DOUBLE TAP

On the Front in Ukraine

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The body bags are kept, neatly folded and out of sight, just behind the wound dressings. Dressings are for medical use. Body bags, on the other hand, are different. We had seen them in Mosul. And in Liberia. We didn't need to see them here.

I had come into Ukraine just three days before, on the night train from Poland. After an all-night rail link, there had been two more days of road travel through serpentine military checkpoints and around water-filled craters – remnants of Russian artillery strikes. It had been a long, sleepless journey to get from Minnesota to the world's deadliest front. There was no fast way. No commercial air travel existed in-country, of course. No SIRI, no Google Maps. In fact, no iPhone. I had left mine in Poland in the hands of our Country Officer. She had dropped it in a plastic bag with my name on it – like a donated kidney. I smiled and said goodbye to the 21st century. On my last deployment to Eastern Ukraine, only two months before, we had exchanged our phones in Kiev for body armor. Both sides of the swap were meant to keep us safe.

The fifteen-hour overnight passage was the most memorable part of the entry. Through a nighttime snow-globe, our train glided over farmlands laid fallow by the war, our lights raking across villages blacked out by the curfew and blanketed by silent snow. The tiny houses in those villages – not much more than hovels, really, were shabby – but their pointed roofs pushed defiantly up into the night. It reminded me of "Fiddler on the Roof". Except there was no singing, just the rhythmic clattering of our train coursing

over a ribbon of track and sparking beneath a lonely power line. I dimmed my cabin lights to see Ukraine pass by. I wondered what the families in those little houses spoke of after dinner was done and cigarettes were lit. I suppose I knew. There was only one thing to speak of in Ukraine.

Hours before, at the border, the Polish guards had been well-dressed and well-mannered. I liked those soldiers because I remembered, last Spring, right after the invasion, how they had treated the women and the kids who streamed across the border on their way to safety. I remembered those Polish soldiers, rifles slung over their broad shoulders, smiling, and bending down to take the hands of bewildered children, helping them pull their clattering little suitcases across the traffic lanes, guiding them to aid stations and food tents. The kids smiled up at them. Their mothers didn't. They had left their husbands and sons behind and, as they pressed into the crush of the refugee lines, they stared bravely across the fences, trying to see a future ahead.

But now it was December, the eleventh month of war. The Polish guards who came aboard the train still wore neat uniforms and they still proffered neat manners, just like they had in March. But this time, when they examined our faces and our passports, their own faces were heavier, wearier than before. It was Ukraine's war, but it had taken its toll on Poland, too.

On the other side, the Ukrainian side, the border guards were different. I was crossing from the European Union and NATO into a somber, poorer land. Putin, like a bully who knew his boundaries, had pushed right up next to the Polish border. But he didn't cross it. In Ukraine, though, nothing was safe. Cruise missiles and hypersonic missiles reached even to Lviv in the far West, ruining lives and livelihoods. Back then, in March, our trauma team had positioned itself in a bunker at the bottom of a parking

structure in Lviv, ready to care for war-wounded and refugees as they streamed past, and also ready to evacuate at the last minute when the inevitable Russian juggernaut rolled over all of Ukraine. But it didn't happen. No one counted on what a brave and determined people could do in the face of terror. Soldiers fought. Office workers shut down their computers, pushed away from their cubicles and picked up AK's. Old men left their gardens behind and fought. Students doffed their jeans, put on uniforms, and fought. An entire country put aside its first-world problems - and fought. The Russian bear was clobbered, bloodied, and pushed back by Ukrainian courage and the will of a free people to survive. "*Slava Ukraini!*" – "Glory to Ukraine!" became the ubiquitous greeting, even a password to enter a restaurant or a club. "*Heroiam Slava*!" was the response – "Glory to the Heroes!".

Time moved on. The war moved on. In October, we pulled up stakes and moved our surgical site to the far East, to a site codenamed "K3". Our build team erected a trauma hospital in a recently liberated city near the front. Civilians, mostly old, sick, and poor, may have been liberated, but they mourned and limped on crutches past abandoned torture chambers and over mass graves. Then the war moved again. So now, in December, we also moved again - to yet another secret location. This time, on the front itself.

Our forward surgical team would do its work at a new site codenamed "K9". Since we had proven ourselves in Lviv in March and then at K3 in October, we were now granted the privilege of treating Ukraine's heroes, right at the thickest part of the fight. Most of us recruited to staff K9 had been in Mosul in 2017. We were familiar with war zones, and with blood. That's what we did. We stopped the bleeding, we mended torn flesh, we pinned shattered bones.

And we offered the love of Jesus. Does that make you wince? It didn't 2,000 years ago, and it didn't down in the bunker where the wounded were brought to us. Soldiers are practical. They knew expertise when they saw it (word had spread that "The American Doctors" were there, and that they could help). Wounded or dying soldiers also know love when they see it. We had two jobs, not just one. But all that would come later. For now, I just had to get myself to K9.

The Ukrainian border guard looking down at my passport was a young woman. Very serious. Typical. The men were at the front. Everyone in Ukraine had a job to do, and everyone took their job seriously. She scanned my visa stamps. Sudan, Uganda, Nigeria (many of those), Cameroon, Turkey, Iraq, Egypt, and, of course, the usual European stopovers. She flipped through the pages and paused at the Ukraine stamps. I had already entered and left her country twice. This was the third time in less than a year. But I suppose I looked innocent enough – most doctors do. That's why I always leave a stethoscope in my duffel. She nodded, handed my passport back then moved on.

Our train slid across the border then pushed into the night, stopping first at Lviv. A short, bald, shifty-eyed conductor tried to push three last-minute cash-paying passengers into my cabin while we were paused at a siding. Thankfully, our Country Officer in Poland had prepped me well for contingencies both large and small.

"We purchased all four berths in your cabin," she had informed me during my briefing in Krakow. "That way you don't have to answer awkward questions about who you are, where you're going, or what you're doing." Then after a pause, she added, "And, of course, you won't run the risk of sharing your cabin with *women*. I doubt the Ministry would like that."

Sure enough, she was right. After I boarded, and conveniently just when I had stripped down to my long underwear, the conductor reappeared in my doorway, trying to push three strangers into my berth. His head reddened as our broken English/Ukraine argument mounted, and it was only made worse by my frequent gestures at the photocopy of my ticket. He hadn't counted on that, and it thwarted his deceit. The conductors on that line take your ticket as you board and they give nothing back to you. But I had been furnished with a copy. A nasty trick. Exasperated, he shook his head finally and huffed off with his cash-paying charges following behind. As they moved on, a young women who had been eavesdropping glanced back at me and smiled. My Country officer had prepped me well. Except, of course, for the attire. But that one was on me.

Ukraine is a big country. Especially at night. And in the snow. I had been given a printed list of stops. Mine was the second to last – 15 hours into the journey. And it was important that I not miss my stop because the train's final station was a long way off course, and not a good place to find yourself alone. The problem with my itinerary was that I don't read Cyrillic letters, and even if I did, most of the stations were not well-marked, especially in the dark. That meant I had to spend the night counting, not sleeping. I didn't mind, though. I dimmed my cabin lights so I could watch Ukraine roll past as I let my mind wander to K9. What would it be like? Would we make it work? Would *I* make it work? Would I fail? This wasn't my first rodeo, but as an anesthesiologist, the potential mistakes that hang over my head are like the Sword of Damocles. They could be fatal. That's just the nature of our profession. And, of course, the circumstances during war surgery are … imperfect.

The stops came and the stops went through the night. I checked off my list. The sun rose. The country never seemed to end. As we pushed further East, the cropland became sparser, the villages poorer, and the abandoned Soviet-era factories more forlorn.

Finally, we arrived at my destination – a major city in the East that had been shelled and struck with missiles often enough to keep everyone in a state of constant wartime vigilance. The train station itself was surreal. It was huge, cavernous, and completely blacked out inside following Russian strikes on the power grid. I had never before moved with masses of people who I could not see. Somehow, though, the disgorged passengers made their way, me with them, through pitch black tunnels and outside, finally, blinking in the afternoon sun.

I searched for my contact. He wasn't there. I checked my watch. Right on time. The armed soldiers guarding the train station didn't like a loiterer. Especially one who couldn't speak their language. I kept as low a profile as I could until I finally wore out my innocent-waiting-passenger welcome. Still no contact. Was I even in the right city? Believe it or not, the answer to that obvious question was not so obvious. And I wasn't yet desperate enough to ask a passerby (or worse, a soldier) what city I was in. So much for Jason Bourne. The wind was getting colder. Finally, desperate, unwelcome, and cold, I spotted a coffee shop off to the side of the station plaza. A lone gasoline generator purred outside the glass door, making just enough power to keep a coffee machine fully employed, but nothing left over for lights or heat. I bought a hot cup of coffee and, gratefully, took a seat at the bar overlooking the plaza. Still no sign of my people.

I dug the coms packet out from my backpack, activated the hot spot and the secure phone, then entered a myriad of codes. When the screen finally blinked to life,

there was only one contact listed and that was a three-way texting group that included our 24/7 U.S.-based security operations command and two unidentified in-country people somewhere in Ukraine.

"NOT an Emergency," I texted. "In (city) but no contact present. Please advise."

Thankfully, someone on the U.S. end responded and promised to roust the locals. My contacts had apparently been given a wrong arrival time. So, relieved that I was at least in the right city and in the right country, I smiled and bought another coffee.

An hour later, two men arrived. One was John, our logistics coordinator. The other was Dima, a Ukrainian translator and driver who I had worked with at K3 in October. I love Dima. He is short, and he sports the kind of haircut that's popular these days among young people in war-torn countries: close-shaven on the sides and floppy at the top. His eyes are coal black, and they manage to exude both intensity and sympathy at the same time. An enigma. Dima doesn't smile much, and, like many of our translators, he doesn't talk much, either. That is, until he's prompted. The Ukrainians, of course, have lives outside of the war. We forget that sometimes. Dima is something of a chef. Perhaps that explains why, for such a slight guy only in his 30's, he sports an incongruous paunch. He owns a massive snail farm. In better times, he supplies France and other countries with as much as sixty tons (yes – that's right - sixty tons) of snails destined for escargot. During harvest time, he employs over a hundred people. That's in normal times. Now, we employ Dima at K9 to translate, to drive, and to acquire food for our team. But no escargot. Please.

My next stop: "Papa 1". That's our staging location. After more long hours on the road through an increasing frequency of military checkpoints, we arrive to a small hotel in a small city. Soldiers linger in full kit, with automatic weapons slung across their

chests, crossing the lobby with Red Bulls in hand. One of them shoulders an RPG. This isn't the Marriott. And, no, I won't get points. Our team has a block of five rooms booked together on the second floor, reserved for the constant coming-and-going of our own members as well as for our support staff. It's too late to make it to K9 before curfew. I'll spend the last night for a month in the luxury of a hot shower and *ad-libitum* access to the deli-case in the lobby. My wife Lisa made me give up the Red Bull habit years ago. Too bad.

But the best thing about Papa 1 is not the deli case. It's Bill. Ex-Special Forces, he's the anesthesia guy who I'm replacing at K9, and he's passing through Papa 1 on his way out while I'm passing through on my way in. I've never met Bill before, but I've corresponded with him a lot about Mosul (where we both served, but at different times) and about Ukraine (where we also both served at K3, again without overlapping). Bill came directly from K3 to K9 when K9 became functional four days ago. Since we're not allowed to have personal cell phones or any other electronics in-country, meetings and greetings and partings are done the old-fashioned way: face-to-face. The prohibition against phones is meant to prevent our locations from being tracked by the Russians, who are good at that sort of thing. You'll see later why that wasn't just paranoia. So now I'm finally face-to-face with someone who has been to K9. And I've finally crossed over the "need to know" threshold. Now I need to know.

K9 is located in the bunkered and sandbagged basement of an abandoned Soviet-era school building. It has old-fashioned, cold-war thick walls. That's good. In fact, that very feature turned out to be lifesaving. But more on that later. It's also close enough to the front so that wounded soldiers can be brought to us fast enough for us to have a

chance to save them. In trauma medicine, we call that the "golden hour". K9 is within golden minutes.

Our team is 12-strong. One operating room, an emergency room with six beds, sleeping quarters with cots for our sleeping bags, and a combined dining/conference room. That's where morning devotionals are held, followed by briefings by our team leader and our security lead. Bill smiles when he tells me that, even at 6:00 in the morning, he finds other guys in the dining room quietly reading their Bibles. It's one of the few times of the day when work-talk and black humor give way to silence.

Our advance build team has worked its usual magic and supplied K9 with diesel generators, heat sources, and limited potable water. Better yet, they've managed to supply me with an oxygen concentrator and a real anesthesia machine. An oxygen concentrator is about as big as a dishwasher, and it sucks in air (containing 21% oxygen), then, at the other end, puts out 80% oxygen at high enough pressure to run an anesthesia machine. An oxygen concentrator is much better than oxygen cylinders. You don't want compressed gas in a war zone. Re-watch the end of the movie "*Jaws*" and you'll see why.

There's more. Lots more. We're embedded at K9 with three Ukrainian military physicians – a surgeon, an anesthesiologist, and an emergency medicine doctor. We'll be practicing elbow-to-elbow beside them. All three speak English. All are highly qualified. In fact, they are at the top of their respective specialties in all of Ukraine. And all three are soldiers: part of the "SOF" (Special Operations Forces).

The good thing about this bit of news about the Ukrainian colleagues: we'll have a few more able hands to treat casualties. We'll also have an "in" with local battalion commanders. The bad thing: we'll have a lot of sheriffs in town, begging the question of

who's in charge when it comes to medical decisions. And another bad thing: these guys themselves are strategic military targets. That means that both we and they are targets, but for different reasons. And a field hospital that receives streams of casualties can never remain totally hidden, no matter where it's bunkered.

So that's the scoop. Sure, some of it is problematic. But there is no other way for us to be in a position to treat the casualties who we're equipped to treat. God made our team, and He made us individually, for a purpose. We've seen that purpose come to life in other austere and hostile places, and we've seen it save and transform lives in those places. Is there a risk? Of course. Which part of "war zone" did we not understand before coming here? We're not stupid. But we have some very astute and very well-connected people looking out for us. Our Incident Management Team and our Global Security Operations Command back in North Carolina have, collectively, a 24/7 paranoid fixation on keeping us safe. More importantly, as someone once wisely observed, "You're never so safe as when you're in the center of God's will." Every one of us joined this team after long prayer and after long discussions with our families. This isn't just about saving lives that may not otherwise be saved. This is about serving the King of Kings when He calls us, and where He calls us, to serve. And this time, we get to serve Him by taking care of real-life heroes. *Heroiam Slava!* It's as complicated, and as simple, as that.

Bill and I talk into the night, then I sleep like a baby. I can't even remember my dreams. We leave Papa 1 early the next morning. I'm in a car driven by a translator with two team members who came out from K9 for a one-day break and are now heading back to the trauma hospital with me. Like Bill, both are ex-U.S. Special Forces. One is now a flight nurse and the other a surgical tech. Both served at our field hospital in

Mosul. From here on, all our travel attire includes body armor. The roads get more pock-marked from shelling, and the checkpoints get more frequent and more serious. It helps that our translator/driver can use the expression “American doctors”. Apparently, that means something here. They usually wave us through without searches.

We arrive to K9 on a bright, sunny morning, just after 8:00. The distant thud of artillery (either outgoing, or incoming – it’s not always easy to tell) punctuates the still, cool air. I’m led through a heavy steel blast door. The door is attached to a rope and pully with a cinder-block counterweight. I turn on my headlamp. We’ve learned to keep our headlamps around our necks at all times during these deployments. We head down a dark flight of stairs to the basement level, through a second plywood door, past a blue plastic curtain, and finally into our “hospital”. A long, dimly lit hallway is lined on both sides by grade-school coatracks. Instead of children’s coats and hats, body armor and helmets hang from the hooks – next to cartons of MRE’s (military “Meals Ready to Eat”). We walk past the curtained openings to the emergency room and O.R. I’ll have time to explore later. I drop my duffel on Bill’s old cot. He’s been kind enough to leave his own camp mattress and pillow behind. I’ve never had the luxury of a real pillow on one of these deployments. I smile. Now it’ll be hard to call this one “austere”.

We walk into the dining area during the team’s daily briefing. I’m introduced around the table. Some are familiar faces – old friends. Some are new. All are smiling warmly. Our team, and each deployment of our team, is called a “Disaster Assistance Response Team”, or “DART”. The best thing about a DART is the people on it. The people sitting around this table have been to more unusual places, and done more unusual things, than any other collection of eccentrics in the world. Ebola outbreaks in Liberia. Earthquakes in Haiti. War in Mosul. Diphtheria outbreaks among Rohingya

refugees in Bangladesh. Covid intensive care units in Italy and New York City's Central Park. Refugee camps in Greece. And the skill sets and backgrounds that come along with these faces are unusual, too: medical, surgical, nursing, pharmacy, supply-line, logistics, finance, firefighting, military, law enforcement, aviation, search-and-rescue, plumbing, electrical, carpentry, sanitation, and security, to name just a few. Even our security staff, many of whom have military or intelligence backgrounds, have more interesting stories to tell from their previous DARTs than they do from their GI-Joe or Secret Squirrel lives.

But this team, the K9 team, is unusual even for a DART. It's the smallest footprint we've ever had. For security. But that means every one of the dozen members must have a clinical skill set in order to treat casualty surges. Our team will need to respond, repeatedly, to "All Call" alarms, sounded by a Rube Goldberg rope-and-pulley apparatus that sounds like a great clattering of pots and pans. Kind of like a dinner bell at a cowboy cookout, except that, instead of the beans being ready, its incoming war casualties.

I'll get to know each one of these men (and eventually, three women) quite well. There's something about the shared austerity, the immediacy of treating emergencies, and perhaps the threat of annihilation, that bonds people together.

I'm also introduced to our three National colleagues. Andre (not his real name) is a surgeon, Igor (not his real name) is an anesthesiologist, and Leo (also not his real name) is an emergency medicine doc. All are also members of the Ukrainian Special Operations Forces (SOF). They won't be wearing uniforms or carrying arms while embedded with us. It's impossible to completely disguise their presence and their other roles in life, but neither do we, or they, want to broadcast it.

Leo is unusually emotional for a Ukrainian. It's almost like he's Italian. His parents need to check on that. He'll be very easy to get to know. Andre and Igor, on the other hand, are serious dudes. They know their stuff – both medically and militarily. The Ukrainian authorities have decided to send their best. In part, we would later learn, to make sure that we ourselves weren't spies. And, in part, to make sure that we knew what we were doing. And, finally, to lend us a hand. This marriage will be awkward on several counts: who's in charge? And what's our primary mission?

War surgery is its own thing. Almost its own specialty. The priorities are different from elective cases, and different from peacetime surgery. Beyond that, we are Christians – believers and followers of Christ. To a man or woman, that's why we're here. That's our motive. That's our calling. Are we adrenaline-addicts? Maybe. Probably. But that's not enough. We literally want to show a hurting world who Jesus is by what we do with our hands, our heads, and our hearts. Back home, we may be difficult – for ourselves and for our families. But here, on a DART deployment, we have the responsibility and the privilege to be a lot less difficult than usual and actually behave more like Jesus and less like us. He is courageous, loving, and humble. We are … well, we are who we are. But on deployment, we aspire to something better.

The All-Call alarm clatters to life. Coffee mugs drop, paper plates are pushed aside, and folding chairs scratch against the floor as everyone jumps up from the table. One member of the team is always left behind in the emergency room to receive unannounced casualties and to roust the rest of us into action. By now he will have opened the external hatch door when he heard fists pounding against it, then he will have pulled the alarm rope.

We rush down the dark corridor and push through the plastic tarp into the emergency room. The first man in steps over to the thermostat left hanging by our build team. We can hear the diesel heaters outside roar to life and, within minutes, the entire emergency room and O.R. are toasty warm. That's important for the wounded men who we'll have to strip bare in a few seconds. Since we're in a half-basement, there is no proper, full-sized door in the external wall. Instead, a half-flight of stone stairs ascends from the E.R. floor to a landing at shoulder height where a 4 x 4-foot wooden hatch opens to the outside world – to a world at war.

Two soldiers struggle down the stairs, carrying a wounded comrade moaning on a stretcher. His uniform is sopped with blood and his boots are caked with many inches of mud. A combat tourniquet circles his right arm and another his right thigh. Both tourniquets are cinched and fixed tight. They appear to be doing their jobs: no blood is currently spurting from his shrapnel wounds.

I dodge into the O.R., which is separated only by a blue plastic tarp from the E.R. I flick the switch on the oxygen concentrator, and it squeals to life. I've never heard a pterodactyl, but that's probably what one sounds like. Next, the anesthesia machine. It sits on the same olive drab green military case that it shipped in. Dials, knobs, a ventilator, an anesthetic gas vaporizer, and glass flow tubes sit ready to put a patient to sleep, keep him asleep, and keep him alive. The corrugated plastic breathing circuit and breathing bag are already attached to the machine and ready, too. A vital sign monitor sits on top of the whole affair, and cables run down from it to a blood pressure cuff, pulse oximeter and ECG leads that are already positioned on the O.R. table. I flick a few more switches and all the above comes to life.

By the time I step back into the E.R., we have already received three more patients – yellows and reds, from the look of it. In trauma care, we triage according to both the gravity and the survivability of the injuries. Green is walking wounded. Low priority. They take chairs off to the side and wait. Yellow is serious, but not immediately life-threatening. They get cots. Red is immediately life-threatening but salvageable. They get the lion's share of our attention. Black is non-survivable. In the cold calculus of war surgery, you can't afford to waste time or resources on priority-blacks. If you do, someone else is going to die who didn't need to die.

The Dead-on-Arrival (DOA) are another matter. According to war surgery doctrine, there is almost never a good reason to do CPR in a place like this. If a wounded patient's heart has stopped in this setting, the chances of successfully resuscitating them are essentially nil. And, again, all the time and resources pursuing that pipe dream only steal someone else's chance to live.

But there's a caveat. Our embedded Ukrainian docs know their own soldiers. They are soldiers themselves. And they understand that, for soldiers carrying their wounded brothers into a trauma hospital, hope matters. Even when it's technically hopeless. For that reason, we have agreed to continue CPR while the victim's brothers are still there to see. It's not for us to strip these heroes of hope or teach them wrong lessons about futility.

Our team buzzes quietly and efficiently around the four wounded as they lay on their cots. One continues to writhe and scream out in pain. We reassure him through our translator, but the best reassurance will come from the ketamine after his IV is started. Layer after layer after layer of uniform is cut off with trauma shears. It's amazing to me that the combat tourniquets are effective on top of so many layers. But

out there on the battlefield, it's freezing, and removing clothing is not an option. As it is, even inside our warm E.R., the arms of our patients are pale and icy, and it's almost impossible for our pulse oximeters to detect pulses or oxygen levels with their arteries clamped down against the blood loss and the cold. We start IV's while continuing the cutting and stripping off of clothes. It's absolutely imperative to search for bullet or shrapnel wounds wherever they may hide. One missed bullet puncture on the back can mean the difference between life-saving surgery or death. Silver foil space blankets are spread over the near-naked soldiers while their muddy clothes and boots are pushed into plastic bags. Once, a grenade was found in a pocket. We have a wooden box outside the hatch for weapons. It's important to disarm wounded soldiers because, in their confusion, they can make bad choices. Passports, ID's and cell phones are garnered from the filthy wreckage of uniforms and saved for them in clear plastic baggies. We have to assume that each of these men will survive, and when their immediate threats have passed, they will want their stuff back – the things that make them men, not just casualties.

One of the soldiers has a lung that's collapsed and bleeding inside his chest from a bullet wound – a bullet that ripped a neat hole through his upper arm before penetrating his chest and then glancing down toward his diaphragm. The Russians often use AK74's – an updated version of the AK47 that shoots a smaller but faster bullet. The kinetic energy of these projectiles more than makes up for their size. This means that the permanent wound channel may be narrow, but the shock damage to the tissues surrounding that wound tunnel can be fearsome.

Our hand-held digital X-ray machine has already produced, within seconds, a high-resolution chest X-ray. As suspected, he has a pneumothorax, or a collapsed lung.

There's also bleeding inside his chest – a "hemothorax". He has two life-threatening threats inside one chest. Our surgeon hurries to numb up a quarter-sized area on his side as the soldier gasps for breath, before making a cut above one of the ribs and then sliding a chest tube into the empty chest cavity. A woosh of air and blood course out through the tube. Success. Now the end of the tube is attached to a device that lets air and blood out, but no air in when the soldier takes a breath. With the chest tube in, the lung re-expanded, and a way for excess air outside of his lung to escape, it's now safe for me to put a breathing tube down his throat and give him positive pressure breaths from my anesthesia machine and ventilator if he needs to go to surgery. Had I done that prematurely, I would have made his collapsed lung and air trapping even worse – perhaps killing him. In our trade, timing matters.

Thankfully, he doesn't need to go to the O.R. That decision is made by another doc who has scanned the soldier's abdomen with a small, hand-held ultrasound in what is called, by acronym, a "FAST" exam. No blood, spilled gut fluid, or air is detectable in his abdomen. He'll be packed up safely and shipped out within minutes to a traditional hospital further away from the front. We are a "surgical stabilization" trauma hospital. That means we don't do definitive surgical repairs. We cannot afford to tie up our only O.R. with long or non-life-saving surgery. We never know what may come in through the hatch next. Thankfully, out surgeons understand that priority and they are prepared to restrain themselves from doing all the surgery that their hands want to do. Not everything that can be done should be done. Not in a place like this.

It's a different story for one of the other soldiers. He looks like he's about 20. Thin, fit. Maybe Special Operations. I don't know. His uniform has been cut off and he's wincing in agony. His right leg, from the knee down, is pointing in the wrong direction

and hanging on by threads. A crude dressing covers his head and left eye. He'll need to go to the O.R. That means I'll be taken out of play as an extra emergency room doc with the other casualties and will have to focus on one and only one patient: this kid. So will our surgeon. And our O.R. tech ("scrub nurse"). And our circulating nurse, who will need to be available to find and open surgical instruments and other items to hand over to the surgeon and his scrub. That translates into four members of our team taken out of E.R. service during the casualty surge for the duration of the surgery. Thus, the imperative of doing only absolutely necessary, lifesaving, surgeries. And doing them fast.

We rush him back to the O.R. and slide him onto the surgical table. Before I put him to sleep, we grab a translator and say a quick prayer for him. This is important. It may the only time that these soldiers have ever had someone pray for them. We don't know. God knows. God cares. Then I put him to sleep and intubate him, using a special device to place the breathing tube that I purchased back in the States and brought to K9 for cases just such as these. It's called a "McGrath video laryngoscope", and it's already proven itself by saving patients with difficult airways back at K3 in October. The McGrath is an old friend, and I'm grateful that he's along for this ride, too.

The kid's leg is amputated right at the knee (a "disarticulation", as it is called), but the tissue damage is so extensive that the definitive stump repair, which will be performed days later at a larger hospital, will likely have to be at a higher level – probably mid-thigh. We hope and pray that he will get a good prosthetic. Legs don't grow back, and he has a whole life ahead of him after Ukraine wins this war. Our circulating nurse removes the severed leg (now called a "specimen") from the O.R. No matter how much of this stuff you do, the sight of a severed limb is always discomfiting.

The news about his eye isn't good, either. The same ultrasound that searches out abdominal injuries probes his orbit. There's not much left.

I wake him up and remove the breathing tube. We roll him back into the E.R., which will now also serve as a recovery room. Our team has patched up and repaired the shrapnel wounds in our yellow patients and several of them have already been transported away to secondary military hospitals. It is astonishing how fast the military and ambulance corps people respond to our transfer requests, show up in the cold outside the hatch, and cheerfully receive our post-care soldiers. Days later, I would actually transfer a patient in an ambulance within five minutes of waking up and being extubated in the O.R. Like so many other things at K9, you shouldn't try this at home.

Fully awake, our young soldier points down to his leg. He makes a chopping motion with his hand while he questions me with the expression on his face. I nod. Then he points to his eye, which we have re-dressed while he was under. At that point, I didn't know the daunting result of his ultrasound exam, so I simply shake my head to indicate that I don't know. A translator is now at the bed. Tears streak down from the soldier's one intact eye while he cries out something over and over again in Ukraine.

"What's he saying?" I ask.

The translator, taciturn as ever, replies, "He's saying that, because of his leg, he couldn't help his buddies. They died." Then the translator adds, "He's very upset."

I have no words. I take the kid's shoulder in my hand and look into his eye.

"Tell him that there was nothing he could have done for his friends," I say. "Tell him that it's a miracle he's alive."

Then I look straight at the interpreter. "Tell him …" I try to keep my voice steady, "… Tell him that he's a hero." *Heroiam Slava*.

Only minutes later, the ambulance transport arrives. Two combat medical staff duck their heads and enter through the hatch. Both are in full battle kit – soft armor, ballistic plates, helmets, coms, med kits attached to their chest rigs and belts. One is a young woman. Pretty. Her name is Olga, and she's a doctor – an anesthesiologist like me – a Ukrainian who's volunteered her time, and perhaps her life, to serve on the ambulance transport crew at the front. We'll see a lot of Olga in the weeks to come. She's always smiling, even amidst the gore. Those smiles mean a lot to our wounded soldiers. They mean a lot to us.

We receive a few more waves of casualties that day. Between those waves, our paramedics and nurses mop the blood and mud from the E.R. floor and fuss to make it spic-and-span again. They obsess over this. I'm glad they do. I wash the blood off the anesthesia equipment after a case. Then, if we have time, we pull chairs into a circle in the E.R. and debrief. This includes not only the team of a dozen Americans and Canadians, but also our three Ukrainian colleagues, who are academic and clinical all-stars in their own country. There is always lots to debate, to second-guess, and to rehash. It's like untying a Gordian knot to work through all the medical lessons learned and the delicate international diplomacy at the same time. So, in the middle of one unnecessarily long debrief, our surgeon simply cuts the knot by standing up and wandering off, not to return. Everyone takes the hint. Talk is important, but, in excess, it can also be destructive to our cohesion – to our mission.

We're not always up to our elbows in blood. There's some downtime, too. Time to read, to talk, to joke, to play Scrabble. For my part, I can't help but to teach, so I ask Nate, our jack-of-all-trades, to install a whiteboard in the O.R. so I can give a few lectures on trauma physiology.

Along with K3, this is our second month now living without cell phones or any other electronics. Our team leader and our security guy have secure coms with the outside world, but we're limited to a once-a-day brief missive home to our families via a circuitous email chain that includes word-for-word censoring for security purposes. That's for a reason. Both armies have used cell phone geolocation to target their missile strikes. And we don't trust that the Russians will spare us just because we're medical. In fact, while we're at K9, our team at K3 had to permanently evacuate after intel was obtained indicating a specific threat, including K3's coordinates. The irony didn't escape us, however, that our team may have been one of the only groups of people in the world without cell phones. Instead, we talked to each other. It was a wonderful change from the electronic disconnection of modern life.

Nate, the paramedic from Colorado, decided to test the boundaries of our communications censoring. Amongst many other things in his young life, Nate had worked in Asia and the Middle East, transporting kids with congenital heart problems from places as difficult as Afghanistan and Syria, to hospitals in Israel. As such, he's a polyglot. Not just a polyglot, but a polyglot with an impish sense of humor. He sent one email home to his wife that was composed with a combination of Arabic, Hebrew, Kurdish, and Farsi. And, course, Mandarin, since his wife's originally from Taiwan. Our security people back home send a reminder for us to keep it to English. Oh.

It was also Nate who, during downtime, taught me to pick locks. What piqued my interest, though, while I was picking padlocks, was the fact that his leather pouch of lock picking tools was so seasoned and so worn. This was no idle hobby for Nate. Nate's reply to my query about that was somewhat … evasive. And he's so mild-mannered. Only on a DART do you meet people like this.

The cold war-era school building that houses K9 is four stories high and constructed with thick masonry walls. The story above us (the second story, as we refer to it, even though we're in the basement) has a bathroom featuring simple holes in the concrete floors and one toilet stall that requires buckets of water to flush. It was always cold and dark up there. And the colorful posters on the walls depicting safety drills and cheerful pictorial lessons for primary school kids only make it creepier somehow. We need to use our headlamps to navigate the pitch-black stairwell to get up there.

One day, I decided to explore the upper floors. Two of our Ukrainian colleagues disappeared up to the fourth floor to work out in a makeshift gym, and I wanted to explore around a bit. I didn't get very far. It was freezing and I wasn't dressed for it. At least that was my excuse. The fact is, I was surprised by an ancient leathery watchman who appeared out of the dark. He was as surprised to see me as I was to see him. He spoke no English, and, except for my attempt at a Ukrainian greeting, I spoke nothing that could have been understandable to him. I don't know who employed him (I don't think it was us), but he apparently lived up there. Somewhere.

We had two port-a-poddies outside the side blast door. They were beyond the reach of the building's safety, and they were freezing cold and hygienically disgusting, but most of our team, especially the three women, preferred them to the dark, lonely trip upstairs.

The days and the weeks passed quickly. Casualties came in bunches. We saved lives. We changed lives. We served, I hope, as a good witness, not only to our wounded soldiers, but also to our Ukrainian colleagues. They chose not to participate in our 15-minute morning "devotionals" (where we would volunteer on a sign-up sheet to give a short lesson on something from the Bible or something from real life, which are, of

course, ultimately the same thing) or prayers. But during side conversations with Leo, several of us came to know that he was distressed with the state of his own agnosticism and was honestly seeking answers from these strange North Americans who seemed to actually know this Jesus Who we pray to and talk about, and His Father, personally. Of course, none of that would have mattered to him if we weren't good at what we did, and also willing to be where we were. That's the beautiful thing about DART.

One night, we watched one of the five movies that had been downloaded on the secure laptop. We chose, for some unfathomable reason, "*I am Legend*" with Will Smith. Under the best of circumstances, that post-apocalyptic horror movie will keep you on the edge of your seat. But here we were, watching it in K9. At night. Surrounded by Russians and their percussions. And faced, daily, with the injuries and deaths that came at the hands of the evil Wagner mercenary group, the same as populated parts of occupied Ukraine with torture chambers and mass graves, and who now led assaults only miles away from us.

All this would have been bad enough if it wasn't for the Woman in White. Earlier that day, our team-lead Pete reported that, while walking upstairs on the second floor, he was suddenly startled by the sight of a young woman who was dressed entirely in white. She was bloodlessly pale, and she simply stared at Pete without speaking. At first, we thought he was only joking. After all, this sounded like something out of a bad movie. And it only took our snarky team a few seconds to make references to twins holding hands or little boys riding their tricycles – as in the even creepier movie, "*The Shining*". But Pete wasn't joking. There really was a Woman in White up there. After our nervous laughter subsided, we reassured ourselves that she was probably only the daughter of the watchman. A human, not a ghost. Then our viewing of "I am Legend". After the

movie, I wondered aloud whether our team, and its setting, would make for a perfect Michael Crichton novel. Or, perhaps, a Stephen King horror story? King won the vote.

The days and weeks churn on, and so does the war machine. And the casualties. There is a rhythm even to war. Most of our wounded come through the hatch in the late morning or the afternoon. We're all creatures of habit, and we adapt our expectations to those rhythms.

"Boom!"

That's how fast it happened. No warning. It was a Wednesday morning at 10:30. We had finished devotionals, split into separate clinical and non-clinical teams, briefed accordingly, tended to our supplies in anticipation of incoming casualties, then scattered ourselves around the hospital.

A few of our team are in the kitchen. The rest of us are in the E.R. and O.R. area. Thankfully, no one is upstairs. Or in the hallway. Or in the makeshift bucket shower room at the back of the building. Or in one of the port-a-poddies outside. Or in one of our own ambulances parked at the side of the building. Or repairing the new generator outside. Or walking, as we were wont to do on a nice day like this, if we didn't have casualties, around the perimeter of the building - next to an old missile crater out back that had caved in the top of an even older cold-war era bomb shelter.

A missile strike is a strange thing. A startling thing. There is no warning. Like an earthquake, your whole world shakes right after the deafening crack. Everything shakes. The floor, the ceiling, the walls, your chair, your teeth, your bones. On the side facing the blast wave, your eardrum compresses. It hurts. Your head compresses a little, too – leaving behind a dizzy, dull ache to accompany the ear.

"Direct hit" we mouth to each other, wide-eyed. We have grown accustomed, during the past weeks, to the sound of intermittent artillery and missile strikes, as well as to the sound of outgoing ordnance. Occasionally, we will feel enough of a vibration to comment. "Close one," we'd observed casually. But this one was different. It wasn't just close. It was *on* us. An odd emotion, but true: you feel angry, you feel like your *work* has been destroyed. You feel more violated than scared.

"Boom!" A second strike – five seconds later, and even more shattering than the first.

We run into the hallway. There's so much dust and blast residue in the air that, even with our headlamps on high beam, we can only see a few feet ahead. Are our teammates at the other end of the hallway - the ones who had been in the kitchen - safe? Is the kitchen where we last saw them even still there?

Pete, who, as our leader, always has the whole team as his number one priority, wades through the dust and debris toward the kitchen, calling out to Joy, his wife, who had been in the kitchen. We work our way past a steel blast door that has been hurled across the hallway. Plaster and broken glass crunch under our boots. We make it to the kitchen just as Joy and the remainder of our team emerge from the dust and the soot. Grateful that our entire team, including the Ukrainian doctors and our national translators and helpers, are accounted for, our security lead Luke moves toward the stairwell upstairs to check on the watchman and on the Woman in White.

I offer to go with Luke, but he objects. This is the time to consolidate, not to scatter. Luke doesn't find the watchman, but he did find the Woman in White, mysterious as ever (*more* mysterious than ever) sitting quietly at a table on the second

floor, surrounded on all sides by debris, sipping a cup of tea. Was she shellshocked in general? Was she shellshocked just now? Was she …?

Luke leaves her and makes his way up to the fourth floor to check on our coms equipment. There is very little left of that floor. Nate sees enough of the stairwell up there to know that the building structure had taken significant damage. As a firefighter and search-and-rescue professional, Nate knows that the structural integrity of stairwells indicated the structural integrity of the building as a whole. Our stairwell is twisted and in shambles.

We have our body armor and helmets on within seconds and have already fetched our go-bags. Now the decision from Pete and Luke: evacuate in 3 minutes, or wait for a secondary strike? The Russians will sometimes hit a target with one or two primary strikes, then, when first responders arrived, hit them again.

It appears that most of the damage is on the East side of the building – no surprise since that's the direction facing the front. But the hallway is the most reinforced part of the basement, so that's where we muster.

One of our pre-planned evacuation vehicles (an ambulance) is destroyed. Another (a Sprinter van) has a dead battery. Nate runs up and outside to jump start it while Pete and Luke do their best to communicate back to North Carolina that we have been hit, that everyone is accounted for and unhurt, and that we are evacuating. With the damage to the equipment on the fourth floor, though, nothing is getting through.

The word "evacuate" makes us cringe. We had spent a hard month doing hard work, tending to the bodies and souls of many wounded soldiers. We had proven ourselves to the Ukrainians like no other NGO had, and we had been granted unprecedented access to their casualties – civilians at K3, and now soldiers at K9. We

didn't want to abandon it all. But, like it or not, we are done. This twin strike was no accident. We were not innocent bystanders. This was deliberate. This was targeted. Even if the physical infrastructure of K9 could be restored, it is no longer a safe haven. It is a target. So are we.

While we wait in the hallway, our Ukrainian colleagues show up at our side. Out of nowhere, my anesthesiologist counterpart has donned full battle kit, his chest rig bristling with 5.56 mags. No more pretense. These are Special Operations guys, not just doctors. He holds a thick piece of shrapnel in his hand for me to see. It's from a missile. The Ukrainian surgeon takes me aside and shakes his head, looking at the debris surrounding us. "This was inevitable," he said. I nod. Of course it was.

"Unpredictable but inevitable" I have remarked many times to Katherine, my filmmaker and novelist daughter, offering her unsolicited advice about what makes a good story.

I give Andre a quick bearhug. He's not the hugging type. Neither am I. We both understand. We will probably never see each other or work together again. It has only been a month, but one of the most intense, and intensely satisfying, months of my life.

Our evacuation vehicles dash away. For once, there is nothing to do but to sit and think while the pockmarked countryside rolls by and Luke hangs out our side door, trying to get a fix on his sat phone. No luck. It seems the signals in our area are jammed today. Pairs of Ukrainian fighter jets streak overhead. I don't know whether to smile or to cry. There will be no more doctoring. No more tending to the wounded. Not for now at least. God has called us to this strange place and to these brave people. He has let us do good work at K9. A lot of work. He has protected us. He has protected our Ukrainian friends. He has protected our heroes. *Heroiam Slava!* And now, He is bringing us home.