

“DEVIL DOCS” IN IRAQ TELL THEIR STORY

BY

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The media, particularly CNN, popularized the military term “devil docs” during Operation Iraqi Freedom. Devil docs are the physicians who went into action in Iraq to save the lives of many U.S. Marines and Iraqis wounded during the war. This article describes our lives as part of Bravo Surgical Company in Kuwait and Iraq during Gulf War II.

SHIPPING OUT

Cdr. Taneja, MC, USN, detached from the Groton sub base in Connecticut, while Capt. Chimiak, MC, USN, and Cdr. Pothula, MC, USNR, were dispatched from the Naval Hospital at Camp Lejeune in North Carolina on January 29. We volunteered to deploy with Marines as part of Camp Lejeune’s Second Field Service Support Group (FSSG) platoon. We were assigned to Bravo Surgical Company of the Second Medical Battalion, which, in turn, is run by the Second FSSG.

After reporting to the Second FSSG, we spent the next few days at Lejeune, collecting our 782 gear (a rucksack called Aliss/Mollie that is carried on one’s back), flak jacket, and helmet. Nuclear, biological, and chemical (NBC) gear, consisting of pants and a top specially coated with charcoal, along with a gas mask, were also issued to us. We were told each pair of clothing cost \$300, and we would have to pay out of our own pockets if we lost them in the theater. Few of us were as concerned about the possible expense as the fact that we would lose our lives without the gear if an NBC attack occurred. We were also issued a 9mm Beretta pistol for self-protection only.

We waited patiently for the next two-and-one-half weeks, expecting a plane to take us to southwest Asia. Meanwhile, we began our series of anthrax vaccinations—a minimum of three is required. Finally, we received word that we would leave from Cherry Point Marine Air Corps Station in North Carolina on February 15. We said goodbye to our families and hopped onto buses, which took us to Cherry Point. Just before we boarded the plane, we were all vaccinated for smallpox, eliminating the worries about isolating vaccinated people from the others. As a result, we had a planeload of servicemen with a live, attenu-



Black Hawk helo



Convoy ride

ated virus. It took 20 hours for the vaccination to run its course, and, as a result, we were exhausted even before we left the U.S.

The chartered United Airlines Boeing 747 took us to Ramstein Air Base in Germany. The captain of the plane, a retired Air Force officer, announced that we might be stuck in Germany for several days because there was no fuel in Kuwait for the return flight. We were shocked that Kuwait was experiencing an oil shortage. Two hours later the captain said he would take us to Kuwait, and we should not concern ourselves

Photo opposite: CH-46 helos bringing in patients.



Iraqi patient being brought into the SST.

with how he would get back. We hoped he made it back safely.

We arrived in Kuwait City in the darkness of the early morning of February 17. Air Force personnel sitting in SUVs with laptop computers greeted us on the tarmac. Our arrival was entered into a database by swiping our ID cards into a contraption attached to the laptop. After checking in, we were whisked off to a waiting area near the airport. A little past sunrise, we were again shuttled by bus deep into the Kuwaiti desert. U.S. Marines and Kuwaiti police dotted the highway. The heightened security was instituted after one American was killed and another wounded days before in a sniper attack.

We were assigned to the First FSSG, which is the support group for the First Marine Expeditionary Force (MEF) based at Camp Pendleton in

California. The First MEF was assigned to defeating the Iraqi military with the assistance of the Third Infantry of the U.S. Army and the British forces. Our job was to provide medical and surgical care for First MEF during Operation Iraqi Freedom.

SETTING UP CAMP

We settled down at Camp Guadalcanal, which became our home for the next six weeks. It was a rectangular area covering three quarters of a mile in a God-forsaken place, protected all around by earthen berms. Camp Guadalcanal was one of dozens of small camps within the larger Camp Coyote. We spent time acclimatizing to the desert, building tents, practicing mock trauma runs. Initially, the days were comfort-



A Marine with gunshot wound to zone 3 of neck, intubated.



An eight-year-old Iraqi boy with significant blast injury to face, intubated.

able and the nights cold. We took three-minute “Navy showers,” mostly cold ones, on alternate days and kept ourselves in good physical shape by running 30 to 35 miles per week.

It seems that at some point during our deployment, time lost its value, and no longer did we talk in terms of minutes, hours, days, nights, weeks, or months. Our time scale was changed to sunrise, sunset, and the changes in the moon, much like the system used by stereotyped Native American characters in the old Westerns.

Several sandstorms pummeled some of our berthing tents. We worked hard to shore up the remaining tents with engineering stakes pounded into the ground with sledgehammers. Fortunately, no one suffered major injuries in the process, other than one shoulder dislocation. The wind blew dust and sand into every hole and crevice. Our eyes, ears, and noses were full of it. The dust became part of our lives, and we came to accept it.

Initially, we slept on plywood floors, and subsequently we got folding cots. Food consisted of a hot breakfast and dinner served by a local contractor. Meal Ready to Eat (MRE) was our lunch.

The gas alarm sounded on the very first day we arrived, and we had several alarms afterwards. When the alarms sounded, we had to don

the gas masks within seconds and leave them in place until the alert was suspended. We practiced drinking water through the masks in case we had to wear them for extended periods in hot weather.

Along with Bravo, Alpha and Charlie Surgical Companies and six Forward Resuscitative Surgical Service (FRSS) units were in our camp to support the First MEF medical/surgical needs. FRSS units are smaller (eight people) and more mobile than surgical companies (200+ people), and they had one OR table instead of the six in the surgical companies.

Alpha company set up shop in the northern Kuwaiti desert (Camp Okinawa). Once the war started on March 20, the company began receiving casualties by helicopter, or “helo.” Charlie Company was tapped for the next mission. We in Bravo felt left out. Charlie was airlifted to Camp Viper in southern Iraq. FRSS units joined long convoys into Iraq. Now we really felt left out. Adding to our misery, we endured more than 50 Scud missile alarms, requiring us to head into a bunker with all the NBC gear. Obviously, our sleep was interrupted several times on successive nights. Cdr. Pothula seriously considered sleeping in the open bunker, but his colleagues persuaded him to do otherwise.



A two-year-old Iraqi toddler with shrapnel injury to both feet.

INTO THE WAR ZONE

We had a false start April 1. We waited 15 hours in an open field for lift by helo into Iraq. After waiting all day, we were told at approximately 8:00 pm that no choppers were coming. April fool!

The next day, we were awakened at 4:00 am and told to get ready for transport to an airfield where we would board aircraft to take us north. We herded into the bellies of two C-130 planes, packing 90 people into each. We were literally sitting in each others' laps, wearing our heavy gear. After a one-hour flight, we landed on a makeshift runway (a highway cleared of all utility poles) in south central Iraq. From there we traveled 20 miles by truck, reaching our final destination around 3:00 am. After the 23-hour trip, we were

exhausted by the time we reached Camp Anderson. Our operations officer told us that the Iraqis had attempted a sneak attack on the camp the night before. They were found hiding in tall grass, and a strong Marine presence forced them to surrender. All the while, our FRSS surgeon colleagues were on the berm with weapons drawn. After a three-hour rest, we spent six hours setting up the tents and preparing to receive the casualties.

The core surgical company consisted of the SST (the military term for the ER), two operating rooms, one ICU, and two wards. All these modules were housed in tents, which were transported in shipping containers. On average, it took six hours to set up these facilities. The ORs had air conditioners, but climate control was only minimally effective.

The OR team consisted of two general surgeons, one orthopaedic surgeon, two anesthesiologists, and five certified registered nurse anesthetists. Three gynecologists were helpful in assisting with surgeries and also readily available for any emergency conditions that might arise among the large contingent of women in Bravo Surgical Company. Fortunately, this situation never occurred. We practiced several mock casualty drills to foster unit cohesiveness.

We soon started receiving casualties at Camp Anderson. It was a mix of Marines, enemy prisoners of war (EPWs), and civilians. Patients arrived by Blackhawks or CH-46s (twin rotor helos). It was nonstop flow for 72 hours. The helos would arrive with little or no notice, other than the clatter of helicopter blades, and unload the patients. Not knowing the number or severity of the casualties kept the SST and OR teams in an ever-ready state.

CASUALTIES OF WAR

General surgery cases included debridement and hemostasis of compound, comminuted skull fractures, debridement of facial wounds, exploration of neck wounds, thoracotomy for lung injury, and repair of bowel injuries. Vascular injuries were repaired with temporary shunts.

Between 75 to 80 percent of the injuries Marines sustained were orthopaedic. The helmet and flak jacket with special plates seemed to prevent significant head and trunk injuries. In all, we saw



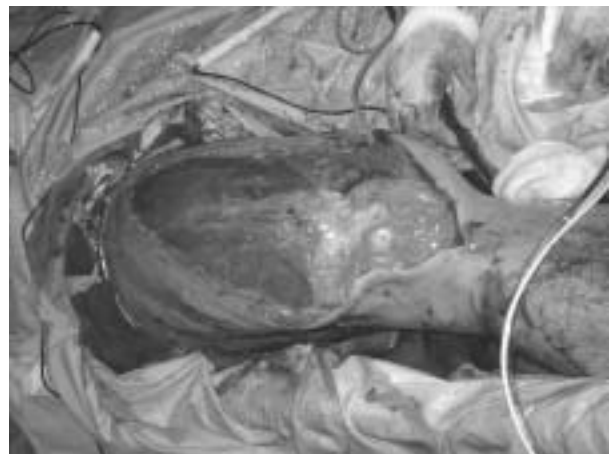
Gunshot wound to sigmoid colon.



Hand injury with finger amputation.



Forearm fasciotomy.



Thigh fasciotomy.

667 patients in the SST and operated on 63 patients, performing over 100 procedures. Orthopaedic injuries included multiple fractures and open and closed dislocations of both upper and lower extremities from blasts and gunshot wounds. A good number of those cases had compartment syndromes. The compartments were fasciotomized, the wounds were debrided, limbs amputated, and fractures stabilized either with splints or external fixative.

After stabilization, patients were transferred to an expeditionary medical facility (EMF), which

had more staff, equipment, and facilities. From there, the Marines were transferred to the USNS *Comfort* or the Army Regional Medical Center in Landstuhl, Germany. Transfer of EPWs to local civilian hospitals was problematic. The process did not always run smoothly, and often they had to remain at EMF for a more extended stay.

Regardless of their degree of injury or how convoluted the process was in terms of getting them transferred, the Marines we treated demonstrated immense stoicism, professionalism, and dignity. They never expressed self-pity. When it was ex-



Ankle external fixator.

plained to them what was being planned medically, they understood and accepted the situation with courage. Minimally injured Marines wanted to go back to the firefight. It was such an emotionally moving attitude—one not often seen in nonmilitary trauma facilities. The injured Marines were kept as comfortable as possible with analgesics from the battlefield to surgical company. These heroic individuals were extremely thankful for the care that we rendered to them and delighted to be able to sleep on a rack with a blanket over their bodies.

In addition to soldiers, we also treated civilians who were caught in the crossfire. One heartbreaking story involved a two-year-old girl, who was brought in with shrapnel wounds to both legs. We were told that both of her parents had died in the crossfire. The child was so cute; she stole everyone's heart. Many servicemen and women wanted to adopt her. She was later transferred to Kuwait Children's Hospital for further care.

An eight-year-old boy was at the center of another gut-wrenching story. His face had been blown off by ordnance. When he arrived, he could talk, apparently asking for his mother. His father was by his side to comfort him. He was expeditiously intubated by Captain Chimiak and transferred to Kuwait Children's Hospital for reconstructive surgery.

A more uplifting case involved an eight-year-old girl who had shrapnel in the brain with minimal neurological deficit. She was seen at our surgical company and transferred to EMF. There, she was operated on by a neurosurgeon. She recuperated at the USNS *Comfort* with full recovery. She was such a darling on the boat. She returned to Iraq loaded down with an ambulance full of toys. Her uncle, who served as her guardian, reportedly collected from the staff \$600 in donations—a huge sum of money by Iraqi standards.

LIMITED RESOURCES

We were fortunate to be able to deliver care that produced good outcomes given that we were in the middle of the desert and were a mobile unit. Needless to say, the working conditions were austere. The supplies were limited in terms of range and quality. We had to be mindful of that fact whenever operating. We would squeeze out the blood-soaked sponges and keep using them rather than asking for new ones. Many times we improvised, bringing out the Thomas Edison in each of us. We heated IV fluids in the sun during the day and used blankets to keep them warm. One of our nurses came up with the idea of using a regular water heater and dipping the IV bags in it. We used a sterile IV bag as temporary cover for exposed brain in a head injury case. We also used IV bags as colostomy bags. Commander Taneja used dental acrylic cement (methyl methacrylate) as a spacer for a bad forearm fracture with significant bone loss. Sterile anosopes were used as a guide for driving pins for external fixators.

The exercise physically and mentally drained most of the physicians. As mentioned previously, when we left for Iraq at the beginning of April, we slept very little due to the constant Scud alarms. It took us much time and effort to reach our first location in Iraq, and then we set about building tents, which was also physically demanding. Then we worked nonstop for 72 hours and repeated the process of moving two more times. We had to operate in protective gear a few times, resulting in dehydration that left us all a few pounds lighter by the time we finished the cases. It took all the strength we could muster to shore up our mental and physical stamina.

We ate MREs for nutrition and drank a lot of



Commander Pothula



Captain Chimiak

water brought from the Tigris River in a “water bull” to offset the dehydration. Apparently, the polluted water of the Tigris was made drinkable through reverse osmosis. We did away with showers. We all smelled bad, so it did not matter. We emptied our bladders in an open field and evacuated our rectums in a small hole dug with a mini shovel, then covered it with dirt. It was a communal exercise that included the females in our company. The area cleared of unexploded ordnance was very limited and obviously we did not venture too far for fear of being blown up while answering calls from nature.

ANOTHER BATTLEGROUND

After 72 hours at Camp Anderson, we were told that we had to move north. We packed up our tents and gear and headed out in trucks during the early afternoon. Our convoy went through several small

towns. We were held up by a firefight nearby. We saw flashes from explosions, and some of us went into “condition one” with our weapons ready to fire. Even so, most of us felt pretty secure. We had a CNN team and their escort in our truck, along with Marines who carried heavy-duty arsenal. After the firefight subsided, the convoy proceeded. By this time it was night, and we were traveling without lights for tactical reasons. Our truck hit a big ditch in the dark, and we were all thrown about on the back of the truck, some of us landing atop others and a few sustaining significant injuries. We made it to Camp Chesty after 12 hours on the road, traveling approximately 50 miles.

We put up the tents again very quickly and started receiving casualties. The pace was intense initially and gradually eased up, reflecting the progress made by the Marines.

We slowly started getting some amenities back, including gender-specific, warm, communal show-



Commander Taneja (in foreground).

ers and hot chow. We also visited a local Iraqi hospital to assist them with their needs.

After 10 days, we were told to move again, this time east to Camp Geiger. We went through the motions of packing and unpacking. This was a relatively short ride—30 miles in four hours.

This time we set up shop on an abandoned Iraqi air base. The hardened bunkers for the planes were used as ORs and wards. The walls were several feet thick and it helped to keep us cool during the day. The surgical load had significantly diminished by this time. We started seeing a lot of blunt trauma from vehicle accidents. We also had a significant problem with the flies. They were numerous and all over the place. Nearly the entire surgical company came down with gastroenteritis. Most of them received IV hydration and Phenergan for nausea. Family practice colleagues say the culprit was either *Shigella* or Norwalk virus.

GOING HOME

Finally we were told our mission was complete, and it was time to move back to the south. We hopped back into two C-130s and made it back to Kuwait.

We spent another two weeks in Kuwait waiting to be retrograded back to the continental U.S. We answered a detailed questionnaire regarding any medical or mental health issues. On May 29, we boarded a United Airlines 747 and landed at Cherry Point Marine Corps Air Station. The all-volunteer flight crew was wonderful. Upon arrival we thought it was a fantastic sight to see green all around us, and we were especially glad to be back with our families.

We slowly got back to our lives, relearning some of the basics in the life, like sleeping on comfortable beds and flushing the toilets. □

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