Citizen-Soldier-RN

By Rick Luna RN, MSN, CNOR

War is ugly and it brings out the worst in people, however, it does bring out the best in people too. I have been working in the operating room since 1999 and I am also a Captain in the U.S. Army Reserve. I returned home last August after spending eleven months serving with the 349th Combat Support Hospital (CSH) in Afghanistan. Serving as the Officer-In-Charge (OIC) of the operating room, my assignment had its share of challenges. Though all of us were medical personnel, my colleagues and I were soldiers first, which meant going through three months of pre-deployment combat training. Our reserve unit had to engage and qualify in Army combatives (hand-to-hand fighting), weapons handling and marksmanship (photo 1), close quarter combat (building assault and room clearing), convoy trips through simulated improvised explosive device (IED) laden roads, mounted and dismounted patrols, day and night navigation utilizing compass and global positioning system (GPS), and other assorted military skills. Following Army Warrior training, the 349th CSH had to successfully demonstrate its medical, organizational, and command/control skills in a final training exercise before getting the nod to deploy. I did a lot of this type of training as a Navy Hospital Corpsman with the Marines in my younger days but doing it all over again as a 42-year-old was physically taxing.

Austere Conditions

Our unit arrived in Afghanistan in late September, 2008. We replaced the outgoing CSH at Forward Operating Base (FOB) Salerno in Khowst Province. Salerno Hospital is the busiest surgical unit in the Regional Command East (RC-East) area of operations. I was optimistic when I toured the one-room, two-table operating suite for the first time. We had the same surgical tables, anesthesia machines, electro-cautery units, pneumatic tourniquets, a mini-fluoroscopy unit, plus oxygen and suction hook-ups that we were used to using at home. These items were all we had as far as 'luxuries' went. Infection control and maintaining sterility during surgical cases were our biggest concerns. The operating room was obviously not built to code like a normal O.R. in the U.S. but we had to adapt and make do with what was there. There were enormous gaps in the doors, no positive pressure nor air exchange available, swirling dust and dirt everywhere, and an abundance of flies in all areas of the hospital. During multiple traumas, my crew and I ran two tables simultaneously, something that is not typical back home where each surgical procedure is done in a separate room (photo 2). Remarkably, despite

1

Claymore mine training

Rick Luna RN, MSN, CNOR was a reserve Navy Hospital Corpsman from 1984 until 2004, achieving the rank of Chief Hospital Corpsman. Twelve of those years were spent as a combat medic with the Marines. He made two deployments to Kuwait/Iraq with the Marines in 2003, arriving in Kuwait five days before the invasion of Iraq. Since he was an RN in his civilian life he transferred to the Army Reserve right after his Navy mobilization for Operation Iraqi Freedom and received a commission as a First Lieutenant. In between mobilizations Rick has spent 21 years at UCSD Medical Center, 12 years as an RN. Rick received his Masters degree from Cal-State University, Dominguez Hills in August 2010.

Running two simultaneous surgical cases in the same room

A wrecked vehicle at an American base outside the Afghan city of Khost on May 14, 2009, after a suicide bomber attacked.

all these difficulties, the CSH was able to maintain a low post-operative infection rate.

UCSD Medical Center's Influence

I credit both the support of my colleagues and my years of experience in Hillcrest's O.R. for my successful performance as a military perioperative nurse in Afghanistan. I was able to contribute my surgical nursing knowledge of trauma and burns to my fellow nurses, surgical technicians, and surprisingly, to the surgeons themselves. Trauma combined with burn surgery is rare for active duty nurses and surgical technicians who have never deployed to a combat zone. Even burn surgery alone is uncommon for active duty surgeons who do not work in burn centers. Upon request from our surgeons at Salerno Hospital, I provided information on techniques and methods utilized by Dr. Bruce Potenza during his burn surgeries at Hillcrest.

Into the Line of Fire

To this day I treasure having been a witness to, as well as a part of, some of the most amazing feats of lifesaving performed by the line medics, flight medics, surgeons, anesthesia providers, nurses, and medics of the 349th CSH. Injuries caused by conventional military ordnance and by unconventional methods (IEDs) are some of the most horrible that I have ever seen. However, with extraordinary skill and determination, our team was able to adapt to the austere environment, overcome the challenges of limited equipment and supplies, and save the majority of our patients who suffered such horrific combat injuries.

One day which exemplifies this heroism occurred on the morning of May 13, 2009, when a Taliban insurgent drove his bomb-laden vehicle up to FOB Salerno and destroyed the front gate (photo 3). The enormous blast was so powerful that it nearly threw me out of my bunk as I slept. Soon after the explosion, the loudspeakers blared that casualties were on the way in, so I quickly dressed and ran to the hospital. When I arrived, the whole scene was surreal. There were civilian Afghani patients strewn all over the hallways, drenched in blood. It was a shocking scene of controlled chaos. Medical personnel were scrambling around trying to get organized in order to properly triage and treat the victims. The emergency room was packed with casualties and treatment teams. I peered out into the ambulance driveway and saw that it was also crowded with blast victims and medical personnel. This was a mass casualty event that medical organizations constantly train for, but hope never to experience. The CSH received 29 gravely injured victims within minutes after the blast and unfortunately, seven of them died during treatment. Special Forces operators at the scene estimated that at least 20-30 victims were practically vaporized at the point of impact. By sheer luck none of the casualties were U.S. personnel. Just as if I was participating in an O.R. resuscitation procedure at home, I located my trauma surgeon, received a situation report, and quickly organized my O.R. crew. We established a game plan for triage and treatment of all the casualties requiring immediate surgery. The CSH worked tirelessly throughout the day and into the long hours of the night. No one stopped to rest until all casualties were treated and cared for.

The message I took away from this experience is that although many people may not agree with the war, that day demonstrated to everyone present that Americans can indeed be a kind and caring people, who can look beyond their own needs and do whatever they can to help others, even in a situation when their own lives and safety may be at risk.