

Medevac

The pager goes off and the rush is on. The boss says to be at the airport in 30 minutes, and airborne in another 5 to pick up the medical team at the time he promised. You have just been called and you, the medical evacuation pilot, are already late. There is no way you can safely preflight and plan in the times given, so you will be late.

You are airborne as soon as you can be, then down to London, Ontario to pick up the transplant team. Two people are dying right now: the donor, whose body is alive, but whose brain is dead, and the recipient, who has a healthy mind in a failing body. The donor is now on the cold slab of an operating table and the recipient is either getting a telephone call, or already in the hospital. You, the captain, are to connect them and aid in the creation of one person with both a healthy mind and body.

Upon arrival to pick up the transplant team, first you must wait. After the big rush to get to the airport to pick up the surgical team, now the doctors are late. The doctors are almost always late, never early. So, you buy food from the airport café, if it is open, or from vending machines, while warily looking at the airport gate for the ambulance or taxi to pull up. When it does, you will load the doctors and launch immediately. There they are—three or four people, some in surgical green, pushing a cooler on a trolley. You load the cooler, instrument bag and folding trolley in the cargo compartment, cracking your teeth on the trolley as you wrestle it into place. The doctors are young and old, male and female, white and black. The only common characteristic is that they are all good people, professional people, with a sense of purpose, coordinating the transfer over their cell phones as they load up into the jet.

After loading, you taxi immediately, using the magic words “priority Medevac” to clear the runways and skies ahead of you. It is not a phrase to use lightly on the radio. You must have time critical team on board if you want the way cleared ahead of you. Air Traffic Control (ATC) will make 30 airliners wait at Toronto for your take off, then give you direct routing anywhere once you call up as a priority Medevac.

Climbing directly to your altitude, you call Medcom, the 24-hour medical flight followers, and give them your time off and an ETA. They alert the surgical teams at both donor and recipient locations. On arrival, there is an ambulance or helicopter waiting, depending on how far it is to the local hospital. After the cooler, equipment bag and trolley are loaded and the team departs, it is your turn to wait again. By this time, the local doctors are stabilizing the donor body with drugs and painting it down with iodine for surgery. The transplant team, who have been sleeping, or eating Swiss Chalet takeout on the flight out, now have anywhere from 3 to 6 hours of intense concentration during surgery ahead of them.

Once—just once—you go along with the doctors to observe the organ removal. After getting lost in the corridors of an unfamiliar hospital, the team finds the change room and dresses you up in surgical scrubs. Off with the pilot uniform and on with the surgical mask and cap, instantly transforming you into a medical intern. In operating room 13, the donor, a young man, seems to be sleeping. He is neither dead nor alive, but

somewhere in between the two states. Various tubes drain fluids from the nude body, which is stretched out with spread arms as if crucified. It is all very undignified, especially the urinary drain tube. The chest rises and falls to the pace of a respirator and an array of video monitors show vital signs such as heart rate and blood pressure. The heart rate jumps up as they begin cutting with the cauterizing scalpel. The stench of burning human flesh is sucked away by the positive air pressure maintained in the operating room, evident by the rush of wind out when the door is opened. Although "surgical doctor" sounds glamorous, it is really just a slaughterhouse job. The doctors wear plastic aprons and wrap packing tape around their shoes to stop all the blood and gore from leaving stains. Perhaps the doctors themselves think more highly of piloting than surgery. A call comes through, saying that a better recipient match came available in Vancouver. The surgeons turn to you, the pilot, to ask about the trip times, and the entire attitude of the local doctors and nurses changes towards you. All of a sudden, you are not a lowly intern, but a jet pilot, which to them is interesting and worthy of respect. An operating room is anything but a healthy and happy place to work.

Usually, the pilots stay around the fixed base operator (FBO) on the field and wait. How long? Nobody knows. If the organ is bad, maybe an hour. Maybe 6 hours if the organ is the last to come out. The heart, for example, gets priority over the liver and kidneys, because it is more time-critical, having only a few hours before it must be in the recipient body. After the plane is fueled and flight plan filed, there is not a lot to do, but neither can you leave the immediate area.

Most Medevacs seem to happen overnight. Maybe this is because donors experience traumatic injuries during the day and by the time they are declared brain-dead, all the paperwork is filled out and a transfer team is assembled, it is evening. As a pilot, you get paged in the evening and fly all night. If you got up at a normal hour in the morning, you are facing a 24 hour day, since your 14 hour duty day starts when you arrive at the airport. At the FBO, usually there is a couch to try to sleep on. You can never really sleep, though, since the team could arrive back at any time. Once the organ is removed, the clock is running and every minute takes it closer to being a worthless chunk of meat. You can not delay. Sometimes there are other Medevac jets there, taking other organs, like a flock of vultures collecting around the body. If sleeping is hopeless, you talk with the other pilots about their jobs, where they are based, how they like their companies and where they are going tonight. A single donor can be spread across North America. The night freight people pass through the airport at 3 am as well. They show up in old DC-9's and B727's and wander through the FBO looking for food. Free donuts on the table or leftover charter catering are considered bonus items, but usually vending machine food has to do. Sometimes there is a darkened room in the back of the FBO with a few sleeping forms already inside. You try to be quiet as you settle into a vacant reclining chair and doze a couple of hours with some people that you never meet or even see clearly. Who were they?

During your sleep, in this unfamiliar place, you dream. You dream that the transplant team has come back and that you hear their voices in the hall, or ambulance doors slamming, or footsteps pushing a trolley. You sleep fitfully, if at all, still dressed in your pilot uniform, since sooner or later, your dreams will come true. Maybe, if they can, the doctors will call a half hour out from the airport and you have time to stretch, wash your face and get the IFR clearance. Maybe your first warning of their return is the heavy beat of the Sikorsky S-76 helicopter hover taxiing over to the jet after flying from the hospital.

Now you have to move quickly. At a great cost in money and human effort, a few minutes have been saved in the transport of this organ, and you do not want those precious minutes lost because of you. The scene is eerie, with no sound except that of the helicopter engine. The powerful lights of the helicopter flood the darkened ramp area, casting long shadows of the jet and the figure beside it, which happens to be you, the captain. The copilot is inside, working the radio to get clearance and you are waiting to load the cooler, now a few pounds heavier. The Sikorsky has hover taxied to 50 feet away and is now stationary. There is a minute of two delay and you wonder if you should approach to take the cooler. No: the right seat pilot can see you, and he would signal if he wanted something. Besides, the blade disc is tilted forward and looks about the same level as your head. Finally the team comes out with the cooler and the helicopter departs without shutting down.

If the organ is good, the team is in good spirits, joking about whatever food you have bought for them for the return trip. They are worn out and aged looking, though, and they will most likely sleep on the return leg. One engine is turning even as the jets' door is closing, and now the objective is to minimize flight time. There are not hard limits for organs, but after about 8 hours, for example, a liver is losing its status as a lifesaving organ and becoming closer to biological waste. The taxi out is generally continuous and the departure delays minimal. ATC will not overshoot landing traffic, but generally everyone else waits for you. Usually by now it is early morning, say 0400, and you are the only ones at the airport, so you can take off as soon as all your checks are done.

Now the jet is lighter on fuel for the return leg, so you pitch 25 degrees nose up on take off and then accelerate to 300 knots for the high-speed 6000 fpm climb. At altitude in minutes, you cruise at Mach 0.80, generally going direct to any destination you choose. In cruise, you call medcom (medical communication) again to coordinate the ambulance or helicopter on arrival, while the doctors either eat or sleep in the back. In what seems like no time, you are again in the descent, where you can ask to ignore the 250 kt speed limit under 10,000 feet. The words "priority medevac" are powerful indeed on the radio.

On arrival you have done your part when the cooler leaves the plane. Sometimes, if the operating surgeons are at the donor hospital, you simply transport a Styrofoam box with the organ. Then you hand it over to somebody who is waiting for you at the FBO on arrival. There are no forms, no papers, and no delays, since who but the right person would come to you on an airport ramp and ask for a human liver?

Your eyes are bloodshot and you feel as you would expect after not sleeping all night. Getting called out just before you are ready for bed is probably more of a factor in the turnover of Medevac pilots than low salaries or any other conditions at the company. But you have done your part to help somebody live. You have no idea who it was, but it does not seem to matter at all. After all, one day it may be you waiting at the recipient hospital. Then your life may well depend on somebody not being late.