There’s emergency medicine, and there’s emergency medicine in a war zone. Dr. Todd Baker spent 15 months as chief of emergency medicine at the Army support hospital in Baghdad, Iraq. He describes his experiences in detail in his book, “Baghdad ER: Fifteen Minutes.”

Dr. Baker graduated in May 2001 from the University of Arkansas for Medical Sciences, Little Rock, with a medical doctorate. He trained in emergency medicine at Fort Hood, Tex., in 2001-2004. After completing his residency in July 2004, he was assigned to the 2nd Armored Cavalry Regiment, Fort Polk, La. He later transitioned to Fort Lewis and joined the emergency medicine residency program at Madigan Army Medical Center, both in Tacoma, Wash., in 2006.

Shortly after being chosen as “Teaching Staff of the Year” by the emergency medicine residents, he was assigned to deploy to Iraq with the 86th Combat Support Hospital, Fort Campbell, Ky., in October 2007.

Dr. Baker earned the Bronze Star Medal and Combat Action Badge for his service in Iraq. After almost 8 years on active duty, he separated from the U.S. Army at the rank of major and now serves as co-medical director of the emergency department at Skaggs Regional Medical Center in Branson, Mo.

What, if any, additional training did you do before deployment?

I worked as a teaching faculty member in the EM [emergency medicine] residency program until August 2007, when I moved my wife and infant daughter closer to home in Arkansas. I reported to Fort Campbell on Sept. 30, and medical personnel
from more than 30 different Army installations gathered to begin
a 3-week preparation for deployment to Iraq. We got to know
each other but actually had minimal time for medical training.
Most of our time was spent performing necessary administrative
tasks prior to deployment.

Could you describe your clinic and operating room setup?

I was the chief of emergency medicine, spending 99% of my
time in the ER, or EMT as the Army called it. We had 10 beds
split between two rooms: 3 in our main trauma room and 7 more
in a larger room. Each bed was surrounded by endotracheal
tubes, tube thoracostomy kits, central line introducers, oxygen,
monitors, and tourniquets.

In our main trauma room, each bed was surrounded by
preloaded endotracheal tubes and multiple tourniquets ready to
go. Chest tube and central line kits were opened and covered
with a blue towel. We did not have time to open these kits once
patients arrived – we had to be able to perform these
procedures within seconds. The SonoSite and GlideScope
corporations allowed me to hand-carry $30,000 ultrasound and
intubating equipment with me to Iraq, and both machines saved
lives on several occasions. Belmont transfusers performed
amazingly.

We had state-of-the-art equipment, and we had many specialists
– from surgeons to orthopedists – ready to help, but we did have
a paucity of emergency medicine providers. We had three ER
docs, myself included, to run 24/7 operations in the busiest
combat hospital in the Army. We had nine nurses, four of whom
had never worked in an ER. Sixteen medics rounded out our
crew, but only a handful had any trauma experience. Radiology
and the blood bank provided essential support. More personnel
worked in the ICU, wards, and other areas of the hospital, but
that was the essential crew of “Baghdad ER.”

What were some of the greatest challenges of operating in a
combat zone? How did you deal with challenges such as
managing infection?

Fatigue was a huge issue. We dealt with death on a daily basis
for 15 months, all the while rotating days and nights, covering
the ER. We routinely had to place expectant patients on
morphine drips and wait for them to die, which is not what we
were used to in the United States. For a 6-week period in the
spring of 2008, we were under rocket fire multiple times per day, and our troops in the field were being hit very hard. We worked 18-20 hours at a time, slept for a few hours, and came back for more at a moment’s notice. The ER docs essentially could not leave the building and go to the dining facility or anywhere else, because the rocket fire would “lock down” the facilities, and we had to be in the ER ready to go. We all missed home and longed for our families, friends, and “normal lives.”

However, we became like a family, and many of us are still very close to this day. We did not have time to deal with infection. Many of my central lines were done without sterile gloves, because we needed to get access within moments or the patients were dead. Of course, we gave antibiotics, and patients received infection-control measures once they were stabilized, but we did not have time to deal with sterile technique on many occasions.

Could you describe a shift in the Baghdad ER, describing one or two cases and how you managed them?

[The following description is excerpted from Dr. Baker’s book, “Baghdad ER” (Branson, Mo.: Gray Fox Publishing, 2011)].

It was 5:55 a.m. on Easter Sunday, and the insurgents were giving us a wake-up call by firing rockets at us. I was just climbing out of the shower, preparing to go on shift at 7:00 after stopping by Chaplain Sermon’s outdoor Easter sunrise service at 6:30. I quickly got dressed and headed down to the ER to check the damage. A Nepalese security guard came in about 6:35 with a large cut to his leg from shrapnel, but that was the only injury we received from the 22 rockets that landed in the International Zone that morning, as they all landed in uninhabited areas. An hour later, we were given a 1-minute heads-up that a Blackhawk helicopter headed to the neurosurgeons in Balad was diverting to us because their patient, a U.S. soldier with a massive open head injury, was becoming unstable and the flight medic did not think he would survive the extra 30 minutes to Balad. Once in the trauma room, I quickly noticed him to be unresponsive and intubated him, followed by venous and arterial line placements.

A patient came in 20 minutes later who will haunt me forever. When he was brought into the trauma room, it was a replay of an incredibly burned soldier I treated just 2 days before. Once he was placed in bed one, I immediately leaned down to his
face, inches from mine, and looked into his eyes. I will never forget him looking straight back at me. His eyelids were missing; he had no hair, eyebrows, or eyelashes left. His skin was charred black and brown from the flame and heat, and the rest of his body was covered in third- and fourth-degree burns. His fingers were blackened, shriveled, and mostly amputated from the heat. But his wedding ring was somehow still in place.

It was carefully removed, and while the other physicians worked feverishly to get central access on his groins, our medics tried their best to stick a vein in his arms, going right through the charred skin. I never pulled away from his face. I held a bag-valve oxygen mask over his nose and mouth, and each time he would take a breath, I would help him.

His eyes continued to stare into mine; he had no ability to blink. I just kept looking into his eyes, keeping my face close to his, and I kept trying to comfort him. “We’re going to take care of you; you’re going to be okay.” He stared back at me, saying with his eyes, “I trust you to take care of me. Don’t let me down.” It was one of the hardest moments of my life. I have never connected with a patient like I did with this hero.

What did you and your team do to stay as safe and calm as possible, and to manage stress?

We exercised, read books, played video games, and smoked cigars to pass the time. Occasionally, an emergency physician from another unit would come to the hospital and relieve us, and we took every chance we could get to fly to another base or just get off the compound. When I had an opportunity, I would go over to another compound in the Green Zone and fish in one of Saddam’s ponds. Staying safe was not hard – the rocket either hit you or it didn’t. There was not much we could do about it, so we just continued to do our jobs and let them land where they fell.

The ER was evacuated down to “essential personnel only” on more than one occasion, because we were the most vulnerable area of the hospital to indirect fire, and we spent a lot of time caring for patients while wearing our body armor. One wounded soldier even told me after we sustained a near-miss, “I want to go back out to my [forward operating base]; you guys are the ones they are shooting at!”

What specialized equipment did you have that was most helpful
to saving lives in a combat setting?

One of the most instrumental items was the **SonoSite MicroMaxx Ultrasound**. I could tell within seconds if there was bleeding into the abdomen, and it helped determine immediate disposition of patients. It also assisted in central lines, peripheral intravenous access, and arterial line access. We also used the **GlideScope to intubate** patients with LeFort II and III facial injuries, and it provided a lifesaving airway that I could not get with direct laryngoscopy on more than one occasion.

Another lifesaving tool was the **Belmont Rapid Infuser**: We could put 6 units of blood into a patient in under 5 minutes with this device. It was nothing short of amazing. We also used pneumatic tourniquets. Patients with lower-extremity amputations would begin bleeding through the field-applied tourniquets once we put blood back into them, but two or three pneumatics on a stump would stop the bleeding and help get the patient to the OR alive.

Are there clinical and/or organizational strategies learned from your time in Iraq that you apply in your current practice?

I learned an amazing amount about leadership. As chief of the department, it was my job to satisfy the requirements of my commanders. However, I also had to earn the respect of my subordinates and peers. I’ve always thought that you could tell a soldier to “charge a hill” for you, but you will not succeed if he does not believe in you or the cause. A good leader will have soldiers who want to charge that hill for them. I’m not sure if I obtained that level, but that is the definition of leadership to me. As the premier combat hospital in the world, we also had to deal on a weekly basis with visiting senators, congressmen, generals, and even the president, when they came through to meet and greet. I got into a little bit of trouble for insisting that these visitors leave the ER when the patients arrived, but patient care came first. I try to utilize these principles in my everyday practice here in the United States now.

Do you have any messages for primary care clinicians about the potential physical and mental health issues of combat-wounded soldiers they might see in their practices?

These soldiers have run the gauntlet and back, some of them multiple times. They deserve our compassion and gratitude, but most importantly, our respect. Many have undiagnosed
posttraumatic stress disorder or other psychological issues, and we have to give them a chance to deal with them. Nightmares, social phobias, and other issues are nothing new – we’ve all endured them since returning home. It doesn’t mean we can’t hold a job or that we need medicine; it just means that these men and women need some room to breathe, some understanding. I think these issues will be around for years, and as physicians we all can help by sitting back and listening with an open mind. These men and women are my heroes, our heroes. They deserve everything we can give them.


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