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EFFECTS OF MECHANIZATION ON EVACUATION.

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The suggestions made by Major F. M. Richardson, R.A.M.C., in his letter in the Journal of the Royal Army Medical Corps for July, 1938, raise some very important points.

It will be of interest to consider first how the present arrangements and constitution of medical units came into being, and then to discuss the principles that underlie our methods of evacuation.

These are developments from the past and are the legacies of horse transport and hand carriage.

At the time of the Boer War, the field medical units were bearer companies, and field hospitals. This was found to be an inefficient arrangement, and after the experience of this campaign, the bearer companies and field hospitals were amalgamated to form field ambulances, while a new unit, then called the casualty clearing hospital, was introduced. These arrangements were still based on horse transport and hand carriage, the slowness of which necessitated attention to the wounded on the long passage from the R.A.P. to the casualty clearing hospital. Hence the institution of the A.D.S. and M.D.S., where patients could be put into fit condition to withstand the slow, jolting journey to the C.C.H., and where they could wait until the transport arrived. Hence also a theory that
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is still held by many, which is rank heresy in the present day of M.T. This theory is that you must take the doctor and attendants to the patient and not the patient to the medical attendants. To implement this idea, the suicidal policy of pushing the A.D.S. as far forward as possible resulted, with the consequent casualties among medical personnel which, at the end of any great war, is practically irreplaceable, and the infliction of further wounds on an already wounded man.

This opinion is no longer tenable or even justifiable. The motor ambulances can work well ahead of the A.D.S. so that the bearers have a short carry and the casualty arrives more quickly.

In this connexion, one misses the "light" motor ambulance of the Great War establishments. This was so useful for such forward work that one can only lament its disappearance.

Under the present arrangements, the casualty can have no fewer than seven changes of transport:

1. Collected on stretcher by regimental stretcher bearers.
2. Transferred to field ambulance stretcher at R.A.P.
3. Placed on wheeled stretcher carrier at bearer collecting post.
4. Placed on motor ambulance at forward car post.
5. Unloaded at A.D.S.
6. Unloaded at M.D.S.
7. Transferred to M.A.C.
8. At last arrives at C.C.S.

These breaks of journey are a relic of the horse and hand days, and are quite unnecessary.

The patient can be evacuated direct to the C.C.S., which has taken on more and more of the treatment of casualties formerly carried out in field ambulances, and all clerical work can be done there, where it is much more likely to be accurate than in the often cramped and disturbed accommodation usually available at the M.D.S.

The question of the administration of anti-tetanus serum which was one of the main duties of the A.D.S. or M.D.S., no longer applies, since the troops will already have been inoculated.

It is remarkable how small a percentage of wounds require re-dressing after they have been attended to at the R.A.P. Those that do require attention can, in the vast majority of cases (uncontrolled haemorrhage and severe shock excepted), quite well wait until they reach the C.C.S. In fact, it is better to leave the first field or shell dressing rather than to disturb it and re-dress the wound under conditions of doubtful asepsis.

The writer had experience of this direct evacuation from A.D.S. by M.A.C. to C.C.S. in several battles in the Great War. It proved a most satisfactory arrangement, and the casualties greatly appreciated not being
re-dressed and transhipped. The returns were made out by field ambulance clerks attached to the C.C.S., each of whom dealt with casualties from his own division only.

If these ideas are tenable, we come to the following conclusions:—

(1) That the A.D.S. should be equipped as lightly as possible, that it be regarded mainly as a collecting station and be termed "Advanced Casualty Collecting Station," and that no treatment, beyond the administration of morphia and the arrest of haemorrhage and profound shock and so forth, be undertaken.

The writer has recently seen photographs of a most imposing A.D.S. formed by collecting a number of lorries together, connected by acres of tarpaulin. On showing this to a Gunner he exclaimed, "Gosh! what a target." Reluctantly one must admit that no display of red crosses would protect such a prominent object of the landscape from destruction by those subscribing to the doctrine of "Shrechlichkeit."

It is, moreover, a tactical mistake of the first order to expose the transport of a field ambulance to a destruction which effectively removes its most important feature, mobility.

(2) The M.D.S., as such, disappears entirely, as there is no need whatever for the casualty to halt.

(3) As a consequence, the A.D.S. or Advanced C.C.S. is cleared by the M.A.C. direct to the C.C.S., thus avoiding transhipping and the organization of a divisional motor ambulance group and car park.

It does not involve removing the motor ambulances from field ambulances. They can work in with and under the control of the M.A.C. They will still be required to relieve bearers by working forward from the A.D.S., and for collecting sick from bivouac and line of march.

(4) It frequently happens that, even under existing conditions, the field ambulance can clear the battle ground more rapidly than the C.C.S. can deal with them.

The abolition of the "Time Lag" at the present M.D.S. will render this more pronounced.

In my experience the C.C.S. is understaffed, and to remedy this and to accelerate the dealing with casualties some of the personnel can be withdrawn from headquarters of field ambulances and added to the C.C.S.

This would increase the mobility of the field ambulance as there would be less personnel to be carried in the three-ton lorries.

Here arises the reflection—Why have two types of field ambulance at all? The equipment and personnel of the cavalry field ambulance and the mechanized field ambulance could be standardized on a scale suitable to the former, with the addition of three-ton lorries and stretcher bearers when functioning with the latter.
This proposal would greatly simplify matters—one set of equipment, one war establishment for both types of field ambulance.

One has the feeling that the mobile field ambulance has too much equipment and the cavalry field ambulance too little.

Again with the disappearance of the M.D.S. the war time constitution of field ambulances could be re-introduced. From the O.C.'s point of view it is much more convenient to have three self-contained sections than two companies. It makes reliefs more easy on the well-known principle “Two in the line and one in reserve.”

If detachments are necessary, the temporary loss of a section is less crippling to a unit than the loss of one company.

The re-introduction of the three sections, as opposed to the two companies, would render the unit more mobile. At present we are supposed to move our personnel in two “lifts.” One wonders if this would ever work out; sending three-ton lorries to the rear against the enormous stream of mechanized traffic moving to the front is none too easy, and we are likely to be deprived of the services of the second “lift” just when they are most required.

Another point in favour of reverting to three sections is that in the event of gas cases one section could be made to take over and deal with all such.

(5) The C.C.S. is completely devoid of any motor ambulances. In these days of bombing of back areas there are bound to be casualties for which no ambulance transport is provided—as the Non-Divisional Field Ambulance attached to Corps will probably have all it can do in the Corps area.

At present there is no provision for dealing with casualties from the masses of transport further back than Corps area. Here, perhaps, we may revive the old controversy of the mobility of the C.C.S. It should surely, under present conditions, have its own transport, even if only for the light section.

In passing, one may note how little provision for the treatment of burns exist in the authorized scales. Millions of gallons of petrol are in transport, and one explosion will lead to many burns.

(6) It is time, especially since the Royal Artillery have done so, to revise our nomenclature.

There are still many people who confuse hopelessly a field ambulance with a motor ambulance and, indeed, in common speech “ambulance” means nothing but a vehicle.

Could we not term our divisional medical units “Medical Regiments,” as is done in the United States Army, which would obviate any such confusion, or if this term is objectionable, “Field Company, R.A.M.C.,” might serve.
One medical regiment, divided into three companies (the present field ambulance), would also remove the deep-rooted idea in the minds of many that field ambulances are brigade troops and under the command of the Brigade Commander.

The foregoing ideas are put forward mainly as a basis for discussion, and it is hoped that the correspondence on this interesting, and indeed vital subject, initiated by Major Richardson, will not die of inanition. There must be many officers who have practical experience and other theories which would be interesting to all of us.

Kipling has said “Transportation is Civilization”—we may say that “Transportation is Evacuation.”