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PHYSICIAN IN WAR

Triage

During the temporary cease-fires on the frontline, when anxious silence was only sporadically interrupted by distant gunshots, we busied ourselves with plans, preparations, and relaxation. Boots were cleaned, weapons maintained, and vehicles repaired. The men would relax, play cards, fasten buttons on the uniforms, sleep, or simply daydream. We, at the medical office, used this time to restock our supply of medications and bandages, update patient protocols and war diaries, write medical reports, and clean ambulances. The commanders had meetings, visited battle stations accompanied by the physicians, analyzed possible actions, anticipated further course of events, made strategic calculations, and exercised simulated situations.

When I had some time away from my duties, I would do some reading, in daylight or under weak candlelight. I read books on war medicine and war surgery, as well as on the history of medical service in war.

I had soon learned from my battle experiences that, for a physician in war, there was only one thing worse than a soldier needing treatment – many soldiers needing treatment at the same time. When faced with such a situation, you are torn between the wish to help everyone at once, easing all their pain and suffering, and the desire to be wounded yourself, so that someone else would take over the horrible responsibility of choosing who to treat first. What a strain it is when a mere mortal, who became a war physician because of patriotism or vain courage, finds himself before thirty bloody and disfigured young faces, groaning from the fear of imminent death! The responsibility that falls on one's soul at such a time is overwhelming. You realize that you have to decide whose life to save at the expense of an eye, leg, or arm. The doubt that you could have saved another life torments you as you weigh and re-weigh the facts over and over again in your life. It resurfaces every time you see a prosthesis, stump, scar, wheelchair, or a missing limb. In such situations, I always find myself thinking "Maybe this is my stump and my prosthesis. Maybe I could have done something to save the limb, maybe my comrade could have pushed a children's stroller instead of his own wheelchair."

I know for certain that I, or any other field doctor, will never get rid of this burden.

Of all the questions arising from the issues of mass field treatment, one is as old as war-surgery itself: the question of triage. The basic description of triage was given by Pirogov in the late 19th century, who divided injuries into light, medium, and heavy categories, saying that "proper triage of the wounded in the field hospitals is the main factor in giving proper medical aid and evading chaos and helplessness." However, his directions on triage mostly concerned transportation and evacuation. Opel was the first to consider triage as the principle of treatment and evacuation "during all stages of surgical treatment, in the best interest of the patients in the given combat situation." This principle became the foundation for all future wars, modified and adapted to the developing strategy and tactics of warring, new weapons, and the size and equipment of the army.

As we were busy organizing our medical field units and hospitals, we did not have time to devise a strategy or engage in theoretical discussions on the applicability of existing systems of war medicine. Looking back now, as a civilian, I see that despite the huge amount of improvisation and near-impossible conditions, we managed to make it look like we made and executed a carefully constructed plan and had a great deal of battlefield experience. I am indeed very proud of us – in a matter of weeks we had grown from inexperienced amateurs into professional soldiers apt to their job.

At first we did not pay much attention to the triage. We had learned the rules of medical urgency and the principles of triage during our medical education, but we could not follow the theoretical principles on where to give first aid, where and to what extent to perform surgery, and where and how to evacuate the patients. The field physicians were constantly on the first line of combat, and the improvised field hospitals were often under artillery attacks or even small arms fire. We could not introduce a firm and strict principle into triage.

We were very lucky to have a nurse or medical technician in every platoon from the very beginning of the war. They were trained to administer first aid and evacuate the patient to the field hospital. However, the main principle of our Medical Headquarters was to go to the wounded and not to wait for him to be brought to us, as well as to go without waiting for a cease-fire. This principle contradicted the existing principles and the theory of battle medicine. Going out to the wounded often put us into a great danger, and presented a problem because of a large number of the wounded on a wide and long frontline, but we managed. Sometimes, it was impossible to reach the wounded with an ambulance. We had to carry them on stretchers, mules, or horses down the mountain slopes, trudging on foot for miles under enemy fire.

We would treat and diagnose the wounded on the spot, whereas the evacuation and transport depended on the situation on the battlefield.

We soon started training medics and nurses for military units smaller than platoons: every squad had a trained medic, who was also a soldier. Moreover, after the first year of the war, most soldiers could administer first aid themselves. We organized short classes on first aid during battle breaks, and many had been in a situation where they had to help a wounded comrade. Everyone carried a first-aid kit, and the braver and more skilled had analgesics for parenteral administration. They all assisted in evacuation, following closely the directions of the medics or hospital crew. I marveled at the speed and competence with which our medics assessed the symptoms and the status of the wounded soldiers, and made decisions on the evacuation order and transport. When I came to the wounded, I was often fascinated by their reports on the patient's status and the medical measures taken before my arrival. In situations when we had many wounded, we would administer first aid on the spot, and then transport them to the nearest medical unit. The most heavily wounded were immediately transported to the war hospitals, those with less severe wounds were treated in our field medical office, and the lightly wounded returned to their unit after first aid.

The transportation of severely wounded soldiers often presented the greatest problem. The evacuation routes were often under heavy fire, and communication with the distant cities was often cut off. In these circumstances, we would leave even the critically wounded in the field-medical office. During transportation to a hospital, the wounded were accompanied by someone from the medical staff, usually not a physician – a physician could not afford to leave the frontline, since he or she had to cover a large and wide war area all alone. The ambulances also presented a problem – each transport meant the best vehicle was removed from the front, leaving us with a single ambulance, usually the worst one. In the second year of the war, we had first surgical teams arriving to the front and forming small war hospitals close to the frontline. We then transported the wounded to these teams, and this presented a great relief for us and gave a feeling of security to all on the front.

Some time ago, while I was writing an article for an international journal on military medicine, my colleagues and I went through the form sheets where physicians checked and described the injury of a particular organ or body system of a patient they treated. The forms were filled out in our medical unit on the frontline and in the war hospitals. Such analysis usually results in counting the patients with either mono- or polytrauma. However, despite the fact that the medical records were rather complete, we could not determine with certainty the type and severity of the wounds of individual soldiers. We were at the same time comforted and saddened by this fact: comforted, because we realized that our more expert hospital surgeons, using sophisticated equipment and working in the security of their hospitals, could not clearly define the severity of the injury and check the right box; and saddened, because all our efforts could eventually be boiled down to two tables, which may never be published.

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