MILITARY DENTISTS IN IRAQ

Earlier this year, together with thousands of British troops, military dentists belonging to the Defence Dental Agency were deployed on operations in Iraq. Here, three dentists recount their stories and experiences of their time in the conflict and give us an insight into day to day dentistry on the frontline. By Arveen Bajaj.

Operational dentistry

Surgeon Lieutenant G. A. Murdoch of the Royal Navy served with the Royal Marines, Commando Logistics Regiment:

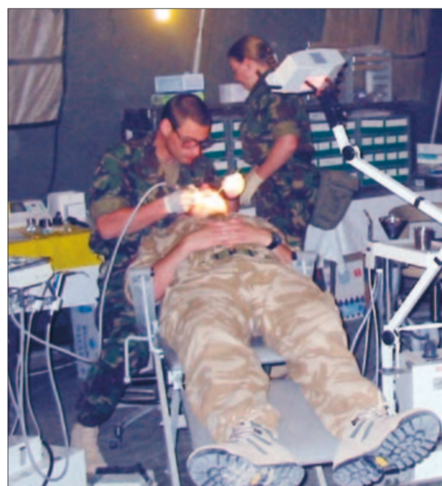
Military dentists are often asked, 'What exactly is your war role?' The traditional response is that we often try to conjure up extra roles for ourselves, such as dealing with facial trauma injuries and acting as triage officers. I, more than others, have been guilty of this having often felt the need to justify my operational military existence. The answer to this question is actually very simple. Our operational military role is dentistry.

When I was deployed to Iraq I was initially attached to Medical Squadron and subsequently Headquarters Squadron, with the re-creation of the Regimental Aid Post (RAP). The RAP consists of a primary medical and dental facility, and a Field Records Office. This unit now deploys with the Squadron main body, providing immediate life saving treatment to injured personnel.

Situated in the middle of nowhere, the environment was extremely severe. There was no protection from artillery fire or air attack or any infrastructure or simple life support necessities such as running water, mains electricity or ablutions.

This combined with loose soft sand underfoot provided a substantial challenge daily. Portable Dental Units can become difficult to maintain during the frequently encountered sandstorms, in addition to the operators!

Surgeon Lieutenant G. A. Murdoch RN carrying out endodontic treatment in sandy conditions



The diesel generator designed to provide electricity failed frequently, often during critical stages of treatment. This caused added anxiety to the patient. Lack of water caused problems with cross-infection control and dental materials were affected by extremes in temperature (temperatures ranged from -3°C to +37°C).

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In the first few days we often had to take cover from scud missile attacks, leaping into shell scrapes (a shallow trench) whilst scrambling for our full body armour and helmets. The threat of chemical attack was ever present and it was not uncommon to have to wear a respirator in response to a chemical alarm, several times a day. We continued to perform dentistry throughout all of this.

One particular problem encountered was that a patient required root canal treatment (RCT) of his central incisor confronting me with a medico-legal dilemma. On the one hand, should I continue with RCT applying full rubber dam, therefore increasing the respirator masking-up time (this should be completed in less than 9 seconds)?

This option could have lead to a possible risk of the patient gagging or worse suffocating on the rubber sheet. On the other hand, do I ignore protocol and carry out RCT with no rubber dam, using floss on files and gauze over the airway? The options were quickly explained to the patient and not surprisingly he opted for a rapid masking-up.

The deployment provided a platform to explore and expand the employment of the Dental Officer and hopefully alter its perception.

Surgeon Lieutenant G. A. Murdoch, Royal Navy

A dentist's perspective

Surgeon Lieutenant (D) Emma J. McGill of the Royal Navy was based on the HMS Ocean off the Iraqi coast:

It was with a fair amount of trepidation and uncertainty that HMS Ocean set sail from Plymouth in January last year. We knew that we were to sail to Cyprus over the following two weeks but thereafter, not much else was for definite.

The intense political wrangling back at home over the situation in Iraq left questions unanswered for HMS Ocean - how long would we wait in the Western Med? How long would we be away from home?

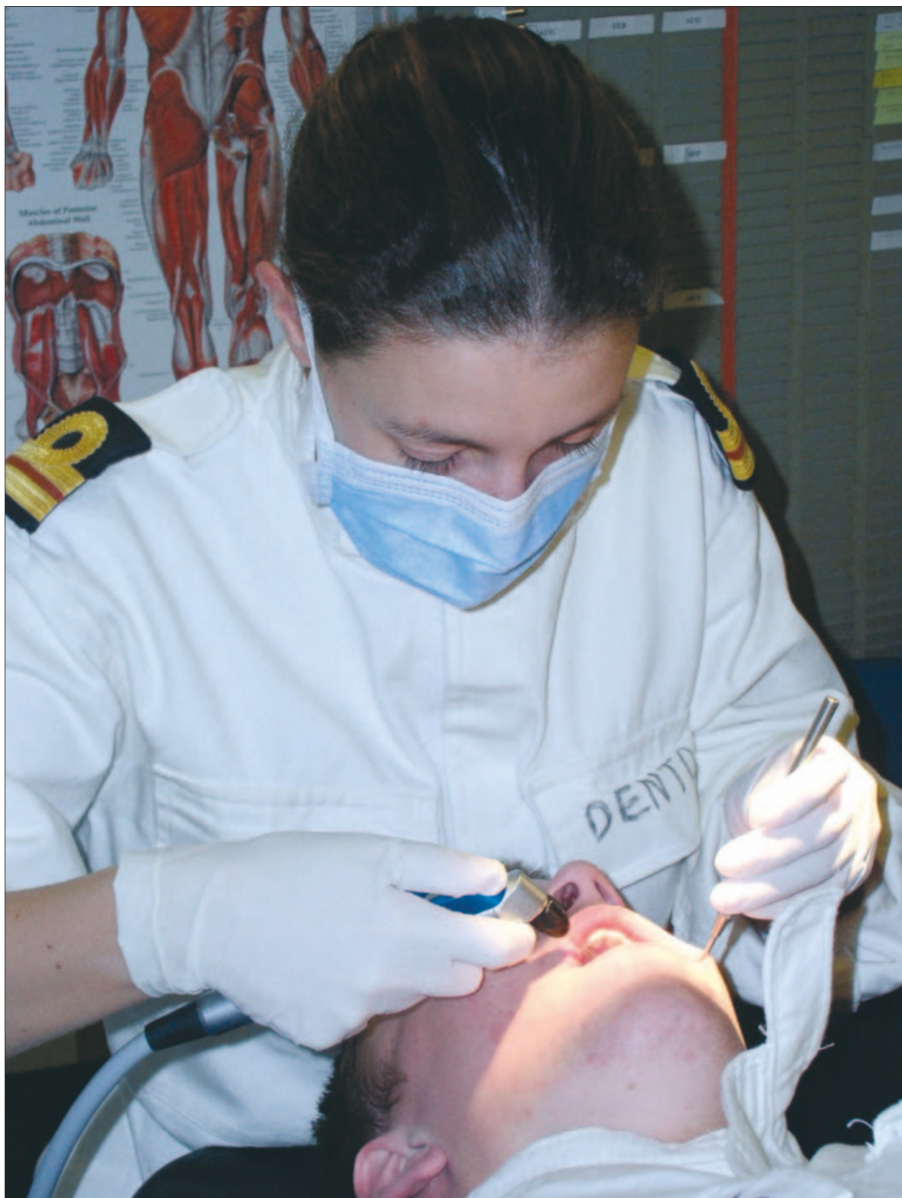
HMS Ocean has her own fully equipped dental department consisting of a lab, waiting area and surgery - complete with chair and x-ray machine. Before we sailed we stocked up on as many of the consumable items as possible - we had been forewarned that priority would not be given to dental supplies. The ship did not always have a dental team on board unless requested and crew was usually around 350 in number.

By the time we entered the Gulf we had over 1100 personnel on board: ship's company, the Tailored Air Group (TAG) from Yeovilton who were a mix of RN, RM, Army Air Corps and RAF members and the LF (Landing Force who were 40 Commando Regiment Royal Marines complete with their own Dental Officer).

Over 80 per cent of these were dentally fit when we sailed. Having a 'captive audience' should have made seeing and treating the remainder straightforward, but everyone was so busy it was deceptively tricky.

Defence watches (8 hours on, 8 hours off) began before the Suez, there were many whole ship exercises and of course the war itself.

When people were not working and were off watch, they needed to eat and sleep, not attend for routine dentistry. Having said that there was no shortage of dentistry for us to do and we were also kept busy with fresh cases, mainly pericoronitis, aphthous ulcers and fractured teeth/fillings. During the war HMS Ocean travelled up and down a strip of water that had been swept for mines off the Iraqi coast while the TAG flew constantly between ship and shore delivering men, ammunition, food and water to the troops. The rest of us remained 'closed up at Action Stations' where absolutely everything is in cupboards and drawers or secured to the decks/bulkheads and the dental light, spittoon and delivery arm of the dental chair lashed tightly. For two weeks we were unable to work or step outside into the fresh air and daylight. My assistant and I then spent a week on HMS Edinburgh, a Type 42 destroyer. We were transferred complete with Portable Dental Unit (PDU) by Lynx helicopter.



Surgeon Lieutenant (D) Emma J McGill

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We mainly saw patients for check ups and routine restorative treatment but managed an extraction and an extirpation whilst there. The PDU worked well and the only downside was having to use the flat doctors' examining couch instead of a proper dental chair.

The last six months I spent there had at times been deathly boring, upsetting, terrifying, confusing and tiring but I would do it all again given the chance and am proud to have been a very small part of a significant piece of history.

I have one nagging fear now though – how will routine nine to five dentistry ever compete?!

Surgeon Lieutenant (D) Emma J. McGill, Royal Navy

From Portsmouth to Kuwait

Major J. J. Lee, RADC

Major J. J. Lee of the Royal Army Dental Corps was deployed to Kuwait as a Senior Dental Officer:

On an ordinary day in a busy dental centre last year, I received a telephone call warning me that I may be deployed with 33 Field Hospital, based in Gosport, as a Senior Dental Officer on a possible deployment to the Persian Gulf. Soon after, 33 Field Hospital deployed to Kuwait in support of the British and coalition troops.

We were accommodated in large 'Lawrence of Arabia' style tents, large enough to accommodate 50 personnel comfortably on camp cots (American style army camp beds). We were on duty to check the guy ropes every time the wind whipped up and were nervous having discovered that the engineers had lost 30 per cent of their tentage in a previous sandstorm.

Food was centrally supplied which consisted of porridge, eggs and a strange chicken sausage for breakfast, an American Meal Ready to Eat (MRE) ration pack for lunch and various flavours of wholesome 'stew' for dinner. Contrary to reports in the UK, we were always well supplied with food, even if the range on offer did not appeal all of the time. Ablutions were the usual outdoor army style, with the strangely versatile portaloos (they go everywhere the British Army go) in desert colours.

Due to the state of flux, only two dental chairs were fully operational at a time when there were approximately 40,000 troops in theatre. Straight forward, regular dental problems presented, some anxiety related, but a lot of them kept the dental team busy.

Gathered in the mess tent we were informed by the second officer in command that all avenues of diplomacy had failed and that American and coalition bombers would soon begin the assault on strategic sites in Iraq. A call to rise to the challenge was met with cheers, but I'll confess now that I felt scared and uneasy.

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Soon after a request came from the military police for a dentist to identify casualties from a crashed helicopter of which there were no survivors. There was no time to think as we assembled some instruments to assist us with this. Sensibly, a forensic team from the UK were eventually detailed to this task, but the news left me praying for a quick end to the conflict.

Our first maxillofacial casualty arrived two days later. An Iraqi soldier had been a victim of an Iraqi landmine, which had killed two of his comrades. His face and upper body were peppered with metallic fragments and other foreign bodies. He was treated by debridement and excision of foreign bodies under general anaesthetic. When 'foreign bodies' mean 'bits of body' the grim reality of war kicks in hard.

Maxillofacial casualties started to arrive with some regularity, sending us to theatre at least every other day. Soon I was attempting a lot of aspects of maxillofacial surgery that I had never experienced before, even in Portsmouth! Debridement of gunshot and shrapnel wounds, excision of necrotic tissue and skin closures were within my capabilities under the careful guidance of Lieutenant Colonel Douglas Bryant.

I assisted in cases involving the removal of large foreign bodies from the face and subsequent stabilisation and initial closure of these wounds, a fractured mandible which had been fractured into many pieces by a piece of shell casing (which was retrieved and presented to the patient the next day - he is going to have it mounted), and in a case where bilateral nasolabial advancement flaps were used to repair the entry and exit wounds of the nose of one 'lucky' Iraqi patient who was otherwise unharmed.

One soldier who conjures up the spirit of any 'British Tommy' presented three days after he crashed his Spartan into a vehicle in front of him, which he had not seen due to the sand that had been kicked up by the forward convoy.

The Spartan has a 'pillar box' type window. As he hit the window, his forehead was protected by his helmet, but his upper jaw hit the edge of the window and promptly gave him a Le Fort I fracture of his maxilla. He finally decided that 'something wasn't quite right' after he had spent two hours attempting to eat one biscuit brown (even your grandmother never made biscuits this tough).

I feel honoured to have been just a small part of that massive machine that supports missions to liberate countries to change and save peoples lives and to have been given the opportunity to use my skills in this way.

Major J. J. Lee,
Royal Army Dental Corps