

Guerilla Surgeon

A Thing of the Past or Warning to the Future?

Rogers L. *Guerilla Surgeon: A New Zealand surgeon's wartime experiences with the Yugoslav Partisans*.

Collins: January 1, 1958. ASIN: B000S5M92O. Hardcover.

Review by Regan Lyon, MD*

Indigenous forces were crucial to resisting and combating ongoing and overwhelming invasions. The front lines of forces were blurred, making freedom of movement of outsiders near impossible. Areas of conflict were unpredictable, and retribution for collaborating with the opposing force was a real threat. Even hospitals were targets, despite medical neutrality described in the Geneva Conventions. Medical supplies were always a rare commodity, and prolonged care by medics with extra training were the rule rather than exception.

While this may sound like a description of current conflicts in Syria or Africa, *Guerilla Surgeon* is a fascinating recount of battlefield medicine in Yugoslavia in World War II. Referenced in the previously reviewed work by COL William “Rocky” Farr titled *Death of the Golden Hour and the Return of the Future Guerilla Hospital*, this provides a reminder that our lessons from the past deserve attention as we prepare for future conflicts.

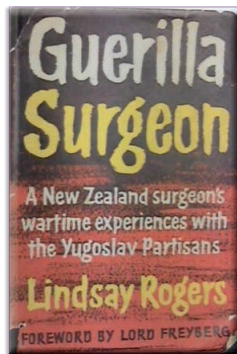
The author of the book, Dr Lindsay Rogers (1901–1962), was a New Zealand native who completed medical school at Otago University and trained in surgery in London. In 1940, he joined the British forces to help defeat the Nazi Germany expansion. Although originally assigned to the Eighth Army in Northern Africa, he believed his services were best warranted closer to the point of injury in regions with poor medical coverage. Rogers volunteered for the Special Operations Executive. After months of specialized training, he and a couple of nonmedical enlisted troops were sent to Yugoslavia to provide surgical care to Yugoslav partisan guerrilla forces. His guerrilla surgeon narrative brings perspective to the reader on working with partner forces and the unique challenges of guerrilla medicine.

As any medic who has deployed in current conflicts knows, integration with partner forces is paramount to mission success. Our operational forces work hand-in-hand with the partner nation in training assault forces on basic soldiering skills. However, a lack of trust from the partner force makes these efforts futile. Although he was assisting partner forces to set up a medical network, the stories shared by Rogers reiterates the need to earn the trust of locals. Understanding their customs, language, limitations, and grievances helps to put into

perspective their priorities and motivations. As medics, we can help foster that trust by advocating for appropriate medical care for their casualties. After all, as Roger’s stories reinforce, the majority of casualties were suffered by the partner force.

The unique operating environment of guerrilla warfare plays a critical role in medical support to the forces. Restricted freedom of movement, logistical conundrums, reduced “footprints,” and reliance on partner forces all shape clinical practice in such conditions. The lack of freedom of movement is the hallmark of guerrilla warfare and impacts the movement of patients, medical supplies, and sustenance. Rogers’ vivid stories emphasize the reliance on prolonged field care by medics and partner forces due to the inability to evacuate patients to more definitive care. He also highlights the need for medical supply caches to store items for resupply or for a hasty hospital relocation. Rogers constantly worked to decrease his hospitals’ and supply caches’ signatures to the enemy, relying on the partisans for movement of patients, supplies, and communication with headquarters. The reduced medical “footprint” in the area also required the training of partisan “medical students” and nurses, establishing a network of guerrilla hospitals to overcome the challenges

of the environment. In the 254 pages of astonishing stories and descriptions of conflicts, patients, and partisan friendships, Rogers describes the practice of medicine in guerrilla warfare. His observations of modifying medical decisions based off reduced resources, prolonged evacuation times, and limited local medical capabilities are eerily familiar to practice in current theaters of operation. While his experience is from World War II, he highlights recurrent themes seen in the history of battlefield medicine and demonstrates that the nature of guerrilla warfare and medicine has not changed. COL Farr asserted in his manuscript that future operations will require the resurgence of guerrilla medicine and acceptance that “the golden hour” is a concept of the past. However, few active military medical personnel have experience in environments with denied freedom of movement or evacuation capabilities. As we look toward conflicts on the horizon and great power competition, we should consider the past lessons of Rogers with the Yugoslavian guerrilla force in preparations for casualty care.



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