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SHOWDOWN WITH IRAQ

`Devil Docs' would follow front lines

Mobile units' goal is to provide care near combat

By JUAN O. TAMAYO Knight Ridder Newspapers

Marines and Navy doctors with Combat Service Support Company 117 unloaded supplies last month

CAMP LSA7, Kuwait - U.S. troops punched so deeply into Iraq in the 1991 gulf war that it took an average of two hours to get a casualty to a hospital. That was four times longer than in Vietnam.

But if it comes to another war with Iraq, the Marine Corps' "Devil Docs" will chase the front lines on trucks and helicopters in a first-ever effort to persistently push top-flight medical care close to combat.

"As the battlefield stretches out, we'll move up," said Navy Cmdr. Peter Mishky, 40, of San Diego, a trauma doctor who heads Combat Service Support Company 117, the Marines' equivalent of a six-bed emergency room.

Tested in Afghanistan, the concept of sending mobile but well equipped medical units to the edge of combat has been embraced by the 7th Marine Regiment, with 10 emergency rooms and six resuscitation-surgery units.

"In '91, the troops were running too far too fast. Now we'll stay 20 miles from the front and cut transport time to 30 to 60 minutes," said Navy Capt. H.R. Bohman, 52, of Camp Pendleton, Calif., who heads a mobile surgery unit.

Mishky's deputy, Lt. Cmdr. Darin Garner, 36, an emergency room doctor at the Navy hospital in San Diego, said: "It's that critical 'golden hour' that civilian emergency medical teams need to get people to hospitals."

These are not your normal physicians. They are combat doctors, the docs of war, the people that Marines, who like to call themselves "Devil Dogs," count on to save their lives and reverentially call the "Devil Docs."

Bohman served in the gulf war and Somalia in 1992, once treating 34 casualties in 36 hours in the African nation. His eight team members wear pistols in shoulder holsters and surgery caps in desert tan or the "chocolate chip" camouflage pattern.

Mishky packs a pistol and wears a ' flak jacket under his stethoscope. He recently fired light and heavy machine guns and an automatic grenade launcher during a training trip to a desert firing range.

Bohman expects that the emergency and surgery teams will treat casualties who need immediate treatment to stay alive before they can sent to more fully equipped hospitals in rear areas. Such patients are about 10 percent to 15 percent of all casualties.

His team of two general surgeons, one anesthesiologist and five nurses and orderlies can perform basic chest and even brain surgery, and can handle 18 casualties in 48 hours without resupply from the rear.

In just one hour, the team can pack up its two tents - one a holding area and the other a surgery room with operating lights - ultraquiet power generators and X-ray and handheld sonogram machines.

Mishky's more basic unit, with two physicians trained in emergency room work, can handle 20 casualties without resupply and will have two Black Hawk medevac helicopters to fly the worst cases to Bohman or hospitals.

The unit can pack its 5,000 pounds of equipment and two canvas tents into two trucks or wrap it in netting and sling it under one helicopter, then set up and be ready to receive casualties in two hours.

"If they arrive alive, I should be able to keep them alive," said Mishky, who, like all members of Marine medical units, carries a Navy rank but wears Marine insignias.

Bohman said that because of the Marines' improved flak jackets - which stop most of the shrapnel that causes 75 percent of war wounds, but not bullets - most of the wounds he may see will be to the limbs, pelvis and head.

His team trained recently for a month at the inner-city Los Angeles County-USC Hospital, which receives about 8,000 cases of gunshot wounds and other violent trauma in an average year.

But Bohman, Mishky and Garner know that war will be different. Eighty percent of the casualties treated by U.S. military doctors in the gulf war were Iraqi prisoners of war, who received the same treatment as friendly troops under the Geneva Conventions, Bohman said.

Doctors can treat enemy and friendly civilians at their discretion.

Guards pointed their M-16s at make-believe patients in a recent training exercise, from the time their litters were unloaded from ambulances until a security corpsman finished searching them, from hats to boots.

"We don't want anyone armed here, an Iraqi suicide bomber or some Johnny in shock who starts to hallucinate and wave his gun around," said one corpsman.

One "casualty" in the exercise was a linebacker-size Marine who fiercely clutched a suspicious bag, despite the efforts of four corpsmen to remove it, until Garner told him to ease up and stop holding up the training.

But all the training in the world may not be enough to prepare the medical units for the mass casualties and frenzy that Cmdr. Bruce Baker, 42, a Fort Lauderdale, Fla., native and anesthesiologist, saw in Afghanistan in December 2001.

Baker was airlifted to Camp Rhino, the Marines' combat base in the heart of Taliban country in southern Afghanistan, in the first test of a mobile resuscitation-surgical unit so close to combat

On the next dawn, Rhino helicopters brought in 40 casualties, half of them U.S. special forces and the rest anti-Taliban Afghan warriors, all wounded by a stray 2,000-pound U.S. bomb.

"It was a madhouse," Baker said, recalling that there were no Pashtun-language translators and that he had to warm IV fluids and blood for transfusions in a microwave oven he had just borrowed from a Navy ship offshore.

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