

## Milly Casey-Campbell CD MSc MD

*Dr Casey-Campbell was born in New Richmond, a mostly Anglophone town in the Gaspé region of Quebec. During the Second World War, the Gaspé had a very high enlistment rate. Dr Casey-Campbell became part of the Gaspé military tradition, joining the Canadian Naval Reserves. She worked as a naval combat information operator while completing her undergraduate and master's degrees. She applied to medical school at the University of Montreal and was accepted. At the end of her first year of medical school, she asked herself: I've been in the naval reserves for almost 10 years. Why not enter the Medical Officer Training Program and become a military doctor? Dr Casey-Campbell spoke to her local recruiting office in Montreal and was accepted into the program—likely owing to her military experience and her bilingual status. In a stroke she went from being a noncommissioned member to being an officer, her rank vaulting from Master Seaman to Acting Sub-lieutenant.*

*One of the main differences between military medicine and civilian medicine identified by Dr Casey-Campbell is the occupational scope of practice. Dr Casey-Campbell sees patients with relatively innocuous problems that, in the context of piloting a plane, can have serious consequences. Pilots with runny noses or sore ears must be assessed with aviation medicine in mind, and they must be grounded if they aren't fit to fly. Even patients with a sore neck might not be fit to fly—a simple neck muscle strain can, in a fighter pilot, be dangerous owing to the heavy helmet the pilot wears, whereas in a Hercules plane, the helmet is much lighter and wouldn't pose as much of a problem. Same decision process with plantar fasciitis—how hard does the pilot need to push down on a pedal with his or her foot?*

*Dr Casey-Campbell recently went to a new flight simulator for 426 Squadron, her squadron, and spent hours in the simulator feeling what it's like to be a part of the crew. Experiences like these help her understand when a medical problem is a risk, but they also build relationships with service members in more informal (for the doctor) settings. Aircrew tend to be reticent about confessing symptoms that might preclude them flying. By spending time with aircrew, trust can be built.*

*The other important difference between civilian and military medicine is the sensitivity to posttraumatic stress disorder—PTSD is a risk for service members who engage in operations overseas: Bosnia, Haiti, Somalia, Rwanda, Afghanistan, and elsewhere. Dr Casey-Campbell has been trained to screen for the condition, using simple questions about sleep, isolation, energy, and sexual dysfunction to open up a discussion about possible PTSD. It's difficult—there must be considerable trust between patient and physician before the problem can be safe to talk about.*

*Yet there will always be regular family practice problems, even of the PTSD variety: during her training, Dr Casey-Campbell treated a woman who needed a gynecological examination. The exterior strength as reflected by youth, health, and uniform was belied by the inner vulnerability: it came out that the patient had been a victim of childhood sexual abuse. Dr Casey-Campbell deferred the exam and left it to the patient to decide what time it would be best to perform it; Dr Casey-Campbell encouraged the patient to keep the subsequent appointment, even if the patient decided she didn't want to do the exam that day. When the exam did occur, Dr Casey-Campbell made sure the patient was in a position of control. The patient trusted Dr Casey-Campbell and thanked her when the exam was over. "I'm glad I had you to do this." 🍁*

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**Cover photo:** Chris Dale/McCallan Photography, Toronto, Ont  
**Story:** Shane Neilson MD CCFP, Erin, Ont

**Additional photos and the French translation of the story appear on page 1238.**  
**D'autres photos et la traduction en français du récit se trouvent à la page 1238.**