management of our soldiers, coalition forces, and local nationals. For this reason, I am immensely grateful for the collaborative efforts rendered by the "Smooth Operators" of OEF AE 9/10.

Colonel Joseph C Sniezek, US Army

My deployment to Afghanistan (along with a short stint in Iraq) has been the highlight of my medical career. Not my military career, my medical career. I left

theater physically tired, but professionally and personally energized. I have never been happier or more proud to be a doctor than I was when deployed. I was graced with a deployment opportunity that allowed me to take direct care of our wounded Soldiers, travel outside the wire to meet and treat local Afghans, and participate in research projects which documented, investigated, and highlighted the amazing medical treatment that was delivered in the deployed setting. I had the rare opportunity to glimpse every Role 3 MTF in Iraq and Afghanistan and to spend time at 5 different Forward Operating Bases in RC-East and South. The care, passion, and dedication that I witnessed will stay with me forever. Interestingly, as I look over the names of those Army Otolaryngologists who deployed to OIF and OEF, I believe that every one of them decided to serve an entire career as a military Otolaryngologist/Head & Neck Surgeon after returning home.

Colonel Guillermo J Tellez, US Air Force

Humbled and had the honor to command Task Force MED-E and Craig Joint Theater Hospital (CJTH-OEF's largest Role III facility); CENTCOM's specialty referral hospital and Contingency Aeromedical Staging Facility.

...

TF MED-E and CJTH itself had ~1,250 AF, Army, and Coalition (Canadian) medical personnel supporting 14 Forwarded Surgical Teams (FSTs), 3 International hospitals (RoK [Republic of Korea], Egyptian and Jordanian), 5 Role I medical brigade units & 6 medical Detachments in support of 100K+ forces across Regional Commands-East, North & Kabul Capitol

...

TF MED-E and Craig Joint Theater Hospital delivered care to >8.3 K casualties with incredible US survival rates of 100% in 2010—trauma care during the highest kinetic operation tempo to date under the Combined Joint Task Forces of the 101st and 1st Cavalry. CJTH staff executed this brilliant care under some of the most austere conditions.

CJTH moved 510 CCATs [critical care air transport teams] and its compassionate staff stood by the beds of 430 wounded warriors, honoring these heroes during Purple Heart ceremonies.

Solemnly our Task Force Med East and CJTH staffs stood on the flight line during 183 US and Coalition Fallen Heroes—sadly of those heroes; 5 TF MED fallen medics (CRNA, 68W, psychologist, psychology tech and behavioral health working dog) were killed by enemy actions.

TF MED-E, FSTs and Craig Joint Theater Hospital in addition to its DoD and world recognized resuscitative combat surgical care of >3.5 K Role 1 trauma casualties w/ >4K multi-trauma surgeries; supported >52 K outpatients, >4 K inpatients, >500 K CT/

MRI/x-rays, >250 K labs, >5 K units of blood. Care which was never-ending, heartfelt, and live-saving—ensuring our sick and/or wounded warriors the opportunity to remain in the fight, and/or guaranteed families their “Intrepids” were coming home.

Colonel Kenneth C Y Yu, US Air Force

As the first official Air Force otolaryngologist to deploy to Bagram in December 2006, I witnessed the smooth assumption of combat medical operations from the Army. After Colonel Joseph Brennan and subsequent Air Force otolaryngologists proved that otolaryngologists are critical members of deployed medical personnel, the Air Force determined that Air Force otolaryngologists would also deploy in support of Operation Enduring Freedom. At that time, the war effort was still concentrated in Iraq. There was less national focus—military, political, media—on Afghanistan. However, the United States quickly adjusted this strategy. A hardened modern hospital, Craig Joint Theater Hospital (CJTH) was built. When we arrived, medical operations were still conducted in a wooden structure. Excellent planning resulted in a smooth move from the old structure to the new hospital, with minimal impact on operations. I was hap-

py I got a chance to experience practicing deployed medicine both in an “austere” environment and in a modern day hospital. While practicing in CJTH felt more comfortable because we were basically working in a hospital one would find in the States, we noticed that working in the wooden hospital created more camaraderie. Everyone worked in close proximity; it also helped tremendously we had a fantastic team—from surgeons to anesthesia to nurses to technicians.

Perhaps due to the focus in Iraq, we did not experience the same trauma workload as Balad. Nevertheless, we were very busy. Trauma from improvised explosive devices was common and kept all surgeons busy. I found my trauma experience to be adequate. Interestingly, I was called upon more for neurosurgical consults than head and neck trauma. I was the product of a controversial decision to send non-neurosurgeons to Balad to learn “damage control neurosurgery.” After Colonel Mark Boston and I reported our high volume of intracranial trauma, the Air Force rightly tasked neurosurgeons to deploy to Bagram.

My deployment was one of the most rewarding experiences I’ve had in my career. It was an honor to take care of our brave servicemen and women, and I felt a great sense of gratification that I was able to contribute to the Air Force mission.