Bloody reality

Last year, the artist **David Cotterrell** went to Afghanistan to observe the work of military medical staff at the main field hospital at Camp Bastion. His diary and photographs, now on show in London, are a harrowing reminder of the cost of war

03/11/07 Leaving Brize Norton

05.25: Waiting in departure lounge of RAF Brize Norton. After wake up call at 04.00, breakfast at 04.30, I have successfully checked in for my C17 transporter flight to Kandahar. I am the only passenger.

Dressed in combat trousers, desert boots, body armour and with a 20kg bag as hand-luggage, I am relieved to be ready and in the right place. [. . .]

At 06.30, I am called to board the RAF C17. A small woman appears, looking flustered, and suggests I follow her . . . The crew are already aboard. I am led up the steps of the squat plane and motioned toward one of the canvas jump seats fixed to the side of the fuselage . . . Half a million rounds of palletised ammunition is cargo netted around me.

04/11/07 Arrival at Camp Bastion

I find myself sitting among a squad of Royal Marine Commandos. They appear incredibly young. One of them, who looks like a teenager, is wearing a commando knife in his chest webbing. It is hard to reconcile my recognition of this student-aged man with the 8in blade fastened at the ready on his armour. After a strange, propeller-powered 45 minutes I wake to realise that we had all been lulled into a fitful sleep by the drone of the engines. [. . .]

The ramp opens to reveal the orange light of Bastion. The sun is setting and vast amounts of dust have been thrown into the air by the landing. The diffused glow of the sun appears to ignite the sky. In the distance I see a burning plume of smoke (apparently the 24-hour waste fires).

05/11/07 First briefing

At 07.00, the lights in the tent crackle to life. I am surrounded by activity. The shower block "ablutions", like everything else, are semi-communal. I feel conspicuously unfit and I try to pretend that my ponytail is not noticeable. [. . .]

I have an invitation to attend the "ops" briefing at the MED GRP CP. Acronyms describe all units, events and places. I imagine the briefing is confidential, but even if it weren't, I would need a code book to decipher the language of common usage. "Enhanced threat of VBIED reported by RC FOB Delhi" = Enhanced threat of vehicle-bourne improvised explosive device reported by regional command, forward operating base Delhi. [. . .]

An insurgent has been captured and MERT [the medical emergency response team] have brought him for treatment. It seems that he was a suspected mortar commander and has been shot in the leg. We photograph the helicopter approaching and find ourselves coated in dust as the Chinook "wheels down" (WD).

The suspected Taliban fighter is blindfolded and searched carefully with metal detectors before being allowed entrance. A team of about 10 people is waiting. Notes are taken in triplicate as x-rays are taken digitally and he is stripped and prepared for surgery. The wound is not life-threatening and within 10 minutes he is being wheeled, already sedated, into theatre.

The MASH-style theatre is an amazing venue. Under canvas like the rest of the hospital, the theatrical lighting of the operating spotlights adds to the incongruity of surgeons with blue gowns over Disruptive Pattern Material (DPM) camouflage uniforms. We stand well back beyond a striped line on the floor, attempting to understand from a distance what is happening in the bubble of intensity at the far end of the dome tent.

06/11/07 First operation

At 10.00, a nine-liner starts to come through the "Jchat" system: a T1 casualty (meaning evacuation needed within an hour or less – life threatened). I rush to my tent to assemble a selection of lenses. I feel a little vulgar; my role is sinister, an ambulance chaser with a camera. I am here [sent by the Wellcome Collection] to consider "War and Medicine" – the role of healthcare in combat. I have never been in the military and have never seen an operation. I am a trauma tourist desperately trying to justify my role – to others but, more difficultly, to myself.

By 11.00, the helicopter has not returned. I begin to hear little bits of news. The casualty may be in a minefield. It will take at least another hour for the other soldiers and engineers to inch their way toward him. He has self-administered morphine and is conscious. I find it impossible to imagine: two hours with a mine injury awake and unable to move. At 13.00, the Chinook finally arrives. As it swings on to the HLS [helicopter landing strip], the sand washes over the waiting Land Rover ambulances, and medics run from both vehicles to meet and make the exchange. The soldier is wheeled across. I watch from a distance with a telephoto lens. By the time I have walked past the quartermaster's office to the entrance, the ambulances have arrived. As always, a crowd of some of the NHS's most highly paid and skilled consultants are waiting in DPM clothing.

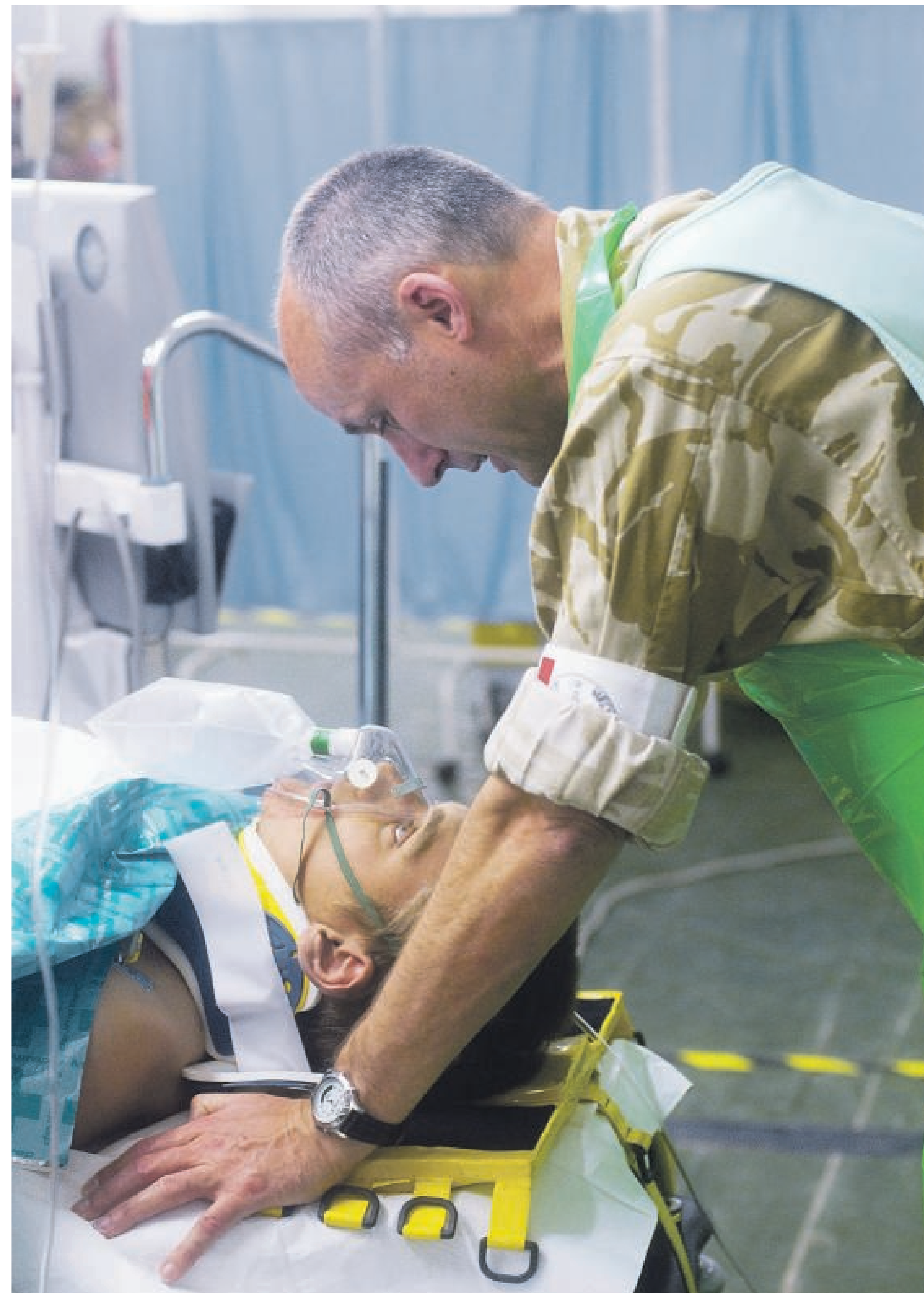
He is taken to Resus. Awake, in pain and bloody. The doctors adopt varying roles. One doctor stands with a nurse and an administrator at a lectern taking notes of every observation. Others direct the x-ray team, manage the unwrapping of the field dressings, check the vital signs, look for internal bleeding and try to calm the soldier. He is young; I suspect, a Commando.

His right leg has been bandaged in three field dressings – each one can absorb a litre of blood. His foot is unwrapped and clothes are cut away. It strikes me that all the kit fetish that follows the FOB [forward operating base] postings is discarded. The boots, the webbing, holsters and DPM are cut into pieces, and deposited into a black plastic bag for incineration.

The most obvious injury is to his foot. Bone and flesh hang from its centre. The heel protrudes about 2in below the base of his sole. The x-ray explains. There are no fragments of shrapnel. The force of the blast has travelled through the armoured vehicle into his foot and, with devastating effect, has forced the bones from the base of the foot upwards. The neat lattice of bone and tendon has been rotated and pushed away from his heel. The anaesthetist is beginning his work. The soldier keeps shouting "Sir!" as he deliriously looks around "Don't take my legs," he appeals. "Have I got my legs?" He doesn't believe the doctor who reassures him.

I find myself cold and sweating profusely. I struggle to stop myself fainting. I must not faint.

»



A patient is given some comfort as he arrives in the field hospital's resuscitation unit

His right leg has multiple fractures and the knee is crushed. His left leg is also broken.

He is still conscious as they wheel him to theatre. The surgeons wear gowns over their DPM and plastic covers over their desert boots. The soldier is put to sleep, and intense but unhurried activity takes place to untangle the mess of bone and skin. Pieces of bone come off the base of his feet in the surgeon's hands. He cuts away the last bits of muscle and skin symbolically attaching the bone fragments to the soldier and places them in a steel tray. The foot is emptied of dead tissue and takes on the form of a near empty bag of skin. The toes are still attached and have the appearance of some remaining circulation. I pray that the surgeons will decide that the foot will survive.

Despite their appearance, the surgeon suspects that they are no longer salvageable. One of the doctors suggests to me that the best case for him will be to lose the lower part of his right leg. I listen quietly but am horrified.

By 15.30, the operation is nearly complete; the wounds are left open and packed with gauze. No amputation will happen here. They will allow the soldier to return to Britain as he is. The decision will be made in Selly Oak. Two more injured patients are waiting for theatre.

07/11/07 Loss of momentum

I feel dislocated and aimless. I am not certain if my anxiety comes from my ethical fears of delivering a facile response or from the thwarting of adolescent fantasies. I am not certain of my own intentions.

08/11/07

Two Afghan children and their dignified elderly-looking father appear from the ambulances. I am struck by how beautiful they are. The son has shrapnel to his face and is in pain. The daughter has a wound to her leg and looks like aliens have abducted her. She is wide-eyed and confused. All three are covered in a thick layer of desert dust. I leave them as they are stabilised in Resus, unable to face another operation so soon.

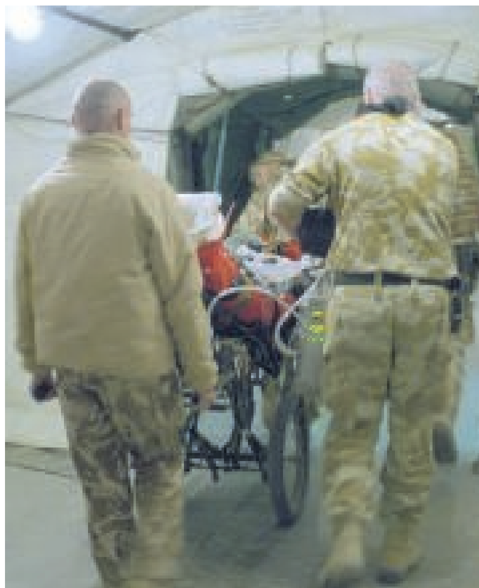
09/11/07 Major incident

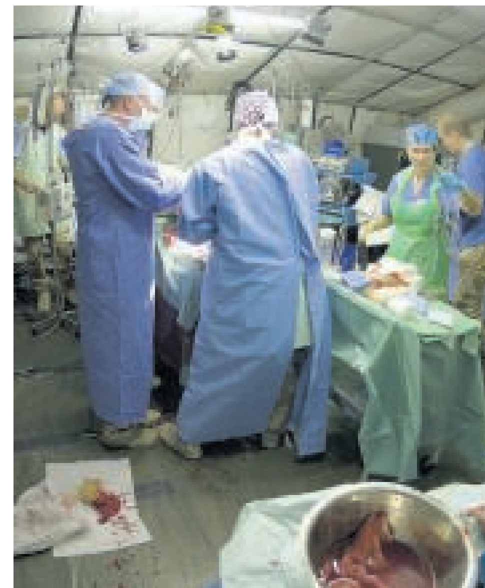
At about 16.00, the hospital fills. Clerks are rushing to don surgical gowns. Rumours are spreading. Hell at Inkerman (commonly renamed as "Incoming"): 2 T1s, 2 T2s + 1 T3. A "major" incident is declared. Eight more wounded may also be on their way. There are only two theatre teams.

This is the first major incident "mass casualty" for the hospital squadron. It is what they have trained for, but there is some uncertainty as to the point at which capacity will be reached.

In Inkerman, the landing zone is still hot. The Apaches have spent 20 minutes attacking fire points before the Chinooks can land. Eventually, we hear the sound of the helicopters and in less than a minute, ambulances begin ferrying patients.

Leg and chest wounds. I notice two men's chests displaying the flutter of Asherman chest seals rhythmically rising as air escapes their collapsed lungs. One of the soldiers is wearing two CAT (combat application) tourniquets and has had his boots tied together, trapping an improvised splint. The beds in Resus fill.





Clockwise from top: **a helicopter arrives at Camp Bastion; surgeons operate on a mine strike victim; evacuating a patient to Kandahar**

X-rays, clothes cut away. Cleaning away the dirt of battle and consultants comparing notes. MERT medics arrive, covered in dust and in full body armour, to brief the Resus staff. They appear as if parachuted into A&E.

Periodically, the senior medics pause and convene to compare priorities. I am impressed by this restraint. A scene of violent injuries is dealt with in a strange, professional way. Any one of the cases would be life-threatening. Here they seem to be received as routine.

The first priority becomes visible. As the clothes are cut away, the bizarre and gory scene is unwrapped. There is a gap in his legs. His thighs appear missing. I feel sick, as I mistakenly fear his groin may have also been destroyed. Bloody rags and gauze are piled around his legs and in the distance I see figures frantically attending to his mangled body.

I withdraw to meet the surgeons grabbing one last cigarette before the casualties become their charge.

10/11/07 Captain Britton

Captain Paul Britton is scheduled [for surgery] later that morning. He was wounded at Inkerman and evacuated with shrapnel embedded in his shoulder and hand. He had been injured at the same time as last night's casualties, but had refused to leave his squad. A fire-support commander, he had been in charge of a small (now depleted) team controlling mortars, air-strikes, artillery and Javelin surface-to-air missiles.

Britton has a shaved head and full beard. [The surgeon] asks him if he minds being filmed. The response causes hilarity among the nurses: "Just make sure he gets my good side."

I set up the camera and step back. I can't face another operation and leave as the camera observes for me.

10/11/07 Padre

I pass the tent chapel and a padre jumps out. "I've been looking for you," he says. "I believe you came to see me earlier when I was out." It is true that I had found myself wandering in to the church a few hours earlier. In a slightly maudlin moment I had heard music and followed it inside. It is a cliche to seek redemption and faith in times of fear or trauma. I was feeling both and had found myself enacting the stereotypical route to religion.

10/11/07 CCAST

The mass of lines and tubes almost conceals the mummified soldier. The bulk of the equipment fights against the confined space of the ambulance. Five medics gingerly slide Fletcher's life-support equipment past the snags and handles of the Land Rover ambulance. I sit in the front and we move off at the regulation 15mph. [. . .]

During take-off and the flight, I am struck by the kindness displayed by the nurses in armour. Even Fletcher is reassured and comforted in his fitful sleep.

We descend in darkness to Kandahar and as the ramp opens we feel the aircraft spinning around. A majestic sight comes into view. The open ramp of a C17 is waiting, framing an illuminated strategic team. The C130 backs up to its larger sibling until 50 yards of ashphalt separates the two worlds of tactical and strategic care. [. . .]

Standing on the runway between these two great transport aircraft, I watch the stretchers being ferried across, illuminated by an honour guard of ambulances and Toyota pick-up trucks. I feel a strange sense of calm as the patients, strapped into the stretchers and protected by an assortment of Day-Glo equipment, are received by the C17 strategic CCAST [combat medical technician] team. I feel that some of the tension has passed away. They are crossing a threshold on the runway between combat and care. Their guilt about leaving the friends and duty, which appears so present at Bastion, seems to be left in the Hercules. As the stretcher crosses the halfway point between craft, it crosses a threshold. The gravitational pull of home overtakes the longing for the immersive FOB community. Powerless to resist, there is no shame for the soldiers. Their injuries answer any inquiries. The comfort, care and cleanliness of the civilian world beckons. The CCAST envoys welcome their cargo, outnumbering the patients three to one, and envelop them in the warm light of the C17 cathedral.

The medical team deals with civilian casualties as well as military

Postscript

During my month-long stay in Helmand, two British soldiers died, 29 were wounded in action and there were 74 admissions to the field hospital. Seventy-one Aeromed evacuations were recorded and an undisclosed number of civilian, insurgent and Afghan National Army soldiers were treated. I arrived back in Britain feeling a great sense of anger. I was frustrated by my previous ignorance of the frequency of injury. Soldiers are surviving wounds that would often have been fatal in previous conflicts. Body armour, medical training and the proximity of advanced surgery to the front line have led to a "disproportionate" number of casualties surviving. In the media, we hear only about the deaths, with occasional reference to the wounded. I came home assuming the violence I had witnessed in Afghanistan would be the focus of the news. But reality television, local politics and other less dramatic events occupied the headlines. For me, the incongruity between what I had seen and what was presented as the public face of conflict was, and continues to be, profound and irreconcilable ●

War and Medicine is at the Wellcome Collection, 183 Euston Road, London NW1 until February 15. Details: www.wellcomecollection.org/war-medicine

On the web
In pictures: View more photographs from David Cotterrell's Afghanistan trip
guardian.co.uk/world