HOW I BECAME A COMBAT MEDIC

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While I was in training in Alabama, I was supposedly learning two trades that the Air Force thought would be useful in my military "career. My primary training was in Medical Administration, which I imagine was the Air Forces way of putting me where I could do the least amount of harm. It's rare for someone to do much damage to another person with a typewriter or a file folder, so this would be my primary career route during my tour of service.

Anyone being trained for medical service in the Air Force, no matter what field, also was trained as a medic, and this was my secondary field of training. The theory, as I understood it, was that in the event of an emergency (like an airplane crash or a war), we could all be pressed into service as medics and be able to tend to the wounded. When we were assigned to our bases we were continually being cross-trained in other medical fields different from our basic field to keep us, theoretically, up to date.

After being at Loring Air Force Base for a while, I learned that I would be assigned to a duty roster called 'Crash Call.' This was a rotating roster with two sections--- weekdays and weekends. When your appointed time came, you were allowed to work at your regular assignment while being on call. At night, instead of going home or back to the barracks, you spent the night in the hospital in the ambulance room. The roster was divided into two classifications-- those who were trained and worked primarily as medics and those of us who were secondary medics. When a medical emergency occurred, the primary medic and an ambulance driver would answer the call, leaving the secondary medic ready to answer another call if it should become necessary.

I was on the roster for several months without ever being called out, so my time was spent mostly playing cards with the secondary ambulance driver. We just never had two emergencies at the same time, and I felt fairly certain my medical skills would never be tested. At the time, I was working in non-medical emergency fields, so what little I had learned soon evaporated.

One day, that which I feared came to pass. The first ambulance crew was called out to some sort of crisis, and I was informed that I would be next out. No sweat, I'd been here before, deal the cards. However, when the phone rang again, everything changed. There was another emergency, and the secondary ambulance crew needed to respond. Wait a minute, that's me! There was no one else to go, so the other driver and I went out with the lights flashing and the siren blaring, just like real life ambulance people.

Now in other circumstances, I might have even enjoyed this moment as we sped to a real, genuine emergency with the lights and the siren, but I realized that when we got there, I was responsible to help someone. My driver was a motor pool driver, trained to drive. Period. We had spent many shifts together, and he knew that if he was ever injured I would probably be the last "medic" he would want to show up. We sped to the Communications Building, a top-secret area of the base. When we pulled up, everyone came running out of the building, probably grateful that expert help had arrived. I think my driver tried to distance himself from the situation to let people know that he was only a driver, not a medic as he went around the ambulance kicking the tires. I'm sure, since he knew my limitations, he probably didn't want to be associated with the inevitable court martial that would likely follow.

With all eyes on me, I rushed into the building and had no trouble spotting the patient. He was the one sitting with the entire from of his uniform covered in blood. The towel he was holding in front of his face was soaked with blood. When I

asked what happened, I was told that he had been shot in the head with a .45 caliber automatic. It seems that all of the personnel in this area carried side arms and several had been playing cops and robbers (or good guy, bad guy). Anyhow, one of the guns discharged, and the bullet struck my patient by his ear, just above the lower jaw. The bullet ran along his gums removing his lower teeth and exited from the front of his mouth. There was a gaping hole in his mouth, and his lower lip was missing.

Wow, I was in trouble. Nowhere in my medical training did I ever remember learning how to treat a wound like this. I knew to apply a tourniquet for bleeding, but I didn't think wrapping one around his neck would be the proper procedure. There was no one to ask so I had to figure out something fast. The poor guy stood up in front of me waiting for my expert care, and all I could think to do was ask him if he could walk. He said he could, so I hurriedly helped him into the back of the ambulance, giving him plenty of towels and gauze. I yelled at the driver to head for the emergency room just as fast as our ambulance could travel and tried to assure our patient that he would be okay. We tore into the hospital parking area, and I signaled for one of the real medics to come running.

The good news was that the man with the gunshot wound would recover, and the Air Force would get him the best of care. He was air-evacuated to another base where there would be specialists to put him back together again. However, it left me feeling a little stupid and wondering what I would have done if it had been worse. I admit that I started asking medically related questions just in case I ever got called to do something like that again, but I never did find out where you should put a tourniquet for a head wound.